Ashford and St. Peter's Hospitals NHS Foundation Trust

**Trust Board**
**26th April 2018**

| | | |
|---|---|---|
| **AGENDA ITEM NUMBER** | 15.5 | |
| **TITLE OF PAPER** | Trust Risk Register | |
| Confidential | **YES** | |
| Suitable for public access | **YES** | |
| **PLEASE DETAIL BELOW THE OTHER SUB-COMMITTEE(S), MEETINGS THIS PAPER HAS BEEN VIEWED** | | |
| Trust Executive Committee | | |
| **STRATEGIC OBJECTIVE(S):** | | |
| Best outcomes | √ | Identify risks to patient safety and acing upon them is inherent in achieving best outcomes for patients. |
| Excellent experience | √ | Proactive management of risks enhances patient experience. |
| Skilled & motivated teams | √ | Safety is improved when teams are proactive in the management of risks to patient safety. |
| Top productivity | √ | Productivity is improved when patient safety risks are managed effectively and risks are avoided. |
| **EXECUTIVE SUMMARY** | | |
| | This report summarises the Trust Risk Register as at 20/04/2018. There are currently 5 risks on the Trust Risk Register<br><br>The Trust Risk Register report provides assurance that relevant risks have been identified as Trust risks and that mitigating actions are in place.<br><br>The Risk Register links to all Strategic Objectives. | |
| **RECOMMENDATION:** | For Assurance | |
| **SPECIFIC ISSUES CHECKLIST:** | | |
| Quality and Safety | Yes | |
| Patient Impact | Yes | |
| Employee | Yes | |
| Other Stakeholder | | |
| Equality & Diversity | Yes | |

| | |
|---|---|
| Finance | Yes |
| Legal | The Trust Risk Register is required by the Department of Health. |
| Link to Board Assurance Framework Principle Risk | |
| **AUTHOR** | Jacqui Rees, Assistant Director of Patient Safety |
| **PRESENTED BY DIRECTOR** | Sue Tranka, Chief Nurse |
| **DATE** | 23 April 2018 |
| **BOARD ACTION** | Review the paper and obtain assurance. |

| ID | Title | Description | Risk Opened | Risk Level Current | Risk Level Target | Action Plan | Progress | Review Date | Monitoring |
|---|---|---|---|---|---|---|---|---|---|
| 1451 | Clinicians may be Unsighted to, or Fail to Review, the Results of Patient Investigations | (CQC outcome 21 & 16) There is a risk that clinicians may be unsighted to, or fail to review, the results of patient investigations and that clinical care may be compromised as a result. There is a lack of consistent, robust processes to ensure that clinicians are aware of the results of clinical investigations and take appropriate actions as a result. This risk replaces 1412. | MAJOR<br>15<br>24/06/15 | MAJOR<br>15<br>⇔ | NEG<br>2 | 1) Implement Order-comms system for investigations.<br>2) Review of current clinical systems to identify best practice.<br>3) Alert Clinical offices to the issue.<br>4) Review of Code 5 process for alerting radiology reports and ensure active tracking of reports. | April 2018: Order-comms project progressing according to plan with Radiology build and system testing on-going. All key project dates remain unchanged at this time but there is a risk of slippage to timescales for the following reasons:<br>Availability of local resource to complete the Radiology build and testing.<br>Dependencies:<br>-Project is dependent on BSPS completing a data cleanse on the “Frimley” ICE server, which is an interim solution for Pathology results reporting (i.e. replaces Ward Enquiry). This is now expected to be completed in May.<br>-No date for delivery of hardware to BSPS for the new BSPS ICE system, which will interface to the ASPH ICE system to provide Pathology orders and results.<br><br>Feb 2018: BSPS kicked off the project formally mid-Feb 2018. The build, configuration & testing of ASPH ICE is underway in preparation for BSPS Go-Live, expected November 2018. Clinical activities has impacted the progress of the Radiology build. Over the next quarter, as a necessary interim step of the overall project, we will move from viewing results in WinPath Ward Enquiry to Frimley SPS ICE solution. ICE is unable to support Code 5 and GP messaging. To mitigate this we plan to continue using CRIS Communicator for sending alerts to GP’s. | 30/05/2018 | Exec Lead: Medical Director<br><br>Lead Manager: Liam Reid |

| ID | Title | Description | Risk Opened | Risk Level Current | Risk Level Target | Action Plan | Progress | Review Date | Monitoring |
|---|---|---|---|---|---|---|---|---|---|
| 1552 | Lost to follow up as a result of patient administrative processes. | There is a risk that patient safety will be compromised and that patients may come to serious harm as a result of failures in core administrative processes, which may lead them to be undetected or lost to follow-up after an outpatient attendance. | CATASTR<br>20<br>06/03/17 | MAJOR<br>15<br>  | MINOR<br>4 | Feb 2018: all specialties confirm that they only using patient centre where there are capacity issues unless another system e.g. DAWN in place to reduce risk of paper systems.<br>4 x SOP's for clinical admin staff being developed and will be complete by end March to standardise practice.<br>Standardised form for use by divisional teams to track outcomes for patients on weekly LTFU report introduced.<br>Digitising of clinic outcome form discussed with AD for IT. Further work required to assess risk of losing patients and Quality and Safety Impact Assessment required before going live.<br>AMES division identified additional resource to assist with patient tracking and follow up actions on a daily basis.<br><br>Dec 2017: Clinical engagement with improvement plans by divisional clinical representatives in attendance at steering group.<br>Convert outpatient outcome form to electronic form.<br>Electronic process for identifying patients with no outcome at end of clinic, pilot with current "as is" process.<br>Provide patient information in outpatient areas (signs and leaflets) advising requirement to book appointment prior to leaving.<br>Process of communications for clinicians trustwide. | April 2018: AMES Division now using patient centre to track patients waiting for diagnostics. To consider roll out to other specialties. 6 monthly cancer audit numbers reducing but numbers of missing outcome codes increasing. SOP's to be introduced in an attempt to get outcomes right first time to reduce rework and duplication.<br><br>Feb 2018: Risk discussed at LTFU Project Group. Overall numbers of LTFU reducing. Actions taken appear to be effective. Cancer LTFU 6 monthly audits continue and numbers of patients on audit to 300. Majority of follow-up waiting lists confirmed as being on patient Centre. SOP's being developed to standardise clinical admin processes. Likelihood of risk has now reduced to possible with severity remaining at catastrophic.<br><br>Jan 2018: No change to the risk or action plan.<br><br>Dec 2017: A clinical lead has been identified for the project and is leading the engagement clinical representatives<br>The electronic outpatient outcome form has been developed and is in test form.<br>The reports for identifying | 17/05/2018 | Exec Lead: / James Thomas<br><br>Lead Manager: Mark Hinchcliffe/ Christine Armitage |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Education and training for all staff involved in process including clinic nursing staff, admin staff and clinicians.<br>2 x Quality Improvement projects looking at processes within clinical office teams in respiratory and urology.<br><br>Oct 2017: Additions to the action plan are as follows:<br>Clinical engagement with improvement plans by divisional clinical representatives in attendance at steering group.<br>Convert outpatient outcome form to electronic form.<br>Electronic process for identifying patients with no outcome at end of clinic, pilot with current "as is" process.<br>Provide patient information in outpatient areas (signs and leaflets) advising requirement to book appointment prior to leaving.<br>Process of communications for clinicians trust-wide.<br>Education and training for all staff involved in process including clinic nursing staff, admin staff and clinicians.<br>2 x quality improvement projects looking at processes within clinical office teams in respiratory and urology.<br>Increased frequency of meetings to fortnightly from monthly. | patients with no outcome and missing appointments are being actioned by the clinical admin teams<br>Following work with two clinical offices, work is underway to establish SOPs and education and training for all Clinical Office staff<br><br>Oct 2017: Action plan has been extended. Risk score to be reviewed. | | |

| | Title | Description | Risk Opened | Risk Level Current | Risk Level Target | Action Plan | Progress | Review Date | Monitoring |
|---|---|---|---|---|---|---|---|---|---|
| 1572 | Joint Trust/CCG QIPP Delivery | There is a risk that Joint QIPP schemes with NWS CCG are not delivered, leading to activity, workforce and facility pressures, unaffordable over performance bills to our commissioners and contract risk sharing arrangements being enacted. Hence the Trust may miss its financial targets. Total risk c£1m for the Trust and £7m for NWS CCG in 2017/18. | CATASTR<br>16<br>05/07/17 | CATASTR<br>16<br>  | MODER<br>9 | Continue regular joint delivery meetings with CCG.<br>Regular meetings with CCG Director of Finance, CCG Programme Manager and Associate Director of Strategy.<br>Monitor QIPP delivery schedules.<br>Continue regular internal meetings to review cost responses to QIPP schemes. | Apr 2018: No change to the risk. The full QIPP was not achieved for 2017/18. There remains a significant risk that sufficient 2018/19 schemes are not identified<br><br>Feb 2018: No change to the risk. The full QIPP will not be achieved for 2017/18. There is a significant risk that sufficient 2018/19 schemes are not identified.<br><br>Jan 2018: No change to the risk.<br><br>Dec 2017: Mitigation to this risk has been hampered by the recent centralisation of the CCG executive function with Guildford & Waverley and Surrey Downs. This has meant joint delivery meetings have been sparsely attended and often cancelled whilst the reorganization was taking place. Following the completion of the centralization there are less executives for ASPH to engage with which could hamper the success of the programme for the | 27/04/2018 | Executive Lead: Simon Marshall<br><br>Lead Manager: George Roe |

| ID | Title | Description | Risk Opened | Risk Level Current | Risk Level Target | Action Plan | Progress | Review Date | Monitoring |
|---|---|---|---|---|---|---|---|---|---|
| 584 | Insufficient Electrical Resilience at St Peter's Hospital | The risks associated with the electrical distribution system at St Peter's hospital comprises four areas of concern.<br>1.Two separate electrical incomers from the grid enter into the same switch-room in Theatre Block and while both are electrically separate the share the same location. Should there be a catastrophic event (e.g. fire or flood) within the area, both supplies from the grid would be lost.<br>2.The Trust is therefore not compliant with HTM 06 "N+1 resilience" (where the failure of one component - in this case the switch-room containing the two supplies has back up).<br>3.There are significant areas of the site (e.g. Diagnostics, Pharmacy and Pathology) that have no; or significantly limited; access to back up generation and these departments would be unable to function should power be lost.<br>4.Some of the equipment used in the affected Department's do not | MAJOR<br><br>26/01/20<br>15 | MAJOR<br><br>15<br><br>⟷ | MINOR | April 2018: External risk assessment has taken place and has identified risks across the St Peter's site distribution system.<br><br>Feb 2018: Report received from electrical consultants relating to risks on the Trust distribution system.<br><br>Dec 2017: External risk assessment has taken place and has identified risks across the St Peters site distribution system.<br><br>Risk has been re-assessed at the Estates & Facilities Assurance Group on the 3rd October to ensure it is correctly reflected on the Risk Register. The initial risk level was given as 15 and it should remain at 15.<br><br>Although critical areas of the hospital have generator back up this is will be insufficient to deal with a power outage to protect the hospital as a whole. It would also leave no diagnostic imaging available to the Trust which would mean that the hospital would not be able to function. | April 2018: A meeting has taken place with Ridge Consultants and agreement has been reached where the project work will commence. Ridge are to check loading requirements in the Diagnostic area and Estates are investigating future activity in the area. This will enable design work to commence the first part of a three year programme.<br><br>Feb 2018: Report on the Trust electrical distribution systems has identified 118 risks. 25 risks are identified as high risk and budget costs to address these risks have been received. Discussions are to take place on 2nd March 2018 to agree which risks to mitigate with the Capital funding for 2018/2019 likely to be £650k. Design work will then be carried out by the consultants.<br><br>Dec 2017: Ridge consultants are now adding the spread of risks onto the electrical distribution drawing so that the Trust can understand where the most benefit is gained when spending the funding. A meeting with Ridge will take place in January where a decision will be made as to w here to focus changes to the distribution system. | 15/05/2018 | Exec Lead: Chris Bell<br><br>Lead Manager: Keith Hayward |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | have integrated battery back-up or UPS, and require power to either complete, or make safe a patient's medical intervention. Loss of data may also occur (e.g. in Diagnostics, the record of dosage rates may be wiped or corrupted).<br>The risks are therefore are to Patient Safety, Service Failure, Infrastructure failure, reputational loss, Legal action, and financial loss of income. | | | | | Oct 2017: Waiting on the results of an electrical resilience survey this will prompt two actions:<br>1. Provide clearly defined areas of vulnerability & a plan to deal with them<br>2. Update of risk register as the issues become more definable | | |

| ID | Title | Description | Risk Opened | Risk Level Current | Risk Level Target | Action Plan | Progress | Review Date | Monitoring |
|---|---|---|---|---|---|---|---|---|---|
| 1598 | Medication harm | There is a clinical risk of harm to patients from the prescribing errors (illegibility, dose errors, discharge information) of medicines | MAJOR<br>29/01/2018 | MAJOR<br>15 | MINOR | March 2018:<br>1. Establish weekly medication safety huddle to review incidents and work together to progress the change ideas<br>2. Increase pharmacy capacity (Medicines Safety Office role) to support medicines safety activities: oversee error trending/analysis and learning systems<br>3. Appoint a medicines safety champion within each Division (mutliprofessional) to take on an active role in improving safe use of medicines within the Divisions.<br>4. New Trust prescription charts | April 2018: Weekly medicines safety huddles now established. MSO post review completed in April 2018, change from 0.75wte to 1wte carried out.<br>Task and Finish group for delivery of new prescription chart set up in March 2018, with plan to deliver new chart before end of Q1.<br>Improvements delivered with performance medicines management training with monthly reporting to Divisions (Mar 2018 – 83%).<br>Pilot of pharmacy service in A&E carried out over Easter period (3weeks), with plans to identify resource to support longer deployment in A&E. | 30/05/2018 | Exec Lead: Sue Tranka<br><br>Lead Manager: Toks |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | (with improvements in safety measures for highlighted high risk medicines).<br><br>5. Divisional actions to minimise risks on:<br>- safe & secure handling of medicines in clinical/ward areas,<br>- misadministration of medicines,<br>- learning from medications incidents/errors<br><br>6. Substitutional Pharmacists' roles alongside junior doctors and nurses on wards and front of house (A&E) to improve medicines safety (Divisional support)<br><br>Jan 2018:<br>1. Increase pharmacy capacity (Medicines Safety Officer role) to support medicines safety activities: oversee error trending/analysis and learning systems<br><br>2. Each Division to appoint a medicines safety champion (matron within the Division) to take on an active role in improving safe use of medicines within the Divisions.<br><br>3. New Trust prescription charts (with improvements in safety measures for highlighted high risk medicines).<br><br>4. Divisional governance actions to minimise risks on safe & secure handling of medicines in clinical/ward areas, misadministration of medicines | March 2018: Action plan updated. | | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | and learning from medications incidents/errors.<br><br>5. Substitutional Pharmacists' roles alongside junior doctors and nurses on wards and front of house (A&E) to improve medicines safety (Divisional support)<br><br>6. Implement of E-prescribing (with decision support) | | | |

## Current Risk Matrix

| | | | Likelihood | | | | |
|---|---|---|---|---|---|---|---|
| | | | Rare | Unlikely | Possible | Likely | Almost Certain |
| | | | 1 | 2 | 3 | 4 | 5 |
| Severity | Negligible | 1 | 1 | 2 | 3 | 4 | 5 |
| | Minor | 2 | 2 | 4 | 6 | 8 | 10 |
| | Moderate | 3 | 3 | 6 | 9 | 12 | 15 |
| | Major | 4 | 4 | 8 | 12 | 16 | 20 |
| | Catastrophic | 5 | 5 | 10 | 15 | 20 | 25 |

Legend

1-3 Green
Negligible Risk

4-6 Yellow
Minor Risk

8-12 Orange
Moderate Risk

15 Red
Major Risk

16-25 Red/Red
Catastrophic Risk