The Royal Wolverhampton
NHS Trust

Trust Risk Register
1 October 2018

Agenda Item No: 11.1

Safe & Effective | Kind & Caring | Exceeding Expectation

The Royal Wolverhampton NHS Trust	

Trust Board

Meeting Date:	1st Oct 2018
Title:	Trust Risk Register
Executive Summary:	Trust Risk Register Key Issues **3 new risks:** **5012 -** External/temporary pacing boxes (COO) **4547 -** Emergency Department with potential safeguarding issues (COO) **5097 -** Implementing the new Agenda for Change pay deal (CFO) **4 risks removed:** **4849 -** CT reporting (COO) **4862 -** Increase in demand for Neonatal cots at level 1, 2, 3. (COO) **4962** - NNU Staffing - Neonatal Workforce (COO) **4841** - Risk of CPE becoming endemic in clinical areas (CNO) **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)	32
Risks managed to target level	0

There are currently 32 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			12 risks	2 risks	2 risks
3 – Possible		1 risk	4 risks	9 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		4		
4) Maintain financial health - appropriate investment enhancement to patient services	2	3	1	
5) Attract, retain & develop our staff & improve employee engagement	1	2	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 (September 2018)

Lead Director	Risk	Risk Title	Field updated	Update made
Chief Operating Officer	4113	Inability to achieve CIP		
			Action Plan - **New**	Progress to be made with LOS - drive across all areas
	5012	External/temporary pacing boxes		
			New risk	If the external/temporary pacing boxes fail to pace or pace incorrectly then the patient may suffer a cardiac arrest resulting in death if not successfully resuscitated.
	4903	Risk of non-compliance with Thoracic Service Specification		
			Positive Assurance – **New**	Thoracic ANP has been recruited and in post
			Positive Assurance – **New**	Consultant Thoracic Surgeon recruited and in post
			Positive Assurance – **New**	Attendance at Worcester MDT commenced in July 2018
			Positive Assurance – **New**	Compliant with frozen sections following audit
			Gap in Assurance - **New**	Attendance at Walsall MDT remains under discussion by Trust Medical Director & COO
			Action Plan - **New**	Agree attendance at Walsall MDT and Worcester MDT
	2080	Risk to quality of patient care: reduced manpower		
			Positive Assurance – **New**	Paper for nursing clinical fellows approved
			Action Plan - **New**	Discussions with BCU and Staffs re sending nurses for training
			Action Plan - **New**	Plan for overseas recruitment for Clinical Nurse Fellow posts
	4849	CT reporting		
			Risk moved from TRR to Directorate Risk Register	Score was 12 AMBER; now is 9 AMBER
	4962	NNU Staffing - Neonatal Workforce		
			Risk closed	Risk amalgamated into (5082) Neonatal Workforce and Activity
	4547	Emergency Department with potential safeguarding issues		
			New risk	If patients attending the Emergency Department with potential safeguarding issues are not identified and escalated/ referred in a timely manner then this may result in further harm to patients.
	4862	Increase in demand for Neonatal cots at level 1,2 3.		
			Risk closed	Risk amalgamated into (5082) Neonatal Workforce and Activity
	4599	Emergency Services		

		Governance Arrangements	Positive Controls – **New**	Substantive consultant establishment to 5 paeds and 9 adults (with 2 additional locums)
			Positive Controls – **New**	HOT reporting of radiological results in place
			Positive Assurance – **New**	Significant improvement in middle grade workforce
			Positive Assurance – **New**	New ED management plan agreed, will include Quality Improvement Lead
			Action Plan - **New**	Management restructure has allowed a Quality & Compliance post who will be responsible for Governance. Currently with VCP panel.
			Action Plan - **New**	Pre governance meeting to be implemented
			Action Plan - **New**	Review results of Discharge checklist audit and Clinical lead to address areas of non-compliance with medical staff
	4161	Shortage of Qualified Nurses across the Division		
			Gap in Assurance - **New**	Most areas are working on amber levels
			Gap in Assurance - **New**	Further risk assessment (5031) regarding ICU staffing agreed as high amber risk
			Action Plan - **New**	Recruitment Calendar agreed re: events for the next year
			Action Plan - **New**	Recruit Clinical Nurse Fellows (currently out to advert)
	4411	NX08/NX09 McHale Building - Fire Safety		
			Gap in Assurance - **New**	Combustible materials within the Tugway has been reduced however, items still remain in area
	3069	Risk of Never Events within Division 1: Risks to Patient Safety and Trust reputation		
			Action Plan - **New**	Discuss Executive approved Never Event Action Plan at Divisional Governance Meetings
			Action Plan - **New**	AfPP training is scheduled to take place in October 2018 and January 2019
	4529	Vacancies in Medical Staffing		
			Positive Controls – **New**	Trust continues to be part of West Mid's Project to reduce Locum Agency use and Pay
			Positive Assurance – **New**	Reduction in medical spend from 2017/2018 to 2018/2019
			Positive Assurance – **New**	Locum Expenditure decreased continually in May June and July
	4565	Delivery of Agency Expenditure		
			Positive Controls – **New**	Meeting with staff to explore existing links with medical resource in Greece
			Action Plan - **New**	Possible use of Agency to cover post in Clinical Chemistry Services
	4472	Delays in Cubicle Assessment and Triage		
			Positive Controls – **New**	Escalation tool developed and identifies pressure points with agreed action

			Positive Assurance – **New**	Reallocation of staff working well to help reduce wait times during pressured times
			Positive Assurance – **New**	Urgent treatment doctor is making an improvement to patients receiving appropriate emergency treatment
			Positive Assurance – **New**	Additional triage room has helped reduce triage wait times
			Action Plan - **New**	Scoping exercise by industry staff to review systems to improve timeliness of reviews
			Action Plan - **New**	Adverts out for speciality Doctors. Awaiting outcome of interviews.
			Action Plan - **New**	Escalation tool to go live on the 1st September
Chief Nursing Officer	3644	Failure to make an improvement in compliance gaps with CQC standards.		
			Positive Controls – **New**	Overall recruitment numbers have reduced in month with a total of 205.64 WTE
			Gap in Assurance - **New**	10 Nursing associates commenced in post
			Action Plan - **New**	Review baseline of Nurse sensitive indicators
			Action Plan - **New**	Develop PLACE action plan in response to recent audit outcome
			Action Plan - **New**	Review of Cochrane review regarding falls evidence
			Action Plan - **New**	Refurbishment and expansion of existing Discharge Lounge
			Action Plan - **New**	Implementation and roll out of NEWS 2
			Action Plan - **New**	Implement Safer Care Software and roll out
	4841	Risk of CPE becoming endemic in clinical areas		
			Risk moved from TRR to Directorate Risk Register	Score was 9 AMBER; now is 4 YELLOW
	2952	Patient developing a pressure ulcer due to inadequacies of pressure ulcer prevention equipment		
			Positive Assurance – **New**	Adult community services collating a report to submit to the CCG regarding mattresses delivery and fault management delays.
			Action Plan - **New**	Adult community services collating trends of failed deliveries and fault management of mattresses to submit via contracting to the CCG.
	4718	Safeguarding Team Staffing		
			Action Plan - **New**	Risk to be reviewed and deescalated
Chief Financial Officer	5097	Implementing the new Agenda for Change pay deal		
			New risk	There is a risk that the cost of implementing the new Agenda for Change pay deal is not fully funded. There is a further risk that any subsequent pay deal for staff not on Agenda for Change is not funded at all. Additionally if the agreements are fully funded then there is a risk that funding in arrears places a pressure on the Trust's cash positon.

	4955	MRET/Readmissions/Fines monies		
			Action Plan - **New**	Trust is now at end of negotiations with Wton CCG and expects to agree Aligned Incentive Contract by the end of July.
Medical Director	4734	Elevated Mortality Statistics		
			Positive Controls – **New**	The early introduction of the Medical Examiner Role has been pursued. The ME and SJR roles have been developed. ME at advert. This new process will improve the timeliness of review and investigation and therefore access to learning. OP87 will be reviewed in line with these new roles.
			Action Plan - **New**	Develop a Bereavement centre with colocoted ME/Coroner registrar / admin/ family services/mortuary o improve quality of service for families and support timeliness of investigations and learning from deaths.
			Action Plan - **New**	Mortality risk to be escalated to BAF with consideration for removal from TRR at Sep QGAC. Decision made at QGAC to remove from TRR and to be managed onto BAF.
			Action Plan - **New**	Embed IT database to integrate across systems
	5045	Sepsis		
			Action Plan - **New**	Business case (for sepsis team) to be reviewed at ED's meeting 19th Sep
			Action Plan - **New**	Testing and roll out of electronic NEWs solution
	4661	Lack of robust system for review and communication of test results		
			Action Plan - **New**	ICE audits to commence with a starting period of June 18 onward, 1st report to be obtained for Oct update
			Action Plan - **New**	Instruction on the electronic filing of OPD results to be communicated as this would enable an audit from the ICE system
			Action Plan - **New**	Local SOPs for results reporting required from all areas

The Royal Wolverhampton NHS Trust

Trust Risk Register

September-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 There are 3 surgeons, each surgeon has 1 slot per list 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. (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 Dec-18 Jul-18	2 x 2 = 4 YELLOW	Sep-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. SUI actions are easily accessable on W Drive and reviewed on a monthly basis in a meeting (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 (links to risk 2374 (medics) and 4496 (nursing) [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]	3) Number of SUI and SUI actions is reducing [09/18] 1) Bd7 nursing forums taking place regularly and working well [09/18] 3) Local audit around documentation of senior review and ECG is showing good compliance [09/18] 8) Significant improvement in middle grade workforce (09/18) 8) New ED management plan agreed, will include Quality Improvment Lead (09/18) 2) Backlog of unnapproved incidents reduced (09/18)	3) Significant number of SUI actions overdue/dates amended [09/18] 3) Some actions not relating to ED are taking a considerable amount of time to implement/ close [09/18] 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 [09/18] 7) No agreed process in place within ED other than GO supporting, to ensure re-attenders report is reviewed in the absence of governance lead - risk accepted [09/18] 3) Discharge checklist and adult safeguarding documentation still showing poor compliance [09/18] 13) Historic incidents need reviewing [09/18] 90 Pre Governance meetings have not taken place (09/18)	13) Governance lead to review and close historic incidents 1-13) Management restructure has allowed a Quality & Compliance post who will be responsbile for Governance. Currently with VCP panel. 1-13) Pre governance meeting to be implemented 3) Review results of Discharge checklist audit and Clinical lead to address areas of non compliance with medical staff	Oct-18 Sep-18 Sep-18 Nov-18	2 x 3 = 6 YELLOW	Sep-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?
				11) Date of governance meeting amended to enable attendance by wider team [04/12/17] 13) Band 7s to pick up incidents so Governance lead can focus on true incidents [04/07/18] 14) Substantive consultant establisment to 5 paeds and 9 adults (with 2 additional locums) [09/07/18] 15) HOT reporting of radiological results in place [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 (06 Sept 2018) 1-3 Anaesthetic candidates sourced via the clinical fellowship programmem and interviews are planned (06 Sept 2018) 1-3 Surgical vacancies filled, await start dates (06 Sept 2018) 1-3 Training of ACCP's continues and will take a further 18 months (06 Sept 2018) 1-3 Agency locums in place for surgical and anaesthetics to ensure safe cover whilst gaps remain (06 Sept 2018)	1 & 2. Anaesthetics - 2 vacancy remains, 1x agency locum covering 17/6/18 (06 Sept 2018) 1 & 3. Surgery - 2 vacancies remain and utilising agency to cover (06 Sept 2018) 2. It takes two years to train ACCP's (06 Sept 2018)	1.Recruit to vacant posts- Surgical and Anaesthetics 2. Training of ACCP's	Sep-18 Aug-19	2 x 3 = 6 YELLOW	Sep-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, £1.1m has been achieved of which £721k is recurrent. In month the variance is £364k adverse to the financial target. The Division achieved £484k (full year effect) in month. The CIP achievement was in the main due to NHS Supply Chain procurement savings £207k, non recurrent savings £150k and sterile services £65k (Sept 18)	2 & 3. Unidentified CIP still remains (Sept 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 1-9) Progress to be made with LOS - drive across all areas	Mar-19 Mar-19 Mar-19 Mar-19 Mar-19	2 x 3 = 6 YELLOW	Sep-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. CFO e-mailed NHS I Regional Director of Finance 25/6 asking about progress and was discussed at PRM on 12/7 with NHS I.	Jan-18	3 x 3 = 9 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	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. 13/12/17 Medical Director held discussions with Walsall Manor Hospital to increase referral cases to RWT (Jan 18) 2. Frozen section samples to be communicated from lab to theatres within one hour (Jan 2018) 3. Recruitment strategy in place (April 2018)	1-3 Thoracic ANP has been recruited and in post (06 Sept 2018) 1-3 Consultant Thoracic Surgeon recruited and in post (06 Sept 2018) 1-3 Attendance at Worcester MDT commenced in July 2018 (06 Sept 2018) 3. Compliant with frozen sections following audit (06 Sept 2018)	1. Attendance at Walsall MDT remains under discussion by Trust Medical Director & COO (07 Sept 18)	1-4 Agree attendance at Walsall MDT and Worcester MDT	Sep-18	1 x 5 = 5 YELLOW	Sep-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. Trust is now at end of negotiations with Wton CCG and expects to agree Aligned Incentive Contract by the end of July.		3 x 3 = 9 AMBER	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 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 2 = 6 YELLOW		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. Final discussions on costs for activity levels to be concluded by end of July	x =	Jul-18	
Chief Financial Officer	5097	There is a risk that the cost of implementing the new Agenda for Change pay deal is not fully funded. There is a further risk that any subsequent pay deal for staff not on Agenda for Change is not funded at all. Additionally if the agreements are fully funded then there is a risk that funding in arrears places a pressure on the Trust's cash positon. Date of origin: 20/07/18 Date of escalation: 20/07/18	3 x 4 = 12 AMBER	The Trust will manage the risk first by understanding it in more detail. Now that the pay award has been agreed the Trust will calculate the financial impact and compare that to the funding that is secured once it is released. The Trust also has a 1% cost of living increase that has been funded internally. It is also anticipated that the funding that is allocated nationally will be based on records put onto ESR by the Trust. Therefore ensuring ESR is accurate is essential.			The Trust has now received notification that its allocation is £4.755m. The Trust is calculating the cost of the pay award to identify the possible gap.	3 x 4 = 12	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:		**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

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	If the Trust is unable to recruit and retain sufficient nursing staff across Division 2 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 (09/18) 3) Safe staffing levels are being maintained across acute wards (09/18) 3) All B7s trustwide filling OOH rota first, then managing in-hours gaps, including putting themselves in if necessary (09/18) 1) Proactive recruitment approach continuing (09/18) 1) Fill rates have been reviewed and weekly eroster meetings continue with Director of Nursing (09/18) 1-10) Monthly workforce group reviewing nurse recruitment and retention (09/18) 1) Electronic VCP process in place for Bd 2 and 5 substantive direct role replacement - working well (09/18) 1) Paper for nursing clinical fellows approved (Aug 18) 1) 36.72 wte trained nursing vacancies remain, 35.92 roles offered, but not in post. This is a significant improvement in vacancy figures (09/18) 1) 3.33 HCA vacancies remain, 30.68 posts offered (09/18)	8) Insufficient RN's available on Bank, backfilled by HCA (09/18) 1) Nationallly we are an outlier re safe staffing levels (Aug 18) 1) Recruited staff are newly qualified which can lead to mentorship and training pressures (09/18)	1) Nursing strategy in development - outline draft produced 1) continue with proactive recruitment approach 1) Discussions with BCU and Staffs re sending nurses for training 1) Plan for overseas recruitment for Clinical Nurse Fellow posts	Sep-18 Oct-18 Oct-18 Dec-18	4 x 3 = 12	Sep-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 Division 1, 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. Baseline resourcing meetings contine to be held to review vacancies and expenditure, identify recruitment opportunities within Directorates explore alternative solutions including future workforce planning and forecasting (Sept 17) 3. Trust continues to be part of West Mid's Project to reduce Locum Agency use and Pay 4. Trust part of Junior Doctors in-training streamlining group (Dec 2017) 1. Recuitment to vacant posts ongoing (Dec 17) 5. Membership to Clinician's Connected (June 18)	1-5) Reduction in medical spend from 2017/2018 to 2018/2019 (Sept 18) 1-5) Medical staffing vacancy rate further reducted to 11.53% (Sept 18) 1-5) Locum Expenditure decreased continually in May June and July (Sept 18)	1-5) Number of vacancies remain across the Division (Sept 18)	1-5. Fellowship Programme ongoing 1. Continuing campaign with regular adverts 1-5. Continuing to develop roles to support medical rota (ANPs and ACCPs) 6. Review of CVs by Clinician's Connected to fill Consultant vacancies	Oct-18 Oct-18 Oct-18 Oct-18	2 x 2 = 4 YELLOW	Sep-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) (July 2018) 3) Quality of information required by MASH has been addressed by response to the review (includes introduction of RAG rating for safeguarding enquiries (July 2018) 3) All cases are referred (July 2018) 8) No issues identified (July 2018)	1), 2) & 4) Certain meetings are not always attended or represented (July 2018) 5) Safeguarding supervision is available to certain staff only due to staffing shortages in Maternity Services. Overall compliance is approx. 75% in Maternity (July 2018) 5) & 7) 1 to 1 adult safeguarding maternity supervision is not provided by Safeguarding Team (this is currently provided by a nominated midwife) (July 2018) 5) Scope of remaining RWT Safeguarding Children and Adult supervision requirements unclear. (July 2018) 6) Level 3 for adults is not provided to clinical staff as outlined in key legislation (July 2018) 4) CQC review of July 2016 identified the need to recruit a named midwife (July 2018) 1) Named Midwife not in post (July 2018) 9) Safeguarding Supervision Policy not implemented (July 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 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 9) Policy tabled to be approved Risk to be reviewed and deescalated	Aug-18 Aug-18 Nov-18 Jul-18 Nov-18 Sep-18 Aug-18 Oct-18	1 x 2 = 2 GREEN	Sep-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?
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 Aug 18. Impact: This may lead to patient harm. Date of origin: 10.05.2012 Date of escalation 19/03/18 Date of expected closure 01/12/18 CCG proceeding with a tender process and will update the Trust 27/9/18. new issues have occurred with ILS failing to respond to faulty mattresses and asking patient relatives to collect mattresses. Ault Community services are collating the data to submit to the CCG about trends.	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 Aug 18 2) Community services can access surface selection guide for mattress selection based on risk and holistic needs Aug 18 2) A £55,000 budget for the out-of-hours pressure relieving mattress service in Community until October 17 Aug 18) 2) SLA in place with Independent Living Service and monitored (Aug 18) 2) ILS service community equipment supplied by them on return (Aug 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 Aug 18 1) Process in place to reassess patients on Symmetrikit Chairs (OT posture managment Chairs) Aug18 3) Notice of concern issued to current provider (Aug 18)	2) Accountability pressure injury process reviewed, October 17 & January 18 Aug 18) 1) Suitable trolley mattresses in use for A&E Aug 18 3) West Park, CCH and New Cross supplied with Hybrid Mattresses - Aug 18 2) CCG Contracting Team/souial services are leading the tender process for community equipment including th TV Team - Aug 18 1) Process in place for wards to monitor integrity of hybrid mattress Aug18 3) Adult community services collating a report to submit to the CCG regarding mattresses delivery and fault management delays	2) Lack of regular assurance data from ILS on order to delivery times Aug 18 2) RWT is not resourced to follow processes for specialist equipment request/order -Aug 18 1) TOTO business case not agreed in April 17 (Aug 18) 1) High demans on mattresses from ILS, no assurance on timely delivery Aug 18 1) Delays in delivering equipment from ILS Aug 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 6) Adult community services collating trends of failed deliveries and fault management of mattresses to submit via contracting to the CCG	May-18 Aug-18 Sep-18	1 x 3 = 3 GREEN	Sep-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 Division 1 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 - 90% for full completion in July 18 (Aug 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 July 18 (Aug18)	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 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. 1-12 Division 1 Management team Never Event Action Plan in place 12. Discuss Executive approved Never Event Action Plan at Divisional Governance Meetings 2. AfPP training is scheduled to take place in October 2018 and January 2019	Sep-18 Sep-18 Sep-18 Sep-18 Sep-18 Oct-18 Oct-18 Oct-18 Jan-19	2 x 4 = 8 AMBER	Sep-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.	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 2018/19 7) CQC insight report shared with Divisions for information, 7) Biannual skill mix review - slight improvement in vacancy rates 3) Lord Carter metrics monitored monthly via Divisional Performance meetings Overall recruitment numbers have reduced in month with a total of 205.64 WTE (Sep 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. 10 Nursing associates commenced in post Sep 18	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 Develop PLACE action plan in response to recent audit outcome Implement Safer Care Software and roll out Review of Cochrane review regarding falls evidence Refurbishment and expansion of existing Discharge Lounge Implementation and roll out of NEWS 2 Review baseline of Nurse sensitive indicators	 Nov-18 Jan-19 Dec-18 Jan-19 Jan-19 Oct-18	2 x 2 = 4 YELLOW	Sep-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 Division 1 then there is a risk to patient safety and quality of care. 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) 1 + 11.General Surgery nearly fully established, T&O fully established for beds open (July 2018) 14. Continuting to recuit new areas (Jan 18) 1. Division 1 participating in the Corporate Recruitment Plan (Sept 18)	5. Peak annual leave seasons challenge to cover bank shifts (Sept 18) 13. Most areas are working on amber levels (Sept 18) 1. Further risk assessment (5031) regarding ICU staffing agreed as high amber risk (Sept 18)	1. Review SOP for enhanced rates for ICCU staff 1.Recuitment Calandar agreed re: events for the next year 1. Recuit Clinical Nurse Fellows (currently out to advert)	Dec-18 Mar-19 Dec-18	2 x 2 = 4 YELLOW	Sep-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)					

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 July and August 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) 0 Unwanted Fire Signals within July 2018	10) 1 Unwanted Fire Signals within August 2018 (dust contaminated detector)	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	Sep-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 Julu & August 2018 1. 0 incidents relating to Reportable Fire's within July & August 2018 7. Fire Stopping has taken place within the Tugway	2) Combusible materials within the Tugway has been reduced however, items still remain in area	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	Sep-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) (04/16) 2) Use of MSS to monitor times for triage and assessment (04/16) 4) Reallocation of doctors to areas with high waiting times if appropriate (04/16) 5) Reallocation of nurse to support triage nurse (04/16) 6) Bed meetings held 3 times a day everyday where status of Emergency Department is discussed with representatives of both Divisions to facilitate flow (04/16) 7) Monitoring staffing ratios and man-power plans regularly reviewed (04/16) 8) Acute Physician team available to support department from 10am until 21.30 every day (04/16) 9) UCC opened on 1st April 2016 and joint triage model in place. (04/16) 10) Powerpoint presentation around National ED standards included in new starters induction and within annual mandatory training sessions (04/16)	8) Acute Physician support continues to work well [08/18] 15) New starters are familiar with the department and its processes/ policies when they start [09/18] 4-5) Reallocation of staff working well to help reduce wait times during pressured times [09/18] 7,17) Reduced reliiance on agency staff. Locums used are long term locums [09/18] 16) Urgent treatment doctor is making an improvement to patients recieving appropiate emergency treatment [09/18] 18) Additional triage room has helped reduce triage wait times [09/18] 19) Escalation tool in use in the dept (09/18)	1, 2) Inability to achieve 2 hour assessment and 15 minute triage consistently [09/18] 4,5) Staff not always available to be reallocated [09/18] 6) Delays in ED linked to bed availability [09/18] 7) Medical and nursing vacancies and sickness/ annual leave resulting in gaps in rota. Link to risk 4496 and 2374 [09/18] 8) Consistently at 2 hour wait by evening [09/18] 9) UCC not impacting on pt numbers and delays in assessments [09/18]	7)Continue with recruitment of medical staff - ECIP tool has identified need for more staff in the morning 7) New ED mgt team to review medical staffing rota to include ACP's 1) Scoping exercise by industry staff to review systems to improve timeliness of reviews 3) Business case for new cubicles is approved and architect design agreed, work due to start Oct 18 7) Adverts out for speciality Doctors. Awaiting outcome of interviews.	Oct-18 Oct-18 Nov-18 Nov-18 Sep-18	1 x 4 = 4 YELLOW	Sep-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?
				11) Human factors review completed and resulted in department restructure. All staff provided with human factors training and rapid improvement events [11/16] 13) Medical and nurse staffing managed via the risk regsiter (risk 2374 & 4496) [11/16] 14) Nurse led RAT and SOP ratified and in place (09/17) 15) Where possible, newly qualified starters have their last student placement transferred to RWT ED [09/17] 16) System in place to ensure that Cat 2 patients are shown red at 15 minutes. Urgent treatment Doctor role developed to see cat 2 patients [10/17] 17) Use of internal bank rather than locum agencies where possible [10/17] 18) Extra Triage room and escalation process in place [03/18] 19) Escalation tool developed and identifies pressure points with agreed action [08/18]					

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	Oct-18 Oct-18	2 x 2 = 4 YELLOW	Sep-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	4547	If patients attending the Emergency Department with potential safeguarding issues are not identified and escalated/ referred in a timely manner then this may result in further harm to patients Date of origin: 1 June 2016 Date of escalation: 17/07/18	4 x 3 = 12 AMBER	2) Agreed process for notification in place [01/06/16] 1) Incidents reported and monitored through Datix. Datix emailed to appropiate leads and reviewed [01/06/16] 3) Referrals currently printed, completed and scanned in to be sent to secure email address [08/09/16] 4) One PC has been set up in base B for safeguarding referrals [08/11/16] 5) Safeguarding attend the department daily to identify any referrals overnight/ not communicated yet. Named Safeguarding support identified to support ED [16/02/17] 6) Senior sister/ clinical governance lead and matron are point of contacts for safeguarding investigations/ incidents. There is a breach report that flags children attended before known to social services/LAC [06/09/17] 7) ED Safeguarding champions x 5 in place [06/09/17] 8) Monthly operational safeguarding meeting in place. Attended by champions + Matron [07/04/17]	1-18) Safeguarding incidents have decreased [09/18] 14) Electronic system in place for Paeds (09/18)	3) Scanned documents are of a poor quality and information is not easy to read [09/18] 11) Paediatric and adults audit results have highlighted poor documentation [09/18] 9) Training records show that not all staff have received training (medical staffing are the major concern and clinical lead aware) [09/18] 14) No electronic system in place for adult safeguarding or DV referrals. There is one for Paeds but it is not fully electronic [09/18] 16) CPIS identifies under 18 who are on a plan however w-ton council are not currently live with this process [09/18] 11) Q1 audit results for safeguarding scored poorly for adults. [09/18]	1-18) waiting for wolverhampton Council to set up live e-referrals. Original timeframe for project was Summer but now pushed to winter 1-18) Chief nurse to meet with local authority to review process and identify proposals for improvement 1-18) Meeting taken place between Chief Nurse, Head of Nursing Div 2 and Head of Safeguarding has taken place with specific action for head of safeguarding to source solutions for the complex referral process.	Dec-18 Sep-18 Dec-18	1 x 2 = 2 GREEN	Sep-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?
				11) Safeguarding audits undertaken by gov lead as part of quarterly documentation audit [06/09/17] 12) Letters are being sent to the individuals involved in missed safeguarding incidents [06/09/17] 14) See and treat sheet includes paeds safeguarding proforma - used for patients coming through see and treat [15/10/17] 15) New training programme for new starters implemented [13/03/18] 16) CPIS system in place [06/06/18] 17) Medical staff training reviewed and now includes level 3 [08/18] 18) Safeguarding training included at induction and more dates available for staff [08/18]					

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	4565	If the use of Agency staffing continues across the Division 1 (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 (Sept 18) 3) Recruitment Strategy in place for consultant + middle grade post (Sept 2018) 1) Agency spend reviewed monthly at Directorate/Divisional Meetings (Sept 18) 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) 7) 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) 8) Challenge for Bank/Agency requests and more effective use/administration of workforce shift through e-roster (Dec 2017) 6) Use of agency reported at Ops Finance + Finance + Performance meeting + directorates via the dashboard (June 2018) 9) Business cases being developed for overseas recuitment (Sept 18)	1-9) Significant decrease in Locum expenditure overall (Sept 18) 1-9) Nursing Agency workforce is minimal (Sept 18) 1-9) Achieved forecasted year end agency cap for April 18, new cap set for April 19 (Sept 18)	1-9) Locum expenditure has increased for some specialties (Sept 18) 6) Orthotist and 2 x Cardiac Investigations HCP in place (Sept 18)	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 1. Possible use of Agency to cover post in Clinical Chemistry Services	Oct-18 Oct-18 Oct-18 Oct-18 Oct-18 Oct-18	2 x 2 = 4 YELLOW	Sep-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?
				9) Meeting with staff to explore exisiting links with medical recource in Greece (Sept 18)							
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) 1-4) ICE audits to commence with a starting period of June 18 onward, 1st report to be obtained for Oct update 1-4) Instruction on the electronic filing of OPD results to be communicated as this would enable an audit from the ICE system 1-4) Local SOPs for results reporting required from all areas	Nov-17 Oct-18 Oct-18 Dec-18	x =	Sep-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. (Aug 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. (Aug 2018) 1) & 2) Equipment replacement confirmed on capital replacement programme 18-19 (Aug 2018)	1) Any breakdown causes disruption to the service offered to patients. Breakdowns encountered with CR readers 2; X-ray equipment 2 (Aug 2018) 2) No focus choice on mobile X-ray unit and reliance on ageing CR processing equipment (Aug 2018) 2) X-ray service will not be available if CR processing facilites fail (Aug 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	Sep-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) (Aug 2018) 4) Review meetings are happening fortnightly (Aug 2018) 1) Backlog has reduced from 7332 May 2017 to less than 4085 in Aug 2018 (Aug 2018) 3) Office space sourced (Aug 2018)	1) Approximately 4085 non-urgent imaging studies unreported Aug 2018 (inclusive of 579 CT scans and 1124 MRI scans) (Aug 2018) 1) Poor patient experience if patients and doctors are unsure when their scans are reported (Aug 2018) 3), 4) & 5) Demand for reporting imaging studies is higher than expanded reporting capacity (Aug 2018) 3) Infrastructure in terms of equipment and office space not currently available for the additional clinical fellows (Aug 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	Sep-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. Sewage Ingress - addressed 2. Drainage system - addressed 2. Electrical infrastructure 3. Fire safety 4. Operating lights - addressed 5. Air-flow/ventilation - addressed 6. Storage 7. Infestations - addressed 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. Reconfiguration of the Reception Storage being planned by the Estates Dept 1. Work to commence this financial year for fire stopping in non-clincial areas	Sep-19 Mar-19	2 x 1 = 2 GREEN	Sep-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 MRed group (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. Develop a Bereavement centre with colocoted ME/Coroner registrar / admin/ family services/mortuary o improve quality of service for families and support timeliness of investigations and learning from deaths. Embed IT database to integrate across systems Mortality risk to be escalated to BAF with consideration for removal from TRR at Sep QGAC. Decision made at QGAC to remove from TRR and to be managed onto BAF.	Jan-19 Sep-18	2 x 2 = 4 YELLOW	Sep-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 has been pursued. The ME and SJR roles have been developed. ME at advert. This new process will improve the timeliness of review and investigation and therefore access to learning. OP87 will be reviewed in line with these new roles.					

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 (1.8.18) 2) Close observation of activity in relation to number of predicted births (1.8.18) 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 (1/8/18)	1,2) Activity levels are variable and uncontrollable due to births occurring at varying gestations and women transferring in from other units (1.8.18)	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	Aug-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	5012	If the external/temporary pacing boxes fail to pace or pace incorrectly then the patient may suffer a cardiac arrest resulting in death if not successfully resuscitated. Date of origin: 16/04/18 Date of escalation: 16/07/18	3 x 4 = 12 AMBER	1.Pacing boxes are sent to Medical Engineering for interrogation to identify the cause of mal-function with pacing (16 April 18) 2.Trial of different pacing wires (16 Apr 18) 3. Daily checks undertaken and recorded by Cardiothoracic Trust Fellow/Anaesthetist/ANP/ ACCP on the ward and ITU (19 June 2018)	1. Pacing boxes are sent to Medical Engineering to be checked by Medical Engineers and Manufacturer for interrogation (06 Sept 2018) 1-3 Incidents with pacing wires are reported via datix for investigation by a cardiologist specialist in pacing (06 Sept 2018) 1-3 Current pacing settings have been checked to ensure optimal capture (06 Sept 2018) 1-3 New pacing wires have been sourced and are in use(06 Sept 2018) 1-3 Email communication and posters have been displayed to raise awareness of the implementation of new pacing wires (06 Sept 2018)	1. Pacing boxes have failed to pace and paced incorrectly causing patients to have a cardiac arrest or peri-arrest.(06 Sept 2018) 1. Two incidents reported in April 2018 Datix 193987 & 195047 - no further pacing related incident reported (06 Sept 2018) 3. There is an inconsistent weekly approach to undertaking the daily checks (06 Sept 2018)	2. Review the alternatives in replacing the current pacing boxes 2. Meeting to be arranged between Cardiologic Rep & Medical Devices 1-3 Poster to be developed for Pacing and be displayed in each area. 3. Implement robust method of undertaking daily checks Super User Training	Sep-18 Sep-18 Sep-18 Sep-18 Sep-18	2 x 4 = 8 AMBER	Sep-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. If patients do not receive high quality and timely sepsis care through detection, recognition and management of the deteriorating patient then patient harm or death could result. Date of origin: Jun 18 Date of escalation: Jun 18	4 x 3 = 12 AMBER	4) Training staff in the recognition and management of sepsis - ongoing monitoring. 2) Early warning systems for paediatric, maternal and adult patients assist in the detection of deteriorating patients - many of whom will have sepsis. 3) 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. 1) A trust antimicrobial guideline has been developed to advise appropriate antibiotics for given indications. This is available as an app and on the intranet and is subject to audit.	4) Mandatory training compliance in IP and Sepsis is monitored at directorate governance 2) 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 3) 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 1) Antimicrobial prescribing compliance. To ensure that antimicrobial prescribing is compliant with trust guidance and that antimicrobials are reviewed to reduce antimicrobial resistance	4) Mandatory training performance report. 2) Non-Compliance with EWS audit. 1) Non-compliance with Antimicrobial audit.	1-4) Business case (for sepsis team) to be reviewed at ED's meeting 19th Sep 1-4) Testing and roll out of electronic NEWs solution	Sep-18 Mar-19	x =	Sep-18	