# Clinical Risk Control Register

| Risk Category | Activity | Top Risk(s) | Initial Likelihood | Initial Severity | Initial Risk Rating | Prevention Controls - reducing likelihood | Mitigation Controls - reducing severity | Final Likelihood | Final Severity | Final Risk Rating | Responsibility? | Last / next review |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Reduced clinical workforce with loss of 0.6 WTE consultant cover | Reduced clinical capacity - specifically risk of loss of Specialist registrar position due to insufficient availability of consultant supervision which would lead to significant decrease in clinical capacity, morale and reputational damage. | 5 | 3 | 15 | Current consultants GTR and NC can provide telephone support/ emergency on site visits if required for ad hoc days with no consultant presence on a short term/ interim basis (on call payment for SRH consultants now agreed. Could approach colleagues in Princess Alice Hospice, St Helier and Epsom Hospital to enquire about capacity to provide emergency either telephone support or on site cover at time of need.<br>Recruitment to 0.6 palliative care consultant successful for Aug 2026 start with locum slots throughout the interim.<br>Exploration of clinical fellow appt in hand alongside other options | Specialty Doctor one day a week contract now extended for a further six months (Sept 2025).Could offer increased sessions to current staff grade doctors (this would help provide clinical cover but would not address need for clinical supervision).<br>Access to Supporter UK is an option. | 4 | 3 | 12 | CD/ NC | July 25/Oct 25 |
| 2 | Reduced clinical workforce / hours | Reduced responsiveness to existing caseloads<br>Management of expectations<br>Lower staff morale<br>Reduced staff retention<br>Reputational damage<br>Reduced referrals | 5 | 3 | 15 | Clear messaging to internal and external stakeholders<br>Review of operational guidelines following a period of existing guidelines and reduced staffing model.<br>Regular staff meetings / open door policy | Manage staffing levels across a 7 day service<br>Collaborative working with external colleagues to promote efficiency and reduce risk of patient outliers<br>Prioritise the support that we are responsible for delivering and reduce the amount that we pick up due to a lack of provision within the community. | 5 | 2 | 10 | CD | July 25/Oct 25 |
| 3 | IT PAS System Failure / Cloud Access Down | Inability to access contemporaneous clinical records or run business continuity reports | 5 | 3 | 15 | IT System Management Controls | · Contactable team OOH (not formal contract)<br>· Back up resource -outsourced at times of AL<br>· 2 x HSCN routers and lines to support fail over<br>· Hard copy daily print outs to provide basic continuity<br>. EMIS mobile has been rolled out for the IPU, medical team and community team incase of system failure.<br>. Medical team can access our EMIS tenant from Princess Alice Hospice IT system.<br>. In an emergency our neighbouring Hospices would allow us access to our EMIS system from either their sites or through remote access.<br>. 2 x Cisco firewalls configured for high availability for EMIS mobile. | 4 | 2 | 8 | IT/CD | July 25/Oct 25 |
| 4 | Breaches of confidentiality involving person identifiable data (PID), including data loss | · Reputational damage<br>· Litigation<br>· Fines from ICO<br>· Service user distress and safety risk | 3 | 3 | 9 | · Protecting Confidential Information Policy<br>· All personnel and volunteers trained on Information Governance on induction and annual mandatory training.<br>· Data User Agreements in place<br>· DPO, ISO, Caldicott Guardian & SIRO in place<br>· Suite of Information Security and Governance policy in place<br>· Test Phishing emails via IT Dept 3rd party contract.<br>· Secure PID communication email channel in place through NHS Net.<br>· Regular organisational sweeps in all departments<br>· Caldicott Guardian attends regular training and presents at associated fora.<br>· Maintenance of shared network drive to ensure file security.<br>- IT policy in place to restrict USB storage devices from being used.<br>- no local workstations store data, all data is accessed on centralised SAN. | · All personnel and volunteers trained on Information Governance on induction and annual mandatory training.<br>· Proactive checking in areas such as photocopier/clear desks.<br>· Established link with Capsticks solicitor who provides ad hoc advice on data access issues<br>· Annual - Information Governance Check list audit / Clinical Record documentation audit | 2 | 2 | 4 | IT/CD | July 25/Oct 25 |

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| 5 | Infection spread within hospice | · Inability to provide full clinical service impacting on both patients, their families and staff.<br>· May impact on external stakeholders.<br>· May impact reputational damage and potential funding streams | 3 | 2 | 6 | · Attention to and compliance with governmental guidance<br>· Implementation and maintenance of CLIN52 COVID policy<br>· Implementation and maintenance of CLIN08 Infection Control policy<br>· IPC Lead in post - overseeing the link nurses on the IPU and Community Team and close working with SWL infection control leads. | · Implementation and maintenance of CLIN52 COVID policy<br>· Implementation and maintenance of CLIN08 Infection Control policy<br>· PPE regular supply available<br>· Contingency planning clarified for any identified cases within the Hospice - as per governmental guidance<br>· Single room nursing. Increased telephone contact<br>· FFP3 mask fit testing ongoing<br>· Refresher PPE training and advice and support from PHE<br>Facility for staff to work from home | 2 | 2 | 4 | CD | July 25/Oct 25 |
| 6 | Extended bed occupancy | · Delay to discharge due to limited availability of CHC funded beds in the community and patient/family reluctance to transfer.<br>· Limits our processing of requests for admission.<br>· Potential effect on reputation, income generation and staff morale.<br>· Does fluctuate but more of an issue in the autumn/winter. | 3 | 2 | 6 | · Maintain relationships with Care Homes/ Sutton and Merton PLACE that have CHC funding.<br>· Provision of information to patient and family | · Staff proficiency in completing fast track.<br>· Screen referrals for potential impact.<br>· Dual planning with Hospital requesting admission.<br>· Consideration of CHC funded IPU beds in future.<br>· Expertise in discussion with patients and family members re discharge planning. | 2 | 2 | 4 | CD/IPU MDT | July 25/Oct 25 |
| 7 | Clinical Incidents | · Serious or moderate harm to patient Safety<br>· Risk of complaints from patients/families<br>· Reputational damage / litigation | 2 | 3 | 6 | · Low threshold to reporting<br>· Culture embraces reporting of all incidents related to clinical care<br>· Hierarchy of investigation<br>· Outputs- Learning informs improved procedures and processes<br>· Report to Clinical Quality & Governance Committee supports transparency<br>· Embrace of the Patient Safety Incident Response Framework (PSIRF)and Plan in OP01 in support of patient safety and learning from incidents | · Continued staff training and awareness of new techniques and products.<br>· Opportunity to participate in refection and sharing learning and outcomes.<br>· Feedback to complainants regarding change in practice.<br>· Encourage an environment of comprehensive reporting to support learning and quality improvement across all departments.<br>· Annual clinical audit /QI / research / data montoring program | 2 | 2 | 4 | CD & Director of QI | July 25/Oct 25 |
| 8 | Clinical Complaints | Local press coverage<br>Potential for public concern<br>Elements of public expecation not being met<br>Loss of confidence in the service<br>Reputational damage | 3 | 2 | 6 | · Organisational policy supporting values, behaviours and practices<br>· Education and training re communication<br>· Adherence to OP05 Feedback and Complaints policy<br>· Reported at Clinical Quality and Governance Committee<br>· All complaints discussed at hospice team meetings for awareness and learning across the organisation | · Reporting culture of any concerns- no blame but responsibility<br>· Use of investigative tools for significant incidents.<br>· Feedback to complainants regarding change/improvment in practice.<br>· All complaints both verbal and written treated with the same level of scrutiny<br>· Scoping to establish all clinical staff access to communication skills training<br>· Training on care delivery<br>· Information shared re: Duty of Candour and scope of the policy<br>· Complainants (both verbal and written) are offered the opportunity to meet and discuss concerns with Clinical Director, and maybe offered opportunity to join HUG to help with SRH future learning<br>· Complaints documented and register maintained<br>· Annual review by EXEC | 2 | 2 | 4 | CD | July 25/Oct 25 |
| 9 | Insufficient Nursing Resource on the Inpatient Unit. | · Unable to admit<br>· Impact on patients, families and reputation<br>· Impact on community team offer of admission | 2 | 3 | 6 | · Bank and Agency Nurses available<br>· Staff adapting/flexing shifts to cover IPU<br>· Monitoring of staffing capacity monthly/weekly/daily<br>· Alignment with Agenda for Change pay scales implemented<br>· Crisis cover payments in place<br>· Active recruitment ongoing | · IPU admissions can be reduced to meet staffing capacity<br>· Majority of patients are cared for in the community<br>· Nursing Associates are being upskilled<br>· Acuity score used to help guide admissions v staffing levels<br>· All Leave policies amended with improved leave entitlements | 1 | 3 | 3 | CD/IPU Clinical Lead | July 25/Oct 25 |
| 10 | Lone working | · Staff/volunteers work singularly in the community within referred patients homes.<br>· Risk of accident/incident in a patients home and individual risk to staff member.<br>· Risk in travel to and from home visits | 3 | 2 | 6 | · OP17 Lone worker Policy<br>· Community staff are supplied with a mobile phone for contact with the hospice or other healthcare professionals. ACC informed of access and egress.<br>· Lone worker alert devices in place.<br>- Increase in joint visiting across HCPs | · Lone Worker Policy informing steps to follow if a colleague does not return to base at expected time.<br>· Clarification and supported training on use of safety devices.<br>· EXEC OOH on call in place for contact and advice on further action.<br>· If there is perceived or hx of risk staff work in pairs and alert is added to the EPR.<br>· Lone Worker Risk assessment and EMIS template updated | 2 | 1 | 2 | CD/MDT | July 25/Oct 25 |

Key

The axis for Likelihood should be from 1. Very Low – 2. Low – 3. Medium – 4. High – 5. Very High

The axis for Severity should be from 1. Light – 2. Serious – 3. Major – 4. Catastrophic – 5. Multi Catastrophic

Over 13 = red
8-13 = amber
7 or under = green