The Royal Wolverhampton
NHS Trust

Trust Risk Register Report
30 July 2018

Agenda Item No: 11.1

Safe & Effective | Kind & Caring | Exceeding Expectation

The Royal Wolverhampton NHS Trust	

Trust Board

Meeting Date:	30th July 2018
Title:	Trust Risk Register
Executive Summary:	Trust Risk Register Key Issues **0 new risks.** **0 risks removed.** **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 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: - 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

Trust Risk Register – Updates (Appendix A)

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			7 risks	7 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 A: Tracking changes within Trust Risk Register (July 2018)

Lead Director	Risk	Risk Title	Field updated	Update made
Chief Operating Officer	4113	Inability to achieve CIP		
			Gap in Assurance - **New**	This year the theatre efficiency programmed has achieved - PID value to be validated
	4706	Infrastructure/environment in Nucleus Theatres		
			Positive Assurance – **New**	Theatre 5 is now fully refurbished
			Gap in Assurance - **New**	12/07/18 since 10/03/18 - 4x incidents of Brown Fluid coming from ceilings in A15 last one 05/07, 1 of the temperature controls failing in Theatre1 (09/07) and 4 of flies in theatres 1 and 2 (13 x flies) last incident of flies was 01/06/18 - Incident report has been attached to this risk assessment
			Action Plan - **New**	Reconfiguration of the Reception Storage being planned by the Estates Dept
	4596	QS104 - Gallstone Disease		
			Positive Assurance – **New**	One dedicated hot gallbladder slot on theatre list available x3 per week
			Action Plan - **New**	Advert out for substantive 3rd Upper GI Surgeon.
	4599	Emergency Services Governance Arrangements		
			Positive Controls – **New**	Band 7s to pick up incidents so Governance lead can focus on true incidents
			Positive Assurance – **New**	Number of SUI's and SUI actions is reducing
			Positive Assurance – **New**	Band 7s are closing down Pressure Injury incidents allowing Governance lead to focus on true incidents.
			Positive Assurance – **New**	When Governance lead is on leave GO to review attendance with management trio
			Positive Assurance – **New**	Substantive consultant establishment increased to 5 Paeds and 11 adult
			Gap in Assurance - **New**	Prehistoric incidents need reviewing (July 18)
			Action Plan - **New**	Governance lead to review and close historic incidents by Aug 18
	4161	Shortage of Qualified Nurses across the Division		
			Positive Assurance – **New**	Children & Neonates Open Day was successful, recruited 18 nurses
			Action Plan - **New**	Pending Business Case being developed for overseas nurse recruitment
	4375	NX87 Heart Centre - Fire SafetyF		
			Action Plan - **New**	The Trust has been awarded funding from NHSI (PDC) of approximately £1.195m. Planning to undertake phase 1 asap (courtyards). Refer to 4 stage plan attached in documents

	4411	NX08/NX09 McHale Building - Fire Safety		
			Positive Assurance – **New**	Fire Stopping has taken place within the Tugway .
			Action Plan - **New**	Risk profile to be reviewed following installation of CCTV within the Tugway.
	3069	Risk of Never Events within Division 1: Risks to Patient Safety and Trust reputation		
			Action Plan - **New**	Division 1 Management team Never Event Action Plan in place
	4529	Vacancies in Medical Staffing		
			Positive Assurance – **New**	Representative still attending these meetings
			Positive Assurance – **New**	To be picked up as part of the Medical Workforce Group, chaired by Trust Medical Director - date of 1st meeting: 12/07/2018
			Positive Assurance – **New**	Recruitment in progress: Appointed x 2 Colorectal Surgeons, interviewing for Locum Consultant CT Anaesthetics and a Consultant in Chronic Pain
	4665	X-Ray Cannock		
			Positive Assurance – **New**	Equipment replacement confirmed on capital replacement programme 18-19
	2080	Risk to quality of patient care: reduced manpower		
			Action Plan - **New**	Review VCP process
			Action Plan - **New**	Paper for nursing clinical fellows to be presented to TMC in July 2018
	4565	Delivery of Agency Expenditure		
			Gap in Assurance - **New**	Orthotist and 2 x Cardiac Investigations HCP in place
			Gap in Assurance - **New**	Some clerical agency remains to support projects
	4528	Incomplete Health Records on Clinical Web Portal		
			Gap in Assurance - **New**	No continuous Datix incidents (Jul 18)
	4472	Delays in Cubicle Assessment and Triage		
			Positive Assurance – **New**	Metric developed re initial assessments
			Action Plan - **New**	DR and WW to review final version of escalation tool before it goes live (Aug 18)
			Action Plan - **New**	Business case for new cubicles is approved and plans are currently being drawn up by the design team and architect (Nov 18)

The Royal Wolverhampton NHS Trust

Trust Risk Register

July-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	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.	1) All requests for beds via patient flow team (July 15) 1) real time bed management improving mon-fri 5) Improvement in dashboard metrics 3) Use of Safehands, real time bed management system from September 16 (paperless).	1) Patients still entered retrospectively on PAS, especially after weekends. 1) System bugs in safehands causing delays to bed allocation - closed	1) 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	Jul-18	Yes

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

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
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 is does not have cholecystectomy within 2 weeks (as recommended by NCEPOD 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. (05.07.18) One dedicated hot gallbladder slot on theatre list available x3 per week	1. (05.07.18) Patients are presenting with complications of gallstones 1. (05.07.18) 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. (05.07.18) Advert put out for substantive 3rd Upper GI Surgeon. 1. (09.04.18) Further discussions to take place re: UGI pathway with Gastroenterology re Acute Pancreatitis patients 1. (05.07.18) Directorate to formulate business case for a 4th Upper GI Surgeon.	Dec-18 Aug-18 Dec-18 Jul-18	2 x 2 = 4 YELLOW	Jul-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. Date of origin: Aug 16 Date of escalation: Mar 17	4 x 3 = 12 AMBER	1) Matron has set up a group to ensure all nursing actions are addressed and learning is shared across the team (22/08/16) 2) Review of Governance work streams at the Divisional Governance meetings, incuding NICE, External guidance, Audit, Risk (22/08/16) 3) Monitoring of all SUI/Audit actions through to completion (22/08/16) 4) Performance meetings in place (22/08/16) 5) Directorate Governance meeting in place and attended by Directorate Management Team (22/08/16) 6) Staff member identified to provide Governance support 2 days per week (22/08/16) 7) Process in place to review re-attendances for potential SUI's proactively (22/08/16) 8) Ongoing recruitment [07/09/17] 9) Governance pre meets in place (14/11/16) 10) Incident reporting and governance covered as part of junior doctors induction [04/12/17] 11) Date of governance meeting has been amended to enable attendance by wider team [04/12/17]	5) Governance meetings taking place regularly [04/07/18] 9) Pre Governance meetings now established and working well to review SUI actions and risks [06/06/18] 3) Number of SUI and SUI actions is reducing [04/07/18] 4) substantive consultant establishment to 5 Paeds and 11 adult (9/7/18) 1) Bd7 nursing forums taking place regularly and working well [04/07/18] 3) Action plan now reviewed in Divisional Friday morning meeting [04/07/18] 3) Local audit of SUI actions is showing good compliance, with exception of Discharge checklist [04/07/18] 3) HOT reporting of radiological results in place [04/07/18] 8) links to recruitment risks 2374 (medics) and 4496 (nursing) [04/07/18] 3,4) SUI actions saved on w drive for easier access to all [04/07/18] 3) Number of overdue SUI actions has reduced [04/07/18] 8) 2 ACP trainee in place [04/07/18]	3) Significant number of SUI actions overdue/dates amended [04/07/18] 2) Number of External Reviews that remain outstanding [04/07/18] 3) Actions are taking a considerable amount of time to implement/ close [04/07/18] 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 [04/07/18] 7) No process in place within ED other than GO supporting, to ensure re-attenders report is reviewed in the absence of governance lead [04/07/18] 3) Local audit of SUI actions is showing poor compliance with Discharge checklist [04/07/18] 3,4) SUI actions reviewed once a month based on avalability of CL [04/07/18] 13) Prehistoric incidents need reviewing [04/07/18]	8) Workforce plan in progress for middle grades 13) Governance lead to review and close historic incidents	Sep-18 Aug-18	2 x 3 = 6 YELLOW	Jul-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?
				13) Band 7s to pick up incidents so Governance lead can focus on true incidents [04/07/18]	13) Band 7s are closing down Pressure Injury incidents allowing Governance lead to focus on true incidents. [04/07/18] 7) When Governance lead is on leave GO to review reattendance with management trio [04/07/18]						
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. Date of origin: May 17 Date of escalation: May 18	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 to date (25 June 18) 1-3 Recruited to Surgical post (2x vacancies remain) (25 June 18) 1-3 Anaesthetic 3x vacancies, one of which will be covered by Agency Locum (25 June 18)	1 & 2. Anaesthetics - 2 vacancy remains, 1x agency locum covering 17/6/18 (25 June 18) 1 & 3. Surgery - 2 vacancies remain and utilising agency to cover (25 June 18) 2. It takes two years to train ACCP's (25 June 18)	1.Recruit to vacant posts- Surgical and Anaesthetics 2. Training of ACCP's 3 Locum Cover - Surgery	Aug-18 Aug-18 Aug-18	2 x 3 = 6 YELLOW	Jul-18	

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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. Date of origin: Sep 17 Date of escalation: Oct 17	4 x 3 = 12 AMBER	1) Neonatal and Obstetric teams working together to plan and prioritise planned cases according to clinical need (15/09/2017) 2) Liaising with neighbouring Trust to initiate intrauterine transfers from RWT when clinically safe (15/09/2017) 3) Additional staffing sought through Trust bank and current workforce (15/09/2017) 4) Loan of essential equipment from Trust within the network (15/09/2017) 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) Business Case for additional staff to TMC April 18	4) Equipment available for loan from other Trusts (01/05/2018) 1) Obstetric and Neonatal teams planning ahead and agreeing delivery times (01/05/2018) 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)	1,2) Incident reports have been received concerning lack of staff and equipment.(01/05/2018) 4) Availability of spare equipment from other Trusts not guaranteed due to their own pressures. (01/05/2018) 2) Neighbouring Trusts cannot always accommodate babies at request due to their own pressures (01/05/2018) 3) Additional staffing cannot always be found leading to increase in stress of those working. (01/05/2018) 3) There are number of incidents relating to staff and over capacity on monthly basis. (01/05/2018) 4) There are ongoing incidents relating to the lack of clinical equipment to support activity, i.e., machines providing ventilation support (01/05/2018) 3) 88 patients were refused admission for various reasons. (01/05/2018)	1-5) Recruitment to circa 20 WTE once business case has been agreed Risk to be amalgamated with 4962	Sep-18 May-18	3 x 2 = 6 YELLOW	Jul-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:		**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-deisgn 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, £591k has been achieved of which £363k is recurrent. In month the variance is £218k adverse to the financial target. The Division achieved £276k (full year effect) in month (June 18)	2 & 3. Unidentified CIP still remains (May 18). 6. This year the theatre efficiency programmed has achieved - PID value to be validated (June 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 Aug-18	2 x 3 = 6 YELLOW	Jul-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.	Jan-18	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	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. Date of origin: 16th Nov 2017 Date of escalation: 18th Dec 2017	4 x 5 = 20 RED	1.Trust have requested that NHSE reconsider codes used to determine number of eligible resections . (Nov 17) 2. 13/12/17 Medical Director held discussions with Walsall Manor Hospital to increase referral cases to RWT (Jan 18) 3. Frozen section samples to be communicated from lab to theatres within one hour (Jan 2018) 4. Recruitment strategy in place (April 2018)	1-3 ANP has been recruited and will commence in post 2nd July 2018 (25 June 18) 4. Business case for 1 additional consultant has been agreed at TMC and interviews to be held in April 2018 (25 June 18) 4. Business case for 1 additional band 7 ANP has been agreed and staff have been recruited. (25 June 18) 4. Locum surgeon has been recruited to cover 1 post from 17th June 2018 (25 June 18)	1. Awaiting decision of NHSE (25 June 18)		1 x 5 = 5 YELLOW	Jul-18	
Chief Financial Officer	4955	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. Date of origin: 20th Feb 2018 Date of escalation: 20th Feb 2018	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.	Further detailed written submission required to the CCG. 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. 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.	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	

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:		**Attract, retain & develop our staff & improve employee engagemen**									
Chief Operating Officer	1713	Failure to effectively maximise workforce productivity; failure to routinely review consultant job plans. Date of origin: 03/06/08 Date of escalation = 11/05/11	4 x 3 = 12 AMBER	2) Areas to be contained with SPA allocation have been agreed 4) Usage reports for medical bank - 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- sign off committee established (Apr-Aug18) 1) New Job Planning Policy agreed by LNC Mar 17 5) Job Planning updates to be presented to clinical excellence group (Jan 18) 6) 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 + April 2018	1) Sign off of all job plans not complete (July 2018) 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.	Jul-18 Mar-18 Sep-18	3 x 2 = 6 YELLOW	Jul-18	Yes

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Chief Operating Officer	2080	If the Trust is unable to recruit and retain sufficient nursing staff across the Division then there will be reduced quality of care for patients, including increased risk of falls from harm. (Linked to local risks 2780 CHU, 4164 Renal, 4272 Therapy Svs, 4321 DN's, 3431 CofE) Date of origin: 02/01/09 Date of escalation = 12/01/16 On BAF	5 x 4 = 20 RED	1) Ongoing active recruitment exercises - including overseas (Jul 2018) 8) Use of Nurse Bank when required (Jan 16) 3) Defined minimum safe staffing levels now in place revised October 2017 5) Modified dependency tool for inpatient areas commenced (Jan 16) 9) Staffing incidents reviewed on monthly basis (Jan 16) 10) Closed Ward 3 at West Park Hospital (June 16) 4) Closed ward B7 (June 2017)	8) HCA's are available via Bank (Jul 18) 3) Safe staffing levels are being maintained across acute wards (Jul 18) 3) All B7s trustwide filling OOH rota first, then managing in-hours gaps, including putting themselves in if necessary (Jul 18) 1) Proactive recruitment approach continuing (Jul 18) 1) Fill rates have been reviewed and weekly eroster meetings now taking place with Director of Nursing (Jul 18) 1-10) Monthly workforce group introduced to review nurse recruitment and retention (Jul 18) 1) Electronic VCP process introduced for Bd 2 and 5 substantive direct role replacement (Jul 18) 1) Proposal to increase number of student nurses per intake from 70 to 100	1) 84.45 wte trained nursing vacancies remain, 63.56 roles offered, but not in post (Jul 18) 8) Insufficient RN's available on Bank, backfilled by HCA (Jul 18) 1) Nationallly we are an outlier re safe staffing levels (Jul 18) 1) Recruited staff are newly qualified which can lead to mentorship and training pressures (Jul 18) 1) 41 HCA vacancies remain, 5 places offered (Jul 18)	1) Nursing strategy in development - outline draft produced 1) continue with proactive recruitment approach 1) Paper for nursing clinical fellows to be presented to TMC in July 2018 1,8) review VCP process	Aug-18 Aug-18 Jul-18	4 x 3 = 12	Jul-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	4529	If there are vacancies in consultant or non-consultant medical staff across the Division, this will compromise the provision of a safe, effective elective service and to the safe staffing of on-call rotas. In that circumstance there may be a need to try to employ locum medical staff with the potential problems of high cost and uncertain quality. Please note: Risk 4239 (Obs & Gynae), Risk 4467 (Cardio) staffing risks have been linked to this overarching Divisional medical staffing risk. Date of origin: 23/04/16 Date of escalation = 17/05/16	4 x 3 = 12 AMBER	2. Review of Obs & Gynae rota's underway as a result of increased activity (Sept 2017) 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) 4. Trust is part of West Mid's Project to reduce Locum Agency use and Pay (Dec 2017) 5. Trust part of Junior Doctors in-training streamlining group (Dec 2017) 1. Recuitment in place (Dec 17) 6. Membership to Clinician's Connected (June 18)	1-5) Some reduction in medical spend (Sept 17) 1-5) Medical workforce vacancy rate 11.53, majority of these are training grades (July 18) 4) Representative still attending these meetings (July 18) 3) To be picked up as part of the Medical Workforce Group, chaired by Trust Medical Director - date of 1st meeting: 12/07/2018 (July 18) 1) Recruitment in progress: Appointed x 2 Colorectal Surgeons, interviewing for Locum Consultant CT Anaesthetics and a Consultant in Chronic Pain	1-5) Number of vacancies remain across the Division including within Anaesthetics and Head & Neck (Sept 2017) 1-5) Locum expenditure increased month on month Oct/Nov/Dec 17 but still significantly decreased overall (Dec 17)	1-4. Continue with Fellowship Programme 1. Continue campaign with regular adverts 1-5. Developing roles to support medical rota (ANPs and ACCPs) 6. Review of CVs by Clinician's Connected to fill Consultant vacancies	Sep-18 Sep-18 Sep-18 Sep-18	2 x 2 = 4 YELLOW	Jul-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	If there is a shortage of staff in the safeguarding team this will result in: 1. Delays in providing safeguarding advice and responding to queries raised by staff and concerns raised via Multi Agency Safeguarding Hub (MASH). 2.Inability to attend all safeguarding meetings either internally or externally to the Trust 3.Inability to work proactively with staff on wards/ in community to ensure key safeguarding messages are disseminated 4.Inability to provide safeguarding supervision to key staff who work with vulnerable clients 5.Delay in providing face to face safeguarding adult and children training. 6.Delay in training staff on key agenda issues, for e.g. Child Sexual Exploitation, Domestic Violence, Slavery, FGM and PREVENT training. There is an Inability to respond to delivering Safeguarding Adult Training as outlined in the Intercollegiate Doc for Adults 2016. Date of origin: 03/03/17 Date of escalation: 25/04/17	2 x 2 = 4 YELLOW	1) Regular review of staff available to work (Jan 2017) 2) Tasks/Meetings are prioritised (Jan 2017) 3) MASH information for adult cases allocated directly to SG adult named professonals (May 2018) 4) Regular review of safeguarding legislation/CQC action plans, CCG assurance framework and Safeguarding Board partnership programme to prioritise workload of team. (Jan 2017) 5) Safeguarding supervision provided to Maternity staff, Health Visitor's, School Nurses and PFN (Jan 2018) 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) 7) Safeguarding Children Team Leader in place (December 2017) 8) Post safeguarding case support is provided as required (Nov 2017) 9) Supervision Policy Draft 1 written (Mar 18) 10) Safeguarding Adults Team Leader in place (April 2018)	1) 4 of 4 posts have been recruited. (1x start 20/11/17, 1x start 4/12/17 and 1x start in Sept 2018) (June 2018) 3) Quality of information required by MASH has been addressed by response to the review (includes introduction of RAG rating for safeguarding enquiries (June 2018) 3) All cases are referred (June 2018) 8) No issues identified (June 2018)	1), 2) & 4) Certain meetings are not always attended or represented (June 2018) 5) Safeguarding supervision is available to certain staff only due to staffing shortages in Maternity Services. Overall compliance is approx. 75% in Maternity (June 2018) 5) & 7) 1 to 1 adult safeguarding maternity supervision is not provided by Safeguarding Team (this is currently provided by a nominated midwife) (June 2018) 5) Scope of remaining RWT Safeguarding Children and Adult supervision requirements unclear. (June 2018) 6) Level 3 for adults is not provided to clinical staff as outlined in key legislation (June 2018) 4) CQC review of July 2016 identified the need to recruit a named midwife (June 2018) 1) Named Midwife not in post (June 2018) 9) Safeguarding Supervision Policy not implemented (June 2018)	1) to 8) To continue to regularly contact the chair of the groups and review urgent actions post meetings. 1) to 8) SG Adult training delivery to be reviewed 5) Review Safeguarding supervision protocol 1) & 4) To recruit named midwife to be in post 1), 2) & 4) To prioritise and attend meetings 5) Additoonal named nurse B7 to be recruited in post 6) Review safeguarding training programme 1) & 4) Awaiting confirmation of approval of business case for Named Midwife post 9) Policy tabled to be approved	Jul-18 Jul-18 Jul-18 Nov-18 Jul-18 Nov-18 Sep-18 Jul-18 Aug-18	1 x 2 = 2 GREEN	Jun-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. Date of origin: Feb 18 Date of escalation: Feb 18	4 x 3 = 12 AMBER	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	3. Offering attractive incentives to successful candidates (01/05/2018) 2. 102% occupancy in Q2 in Intensive care (01/05/2018)	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)	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	Jul-18 Jun-18 Jul-18 Jul-18 Jul-18 Jul-18	2 x 2 = 4 YELLOW	Jul-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	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 June 18. Impact: This may lead to patient harm. Date of origin: 10.05.2012 Date of escalation 19/03/18 Date of expected closure 01/09/18	4 x 3 = 12 AMBER	1) Mattresses are supplied and maintained by CERL in Hospitals. Independant Living Service for community patients with foam and alternative systems July 18 2) Community services can access surface selection guide for mattress selection based on risk and holistic needs July 18 2) A £55,000 budget for the out-of-hours pressure relieving mattress service in Community until October 17 July18) 2) SLA in place with Independent Living Service and monitored (July 18) 2) ILS service community equipment supplied by them on return (July 18) 2) Special Order Requests for TOTOs, double/unusual sized mattressess, special pressure relief aids are requested via individual funding requests - either approved or rejected by CCG July 18 1) Process in place to reassess patients on Symmetrikit Chairs (OT posture managment Chairs) July18 3) Notice of concern issued to current provider (July 18)	2) Accountability pressure injury process reviewed, October 17 & January 18 July 18) 1) Suitable trolley mattresses in use for A&E July18 3) West Park, CCH and New Cross supplied with Hybrid Mattresses - July18 2)CCG Contracting Team/souial services are leading the tender process for community equipment including th TV Team - July 18 1) Process in place for wards to monitor integrity of hybrid mattress July 18	2) Lack of regular assurance data from ILS on order to delivery times July 18 2) RWT is not resourced to follow processes for specialist equipment request/order -July 18 1) TOTO business case not agreed in April 17 (July 18) 1) High demans on mattresses from ILS, no assurance on timely delivery July 18 1) Delays in delivering equipment from ILS July 18	1.6-8) Contracting Team tendering for new community equipment service - including special orders 1) Contracting looking at solutions to RWT funding for ordering specialist equipment	May-18 Aug-18	1 x 3 = 3 GREEN	Jul-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	If a Never Event occurs within the Division this may result in an adverse outcome, there is potential for severe harm and/or patient death and also reputational impact including increased external monitoring Date of origin: 19/07/12 Date of escalation = 17/11/15	3 x 4 = 12 AMBER	5. Monitoring and circulation of incident notification reports to all senior staff for review 6. Trustwide learning via a "Lessons Learned" sheet in the monthly IGR, Risky Business Newsletter and the CLIP Group. 8. Regular scrutiny of Directorate risk registers and minutes of Directorate governance meetings at the Quality Meetings 2. Review completed of all documentation and Theatre protocols/procedures amalgamating where possible 1. Perioperative care plans are in place across the Trust 9. Agreed communication strategy with Division 2 to share/raise awareness of never events and lessons learnt 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. 4. New NE Guidance (published Jan 2018) being used for NE classification	10. Human Factors has been identified as a trend (Jan 2018) 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) 11. Staff supported to undertake PCM training in Maternity & T&O (Dec 17) 12. Audit of LocSSIPs are being presented to Division before presentation at QSIG (June 2018) 3. Monthly monitoring data of compliance with WHO checklist and Procedural Safety Checklist - 100% for full completion in June 18 (July 2018) 1 - 8 Meeting between CCG and Trust (April 18) to provide assurance and context regarding reported NEs was largely positive. Actions being taken by the Trust were recognised to be proportionate and timely in response. (June 18) 3. Monthly monitoring and compliance with WHO checklist use - There has been 100% compliance achieved during June 18 (July 18)	4. There have been 3 x Never Event incidents 2 x Wrong Site Surgery and 1 x Retained foreign object) reported and investigated during 2015 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. Opthalmology (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) occured Mar 2017 4. 5 x NE incidents reporting in 17/18 reported to CCG from April 2017 (175581,179911,181941,185875 186479) (Dec 17) 4. 2018/2019 There has been 4 x NEs reported since April 2018 - 2 x Wrong Site Surgery incidents (Neonates Datix 194205 and H&N Datix 194977 - both in April 2018). There has been and 2 Retained Foreign Object incidents (Theatres 197654 and Obstetrics 197996 - both in June 2018) (July 2018)	1-11. All theatre staff to undertake Human Factors Training from AFPP 2. Programme of Human Factors Training for Theatre Staff under-development 1-11. Staff continue to undertake PCM training 12. Directorates to continue to audit LoCSIPS, presenting at the Divisional Governance Meeting ahead of QSIG presentation 12. Review/Gap analysis of LoCSIPS with AFFP 6. RCA Investigation to be undertaken into the NE Wrong Site Surgery (Wrong tooth) Datix:194977 1-8 Further to CCG meeting, await work to be commenced by AfPP and the CQC National review of NE with RWT participation. Implement recommendations. 6. RCA Investigation to be undertaken into the NE Retained Foreign Object (Retained Tampon) Datix:197654 6. RCA Investigation to be undertaken into the NE Retained Foreign Object (Retained Swab) Datix:197654 6. RCA Investigation to be undertaken into the NE Retained Foreign Object (Retained Swab Datix:1976966 1-12 Division 1 Management team Never Event Action Plan in place	Sep-18 Jul-18 Sep-18 Sep-18 Sep-18 Jul-18 Sep-18 Sep-18 Sep-18 Aug-18	2 x 4 = 8 AMBER	Jul-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	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	4161	If there are reduced qualified nursing staffing levels across the Division then there is a risk to patient safety and quality of care. Please note: Risk 4553 (Children Services's) staffing risks have been linked to this overarching Divisional staffing risk. Date of origin: 13/05/15 Date of escalation = 18/11/15	4 x 3 = 12 AMBER	1. Recruitment strategy in place 2. Developed a programme for Band 7s with a support programme wrapped around to assist with attrition and development 4. Increasing Band 2 support to manage qualified shortfall 5. Scrutinising staffing levels daily and moving /re-deploying staff across the Division as necessary 6. Friday morning meetings taking place for Matrons to check staffing across the Trust for the weekend to assure safety 7. There is now a trustwide transfer staffing pool (aimed to retain staff) (Aug 2016) 8. Appointed to Nursing Associate posts - to start end of Jan 17 (Jan 2017) 9. Trained and untrained vacancies reviewed by Head of Nursing and reported back to Trust Management Committee (Oct 17) 10. Regular workforce reviews to ensure staffing and service needs match (Oct 2017) 11. Nursing posts being reviewed to further retain staff (Surgical Nurse Practitioners, ACCPs, ANPs) (Oct 2017)	1. Utilising bank where possible and increasing HCA cover as necessary 7. Safer escalation - Areas are amber or green. No area has been red. 2. Positive feedback received from Band 7s who have attended programme 1. Continuing to support offered applicants. 3. 5 T&O beds on Ward A5 have been opened (Oct 2017) 8. From March 2018, all areas will have one Nursing Associate (Jan 2018) 1 + 11.General Surgery nearly fully established, T&O fully established for beds open (July 2018) 12. Theatre Agenda spend usage down to 2 staff, on track to completely remove by Dec 2017 (Oct 2017) 13. On review - all green now (Jan 18) 14. Continuting to recuit new areas (Jan 2018) 1. Recruited to Consultant Nurse post (March 18) 1. Previoulsy increased expenditure for bank payments in ICCU, month 12 no enhanced payments since 2/04/2018 (Apr 2018)	5. Peak annual leave seasons challenge to cover bank shifts. 1. Trustwide position: Philippines recuitment successful but long lead in time for staff to arrive in UK 1. SEU Band 5 gaps lilkely due to internal promotions (March 18)	1. Review SOP for enhanced rates for ICCU staff 1. Pilot 'Stay' Interviews within Paediatrics Directorate 1. Scoping with Division 2 and Corporate Services re: recruitment events for the next 12 months 1. Pending Business Case being developed for overseas nurse recruitment	Aug-18 Aug-18 Aug-18 Aug-18	2 x 2 = 4 YELLOW	Jul-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 scruitny of unused by the ward (Jan 18) 14. Shared Governance being rolled out to the pilot areas (Jan 18)	1. Children & Neonates Open Day was successful, recruited 18 nurses (July 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 Date of escalation: Sep 17	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 June 2018 3) Additional Security Fire Patrols undertaken and recorded 9) Priority Planned Preventative Maintenance undertaken 2) Waste compound has been relocated 7) Third Floor Fire Evacuation Exercise on 31.05.18	10) 2 Unwanted Fire Signals within June 2018 (aerosol & cooking)	9) Compartmentation survey to be completed (commenced) 7) Further Evacuation Exercises to be completed for Wards 1-10) The Trust has been awarded funding from NHSI (PDC) of approximately £1.195m. Planning to undertake phase 1 asap (courtyards). Refer to 4 stage plan attached in documents	2 x 2 = 4 YELLOW	Jul-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 Date of escalation: Sep 17	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 due 13th June 2018 5.Departmental Fire Warden Daily Checks undertaken 7. Tugway Safety & Environmental Group commenced May 2018	1. 0 Unwanted Fire Signals within June 2018 1. 0 incidents relating to Reportable Fire's within June 2018 7. Fire Stopping has taken place within the Tugway	2. Poor housekeeping including combustible materials in the Tugway	4. Remove or relocate combustible storage in the Tugway 2. Departmental Business Continuity Plans need to be updated 4. Tugway Safety Environmental Audit Group monitoring action plan 7. Risk profile to be reviewed following installation of CCTV within the Tugway.	Aug-18	2 x 2 = 4 YELLOW	Jul-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	1) National guidance in place (15 minutes for triage & 2 hours for assessment) (15/04/16) 2) Use of MSS to monitor times for triage and assessment (15/04/16) 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) 4) Reallocation of doctors to areas with high waiting times if appropriate (15/04/16) 5) Reallocation of nurse to support triage nurse (15/04/16) 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) 7) Monitoring staffing ratios and man-power plans regularly reviewed (15/04/16) 8) Acute Physician team available to support department from 10am until 21.30 every day (15/04/16) 9) UCC opened on 1st April 2016 (15/04/16) and joint triage model in place.	8) No concerns raised re Acute Physician support [04/07/18] 14) Nurse led RAT working well [11/07/18] 15) New starters are familiar with the department and its processes/ policies when they start[04/07/18] 7) Reduced reliance on locum agencies (internal staff have knowledge of local policies and processes) [04/07/18] 2) Metric developed re initial assessments (10/07/18)	1, 2) Inability to achieve 2 hour assessment and 15 minute triage [04/07/18] 3) Huddles not routinely taking place and escalation tool does not include actions to address ratings and does not highlight problem areas [04/07/18] 4,5) Staff not always available to be reallocated [04/07/18] 6) Delays in ED linked to bed availability [04/07/18] 7) Medical and nursing vacancies and sickness/ annual leave resulting in gaps in rota. Link to risk 4496 and 2374 [04/07/18] 8) Consistently at 2 hour wait by evening [04/07/18] 9) UCC not impacting on pt numbers and delays in assessments (on average 29 patients per day redirected to UCC in Feb) [04/07/18] 10) BEST tool identified dept is 20 nurses short (10 trained/10 untrained) [04/07/18]	7)Continue with recruitment of medical staff - ECIP tool has identified need for more staff in the morning 1, 2) Work commenced with VOCARE and CCG to process map current pathways to Urgent Care. Follow up meeting to be arranged 2) Metric developed re initial assessments, dashboard with ED for review 7) New ED mgt team to review staff rota 1) Division in discussion with industry staff to review systems to improve timeliness of reviews 3) DR and WW to review final version of escalation tool before it goes live 3) Business case for new cubicles is approved and an the drawings are currently being drawn up by the design team and architect	Jul-18 Aug-18 Jul-18 Jul-18 Aug-18 Aug-18 Nov-18	1 x 4 = 4 YELLOW	Jul-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?
				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 regsiter (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) No continuous Datix incidents (July 2018)	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 identiifed re: 2017/30511 (186645) - Unexpected Injury/Extravasation injury to neonate (Apr 2018) 1. Inability to access medical records is also impacting upon the Legal Services Dept, slowing down leagl services work (June 2018)	1-2. Monitor ongoing incidents 1-2. Non-STEIS investigation being undertaken Datix: 185209	Sep-18 Aug-18	2 x 2 = 4 YELLOW	Jul-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	2) Utilisation of fellowship programme 3) Recruitment Strategy in place for consultant + middle grade post (Jul 2018) 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 continuing via Clinicans Connected membership (June 2018) 6) Focus on reducing agency spend in non-clinical areas initially (Nov 2017). Star chamber review in Sept 17 8) 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)	1-9) Significant decrease in Locum expenditure overall (May 2018) 1-9) Medical workforce vacancy rate 69.96 for Band 5 qualified nurses (July 18) 1-9) Nursing Agency workforce is minimal (July 2018) 6) There continues to be a decrease in agency spend in non-clinical areas (June 2018) 1-9) Achieved forecasted year end agency cap for April 18, new cap set for April 19 (July 2018)	1-9) Locum expenditure has increased for some specialties (July 2018) 6) Orthotist and 2 x Cardiac Investigations HCP in place (July 2018) 8) Some clerical agency remains to support projects (July 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 2. Continue scrutiny of CPD to use academic fellowship programme 7. Review of CVs with Clinicans Connect	Aug-18 Aug-18 Aug-18 Aug-18 Sep-18	2 x 2 = 4 YELLOW	Jul-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) Use of agency reported at Ops Finance + Finance + Performance meeting + directorates via the dashboard (June 2018)							
Medical Director	4661	Lack of robust effective system for the communication of high risk or abnormal/ unexpected investigation results, and evidence of receipt, review and actions taken by clinicians. Risk of delayed or missed opportunities for diagnoses and appropriate treatment for patients, which could result in Serious Incidents, litigation and complaints. Date of origin: 17/11/16 Date of escalation = 17/11/16	4 x 4 = 16 RED	5) Monitoring via incident reporting 4) Directorate/ specialty local 'safety net' procedures to ensure results are received and reviewed 3) Pathology local procedure(s) for the escalation of abnormal results 2) Radiology local procedure(s) "Communication of Critical and/ or Unexpected Findings to Referring Doctors" 1) Trust wide Policy CP50 for the Management of Risks Associated with Clinical Diagnostic Tests and Screening	5) Small proportion of incidents to number of investigations undertaken 2) There is a policy for urgent and critical findings (June 2017) 2) A flag is also added to the report which will send in the subject matter of the e-mailed report ***Urgent Findings*** or Unexpected Significant Findings, this will alert the referring consultant (June 2017) 2) There is now also a Cancer Suspicious flag which can also be attached (June 2017) 3) There are a list of tests that fall into the urgent action category, the clinicans are telephoned about these. Other less urgent abnormal results are highlighted as such in TD Web when they are reviewed (June 2017)	1-4) Audit of local safety net procedures demonstrated significant gaps (Nov 16) 2) Size of Radiology reports is significant resulting in inbox limits being frequently exceeded (Nov 16) 5) Incidents continue to be reported where the reviewing if abnormal results has been delayed with significant consequences to patient outcome (May 17) 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 =	Jul-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. Date of origin: 17 November 2016 Date of escalation: 26 April 2017	3 x 4 = 12 AMBER	1) Maintenance Contract in place (£19,000 per annum) (Jul 2018) 2) Access to Mobile Imaging (if required) (Oct 2016)	1) Breakdowns are usually fixed under a 'fix as you go' contract. (Jul 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 X-ray service for patients. (Jul 2018) 1) & 2) Equipment replacement confirmed on capital replacement programme 18-19 (Jul 2019_	1) Any breakdown causes disruption to the service offered to patients. Breakdowns encountered with CR readers 2; X-ray equipment 0 (Jun 2018) 2) No focus choice on mobile X-ray unit and reliance on ageing CR processing equipment (Jul 2018) 2) X-ray service will not be available if CR processing facilites fail (Jul 2018)	1) & 2) To continue to monitor any equipment breakdown 1) & 2) Replacement of equipment planned for 18/19	Oct-18 Apr-19	2 x 2 = 4 YELLOW	Jul-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	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 unreported 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) (Jul 2018) 4) Review meetings are happening fortnightly (Jul 2018) 1) Backlog has reduced from 7332 May 2017 to less than 3673 in June 2018 (Jun 2018) 3) Office space sourced (Jul 2018)	1) Approximately 3673 non-urgent imaging studies unreported June 2018 (inclusive of 620 CT scans and 1181 MRI scans) (Jun 2018) 1) Poor patient experience if patients and doctors are unsure when their scans are reported (Jul 2018) 3), 4) & 5) Demand for reporting imaging studies is higher than expanded reporting capacity (Jul 2018) 3) Infrastructure in terms of equipment and office space not currently available for the additional clinical fellows (Jul 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	Oct-18 Oct-18 Oct-18 Oct-18 Oct-18	2 x 4 = 8 AMBER	Jul-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	Longstanding maintenance challenge around infrastructure/environment in Nucleus Theatres, which includes: 1. Sewerage ingress 2. Drainage system 2. Electrical infrastructure 3. Fire safety 4. Operating lights 5. Air-flow/ventilation 6. Storage 7. Infestations Could lead to a risk of patient and staff safety being compromised, non-compliance with external regulations and/or internal standard/ audits and also adverse media publicity and increasing number of raising concerns via local policy. Date of origin: Feb 17 Date of escalation: Sep 17	4 x 3 = 12 AMBER	1. Existing programme of theatre works in place (1 per year) - (Feb 17) 2. All incidents reported to management are escalated to Hotel Services - (Sept 17) 3. Theatre 5 has remained closed since 25th April 2017 (Apr 18) 4. Moving work to Cannock Theatres (Apr 18)	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) 3. Theatre 5 is now fully refurbished (July 18)	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) 1+2 12/07/18 since 10/03/18 - 4x incidents of Brown Fluid coming from ceilings in A15 last one 05/07, 1 of the temperature controls failing in Theatre1 (09/07) and 4 of flies in theatres 1 and 2 (13 x flies) last incident of flies was 01/06/18 - Incident report has been attached to this risk assessment	1. Work commence on Theatres 9 and 10 and then 3 and 4 to repair minor defects, surface and paint issues 1. Reconfiguration of the Reception Storage being planned by the Estates Dept	Aug-18 Sep-18	2 x 1 = 2 GREEN	Jul-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?
Medical Director	4734	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. There is no increase in unadjusted mortality rates, which have seen very little variation for the past 3 years. 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. Date of origin: 03/04/17 Date of escalation: 03/04/17	4 x 3 = 12 AMBER	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. 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 3. The Trust requires all directorates to follow the process set out by the Learning form 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 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. 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.			Robust governance processes to evidence learning from mortality reviews embedded in all clinical areas. Follow up on the recommendations from the internal and external data and clinical audits Ensure the mortality policy (OP87) is correctly followed by all specialties. 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. Reducing the number of unspecific primary diagnoses and imrpoving the capture and coding of secondary diagnoses on the admission episode by reducing the number of the multiple short episodes for emergency medical admissions.	2 x 2 = 4 YELLOW	Jul-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?
				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.						

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?
				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. Date of origin: Apr 17 Date of escalation: May 17	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) Predicted births/booking are recorded on the Maternity Dashboard, RAG-rated and discussed at monthly Governance & Risk Management meeting (13.6.18) 2) Close observation of activity in relation to number of predicted births (13.6.18) 3) HOM raised at the last governance risk management directorate meeting held on 23/5/18 that from reviewing the dashboard figures the cap is starting to become effective (13/6/18)	1,2) Activity levels are variable and uncontrollable due to births occurring at varying gestations and women transferring in from other units (13.6.18)	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	Sep-18 Sep-18 Sep-18 Sep-18 Sep-18	3 x 2 = 6 YELLOW	Jul-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	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 July 18 1) Electronic monitoring of CPE screens July 18 1) 7 day montiriing of IP alters by Infection Prevention Team July18 1) All CPE contacts tagged on ICNet with link to Clinical Web portal Infections alerts July18 1) Higest level of national guidance in Trust Policy July 18 2) Electronic observation allowing identification of patients with urinary catheters and Peripheral venous cannuale (July18) 1) Isolation matrix reviewed and relaunched July 18	2) CPE performance dashboard de-escallated to quarterly at Feb 18 IPCG due to reduced numbers July18 1) CPE screening compliance audits 70% compliant July 18 1) Known CPE poistive patients being alerted on readmission 7 days/week July 18 1) Automated 1) link to Clinical Web Portal on patients requiring screens due to previous alerts July 18 2) Understanding of impact of isolation due to high risk of CPE on bed utilisation July18 1) Reduction to 2 cases of RWT acquired CPE cases in 17/18 despite increased numbers from improved screening compliance July 18.	1) Lack of denominator data for those at high/increased risk of CPE July18 2) Increase in numbers of CPE detected iin 17/18 (Ju;y 18)	1) Complete business case for molecular testing for CPE 2) Reaudit compliance with screening high risk patients	Aug-18 Aug-18	3 x 1 = 3 GREEN	Jul-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. Date of origin: 29.08.2017 Date of escalation: 11.11.2017	3 x 3 = 9 AMBER	3) ED have access to Radiology on call (Jul 2017) 2) All scans are reported by Radiology the following day (Jul 2017) 1) CT head scans are interpreted by ED Consultants (Jul 2017) 4) Audit has been undertaken to compare ED interpretation of CT head scans with radiology report (Sep 2017) 5) Two tier reporting system now in place to enable reporting of all CT heads within 1 hour (Dec 2017) 6) Ongoing recruitment of radiologists (Dec 2017) 7) Outsourcing ED CTscans process in place (Mar 18)	4) No significant discrepancies found between ED Consultant interpretation and Radiology report [Jul 2018) 5) CTs are being reported within 1 hr [Jul 2018) 1-4) Compliance met with CG176 Head injuries recommendations (Jul 2018) 7) WMQRS from their visit in Feb 2018 are happy with this process (Jul 2018) 6) 3 Clinical Fellows commenced position (Jul 2018)	1) Two incidents under investigation involving CT images [Jul 2018) 3) Excessive use of on-call for emergencies can result in Radiologist elective sessions being cancelled [Jul 2018) 1-6) There are often delays in remote access to PACS/ loss of connection [Jul 2018)	1-6) Identify and solve problems with remote access to PACS	Jun-18	1 x 4 = 4 YELLOW	Jul-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?
Medical Director	5045	Sepsis and severe infection are perhaps the most common reasons for admission to hospital and cause of inpatient deterioration. It is estimated by the Sepsis trust that sepsis claims at least 46,000 lives every year and may be as high as 67,000. By recognising and managing sepsis promptly, it is estimated that we can save 14,000 lives every year. Reducing deaths from sepsis is a priority for the NHS, the Royal Wolverhampton Hospitals NHS Trust and must be a priority for all healthcare professionals. All healthcare professionals at the Royal Wolverhampton Hospitals NHS Trust have a responsibility and are accountable to ensuring patients with sepsis receive high quality and timely care. Fundamental to preventing death and harm to patients from sepsis is the detection, recognition and management of deteriorating patients: * The early warning score and sepsis screening tool assist in the early detection and recognition of deteriorating patients and those with sepsis * The sepsis 6 and staff training provide the means to ensure an effective response to reduce	4 x 3 = 12 AMBER	Training staff in the recognition and management of sepsis. Early warning systems for paediatric, maternal and adult patients assist in the detection of deteriorating patients - many of whom will have sepsis. Sepsis screening tools exist for paediatric, maternal and adult patients who deteriorate and may have sepsis. Optimal utilisation of these tools help reduce the mortality and morbidity from sepsis. A trust antimicrobial guideline has been developed to advise appropriate antibiotics for given indications. This is available as an app and on the intranet.	Mandatory training compliance in IP and Sepsis is monitored at directorate governance Early Warning Score audit compliance. Auditing medical records to ensure the processes of detection, recognition and management of deteriorating patients is robust with feedback of performance to directorates and the development of action plans to achieve compliance Compliance with sepsis screening and sepsis 6 delivery. Auditing the use of the sepsis screening tool and delivery of the sepsis 6 with feedback of performance to directorates and the development of action plans to achieve compliance Antimicrobial prescribing compliance. To ensure that antimicrobial prescribing is compliant with trust guidance and that antimicrobials are reviewed to reduce antimicrobial resistance	Mandatory training performance report. Non-Compliance with EWS audit. Non-compliance with Antimicrobial audit.		x =	Jul-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?
		morbidity and mortality * To ensure that antibiotics are prescribed and reviewed appropriately to ensure ongoing effectiveness and to reduce antimicrobial resistance * Audit provides feedback on clinical effectiveness and performance Date of origin: Jun 18 Date of escalation: Jun 18								