The Royal Wolverhampton
NHS Trust

Trust Risk Register September-2017

Agenda Item No: 10.2.3

Safe & Effective | Kind & Caring | Exceeding Expectation

The Royal Wolverhampton NHS Trust

Trust Risk Register

September-2017

5	10	15	20	25
4	8	12	16	20
3	6	9	12	15
2	4	6	8	10
1	2	3	4	5

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Risk Lead	ID	Principal Risk		Controls	Positive Assurances	Gaps in Assurance/Control	Action Plan that addresses Gaps in Control	Residual Risk Level		
Risks Currently Being Managed										
Trust Objective:		**Be in the top quartile for all performance indicators**								
Chief Operating Officer	4286	If the Trust fails to achieve all mandatory criteria for the Paediatric Diabetes Best Practice Tariff, then this will potentially lead to poor clinical outcomes for patients. Also, if the Best Practice criteria are not achieved, this will result in the directorate failing to achieve additional income of BPT. Date of Origin: 14/08/2015 Date of escalation: 22/05/2017	3 x 4 = 12 AMBER	1) Cover Mon - Fri for discussion with Diabetes Team within 24hrs and new patients seen by next working day 2) Working with schools to develop educational programme targeted for patients (24/08/2016) 3) Letter sent to all parents informing of availability of drop in clinic Fri 2-4pm - (24/08/2016) Drop in clinic available for patients with Diabetes. 4) Interim support from dieticians and family youth worker (24/08/2016) 5) BPT compliance monitored monthly and quarterly using in house systems. (24/08/2016) 6) Compliance is reported through the Governance and Business structure. (24/08/2016) 7) BPT Best Practice standards met for 2015/2016.	5) Partial achievement 7/14 criteria (H-N) (14/08/2017) vacancies outstanding X2. 3) Positive feedback from parents following attendance at drop-in sessions. (14/08/2017) 7) Additional support enabled compliance to BPT standards for 2017 - 14/08/17	1) Insufficient staff to cover weekends 14/08/17 2) There are a number of patients whose education programme are still outstanding. 14/08/17 1-5) Unable to meet criteria re: 4 clincial appts in the financial year and 8 contacts in the financial year due to nursing vacancies (running at 50% capacity) (14/08/17) situation status remains the same. 1-4) Unable to meet criteria re: HbA1 measurements in financial year due to high DNA rates (14/08/2017) pending update from Consultant. 1 - 5) Posts remain vacant presently - post has been advertised. Risk upgraded to High Amber (14/08/2017) 7) Present service level will not enable compliance to BPT for 2017 (14/08/2017) - Risk upgraded following discussions at Governance meeting on the 10th February 2017.	1-5) Recruit to nursing vacancies. 1) Demand and capacity exercise to be undertaken to plan for 2017/2018 1) Business case required to resource 24 hour cover on call (31/01/2017	Oct-16 Sep-17 Sep-17	2 x 1 = 2 GREEN	Sep-17	Yes

CQC standards: Safe, Effective, Caring, Responsive, Well Led.

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Trust Objective:		**To have an effective & well integrated organisation that operate**									
Chief Operating Officer	1714	Failure of other agencies to support discharge process resulting in delayed hospital discharge. Date of origin: 03/06/08 Date of escalation = 11/05/11& Jan 16 On-going escalation to relevant L.A to ensure proactive response. Revised DTOC position agreed for reduction by Sept 2017. Superceded by revised trajectory for Wolverhampton DTOC submitted as part of better care fund bid - September 2017.	4 x 3 = 12 AMBER	1) Daily discharge meeting to review and troubleshoot internal actions aimed at improving discharges (Nov 2014) 3) Weekly monitoring of formal delayed transfers of care by CCG 4) Engagement of Intensive Support Team to review system and processes (Mar 15) 5) Commission of PWC to undertake review of DTOC and delay proccesses Aug-Sept 15 6) Additional Social workers funded by SRG Agreed - Sept 16 2) Implementation of discharge Assess Sceme (PID Comp Mar 17). Lead by LA-supported by ED Delivery Board Sept - Dec 2017. 7) Development of Trusted assessor model - linked to 2 - Led by LA.	3) Reduction in patients waiting for continuing Healthcare Assessments - Sep 14 2) Integrated Health and Social Care Team commenced January 2014. 2) Yearly review of re-imbursement of funds 2&7) Implementation of Wolverhampton Task and Finish Group established; agreed PID and timescale for recovery Sept 17	2) Increase in delays in Staffordshire	2) Discussions with social care partners for 7 day services to be available 3) Escalation of delays to L.A Director as necessary - on-going 7) Introduction of discharge to assess scheme - Sept 17 3) Increase monitoring and review of patients with social care to delays on-going. 1) Work with LA to ensure that any additional monies allocated in Spring budget (17) are directed towards achieving reduction in DTOC's.	Aug-16 May-17 Sep-17 May-17 May-17	3 x 3 = 9 AMBER	Sep-17	Yes

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Chief Operating Officer	2719	Lack of real time bed management and retrospective admissions on PAS can have a significant impact on electronic testing and potentially e-discharge systems leading to a potential impact on patient care/safety. Date of origin: 23/05/11 Date of escalation = 24/05/11	3 x 3 = 9 AMBER	1) Monitoring of PAS update / use (monthly) (Nov 14) 3) Implementation of safehands bed management (Apr 15) 4) Additional support from Teletracking to optimise use of real time system - (Jan 16) 5) Establishment of task and finish groups to manage and improve. Compliance to real time bed allocation (Aug 16) 2) Ward clerk review to be undertaken as part of transformation project. Revised deadline Dec 2017	1) All requests for beds via patient flow team (July 15) 1) real time bed management improving mon-fri 5) Improvement in dashboard metrics 3) Use of Safehands, real time bed management system from September 16 (paperless).	1) Patients still entered retrospectively on PAS, especially after weekends. 1) System bugs in safehands causing delays to bed allocation - closed	1) Long term review of real time bed management and link to I.T. Strategy. Closed safehands 1) Communication plan to remind staff to ensure timely and appropriate admission onto PAS and other Trust Clinical systems 4) Appointment (via teletracking) of additional support to assist with real time allocations - commenced - Sept 16 - closed in post 2) Ward clerk review - transformation project revised date Sept - Dec 2017.	Apr-16 Jun-17 Sep-16 Jun-17	2 x 3 = 6 YELLOW	Sep-17	Yes

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	4523	If Heater Cooler Units used in cardiac surgery harbour mycobacterium chimaera (as a national incident has identified) then the potential outcome may be, cancellation of elective surgery due to unavailability of the required number of machines and a failure of a machine during cardiac procedure. Date of origin: 28/04/16 Date of escalation = 17/06/16	4 x 3 = 12 AMBER	1. Currently in place is a comprehensive service contract, which provides a loan machine on breakdown of our machines (May 2016) 2. 6 monthly service within comprehensive service (May 2016) 4. Regular in-house cleaning and visual inspection of the water (May 2016) 3. Enhanced disinfection protocol put in place to clean of the HCUs leads to degradation of the heating/cooling coils (May 2016) 5. The department took loan of the last loan machine available in Europe (May 2016) 6. Patients are informed before every case of the risk and it is documented on the consent form (01/03/17) 7. All patients who have had valve surgery since January 2013 have been contacted and told of the risk of contracting Mycobacterium Chimera. There is a dedicated national helpline for patients to contact should they have any queries (March 2017)	2+3. There have been no further HCU failures since the end of April 2016 4. Undertaken on a weekly basis and no bacterium found 6. No patients have declined the procedure as a result of being open	3. New cleaning protocol may result in a potential increase in machine failure and a 4-6 month repair time. 1.There has been one failure (pre-April 2016) and the other machines are showing signs of wear and tear. 5. If another machine was required there is now a waiting list. This would likely mean that no loan equipment is available for future breakdowns	1+3. Continue to monitor 1-7) Action for med physics: A new fix is being released; A vaccum will be required to be inserted into theatres, estates to be contacted. 1-7) Action for med physics: A new fix is being released; associated costs to be provided to DM	Sep-17 Dec-17 Dec-17	3 x 2 = 6 YELLOW	Sep-17	Yes

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Chief Operating Officer	4596	If a patient with acute cholecystitis is not having surgery within 1 week, then this may result in recurrent admissions with the same problems and / or complications relating to gallstones such as pancreatic cholangitis and gallbladder empyema. Date of origin: 09/08/16 Date of escalation = 06/02/17	4 x 3 = 12 AMBER	1. CEPOD list to deal with these cases (Aug 2016) 2. Meeting taken place with UHB regarding change to UGI pathway (May 2017)	1. (09.08.16) There are no positive assurances	1. (09.08.16) No dedicated hot gallbladder theatre slots available 1. (09.08.16) Patients are presenting with complications of gallstones 1. (09.08.16) Local audit showing recurrent admissions	1. Appoint 3rd UGI Surgeon to support acute hot gallbladder list 1. Secure an acute hot gallbladder list 1. Directorate to produce a Business Case to address requirements - 1. Theatre capacity - separate CEPOD List, 2. 3rd Consultant, 3. Anaesthetic Time 2. Further discussions to take place re: UGI pathway	Dec-17 Dec-17 Dec-17 Dec-17	2 x 2 = 4 YELLOW	Sep-17	Yes

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Chief Operating Officer	4599	If there are staffing issues within the Emergency Dept, especially substantive shortages within the Medical team, along with increased numbers of patients attending, leading to significant pressure on the staff within ED. This will lead to an inability to engage fully with Governance processes. This will result in potential compromised patient care, inability to provide assurance in relation to the Governance agenda and financial penalties as a result of missed targets re RCA's and DoC.	4 x 3 = 12 AMBER	1) Matron has set up a group to ensure all nursing actions are addressed and learning is shared across the team 2) Review of Governance work streams at the Divisional Governance meetings, incuding NICE, External guidance, Audit, Risk 3) Monitoring of all SUI/Audit actions through to completion 4) Performance meetings in place 5) Directorate Governance meeting in place and attended by Directorate Management Team 6) Staff member identified to provide Governance support 2 days per week 7) Process in place to review re-attendances for potential SUI's proactively 8) Ongoing recruitment [07/09/17] 9) Governance pre meets in place	5) Governance meetings taking place regularly 2) Identified post 2xdays per week to provide Governance support 8) Extra ACP's now in post 9) Pre Governance meetings now established and working well 3) Number of SUI actions is reducing 4) Adult Cons post recruited to 5) Directorate manager post appointed Apr 17 2) NICE guidance is progressing 8) 2 additional consultants in post [07/09/17] 1) Bd6/7 nursing forums taking place regularly and working well 5) CD now has extra admin day 3) Action plan now reviewed in Divisional Friday morning meeting	5) Occasions when members of the Management team unable to attend meeting or stay for whole meeting 3) Significant number of SUI actions overdue/dates amended 2) Number of NICE and External Reviews that remain outstanding 2) L.Gardiner has to be used clincallly 8) 2 ACPs have left the department [07/09/17] 3) SIs have increased in August [07/09/17]	3, 4) Action plan devised to complete all outstanding SUI actions by end of Feb 17 - due date extended to July 17 - now agreed that ED will amalgamate all actions onto one departmental action plan to minimise duplication and prioritise key areas 2) Directorate to clear backlog and implemement robust process to manage processes	Sep-17 Sep-17	2 x 3 = 6 YELLOW	Sep-17	Yes

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Trust Objective:		**Maintain financial health - appropriate investment enhancement**									
Chief Operating Officer	4113	If Division 1 are unable to achieve the identified CIP target for 2017/2018 then there are implications for the financial position of the Trust Linked to BAF risk SR8. Date of origin: 07/04/15 Date of escalation =	4 x 5 = 20 RED	3. Vacancy control panel in place (Oct 2015) and higher restrictions being applied (Jan 2017) 2. Directorates holding monthly Financial Forecasting meetings and discussing CIP at Directorate meetings (Oct 2015) 1. Increased PMO resources to support delivery of the Trusts efficiency programme (June 2016) 6. Trust roll-out of Carter methodology now in place (June 2016) 4. Monitored by the Financial Recovery Board (FRB) 5. CIP confirm and challenge meetings in place (Sept 2016) 7. Member of Service Re-design Team aligned to Division 1 Programme to provide structure and targeted support to operational teams in their delivery of CIP 8. Division involved in Trust transformation projects - Key aspect - Theatres (Dec 16) 9. All agency requests above £120 P.H to be approved by COO/CEO	2, 3 & 4. Structure in place to discuss and identify opportunities to create efficiencies and business growth 3. VCP meetings held weekly and posts go through this process 7. If there is a risk that impacts on a team's ability to deliver their CIP schemes then the member of Service Re-deisgn Team would be available to support as and when required at the Quality Meetings.	2 & 3. Unidentified CIP still remains Sept 17.	1-6) Continue with process to identify and deliver efficiencies 2) Review of year to date underspends with a view to take non-recurrent to CIP 2+5) PIDs are forthcoming to the finance team 1) Divisional Management Team to meet with CDs collectively to discuss growing the business, increasing utilisation of theatres and OPD 1-7) Division to be involved in Financial Recovery Board chaired by CEO - complete Proposal to be involved in NHSI Deep Dive productivity programme. Scoping meeting Sept 17.	Oct-17 Oct-17 Oct-17 Oct-17 Oct-17 Sep-17	2 x 3 = 6 YELLOW	Sep-17	Yes

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Chief Financial Officer	4791	Activity that has not been planned materialises throughout the year as a result of other local trusts having quality/ capacity/ reputational issues. The financial risk is that the cost to provide the extra capacity might be at a premium and might not be covered by the additional income. Some evidence that this is happening with maternity, neurology and ophthalmology. Date of origin: 19th Jun 2017 Date of escalation: 19th Jun 2017	4 x 2 = 8 AMBER	1) Discussions have taken place with other providers and with commissioners of these services therefore, the impact of the problem can be anticipated to an extent.		1) The Trust does not have this activity in the plan for the year and has therefore not necessarily got the capacity to absorb the activity without incurring a cost premium.	Identify service related issues and align capacity with additional service demand. Seek to put CVOs in place with commissioners in order to allow the Trust to better plan capacity. Business case for agreed additional activity to be formulated by specialty and submitted to Contracts and Commissioning Group.	3 x 1 = 3 GREEN	Sep-17	Yes
Chief Financial Officer	4793	Risk to the income of the Trust as new clinical coding categories has been introduced (HRGv4+). There has been some evidence at month one that coding issues have contributed to an income shortfall. Date of origin: 19th Jun 2017 Date of escalation: 19th June 2017	3 x 3 = 9 AMBER	1) Undertake an exercise to check the clinical coding for all activity that the Trust delivers and ensure it reflects the depth of coding required by HRG4+ to get the correct payment.		1) The resources to systematically check all of the Trust's coding are not easily available.	1) Ensure that directorates are aware of the financial consequence of insufficient coding. 2) Analyse monthly data to pick out priority areas to target the Trust's limited resource to resolve coding issues. 3) Ensure that directorates notify the operational finance group of known coding issues with a plan for resolving the issue.	2 x 2 = 4 YELLOW	Sep-17	Yes

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Chief Financial Officer	4794	The 2016/17 year end invoice for £4.8m is not paid and the debt has to be written off. Date of origin: Mar 2017 Date of escalation: 19th Jun 2017	3 x 3 = 9 AMBER	2) Escalate as necessary 1) Continue to follow up on debt		1) Currently arbitration process has stopped	1) Issue was raised at the quarterly review meeting with NHS Improvement on 13 July 2017. Directors of both organisations were present and it was agreed that NHS Improvement would now escalate further for a conclusion. 2) NHS I informed Trust at IDM 31 Aug that the debt was now being escalated out of region for conclusion	3 x 3 = 9 AMBER	Sep-17	Yes
Chief Financial Officer	4866	A change in guidance from NHSI/E has led to a £1.362m risk in the income plan. The guidance suggests that 0.5% of provider CQUIN must be uncommitted and can only be spent if the NHS position across the whole NHS is in line with plan at the end of the financial year. The Trust's financial plan assumes that funding is committed in order to deliver current control total for 2017/18. Date of origin: 18/09/17 Date of escalation: 18/09/17	4 x 4 = 16 RED	The income in August was greater than planned and so the Trust is holding a YTD reserve for 5/12th of the entire value and will seek to add to that reserve as the year goes on.	None. It is unlikely that the Trust will be able to maintain the reserve.	The ability to use the monies is currently outside of the Trust's control and at the behest of the regulators (NHS I and E).	NHSI have asked Trust to provide assurance that the funding is not committed. RWT have not provided that assurance and have flagged that it is very likely the Trust will need to commit the funding in order to achieve the control total.	4 x 4 = 16 RED	Sep-17	

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Trust Objective:		**Attract, retain & develop our staff & improve employee engagemen**									
Chief Operating Officer	1713	Failure to effectively maximise workforce productivity; failure to routinely review consultant job plans. Date of origin: 03/06/08 Date of escalation = 11/05/11	4 x 3 = 12 AMBER	2) Areas to be contained with SPA allocation have been agreed 4) Usage reports for medical bank 3) RAG rated tool to monitor compliance against Job Plans has been developed and now shared with directorates Sept 17. 1) Job plans continue to be reviewed and sign off by DMD / MD- ongoing 1) New Job Planning Policy agreed by LNC Mar 17	1) Job Planning Audit indicated a number of actions now addressed 1) Training commenced on new job planning process - Feb 16	1) Slow progress in terms of Job Plan completion - Apr 17 4) Medical agency costs slowly reducing 1) Audit review still raised concerns - 2016	1) Develop business case for recording electronic tool to assist with job planning.	Mar-18	3 x 2 = 6 YELLOW	Sep-17	Yes

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Chief Operating Officer	2080	If the Trust is unable to recruit and retain sufficient nursing staff across the Division then there will be reduced quality of care for patients, including increased risk of falls from harm. (Linked to local risks 2780 CHU, 4160 Renal, 4272 Therapy Svs, 4321 DN's, 3431 CofE) Date of origin: 02/01/09 Date of escalation = 12/01/16 On BAF	5 x 4 = 20 RED	1) Ongoing active recruitment exercises - including overseas 8) Use of Nurse Bank when required 3) Defined minimum safe staffing levels now in place 5) Modified dependency tool for inpatient areas commenced 9) Staffing incidents reviewed on monthly basis 10) Closed additional Ward 3 at West Park Hospital (June 16) 4) B7's have daily staffing meetings	8) HCA's are available via Bank 3) Safe staffing levels are being maintained across acute wards, some issues with NRU 3) Band 7 vacancies filled, 1 remains 3,9) Internal transfer pool introduced across the Trust as part of the retention strategy 1) Change to recruiting processes to speed up the process 3) Daily staffing template produced at 4pm detailing all registered staffing 3) All B7s trustwide filling OOH rota first, then managing in-hours gaps, including putting themselves in if necessary 1) OSCI ward working well - 4 staff passed with 100% pass rate 1) ACSG matron role secondment appointed to (6 month initially) 9) Some improvement in compliance with Special Measures action plan on A7 & A8	1) 44 wte trained nursing vacancies remain (35 jobs offered but staff not in post yet) 8) Insufficient RN's available on Bank, backfilled by HCA 1) Nationallly we are an outlier re safe staffing levels 3) Weekends and nights remain an issue in relation to staffing numbers 3) Delay to skill mix review in ED due to RCN reviewing tool being used. 1) Cancer Svs/Derm Matron vacancy not appointed to following interviews 1) Recruited staff are newly qualified which can lead to mentorship and training pressures	3) Skill mix review to be completed across the organisation - outstanding areas are Specialist areas and ED 9) A7/A8 working through local 'special measures' action plan.	Oct-17 Oct-17	4 x 3 = 12 AMBER	Sep-17	Yes

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Chief Operating Officer	4529	If there are vacancies in consultant or non-consultant medical staff across the Division, this will compromise the provision of a safe, effective elective service and to the safe staffing of on-call rotas. In that circumstance there may be a need to try to employ locum medical staff with the potential problems of high cost and uncertain quality. Please note: Risk 4239 (Obs & Gynae), Risk 4467 (Cardio) staffing risks have been linked to this overarching Divisional medical staffing risk. Date of origin: 23/04/16 Date of escalation = 17/05/16	4 x 3 = 12 AMBER	1. Division approached HR re: targeted recruitment for Consultants (May 2016) 2. Division are working with the Fellowship Programme to enhance recruit of non-Consultant Doctors (May 2016) 3) Review of Obs & Gynae rota's underway as a result of increased activity - Sept 2017	2) Some clinical fellowship appointed (Aug 16) 1) Some reduction in medical spend Sept 2017	1+2) Number of vacancies remain across the Division including within Radiology, Anaesthetics and Head &Neck Sept 2017	1+2) Continue with Fellowship Programme 1) DCOO and DMD to discuss targeted recruitment radiology (overseas) with HR department 1) Review clinical fellowship programme for surgical specialties - Sept - Dec 17	Dec-17 Sep-17 Dec-17	2 x 2 = 4 YELLOW	Sep-17	Yes

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Chief Operating Officer	4540	If there is non-compliance with Mandatory Training across the Division then individuals are potentially not up-to-date with the most recent information to support their skills/ knowledge in these specific key areas. Impact of which would be quality and safety of patient care, safety of staff whilst at work, non-compliance with Trust policies and procedures which will result in a breach of contract and potentially disciplinary sanctions being implemented. Date of origin: 19/05/16 Date of escalation = 17/06/16	3 x 3 = 9 AMBER	1. Line Managers receive Mandatory Training Compliance Reports and discuss/challenge compliance with individual staff members (June 2016) 2. Divisional compliance is reported by the Divisional HR Manager at Team Meetings and Buisness Forum Meetings (June 2016) 3. HoN - Division 1 had written to non-compliant nursing staff members to advise of need to complete training or formally explain non-compliance (June 2016) 4. Divisional Management Team are meeting with non-compliant medical staff members 5. IP training is being escalated at IPCG (Feb 2017) 6.Non-compliance with Mandatroty Training is being challenged at Quality Assurance Meetings with Directorates (Feb 2017)	1-4) Improvements made in IP compliance (Sept 16) 1-4) Divisionally all of the mandatory training completion rates have increased since June 2016 (Sept 16)	1) Baseline for mandatory training increased to 9590 - some green areas now look red. Nov 16 1) Jan Mandatory training report has shown compliance for local induction as 69.7% (March 17)	1.Ongoing Divisional challenge of Directorate performance at the Directorates Quality Assurance Meetings	Dec-17	2 x 2 = 4 YELLOW	Sep-17	Yes

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Chief Nursing Officer	4718	If there is a shortage of staff in the safeguarding team this will result in: 1. Delays in providing safeguarding advice and responding to queries raised by staff and concerns raised via Multi Agency Safeguarding Hub (MASH). 2.Inability to attend all safeguarding meetings either internally or externally to the Trust 3.Inability to work proactively with staff on wards/ in community to ensure key safeguarding messages are disseminated 4.Inability to provide safeguarding supervision to key staff who work with vulnerable clients 5.Delay in providing face to face safeguarding adult and children training. 6.Delay in training staff on key agenda issues, for e.g. Child Sexual Exploitation, Domestic Violence, Slavery, FGM and PREVENT training. There is an Inability to respond to delivering Safeguarding Adult Training as outlined in the Intercollegiate Doc for Adults 2016. Date of origin: 03/03/17 Date of escalation: 25/04/17	4 x 2 = 8 AMBER	1) Regular review of staff available to work (Jan 2017) 2) Tasks/Meetings are prioritised (Jan 2017) 3) MASH information for adult cases: Allocated to SG admin initially and referred to SG adult named professonals if available to respond to. (Jan 2017) 4) Regular review of safeguarding legislation/CQC action plans, CCG assurance framework and Safeguarding Board partnership programme to prioritise workload of team. (Jan 2017) 5) Safeguarding supervision provided to Maternity staff, HV's, School Nurses and FNP (Jan 2017) 6) Safeguarding training is available: Level 1 - Induction (face to face) and face to face., Level 2 - via e-learning, Level 3 - via face to face for children and adults (Jan 2017) 7) Safeguarding Children Team Leader (Band 8a) recruited (April 2017)	1) 3 of 4 vacant posts occupied (Aug 2017) 3) Quality of information required by MASH has been addressed by response to the review (includes introduction of RAG rating for safeguarding enquiries (Sept 2017)	1) 1 staff not at work. (Aug 2017) 1), 2) & 4) Certain meetings are not always attended or represented. e.g. MASH Meetings, RWT variety of meetings. (Sept 2017) 5) Safeguarding supervision is available to certain staff only. (Jan 2017) 5) Adult safeguarding supervision is not provided. (Jan 2017) 5) Scope of remaining RWT Safeguarding Children and Adult supervision requirements unclear. (Jan 2017) 6) Bespoke training is not delivered due to capacity within the team. (Jan 2017) 1) External trainers have finished (April 2017) 7) Unavailability of post holder (April 2017)	1) to 7) To continue to regularly contact the chair of the groups and review urgent actions post meetings. 1) to 7) SG Adult training delivery to be reviewed 1) to 7) Existing named nurse to continue to cover Safeguarding Children Team Leader role	Oct-17 Oct-17 Oct-17	1 x 2 = 2 GREEN	Sep-17	Yes

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Trust Objective:	**Create a culture of compassion, safety & quality**									

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	2898	(High level risk) If patients have to wait in ambulance off load area to be seen in ED due to a lack of staff and lack of 'flow' through the hospital then there will be a risk to patient safety, experience, privacy, dignity and comfort to patients Link to risk 3051- Insufficient bed capacity Date of origin: 27 Feb 2012 Date of escalation: 25 Feb 2013	4 x 3 = 12 AMBER	3) Daily monitoring process in place to ensure appropriate action is taken to prevent the delay of safe treatment for patients 1) Increased capacity within ED by use of surge corridor (1/7/2016) 2) Monitoring of ED targets in place (waiting times and ambulance handover times) 6) Internal protocol to support the management of patients in AOA in place (available on the intranet) 7) Esclation plan in place 8) When required staffing is reviewed and adjusted to include ambulance off load area [08/11/16] 9) Increased Consultant cover until 02:00am [08/11/16] 11) 3 new Consultants (2 Paeds/ 1 ED) in position March 2017 [10/03/17] 12) Plan agreed to reconfigure department to reduce congestion in ambulance off load area [10/05/17] 13) Nurse led RAT is being trialled in ED [12/06/17] 14) 2 new consultants in post Sept [07/09/17] 15) Building work in progress to ease congestion in ambulance offload area [07/09/17]	13) Nurse led RAT working well and due to be officially launched end of Sept [12/06/17]	2) Delays in patient transfer - linked to bed availability / bedflow / waiting to be transferred [07/09/17] 1) Increase in number of ambulances - on avergae 100+ ambulances per day [07/09/17] 11) Continued congestion within the ambulance off load area at peak times commenced Aug 2017 2) Highest volume of pts seen in unit on single day experienced in month, 500+ pts and 160+ ambulances 2) Attendance rates fluctuate - often higher than forecast [07/09/17] 2) verage ambulance to triage time in Aug was 20 minutes [07/09/17] 7) No process in place to address escalation ratings [07/09/17]	1, 2) Continue with daily bed meetings 1-11) Continue with recruitment of substansive medical and nursing staff 12) Review of staffing in line with reconfiguration of department to be undertaken 12) Reconfiguartion of department to ease congestion in ambulance offload area to becompleted 13) Nurse led RAT to be officially launched 7) Review of escalation process (to include development of a live escalation tool with a live feed from MSS to include patient numbers etc, purchase of screen to display live escalation tool, and agreement of process for addressing escalation ratings 13) Nurse led RAT SOP and competencies to be implemented	Oct-17 Oct-17 Sep-17 Oct-17 Oct-17 Dec-17 Oct-17	2 x 3 = 6 YELLOW	Sep-17	Yes

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	3069	If a Never Event occurs within the Division this may result in an adverse outcome, there is potential for severe harm and/or patient death and also reputational impact including increased external monitoring Date of origin: 19/07/12 Date of escalation = 17/11/15	3 x 4 = 12 AMBER	7. Monitoring and circulation of incident notification reports to all senior staff for review 8. Trustwide learning via a "Lessons Learned" sheet in the monthly IGR, Risky Business Newsletter and the CLIP Group. 10. Regular scrutiny of Directorate risk registers and minutes of Directorate governance meetings at the Quality Meetings 3. Review completed of all documentation and Theatre protocols/procedures amalgamating where possible 1. Perioperative care plans are in place across the Trust 11. Agreed communication strategy with Division 2 to share/raise awareness of never events and lessons learnt 5. Monitoring of Policy OP100 and monthly audit of WHO Checklist for agreed procedures. Directorates providing assurance of the shortfalls in performance at Directorate Governance Meetings and Quality Meetings. 6. New NE Guidance 15/16 being used for NE classification	5. Monthly monitoring and compliance with five steps to safer surgery greater than 95% - There has been 100% compliance achieved between Aug 2015 - Apr 2017. 10. Risk Registers continue to be reveiwed as part of the Quality Assurance Meetings (July 16) 8. Lessons Learnt included within IGR Lesson Learnt page and circulated across the Directorates. Risky Business newsletter contained lesson learnt from incident. Quarterly reporting to CLIP Group continues (July 2016) 12. Review of NE action plans highlighted that of the last three NE the majority of actions had been completed and there was evidence of completion 5. Monthly monitoring and compliance with WHO checklist use - There has been 100% compliance achieved during August 2017	6. 1st NE in 16/17 reported to CCG - Maternity NE (retained tampon) reported (Datix ID: 158830) occured May 2016 6. There have been three Never Event incidents 2 x Wrong Site Surgery and 1 x Retained foreign object) reported and investigated during 2015 12. There are still some actions where evidence of completion needs to be obtained. 6. 2nd NE in 16/17 reported to CCG - Radiology NE (wrong ankle injected) reported (Datix 165455) occured August 2016, reported as NE Sept 2016 6. 3rd NE in 16/17 reported to CCG - Opthalmology (wrong eye injected) reported (Datix 166680) occured Oct 2016 6. 4th NE in 16/17 reported to CCG - Theatres (retained foreign object) reported (Datix ID: 169339) occured Dec 2016 6. 5th NE in 16/17 reported to CCG - Theatres/T&O Cannock (wrong prosthesis) reported (Datix ID: 174038) occured Mar 2017	2. Opthalmology Staff to undertake Human Factors Training from AFPP 2. Programme of Human Factors Training for Theatre Staff 6. RCA Investigation to be undertaken into the NE Wrong Site Surgery (wrong block) Datix:179911 6. RCA Investigation to be undertaken into the NE Wrong Site Surgery (wrong organ) Datix:181941	Oct-17 Oct-17 Sep-17 Oct-17	2 x 4 = 8 AMBER	Sep-17	Yes

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
				9. Policy for the management of retained swabs now in place 2. Implementation of Human Factor training across the Trust 4. Provision of bespoke training for individual theatre teams using simulation and actors to identify poor practice and encourge staff to speak out. 12. Review of NE action plans at Divisional Governance Meeting		5. Monthly monitoring and compliance with five steps to safer surgery greater than 95% - 90% compliance was achieved in May 2017. 5. Monthly monitoring data of compliance with WHO checklist and Procedural Safety Checklist - Mar -May 17 - 92% compliance 6. 1st NE in 17/18 reported to CCG - CCH/Theatres (wrong site surgery - regional block administered to wrong limb) reported (Datix ID: 179911) occured June 2017, 6. 2nd NE in 17/18 reported to CCG - Gynae Theatres (wrong site surgery - wrong organ) reported (Datix ID: 181941) occured August 2017, reported August 2017				

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Nursing Officer	3644	Failure to make an improvement in compliance gaps with CQC standards. Date of origin: 14/01/14 Date of escalation = 14/01/14	3 x 3 = 9 AMBER	2) Monitor recruitment plan (Nov 14) report to Trust Board monthly 3) Monitor monthly performance through the nursing midwifery KPIs for signs of deterioration (Nov 14) 4) Monitor capital funded environmental refurbishment in areas highlighted by the CQC requiring improvement 1) Monitor IMR quarterly (Nov 2014) 6) Monitor staffing establishments nursing reviewed and re-calculated bi-annually 5) Compliance to action plan refreshed (Jan and Apr 2015). Compliance reported through Trust Governance framework 7) CQC action plan continues to be reviewed on monthly basis and report to QSAG monthly. 8) Governance framework around CQC fundamental standard is now in progress. 9) Monitoring of metrics regards Quality / Performance issues monthly identifying trends and themes of non-compliance	3) Initial business case was approved by the Board and the CCG to fund additional nursing staff, investment now in place. Decrease in vacancies. 4) Overseas recruitment saw 19 European nurses commence employment W/C 11/1/16 5) Nursing and Midwifery KPIs moved to Health Assure reporting and emailed out to ward sisters/matrons and HoNs monthly. 6) Refurbishment of Mortuary body store and viewing room due mid April 2015 1) Action Plan now closed - outstanding actions addressed and monitored via monthly report to PSIG 2) A system of internal review is in development to run mini CQC audits 7) CQC intelligence monitoring report for Dec '14 indicated low risk (6) 4) Philippines trip Dec 15 saw 223 posts offered - awaiting IELTS and CBT passes before visa's can be applied for - so far 8 have been requested. Further trip planned Jan 16. 6) Eroster scoping meeting took place 14/1/16 this will be report to an workforce efficiency steering group	1) Electronic Rostering demonstrates more work needs to be done on using e roster to fully to maximise staff resource 2) Sickness absence needs to be driven down to Trust average in all ward areas. 3) Vacancy rates remain high in some areas 3) Skill mix review has been undertaken as per annual programme, outcome, no business case required at this time, given the number of vacancies in the organisation. 4) Safer staffing fill rates remain transient particularly for nights 9) Falls with serious harm continue to rise 7) A noticeable increase regards information / handover / communication related to discharge, particularly those going to residential/nursing homes are being cited in safeguarding referrals against the Trust. 9) Rising Mortality HSMR and SHMI rates are being reported in National data sets 10) Inpatient survey results show an average score of 76.7 which is a deterioration from 2015. Scoring is in the bottom 20% on 11 questions.	5) Trust is taking part in the workforce collaborative led by DOH (Lord Carters team) to receive and share good practice Complete QRV visits for all inpatient areas Information sharing events regards inspection for VI practices 7) Current review of Mortality review process and coding. Roll out of Falls collaborative inititaves tested via pilot areas Action Plan to be developed regarding National Inpt Survey results Audit of safeguarding and complaints regarding discharge communication as a theme Development of E-learning training package for DOLS Purchase of MCA/DOLS Educational material Gap analysis of NHSI 'Developmental reviews of leadership and Governance using the well led framework guidance for NHS Trusts' to be presented to Board Collaborative working with CCG regarding information/education to care homes and carers regarding safeguarding requirements for PI's	 Dec-17 Aug-17 Nov-17 Aug-17 Oct-17 Sep-17 Aug-17 Sep-17 Sep-17	2 x 2 = 4 YELLOW	Sep-17	Yes

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
					6) E-roster upgrade to version 10 live from 13/02/17 2) Agreement of NMC to reduce IELTS level for Nursing professionals 7) CQC steering group ceased 6) E-roster manager appointed 6) E-roster upgrade planned to commence Sep 16 - Jan 17 8) Submission of CHPPD data monthly. Dashboard available of Year benchmarking data. 7) Biannual skill mix review - slight improvement in vacancy rates 9) April 17 has seen an increase in referrals for MCA/DoLS following audit and training events 5) Draft report received regards CQC announced inspection to the Phoenix walk in centre - overall positive outcome 7) CQC checklist now in use operationally - led by Matrons and the triumvirate team Discharge action plan on track and presented to PSIG July by HofN's.					

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	4161	If there are reduced qualified nursing staffing levels across the Division then there is a risk to patient safety and quality of care. Please note: Risk 4475 (Cardio) and Risk 4553 (Children Services's) staffing risks have been linked to this overarching Divisional staffing risk. Date of origin: 13/05/15 Date of escalation = 18/11/15	4 x 3 = 12 AMBER	1. Recuitment strategy in place which includes as agreed at NOG presence at local Uni open days to promote RWT opportunities 2. Pursuing overseas recruitment (EU and outside EU) 3. Staff are being re-deployed daily across the Division as per Safer Staffing Escalation Procedure, escalation process has been streamlined. 4. Developed a programme for Band 7s with a support programme wrapped around to assist with attrition and development 5. 12 beds closed on the T&O ward to improve the ratio /reduce the burden on current staff members 6. Increasing Band 2 support to manage qualified shortfall 7. Scrutinising staffing levels daily and moving /re-deploying staff across the Division as necessary 9. Monthly red round days by HoN to be visible and listening to staff and the pressures they face as a way of support and quality checking. 10. NMC Challenge by Chief Nurse re: IELTs 11. Friday morning meetings taking place for Matrons to check staffing across the Trust for the weekend to assure safety	1 + 10. Utilising bank where possible and increasing HCA cover as necessary 3. Safer escalation - Areas are amber or green. No area has been red. 4. Positive feedback from Band 7s who have attended programme 2. Continuing to support offered applicants. 10. No known issues with staffing since commencement 8. Continuing with meetings staff have attended so far 9. Positive feedback received re: red round days 10. IELTs expected levels have now been reduced/changed nationally (Aug 16) 1. Vacancies at Cannock have now been nearly filled 2. 20 nurses recruited at recent RCN event, approx 10 for Div 1 2. 20 new nurses from the Phillipines starting within Trust 1. Vancancies for trained staff slowly decreasing month on month (May 2017) 5. T&O now fully established for open beds (June 2017)	1+2. Regional/Overseas recruitment via Health England/NHS England is not providing the numbers/volume of nurses required. Only 5/9 are now coming to the Trust. 1. Peak annual leave season, unable to cover bank shifts. 2. Trustwide position: Philippines recuitement successful but long lead in time for staff to arrive in UK 1. Nursing vacancies still high (Aug 16) 1. Surgical Recuitment Open Day, 64 attendances only 1 trained appointable for Cannock (Oct 16)	14) Assess the impact on staffing levels of Nursing Associate posts 1-15. Action Plan to remove all agency spend in theatres (plan to complete by Dec 17) 5. Active recruitment being pursued to open another 6 trauma beds 1. Commencement of nursing workforce strategy	Sep-17 Dec-17 Sep-17 Sep-17	2 x 2 = 4 YELLOW	Sep-17	Yes

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
				12. Matron Rep from both Divisions attends the Friday 4pm Bed Meeting to provide assurance of staffing safety (Aug 16) 13. There is now a trustwide transfer staffing pool (aimed to retain staff) (Aug 2016) 14. Appointed to Nursing Associate posts - to start end of Jan 17 (Jan 2017)	14. In place - one Nursing Associate for each 28 bedded ward area (June 2017) 1-10 - General Surgery nearly fully established, T&O fully establish for beds open and ICCU have no vacancies (July 2017)				

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	4375	(NX87) Heart Centre - Fire Safety: As a consequence of shortfalls in structural fire protection (including emergency lighting) and the recent failure of external ACM cladding, fire could spread both externally and internally throughout the building , compromising life safety.	3 x 4 = 12 AMBER	1) Building (Functional Provision) - The existing fire alarm system and ancillary equipment (regularly tested) will help to reduce the spread of fire, and provide staff with an early warning to take action. However requires updating. 2) Fire Risk Assessments - completed and passed to Managers of all 'departments' within Block 87 (14 areas Wards B7, B8, B9, B10, B11, B12, B14, B15, Cardiac Investigations, Cardiac Rehab, Neurophysiology, 1st Floor plant room, roof plant room, MPCE) 3) Compartmentation survey completed for block - where necessary, factored into FRAs 4) Planet updated with all jobs required following completion of fire risk assessments	1) Routine fire alarm tests weekly 1) Annual fire damper testing and maintenance 2) Minutes of the Governance meeting confirming closure of actions on FRAs Period 01.04.17 to 31.06.17 (2/14 complete) 4) 0 completed 'jobs' via planet during period 01.04.17 to 31.06.17 2) Clinical Evacuation exercise has been carried out by all clinical areas 1) Fire Damper Survey completed Feb 2015. 1) Emergency lighting in building 1) Enhanced reponse from WMFS and Trust Fire Reponse Team 2) Review of all in-patient FRAs including location of ACM cladding 1) 0 unwanted fire signals within Block during 01.04.17 to 31.06.17 1) 0 incidents relating to Fire within block during 01.04.17 to 31.06.17	2) of the 14 departments in block 87 - 12 yet to confirm actions complete 4) 0 planet jobs for Block yet to be completed. 1) Fire Damper PPM not in place 1) Deficiencies from original Fire Damper Survey have not been rectified. Additional fire damper survey to be completed. Condition report due September 2017 1) Deficiencies with emergency lighting have not been addressed. However, there is a generator back up for critical services 3) Compartmentation survey not completed	3) Complete 0 planet jobs in quarter 1 (17/18)	2 x 2 = 4 YELLOW	Sep-17	

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	4411	(NX08) McHale - Fire Safety: As a consequence of shortfalls in structural fire protection and the identification of polystyrene foam insulation installed between metal cladding, fire could spread uncontrolled throughout the building effecting critical operational services that could compromise hospital business continuity.	3 x 4 = 12 AMBER	1) Building (Functional Provision) - The existing fire alarm system and ancillary equipment (regularly tested) will help to reduce the spread of fire, and provide staff with an early warning to take action. However requires updating. 2) Fire Risk Assessments - completed and passed to Managers of all 'departments' within Block 8 (2 areas Div 2 Offices, Medical Physics) 3) Compartmentation survey completed for block - where necessary, factored into FRAs 4) Planet updated with all jobs required following completion of fire risk assessments	1) Routine fire alarm tests weekly 1) Annual fire damper testing and maintenance 4) 0 completed 'jobs' via planet during period 01.04.17 to 30.06.17 1) Fire drill completed for Building, satisfactory results 2) Minutes of the Governance meeting confirming closure of actions on FRAs Period 01.04.17 to 31.06.17 (0/2 complete) 1) 0 incidents relating to Fire within block during 01.04.17 to 31.06.17 1) 0 incidents relating to Fire within block during 01.04.17 to 31.06.17	2) of the 2 departments in block 8 - 2 yet to confirm actions complete 4) 0 planet jobs for Block yet to be completed. 1) 1 unwanted fire signals within Block during 01.04.17 to 31.06.17 1) Fire Damper PPM not in place 1) Fire Damper Survey not yet completed 3) Compartmentation Survey not completed for Block	3) Complete 0 planet jobs in quarter 1 (17/18)	2 x 2 = 4 YELLOW	Sep-17	

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	4412	(NX09) McHale - Fire Safety: As a consequence of shortfalls in structural fire protection and the identification of polystyrene foam insulation installed between metal cladding, fire could spread uncontrolled throughout the building effecting critical operational services that could compromise hospital business continuity.	4 x 3 = 12 AMBER	1) Building (Functional Provision) - The existing fire alarm system and ancillary equipment (regularly tested) will help to reduce the spread of fire, and provide staff with an early warning to take action. However requires updating. 2) Fire Risk Assessments - completed and passed to Managers of all 'departments' within Block 9 (10 areas Workshops, ICT, IT, Laundry, Sewing Room, Medical Records, Mortuary, R&D, Switchboard, Tech Services) 3) Compartmentation survey completed for block - where necessary, factored into FRAs 4) Planet updated with all jobs required following completion of fire risk assessments	1) Routine fire alarm tests weekly 1) Annual fire damper testing and maintenance 2) Minutes of the Governance meeting confirming closure of actions on FRAs Period 01.04.17 to 31.06.17 (2/10 complete) 3) 0 completed 'jobs' via planet during period 01.04.17 to 31.06.17 1) Fire Drill complete for block, satisfactory results 1) 0 incidents relating to Fire within block during 01.04.17 to 31.06.17	2) of the 10 departments in block 9 - 8 yet to confirm actions complete 4) 0 planet jobs for Block yet to be completed. 1) 1 unwanted fire signals within Block during 01.04.17 to 31.06.17 1) Fire Damper PPM not in place 1) Fire Damper Survey not yet completed 3) Compartmentation Survey not completed for Block	3) Complete 0 planet jobs in quarter 1 (17/18)	2 x 2 = 4 YELLOW	Sep-17	

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	4472	If patients wait over 2 hours for assessment in cubicles in the Emergency Department and wait over 15 minutes for triage, then an urgent clinical need may not be identified within appropriate timescale's, which could compromise patient care. Date of Origin: 24/02/2016 Date of escalation = 15/04/16	4 x 4 = 16 RED	1) National guidance in place (15 minutes for triage & 2 hours for assessment) 2) Use of MSS to monitor times for triage and assessment 3) Huddles held with ED management, Consultant in charge, Nurse co-ordinator and nurse change at regular intervals to monitor times and implement actions to reduce waiting times and escalate as appropriate using escalation plan. 4) Reallocation of doctors to areas with high waiting times if appropriate 5) Reallocation of nurse to support triage nurse 6) Bed meetings held at regular intervals where status of Emergency Department is discussed with representatives of both Divisions to facilitate flow 7) Monitoring staffing ratios and man-power plans regularly reviewed 9) Acute Physician team available to support department from 10am until 21.30 every day 10) UCC opened on 1st April 2016 12) Powerpoint presentation around National ED standards included in new starters induction and within annual mandatory training sessions	9) No concerns raised re Acute Physician support [07/09/17] 2) System upgrade for automatic trigger developed (15/12/16) 15,17) 2 further consultants in place April17 (equates to 1 ED post as shared with Paeds) [10/05/17] 17) 14 new nursing posts offered following interviews [07/09/17] 17) 3-4 new nurses to start between Jun-Sep17 [07/09/17] 17) 1 NHS 2 year locum appoointed to start 01/09/17 (CESR Dr) [12/07/17] 17) 2 Consultants commenced in post Sept [07/09/17] 16) Nurse led RAT working well and due to be officially launched end Sept [07/09/17] 18(New starters are familiar with the department and its processes/ policies when they start [07/09/17]	1,2) Inability to meet Department of Health guidance - 88% compliance in Aug [07/09/17] 1, 2) Inability to achieve 2 hour assessment and 15 minute triage.[07/09/17] 3) Huddles not currently taking place consistently 24/7 [07/09/17] 4,5) Staff not always available to be reallocated [07/09/17] 6) Bed availability linked to delays in Emergency Department [07/09/17] 7) Medical and nursing vacancies, sickness and reliance on locum doctors resulting in gaps on rotas. [07/09/17] 8) Patients may not be seen straight away on arrival but on average within 20 minute. However can be delayed due to flow constraints. [07/09/17] 10) UCC not impacting on pt numbers and delays in assessments [07/09/17] 17) A number of the nursing posts offered are to newly qualified staff so unable to start until Sept17 and will not have their PINs [07/09/17] 3) No process in place to address escalation tool ratings [07/09/17]	16) Nurse led RAT SOP and nursing competencies to be introduced 7) Continue with recruitment of medical staff 16) Nurse led RAT to be officially launched 3) Review of escalation process (to include development of a live escalation tool with a live feed from MSS to include patient numbers etc, purchase of screen to display live escalation tool, and agreement of process for addressing escalation ratings	Oct-17 Sep-17 Oct-17 Dec-17	1 x 4 = 4 YELLOW	Sep-17	Yes

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
				14) Human factors training undertaken [08/11/16] 13) Joint triage model in place with UCC [08/11/16] 15) Medical and nurse staffing managed via the risk regsiter (risk 2374 & 4496) [08/11/16] 17) Recruitment ongoing [06/01/17] 16) Nurse led RAT being trialled in ED [07/09/17] 18) Where possible, newly qualified starters have their last student placement transferred to RWT ED [07/09/17]						
Chief Operating Officer	4528	If Clinical Web Portal does not contain full copies of patient's notes/health records if seen before 2013 as well as all Paediatric admissions then incomplete health records may be the only record available for inpatient and outpatient encounters. Lack of a comprehensive record may impact on the accuracy and/or timeliness of clinical decision making. Date of origin: 29/04/16 Date of escalation = 17/05/16	4 x 3 = 12 AMBER	1. Ability to request paper notes (May 2016) 2. Process for both access to patient records aswell as the process for when there is a need to have a complete patient scanned has been circulated by Patient Access (Dec 16)		1. Datix Incidents reported 1. Records are not always available for elective clinics, even if they are available this creates a time lag within 1. Incident identified with migration over to electronic system where patient did not receive timely suveillence (Datix No awaited) (May 2017)	1&2. Monitor ongoing incidents	Dec-17	2 x 2 = 4 YELLOW	Sep-17	Yes

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	4565	If the use of Agency staffing continues across the Divisions (due to being unable to recruit to sustentative posts) then there is potential for an impact upon the continuity of patient care and service being delivered. Also, as staffing is dependent on the market place this may also result in an unavoidable breach in the agency cap levels. Date of origin: 22/06/16 Date of escalation = 28/07/16	4 x 3 = 12 AMBER	4. Reported at Ops Finance Group 3. Utilisation of fellowship programme 2. Recruitment Strategy in place 1. Agency spend reviewed monthly at Directorate/Divisional Meetings 6. Establishment of workforce group to review/monitor use of medical locums/agency (Oct 16) 5. Overseas recruitment for some specialties (radiology). 7. HoN reviewing Nursing Overspend Report for Theatres (Feb 2017) 8) Review of non-medical agency in Sept 17. Action plan in place to reduce by Dec 17.	2. Recruitment to Paed ED and adult ED post in Nov 16 1-4.Some reduction in agency spend in ED and other specialties as clinical fellows come on line (oct 16) 7. Reducing overspend in Theatres (Feb 2017) 2. 35 Clinical Fellows (May 2017) 2. Nursing vacancies reduced across the Trust (May 2017)	2. Many areas now are experiencing national shortages i,e Radiologists/Anaesthetists 1-4. Very slight reduction in vacancies over the last couple of months however it continues to be a significant challenge Apr - 17 2. Significant recruitment gaps in clinical workforce	2. Continue to implement Recruitment Strategy 2+3. Request further support nationally - collaborative working with other organisations 1. Focus on reducing agency spend in non-clinical areas initially 4. Ensure exclusion of GP Integration locum spend 2. Actively recruiting to Bank for Theatres trained staff 1-7. Action Plan for cummulative reduction of agency spend in theatre in place with no agency spend by December 2017 1-7 Continue scrutiny of CPD to use academic fellowship programme	Jun-17 Jun-17 Jun-17 Jun-17 Aug-17 Dec-17 Dec-17	x =	Sep-17	Yes

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Medical Director	4661	Lack of robust effective system for the communication of high risk or abnormal/ unexpected investigation results, and evidence of receipt, review and actions taken by clinicians. Risk of delayed or missed opportunities for diagnoses and appropriate treatment for patients, which could result in Serious Incidents, litigation and complaints. Date of origin: 17/11/16 Date of escalation = 17/11/16	4 x 4 = 16 RED	5) Monitoring via incident reporting 4) Directorate/ specialty local 'safety net' procedures to ensure results are received and reviewed 3) Pathology local procedure(s) for the escalation of abnormal results 2) Radiology local procedure(s) "Communication of Critical and/ or Unexpected Findings to Referring Doctors" 1) Trust wide Policy CP50 for the Management of Risks Associated with Clinical Diagnostic Tests and Screening	5) Small proportion of incidents to number of investigations undertaken 2) There is a policy for urgent and critical findings (June 2017) 2) A flag is also added to the report which will send in the subject matter of the e-mailed report ***Urgent Findings*** or Unexpected Significant Findings, this will alert the referring consultant (June 2017) 2) There is now also a Cancer Suspicious flag which can also be attached (June 2017) 3) There are a list of tests that fall into the urgent action category, the clinicans are telephoned about these. Other less urgent abnormal results are highlighted as such in TD Web when they are reviewed (June 2017)	1-4) Audit of local safety net procedures demonstrated significant gaps 2) Size of Radiology reports is significant resulting in inbox limits being frequently exceeded 5) Incidents continue to be reported where the reviewing if abnormal results has been delayed with significant consequences to patient outcome 3) No further action can be taken by Pathology until ICE is implemented (June 2017)	1-4) Implement the ICE system, ensuring it addresses the current gaps in review of reports	Nov-17	x =	Sep-17	Yes

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	4665	If the X-ray and CR processing equipment at Cannock Hospital (which is over 13 years old) is not replaced within the Capital Programme then due to the age of the equipment there is an increased possibility that there will be equipment breakdowns/failures which could then directly impact the service offered. Also, patients are currently not in receipt of the advances in technology which a new machine could offer them i.e. lower doses of radiation and a speedier/quicker service. Date of origin: 17 November 2016 Date of escalation: 26 April 2017	3 x 4 = 12 AMBER	1) Maintenance Contract in place (£17,000 per annum) (Oct 2016) 2) Access to Mobile Imaging (if required) (Oct 2016)	1) Breakdowns are usually fixed within 24 hours under the contract - this is on a 'fix as you go' basis. (Oct 2016) 2) There is a mobile X-ray unit iat CCH which can be brought down to the X-ray room and used there to continue the service for patients (Oct 2016)	1) Any breakdown will cause a disruption to the service offered to patients. Breakdowns encountered with CR Readers 0; X-ray Equipment 1 (Aug 2017) 2) No focus choice on mobile x-ray units and reliance on ageing CR processing equipment (Oct 2016)	1) & 2) To continue to monitor any equipment breakdown 1) & 2) To be included on the capital programme next year	Sep-17 Apr-18	2 x 2 = 4 YELLOW	Sep-17	Yes

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	4696	If non-urgent imaging studies are not reported within the timescale of 3 - 6 weeks, delays may have an impact on timely patient management. Ideally imaging should be reported as soon as they are undertaken but this is not possible given the national shortage of staff. Date of origin: 5 January 2017 Approved by Division: 28 Dec 2016 Accepted onto Trust Risk Register: 5 Jan 2017	3 x 4 = 12 AMBER	1) Monitoring of unreported scans/imaging studies on a weekly basis 2) Locum Consultant Radiologists are being employed 3) Clinical Fellows are being employed 4) Regular meetings between Clinical Director and Group Manager 5) Waiting list initiatives for Trust Radiologists on going	2) 0 locums have successfully been employed 3) 2 Clinical Fellows have been selected 4) Review meetings are happening fortnightly	1) Approximately 6532 non-urgent imaging studies unreported Sept 2017 (inclusive of 901 CT scans and 1633 MRI scans) 1) Poor patient experience if patients and doctors are unsure when their scans are reported 2), 3), 4) & 5) Demand for reporting imaging studies is higher than expanded reporting capacity	1,2,3,4 & 5) Offer opportunities to Radiologists from other localities to work in our Trust. Radiology will liaise with HR about the possibility of head hunting Radiologists from other Trusts 1,2,3,4 & 5) To revisit plan to recruit 7 or 8 Radiologists 1,2,3,4 & 5) Educate referrers periodically on requesting only appropriate imaging studies. Clinical Directors will be contacted about this via e-mail to help with reducing inappropriate demand for imaging studies 1,2,3,4 & 5) Monitor outsourcing work and assess impact on reducing outstanding numbers 1,2,3,4 & 5) SS to provide report to Division re imaging waiting times	Dec-17 Dec-17 Sep-17 Sep-17 Sep-17	2 x 4 = 8 AMBER	Sep-17	Yes

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	4706	Longstanding maintenance challenge around infrastructure/environment in Nucleus Theatres, which includes: 1. Sewerage ingress 2. Drainage system 2. Electrical infrastructure 3. Fire safety 4. Operating lights 5. Air-flow/ventilation 6. Storage 7. Infestations Could lead to a risk of patient and staff safety being compromised, non-compliance with external regulations and/or internal standard/ audits and also adverse media publicity and increasing number of raising concerns via local policy.	4 x 3 = 12 AMBER	1. Existing programme of theatre works in place (1 per year) - (Feb 17) 2. All incidents reported to management are escalated to Hotel Services - (Sept 17)	1 + 2. Works on 2nd theatre in programme of works underway (Feb 17)	1 + 2. There continues to be sewerage ingress into Theatres (June 2017) 1 + 2. In 2017 there were 9 incidents were reported, two during operations, one where sewage dripped onto the scrub nurse, there are also no known consequences for the patients (Sept 17) 1 + 2. In 2017 there were 16 incidents reported on Datix of insects in theatres, two during operations with no known patient consequences (Sept 17)	1. Capacity modelling underway to support development of robust options appraisal 1. Fire Exercise with Fire Brigade 1. Full drainage review being undertaken by the Head of Estates	Sep-17 Oct-17 Sep-17	x =	Sep-17	
Chief Operating Officer	4711	Porters manage the large medical gas cylinders between the medical gas store and the hospital site. Adverse weather conditions; traffic hazards and time pressures could lead to the risk of serious injury to staff/public. This will lead to potential of personal injury claims and litigation. Date of origin: 01.02.2017 Date of escalation: 08/05/17	4 x 4 = 16 RED	1) Manual Handling Hazard Assessment - AUGUST 2017 2) Manual Handling Risk Assessment undertaken at induction - AUGUST 2017 3) Cylinder cradles trolleys or cradles are used to transport medical gas cylinders - AUGUST 2017 4) Trust Training records are regularly reviewed by managers - AUGUST 2017 5) Staff raise any concerns at the local Hotel Services Risk Management meeting - AUGUST 2017	1, 2, 4) No incidents reported in the previous month - AUGUST 2017	5) Medical gas storage facilities is in-adequate - AUGUST 2017 3) New method of moving medical gas cylinders required - AUGUST 2017	5) Estates to support Porter in establishing a new storage facilities/trolley 3) Motorised trolley to be purchased	Oct-17 Oct-17	3 x 2 = 6 YELLOW	Sep-17	Yes

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	4715	If the Trust is unable to recruit substantive Dermatology consultants it will not be possible to provide the right level of care for patients. Currently there is only 1 long term locum covering at CCH and 2 Consultants covering NXH. This will result in a decrease in the number of patients that can be seen; loss of recognition as a teaching centre; loss of reputation; increase in the number of complaints; increase costs due to the employment of locums. Date of origin: 22/2/17 Date of escalation: 18/04/17	3 x 4 = 12 AMBER	5) Utilisation of nursing staff to support (Feb 17) 4) Ensure capacity available for suspected cancer patients (Feb 17) 3) Ensure inappropriate referrals are returned to GP with appropriate reason (Feb 17) 2) Assessment of nursing skills (Feb 17) 1) Managing activity on a daily basis (Feb 17) 6) Review provision of Teledermatology Service (Feb 17) 7) Use of locum staff (August 2017) 8) 1 x doctor stepping up as Locum Consultant (as of 31/07/17) to split between NXH and CCH (July 17)	1, 4) WLI to meet demand. Planned to continue (Sep 17) 4) All Fast track patients who can't be found a slot are being seen by a specific consultant (Sep 17) 2) 1 x B5 and 1.5 WTE xB7 due to start Sep 17 (Sep 17) 3, 6) No issues with this control (Sep 17) 5) Cross site nursing being used (Sep 17) 7, 8) 3 x Locum consultants recruited (1 stepping up; 1 starting September; 1 starting November) (Sep 17)	2) 2 x B5 Nursing staff on maternity leave - unable to back fill (Sep 17) 1, 4) 1 x substantive consultant on long term planned sick leave which started in Feb 17. Hoping to return Oct 17 (Sep 17) 2) 1 x B2 vacancy on hold. Awaiting relocation (Sep 17)	7, 8) Interview for specialty doctor vacancy 7, 8) Interview for a Clinical Fellow	Sep-17 Sep-17	3 x 3 = 9 AMBER	Sep-17	Yes

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Medical Director	4734	The Trust currently has elevated mortality statistics (the HSMR and SHMI are both significantly higher than normal). This does not correlate with any evidence within the Trust to suggest excess mortality rates or preventable deaths in RWT. The Trust needs to investigate. Date of origin: 03/04/17 Date of escalation: 03/04/17	4 x 3 = 12 AMBER	1) All statistics and data underpinning mortality are looked at MRG (monthly) and MoRAG (bimonthly) 2) The Trust requires all directorates to follow the mortality policy (OP87) and formally review deaths on a monthly basis and categorise deaths according to NCEPOD 3) All alerting diagnostic categories are formally investigated with retrospectives case note reviews to identify the level of care provided to patients. 4) Additional work is being undertaken to investigate the elevated mortality statistics and to review care delivered to patients and clinical pathways as follows; i) an independent company has been commissioned to take a data analysis and independent coding exercise, ii) an independent retrospective case note review will be undertaken to review robustness of RWT case note reviews iii) an independent review of clinical pathways will be undertaken, iv) targeted support by the clinical support unit to help analyse reasons behind alerting diagnostic area.			1) Review outcomes of MRG and MoRAG 2) Continue work between Clinical Coding and clinicians regarding accuracy of coding 3) Ensuring the mortality policy (OP87) is correctly followed across the organisation 4) Address any issues resulting from additional pieces of work	2 x 2 = 4 YELLOW	Sep-17	Yes

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	4756	If the activity continues above 5000 births, then it will have a detrimental effect on patient safety and experience. This will potentially result in challenges and limitations due to: 1/ Physical size & configuration of the building 2/ Medical staffing 3/ Midwifery staffing (and ancillary staffing) 4/ Theatre capacity & staffing 5/ Safeguarding 6/ Screening In addition to safety concerns there may also be an impact on patient experience. NB; Please see Notepad SEE RISK 4862 ON NEONATAL RISK REGISTER	3 x 4 = 12 AMBER	1) Number of women having Mid Trimester scans giving EDD data is being monitored and indicates predicted monthly activity in relation to births 2.5.17 2) The number of women booking at RWT is being monitored by Antenatal Payment By Results (PBR) 2.5.17	1) Predicated births/booking are recorded on the Maternity Dashboard, RAG - rated and discussed at monthly Governance & Risk Management meeting (14.7.17) 2) Close observation of activity in relation to number of predicted births (14.7.17)	1,2) Activity levels are variable and uncontrollable due to births occurring at varying gestations and women transferring in from other units (14.7.17)	1,2) Liaise with Neonatal Services to utilise/staff to full capacity on the TC Ward 1,2) Continue to monitor activity via dashboard	Oct-17 Dec-17	3 x 2 = 6 YELLOW	Sep-17	Yes
Chief Operating Officer	4767	If the trust fails to achieve all 5 mandatory criteria for the Hip Fracture Clinic Best Practice Tariff, then this will potentially lead to poor clinical outcomes for patients. Also, if the best practice criteria are not achieved this will result in the Directorate failing to achieve additional income of BPT.	4 x 3 = 12 AMBER	1) Informatics pulls a report twice a month for validation of BPT 2) The patient remains under the care of an orthopaedic consultant who can track their care ensuring key aspects are not missed 3)Gap in the ortho-geriatrician support currently filled by Associate Specialist - when not available consultant to consultant discussion with the Geriatrician. 4) BPT reports reviewed at CG meeting quarterly	2) BPT criteria is available on the ward for junior doctors	1) Currently informatics does not have access to the NHFD which would make reporting much more streamlined. They currently use a datasheet which is time consuming 2) BPT criteria not available in notes 3) The Directorate does not have 7 day cover from orthogeriatrician	2) Directorate to devise BPT checklist 3) Group Manager to submit business case	Sep-17 Oct-17	x =	Sep-17	