RISK ASSURANCE COMMITTEE – December 2015

Agenda Item Number:
Enclosure Number:

Subject:	Trust Risk Register
Prepared by: **Sponsored by:** **Presented by:**	Code A Acting Head of Risk Management Fiona McNeight – Associate Director of Quality and Governance Code A – Acting Head of Risk Management
Purpose of paper *Why is this paper going to the Risk Assurance Committee (RAC)?*	Requires RAC guidance Discussion requested by RAC Regular Reporting
Key points for RAC members *Briefly summarise in bullet point format the main points and key issues that the RAC members should focus on including conclusions and proposals*	RAC are asked to note • Top risks • Increase of risks 9-1516 and 27-1516 • Decrease of risk 21-1415 • New Risk 43-1516
Options and decisions required *Clearly identify options that are to be considered and any decisions required*	• Review the risks from the Trust Risk Register and consider requirement for further assurance on actions related to significant risks. • Determine any further assurance required on any aspect of the Register
Next steps / future actions: *Clearly identify what will follow the RAC discussion*	Any decisions with regard to the severity and/or removal of the risks will be actioned as appropriate and reported to RAC in January 2016.
Consideration of legal issues (including Equality Impact Assessment)?	None
Consideration of Public and Patient Involvement and Communications Implications?	None

RISK REGISTER REPORT

Purpose: To provide the RAC with an update on the Trust Risk Register as of 24 November 2015.

Top Risks

15-1415 ◄► (20): Repeated and prolonged overcrowding within ED results in poor patient experience, compromised safety and impacts on staff wellbeing.

26-1516 ◄► (20): The Trust is unable to achieve its planned year end financial position 2015/16.

30- 1415 ◄► (20): Stroke service pathway (including follow up after discharge) commissioning and provision (medical, therapy and nursing) is sub-optimal and non-sustainable in current format.

42-1516 ◄► (20): Lack of capacity in Radiography to report ED plain films and backlog in complex reporting

13-1516 ◄► (16): The Trust fails to achieve referral to treatment (RTT) access targets excluding those specific to ED.

20-1415 ◄► (16): Review of delivery of colorectal service model of care to achieve optimum patient experience current workforce instability impacting on delivery of required performance.

32-1415 ◄► (16): QA@home increases demand on pharmacy resources and expenditure and impacts on patient safety.

33-1415 ◄► (16): Inability to recruit to vacant post within the DSC post TUPE with reduced resilience for sustainability of the service due to difficulty in recruiting to a specialist area.

35-1516 ◄► (16): Lack of capacity to supply medicines under section 10 or for clinical trials from Manufacturing Unit.

39-1516 ◄► (16): Insufficient theatre capacity to meet planned demand.

43-1516 *NEW* (16): Proposed industrial action by Junior Doctors.

27-1516 ▲ (15): The Trust is unable to maintain sufficient liquidity/cash

36-1516 ◄► (15): Lack of robust identification of clinicians and doctors taking responsibility for blood tests and the lack of audit and review around filing and viewing results.

Risks with Increased Score

9-1516 ▲ (Amber 8 to Amber 12): Failure to achieve internal and external set quality/patient safety improvements – pressure ulcer incidence and patient moves increased and lack of falls nurse specialist.

27-1516 ▲ (Amber 12 to Red 15): The Trust is unable to maintain sufficient liquidity/cash.

21-1415 ▼ (Amber 12 to Amber 8): Mental capacity act (MCA) and deprivation of liberty safeguards

New Risks

43-1516 *NEW* (Red 16): Proposed industrial action by Junior Doctors.

Risks to be Removed

Nil

Target Date Changes

Nil

Of Note

HW to update risks 33-1516 and 37-1516 at RAC 30 November 2015

No update received for 39-1516

Prepared by: Annie Green – Acting Head of Risk Management

Presented by: Annie Green – Acting Head of Risk Management

Trust Risk Profile - November 2015

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Rare (1)					
Unlikely (2)			41-1516 Sprinkler replacement ***NEW***	10-1516 Unintended consequences of CIP ◄► 19-1415 Cancer wait targets ◄► 21-1415 MCA and DOLs safeguards▼ 40-1516 Fire precaution deficiencies ◄►	
Possible (3)			7-1415 Non-Luer spinal devices ◄► 22-1415 Provision of discharge summaries to GPs ◄► 23-1415 Increased vacancies and NHSP fill rate◄► 37-1516 Patient transport ◄► 38-1415 Clinical Coding ◄►	1-1415 Use of Non-Buying Solutions agencies◄► 3-1516 Healthcare associated infection trajectories◄► 4-1415 Loss/disclosure of PID◄► 8-1516 Risk of patient injury following inpatient falls / CQUIN ◄► 9-1516 Quality requirement ▲ 18-1415 7 day Working ◄► 16-1516 Data Quality ◄► 17-1415 Outliers ◄► 24-1415 Essential Skills Training ◄► 34-1516 Typing Issues◄►	27-1415 Cash Liquidity ▲
Likely (4)			11-1415 Concerns with Health Record function ◄► 12-1415 Sewage flooding ◄►	13-1516 National and local access targets◄► 20-1415 Colorectal Service model of care ◄► 32-1415 QA@H pharmacy resource◄► 33-1415 DSC vacancy and sustainability of service ◄► 35-1516 Supply of drugs from PMU◄► 39-1516 Insufficient theatre capacity ◄► **43-1516 *NEW*** Jnr Doctor Strike	30-1415 Sicke Service ◄►
Highly Likely (5)			36-1516 Review of test results ◄►	15-1415 ED queue and Trust bed capacity ◄► 25-1516 Year end financial position◄► 42-1516 ◄► Lack of reporting capacity in Radiography	

TRUST RISK REGISTER 2015/16 – PROGRESS SUMMARY – NOVEMBER 2015

STRATEGIC AIMS REFERENCE	Risk Reference	Operational Leads	RESPONSIBLE COMMITTEE	PRINCIPAL RISK (Obstacle to achievement of strategic aim)		PROGRESS MONTH ON MONTH												REVIEW DATE	TARGET DATE TO ACHIEVE RESIDUAL RISK SCORE
						APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR		
1,4	1-1415	RK	OB	Use of non-crown commercial service framework approved staffing agencies.		TOLERATE												Jan 16	12
1,3,4	3-1516	CM	ICMC	Trust fail to achieve objectives for reducing healthcare associated infections		20	12	12	12	12	12	12	12					Jan 16	12 Mar 16
1,3	4-1415	JT	IGSG	Potential loss /misdirection/inappropriate disclosure of personal data.		TOLERATE												Jan 16	12
1	7-1415	SE	MDMC	NPSA alert demands that all spinal devices are non-luer by April 1st 2012. This is to reduce risk of accidental misconnection with other, ie intravenous devices. Non-luer devices did not exist at the time of the alert		TOLERATE												Jan 16	3
1,3	8-1516	CM	PSSG	Risk of patient injury following inpatient falls due to failure to follow policy. Non delivery of patient safety CQUIN falls element		12	12	16	16	12	12	12	12					Dec 15	8 Apr 16
1,3	9-1516	CM	G&Q	Failure to achieve internal and external set quality/patient safety improvements		16	8	8	8	8	8	8	12					Nov 15	8 Mar 16
1,3,5	10-1516	CS	G&Q	Unintended consequences to delivery and quality of care due to cost improvement programme		8	8	8	8	8	8	8	8					Dec 15	8 Mar 16
1	11-1415	AF	RAC	Concerns with the condition of health records and growing issue of production of temporary sets of notes.		12	12	12	12	12	12	12	12					Jan 16	6 Jun 16
1,3,4	12-1415	JA	CCRG	Blockage of sewage services leading to flooding within departments, predominantly Paediatrics		6	6	6	12	12	12	12	12					Dec 15	6 Dec 15
1,3,5	13-1516	MD	OB	The Trust fails to achieve key local and national access standards and targets.		16	16	16	16	16	16	16	16					Dec 15	12 Jun 16
1,3,4	15-1415	GM	OB	Repeated and prolonged overcrowding within ED results in poor patient experience, compromised safety and impacts on staff wellbeing		20	20	20	20	20	20	20	20					Dec 15	12 Dec 15
3,5	16-1415	MK	OB	Quality of data produced and provided for use in internal performance reporting and for external reporting is inaccurate		12	12	12	12	12	12	12	12					Jan 16	8 Jun 16
1,3,4	17-1415	MQ	SMT	At times of high capacity decisions are made to move patients out of their specialty foot print for the provision of their care		20	12	12	12	12	12	12	12					Jan 16	12 review Jan 16
1,3	18-1415	SH	SMT	Lack of equivalent workforce across seven days of the week		12	12	12	12	12	12	12	12					Dec 15	8 Apr 16
1,3	19-1415	NM	SMT	Failure to achieve cancer wait targets		8	8	8	8	8	8	8	8					Dec 15	8 Apr 16

1,3	20-1415	NM	TB	Review of delivery of colorectal service model of care to achieve optimum patient experience		16	16	16	16	16	16	16	16					Dec 15	8 Dec 16
1,3,4	21-1415	AT	SC	Mental capacity act (MCA) and deprivation of liberty safeguards		16	16	16	16	16	12	12	8					Jan 16	8 Mar 16
1,3	22-1415	CT	RAC	The Trust requirement to use Vitalpac to generate an electronic discharge summary for all patients is experiencing delays in implementation and where it is in use the time taken to complete is impacting on Junior Doctor working times		9	9	9	9	9	9	9	9					Dec 15	6 Dec 15
1	23-1415	NS	NW/HR R C	The NHSP/agency fill rate has decreased slightly (80 %) the gap is registered nurses. This resulting gap, can be critical within some high demand and acuity areas – ED, acute wards. Aggressive recruitment continues however march – sep is a difficult time to recruit large numbers		9	9	9	9	9	9	9	9					Jan 16	9 review Jan 16
1	24-1415	RK	SMT	Completion of face-to-face essential skills training falls below 85% which is the acceptable level to the trust board. This includes: Manual handling, Fire awareness Basic life support and Blood awareness		12	12	12	12	12	12	12	12					Jan 16	4 Apr 16
3,5	26-1516	CA	FC	The Trust is unable to achieve its planned year end financial position 2015/16		16	16	16	16	16	20	20	20					Dec 15	12 Mar 16
3,5	27-1516	LW	FC	The Trust is unable to maintain sufficient liquidity/cash		9	12	12	12	12	12	12	15					Dec 15	9 Mar 16
1,3,4	30-1415	LF	SMT	Stroke service pathway (including follow up after discharge) commissioning and provision (medical, therapy and nursing) is sub-optimal and non-sustainable in current format		20	20	20	20	20	20	20	20					Jan 16	10 Mar 16
1,3,4	32-1415	AC	QA@H GC	QA@home increases demand on pharmacy resources and expenditure and impacts on patient safety		16	16	16	16	16	16	16	16					Dec 15	8 Mar 16
1,3,4	33-1415	HW	CSC GC	Inability to recruit to vacant post within the DSC post TUPE with reduced resilience for sustainability of the service due to difficulty in recruiting to a specialist area		16	16	16	16	16	16							Nov 15	8 Nov 15
1,3,4	34-1516	AF	CSC GC	Quality of typing transcription is variable			12	12	12	12	12	12	12					Jan 16	8 May 16
1,3,4	36-1516	CJ	OB	Lack of robust identification of clinicians and doctors taking responsibility for blood tests and the lack of audit and review around filing and viewing results					15	15	15	15	15					Dec 15	9 Dec15
1,3,5	37-1516	HW	OB	Non-compliance with current CSU commissioned patient transport booking processes					9	9	9							Oct 15	6 Dec 15
1,3,5,	38-1516	JA	CSS Gov	Delay in migration to 3m Medicode clinical coding system					12	12	9	9	9					Dec 15	6 Mar 16
1,3,5	39-1516	NM	S&C Gov	Insufficient theatre capacity to meet planned demand							16	16						Nov 15	8 Mar 16
1,3,4	40-1516	JA	CCRG	Physical and operational fire precaution deficiencies. (Maybe identified ad hoc or by programmed risk assessments)								8	8					Feb 16	4 Apr 17
1,3,4	41-1516	JA	FCCRG	Fire sprinkler installations require updating to a compliant life safety system.								6	6					Feb 16	3 Jun 16
1,3	42-1516	AF	OB	Lack of reporting capacity in Radiography to report ED and MAU plain films.								20	20					Jan 16	8 Aug 16
1,3,4,5	43-1516	RK	OB	Proposed industrial action by Junior doctors									16					Jan 16	12 Jan 16

TYPE (may be more than one type)	C = Clinical	F = Financial	H&S = Health & Safety	L = Legal	Q&P = Quality / Performance	R = Reputation	SD = Service Delivery
SOURCE	Incident	Assessment	Escalation from other register	CAS Alert	Other – please specify		
Risk scores are calculated by	Consequence I x Likelihood (L) using the 5 x 5 matrix						
TARGET DATE – RAG RATED FOR PROGRESS	ON TARGET		MINOR OBSTACLE TO ACHIEVING TARGET		INABILITY TO ACHIEVE PREDICTED TARGET		

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											Review Date	Target Date	
1-1415	R / H & S / L – Assessment	18/08/07	DH HAVE STATED NO NHS TRUSTS ARE ALLOWED TO USE OFF-FRAMEWORK AGENCIES WITH EFFECT 1ST SEPTEMBER 2015. FURTHER AGENCY CONTROLS ARE TO BE IN PLACE INCLUDING CAPPED RATES WHICH MAY RESULT IN LESS SUPPLY OF AGENCY STAFF.	• Full/ appropriate engagement checks may not be in place when using such agencies putting patients and staff at risk of harm. • Potential for agencies to be charging rates higher than CCS framework agencies. • Not complying with DH edict.	• Meeting been held with all temporary staff from agencies and all off framework agencies have been written to to say no off framework allowed from 1s September 2015. • Finance , Procurement, HR and NHSP meeting to monitor bills from other sources. • On monthly basis examining the invoices that do not go through NHSP and working with CSCs to confirm appropriateness of staff. • Reports sent to TDA when off-framework agency used.	12 4X3	9 3X3	3 3x1	• Finance , Procurement, HR and NHSP meeting to monitor bills from other sources. • On monthly basis examining the invoices that do not go through NHSP and working with CSCs to confirm appropriateness of staff.	Audit undertaken in December 2014 – SUBSTANTIAL ASSURANCE given by Auditors	Jan 2016	N/A	Rebecca Kopecek SMT

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3-1415	C / R / Q&P – Assessment	May 2012	TRUST FAILS TO ACHIEVE OBJECTIVES FOR REDUCING HEALTHCARE ASSOCIATED INFECTIONS (HCAIS). Objective of 0 (zero) avoidable MRSA bacteraemias Objective of 40 hospital acquired cases of C.Difficile. Failure to reduce hospital acquisition of other health care infections (e.g. MSSA), E.coli bacteraemias) Failure to control spread and acquisition of multidrug resistant infection e.g. VRE (vancomycin resistant enterococci), ESBLs (extended spectrum beta lactam producing bacteremia and carbapenamase producing enterobactereae Lack of isolation facilities in key clinical areas (e.g. renal), sub-optimal use of isolation facilities in other clinical areas due to poor bed management.	• Failure to meet national HCAI objectives for 2015/16 • Failure to meet quality performance indicators for CCGs, TDA • Resulting in potential financial penalties. • Failure to meet CQC standards • Increased patient morbidity and mortality, readmission rate and LOS • Loss of bed days due to infection outbreaks. • Increase cost of antibiotics and antibiotic resistance • Decreased patient experience • Loss of public and professional reputation • Potential Increase in litigation and complaints	• Monthly Trust Board and quarterly exception report, annual DIPC report • Weekly infection dashboard to all CSCs • Daily list of infected patients and overdue devices to all senior clinicans. • Feedback of infection metrics at HoNs & NMAC, PSWG, PEAG meetings • Multidisciplinary participation at ICMC • Multi-disciplinary RCAs for all sentinel infections. • Mandatory infection prevention training for all staff at induction and part of Patient safety day. • Peer review of cleaning and soft FM standards. • Link Infection practitioner network • Participation at CSC governance and MM meetings • Prominent hand hygiene prompts throughout Trust. • Infection prevention included in all staff contracts. • Participation in surveillance schemes to allow benchmarking of Trust performance. • Targeted surveillance (real time) of HCAIs (VitalPac IPC-Manager) • On Call Infection Prevention Service • Introduction hydrogen peroxide decontamination service.	12 4x3	12 4x3	12 4x3	Infection Control priorities 2015/16 Action plans and HCAI plan 2015/16 Antimicrobial strategy 2015/16 Learning from multi-disciplinary RCAs Action plans to address specific CSC issues CPE action plan	• Monitored by ICMC. • Monthly exception reports to TB, • Reports to Trust Risk Assurance & and clinical governance committees, PSWG • Quarterly report to CCGs at CQRM • PHE &DH reporting of HACAI.	Jan 16 2015	Mar 2016	Simon Holmes, Caroline Mitchell, ICMC

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4-1415	C, F, L, Q&P, R, SD / Assessment	28/3/08	POTENTIAL LOSS / MISDIRECTION / INAPPROPRIATE DISCLOSURE OF PERSONAL DATA: ▪ E-mail ▪ Direct electronic transfer ▪ Post	▪ Breach of confidentiality (unauthorised disclosure) ▪ Damage / distress to individuals affected ▪ Potential legal action against Trust ▪ Damage to Trust reputation ▪ Loss of confidence in Trust services ▪ Potential regulatory action including financial penalties (up to £500k)	• Applicable Trust policies and policy compliance monitoring activities • Encryption of removable media / e-mail tools available / use of NHSMail promoted and within policy • User accounts and passwords / password changes • Password protected screensavers • Deviation from certain expected practices must be agreed through RAC (i.e. encryption)	16 4X4	12 4X3	12 4X3	Current practice recently at IGSG reviewed and no changes required SIRO report to Trust Board October 2015 **TOLERATE**	• Reporting of compliance to IGSG • Ongoing monitoring through the Information Governance Compliance Framework • Incident analysis and reporting • Process for accepting certain kinds of risk (e.g. unencrypted devices) formalised	Jan 2016	N/A	Code A IGSG

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7-1415	C / Q&P / R - NPSA Alert	Oct 12	NPSA ALERT DEMANDS THAT ALL SPINAL DEVICES ARE NON-LUER BY APRIL 1ST 2012. THIS IS TO REDUCE RISK OF ACCIDENTAL MISCONNECTION WITH OTHER, IE INTRAVENOUS DEVICES. NONLUER DEVICES DID NOT EXIST AT THE TIME OF THE ALERT	• Non-Compliance with NPSA Alert • Patient Safety	• Decision made to avoid additional risk to patients by not having a mixed stock of Luer and Non-Luer spinal devices within the Trust, or employing an inferior quality device. Update • Reviewed again in 2015 and the department unanimously feels that there would be no advantage and additional risk to converting temporarily to nonluer spinal needles of inferior quality with potential block failure and risk of mixing up luer and nonluer equipment. The plan is to await the new equipment resulting from the soon to be announced new ISO standard for these devices. • The main manufacturer of epidural equipment has withdrawn from producing nonluer equipment until the international standard design is set. There is not acceptable equipment on the market to convert to nonluer equipment for epidural nor regional anaesthesia. We are noncompliant with NPSA/2009/PSA004B like the great majority of Trusts. • Oncology has introduced nonluer devices for safe delivery of chemotherapy and are compliant with NHS/PSA/D/2014/002	9 3x3	9 3x3	3 3x1	• Interim decision to continue to use the Luer devices which we have always used until the favored companies can assure us that they can provide the full range of ISO compatible devices, allowing a complete move across to Non-Luer for spinal, epidural and regional blocks and infusions. • ISO have determined that an international standard for non luer connectors be introduced by 2015. Therefore some manufacturers are ceasing production of non luer connectors until clarification of requirements by ISO **TOLERATE**	• n/a	Jan 2016	N/A	MDMC

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8-1516	C,F,H&S,Q&P,R,SD / Incidents	April 13	RISK OF PATIENT INJURY FOLLOWING INPATIENT FALLS. NON DELIVERY OF PATIENT SAFETY CQUIN FALLS ELEMENT NON COMPLIANCE WITH NICE CG161 PREVENTING FALLS IN OLDER PEOPLE	• Harm (moderate/ severe/ avoidable/ unavoidable) patient harm • Significant patient injury e.g. fracture of long bones, head injury hemorrhage • Increase in LOS and associated costs • Increase in morbidity and mortality due to direct and indirect consequences from fall • Organisational reputation – links to Coroner's inquest findings • Financial impact on Trust due to litigation costs, lack of CQUIN payments • Increased burden of care for community partners post discharge	• Falls policy • Bedrail policy • Falls link champions • CSC based practice educators • Falls assessment in nursing admission document. • Comprehensive Falls training/ essential skills/ induction and patient safety for RNs • Deep dive multidisciplinary root cause analysis • Falls action plans for high incidence CSCs • Engagement of CSC Governance meetings through presentations • QA@H staff fully trained with ongoing updates – champion in place • Trust wide falls prevention group	12 4x3	12 4x3	8 4x2	• Refocus on proactive learning from RCA process • Appropriate risk assessment and care planning, with 24 hours of admission (95% compliance).. • Monitor action plans and audit sustained learning from incidents across CSCs. • Disseminate learning from falls incidents- within and across CSC structures • Focus on out- of hours falls-route causes and remedial actions	• Reporting/ monitoring by Patient Safety Steering Group • Monthly and quarterly quality report to Trust Board. • Discussed at CQRM • Monitored as part of patient safety CQUIN • Progress monitored through Safety improvement plan	Jan 2016	Apr 2016	Code A PSSG

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9-1516	C, Q&P, R	June 2013	FAILURE TO ACHIEVE INTERNAL AND EXTERNAL SET QUALITY/PATIENT SAFETY IMPROVEMENTS High risk areas include • Achieving reduction in Red and Amber falls • Achieving reduction in Grade 3 and 4 pressure ulcers • Achieving Dementia and Delirium targets • Update • Reducing patient moves after midnight • Improvement in Friends and Family response rate	• Reputational damage • Potential fines • Patient safety • Update • CQC Compliance	• Governance Framework and monitoring – Quality Improvement Framework • Quality Performance measures • Monitor Compliance Framework • CSC performance reviews • Kitbag performance metrics • Clinical Audit programme • Gov & Quality Committee • Patient safety Steering Group and associated Safety work streams • Monthly and Quarterly Board reporting • Monthly CQUIN Meetings • Quality Impact Assessments of CIP plans and transformation schemes • Clinical Effectiveness Steering Group • CSC Governance meetings • Specialty M&M meetings • Electronic Mortality Review tool • Quality Heatmap	8 4x2	12 4x3	8 4x2	• Implement Friend & Family action plan to increase positive feedback • Update • From September the CSCs have been requested to provide a daily submission describing their non-clinical moves before 2100; along with a report from the Duty Hospital Manager with the number of non-clinical moves after 2100 in order that more robust data is available. Since the 27th October 2015, the DHM has started to record the number of non-clinical moves before 2100. A full data set will be available for the November 2015 quality report. • Focused work on pressure ulcer reduction (increase noted in October). TVN validation of all grades of pressure damage. • Appointment of falls nurse specialist in January 2016. Increased emphasis on the integration of the risk factors of hypotension into clinical falls risk assessments.	• Gov and Quality Committee • Patient Safety Steering Group • Clinical effectiveness Steering Group • Patient Experience steering Group • CQRM and quality contract reporting • Quality heatmap and exception reports to Trust Board monthly • Quality report quarterly to Governance & Quality	Jan 2016 / Mar 2016	Code A G & Q

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10-1415	C, F, R, Q&P/ Assessment	June 2013	UNINTENDED CONSEQUENCES TO DELIVERY AND QUALITY OF CARE DUE TO COST IMPROVEMENT PROGRAMME	• Reputational damage • Patient safety compromised • Poor patient experience • Poor staff experience and engagement • Clinical outcomes	• QIA metrics and tracker system hosted by PMO • MD/DN sign off of any QIAs • Performance monitoring framework • Trust performance and kit bag metrics • Governance structures • CSC level performance reviews • QIA process and associated policy • Quarterly exception reporting on risks through RAC • Monthly meetings with DoN and MD to sign off and discuss any QIAs • CSCs to report CIP impact and progress as part of regular quality reporting template to Governance and Quality Committee	12 4x3	12 4x3	8 4x2	• All CSC CIP schemes as a result of 2015/16 business planning to be overseen by Transformation Team and approved by MD and DoN. • Review of QIAs to be undertaken by TDA and Director of Nursing • Review and revision of policy • Establish tracking system for CSC specific CIP initiatives	• Governance and Quality Committee • SMT • Trust Board • Financial recovery Group	Dec 2015	Mar 2016	G&Q

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11-1415	C, H&S, L, Q&P,R, SD		CONCERNS WITH THE CONDITION OF HEALTH RECORDS AND GROWING ISSUE OF PRODUCTION OF TEMPORARY SETS OF NOTES	• Unwieldy notes that present a clinical risk • Unable to store records to accepted standard and increasing clinical risk associated • Large volumes of temporary sets of patient notes are not marrying up with the main patient record • Clinical risk due to patient records not being held with the main record.	• Good standards and controls for management of patient health records in the main library • Some culling is being performed • IGSG does monitor some of the issues raised • Review of all notes storage completed, plan has been instigated. • Health Records Steering Group • IDesktop in some clinics • New file with double flange being used for all new notes. •	15 3x5	12 3x4	6 3x2	• Fully scope the problem of notes being maintained separately to the main health record and being stored outside the main record library, and develop an associated plan and business case • Ophthalmology amalgamation to be raised as a cost pressure – but a plan has been devised • New project to be scoped by Clinical Support to improve issue around temporary sets of notes.	• Monitor through RAC • Monitor through IGSG • Monitor through CS CSC Governance meetings	Jan 2016	Jun 2016	Code A HRSG

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12-1415	F / H&S / R / SD / -Risk Assessment	Jan 12	BLOCKAGE OF SEWAGE SERVICES LEADING TO FLOODING WITHIN DEPARTMENTS, MAINLY AFFECTING PAEDIATRICS, RENAL AND F LEVEL WARDS	• Ward Evacuation • Cancellation of elective activity • Infection hazard • Replacement of contaminated equipment • Trust reputation	• Initial survey resulting in drain repairs, drain realignment and flushing where required. • Identified defects repaired • Completed 2012 drains survey • Flow tests undertaken: inappropriate items being disposed of through system: hand towels / pt wipes • Trial carried out with new degradable wipes, but due to financial constraints and macerator issues, will return to Conti wipes. Campaign is being launched to raise staff awareness.	9 3x3	12 3x4	6 3x2	• CSL to educate all users to avoid overloading • Carillion to provide detailed reports for each blockage • 10 alarms will be installed by the end of November 2015. • Map of drains to be produced	• Incident reporting • Infection control monitoring • Patient experience working group	Dec 2015	Dec 2015	Code A CCRG

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13-1516	C/F/Q&P/R/SD – Risk Assessment	Oct 12	THE TRUST FAILS TO ACHIEVE KEY LOCAL AND NATIONAL ACCESS STANDARDS AND TARGETS EXCLUDING ED.	• Patient experience • Patient safety • Quality/clinical outcomes • Trust financial position • Trust reputation	• Weekly specialty PTL meetings led by CSC GM. • Weekly assurance meeting chaired by Deputy COO/Head of Performance • Performance team co-ordination of breach position at Trust aggregate level • RTT compliance plans and 35 week recovery plans for all "at risk" specialties – reviewed weekly • Increased use of ISTC to support gaps in capacity • Theatre scheduling policy and cancellation day of surgery policy • • Weekend operating sessions programme in place • Diagnostic recovery and resilience plan	8 4x2	16 4x4	8 4x2	• Referrals and CQUIN plans monitored weekly at ODG to facilitate "early warning" of capacity / demand problems • OP transformation project launched and ongoing • Theatres transformation project led by PMO • Detailed RTT compliance recovery strategy being developed for TB approval • Business case to increase capacity • Recruitment plans-Superceded by strategic changes in spinal service. Awaiting outcome of discussions with SUHT. • Colorectal service recruitment under review • Validation 1st phase completed in Gastro with positive impact. Further phase commenced.	• Activity plans to meet GURROO 3 model. Including growth plans • Performance dashboard and weekly assurance meeting • Reports to TDA, Commissioners and Trust Board	Dec 2015	Jun 2016	SMT

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15-1415	SD / R / C / Q&P – Assessment	May 2010	REPEADTED AND PROLONGED OVERCROWDING WITHIN ED RESULTS IN POOR PATIENT EXPERIENCE COMPROMISED SAFETY AND IMPACTS ON STAFF WELLBEING	• Clinical safety of patients • Reputation of Trust compromised • Patients not having initial assessments within 15 minutes and not seeing doctor within one hour of arrival. • Financial penalties linked to ambulance handover times and non - achievement of 4 hour target • Poor privacy, dignity and overall patient experience as little or no facilities available in ED corridor, • Unsuitable environment for patients • Staff stress • Potential for increased errors • Inability to achieve Emergency care quality standards	• CSC Strategy • CSC Strategy • PHT Unscheduled Care Quality Improvement Plan ratified by UCB and PHT Trust Board Phase II with implementation timetable • 12 Hour escalation process in place (standard: no patient to remain in ED for >12 hours) • Enhanced role of ED Nurse in Charge to reduce 4hr breaches • Ambulatory Emergency care to be moved to dedicated ring fenced area • AMU Orange – 22 beds to be re-introduced to assessment bed stock to allow post taking to move from ED and off 4hr clock • Update • Introduction of 'PIT Stop'	25 5x5	20 5x4	12 4x3	• Trust recovery plan to be fully implemented • Review and enhance MDT Discharge Processes to increase daily discharge • Medical wards to review criteria for admission increasing availability of bed stock to ED/AMU • Mapping of frailty pathway commenced to agree WHE frailty strategy • Auditing of internal professional standards • WHE KPIs to monitor performance against Phase II WHE plan – agreed and plan well underway • Frailty Intervention Team (FIT) Business care for approval end November 2015 • Update • Re-establish frailty model at front door with health and social care partners increasing < 48 hour turnaround • Bring forward discharges earlier in the day, in line with the national profile • Increase discharge to assess capacity at home/ in the community for AEC/ AMU and medical wards to access quickly to prevent admission and speed up discharge	• ODG • Trust Board • Reviewed at Trust Recovery Group and monthly by TDA • Operational Delivery Group • Transformation programme commenced • Plan monitored weekly by Urgent Care Quality Improvement Group and chaired by CEO.	Dec 2015	Dec 2015	SMT

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16-1516	C//F/Q&P/SD Audit / Incident	Jul 2013	QUALITY OF DATA PRODUCED AND PROVIDED FOR USE IN INTERNAL PERFORMANCE REPORTING AND FOR EXTERNAL REPORTING MAY INCLUDE INACCURACIES (DATA ENTRY AND/OR REPORTING)	• Patient safety • Trust reputation is undermined • Financial penalties associated with loss of CQUIN or fines due to contract requirements, impacts on overall Trust financial position • Incorrect data affects decisions for operational management and business planning • Patient safety	• Data Quality Steering Group meets monthly and all CSCs and Information Asset Managers report on their compliance with local and national standards annually. • Exceptional issues will be fed into SMT, including an annual DQ Report to Trust Board • Data Quality Reporting Dashboard provides a local replica of the national SUS Data Quality Dashboard at CSC and Specialty level. • Standard Operating Procedures in place for routine internal reports, covering data quality checks and sign-off.	12 4x3	12 4x3	8 4x2	• Establish accountability for data quality at CSC and Executive level to promote a strong data quality culture throughout the Trust, ensuring engagement in Data Quality Steering Group from the appropriate level to effect organisational change. • Review effectiveness of data quality processes and structure put in place in improving Trust data quality and reducing inaccuracies in external and internal reporting. • Key national targets to be written up by Dec 14, with further Trust-wide review in Q4- In progress. Currently being developed, due to the level of returns this will need to extend into the beginning of 2015/16	• Data validation exercises • Regular reporting to Audit Committee	Jan 2016	Jun 2016	Audit Committee

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17-1415	C/Q&P/SD - Assessment	August 2013	AT TIMES OF HIGH CAPACITY DECISIONS ARE MADE TO MOVE PATIENTS OUT OF THEIR SPECIALTY FOOT PRINT FOR THE PROVISION OF THEIR CARE.	• Patient safety is potentially compromised as a result of care on non-specialist outlier ward • Dilution of specialty clinical staff (outliers • Increased likelihood of delay in patient journey • Difficulty in identifying suitable patients can result in complex patients being moved thereby increasing the risk • Financial risk associated with outlaying to G5 (PPU)	• Daily list of patients that are outlied produced and medical team review daily • Clinical staff undertake individual decision making process for each patient moved • Outlay to G5 criteria QA@H and referral criteria extended to cover social care, bridging gaps • D2 - acute General Medicine admissions ward • G1 commissioned mid September 2014 • Improved access of community beds and spot purchase capacity • Additional Consultant Ward rounds in Medicine at weekends 22 Nov 14 allow earlier discharge decisions/actions and reduce risk of outlaying • Medicine outlier discharges tracked daily via the Medicine CSC discharge audit tracker • Non-Clinical Moves after Midnight reported daily by DHM, these are captured and included in the monthly report to Trust Board. • Daily monitoring of Target – to achieve no greater than 30 outliers • D3 General Medicine Ward is now a 'step-down' facility for Medicine CSC. • Non-Clinical Moves before and after 2100 are being monitored wef 1st September 2015	15 4x4	12 4x3	12 4x3	• Hospital work in place to increase efficiencies in patient pathway through CQUIN work and Newton • Early Bird Discharge (IDB) work continuing – targets have been set for all CSCs, performance against targets are reported daily via the Unscheduled Care Dashboard. These are ring-fenced to prevent outlaying of this cohort of patients impact to flow the following morning. • Stretch target of 48 discharges per weekend applied to Medicine CSC – associated resource to achieve supported by winter pressures investment. • Daily discharge targets agreed across the Trust with focus on discharges before 1300 and before 1400. Key target –30% of all daily discharges achieved by 1300 and 50% by 1400. Monitored daily. Monitored daily. • Increasing focus on improving pace of flow supported by Community Partners. Ongoing discussions led by COO. • Daily monitoring of Target – to achieve no greater than 30 outliers. • Simple Discharge Working Group now in place focusing on achievement of daily discharge targets • Fortnightly High Impact Change Meetings with CSC to ascertain achievement against key actions agreed at Urgent Care Quality Improvement Programme • Re launch of SAFER Discharge Bundles with Master lass booked for 2nd Nov with ECIST	• Through CSC governance monthly reviews • Monitoring IDB performance on weekly basic as part of Trust Recovery Group • IDB Meetings are taking place twice weekly at 1030am, actions are chased hourly • Progress Chaser role has also been introduced to ensure actions are progressed • Medicine and MOPRS outliers numbers continue to be monitored daily and are reported via the weekly Back Door Tracker • Performance is discussed weekly at Operational Delivery Group • Weekly monitoring of daily unscheduled admissions via ED that result in a LOS <24 hours • Daily system-wide conference calls in place to agree remedial actions as capacity pressures increase	Jan 2016	Review position Jan 2016	SMT

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18-1415	C/Q&P/SD - Assessment		LACK OF EQUIVALENT WORKFORCE ACROSS SEVEN DAYS OF THE WEEK	• Reduced quality of care • Damage to Trust reputation • Poor patient experience	• Governance systems in place to ensure patient safety and quality of care is maintained • Increased Consultant presence at weekends • Mortality review toolkit • Gradual increase in Consultant presence out of hours across the Trust • Scheduled care is also provided at weekends • All staff groups contractually have to work weekends if required and 7 day working has been implemented in most parts of the Trust – medical staff are the only group who cannot be compelled to work 7 days	12 4x3	12 4x3	8 4x2	• Mortality review Toolkit will become available soon which will allow monitoring of week end mortality • National consultant contract negotiations are underway and outcomes awaited • Development of unscheduled care medical model • Introduction of new junior and consultant medical contract	• Review of hospital mortality with emphasis on weekend mortality with TDA • Weekend HSMR shows no significant difference to comparable Trusts • Weekend HSMR shows no significant difference from rates recorded during the week	Dec 2015	Apr 2016	Code A SMT

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19-1415	C/Q&P/SD - Assessment		TRUST FAILS TO ACHIEVE CANCER WAIT TARGETS	• Patient safety and clinical outcomes • Patients are not seen in a timely manner • Financial penalties may be applied by commissioners	• Capacity and demand modelling undertaken and in place within CSCs • Weekly assurance meeting with forecast planning and triggers for escalation • Weekly PTL meetings with clinical leads of tumour sites and CSC rep to track progress of patients on cancer pathway. • Cancer improvement plan in place, monitored fortnightly and reported to cancer steering group • Monthly cancer steering group receives update on performance and key issues • Escalation of late inter-trust referrals through deputy COO • Consultant Uro-oncologist appointed • Development of dashboards by tumour site part of Information Services schedule of work • Cancer access policy review complete and ratified • Cancer Improvement Manager appointed • Cancer Improvement plan 15/16 • Short term solution for breast 2ww symptomatic capacity developed and implemented. • Weekly review of full PTL in Waiting List Assurance Meeting	8 4x2	8 4x2	8 4x2	• Development of dashboards by tumour site part of Information Services schedule of work • New 2WW referral forms, with enhanced guidance on criteria for referral only upload to PiP outstanding • Detailed work on clinical pathways due in 15/16 to improve ability to deliver wait times consistently • Improvement plan and trajectories to be developed for urology, • Cancer management structure including MDT team to be reviewed presented to Board • Reinstatement of monthly cancer steering group to include D of Ops • weekly review of full PTL in Waiting List Assurance Meeting • Urology Consultant post currently advertised. CSC to produce potential rationalisation proposal for Board should recruitment be unsuccessful	• Annual training on Cancer Access policy for all staff involved in managing cancer pathways (due autumn 14) • Cancer remedial action plan being delivered and reported to CCG monthly • Improved visibility and tracking of long waiting patients and significant reduction in numbers • Improved ability to predict performance accurately • Cancer improvement plan reviewed • Operational Board • Monthly cancer steering group to include D of Ops	Dec 2015	Apr 2016	Code A SMT

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20-1415	Risk Assessment	Dec 2013	REVIEW OF DELIVERY OF COLORECTAL SERVICE MODEL OF CARE TO ACHIEVE OPTIMUM PATIENT EXPERIENCE CURRENT WORKFORCE INSTABILITY IMPACTING ON DELIVERY OF REQUIRED PERFORMANCE	• Poor quality of care and patient experience • Failure to meet RTT and cancer targets • Trust reputation	• PLL meetings for RTT and Cancer • New processes following action plan for 2014 have been implemented • Mediation agreement reached June 2014 • Monthly department meetings. • Service moved into special measures with Medical Director acting as Clinical Lead/Director and Director of Operations for Scheduled Care acting as General Manager. Management removed from CSC • Clinical Fellow in post • Consultant locums x 2 in post until 2016 • Additional OPD capacity being operationalized by movement of Pain Service, to support changes in workforce and job planning.	12 4x3	16 4x4	8 4x2	• Continuing actions to manage waiting times for cancer and RTT patients • Recovery plan in place for RTT. • Additional activity for outpatient clinics being undertaken ad hoc basis • Individual strategy meetings held with MD and DoO, agreed vision for service • Detailed job planning programme to commence November 2015 • Requirements of work patterns of consultant team members identified by MD and awaiting final outcome • Meeting with Consultant team scheduled for Oct to agree requirements for 2 x substantive posts to stabilize team • Specialist nursing roles to be reviewed by external adviser to ensure appropriate for service Planned for end November 2015. • Cancer pathways to receive external support, benchmarked regionally to improve delivery. Planned for November 2015 • Enhanced recovery programme being reviewed and relaunched by external specialist nurse, supported by lead clinicians to improve patient experience and length of stay	• Review by Executive team • Review by Medical Director and Director of Operations Scheduled Care • Weekly meetings with D of Ops instigated to address any outstanding and new service delivery/performance issues.	Dec 2015	Dec 2016	Trust Board

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21-1415	L, C, F, R, Q&PAssessement	May2014	MENTAL CAPACITY ACT (MCA) AND DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS) post Supreme Court Ruling setting out an 'Acid Test' for DoL: • Failure to demonstrate through robust documentation the legal basis for admitting someone to hospital when they lack mental capacity to consent to this. • Failing to apply / delays in applying for a DoLS Authorisation when required resulting in potential unlawful deprivation of a patients liberty. • DoLS Offices struggling to meet demand for DoLS Assessments resulting in 'lapsed' DoLS. • Limited MCA and DoLS trainer within the Trust. • Failure to comply with Coroner notification (all patients who die under DoLS Authorisation)	• Breach of CQC Regulations: Safeguarding people who use services from abuse • Breach of NHS Contract • Potential legal action for unlawfully depriving someone of their liberty • Reputational damage • Failure to meet contractual training compliance • Applying for DoLS Authorisation is time-consuming putting increased pressure on clinical teams. • Current Adult Safeguarding resources will be unable to meet increased workload / data recording and CQC notification requirements • Lack of assurance for internal audit	• Working with local external partners (DoLS Offices and acute health providers) to facilitate the implementation of the Supreme Court ruling (March 2014) • Multiagency training on MCA and DoLS for Trust and CSC Operational Adult Safeguarding Leads, designated CSC staff. • In-house provision of training by Trust Adult Safeguarding Lead. • Briefings on DoLS changes to Corporate Nursing team, Heads of Nursing, Matrons, Chiefs of Service and Clinical Directors. • In-house training material developed and available for all Safeguarding Leads to access • How to apply for DoLS information on intranet • MCA admission form introduced • MCA and DoLs training strategy agreed • Introduction of shortened application form to simplify process and reduce clinical workload • Training compliance established • Safeguarding leads completed training • Agreed funded additional training implemented and on-going • Admin support in place Update Centralised application process	16 4 x 4	8 4 x 2	8 4x2	• Continued roll-out of attendance on external multiagency MCA and DoLS training. – on-going • Repeat MOPRS DoLS audit in other CSCs to establish baseline situation • Centralised application process to commence 05/10/2015 • Update • DOLS policy ratified Nov 15. • Compliance figures for enhanced MCA and DoLS training will be available for Q3 (first data set). Anticipated there to be low compliance as a baseline. Individuals now identified who require the training. Once baseline data available, training can be targeted to areas of low compliance.	• Quarterly Board exception reports – number of applications, declaration of any unlawful DoL • CSC monthly Safeguarding reports • Monitoring by CSC Governance, Trust Safeguarding Committee and monthly Adult Safeguarding Leads meeting • Analysis of trends and data within Quarterly Safeguarding reports • Quarterly Board reporting	Jan 2016	Mar 2016	Code A Safeguarding Committee

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22-1415	C/F/Q&P/R/SD – Assessment	Aug 2011	THE TRUST REQUIREMENT TO USE VITALPAC TO GENERATE AN ELECTRONIC DISCHARGE SUMMARY FOR ALL PATIENTS IS EXPERIENCING DELAYS IN IMPLEMENTATION AND WHERE IT IS IN USE THE TIME TAKEN TO COMPLETE IS IMPACTING ON JUNIOR DOCTOR WORKING TIMES	• Loss of Trust Reputation • Damaged Relationships with commissioning GPs • Sub optimal patient pathway and patient safety • Failure to comply with contract • Inconsistent use of EDS across specialties • Potential delay in information transfer to GPs • Reduced patient contact time for junior doctors or unacceptably long working hours • CCG-imposed financial penalties for failure to comply with 24 hour discharge summary delivery requirement	• Proposal to implement ICE EDS solution agreed at SMT 19.11.2014. • Project to implement ICE EDS initiated. • Project Board in place & meeting twice monthly • Upgrade of ICE IT infrastructure completed • IT support staff trained in ICE management • Drugs table provided • Clinical Safety Officer/Lead in place • CCGs represented on Project Board and agreed to revised completion date of 30.09.2015 • Technical problems with GP codes & non-delivery notifications resolved • Pilot successfully completed on E2 & E3 on 10.07.2015 with 58 EDS transmitted to 62% of local GP practices. • Jnr docs happy with ease of use of ICE EDS • idesktop rollout complete • ICE EDS now live & rolling out to wards. • VitalPAC EDS to be switched off 30.09.15 and old EDS to be made available in Graphnet.	9 3x3	9 3x3	6 3x2	• Address Clinical Safety action plan • Train clinical staff in use of ICE EDS • Complete roll-out of ICE EDS to all agreed areas • Monitor usage & enforce adoption to reach required completion rates • Request 6-month roll-out period instead of 2-month to ensure effective • Medical Director to ensure Clinical Lead has time freed to keep project on track	• Monitored at monthly commissioning meeting • Monitored by Performance Tool at CSC level • Monitored at Audit Committee and RAC • Project delivery for new EDS monitored by IT Project & Programme Boards	Dec 2015	Dec 2015	Code A RAC

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23-1415	C / H & S / R / SD – Assessment	Dec 2009	THE NHSP/AGENCY FILL RATE FOR REGISTERED NURSES IS CURRENTLY 70 – 75% VACANCY RATE WITHIN THE TRUST CURRENTLY 9% THIS RESULTING GAP, CAN BE CRITICAL WITHIN SOME HIGH DEMAND AND ACUITY AREAS – SUCH AS ED AND THE ACUTE WARDS. 120 NEW RN'S WILL HAVE STARTED IN THE TRUST BY END OCT 2014, HOWEVER SIGNIFICANT GAPS WILL REMAIN IN MOPRS ACUTE WARDS WHEN EXTRA CAPACITY IS OPENED AGGRESSIVE UK RECRUITMENT CONTINUES ALONG WITH FURTHER OVERSEAS RECRUITMENT	• Quality and safety of patient care. • Clinical wards are staffed with a lower level of permanent staff, impacting on quality of care	• Provision of Senior Nurse/Matron cover over 24 hour period to ensure patient care and escalation process to request temporary staffing from NHSP and other agencies • Re-allocation to wards of other clinical staff from non ward based nursing duties • Partner organisations work with PHT to reduce extra capacity • Non Framework agencies now removed from agency cascade, exception requiring Executive approval • On-going NHSP and Trust recruitment for band 5s from the EU • NHSP and agency staffing is filling the vacancy gaps • Extra capacity staffing being supported by all CSC's. • Monthly reporting of staffing at ward level to Trust Board • Extra capacity staffing being supported by all CSC's. • June 2015 ward based staffing review to July board • Budget reset of all ward based staffing	20 5 x 5	9 3x3	9 3x3	• Monthly monitoring through vacancy and temporary reporting • Other permanent PHT staff support clinical ward teams where feasible/practical • Continued recruitment to identified and agreed vacancies overseen by lead nurse for workforce • Quarterly overseas (EU) RN recruitment with NHSP to cover vacancies • Rolling advert for ED (120 per year). • Part of Wessex Adult Nursing Task and Finish Group to monitor adult nursing numbers and determine commissions for adult nursing. • Ongoing project to recruit to establishment • 2015/2016 Recruitment plan in place incorporating on going monthly adverts • Potential for International recruitment commencing Spring 2016 • Trainee Assistant Practitioner (Nursing) in post (2 year course)	• Daily senior nurse monitoring meetings • Operations report x 3 daily • Daily written report from staffing and duty matron detailing actions to ensure safe care • Weekly monitoring of recruitment by Lead Nurse for Workforce. • Weekly staffing planning meeting • Weekly monitoring of current staff in post, temp use and number of extra beds • Weekly monitoring of agency cascade and impact of changes • Weekly monitoring of temp staffing utilization • Weekly roster clinics	Jan 2016	Review Jan 2016	Code A NW/HR RC

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24-1415	C/ H&S/ L/ Q&P/ R/ SD	April 2014	COMPLETION OF FACE-TO-FACE ESSENTIAL SKILLS TRAINING FALLS BELOW 85% WHICH IS THE ACCEPTABLE LEVEL TO THE TRUST BOARD: This includes: Fire awareness Basic life support Blood awareness Violence and Aggression Training (Conflict Resolution)	• Basic training that is deemed essential is not completed leading to clinical risk • Staff not provided with the necessary knowledge to undertake their roles successfully. • Lack of fire awareness likely not to comply with Hampshire Fire Brigade potentially leading to enforcement action on the Trust . • Staff morale with the Trust being seen not taking the personal safety, health and well-being of our employees appropriately. • Lack of provision at end of year for those requiring training • Waste of resources • Noted as an area for improvement in NHS Protect Inspection June 2015	• Compliance is monitored through the monthly performance review meetings with each CSC. • Compliance is reported to the Trust Board monthly. • Training is being delivered by the appropriate teams including ESR support with data entry • Personalised lists are provided monthly to the CSCs by Human Resources • Total essential skills compliance decreased in September from 87.5% to 86.1% but remains above the 85% target. • DNA notification sent to manager via ESR workflow. • DNA report to manager on a weekly basis via email • Quarterly Education Dashboard identifying trend by CSC and programme • The L&D team are targeting staff who are out of date with more than 3 face to face essential skills. Staff have been given 2 months to complete their training, and any staff who have not complied with this request will be escalated to the CSC	12 4x3	12 4X3	4 4x1	• Ongoing monitoring to ensure continued compliance • Bespoke sessions can be requested by the CSCs from training and development • CSCs significantly below compliance in any area to monitor through local risk registers • All CSCs have got on individual risk registers but concerned about level of scoring Director of Workforce to raise with the CSCs at the Performance Reviews. • Increase awareness of staff responsibility to attend training • CPD Activity to be dependent on compliance with Essential Skills • Additional sessions for Conflict resolution Training have been procured and cascade trainers developed.	• Monthly performance review meeting process with CSC's.	Jan 2016	April 2016	SMT

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26-1516	F / R – Assessment	Oct 2011	The Trust is unable to achieve its target financial position for the year 2015/16 of a planned deficit of £9.7m on Income and Expenditure	• Potential for TDA intervention • Potential for liquidity (cash) problems • Potential for measures being required that might risk posing a detrimental effect on services • Reputational, perceived as a failing organization • Jeopardise successful FT application • Failure to comply with the TDA's 'stretch' limit of £9.7m set to improve the aggregate bottom line revenue position for the NHS Trust sector	• **Monthly performance meetings:** Finance reporting and monitoring mechanisms at CSC to Board level • **Pay:** Controls include, budget monitoring and control, workforce strategy committee, temp staffing review meetings and Executive sign off for temporary posts. • Corporate recruitment requires executive sign off from June. • **Non Pay:** Controls include budget monitoring, agreed authorisation levels technical approvers for specific categories. • **Income & Contract Penalties (inc CQUIN):** Controls include, contract monitoring reports and meetings, income assurance group with CSC's. • Regular CQUIN meetings with CSCs to assess performance. • **CIP programme:** Controls include monthly reports and Transformation Office oversight. • Controls include budget monitoring and monthly performance reviews with Exec team • Visibility of Financial Information through Qlikview	12 4x3	16 4x4	12 4x3	• Rolling forecast to be regularly updated and subject to rigorous review and challenge at reinforced monthly performance meetings. • Update • Revised year end forecast to be prepared by EMT with specific supporting documentation, clear actions and accountability • Delivery of the revised plan to be reviewed and monitored at the Finance and Performance Committee	• Monthly reporting to all relevant meetings (EMT, SMT, Finance and Performance Committee & Trust Board) • Greater CSC Scrutiny at Finance and Performance Committee re action plans and assurance of recovery of the position	Dec 2016	Mar 2016	Code A FC

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27-1516	F / R – Assessment	July 2013	• THE TRUST IS UNABLE TO MAINTAIN SUFFICIENT LIQUIDITY/CASH	• Potential for TDA intervention. • Potential for measures being required that might have a detrimental effect on services. • Reputational - perceived as failing organisation. • Insufficient liquidity would prevent successful FT application. • Interest is charged on all temporary DH financing from April 2015	• Daily updates to actual cash flow and monthly update to forecast. • Regular reporting to Finance Committee and Board, via Integrated Performance Report. • Working Capital being reviewed regularly • The limit on the Trust's Interim Revolving Working Capital Facility has been increased to £37.2m	9 3x3	12 4x3	9 3x3	• A detailed cash forecast for the year is being produced against various scenarios • Ongoing review and management of working capital balances • Application to ITFF for long term financing once requirements are fully understood (Nov 15) • Work to continue on the Long Term Financial Model to support the ITFF application (Nov 15)	• Monthly reporting to Finance Committee and Trust Board. • Monthly and Quarterly reporting to TDA.	Nov 2015	Mar 2016	Code A FC

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30-1415	C/F/R/Q&P/SD Risk assessment	December 2014	FAILURE TO MAINTAIN THE STROKE SERVICE PATHWAY • Thrombolysis door to needle time • Staffing levels on the HASU including continuity of Consultant care • Maintaining 90%direct admission and 90% LOS • Lack of Stroke follow up clinic	• Potential for patient harm and poor patient experience due to: • Delay door to needle time • Failure to meet national targets and quality indicator • Negative impact on SSNAP score • Increase in aspiration pneumonia • Delay in recognizing thrombolysis complications • Failure to meet national standards level 2 nursing care • Reputation to Trust/Stroke Service	• New SPR rota commenced 06/02/15 • Nursing recruitment / training • Business case has been approved to increase nursing staff levels • Stroke operational policy in progress to be ratified and agreed • Increase to Stroke nurse Coordinator/ reviewing current skills and training required • Robust governance structure to review patient pathway • Escalation to medical director • Update • Increased bed capacity by swapping F2/ F4- completed July 2015 • Stroke Follow up being completed	20 5x4	20 5x4	10 5x2	• June 2015: Stroke action plan implementation in progress • Meeting planned with neighboring Trusts ambulance service and PHT stakeholders to review the Stroke Pathway for Portsmouth • Recruitment in progress for nursing staff/ Stroke Coordinator • Update • The stroke action plan is expecting to deliver an improved SSNAP performance by the end of December. • On-going discussions with ED to improve thrombolysis performance • The ward will be fully recruited however the skills of the staff need developing as they are very junior.	• Dr Foster data scrutiny • Monthly thrombolysis review meeting and mortality meetings • Ongoing monitoring of patient experience via complaints and Friends and Family Test. • Stroke Lead Action Group reviewing and escalating to MOPRS SM • SSNAP data improved from E to D (January-March Data) • Dr Foster data scrutiny	Jan 2016	Mar 2016	MOPRS SMT and Stroke Lead Group

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32-1415	C/F/R/Q&P/SD Risk assessment	February 2015	• QA@Home – Lack of pharmacist capacity to deliver ongoing clinical service to all patient safety and monitoring of medication. • Patients discharged rather than transferred therefore unable to have accurate patient list. • Increase demand for NOMADS for patients awaiting Social Care • QA@home increases demand on pharmacy resources and expenditure. • Suggested increase to 30 beds puts more patients at risk of harm from medication errors	• Potential harm to patients due to lack of pharmaceutical optimization • No definitive list of patients • Increased work load for pharmacy and consequential knock on effect on nursing staff due to lack of single access point • Delay in dispensing of changes to prescriptions for patients at QA@home	• Patients TTOs dispensed at time of transfer to QA@home • Complex patients requiring NOMADS will not be frequent users of the service • All patients accessing QA@home for IVabs will be reviewed by Microbiology prior to transfer • No patients will be transferred on regular aminoglycosides • Weekly microbiology & pharmacist review of patients on IVabs	16 4x4	16 4x4	8 4x2	• To review if the service grows in size to consider a business case for a link pharmacist resource for QA@home • Process to prompt review from QA@Home to ward pharmacist to be developed to highlight patients who have clinically changed – disregarded as appropriate due to visits being undertaken by non-nursing healthcare professionals who do not have the necessary clinical skills and knowledge to prompt a review • Appointment of pharmacist to cover QA@Home patients • Requires further discussion regarding service provision expansion and funding stream. • Appointment of pharmacist to cover QA@Home patients - job description complete, requires WSC approval. • No governance meetings for many months and not aware next will run.	• Monthly Clinical Governance Review Group • Monthly Contract Review Group • Monthly review of Datix and incident reporting for medications by Head of Quality & Medication Safety Pharmacist	Dec 2015	Oct 2015	QA@H Governance Committee

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33-1415	C/F/R/Q&P/SD Risk assessment	February 2015	INABILITY TO RECRUIT TO VACANT POST WITHIN THE DSC POST TUPE WITH REDUCED RESILIENCE FOR SUSTAINABILITY OF THE SERVICE DUE TO DIFFICULTY IN RECRUITING TO A SPECIALIST AREA.	• In February 2015 there will only be 1 band 7 for 2 days per week total 15 hrs. • Erosion of rotating therapist to this service has reduce the ability to back fill • Agency support is in practical as there is no level of skill suitable and none that can fit within a small specialist team • Increase in waiting list time. This is currently creeping to -8 weeks and is set to deteriorate rapidly as staff go on maternity leave end of March • PHT will need to consider notification to NHS England that the department is unable to meet the criteria of the Murrison Centre. Potentially PHT are at risk of losing that status with the Qudos/reputation and significant funding that PHT have benefited from. This will have to be an early escalation in January 2015	• Additional hrs. have been offered by the Centre paid for by the veterans fund • Current staff cannot extend their secondments to DSC as required to return to their specialties to back fill vacancies within other specialties namely MSK • Clinical Support has been approached to request that the amputee nurse specialist who is currently moving to tissue viability is released for a half a day per week until mid-February to support the DSC wound pathway to help elevate waits and or unnecessary determination of complex wounds,. This has been agreed. • A risk share agreement has been reached as an interim for 50 :50 share of the costs with the association resources required,	16 4x4	16 4x4	8 4x2	• Agree 50 50m share of costs for increased resources. • Recruit to vacant band 3 post • Utilize the current band 7 post to support enhanced rotation at band 5 and band 6 level • Address with the commissioners who should fund the service going forward • The band 5 rotation is in place but still no plan to cover the band 6 maternity leave and still no plan to cover the vacant band 7 which has happened since the last escalation. • Contractual negotiations have continued with Solent with a resolution that those therapy staff left at DSC and AMDH will TUPE .CS are taking this forward. • Rotational posts at band 5 are in post with Increased hrs to support a more robust skeletal service in the short term. • Looking to TUPE staff in September 2015 - • TUPE should be completed by end of November 2015	• Open dialogue between Solent and PHT finance contracting team to reach a swift resolution • Open dialogue with the Solent therapy team to work with a flexible model in order to grow the service	Nov 2015	Nov 2015	CSC Governance Committee

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34-1516	C/F/L/Q&P/R/SD/Assessment	May 15	QUALITY OF TRANSCRIPTION IS VARIABLE • Dictation clarity is poor • No standard formatting across PHT • Length of dictation • A lack of strategy for transcription services,	• Poor quality letters may be released to GP's having a potential clinical impact and a negative effect on reputation • PHT will not be able to keep up with the cost an demand for typing	• Double validation system in process for quality. • Encourage Clinicians to feedback on quality • Turnaround times constantly monitored • Auditing Programme • Full feedback process to OKS agreed and in place	12 4x4	12 4x3	8 4x2	• Auditing Programme to be set up for quality of letters – on-going • Strategy group for transcription to be set up as task and finish project. • Continue to monitor and report turnaround times • Consideration now to be given to introducing Trust template for letters to reduce length and therefore reduce errors. • Continue with feedback to clinicians providing poor dictation and lack of robust checking of final letters.	• CSC Governance Committee • RAC • Operational Board Meeting • Transformation Board	Jan 2016	May 2016	Code A CSC Governace

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36-1516	Clinical / Assessment	July 2015	CURRENTLY THERE IS A HIGH RISK AROUND THE IDENTIFICATION OF CLINICIANS AND DOCTORS TAKING RESPONSIBILITY FOR BLOOD TESTS AND THE LACK OF AUDIT AND REVIEW AROUND FILING AND VIEWING RESULTS. There are 2 systems in place to review blood review results but APEX cannot log information as to who reviewed the results. ICE can produce audit trails but we need to ensure Doctors are checking results daily. This is currently not happening.	• Patient safety, if results are not checked in a timely manner. • No audit trail if an incident happens.	• ICE instead of APEX for external partners has been instigated • IT department educated as to licence allocated	15 3x5	15 3x5	9 3x3	• Change training of ICE to include more education around lack of controls in APEX • Pilot in place in MOPRS start 3rd August 2015 for 4 weeks. This pilot will make it mandatory for all junior docs to log into ICE once per day • The pilot will assess: • Additional time it takes to log in each day •Load on time and effort •Any technic al issues to be addressed	• Project lead to monitor and complete outcome of review • Risk assurance committee to monitor • Project lead to feed back to Risk assurance committee in October 2015	Dec 2015	Dec 2015	[redacted]

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37-1516	F/Q/H&S / Risk Assessment	June 2015	NON-COMPLIANCE WITH CURRENT CSU COMMISSIONED PATIENT TRANSPORT BOOKING PROCESSES ARE RESULTING IN INAPPROPRIATE BOOKINGS/MISUE OF TRANSPORT PROVISION AND ELIGIBILITY CRITERIA.	• Patient experience • Compromised whole process for central booking of outpatients • Financial penalties if PHT are seen to be non-compliant with the booking of transport that has been commissioned by the CSU	• Some specialist areas, have their own discrete outpatients bookings i.e. oncology, and therefore they are better placed to follow the guidance for the re booking of transport.	9 3x3	9 3x3	6 3x2	• Small working group to address the issues and impact, supported by Clinical support as the booking center for outpatients sits within this CSC: • Transport bookings for outpatients are completed retrospectively as a majority of PHT outpatient work is organized centrally, i.e. booked after the patient has gone. • Transport can only then be booked as per the last request which may or may not be valid and therefore potentially ineligible	• Limited to specialist clinics	Oct 15	Mar 16	OB
38-1516	F/Q/H&S – Risk Assessment	May 2015	DELAY IN MIGRATION TO 3M MEDICODE CLINICAL CODING SYSTEM, AS CURRENT SYSTEM IS NO LONGER SUPPORTED / MAINTAINED BY 3M	• Patient safety. • Coding updates not available on old system. • Potential loss of revenue to the Trust (100k per month). • Incorrect clinical outcome data. Increase in coding backlog.	• Backup system available (KEE), will result in reduced productivity. • Maintenance agreement with current encoder provider to end of 15/16 (from June 2015	12 3x4	9 3x3	6 3x2	• Working with IT project manager , 3M and procurement to find a solution. • Business case produced (July 2015) and approved for IT capital monies – completed Sept 2015. • Procurement process underway for new encoder system. • Expected date of migration to new system by end January 2016.	• Monitor coding updates that cannot be entered on to current system. • Coding Manager and CSC management review progress at least monthly.	Dec 15	Mar 16	CSS Clinical Governance

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39-1516	Q&P/SD/R – CSC Risk Registe	01/04/15	INSUFFICIENT THEATRE CAPACITY TO MEET PLANNED DEMAND	• Increase in patient delays • Inability to meet 18 week RTT target • Increase in complaints • Financial liability if fail to achieve targets • Trust reputation	• Reviewed as part of business planning and additional list requirement remodeled • Active management of PTL by Access centre • Activity and performance data reviewed by CSC Board weekly • Additional list requirement submitted to executive team.	16 4x4	16 4x4	8 4x2	• Capacity shortfall in some specialties remains, additional lists arranged for backlog clearance • Additional lists should be available in October. • Options for longer days and weekend working being explored	• Weekly PTL meeting • Waiting list review	Nov 15	Mar 16	Code A: S&C Governance
40-1516	H&S/L/Q&P/SD/R –assessment	01/10/2015	PHYSICAL AND OPERATIONAL FIRE PRECAUTION DEFICIENCIES. (Maybe identified ad hoc or by programmed risk assessments)	• Patient and staff safety. • Potential ignition spread and/or delayed detection of fire. • Potential for inadequate response to fire incident • Potential enforcement action by Hampshire Fire and Rescue Service (HFRS) under Fire Safety Order • Scale of works identified is large and rectification will be disruptive and prolonged.	• Fire risk assessments completed and mitigation actions underway. • Follow up actions are identified prioritized and monitored to completion. • Planned preventative maintenance in place. • HFRS Alterations Notice in force to ensure FPs are not compromised. • New build fire stopping deficiencies completed. • Fire risk review meetings are set up to determine actions required from risk assessments.	8 4x2	8 4x2	4 4x1	• On-going progress with identified works and monitoring of life cycle programme. • Prompt attention to deficiencies as they are identified without initial recourse to commercial liability. • Retained Estate residual fire stopping issues works have commenced and on-going	• Monthly fire issues meetings (PHT/CSL/THC) • Monthly FRA review meetings (PHT/CSL/THC) • Agenda item at Liaison meetings. • HFRS audits.	Feb 16	Apr 17	

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											Review Date: Feb 16	
41-1516	H&S/L/Q&P/SD/R –assessment	01/10/2015	FIRE SPRINKLER INSTALLATIONS REQUIRE UPDATING TO A COMPLIANT LIFE SAFETY SYSTEM.	• Patient and staff safety.	• System is operational but activation of sprinkler heads may be delayed.	6 3x2	6 3x2	3 3x1	• Specialists are reviewing the system and providing recommendations as to the risk, options to resolve and costs. • Phase A replacement programme underway on target for completion November 2015. • Phase B in programming completed and submitted/discussed with HFRS – completion for June 2016.	• Fire issues meetings • Separate progress meetings • HFRS briefing.	Target Date: Jun 16	
											Review Date: Jan 16	
42-1516	C/Q&P/SD/R – Risk Assessment/Incidents		LACK OF REPORTING CAPACITY IN RADIOLOGY TO REPORT ED AND MAU PLAIN FILMS.	• Impact on patient outcome through missed or delayed diagnosis. • Trust reputation	• Whilst the PHT plain film reporting and evaluation policy states Diagnostic Imaging will undertake the routine reporting of Emergency department "normal" examinations, it is recognised that there is insufficient capacity to deliver this. • The Emergency Department are aware that advice can be sought via the Radiology Access Unit and the results service for any images where an immediate radiological opinion is required. • In addition, whilst radiographers do not provide a radiological opinion they will, if able, highlight pathology to the referrer.	20 4x5	20 4x5	8 4x2	• Contact other Trusts to see how they have addressed Plain film reporting capacity. - completed • Return to RAC Oct 5th 2015 with outcome of above and potential options for further discussion – plan to be developed by Dec 15	• CSC Clinical Governance Meeting • Operational Board • RAC	Target Date: Aug16	CSS CSC Governance

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43-1516	C/Q&P/SD/R - National	November 2015	The BMA has just announced the dates of proposed industrial action for junior doctors. The BMA has said that action would begin with an emergency care-only model, which would see junior doctors provide the same level of service that happens in their given specialty, hospital or GP practice on Christmas Day: • **Emergency care only — from 8am Tuesday 1 December to 8am Wednesday 2 December** The industrial action would then be escalated to a full walk-out by junior doctors: • **Full walk out — from 8am to 5pm, Tuesday 8 December** • **Full walk out — from 8am to 5pm, Wednesday 16 December**	• Junior Doctors not available to look after patients leading to significant issues with patient care • All targets being compromised.	• Staff side meeting being organized to minimize the impact on patient care. • Emergency amended Business Continuity Plan being agreed with the CSCs to enable appropriate local action. • Internal & external communications being prepared to be launched shortly.	16 4x4	16 4x4	12 4X3	• Continue working with staff side to minimize impact. • Emergency Planning meeting with CSCs for CSC action plans • Communications launched	• Constant discussions with Staff Side, Emergency Planning, HR, CSCs, Chiefs of Serviceand Communications	Jan 2016	Jan 2016	Code A / EMT

LEADS		COMMITTEE/GROUP ABBREVIATIONS			OTHER ABBREVIATIONS	
JA	**Code A**	CS Gov	Clinical Services Governance Committee		CSC	Clinical Service Centre
DB		CCRG	Combined Contract Review Group		CSL	Carillion Services Limited
AC		G&Q	Governance & Quality Committee		CQC	Care Quality Commission
MD		FC	Finance Committee		CRB	Criminal Records Bureau
SE		F&S C	Fire and Safety Committee		EDS	Electronic Discharge Summary
AF		ICMC	Infection Control Management Committee		HFRS	Hampshire Fire and Rescue Service
SH		IGSG	Information Governance Steering Group		HII	High Impact Interventions
CJ		ITSG	Information Technology Steering Group		OBC	Outline Business Case
RK		MDMC	Medical Devices Management Committee		PID	Person Identifiable Data
NM		MHLG	Mental Health and Learning Disabilities Group		NHSP	National Health Service Professionals
CM		NW/HR RC	Nursing Workforce/ HR Risk Committee			
TP		PEWG	Patient Experience Working Group			
CT		PSSG	Patient Safety Steering Group			
JT		SC	Safeguarding Committee			
HW		WSC	Workforce Strategy Committee			
LW						

Guidance for the Assessment of Risk Rating

LIKELIHOOD (frequency)		CONSEQUENCE (impact/severity)				
		Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Serious (5)
Rare	(1)	1	2	3	4	5
Unlikely	(2)	2	4	6	8	10
Possible	(3)	3	6	9	12	15
Likely	(4)	4	8	12	16	20
Highly likely	(5)	5	10	15	20	25

Green	Low Risk (1 – 3)
Yellow	Moderate Risk (4 – 6)
Amber	High Risk (8 – 12)
Red	Extreme Risk (15 – 25)

LIKELIHOOD	DESCRIPTOR	DESCRIPTION
1	Rare	Not expected to happen again except only in exceptional circumstances e.g. once a decade, or a probability of <1%
2	Unlikely	The event may re occur infrequently, but it is a possibility e.g. once a year or a probability of 1-5%
3	Possible	The event may re occur e.g. once a month, or a probability of 6-20%
4	Likely	The event will probably re occur e.g. weekly or a probability of 21-50%
5	Highly likely	The event is likely to re occur on many occasions, is a constant threat e.g. at least once a day or probability of >50%. More likely to occur than not.

Portsmouth Hospitals NHS
NHS Trust

GUIDANCE ON COMPLETION OF THE RISK REGISTER / RISK ASSESSMENT FORM

SECTION	COMMENTS
Ref No	• A number which allows the risk to be uniquely identified: this will inserted, once the risk is placed on the register
Type	• This is outlined on the top of the risk register and assessment form: a risk may be of more than one type
Date	• The date the risk was first placed onto the Register
Risk Description	• A statement that provides a brief, unambiguous and workable description, which enables the risk to be clearly understood, analysed and the requirement for additional controls identified
Impact	• This is the consequence should the risk be realised
Active Controls	• Details of any actual controls already in place i.e. factors that are exerting material influence over the risk's likelihood and impact: the risk rating. • An effective control is one that is properly designed and delivers the intended objective / mitigates the risk
Initial Risk Rating	• The rating determined by likelihood x consequence using the 5 x 5 matrix o Likelihood: the likelihood of the risk happening - this score should take into account the existing controls o Consequence: the impact should the risk occur - this score should take into account the existing controls
Current Risk Rating	• This will initially be the same as the initial risk rating • As time progresses, the current risk rating should decrease (if your controls are appropriate and effective) and move closer to the predicted residual risk rating
Further actions	• Further action(s) required to be taken in order to eliminate, mitigate or control the risk
Progress Update	• A brief update on progress made since the last review. NB: if no progress has been made, do not make it up.
Monitoring / Assurance	• How you are going to monitor that the controls in place are effective in managing the risk Plus • Evidence that shows risks are being reasonably managed
Predicted Residual Risk	• The risk rating after the further actions have been implemented: expressed as the product of the likelihood x the consequence
Initial Target Date	• Realistic date by which you consider the proposed actions will be completed
Revised Target Date	• A revised date should the initial target date not be achieved. A reason for this revised target date must be provided
Risk Owner	• This is you and you should o Understand the risk and monitor it through its lifetime o Ensure the appropriate controls are enacted o Report on the risk whenever required to do so
Responsible Committee	• The Committee which has responsibility for monitoring progress of the management of the risk

CONSEQUENCE SCORE (1 – 5)	1 Insignificant/None (Green)	2 Minor (Yellow)	3 Moderate (Amber)	4 Major (Red)	5 Extreme (Red)
Injury (physical / psychological)	Adverse event leading to minor injury not requiring first aid and managed satisfactorily on the ward	Minor injury or illness, first aid treatment needed Staff sickness <3 days	RIDDOR / Agency reportable. Adverse event which impacts on a small number of people	Major injuries or long term incapacity / disability (e.g. loss of limb)	Incident leading to death or major permanent incapacity Event which impacts on large numbers of people
Additional Guidance	Bruise/graze (no time off work)	Laceration, sprain. Anxiety requiring counselling (less than 3 days off work)	Injury requiring more than 3 days off work/admission < 24hrs	Fractured of major bone, loss of limb, post-traumatic stress disorder	Death, paralysis
Quality of the patient experience / outcome	Reduced quality of patient experience not directly related to delivery of clinical care	Unsatisfactory patient experience directly related to clinical care – readily resolvable	Mismanagement of patient care + short term effects (less than a week)	Mismanagement of patient care + long term effects (more than a week)	Totally unsatisfactory patient outcome or experience
Additional Guidance	Outpatient clinic waits	Drug error with no apparent adverse outcome, grade 1 pressure ulcer	Increased length of stay less than 1 week. HAI (short term) Grade 2/3 pressure ulcer	Increased length of stay more than 1 week. Long term HAI Grade 4 pressure ulcer	Infant abduction. Removal of wrong body part leading to death or permanent incapacity
Complaints / Claims	Locally resolved complaint	Justified complaint peripheral to clinical care	Below excess claim. Justified complaint involving lack of appropriate care	Claim above excess level Multiple justified complaints	Multiple claims or single major claim
Staffing and Competence	Short term low staffing level (<1 day), where there is no disruption to service	Ongoing low staffing levels resulting in minor reduction in quality of care	Late delivery of key objective / service due to lack of staff. Minor error due to ineffective training. Ongoing problems with staffing levels	Uncertain delivery of key objective / service due to lack of staff. Serious error due to ineffective training	Non-delivery of key objective / service due to lack of staff. Critical error due to insufficient training
Service / Business Interruption	Interruption in a service which does not impact on the delivery of care or the ability to continue to provide the service Trust would not encounter any significant accountability implications	Short tem disruption to service with minor impact on care Some accountability implications but would not affect Trust's ability to meet key reporting requirements	Some service disruption with unacceptable impact on care. Non-permanent loss of ability to provide service Trust may experience difficulty in complying with some key reporting requirements	Sustained loss of service with serious impact on delivery of care, major contingency plans involved Trust would be unable to comply effectively with the majority of its reporting requirements Recovery would be highly complicated and time-consuming	Permanent loss of core service or facility. Disruption to facility leading to significant 'knock-on' effect across Local Health Economy Trust would be unable to meet key reporting requirements Recovery would be extremely complicated
Projects / objectives	Insignificant cost increase / schedule slippage. Barely noticeable reduction in scope or quality	< 5% over budget / schedule slippage. Minor reduction in quality / scope	10% over budget / schedule slippage. Reduction in scope or quality	10 – 24% over/ under budget/ schedule slippage. Does not meet secondary objectives	> 25% over /under budget / schedule. Doesn't meet primary objectives. Reputation of the Trust seriously damaged. Failure to appropriately manage finances
Financial	Small loss	Loss < 5% of budget	Loss < 10% of budget	Loss of 10 – 25% of budget	Loss of > 25% of budget
Inspection / Audit	Small number of recommendations which focus on minor quality/ process improvement issues	Minor recommendations which can be addressed by low level of management action	Challenging recommendations but can be addressed with appropriate action plan	Enforcement Action. Critical report / low rating	Prosecution. Zero Rating. Severely critical report
Adverse Publicity / Reputation	Coverage in the media, little effect on public confidence / staff moral Public perception of the organisation would remain intact	Local media – short term. Minor effect on public attitude / staff morale Public perception of the organisations may alter slightly but with no significant damage or disruption	Local media – long term. Considerable adverse public reaction / staff morale may be affected	National media < 3 days. Usage of services affected Public confidence in Trust undermined, could result in major problems	National media > 3days. MP concern (questions in the House) Major adverse public reaction
No. Of Persons Affected	N/A	1-2	3-15	16-50	>50

Consequence	Description
Insignificant	Operational performance of the function/activity area would not be materially affected The organisation would not encounter any significant accountability implications The interests of stakeholders would not be affected Public perception of the organisation would remain intact
Minor	Slight inconvenience / difficulty in operational performance of function/activity Some accountability implications for the function/activity are but would not affect the organisation's ability to meet key reporting requirements Recovery from such consequences would be handled quickly without the need to divert resources from core activity areas Some minor effects stakeholders e.g. other sources or avenues would be available Public perceptions of the organisation may alter slightly but with no significant damage or disruption occurring
Moderate	Operational performance of the organisation would be compromised to the extent that revised planning would be required to overcome difficulties experienced by function/activity area The organisation would experience difficulty in complying with some key reporting requirements Recovery would be gradual and required detailed corporate planning with resources being diverted from core activity areas Stakeholders would experience some difficulty Considerable adverse public reaction
Major	Operational performance of the function/activity area would be severely affected, with the organisation unable to meet a considerable proportion of its obligations. The organisation would not be able to comply with the majority of its reporting requirements effectively Recovering from the consequences would be highly complicated and time-consuming Stakeholders would experience considerable difficulty Public reaction could result in major problems
Serious	Operational performance would be compromised to the extent that the organisation is unable to meet its obligations The organisation would be unable to meet key reporting requirements The organisation would incur huge financial losses Recovering from the consequences would be extremely complicated Major adverse public reaction.