

Board Assurance Framework/ Trust Risk Register 4 June 2018

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Agenda Item No: 11.2

Trust Board

Meeting Date:
4th June 2018
Title:

Board Assurance Framework / Trust Risk Register

Executive Summary:
BAF Key Issues
0 new risks.
2 risk closed:

Risks **SR4** (Risk of adverse impact on the Trust following service transfer in November 2014 due to underlying financial gap of £6million) and **SR10** (That the Trust fails to generate sufficient cash to pay for its commitments) have been amalgamated into risk SR9.

3 red risks:

SR1 - Workforce - Recruitment and Retention of staff across the Trust and in particular the future pipeline of nursing and medical staff

SR8 - That there is a failure to deliver recurrent CIP's.

SR9 - That the underlying deficit that the Trust has (in 2017/18) is not eliminated in medium term to bring the Trust back to financial surplus.

Trust Risk Register Key Issues
2 new risks:

4761 - Cardiothoracic Surgical / Anaesthetic vacancies (COO)

5017 - Unable to achieve the activity levels (CFO)

1 risk removed:

1714 - Failure of other agencies to support discharge process resulting in delayed hospital discharge (COO)

5 red risks:

2080 - Risk to quality of patient care: reduced manpower (COO)

4661 - Lack of robust system for review and communication of test results (MD)

4472 - Delays in Cubicle Assessment and Triage (COO).

4113 - Division 1 failure to achieve CIP target (COO)

4903 - Risk of non-compliance with Thoracic Service Specification (COO)

Action Requested:	To inform the Committee of updates to the Board Assurance Framework (AF) and Trust Risk Register.
Report of:	Chief Nursing Officer
Author: Contact Details:	Governance IM&T Lead Tel: 01902 695114 Email:
Resource Implications:	None identified
Public or Private: (with reasons if private)	Public Session
References: (eg from/to other committees)	
Appendices/ References/ Background Reading	
NHS Constitution: (How it impacts on any decision-making)	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: <ul style="list-style-type: none"> ✦ Equality of treatment and access to services ✦ High standards of excellence and professionalism ✦ Service user preferences ✦ Cross community working ✦ Best Value ✦ Accountability through local influence and scrutiny

Background Details

The Board Assurance Framework “provides organisations with a simple but comprehensive method for the effective and focused management of the principal risks that arise in meeting their objectives. It also provides a structure for the evidence to support the Annual Governance Statement”.

Board Assurance Framework (Appendix A)

Following updates the split of the Assurance Framework is:

Risks currently being managed (on-going)	4
Risks managed to target level	1

There are currently 5 risks contained within the Assurance Framework which are distributed across the Trust (5x5) categorisation matrix as below:

Likelihood	Consequence				
	1 Low	2	3	4	5 High
5 – Almost Certain				3 risks	
4 – Likely					
3 – Possible		1 risk		1 risk	
2 – Unlikely					
1 – Rare					

Utilising the Trust's categorisation matrix (risk plot above) as a way of pragmatically prioritising the Trust's risks, the following are considered to be of high risk to the Trust:

	ID	Risk Title	Lead
RED	SR1	Workforce - Recruitment and Retention of staff across the Trust and in particular the future pipeline of nursing and medical staff	HRD
	SR8	That there is a failure to deliver recurrent CIP's	COO
	SR9	That the underlying deficit that the Trust has (in 2018/19) is not eliminated in medium term to bring the Trust back to financial surplus.	CFO

Trust Risk Register – Updates (Appendix B)

Following updates the split of the Trust Risk Register is:

Risks currently being managed (on-going)	33
Risks managed to target level	0

There are currently 33 risks contained within the Trust Register which are distributed across the Trust’s (5x5) categorisation matrix as below:

Likelihood	Consequence				
	1 Low	2	3	4	5 High
5 – Almost Certain				1 risk	
4 – Likely			13 risks	2 risks	2 risks
3 – Possible			6 risks	8 risks	
2 – Unlikely		1 risk			
1 – Rare					

Utilising the Trust’s categorisation matrix (risk plot above) as a way of pragmatically prioritising the Trust’s risks, the following are considered to be of high risk to the Trust:

	ID	Risk Title	Lead
RED	2080	Risk to quality of patient care: reduced manpower	COO
	4661	Lack of robust system for review and communication of test results	MD
	4113	Division 1 failure to achieve CIP target	COO
	4472	Delays in Cubicle Assessment and Triage	COO
	4903	Risk of non-compliance with Thoracic Service Specification	COO

The following illustrates how risks on the TRR are mapped against the strategic objectives:

Strategic Objective	TRR			
	R	A	Y	G
1) Be in the top 25% for key performance measures				
2) Proactively seek opportunities to develop our services				
3) To have an effective & well integrated health and care system that operates efficiently		5		
4) Maintain financial health - appropriate investment enhancement to patient services	2	3		
5) Attract, retain & develop our staff & improve employee engagement	1	3	1	
6) Create a culture of compassion, safety & quality	2	16		

Recommendation(s)

- The Board considers the report and any changes with the Board Assurance Framework and Trust Risk Register.











Appendix B: Tracking changes within Trust Risk Register (May 2018)


Lead Director	Risk	Risk Title	Field updated	Update made
Chief Nursing Officer	4841	Risk of CPE becoming endemic in clinical areas		
			Positive Assurance – New	Reduction to 2 cases of RWT acquired CPE cases in 17/18 despite increased numbers from improved screening compliance
	3644	Failure to make an improvement in compliance gaps with CQC standards.		
			Positive Controls – New	Daily staffing is monitored via the Divisional QSIG ops meetings
			Positive Assurance – New	Lord Carter metrics monitored monthly via Divisional Performance meetings
			Positive Assurance – New	Business case approved to support the first cohort of 10 Nurse Associate Apprenticeship and 20 RN Apprenticeships to commence Sep/Oct 18
			Positive Assurance – New	Business Case approved for NN to increase staffing towards BAPM standards
			Gap in Assurance - New	Phase 1 skill mix review for Adult inpatients shows a deficit
			Action Plan - New	Opportunities for recruitment paths currently being explored
	2952	Patient developing a pressure ulcer due to inadequacies of pressure ulcer prevention equipment		
			Positive Assurance – New	Accountability pressure injury process reviewed, October 17 & January 18
	4718	Safeguarding Team Staffing		
			Positive Controls – New	Safeguarding Adults Team Leader in place
			Gap in Assurance - New	Level 3 for adults is not provided to clinical staff as outlined in key legislation
			Gap in Assurance - New	Safeguarding Adult Trainer not in post
			Gap in Assurance - New	Named Midwife not in post
			Gap in Assurance - New	Safeguarding Supervision Policy not implemented
			Action Plan - New	Review safeguarding training programme
			Action Plan - New	Awaiting confirmation of approval of business case for Named Midwife post
Action Plan - New			Interviews to be carried out for Adult Trainer post	
		Action Plan - New	Policy tabled to be approved	
Chief Operating Officer	4665	X-Ray Cannock		
			Action Plan - New	Replacement of equipment planned for 18/19
	1714	Failure of other agencies to support		

	discharge process resulting in delayed hospital discharge.	***Risk removed***	Moved risk to Div 2 risk register following agreement from Div 2.
4761	Cardiothoracic Surgical / Anaesthetic vacancies	***New risk***	If we are unable to fill our vacancies and obtain visas in JMS anaesthetics and JMS Cardiothoracic Surgery we will be unable to provide a comprehensive cardiac and anaesthetic service. As of 19 April 2018 we will have 4 empty posts in JMS Surgery and 2 for anaesthetics. Implications are - we will be unable to provide an assistant for elective planned surgery and cover OOH emergencies in theatre and in ITU with 4 vacancies. Two agency locums for JMS surgery are being used.
4599	Emergency Services Governance Arrangements	Gap in Assurance - New	Number of overdue SUI actions has red
4375	NX87 Heart Centre - Fire Safety	Gap in Assurance - New	1 Unwanted Fire Signals within April 2018 (Aerosol)
4411	NX08/NX09 McHale Building - Fire Safety	Positive Controls – New	Tugway Safety & Environmental Group commenced May 2018
		Gap in Assurance - New	1 incidents relating to Reportable Fire's within April 2018 (Medical Records, Light Fitting)
		Action Plan - New	Tugway Safety Environmental Audit Group monitoring action plan
4696	Unreported Imaging Studies	Positive Controls – New	Outsourcing work to external company
		Positive Assurance – New	Office space sourced
4903	Risk of non-compliance with Thoracic Service Specification	Positive Controls – New	Recruitment strategy in place
		Positive Assurance – New	Business case for 1 additional consultant has been agreed at TMC and interviews to be held in April 2018
		Positive Assurance – New	Business case for 1 additional band 7 ANP has been agreed and staff have been recruited.
2080	Risk to quality of patient care: reduced manpower	Positive Assurance – New	Retention group in place to look at retention strategies across the Trust
		Gap in Assurance - New	26 HCA vacancies remain, 12 places offered
		Action Plan - New	HoN (Div1&2 to develop grading for vacancies, with Chief Nurse
3069	Risk of Never Events within Division 1: Risks to Patient Safety and	Gap in Assurance - New	2018/2019 There has been two Never Events reported in April 2018. Both were

		Trust reputation		Wrong Site Surgery incidents (Neonates Datix 194205 and H&N Datix 194977)
			Gap in Assurance - New	Monthly monitoring and compliance with WHO checklist use - There has been 89% compliance achieved during Apr 18
			Action Plan - New	RCA Investigation to be undertaken into the NE Wrong Site Surgery (Wrong tooth) Datix:194977
			Action Plan - New	Letter to be sent by DMD and Executives to challenge CCG decision not to support de-escalation of 187201 NE - Facet Joint Injection
	4706	Infrastructure/environment in Nucleus Theatres		
			Gap in Assurance - New	From Jan-April 2018 there have been 4 incidents reported on Datix of insects in Nucleus Theatres
	4849	CT reporting		
			Positive Assurance – New	2 clinical fellow commenced position
	4472	Delays in Cubicle Assessment and Triage		
			Positive Assurance – New	Opening of 3rd room has improved assessment times
			Action Plan - New	Metric to be developed re initial assessments, for review at Division/ED meeting
			Action Plan - New	ED Mgt Team to undertake formal review (hard and soft intelligence) of Nurse led RAT to establish how well it is working and bring to Divisional meeting
			Action Plan - New	New ED mgt team to review staff rota
	4862	Increase in demand for Neonatal cots at level 1,2 3.		
			Action Plan - New	Risk to be amalgamated
Chief Financial Officer	4955	MRET/Readmissions/Fines monies		
			Action Plan - New	Further dialogue has taken place with Wolverhampton CCG as to risk share agreement using the Staffordshire format. The Trust is considering its response based on the counter offer from Wolverhampton CCG 21/5.
	5017	Unable to achieve the activity levels		
			New risk	The Trust has followed national instructions on activity growth instructions and secured commissioner monies to this effect. The risk is that the Trust is unable to achieve the activity levels and therefore income target due to incorrect modelling assumptions/operational challenges (referral patterns, staffing, etc).

CORPORATE OBJECTIVES RISK MATRIX

		RISK SCORES: LIKELIHOOD x CONSEQUENCE = TOTAL									STRATEGIC OBJECTIVES					
REF	STRATEGIC RISK	ASSURANCE TO	INITIAL RISK SCORE	SCORE AT QUARTER 1	SCORE AT QUARTER 2	SCORE AT QUARTER 3	SCORE AT QUARTER 4	MOVEMENT Q4 TO Q1	SINCE LAST UPDATE	CURRENT RISK & SCORE AT QUARTER 1 (18/19)	Be in the top quartile for all performance indicators	Proactively seek opportunities to develop our services	To have an effective & well integrated organisation that operates efficiently	Maintain financial health - appropriate investment enhancement to patient services	Attract, retain & develop our staff & improve employee engagement	Create a culture of compassion, safety & quality
SR1	Workforce - Recruitment and Retention of staff across the Trust and in particular the future pipeline of nursing and medical staff.	Director of Human Resources and Organisational Development	15	20	20	20	20			20					✓	
SR6b	Black Country or Staffordshire STP has an adverse impact on RWT income or services	Director of Strategic Planning and Performance	15	9	9	9	9			6				✓		
SR8	That there is a failure to deliver recurrent CIP's	Chief Operating Officer	20	20	20	20	20			20				✓		
SR9	That the underlying deficit that the Trust has (in 2018/19) is not eliminated in medium term to bring the Trust back to financial surplus.	Chief Financial Officer	15	20	20	20	20			20				✓		
SR11	Condition of the existing Estate - Quality and flexibility	Chief Financial Officer	12	12	12	12	12			12				✓		


ASSURANCE FRAMEWORK						
Strategic Objective: To attract, retain and develop all employees and improve employee engagement year on year.						
STRATEGIC (PRINCIPLE) RISKS	IMPACT x LIKELIHOOD = RISK SCORE				CURRENT ASSURED LEVEL	Movement
	INITIAL RISK SCORE	PREVIOUS QUARTER RISK SCORE	CURRENT RISK	TARGET RISK SCORE		
	5x3=15	3x5=15	20	5x2=10		
What is the strategic risk to be controlled?						
REF	STRATEGIC RISK		EXECUTIVE DIRECTOR	BOARD COMMITTEE		
SR 1 Date of origin - May 2015	Workforce - Attraccation, Recruitment and Retention of staff across the Trust and in particular the future pipeline of nursing and medical staff.		Director of Workforce	Workforce & OD/Finance & Performance		
OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC OBJECTIVE						
RISK TITLE	RISK No.	GRADE	OPERATIONAL RISK DESCRIPTION			
Consultant Job Plans	1713	4 x 3 = 12 amber	Failure to effectively maximise workforce productivity; failure to routinely review consultant job plans.			
Recruitment and retention of Nursing staff - Division 2	2080	5 x 4 = 20 red	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 or harm.			
Qualified Nurse staffing levels - Division 1	4161	5 x 3 = 15 red	If there are reduced qualified nursing staffing levels across the Division then there is a risk to patient safety and quality of care.			
Unable to recruit substantive Dermatology consultants	4715	5 x 3 = 15 red	If the Trust is unable to recruit substantive Dermatology consultants it will not be possible to provide the right level of care for patients.			
Vacancies in consultant or non-consultant medical staff across Division 1.	4529	4 x 3 = 12 amber	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.			
IMPACTS / CONSEQUENCES OF THE RISK?			ORIGINS OF THE RISK?			
REF			REF			
IC 1	Potential over reliance on agency / locum resource which may lead to quality issues and may lead to the temporary medical workforce cost become unaffordable.		O1	Reduction in the number of Doctors in Training coming through the deanery. There are recruitment gaps for some specialities increasing reliance on temporary workforce and locum, the market is highly competitive.		
IC 2	Inability to deliver the future workforce plan with the potential that the Trust is unable to provide the level of service it is commissioned for and putting quality of patient experience and outcomes at risk.		O2	Lower interest medical training as a career - number of nurses leaving profession, increasing levels of voluntary turnover for Band 5 nurses in particular. Number of doctors in training leaving the profession before FY2 has increased nationally.		
IC3	Ability to attract suitability qualified staff and retain them with the potential for costs involved in attracting and retaining staff becoming unaffordable.		O3	There is a national shortage of trained nurses and medics in the UK. The cost of attracting and retaining EU and non-EU staff is significant and the length of time from interview to start date is 6 months on average and up to a year for non-EU staff. The potential impact of Brexit is not quantified.		
IC4	Potential for employee engagement indicators to decline (eg satisfaction, motivation) and for negative indicators (sickness, incidents greater than peer group upper quartile) which may lead to quality and cost issues, reduced staffing, impacting patient care and remaining staff morale and satisfaction.		O4	Shortage of workforce supply and competition from other NHS Providers and agencies - who may have stronger benefits or workforce initiatives.		
IC5	With the potential for increased competition with other NHS organisations there is the possibility of salary escalation along with the wider issue of NHS competitive pay compared with the private sector					
Ref	Controls What are the controls in place to mitigate these risks?		*Level of assurance (L1, L2, L3)	Where and how often reported/monitored?		
C1	Recruitment and recruitment initiatives (including Overseas) for Doctors to complement local and national recruitment.		L2	Workforce & OD Committee, Resourcing Operational Group, TMC, TB		
C2	Recruitment and recruitment initiatives (including Overseas) for Nurses to complement local and national recruitment.		L1, L2	Workforce & OD Committee, Resourcing Operational Group, TMC, TB		
C3	Staffing establishment reviewed regularly through the annual workforce plan to provides a clear route/organisational plan for bringing in future workforce pipelines.		L1, L2, L3	Workforce & OD Committee, NHSI		
C4	Progress report on Trustwide workforce review to include the development of new roles.		L2	Workforce & OD Committee		
C5	Develop a strategic approach to People Management and employee engagement and measure outcomes of people and OD strategy.		L2	Workforce & OD Committee		

*Level 1 = Operational/Level 2 = internal oversight/Level 3 = Independent Assurance

What are the positive assurances (actual as opposed to potential) received?				
Control Ref	Date Assurance provided	What is the source for assurance?	POSITIVE ASSURANCE What assurance is provided?	COMMENT
C1	01/01/2017 June 17	1. Workforce & OD Committee - Resourcing Workforce Updates. 2. Executive HR Report to TMC and Trust Board. 3. Medical Resourcing Group established to review Medical Recruitment and Retention Actions.	At Jan 2017 EEA workforce was 2.5% of the whole Trust workforce, retention rates have been reviewed and there is continued monitoring of retention rates. - Agencies are used to source UK and overseas doctors in addition to the standard recruitment routes within the UK, Overseas medical recruitment continues and has increased. - In addition, for medical staff the Trust has introduced a Clinical Fellowship programme to attract medics into the Trust securing 73 new starters to June 2017. Clinical Fellow recruitment has increased. Retention of staff was the focus of Chatback 2016. The Trust exit process has been reviewed and has been refreshed. Chatback 2017 focused on Trust vision and values - there is a report to WAG and Trust Board on the issues identified.	R&R split for Medics C1 and Nursing C2.
C2	01/05/2017 June 17	1. Workforce & OD Committee 2. Recruitment and Retention steering group. 3. Safer Staffing Updates in Chief Nurse Update report to TMC and Trust Board. 4. Executive HR report to TMC and Trust Board.	International Phillipine campaign closed in January 2018 - 54 registered nurses have joined the Trust. The Trust appointed 19 Trainee Nursing Associates in 2017, the funding stream has now changed to a 2 year apprenticeship programme and 15 offers have been made to commence training March 2018. Proposals are being considered in respect of future cohorts. Employee engagement indicators are stable within the Trust, detailed work on retention and the Trust values have been reviewed within the newly established Attract and Retain Steering Group.	
C3	01/05/2017 June 17	Workforce & OD Committee - Resourcing Workforce Updates. 2. Executive HR Report to TMC and Trust Board. 3. Finance & Performance Committee 4. Update reports to Executive Directors through Director of Workforce. 5. Trust CIP Workforce Programme Updates on a monthly basis to include E-roster and Agency/Bank/Locum analysis.	Review of staffing establishment takes place through the annual workforce plan and this is reviewed regularly. - Nurse Recruitment team maintain a blueprint of nursing vacancies and placements. - Medical Recruitment maintain and report on medical staffing establishment and vacancy levels. - NHSI return of Workforce Plan submitted - scenario planning initiated supported by HEE. - Clinical Fellowship Programme established to assist with recruitment of posts at 'middle grade junior doctor level' and to provide a new career path for medical roles. - Trust CIP Workforce Programme has a work stream to control the use of agency, locum and bank staff - AndTrust wide resource review is planned. - E-rostering established to ensure staffing levels on wards are optimised. - Discussions with Allocate have taken place to review the use of Job Planning Module to provide a control and baseline for medical staffing.	There is now some evidence that the spend on agency is decreasing - NHSI have reviewed the Trust agency data - assurance is now looked for that the permanent workforce spend is also being controlled and is not rising as a result.
C5	01/09/2016 June 17	People and Organisation Development Strategy 2016-2020 progress report to WOD Committee	People and Organisation Development Strategy 2016-2020 KPI to be reported have been agreed.	

NEGATIVE ASSURANCES are ...					May 18 Status
What are the negative assurances received?					Updates made
Control Ref	Date Assurance provided	NEGATIVE ASSURANCE (include reasoning as appropriate)	ACTION PLAN	ACTION LEAD	AGREED DEADLINE
C1	01/01/2017 June 17	Length of time from interview to start date over 6 months. (Medical & Overseas Nursing)	- At Jan 2017 EEA workforce is 2.5% of the whole Trust workforce, retention rates have been reviewed and there is continued monitoring of retention rates. - Agencies are used to source UK and overseas doctors in addition to the standard recruitment routes within the UK.	Chief Nurse Medical Director	Closed
C1, C2, C3	Jan-18	Current overseas nurse recruitment comes to an end in early 2018/19	Develop an options approach for the future of overseas recruitment	Director of Workforce	01/04/2018 Complete
C1, C2, C3	May-18	Current overseas nurse recruitment comes to an end in early 2018/19	Develop business case to fund the above	HR Manager (Workforce)	Jul-18
C1, C2	Sep-17	Lack of a consistent/coordinated approach to the provision of staff benefits	An approach to staff benefits to be established	HR Manager (Workforce)	01/11/2017 Complete
C1, C2	Dec-17	Lack of a consistent/coordinated approach to the provision of staff benefits	Following the agreement of additional resource, implementation of the staff benefits approach.	HR Manager (Workforce)	Ongoing
C1, C2	Oct-17	The benefits of employment with the NHS are not adequately promoted	As part of improving attraction and recruitment, review and enhance the trust communication of the benefits of working within the NHS.	Senior Resourcing Manger Head of Communications	Mar-18
C1, C2	Jun-17		Trust wide Workforce CIP Resourcing review to be initiated through FRB.	Director of Workforce Medical Director Chief Nurse	Ongoing
C1, C2	Jun-17	Further develop Recruitment and Retention reporting focus	Develop monitoring of length of time to recruit (advert to appointment timescale) Develop Steering group to target work progress. Establish and report on a Workforce stability index (focus on outlying depts)	Deputy Director of HR	01/11/2017 Complete
	Dec-17		Develop monitoring of length of time to recruit (advert to appointment timescale) Develop electronic exit interviews. Deadline extended to align with implementation of TRAC	Senior Resourcing Manger	Aug-18
C1, C2	Sep-17	There is no single coordinated central mechanism for recruitment across the Trust	Explore the option of centralising recruitment for the Trust	Senior Resourcing Manger	01/11/2017 Complete
C1, C2	Dec-17	There is no single coordinated central mechanism for recruitment across the Trust	Following the support of the business case, establish a centralised recruitment approach for RWT	Senior Resourcing Manger	01/05/2018 Complete
C1, C2	Dec-17	There is no single coordinated central mechanism for recruitment across the Trust & a need to further focus on effective reporting	Review the option of procuring an electronic tool (such as TRAC) to improve recruitment processes & reporting. Now procured and focus moved onto implementation	Senior Resourcing Manger	Aug-18


C1, C2	Sep-17	The Trust lacks an integrated marketing approach to make best use of electronic media and events to improve attraction	Review options for improved marketing in order to enhance attraction	Senior Resourcing Manger Head of Communications	May-18
C1, C2	Sep-17	With regards to some roles within the Trust there is a lack of consistency and standardisation	Develop a project plan to establish a more consistent and coordinated approach to recruiting to generic roles	Deputy Director of HR	Oct 2017 Complete
C1, C'	Oct-17	With regards to some roles within the Trust there is a lack of consistency and standardisation	Implement agreed action plan. PID agreed	Deputy Director of HR	Ongoing
C3	Sep-17	There is a need to review the organisational employment model to support greater flexibility, recruitment & attraction	Establish and promote and enhanced employment model	Deputy Director of HR	Apr-18
C4, C5	Sep-17	There is no formal board committee responsible for the wider workforce agenda	Revise the ToRs for WAG to move it into a formal board committee responsible for Workforce & OD	Director of Workforce	Complete
C1	Jan-18	The current corporate induction is not fully focused on onboarding new staff in order to improve retention	Undertake a full review of corporate induction in order to support improved retention of staff	Senior Resourcing Manger Head of Communications	Apr-18
C4, C5	Jun-17	There is no strategic approach to focus on attraction and retention.	Develop a draft Trust approach to Attraction and Retention for all staff.	Director of Workforce	Apr-18
C3	Jun-17	Longer term plans to establish a central resourcing and temporary staffing function that handles internal bank and external agency placement requests for all. Exploratory meetings with stakeholders were completed by April 2017.	The Workforce CIP Group reviews the action plan and deliverables for the PID on Agency, Locum and Bank use - this is done on a monthly basis. Regional work has been initiated to balance safe staffing provision and compliance with agency cap. Closed following NHSI letter on collaborative bank (see new action below)	Director of Workforce	01/09/2017 Closed
C1, C3	Mar-18	Failure to effectively maximise workforce productivity; failure to routinely review consultant job plans.	Review options for the procurement and implementation of electronic tools to support effective use and reporting of job plans. Options reviewed and business case now under development	Dep Medical Director Senior Resourcing Manger	Jul-18
C3	Dec-18	Longer term plans to establish a central resourcing and temporary staffing function that handles internal bank and external agency placement requests for all. New NHSI requirement to establish BC collaborative bank.	Review options and support for a single collaborative bank mechanism across the BC. It has been agreed that the first phase is focusing on medical bank. Delays in obtaining multi organisational agreement	Director of Workforce	Apr-18
C3	Jun-17	Controls over agency and locum use require further control in place in order to have a planned and financially sustainable approach to temporary staffing, including to: - review compliance and spend levels against cap levels - review of the effectiveness of controls systems (i.e. business process, IT, monitoring) - review the operation and effectiveness of internal bank	This is monitored on a monthly basis at Workforce CIP with target for 2017-2018 year of £2 million reduction. Agreed to continue into 2018-19	Deputy Director of HR	Oct-18
C3	Sep-17	Variability in rates for medical locums across the West Midlands	In collaboration with other WM Trusts, with a particular focus in the BC, establish common (lower rates) for medical locums	Director of Workforce	Nov 2017 Implemented 6th Nov - Complete
C4, C5	Sep-17	There is no strategic approach to the implementation of apprentices across the Trust	Develop a Trust approach to the application of apprentices across the organisation. Draft presented to Feb WOD Committee. Final version agreed at April WOD	Director of Workforce	01/02/2018 Complete
C1, C2	Nov-17	No consistent and coordinated mechanism to review & monitor job planning across the Trust	Explore options for establishing electronic job planning across the Trust	Senior Resourcing Manger	01/03/2018 Complete
C5	Mar-18	Engagement and Culture and Organisation Development require further action planning in order to ensure improved employee engagement, involvement and satisfaction	Review national staff survey actions that may be required at both an organisational level and at a divisional level	Deputy Director of HR	May-18
C5	Mar-18	Engagement and Culture and Organisation Development require further action planning in order to ensure improved employee engagement, involvement and satisfaction	Review electronic options/tools to monitor & improve staff engagement, communication and overall staff involvement	Deputy Director of HR Head of Communications	Apr-18
C1	Mar-18	Increased difficulty in obtaining Certificate of Sponsorship for overseas Drs	Look to front load requests in the first two quarters of the financial year	Senior Resourcing Manger	Oct-18
C4	Mar-18	Increased difficulty in obtaining Certificate of Sponsorship for overseas Drs	Establish a working group to provide a more strategic approach to the development of new roles to address key gaps and support career development	Director of Workforce	01/05/2018 Complete
C5	Jun-17	The People and Organisation Development Strategy 2016-2020 has outcomes, measures and metrics. Engagement and Culture and Organisation Development require further action planning in order to ensure improved employee engagement, involvement and satisfaction are reflected in improved retention figures to result in increased tenure and improved patient experience within the Trust. KPI reporting against the People and OD Strategy is not yet commenced.	The outcomes within the strategy on Organisation Development and Engagement and Culture are being developed and action planning is underway in order to ensure employee engagement, involvement and wellbeing have a positive impact on retention and ultimately upon patient experience. The next step is to report on metrics and KPIs to provide Board assurance on Trends.	Deputy Director of HR	Complete

ASSURANCE FRAMEWORK						
Strategic Objective: Maintain financial health - appropriate investment enhancement to patient services						
STRATEGIC (PRINCIPLE) RISKS	IMPACT x LIKELIHOOD = RISK SCORE				CURRENT ASSURED LEVEL	Movement
	INITIAL RISK SCORE	PREVIOUS QUARTER RISK SCORE	CURRENT RISK SCORE	TARGET RISK SCORE		
	15	9	6	0		
What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR	BOARD COMMITTEE			
REF	STRATEGIC RISK					
SR6b	Black Country or Staffordshire STP has an adverse impact on RWT income or services	Director of Strategic Planning & Performance	Finance and Performance			
	Date of origin - July 2016					
OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC OBJECTIVE						
RISK TITLE	RISK No.	GRADE	OPERATIONAL RISK DESCRIPTION			
Significant financial pressure in the NHS Capital programme.	4584	Amber	Due to significant financial pressures in the NHS the Capital programme presented to the Trust in April may be under threat if the CRL is not approved by NHSI.			
IMPACTS / CONSEQUENCES OF THE RISK?			ORIGINS OF THE RISK?			
REF			REF			
IC 1	This will result in reduced income for the Trust		O1	All Trusts are required to participate in Strategic Transformation programmes.		
IC 2	Commissioners may decommission services					
Ref	Controls <i>What are the controls in place to mitigate these risks?</i>	*Level of assurance (L1, L2, L3)	Where and how often reported/monitored?			
C1	Stafforshire STP published in December 16, Black Country STP published November 16, updates to be reported.	L2	Reported to F&P and Trust Board (monthly)			
C2	Staffordshire STP - Clinical and managerial staff engaged in orthopaedics and ophthalmology workstreams and estates director invovled in estates workstream	L1, L2	Reported to F&P			
C3	Black Country STP - CEO or Director of Strategic Planning and Performance attends Sponsor Group.	L2	Reported to F&P and TB			
C4	Finance Lead attends Staffordshire and Black Country STP workstreams providing a report as and when appropriate.	L2	Reported to F&P			
C5	The Director of Strategic Planning & Performance provides a monthly verbal progress update at the Finance & Performance Committee Meeting.	L2	Reported to F&P			

*Level 1 = Operational/Level 2 = internal oversight/Level 3 = Independent Assurance

What are the positive assurances (actual as opposed to potential) received?				
Control Ref	Date Assurance	POSITIVE ASSURANCE		COMMENT
		What is the source for assurance?	What assurance is provided?	
C1	01/09/2016 June 17	Director STP progress report	Current STP submissions have not identified any adverse impact on the Trust	
C2	Jun-17	Staffordshire STP and Black Country STP update.	Progress feedback to Directors on workstreams on an as and when basis.	
C3	Jun-17	Sponsor group update	Discussion commenced around the development of RWT as the main provider of specialist services in the Black Country.	
C4	Oct-17	Staffordshire STP and Black Country STP update.	Written update on latest developments provided to F&P Committee	
C5	Apr-18	Black Country Sponsor Group update	Governance being revised and no threats identified	

NEGATIVE ASSURANCES are ...					May 18 Status
What are the negative assurances received?					No updates to be made
Control Ref	Date Assurance provided	NEGATIVE ASSURANCE (include reasoning as appropriate)	ACTION PLAN	ACTION LEAD	AGREED DEADLINE
C1		Need to strengthen Staffordshire engagement	Ensure engagement of clinical teams in planned care workstream and strengthen relationship with Staffordshire commissioners and GPs	Director of Strategic Planning & Performance	01/07/2016 and ongoing

ASSURANCE FRAMEWORK							
Strategic Objective: Maintain financial health - appropriate investment enhancement to patient services							
STRATEGIC (PRINCIPLE) RISKS	IMPACT x LIKELIHOOD = RISK SCORE			CURRENT RISK SCORE	TARGET RISK SCORE	CURRENT ASSURED LEVEL	Movement
	INITIAL RISK	PREVIOUS QUARTER RISK SCORE					
	4x5 = 20	4x5 = 20		4x5= 20	4x3 = 12		
What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR		BOARD COMMITTEE			
REF	STRATEGIC RISK						
SR8 Date of origin - June 2015	That there is a failure to deliver recurrent CIP's (Revised 2018/19)	Chief Operating Officer		Finance and Performance			
OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC OBJECTIVE							
RISK TITLE	RISK No.	GRADE	OPERATIONAL RISK DESCRIPTION				
Division 1 failure to achieve CIP for 2018/19	4113 - amended	4 x 5 = Red	Failure to achieve operational CIP target for 18/19.				
IMPACTS / CONSEQUENCES OF THE RISK?				ORIGINS OF THE RISK?			
REF				REF			
IC 1	Inability to meet financial targets			O1	Efficiency targets within tariff requiring release of CIP. Increase in underlying deficit.		
IC 2	Inability to invest in services capital and/or revenue due to a lack of funds			O2	Continuing CIP targets with reduced ability to make efficiencies.		
IC3	Reputational risk to organisation			O3	Workforce challenges (recruitment) resulting in failure to achieve savings. Failure to achieve previous year		
IC4	Trust is placed in financial special measures			O4	Failure to deliver on some identified schemes of slippage ie procurement, outpatients.		
				O5	Failure to identify recurring CIP schemes		
				O6	Slippage in appointment of transformation team to assist with CIP delivery. Subsequent failure to appoint to the 'Head' post.		
				O7	Additional CIP required as a result of signing up to the strategic transformation fund (STF)		
Ref	Controls What are the controls in place to mitigate these risks?		*Level of assurance (L1, L2, L3)	Where and how often reported/monitored?			
C1	Monitoring of CIP target bi-weekly at financial recovery group (FRG) chaired by CEO.		L2	Reported to F&P and Trust Board (monthly)			
C2	Use of transformational schemes via benchmarking to assist in CIP efficiencies.		L1, L2	Reported to F&P (monthly)			
C3	Carter efficiency team identified savings via hospital model. Includes GIRFT (getting it right first time). Establishment of clinical excellence programme to focus on GIRFT reports.		L1	FRB, TB (monthly) & TMC			
C4	Appointment of Deloitte to assist with CIP delivery ie outpatients.		L2	F&P (monthly)			
C5	MD & COO reviewed all medical (doctor) establishment with Directorates and HR to understand vacancies, locum plans. Feeds into workforce plan.		L1	FRG (6 monthly)			
C6	Divisional review of posts filled by agency staff - to be linked with revised plan for recruitment via AIM		L1,L2	Workforce Group, FRB, F&P (Monthly) & TMC			

*Level 1 = Operational/Level 2 = internal oversight/Level 3 = Independent Assurance


What are the positive assurances (actual as opposed to potential) received?				
Control Ref	Date Assurance provided	POSITIVE ASSURANCE		COMMENT
		What is the source for assurance?	What assurance is provided?	
C1	May-18	FRG reporting	Focus on key workstreams which includes Theatres, Outpatients, Workforce, Pharmacy, Pathology and back office (procurement)	CIP target is phased into the latter part of the year. Theatre presentation at FRB provided assurance on progress. Outpatient programme work commenced - amber status for delivery.
C2	May-18	FRG reporting	CIP schemes continue to be identified (mainly non recurrent). PIDs agreed by Directors and QSIG.	Non-recurrent CIP higher than forecast. Identification of schemes for 18/19 commenced and ongoing .
C3	May-18	FRB CIP reporting	CIP continues to be identified	See Above. Recurrent schemes under achieved. Vacancy factor introduced. Methodology to be confirmed.
C4	May-18	CIP Report	Clinical Excellence Group established with a rolling programme of reviews for each speciality. Action plans to be developed.	Schemes have been reviewed. Will now include GIRFT schemes. GIRFT clinical excellence group has met and developed programme of review.
C4	May-18	Product lines standardised by Procurement.	Catalogue lines reduced and further review on-going	Links with UHNM procurement team established.
C5	May-18	FRG reporting to F&P	Deloitte onsite (June 16) and extended Sept 2018. FRP developed - actions commenced formal sign off. Regular FRG report to F&P.	Contract extended until Sept 2018. Appointment made to Head of Service Improvement.
C6	May-18	Progress update	Meetings identifying plans for recruitment use of clinical fellows and also where gaps in directorate planning.	Resource meetings completed April 17 - completed report produced September 17. Deloitte report on impact of clinical fellows received. Action plan in place for Obstetrics and Gynaecology and Anaesthetics (Jan 18).
C7	May-18	Workforce & FRG	Review of non-medical agency (32 posts). Forecast only 7 posts to remain at the end of February.	Weekly review of non-medical will be undertaken by COO. Agency forecast to be within capped limit. 11 posts remain at Dec 17 plans for 4 to increase Mar 18. Review of agency undertaken weekly.

NEGATIVE ASSURANCES are ...

May 18 Status

Update received

What are the negative assurances received?					
Control Ref	Date Assurance provided	NEGATIVE ASSURANCE (include reasoning as appropriate)	ACTION PLAN	ACTION LEAD	AGREED DEADLINE
C1	May-18	There remains a CIP target with no plans for achievement	All areas reviewing plans. Focusing on 17/18 delivery. Update to F&P and Trust Board monthly.	Head of Transformation	Jun-18
C2	May-18	There is a shortfall against recurrent CIP.	All groups in FRB have an action plan for delivery.	Head of Transformation	Jun-18
C3	May-18	As a result of agreeing (STF) control totals additional CIP is required.	All Trust members to identify CIP when possible - Link to C1.	All (COO)	on-going
C4	May-18	Carter GIRFT efficiencies are not yet confirmed	Continuing work to 'realise' what has been identified and ascertain potential savings. Work is ongoing. Clinical Excellence Group established.	Deputy Medical Director	Jan 18 on-going
C5	May-18	Failure to appoint transformational lead post	Continue with Deloitte. Appointment made.	Director of Strategy	Jun-18
C6	May-18	Agency spend variance from control total.	Focus on reduction in agency spend, medical i.e. clinical fellowship, recruitment. Non medical appointment to post. Reductions in agency online.	Chief Operating Officer	Jun-18
C3	May-18	FIP 2 (NHS) Finance Improvement - Trust considering joining FIP 2, matching process currently underway.	Closed - Trust did not join FIP 2.	CEO/FD	Apr-17

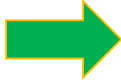
ASSURANCE FRAMEWORK						
Strategic Objective: Maintain financial health - appropriate investment enhancement to patient services						
STRATEGIC (PRINCIPLE) RISKS	IMPACT x LIKELIHOOD = RISK SCORE				CURRENT ASSURED LEVEL	Movement
	INITIAL RISK	PREVIOUS QUARTER RISK SCORE	CURRENT	TARGET RISK		
	5x3 = 15	5x4 = 20	5x4 = 20	5x2 = 10		
<i>What is the strategic risk to be controlled?</i>						
REF	STRATEGIC RISK	EXECUTIVE DIRECTOR		BOARD COMMITTEE		
SR9 Date of origin - June 2015	That the underlying deficit that the Trust has (in 2018/19) is not eliminated in medium term to bring the Trust back to financial surplus.	Chief Finance Officer		Finance and Performance		
OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC OBJECTIVE						
RISK TITLE	RISK No.	GRADE	OPERATIONAL RISK DESCRIPTION			
Division 1 failure to achieve CIP target	4113	4 x 5 = 20 red	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			
Capital Programme under threat	4584	3 x 4 = 12 amber	Due to significant financial pressures in the NHS the Capital programme presented to Trust Board in April may be under threat if the CRL is not approved by NHSI.			
IMPACTS / CONSEQUENCES OF THE RISK?			ORIGINS OF THE RISK?			
REF			REF			
IC 1	That the Trust will be placed into recovery and turnaround by NHSI		O1	Lack of fully detailed Recurrent Cost/Efficiency Improvement Programme in 2016/17		
IC 2	The Trust could have to apply for a working capital loan to the Independent trust Financing Facility for working capital/financing That the Trust is judged as not sustainable					
IC3	Reputational risk to organisation					
Ref	Controls <i>What are the controls in place to mitigate these risks?</i>	*Level of assurance	Where and how often reported/monitored?			
C1	Further detailed Efficiency/Productivity plans from Divisions and Departments.	L1	Reported to F&P and Trust Board (monthly)			
C2	Detailed plans to deliver to contracted levels of activity	L1	Reported to F&P			
C3	On-going identification and delivery of Carter initiatives on staffing, estates, procurement and pharmacy/medicines.	L1	Reported to FRB			
C4	Action on Agency Costs as per TDA guidance on capping arrangements.	L1	Reported monthly to F&P			
C5	Receipt of Deloitte report on Trust CIP and Transformation Programme. Management capacity. Clear list of actions identified.	L2	Reported to F&P			
C6	Update of Long Term Financial Model for discussion at Finance and Performance and then Trust Board on medium term financial plans. This will include a high level assessment of the STPs as they could impact on the organisation.	L2	Reported to F&P			
C7	The final year of the MSFT funding deal is realised and paid in 2018/19	L2	Reported to F&P			
C8	There is close cash monitoring and forecasting to ensure that the Trust has sufficient cash to operate	L2	Reported to F&P			

*Level 1 = Operational/Level 2 = internal oversight/Level 3 = Independent Assurance

<i>What are the positive assurances (actual as opposed to potential) received?</i>				
Control Ref	Date Assurance provided	POSITIVE ASSURANCE		COMMENT
		<i>What is the source for assurance?</i>	<i>What assurance is provided?</i>	
C1	Apr-18	Finance and Performance FRB report	Further efficiency from deep dive reviews being identified. FRB is focussing on the CIP gap and identifying recurrent CIP where possible.	
C2	To be Agreed	Capacity Report to Finance and Performance Committee.	Commissioners have bought additional activity in 2018/19 above outturn levels in line with National requirements. Detailed activity levels and a capacity plan has been shared. Directorates/Groups actively considering whether further capacity is required.	
C3	Apr-18	FRB report to Finance and Performance Committee and the Board	Further opportunities have been identified. Ongoing review of Agency spend and temporary staffing costs including WLIs. Work with External Consultancy now identified further efficiencies in Outpatients and this is being rolled out. The Trust in establishing its financial plan had an additional efficiency challenge requirement of £9.8m. The non-recurrent vacancy control factor now taken as recurrent has been re-evaluated and increased and used to offset this challenge in the first instance.	
C4	Apr-18	FRB report to Finance and Performance Committee and the Board	Balanced scorecard now being produced monthly on key issues as per NHS Improvement best practice. Agency Staffing continues to be carefully monitored as does temporary staffing including locums/bank costs and WLIs.	
C5	Q2 2018	Audit Committee and Finance and Performance Committee	Internal Audit Plan for 2018/19 incorporates a review of this financial risk and the Cost Improvement programme.	
C6	Sep-18	Update to Finance and Performance Committee and then the Board.	LTFM to be updated for in year performance/contract mitigations/Forecast year End updated underlying financial position.	
C7	Jun-18	Update to Finance and Performance Committee.	Invoice to be raised to the Department of Health to secure 2018/19 MSFT financial payment. In addition £0.2m outstanding for 2017/18 to be pursued.	

C8	May-18	Audit Committee and Finance and Performance Committee	Internal Audit Report on cash management completed and taken to May Audit Committee. Controls in place and management action agreed. 12 month rolling cash forecast implemented. Clear Prompt Payment Statistics reported to Board. Self review against GT report on Barking, Havering & Redbridge Universities Hospitals.	
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NEGATIVE ASSURANCES are ...					May 18 Status
What are the negative assurances received?					Updates received
Control Ref	Date Assurance provided	NEGATIVE ASSURANCE (include reasoning as appropriate)	ACTION PLAN	ACTION LEAD	AGREED DEADLINE
C2	May-18	The Trust may not be able to deliver commissioned activity levels.	The Trust has secured a draft risk/gain share agreement with Staffordshire CCGs and is in discussion with Wolverhampton CCG.	CFO/DoSPP	On-going
C6	May-18	The increasing reliance on Non-recurrent CIPs means that the underlying position is deteriorating.	Further work on the underlying financial position identifies that the underlying position is deteriorating due to increasing levels of Non-Recurrent CIP. This will be shared in detail with F&P.	CFO	On-going

ASSURANCE FRAMEWORK						
Strategic Objective: Maintain financial health - appropriate investment enhancement to patient services						
STRATEGIC (PRINCIPLE) RISKS	IMPACT x LIKELIHOOD = RISK SCORE				CURRENT ASSURED LEVEL	Movement
	INITIAL	PREVIOUS QUARTER RISK SCORE	CURRENT RISK SCORE	TARGET RISK		
	4x3 = 12	4x3 = 12	3x3= 9	3x3 = 9		
What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR		BOARD COMMITTEE		
REF	STRATEGIC					
SR11	Condition of the existing Estate - Quality and flexibility	Chief Finance Officer		Finance and Performance		
Date of origin - June 2015						
OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC OBJECTIVE						
RISK TITLE	RISK No.	GRADE	OPERATIONAL RISK DESCRIPTION			
Capital Programme under threat	4584	3 x 4 = 12 amber	Due to significant financial pressures in the NHS the Capital programme presented to Trust Board in April may be under threat if the CRL is not approved by NHSI.			
IMPACTS / CONSEQUENCES OF THE RISK?			ORIGINS OF THE RISK?			
REF			REF			
IC 1	Inability to maintain Quality and Safety		O1	Ability to find resource to invest in retained Estate		
IC 2	Inability to deliver operational and commissioner targets		O2	Reduced income from commissioners		
Ref	Controls <i>What are the controls in place to mitigate these</i>	*Level of assurance (L1, L2, L3)	Where and how often reported/monitored?			
C1	Five Year Capital Plan.	L2	Yearly at Board around February as part of the planning round unless any issues cause the strategy to be required to be reviewed earlier.			
C2	2017/18 capital programme has identified high risk backlog	L2	Quarterly to F&P			
C3	Further work on estates rationalisation as part of updated clinical strategy.	L2	Quarterly to F&P			

*Level 1 = Operational/Level 2 = internal oversight/Level 3 = Independent Assurance

<i>What are the positive assurances (actual as opposed to potential) received?</i>				
Control Ref	Date Assurance provided	POSITIVE ASSURANCE		COMMENT
		<i>What is the source for assurance?</i>	<i>What assurance is provided?</i>	
C1	Mar-18	5 year capital programme presented to Board	Trust Board discussion on the estates strategy, 5 year capital programme and phasing. Board approved 5 year Capital programme.	
C2	Mar-18	Annual capital Programme submitted for Board approval	<p>Risk Assessed Annual Capital Programme. An application is being made to increase the CRL using the Trust's working capital to enhance the capital programme for 2017/18 to NHS 1. Detailed backlog maintenance programme to be identified for 2017/18 spend by August CRG for approval. Action to be taken by Head of Estates Development in conjunction with Head of Estates.</p> <p>Due for completion by end of Feb 18.</p> <p>Backlog investment report and benchmarking data being presented to F&P on 21st March. This details that the total cost to eradicate all backlog maintenance (high, significant, moderate and low risk) reported in the 16/17 ERIC returns equates £86/m2. This figure is below average for Midland and East region and suggests that RWT does not suffer from underinvestment in backlog in comparison to other similar trusts.</p> <p>The detailed asset review by external professionals will be presented to F&P in July for discussion and agreement.</p>	
C3	Sep-17	Further work on estates rationalisation as part of updated clinical strategy.	<p>A structured 'Property Management' function under Estates (Development) being advanced alongside the clinical service strategy. Regular Property Management reporting has now commenced and includes community accommodation functions. Utilisation information is to be developed further. Room booking and agile working systems and options are being investigated. Business Case due for Feb 18.</p> <p>Work continues on rationalising options at West Park with a project led by the Director of Strategic Planning and Performance. This will be discussed at F&P when the analysis is complete.</p>	

NEGATIVE ASSURANCES are ...					May 18 Status
<i>What are the negative assurances received?</i>					Updates received
Control Ref	Date Assurance provided	NEGATIVE ASSURANCE (include reasoning as appropriate)	ACTION PLAN	ACTION LEAD	AGREED DEADLINE

C1	Sep-17	On-going discussions commenced with Commissioners with regard to primary care estate strategy	<p>Develop primary care strategy with CCG.</p> <p>Ongoing discussions with commissioners, Local Authority and BCPFT as part of the Local Estates Framework (LEF). A joint service strategy is being developed to consider community estates rationalisation with local partners.</p> <p>Joint service strategy with Local Authority, BCPFT and Wolverhampton CCG has now been completed. Recommendations contained within the strategy for joint hub working are being explored. The development of a business case for such a hub is currently being procured.</p> <p>A new software system is being procured to record occupancy and report on occupancy. It is expected that for the system to be implemented and fully populated it could take 6-12months.</p> <p>Separate piece of work is underway to research space requirement and availability around the trust in order to satisfy existing need.</p>	Head of Estates Development	Joint Service Strategy has now been completed. Date for Hub business case yet to be confirmed.
C1	May-18	The Trust needs to secure payment of CRL as per the requirements of NHS Improvement for access to Pathology and Stroke resources	Work has commenced in gathering together the required documents for submission to NHS Improvement.	CFO/Director of Strategic Planning & Performance	End of May 18
C3	Sep-17	Lack of supporting information with regards to long term plan with regards to services. Also lack of information on space and room occupancy.	Monitor service strategy development. Develop business case for capital and revenue requirements required to manage occupancy and utilisation of space.	Head of Estates Development	Oct-17

The Royal Wolverhampton NHS Trust

Trust Risk Register

May-2018

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: To have an effective & well integrated health and care system th

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	<ul style="list-style-type: none"> 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 completed. Pilot for weekend working commences Feb 18. 	<ul style="list-style-type: none"> 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). 	<ul style="list-style-type: none"> 1) Patients still entered retrospectively on PAS, especially after weekends. 1) System bugs in safehands causing delays to bed allocation - closed 	<ul style="list-style-type: none"> 1) Communication plan to remind staff to ensure timely and appropriate admission onto PAS and other Trust Clinical systems Business Case for additional Ward Clerks. 	Feb-18 May-18	2 x 3 = 6 YELLOW	Yes
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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	4596	If a patient with acute cholecystitis does not have cholecystectomy within 1 week (as recommended by NICE QS104) and a patient with acute gallstone pancreatitis does not have cholecystectomy within 2 weeks (as recommended by NICEPOD in Treat the Cause) the patient is at increased risk of recurrent admissions with complications of gallstones, potentially serious morbidity and an increased risk of mortality. 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. (27.02.18) SLA with Stoke reversed to bring additional resources from current RWT Consultant and buy service from Stoke		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. (09.04.18) Secure an acute hot gallbladder list - Radiography support agreed week commencing 12/02/18. UGI Consultant to discuss pathway with Anaesthetist. Clinical Director to draft SOP for discussion / agreement within Directorate. 1. (09.04.18) Directorate to advertise for substantive 3rd Upper GI Surgeon once job description approved by Royal College of Surgeons. 2. (09.04.18) Further discussions to take place re: UGI pathway with Gastroenterology re Acute Pancreatitis patients 1. (09/04/18) Directorate to formulate business case for a 4th Upper GI Surgeon.	Apr-18 Jun-18 Apr-18 Jul-18	2 x 2 = 4 YELLOW	May-18	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	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	<p>1) Matron has set up a group to ensure all nursing actions are addressed and learning is shared across the team (22/08/16)</p> <p>2) Review of Governance work streams at the Divisional Governance meetings, including NICE, External guidance, Audit, Risk (22/08/16)</p> <p>3) Monitoring of all SUI/Audit actions through to completion (22/08/16)</p> <p>4) Performance meetings in place (22/08/16)</p> <p>5) Directorate Governance meeting in place and attended by Directorate Management Team (22/08/16)</p> <p>6) Staff member identified to provide Governance support 2 days per week (22/08/16)</p> <p>7) Process in place to review re-attendances for potential SUI's proactively (22/08/16)</p> <p>8) Ongoing recruitment [07/09/17]</p> <p>9) Governance pre meets in place (14/11/16)</p> <p>10) CD had additional admin day [10/10/17]</p> <p>11) Incident reporting and governance covered as part of junior doctors induction [04/12/17]</p>	<p>5) Governance meetings taking place regularly [13/04/18]</p> <p>9) Pre Governance meetings now established and working well to review SUI actions and risks [13/04/18]</p> <p>3) Number of SUI and SUI actions is reducing [13/04/18]</p> <p>4) 1 Adult ED Consultant commenced substantively from Mid October 2017 taking the substantive establishment to 5 PEM,9.5 Adult [13/04/18]</p> <p>1) Bd6/7 nursing forums taking place regularly and working well [13/04/18]</p> <p>3) Action plan now reviewed in Divisional Friday morning meeting [13/04/18]</p> <p>3) Local audit of SUI actions is showing good compliance, with exception of Discharge checklist [13/04/18]</p> <p>3) HOT reporting of radiological results in place [13/04/18]</p> <p>8) 2 x Consultant appointments confirmed (1 x substantive; 1 x NHS Locum for six months) [13/04/18]</p> <p>3,4) SUI actions saved on w drive for easier access to all [13/04/18]</p> <p>3) Number of overdue SUI actions has red</p>	<p>3) Significant number of SUI actions overdue/dates amended [13/04/18]</p> <p>2) Number of NICE and External Reviews that remain outstanding [13/04/18]</p> <p>8) 2 ACPs have left the department [13/04/18]</p> <p>3) Actions are taking a considerable amount of time to implement/ close [13/04/18]</p> <p>9) Difficulties in reviewing whole agenda at pre meet due to the volume of outstanding SUI actions/ number of RCAs to be reviewed and signed off [13/04/18]</p> <p>7) No process in place to ensure re-attenders report is reviewed in the absence of governance lead [13/04/18]</p> <p>3) Significant increase in SIs reported in October - 7 [13/04/18]</p> <p>3) Local audit of SUI actions is showing poor compliance with Discharge checklist [13/04/18]</p> <p>3,4) SUI actions reviewed once a month based on availability of CD [13/04/18]</p>	<p>6,7) Directorate to agree process to ensure incidents are reviewed and reported when the Governance lead is on leave</p> <p>8) Workforce plan in progress (MD)</p>	<p>2 x 3 = 6 YELLOW</p>	<p>May-18</p> <p>May-18</p>	<p>Yes</p>

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) Date of governance meeting has been amended to enable attendance by wider team [04/12/17]						
Chief Operating Officer	4761	If we are unable to fill our vacancies and obtain visas in JMS anaesthetics and JMS Cardiothoracic Surgery we will be unable to provide a comprehensive cardiac and anaesthetic service. As of 19 April 2018 we will have 4 empty posts in JMS Surgery and 2 for anaesthetics. Implications are -we will be unable to provide an assistant for elective planned surgery and cover OOH emergencies in theatre and in ITU with 4 vacancies. Two agency locums for JMS surgery are being used.	3 x 4 = 12 AMBER	2. Anaesthetics - Agreed we can recruit 2 training ACCPs (4.4.18) 1. Job Vacancies are being advertised in BMJ as well as on NHS Jobs. (09.17) 3. Surgery - 2 agency locums in place. (4.4.18)	1-3 No incidents have occurred (4.4.18)	1 & 2. Anaesthetics - 1 vacancy remains but 2 gaps until visa/start date agreed. 1 post filled awaiting agreement by Anaesthetic College for visa (4 April 18) 1 & 3. Surgery - 1 vacancy remains but 4 gaps until visa/start date agreed 3 out of 4 recruited but waiting visas and GMC (4 April 18) 2. It takes two years to train ACCP's (4 April 18)	1. Recruit to vacant posts- Surgical and Anaesthetics 2. Training of ACCP's 3 Locum Cover - Surgery	Jun-18 Jun-18 Jun-18	2 x 3 = 6 YELLOW	May-18

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	4862	Currently, there is an increase in demand for neonatal cots at Levels 1, 2, 3, which exceeds agreed commissioned activity and funded nursing establishment. If funding and service commissioning is not increased to meet BAPM standards, then this will lead to delays in delivering high risk ladies, transfer intrauterine cases and repatriation of RWT babies resulting in the potential for an adverse outcome for mother and/ or baby leading to increase in legal cases as a result of harm.	4 x 3 = 12 AMBER	<p>1) Neonatal and Obstetric teams working together to plan and prioritise planned cases according to clinical need (15/09/2017)</p> <p>2) Liaising with neighbouring Trust to initiate intrauterine transfers from RWT when clinically safe (15/09/2017)</p> <p>3) Additional staffing sought through Trust bank and current workforce (15/09/2017)</p> <p>4) Loan of essential equipment from Trust within the network (15/09/2017)</p> <p>5) Actions implemented/lessons learnt from RCA 2017/10549 (175503) - Transfer the most stable babies out where possible to reduce risk of an emergency enroute (Oct 17)</p> <p>Business Case for additional staff to TMC April 18</p>	<p>4) Equipment available for loan from other Trusts (01/05/2018)</p> <p>1) Obstetric and Neonatal teams planning ahead and agreeing delivery times (01/05/2018)</p> <p>1-5) This is now part of the overall NNU staffing business case. The mix of levels 1,2 and 3 cots have been changed and the figures in this business case now are reflective of this (01.05.18)</p>	<p>1,2) Incident reports have been received concerning lack of staff and equipment.(01/05/2018)</p> <p>4) Availability of spare equipment from other Trusts not guaranteed due to their own pressures. (01/05/2018)</p> <p>2) Neighbouring Trusts cannot always accommodate babies at request due to their own pressures (01/05/2018)</p> <p>3) Additional staffing cannot always be found leading to increase in stress of those working. (01/05/2018)</p> <p>3) There are number of incidents relating to staff and over capacity on monthly basis. (01/05/2018)</p> <p>4) There are ongoing incidents relating to the lack of clinical equipment to support activity, i.e., machines providing ventilation support (01/05/2018)</p> <p>3) 88 patients were refused admission for various reasons. (01/05/2018)</p>	<p>1-5) Recruitment to circa 20 WTE once business case has been agreed</p> <p>Risk to be amalgamated with 4962</p>	<p>Sep-18 3 x 2 = 6 YELLOW</p> <p>May-18</p>	<p>May-18</p>	

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 2018/2019 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 = 09/10/15 & June 16	4 x 5 = 20 RED	3. Vacancy control panel in place (Oct 2015) and higher restrictions being applied (Jan 17) 2. Financial Forecasting meetings now include Confirm & Challenge CIP so that there is a consistent approach to Directorate financial position/challenge (Sept 17) 1. Increased PMO resources to support delivery of the Trusts efficiency programme (June 16) 4. Monitored by the Financial Recovery Board (FRB) (Oct 2017) 5. 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 6. Operating Theatre Efficiency Group (OTEG) set-up and running for 12 months. Each Directorate has 'Local' sub-groups (Sept 17) 7. All agency requests above £120 P.H to be approved by COO/CEO 8. Division involved in Financial Recovery Board chaired by CEO (Nov 2017) 9. PIDs are forthcoming to the Finance team (Nov 2017)	2, 3 & 4. Structure in place to discuss and identify opportunities to create efficiencies and business growth (Oct 17) 3. VCP meetings held weekly and posts go through this process (Oct 17) 5. If there is a risk that impacts on a team's ability to deliver their CIP schemes then the member of Service Re-design Team would be available to support as and when required at the Quality Meetings. (Oct 17) 1-9. Against an annual CIP target of £9.9m, £315k has been achieved of which £204k is recurrent. In month the variance is £188k adverse to the financial target. The Division achieved £315k (full year effect) in month (May18) 6. This year the theatre efficiency programmed has achieved £0, PID value to be validated (May 18)	2 & 3. Unidentified CIP still remains (May 18).	1-9) Continue with process to identify and deliver efficiencies 2) Review of year to date underspends with a view to take non-recurrent to CIP 1) Divisional Management Team to meet with CDs collectively to discuss growing the business, increasing utilisation of theatres and OPD 1-9) Trust commencing roll-out of Clinical Excellence Programme to cover Carter, GIRFT and Model Hospital, led by Deputy Medical Director	Aug-18 Aug-18 Aug-18	2 x 3 = 6 YELLOW	May-18	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 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 (June 17) 1) Continue to follow up on debt (June 17)		1) Currently arbitration process has stopped (Sept 17)	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. (Sept 17) 2) NHS I informed Trust at IDM 31 Aug that the debt was now being escalated out of region for conclusion (Sept 17) 4) NHS I confirmed at telephone conference on 19 Jan 2018 that the issue was being put on the arbitration list for national escalation with NHS England (Jan 18) Trust contacted NHS I in writing on 14th Feb requesting an update but no response received yet (Feb 18). 4) Trust made verbal contact with NHS Improvement Regional Director of Finance on 8 March and assured that arbitration process was still being pursued with NHS England Trust maintained position in its 2017/18 accounts. NHSI confirmed that the arbitration case will be pursued after the accounts closure.	3 x 3 = 9 AMBER	May-18	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	4903	<p>If the Directorate are unable to meet the new NHSE service specification for thoracic work then thoracic work will no longer be commissioned at this Trust from April 2019. This will result in a loss of income circa £2,000,000 of income for the Trust per year.</p> <p>Date of origin: 16th Nov 2017</p> <p>Date of escalation: 18th Dec 2017</p>	4 x 5 = 20 RED	<p>1.Trust have requested that NHSE reconsider codes used to determine number of eligible resections . (Nov 17)</p> <p>2. 13/12/17 Medical Director held discussions with Walsall Manor Hospital to increase referral cases to RWT (Jan 18)</p> <p>3. Frozen section samples to be communicated from lab to theatres within one hour (Jan 2018)</p> <p>4. Recruitment strategy in place (April 2018)</p>	<p>1-3 ANP has been recruited (09 Apr 18)</p> <p>4. Business case for 1 additional consultant has been agreed at TMC and interviews to be held in April 2018 (09 Apr 18)</p> <p>4. Business case for 1 additional band 7 ANP has been agreed and staff have been recruited. (09 Apr 18)</p>	1. Awaiting decision of NHSE (09 Apr 18)	4. Consultant to be recruited	May-18	1 x 5 = 5 YELLOW	May-18
Chief Financial Officer	4955	<p>The Trust is expecting the return of MRET/Readmissions/Fines monies from Wolverhampton CCG (worth £1.7m) for the 2018/19 year end but has yet to secure payment.</p> <p>Date of origin: 20th Feb 2018</p> <p>Date of escalation: 20th Feb 2018</p>	3 x 3 = 9 AMBER		Ongoing dialogue and planning assumption from Wton CCG of intent to pay.	The Trust needs to provide sufficient evidence to the CCG's satisfaction for the payment to be made.	<p>Further detailed written submission required to the CCG.</p> <p>Constructive dialogue between Deputy CFOs and agreement on the process for returning Readmissions/Fines and payment of monies for stranded costs. MRET return is subject to agreement from Economy wide Emergency Services Board.</p> <p>Further dialogue has taken place with Wolverhampton CCG as to risk share agreement using the Staffordshire format. The Trust is considering its response based on the counter offer from Wolverhampton CCG 21/5.</p>	3 x 3 = 9 AMBER	May-18	

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 Financial Officer	5017	The Trust has followed national instructions on activity growth instructions and secured commissioner monies to this effect. The risk is that the Trust is unable to achieve the activity levels and therefore income target due to incorrect modelling assumptions/operational challenges (referral patterns, staffing, etc). Date of origin: 24th April 2018 Date of escalation: 24th April 2018	3 x 3 = 9 AMBER		Ongoing Discussion with Divisions/Groups/Directorates on activity level plans for 2018/19	Some specialties are challenged due to manpower shortages.	Further refine capacity and demand issues Detailed activity levels and a capacity plan has been shared. Directorates/Groups actively considering whether further capacity is required.	x =	May-18	
Trust Objective: Attract, retain & develop our staff & improve employee engagement										
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 - Dec 17 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 5) Job Planning updates to be presented to clinical excellence group (Jan 18) Job Planning Consistency Panel established 18/19 (May 18 first one).	1) Job Planning Audit indicated a number of actions now addressed 1) Training commenced on new job planning process - Feb 16 4) Medical agency costs reducing Dec 17. 1) Increase in number of 'signed off' job plans October 2017	1) Slow progress in terms of Job Plan completion - Apr 17 1) Audit review still raised concerns - closed Dec 17	1) Develop business case for recording electronic tool to assist with job planning. 1) Internal audit to review progress made on job planning (Jan-Mar 2018) 5) Further update to Audit Committee in progress.	Mar-18 Mar-18 Feb-18	3 x 2 = 6 YELLOW	May-18 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	2080	<p>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.</p> <p>(Linked to local risks 2780 CHU, 4164 Renal, 4272 Therapy Svs, 4321 DN's, 3431 CofE)</p> <p>Date of origin: 02/01/09</p> <p>Date of escalation = 12/01/16</p> <p>On BAF</p>	5 x 4 = 20 RED	<p>1) Ongoing active recruitment exercises - including overseas (Jan 16)</p> <p>8) Use of Nurse Bank when required (Jan 16)</p> <p>3) Defined minimum safe staffing levels now in place revised October 2017</p> <p>5) Modified dependency tool for inpatient areas commenced (Jan 16)</p> <p>9) Staffing incidents reviewed on monthly basis (Jan 16)</p> <p>10) Closed Ward 3 at West Park Hospital (June 16)</p> <p>4) Closed ward B7 (June 2017)</p> <p>Training Nurse Associate and clinical apprenticeship Business Case for TMC April 18</p>	<p>8) HCA's are available via Bank (May 18)</p> <p>3) Safe staffing levels are being maintained across acute wards (May 18)</p> <p>3) All B7s trustwide filling OOH rota first, then managing in-hours gaps, including putting themselves in if necessary (May 18)</p> <p>1) Proactive recruitment approach continuing, successful recruitment exercise in B'ham (May 18)</p> <p>1) Fill rates have been reviewed and weekly roster meetings now taking place with Director of Nursing (May 18)</p> <p>3) Skill mix review found appropriate staffing by and large. Shortage of trained staff identified in CHU, this has been addressed (May 18)</p> <p>1) Successful recruitment day in Birmingham with a number of places offered (May 18)</p> <p>1) Retention group in place to look at retention strategies across the Trust (May 18)</p>	<p>1) 38.43 wte trained nursing vacancies remain (May 18)</p> <p>8) Insufficient RN's available on Bank, backfilled by HCA (May 18)</p> <p>1) Nationally we are an outlier re safe staffing levels (May 18)</p> <p>1) Recruited staff are newly qualified which can lead to mentorship and training pressures (May 18)</p> <p>1) 26 HCA vacancies remain, 12 places offered (May 18)</p> <p>9) Newly developed review tool for special measure wards did not work. (May 18)</p>	<p>1) Skill mix review results to TMC and Trust Board. Div 2 request for more money to be considered</p> <p>9) HoN and Matron to review progress in A7/A8 with view to taking them out of 'special measures'</p> <p>HoN (Div1&2 to develop gradings for vacancies, with Chief Nurse</p>	4 x 3 = 12	<p>Jun-18</p> <p>May-18</p> <p>May-18</p>	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	4529	<p>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.</p> <p>Please note: Risk 4239 (Obs & Gynae), Risk 4467 (Cardio) staffing risks have been linked to this overarching Divisional medical staffing risk.</p> <p>Date of origin: 23/04/16</p> <p>Date of escalation = 17/05/16</p>	4 x 3 = 12 AMBER	<p>2. Review of Obs & Gynae rota's underway as a result of increased activity (Sept 2017)</p> <p>3. Baseline resourcing meetings held to review vacancies and expenditure, identify recruitment opportunities within Directorates explore alternative solutions including future workforce planning and forecasting (Sept 17)</p> <p>4. Trust is part of West Mid's Project to reduce Locum Agency use and Pay (Dec 2017)</p> <p>5. Trust part of Junior Doctors in-training streamlining group (Dec 2017)</p> <p>1. Recruitment in place (Dec 17)</p>	<p>1-5) Some reduction in medical spend (Sept 17)</p> <p>1-5) Medical workforce vacancy rate further reduced to 12.61% (Dec 2017)</p> <p>1-5) Radiology vacancies have reduced to 5 - 3 x Consultant interviews in Jan 2018 (Dec 2017)</p>	<p>1-5) Number of vacancies remain across the Division including within Radiology, Anaesthetics and Head & Neck (Sept 2017)</p> <p>1-5) Locum expenditure increased month on month Oct/Nov/Dec 17 but still significantly decreased overall (Dec 17)</p>	<p>1-4. Continue with Fellowship Programme</p> <p>1. Actively recruiting radiology (overseas) with Resourcing Team</p> <p>1. Continue campaign with regular adverts</p> <p>1-5. Developing roles to support medical rota (ANPs and ACCPs)</p> <p>1. Radiology interviewing for 6 Clinical Fellow posts</p>	<p>Apr-18</p> <p>Apr-18</p> <p>Apr-18</p> <p>Apr-18</p> <p>Apr-18</p>	2 x 2 = 4 YELLOW	May-18	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 Nursing Officer	4718	<p>If there is a shortage of staff in the safeguarding team this will result in:</p> <p>1. Delays in providing safeguarding advice and responding to queries raised by staff and concerns raised via Multi Agency Safeguarding Hub (MASH).</p> <p>2. Inability to attend all safeguarding meetings either internally or externally to the Trust</p> <p>3. Inability to work proactively with staff on wards/ in community to ensure key safeguarding messages are disseminated</p> <p>4. Inability to provide safeguarding supervision to key staff who work with vulnerable clients</p> <p>5. Delay in providing face to face safeguarding adult and children training.</p> <p>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.</p> <p>Date of origin: 03/03/17</p> <p>Date of escalation: 25/04/17</p>	2 x 2 = 4 YELLOW	<p>1) Regular review of staff available to work (Jan 2017)</p> <p>2) Tasks/Meetings are prioritised (Jan 2017)</p> <p>3) MASH information for adult cases allocated directly to SG adult named professionals (May 2018)</p> <p>4) Regular review of safeguarding legislation/CQC action plans, CCG assurance framework and Safeguarding Board partnership programme to prioritise workload of team. (Jan 2017)</p> <p>5) Safeguarding supervision provided to Maternity staff, Health Visitor's, School Nurses and FNP (Jan 2017)</p> <p>6) Safeguarding training is available: Level 1 - Induction (face to face), Level 2 - via e-learning, Level 3 - via face to face for children (Jan 2017)</p> <p>7) Safeguarding Children Team Leader in place (December 2017)</p> <p>8) Post safeguarding case support is provided as required (Nov 2017)</p> <p>9) Supervision Policy Draft 1 written (Mar 18)</p> <p>10) Safeguarding Adults Team Leader in place (April 2018)</p>	<p>1) 4 of 4 posts have been recruited. (1x start 20/11/17, 1x start 4/12/17 and 1x start date TBC) (May 2018)</p> <p>3) Quality of information required by MASH has been addressed by response to the review (includes introduction of RAG rating for safeguarding enquiries (May 2018)</p> <p>3) All cases are referred (May 2018)</p> <p>8) No issues identified (May 2018)</p>	<p>1), 2) & 4) Certain meetings are not always attended or represented. e.g. MASH Me</p> <p>5) Safeguarding supervision is available to certain staff only due to staffing shortages in Maternity Services. Overall compliance is approx. 75% in Maternity (May 2018)</p> <p>5) & 7) 1 to 1 adult safeguarding maternity supervision is not provided by Safeguarding Team (this is currently provided by a nominated midwife) (May 2018)</p> <p>5) Scope of remaining RWT Safeguarding Children and Adult supervision requirements unclear. (May 2018)</p> <p>1) 1 of 4 posts not yet recruited to (Safeguarding Adults Lead) (May 2018)</p> <p>6) Level 3 for adults is not provided to clinical staff as outlined in key legislation (May 2018)</p> <p>4) CQC review of July 2016 identified the need to recruit a named midwife (May 2018)</p> <p>1) Safeguarding Adult Trainer not in post (May 2018)</p> <p>1) Named Midwife not in post (May 2018)</p> <p>9) Safeguarding Supervision Policy not implemented (May 2018)</p>	<p>1) to 8) To continue to regularly contact the chair of the groups and review urgent actions post meetings.</p> <p>1) to 8) SG Adult training delivery to be reviewed</p> <p>5) Review Safeguarding supervision protocol</p> <p>1) & 4) To recruit named midwife/Safeguarding Adults Lead to be in post</p> <p>1), 2) & 4) To prioritise and attend meetings</p> <p>5) Additional named nurse B7 to be recruited</p> <p>6) Review safeguarding training programme</p> <p>1) & 4) Awaiting confirmation of approval of business case for Named Midwife post</p> <p>1) Interviews to be carried out for Adult Trainer post</p> <p>9) Policy tabled to be approved</p>	<p>May-18</p> <p>Jul-18</p> <p>May-18</p> <p>Nov-18</p> <p>May-18</p> <p>Nov-18</p> <p>Sep-18</p> <p>Jun-18</p> <p>May-18</p> <p>May-18</p>	1 x 2 = 2 GREEN	May-18	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	4962	If the workforce establishment on the Neonatal Unit is not being funded to meet British Association of Perinatal Mortality (BAPM) standards resulting in inadequate staffing levels from vacancies, maternity leave and sickness absence then there is potentially a risk to the quality and safety of care provision for these babies.	4 x 3 = 12 AMBER	<ol style="list-style-type: none"> 1. Workforce review plan 2. Monitoring of staff levels and skill mix daily with escalation and capacity plan. 3. Proactive recruitment of qualified and unqualified staff to the Neonatal Unit 4. Development of and recruitment to rotational posts between Neonatal Unit, A21, Transitional Care and external trusts' within the Network 5. On-going recruitment drive by tertiary children's hospital and local LNU 6. Robust preceptorship programme for new starters to include commencement on foundation course within first 6 month period to encourage retention 7. Proactive sickness absence management 8. Use of available neonatal nurses registered on Trust nurse bank 	<ol style="list-style-type: none"> 3. Offering attractive incentives to successful candidates (01/05/2018) 2. 102% occupancy in Q2 in Intensive care (01/05/2018) 	<ol style="list-style-type: none"> 1. Trust not currently meeting current version of BAPM standards (01/05/2018) 2. Sickness absence - predominantly affected by long term sickness and creeping short term sickness absence levels (01/05/2018) 5. Inability to repatriate babies when they reduce to level 2 care needs due to lack of cots in level 2 LNU units (01/05/2018) 3. Insufficient suitable applicants (01/05/2018) 8. Some successful assignments, but unreliable source (01/05/2018) 	<ol style="list-style-type: none"> 1. Work to be undertaken by Staffordshire, Shropshire and Black Country Neonatal & Maternity Network (SSBCNMN) in regard to skillmix / workforce profiles 3. Recruitment to Band 7, 6, 5 and 3 vacancies in a timely manner 4. Explore further rotational posts between neonatal unit and Birmingham Children's Hospital 3. Secure additional recruitment support from Head of HR Shared Services - to develop a medium / long term recruitment plan for children's services 4. Identify rotation opportunities internally and externally via Network, local hospitals and tertiary centre. 3+4 Develop a recruitment and retention plan for Neonatal Unit specifically 	<p>Jul-18 2 x 2 = 4 YELLOW</p> <p>Jun-18</p> <p>Jul-18</p> <p>Jul-18</p> <p>Jul-18</p> <p>Jul-18</p>	May-18	

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: Create a culture of compassion, safety & quality										
Chief Nursing Officer	O4 2952	<p>Cause: There is a risk of some patients developing a pressure ulcer/s due to delays in the ordering of equipment, poor information and instruction due to significant service under-performance. CCG proposing monthly contract renewal from April 18.</p> <p>Impact: This may lead to patient harm.</p> <p>Date of origin: 10.05.2012</p> <p>Date of escalation 19/03/18</p> <p>Date of expected closure 01/09/18</p>	4 x 3 = 12 AMBER	<p>1) Mattresses are supplied and maintained by CERL in Hospitals. Independent Living Service for community patients with foam and alternative systems May 18</p> <p>2) Community services can access surface selection guide for mattress selection based on risk and holistic needs May 18</p> <p>2) A £55,000 budget for the out-of-hours pressure relieving mattress service in Community until October 17 (May18)</p> <p>2) SLA in place with Independent Living Service and monitored (May 18)</p> <p>2) ILS service community equipment supplied by them on return (May 18)</p> <p>2) Special Order Requests for TOTOs, double/unusual sized mattresses, special pressure relief aids are requested via individual funding requests - either approved or rejected by CCG May 18</p> <p>1) Process in place to reassess patients on Symmetrikit Chairs (OT posture management Chairs) May18</p> <p>3) Notice of concern issued to current provider (May 18)</p>	<p>2) Accountability pressure injury process reviewed, October 17 & January 18 (May 18)</p> <p>1) Suitable trolley mattresses in use for A&E May 18</p> <p>3) West Park, CCH and New Cross supplied with Hybrid Mattresses - May 18</p> <p>2)CCG Contracting Team/souial services are leading the tender process for community equipment including th TV Team - May 18</p> <p>1) Process in place for wards to monitor integrity of hybrid mattress May 18</p>	<p>2) Lack of regular assurance data from ILS on order to delivery times May 18</p> <p>2) RWT is not resourced to follow processes for specialist equipment request/order -May 18</p> <p>1) TOTO business case not agreed in April 17 (May 18)</p> <p>1) High demans on mattresses from ILS, no assurance on timely delivery May 18</p> <p>1) Delays in delivering equipment from ILS May 18</p>	<p>1.6-8) Contracting Team tendering for new community equipment service - including special orders</p> <p>1) Contracting looking at solutions to RWT funding for ordering specialist equipment</p>	1 x 3 = 3 GREEN	May-18 May-18	May-18

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	<p>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</p> <p>Date of origin: 19/07/12</p> <p>Date of escalation = 17/11/15</p>	3 x 4 = 12 AMBER	<p>5. Monitoring and circulation of incident notification reports to all senior staff for review</p> <p>6. Trustwide learning via a "Lessons Learned" sheet in the monthly IGR, Risky Business Newsletter and the CLIP Group.</p> <p>8. Regular scrutiny of Directorate risk registers and minutes of Directorate governance meetings at the Quality Meetings</p> <p>2. Review completed of all documentation and Theatre protocols/procedures amalgamating where possible</p> <p>1. Perioperative care plans are in place across the Trust</p> <p>9. Agreed communication strategy with Division 2 to share/raise awareness of never events and lessons learnt</p> <p>3. 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.</p> <p>4. New NE Guidance (published Jan 2018) being used for NE classification</p>	<p>10. Human Factors has been identified as a trend (Jan 2018)</p> <p>6. 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 (Oct 17)</p> <p>11. Staff supported to undertake PCM training in Maternity & T&O (Dec 17)</p> <p>12. Audit of LocSSIPs are being presented at PSIG (Jan 2018)</p> <p>3. Monthly monitoring data of compliance with WHO checklist and Procedural Safety Checklist - 100% for full completion (May 2018)</p>	<p>4. There have been three Never Event incidents 2 x Wrong Site Surgery and 1 x Retained foreign object) reported and investigated during 2015</p> <p>4. 5 x NE in 16/17 reported to CCG - 1. Maternity NE (retained tampon) reported (Datix ID: 158830), 2. Radiology NE (wrong ankle injected) reported (Datix 165455), 3. Ophthalmology (wrong eye injected) reported (Datix 166680) 4. Theatres (retained foreign object) reported (Datix ID: 169339) 5. Theatres/T&O Cannock (wrong prosthesis) reported (Datix ID: 174038) occurred Mar 2017</p> <p>4. 6 x NE incidents reporting in 17/18 reported to CCG from April 2017 (175581,179911,181941,185875 186479 and 187201) (Dec 17)</p> <p>4. 2018/2019 There has been two Never Events reported in April 2018. Both were Wrong Site Surgery incidents (Neonates Datix 194205 and H&N Datix 194977) (Apr 2018)</p> <p>3. Monthly monitoring and compliance with WHO checklist use - There has been 89% compliance achieved during Apr 18 (May 18)</p>	<p>1-11. All theatre staff to undertake Human Factors Training from AFFP</p> <p>2. Programme of Human Factors Training for Theatre Staff under-development</p> <p>1-11. Staff continue to undertake PCM training</p> <p>12. Directorates to continue to audit LoCSIPS, presenting at the Divisional Governance Meeting ahead of QSIG presentation</p> <p>12. Review/Gap analysis of LoCSIPS with AFFP</p> <p>1-11 AFFP Peer Review to be undertaken</p> <p>6. RCA Investigation to be undertaken into the NE Wrong Site Surgery (Lumbar Puncture wrong baby) Datix:194205</p> <p>6. RCA Investigation to be undertaken into the NE Wrong Site Surgery (Wrong tooth) Datix:194977</p> <p>6. Letter to be sent by DMD and Executives to challenge CCG decision not to support de-escalation of 187201 NE - Facet Joint Injection</p>	2 x 4 = 8 AMBER	May-18	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?
				7. Policy for the management of retained swabs in place 10. New qualitative and observational WHO checklist being used in Theatres (Oct 17) 11. Continue to support the Sign up to Safety campaign - T&O and Maternity participation (Oct 17) 12. LocSSIPs developed by Directorates auditing underway (Jan 2018)						

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 and retention via WODG and Board monthly 3) Monitor monthly performance through the nursing midwifery KPIs for signs of deterioration 4) Environmental Standards are monitored via the environmental group monthly 6) Daily staffing is monitored via the Divisional QSIG ops meetings 5) Internal audit has reviewed the CQC action plan in 2016 and self assessment process in 2017. CQC actions which remain ongoing are monitored via relevant Trust level groups e.g recruitment & retention and Medicines Management group which are then reported to the relevant sub board committee. 8) Fundamental standards are reviewed & monitored by the designated specialist groups and bi annually by the sponsor which then reports to COG. 9) HON/M monitor quality performance metrics on a monthly basis for trends and themes, these are further analysed via QSIG.	4) Overseas recruitment has seen a further 4 potential nurse candidates from the Philippines arrive Jan 18, March OSCE is booked for March 2018 - this will add to the current total of 54 qualified Philippine nurses currently in post. 5) Nursing and Midwifery KPIs moved to Health Assure reporting and emailed out to ward sisters/matrons and HoNs monthly. 2) QRV process is now embedded and refined, plan formulated for ongoing inspections 2018 7) CQC insight report shared with Divisions for information, Dec 2018 shows a slight decline in the safe domain, remaining domains remain stable 7) Biannual skill mix review - slight improvement in vacancy rates 3) Lord Carter metrics monitored monthly via Divisional Performance meetings Business case approved to support the first cohort of 10 Nurse Associate Apprenticeship and 20 RN Apprenticeships to commence Sep/Oct 18	2) Sickness absence needs to be driven down to Trust average in all ward areas. 3) Vacancy rates remain high in some areas 3) Phase 1 skill mix review for Adult inpatients shows a deficit 4) Safer staffing fill rates remain transient particularly for nights 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 Collaborative working with CCG regarding information/education to care homes and carers regarding safeguarding requirements for PI's Action plans to be developed to support National Maternity and CYP survey outcomes Feb 2017 Opportunities for recruitment paths currently being explored	2 x 2 = 4 YELLOW	Apr-18	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	4161	<p>If there are reduced qualified nursing staffing levels across the Division then there is a risk to patient safety and quality of care.</p> <p>Please note: Risk 4553 (Children Services's) staffing risks have been linked to this overarching Divisional staffing risk.</p> <p>Date of origin: 13/05/15</p> <p>Date of escalation = 18/11/15</p>	4 x 3 = 12 AMBER	<p>1. Recruitment strategy in place</p> <p>2. Developed a programme for Band 7s with a support programme wrapped around to assist with attrition and development</p> <p>4. Increasing Band 2 support to manage qualified shortfall</p> <p>5. Scrutinising staffing levels daily and moving /re-deploying staff across the Division as necessary</p> <p>6. Friday morning meetings taking place for Matrons to check staffing across the Trust for the weekend to assure safety</p> <p>7. There is now a trustwide transfer staffing pool (aimed to retain staff) (Aug 2016)</p> <p>8. Appointed to Nursing Associate posts - to start end of Jan 17 (Jan 2017)</p> <p>9. Trained and untrained vacancies reviewed by Head of Nursing and reported back to Trust Management Committee (Oct 17)</p> <p>10. Regular workforce reviews to ensure staffing and service needs match (Oct 2017)</p> <p>11. Nursing posts being reviewed to further retain staff (Surgical Nurse Practitioners, ACCPs, ANPs) (Oct 2017)</p>	<p>1. Utilising bank where possible and increasing HCA cover as necessary</p> <p>7. Safer escalation - Areas are amber or green. No area has been red.</p> <p>2. Positive feedback received from Band 7s who have attended programme</p> <p>1. Continuing to support offered applicants.</p> <p>3. 5 T&O beds on Ward A5 have been opened (Oct 2017)</p> <p>8. From March 2018, all areas will have one Nursing Associate (Jan 2018)</p> <p>1 + 11. General Surgery nearly fully established, T&O fully established for beds open and ICCU have no vacancies (July 2017)</p> <p>12. Theatre Agenda spend usage down to 2 staff, on track to completely remove by Dec 2017 (Oct 2017)</p> <p>13. On review - all green now (Jan 18)</p> <p>14. Continuing to recruit new areas (Jan 2018)</p> <p>1. Recruited to Consultant Nurse post (March 18)</p> <p>1. Previously increased expenditure for bank payments in ICCU, month 12 no enhanced payments since 2/04/2018 (Apr 2018)</p>	<p>5. Peak annual leave seasons challenge to cover bank shifts.</p> <p>1. Trustwide position: Philippines recruitment successful but long lead in time for staff to arrive in UK</p> <p>1. SEU Band 5 gaps likely due to internal promotions (March 18)</p>	<p>1. Review SOP for enhanced rates for ICCU staff</p> <p>1. Pilot 'Stay' Interviews within Paediatrics Directorate</p> <p>1. Scoping with Division 2 and Corporate Services re: recruitment events for the next 12 months</p>	<p>Jul-18</p> <p>Aug-18</p> <p>Apr-18</p>	2 x 2 = 4 YELLOW	May-18	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. Action Plan to remove all agency spend in theatres completed (Jan 18)						
				3. Beds reconfigured on Ward A5 and A6 and Hilton Main (Oct 2017)						
				13. Continuing with Weekly e-rosta meetings to ensure scrutiny of unused by the ward (Jan 18)						
				14. Shared Governance being rolled out to the pilot areas (Jan 18)						

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. Date of origin: July 2017	3 x 4 = 12 AMBER	Implementation of a 4 Stage Risk Mitigation Plan; details include 1) Restricted parking of vehicles to 6m 2) Management of waste in the external compound 3) Increased security and surveillance 4) Augmented Fire Service reponse 5) Increased Trust Fire Response 6) Additional Fire Wardens trained 7) Additional fire exercises and drills 8) Review of fire risk assessments (15 completed, local risks managed by Directorates) 9) Building & Maintenance risks managed by Estates via Planet FM 10) Statutory fire alarm testing (weekly), Fire Damper Testing (Annual)	10) 0 incidents relating to Reportable Fire's within April 2018 3) Additional Security Fire Patrols undertaken and recorded 9) Priority Planned Preventative Maintenance undertaken 2) Waste compound has been relocated	10) 1 Unwanted Fire Signals within April 2018 (Aerosol)	9) Compartmentation survey to be completed (commenced)	2 x 2 = 4 YELLOW	May-18	

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	(NX08/09) 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. Date of origin : 14/02/2018	3 x 4 = 12 AMBER	1. Statutory fire alarm testing (weekly) 2. Departmental Fire Risk Assessments undertaken 3. Statutory Planned Preventative Maintenance 4. Waste Management 6. Fire Evacuation Drill on 18/5/2017 5. Departmental Fire Warden Daily Checks undertaken 7. Tugway Safety & Environmental Group commenced May 2018	1. 0 Unwanted Fire Signals within April 2018	3. Penetrations in compartment walls could allow fire to spread from the tugway into the building 2. Poor housekeeping including combustible materials in the Tugway 1. 1 incidents relating to Reportable Fire's within April 2018 (Medical Records, Light Fitting)	4. Remove or relocate combustible storage in the Tugway 3. Carry out remedial fire stopping works in the Tugway 2. Departmental Business Continuity Plans need to be updated 4. Tugway Safety Environmental Audit Group monitoring action plan	2 x 2 = 4 YELLOW	May-18	

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 timescales, which could compromise patient care. Date of Origin: 24/02/2016 Date of escalation = 15/04/16	4 x 4 = 16 RED	<p>1) National guidance in place (15 minutes for triage & 2 hours for assessment) (15/04/16)</p> <p>2) Use of MSS to monitor times for triage and assessment (15/04/16)</p> <p>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. (15/04/16)</p> <p>4) Reallocation of doctors to areas with high waiting times if appropriate (15/04/16)</p> <p>5) Reallocation of nurse to support triage nurse (15/04/16)</p> <p>6) Bed meetings held at regular intervals where status of Emergency Department is discussed with representatives of both Divisions to facilitate flow (15/04/16)</p> <p>7) Monitoring staffing ratios and man-power plans regularly reviewed (15/04/16)</p> <p>8) Acute Physician team available to support department from 10am until 21.30 every day (15/04/16)</p> <p>9) UCC opened on 1st April 2016 (15/04/16) and joint triage model in place.</p>	<p>8) No concerns raised re Acute Physician support [21/03/18]</p> <p>7) 8 new nurses started Sept17 and 5 started in Jan18 and a further 8 to start in March 18 [21/03/18]</p> <p>7) 1 NHS 2 year locum appointed (CESR Dr) [13/02/18]</p> <p>14) Nurse led RAT working well, phased implementation in place [21/03/18]</p> <p>15) New starters are familiar with the department and its processes/ policies when they start [21/03/18]</p> <p>7) 3 PEM Consultants recruited with joint working in Paeds, this ceases in April 2018 with all three posts becoming wholly ED [21/03/18]</p> <p>7) Reduced reliance on locum agencies (internal staff have knowledge of local policies and processes) [21/03/18]</p> <p>9) Opening of 3rd room has improved assessment times (18/04/18)</p>	<p>1,2) Inability to meet Department of Health guidance - 76% compliance in Feb [13/02/18]</p> <p>1, 2) Inability to achieve 2 hour assessment and 15 minute triage [10/04/18]</p> <p>3) Huddles not routinely taking place and escalation tool does not include actions to address ratings and does not highlight problem areas [13/02/18]</p> <p>4,5) Staff not always available to be reallocated [21/03/18]</p> <p>6) Delays in ED linked to bed availability [10/04/18]</p> <p>7) Medical and nursing vacancies and sickness/ annual leave resulting in gaps in rota [21/03/18]</p> <p>8) Consistently at 2 hour wait by evening [10/04/18]</p> <p>9) UCC not impacting on pt numbers and delays in assessments (on average 29 patients per day redirected to UCC in Feb) [10/04/18]</p> <p>10) BEST tool identified dept is 20 nurses short (10 trained/10 untrained) (10/04/18)</p>	<p>7)Continue with recruitment of medical staff - ECIP tool has identified need for more staff in the morning</p> <p>3) IT to review escalation tool as it was not working as intended</p> <p>3) Business case for capital bid to increase cubicles</p> <p>1, 2) Work to commence with VOCARE and CCG to process map current pathways to Urgent Care</p> <p>2) Metric to be developed re initial assessments, for review at Division/ED meeting</p> <p>14) ED Mgt Team to undertake formal review (hard and soft intelligence) of Nurse led RAT to establish how well it is working and bring to Divisional meeting</p> <p>7) New ED mgt team to review staff rota</p>	<p>May-18</p> <p>Apr-18</p> <p>Apr-18</p> <p>Jun-18</p> <p>Jun-18</p> <p>Jun-18</p> <p>Jul-18</p>	<p>1 x 4 = 4 YELLOW</p>	<p>May-18</p>	<p>Yes</p>

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?
				10) Powerpoint presentation around National ED standards included in new starters induction and within annual mandatory training sessions (15/04/16)						
				11) Human factors training undertaken [08/11/16]						
				13) Medical and nurse staffing managed via the risk register (risk 2374 & 4496) [08/11/16]						
				14) Nurse led RAT and SOP ratified and in place (Sept 17)						
				15) Where possible, newly qualified starters have their last student placement transferred to RWT ED [07/09/17]						
				16) System in place to ensure that Cat 2 patients are shown red at 15 minutes [05/10/17]						
				17) Use of internal bank rather than locum agencies where possible [05/10/17]						
				18) Extra Triage room and escalation process in place [13/03/18]						

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	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 Incident reported - 185209 non-STEIS investigation underway. There has been identification that the information included in hospital notes not available via clinical web-portal (Apr 2018) 1. Records are not always available for elective clinics, even if they are available this creates a time lag within the clinic (Apr 2018) 1. Further incident identified re: 2017/30511 (186645) - Unexpected Injury/Extravasation injury to neonate (Apr 2018)	1-2. Monitor ongoing incidents 1-2. Non-STEIS investigation being undertaken Datix: 185209	Jun-18 May-18 2 x 2 = 4 YELLOW	May-18	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 substantive 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	8) Reported at Ops Finance Group and Finance & Performance 2) Utilisation of fellowship programme 3) Recruitment Strategy in place 1) Agency spend reviewed monthly at Directorate/Divisional Meetings 4) Establishment of workforce group to review/monitor use of medical locums/agency (Oct 16) 5) Overseas recruitment for some specialties (radiology). 6) Focus on reducing agency spend in non-clinical areas initially (Nov 2017). Star chamber review in Sept 17 7) Agency Dashboard are now produced monthly at a Trust and Divisional Level (Nov 2017) 9) The Trust is working collaboratively with other Trusts in the region as part of a Regional Agency Cluster Group to standardise rates of pay and reduce agency spend. This became effective on 30th October 2017 (Nov 2017) 10) Challenge for Bank/Agency requests and more effective use/administration of workforce shift through e-roster (Dec 2017)	1-10) Significant decrease in Locum expenditure overall (Dec 17) 1-10) Medical workforce vacancy rate decreased to 12.61% (16.30% in August 2016) (Dec 17) 1-10) Nursing workforce comparison May 2017-August 2017 shows reduction of 6.66 WTE vacancies. Vacancies further reduced from 134.42 in August 17 to 110.73 (shift - 23.69) (Dec 2017) 6) There continues to be a decrease in agency spend in non-clinical areas (Dec 2017) 1-10) Forecast to achieve year end agency cap (Dec 17)	1-10) Locum expenditure has increased during Nov and Dec 2017 (Dec 17) 1-10) Radiographer x 5, Orthotist x 1 and 2 X Cardiac Investigations HCP in place (Jan 2018)	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 8. Ensure exclusion of GP Integration locum spend 2. Continue scrutiny of CPD to use academic fellowship programme	2 x 2 = 4 YELLOW	Apr-18 Apr-18 Apr-18 Apr-18 Apr-18	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 clinicians 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 (ongoing)	Nov-17 x =	May-18	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.	3 x 4 = 12 AMBER	1) Maintenance Contract in place (£19,000 per annum) (May 2018) 2) Access to Mobile Imaging (if required) (Oct 2016)	1) Breakdowns are usually fixed under a 'fix as you go' contract. (May 2018) 2) There is a mobile X-ray unit at CCH which can be brought down to the X-ray room and used to continue the service for patients. (May 2018)	1) Any breakdown causes disruption to the service offered to patients. Breakdowns encountered with CR readers 2; X-ray equipment 1 (May 2018) 2) No focus choice on mobile X-ray unit and reliance on ageing CR processing equipment (May 2018) 2) X-ray service will not be available if CR processing facilities fail (May 2018)	1) & 2) To continue to monitor any equipment breakdown 1) & 2) Replacement of equipment planned for 18/19	Jul-18 Aug-18	2 x 2 = 4 YELLOW	May-18	Yes
		Date of origin: 17 November 2016 Date of escalation: 26 April 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	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 December 2016 Accepted onto Trust Risk Register: 5 January 2017	3 x 4 = 12 AMBER	1) Monitoring of scans/imaging studies on a weekly basis (Jan 2017) 3) Clinical Fellows are being employed (Jan 2017) 4) Regular meetings between Clinical Director and Group Manager (Jan 2017) 5) Waiting list initiatives for Trust Radiologists on going (Jan 2017) 6) Outsourcing work to extenal company (May 2018)	3) Clinical Fellows have been appointed (3 in place) (May 2018) 4) Review meetings are happening fortnightly (May 2018) 1) Backlog has reduced from 7332 May 2017 to less than 3000 in May 2018 (May 2018) 3) Office space sourced (May 2018)	1) Approximately 3263 non-urgent imaging studies unreported May 2018 (inclusive of 575 CT scans and 967 MRI scans) (May 2018) 1) Poor patient experience if patients and doctors are unsure when their scans are reported (May 2018) 3), 4) & 5) Demand for reporting imaging studies is higher than expanded reporting capacity (May 2018) 3) Infrastructure in terms of equipment and office space not currently available for the additional clinical fellows (May 2018)	1,3,4 & 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 1,3,4 & 5) To revisit plan to recruit 5 Radiologists 1,3,4 & 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 1,3,4 & 5) Monitor outsourcing work and assess impact on reducing outstanding numbers 1,3,4 & 5) Continue to utilise waiting list initiatives	2 x 4 = 8 AMBER	May-18	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	<p>Longstanding maintenance challenge around infrastructure/environment in Nucleus Theatres, which includes:</p> <ol style="list-style-type: none"> 1. Sewerage ingress 2. Drainage system 2. Electrical infrastructure 3. Fire safety 4. Operating lights 5. Air-flow/ventilation 6. Storage 7. Infestations <p>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.</p>	4 x 3 = 12 AMBER	<ol style="list-style-type: none"> 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) 3. Theatre 5 has remained closed since 25th April 2017 (Apr 18) 4. Moving work to Cannock Theatres (Apr 18) 	<ol style="list-style-type: none"> 1+2. Programme of works underway (Mar 18) 4. Lack of cancellations on site due to estate issues (Apr 18) 3. Ceiling space above Theatre 5 has been surveyed regarding the sewage leaks (Mar 18) 	<ol style="list-style-type: none"> 1+2. There has been 1 incident (Datix 192843 - 10/03/2018) of sewage ingress into Theatres (Mar 18) 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+2 From Jan-April 2018 there have been 4 incidents reported on Datix of insects in NucleusTheatres (April 18) 	<ol style="list-style-type: none"> 1. Review and action recommendations from the report received after the Fire Brigade exercise in Oct 2017 3. Await report from the full drainage review and implement required actions 1. Action to remove ceiling - deep clean and then review opportunity to redirect drains to commence shortly 3. Theatre 5 anticipated to open September 2018 1. The Reception area and storage space is being reviewed by the Matron and TOM 1. Work to commence on Theatres 9 and 10 and then 3 and 4 to repair minor defects, surface and paint issues 	<p>2 x 1 = 2 GREEN</p>	<p>May-18</p>	

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	<p>The Trust is shown to have a higher than expected standardised mortality rate (SMR; the SHMI indicator published in England) based on a statistical model where the Trust's outcomes are compared with the rest of the acute trusts in England. This is driven by a decrease in expected mortality, which does not reflect the severity of illness of patients admitted at the Trust.</p> <p>There is no increase in unadjusted mortality rates, which have seen very little variation for the past 3 years.</p> <p>The higher than expected SHMI does not indicate quality of care or excess mortality but variation in data. The Trust has investigated and has put actions in place to address the issues identified.</p> <p>Date of origin: 03/04/17</p> <p>Date of escalation: 03/04/17</p>	4 x 3 = 12 AMBER	<p>1. Mortality data are reviewed and investigated and findings are discussed at MRG (monthly) and MoRAG (bi-monthly). A report is presented at TB on a quarterly basis.</p> <p>2. Audits of coding and clinical documentation are undertaken regularly to ensure the treated conditions are reflected accurately in the data used for the calculation of mortality statistics</p> <p>3. The Trust requires all directorates to follow the process set out by the Learning from Deaths policy (OP87). All deaths are undergoing an initial review using an approved methodology; a cohort of cases is then referred for a second stage, multidisciplinary review. The findings are reviewed at MRG</p> <p>4. For all diagnosis groups showing a higher than expected SHMI (at internal alert level, which is a lower threshold than external alerts) a coding and data quality as well as a clinical review where appropriate are undertaken.</p> <p>5. A Trust wide action plan was approved to investigate potential causes of the elevated SMRs and provide assurance in relation to the quality of clinical care.</p>			<p>Robust governance processes to evidence learning from mortality reviews embedded in all clinical areas.</p> <p>Follow up on the recommendations from the internal and external data and clinical audits</p> <p>Ensure the mortality policy (OP87) is correctly followed by all specialties.</p> <p>Strengthening the collaborative working between coders and clinicians in order to improve quality of clinical documentation and coding. The Head of Coding and Data Quality is setting out the revised working process with senior clinicians.</p> <p>Reducing the number of unspecific primary diagnoses and improving the capture and coding of secondary diagnoses on the admission episode by reducing the number of the multiple short episodes for emergency medical admissions.</p>	2 x 2 = 4 YELLOW	May-18	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?
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5.1. An external data review was undertaken by an independent company. The results confirmed internal findings that the higher SMRs were due partly to the admission avoidance program (reduced denominator), the higher than average number of short episodes for emergency medical admissions leading to a higher proportion of unspecific primary diagnoses on admission, which drive a lower expected mortality.

5.2. An external coding review was undertaken by an independent company. Overall coding quality was found to be good in the sample audited. Recommendations were made also for reducing the number of short emergency medical admission which can lead to richer coding on the admitting episode. Some room for improvement was identified in the coding for primary diagnosis where a 7% error rate was found.

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				5.3 An external retrospective case notes review of a sample of 100 deceased patients was undertaken by an independent clinician. The reviewer highlighted that care for the deceased patients was found generally to be good and outstanding in some cases. A query was raised around an important proportion of frail, elderly patients who died within 5 days, as to whether admission to hospital was in the patients' best interest or they could have been cared for in the community.						
				5.4 A review of the pneumonia clinical pathway was undertaken by an independent company. The findings were generally positive and areas where improvement was needed were identified.						
				5.5 The early introduction of the Medical Examiner Role is being pursued.						

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 the increased activity could potentially lead to increasing challenges for staff to provide safe midwifery and medical care. This could also potentially result in increased maternal morbidity and/or mortality. Poor patient experience may also occur due to care being compromised as a result of delays which include medical reviews, treatment/procedures, seeing new admissions, admissions for induction of labour, starting the induction of labour process, transfers to Delivery Suite and/or theatre and delay in antenatal and postnatal transfers to the ward.	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 24.1.18 2) The number of women booking at RWT is being monitored by Antenatal Payment By Results (PBR) 24.1.18 3) 13/11/2017 Birth Activity capped (24/1/18)	1) Predicated births/booking are recorded on the Maternity Dashboard, RAG-rated and discussed at monthly Governance & Risk Management meeting (1.5.18) 2) Close observation of activity in relation to number of predicted births (1.5.18)	1,2) Activity levels are variable and uncontrollable due to births occurring at varying gestations and women transferring in from other units (1.5.18)	1,2) Liaise with Neonatal Services to utilise/staff to full capacity on the TC Ward 1,2) Recruitment of Midwives to fill vacancies and achieve 1:30 Birthrate Plus ratio 1,2) Continue to monitor activity via dashboard 3) Continue to monitor birth activity as a result and decline inappropriate bookings 1,2 Full service review to be carried out by Birth Rate Plus	Jul-18 Jul-18 Jul-18 Jul-18	3 x 2 = 6 YELLOW May-18	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	4767	If the Directorate fails to achieve all 8 mandatory criteria for the Hip Fracture Clinic Best Practice Tariff this could mean patients are not receiving care as per NICE guidelines resulting in poor clinical outcomes, a financial loss of additional income and poor national figures.	4 x 3 = 12 AMBER	<p>1) Informatics pulls a report twice a month for validation of BPT (May 17)</p> <p>2) The patient remains under the care of an orthopaedic consultant who can track their care ensuring key aspects are not missed (May 17)</p> <p>3) Clinical Fellow Orthogeriatrician in post, reviews patients daily (dec 17)</p> <p>4) BPT reports reviewed at CG meeting quarterly (May 17)</p> <p>5) Whiteboard put up in seminar room with NOF patients/ BPT elements to identify gaps (Nov 17)</p> <p>6) BPT criteria is available on the ward for junior doctors (Jan 2018)</p> <p>7) NOF patients and BPT elements are discussed at the daily trauma meeting (Jan 2018)</p>	<p>3. Business Case for 1 x Orthogeriatrician and 1 x Middle Grade approved in principle at Business Forum Meeting 18/04/2018 (Apr 18)</p>	<p>3) The Directorate does not have 7 day cover from consultant orthogeriatrician (April 2018)</p> <p>1-7) BPT met in last 3 months; Dec 54.5% , Jan 60% & Feb 61.8% (April 2018)</p>		2 x 3 = 6 YELLOW	May-18	

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	4841	If CPE is not detected early then outbreaks and incidents of untreatable clinical infections are possible. CPE is a group of emerging organisms that has become endemic in some areas of the NHS and international healthcare. National policy has not responded to changes in epidemiology. Local processes are in place but there is a significant threat from inter hospital transfers in particular. Date of risk 17/08/17 Expected date of closure 17/08/18 Escalated 10/05/18	3 x 3 = 9 AMBER	2) Trust IV team in place supporting best IV practice May 18 1) Electronic monitoring of CPE screens May 18 1) 7 day monitoring of IP alters by Infection Prevention Team May 18 1) All CPE contacts tagged on ICNet with link to Clinical Web portal Infections alerts May18 1) Highest level of national guidance in Trust Policy May 18 2) Electronic observation allowing identification of patients with urinary catheters and Peripheral venous cannulae (May18) 1) Isolation matrix reviewed and relaunched May 18	2) CPE performance dashboard de-escalated to quarterly at Feb 18 IPCG due to reduced numbers May 18 1) CPE screening compliance audits 70% compliant May 18 1) Known CPE positive patients being alerted on readmission 7 days/week May 18 1) Automated 1) link to Clinical Web Portal on patients requiring screens due to previous alerts May 18 2) Understanding of impact of isolation due to high risk of CPE on bed utilisation May 18 1) Reduction to 2 cases of RWT acquired CPE cases in 17/18 despite increased numbers from improved screening compliance (May 18).	1) Lack of denominator data for those at high/increased risk of CPE May18 2) Increase in numbers of CPE detected in 17/18 (May 18)	1) Complete business case for molecular testing for CPE 2) Reaudit compliance with screening high risk patients	Jun-18 Aug-18	3 x 1 = 3 GREEN	May-18

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	4849	If the Trust is not able to achieve CT reporting for trauma patients within 1 hour then this may lead to delayed diagnosis and treatment of patients and a failure to meet national requirements, potentially resulting in harm to patients and legal action being taken against the Trust . If ED are unable to obtain 1hr reporting for trauma patients out of hours then this will result in the Trust consistently failing to achieve national standards as reflected by the data submitted to the Trauma Audit and Research Network (TARN) and through Peer review. The RCR standard is that the report should be issued by a radiologist within 1 hour of image acquisition which is a recommendation from the Royal College of Radiologists and not an actual regulation. NICE guidelines only state the report should be done as early as possible.	3 x 4 = 12 AMBER	3) ED have access to Radiology on call [14/07/17] 2) All scans are reported by Radiology the following day [14/07/17] 1) CT head scans are interpreted by ED Consultants [14/07/17] 4) Audit has been undertaken to compare ED interpretation of CT head scans with radiology report [06/09/17] 5) Two tier reporting system now in place to enable reporting of all CT heads within 1 hour [05/12/17] 6) Ongoing recruitment of radiologists [05/12/17] 7) Outsourcing ED CTscans process in place [13/03/18]	4) No significant discrepancies found between ED Consultant interpretation and Radiology report [May 2018] 5) CTs are being reported within 1 hr [May 2018] 1-4) Compliance met with CG167 Head injuries recommendations (May 2018) 7) WMQRS from their visit in Feb 2018 are happy with this process (May 2018) 6) 2 clinical fellow commenced position (May 2018)	1) Two incidents under investigation involving CT images [May 2018) 3) Excessive use of on-call for emergencies can result in Radiologist elective sessions being cancelled [May 2018) 1-6) There are often delays in remote access to PACS/ loss of connection [May 2018)	1-6) Identify and solve problems with remote access to PACS	Jun-18 1 x 4 = 4 YELLOW	May-18	
		Date of origin: 29/08/17 Date of escalation: 11/11/17								