The Royal Wolverhampton
NHS Trust

Chief Nursing Officer Governance Report
3 December 2018

Agenda Item No: 11.2

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	3rd December 18
Title:	CNO Governance Report
Executive Summary:	Headlines contained in this report: 1. Trust Risk register progress update 2. Red incidents – Non SUI 3. Serious Untoward incident (SUI) Performance 4. Information Governance work plan and risk 5. Governance staffing 6. Local Policy Governance 7. Mortality returns
Action Requested:	**Receive and note,**
For the attention of the Board	To advise members on headline updates on the Governance portfolio.
Assure	SUI • Good progress made on the closure and submission of overdue RCA by November should revert to 0 overdue – monitoring continues via week Executive sign off meeting. TRR • Operational risks graded as 12 or above are escalated to an Executive following Dir/Div approval. • All TRR risks are requested for monthly review/update • The QGAC reviews the TRR monthly providing challenge and seeking assurance on progress/management of the risks. • Trust Management Team receive the report for note of current updates
Advise	• Some risks are beneath the trigger score for the TRR and require review by risk owners
Alert	Information Governance • A risk has been escalated to Execs for approval around IG capacity, GDPR and IG toolkit compliance. This will feature in next report once approved. TRR The following red risks are subject to specific review: • 4113 – Risk description to be reviewed to apply to clinical divisions • 4903 – Risk realisation and impact to be reviewed and reconsider grade
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Links to Trust Strategic Objectives	1. Create a culture of compassion, safety and quality 2. Proactively seek opportunities to develop our services 3. To have an effective and well integrated local health and care system that operates efficiently 4. Attract, retain and develop our staff, and improve employee engagement 5. Maintain financial health – Appropriate investment to patient services 6. Be in the top 25% of all key performance indicators

Resource Implications:	Contained within specific risks assessments
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.
CQC Domains	**Safe:** patients, staff and the public are protected from abuse and avoidable harm. **Effective:** care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence. **Caring:** staff involve and treat everyone with compassion, kindness, dignity and respect. **Responsive:** services are organised so that they meet people's needs. **Well-led:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.
Equality and Diversity Impact	No impact on PPC's
Risks: BAF/ TRR	TRR 3644 – Failure to improve CQC Compliance gaps TRR 3069 – Risk of Never Events – Div 1 TRR 4599 – Emergence Services Governance arrangements TRR 4734 – Elevated Mortality Statistics SR 1 Workforce Recruitment and Retention SR 8 – Failure to deliver recurrent CIP SR 9 – Trust Underlying deficit SR11 – Condition of Existing Estate SR 12 – Elevated SHMI
Public or Private:	Public
Other formal bodies involved:	Quality Governance Assurance Committee (QGAC) Trust Management Committee (TMC)
References	CQC Well Led Domain
NHS Constitution:	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

Report Details	
1	**<u>Trust Risk Register (TRR)</u>** The Trust Risk Register consists of operational risks escalated from the Clinical and Corporate Divisions as well as those identified from Corporate and Executive portfolios graded 12 or over. Risk reviews and updates are requested monthly (at Directorate and Divisional level) to inform this report. TRR status 1 new risks: 4916 - Dietetic Staffing (COO) 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)

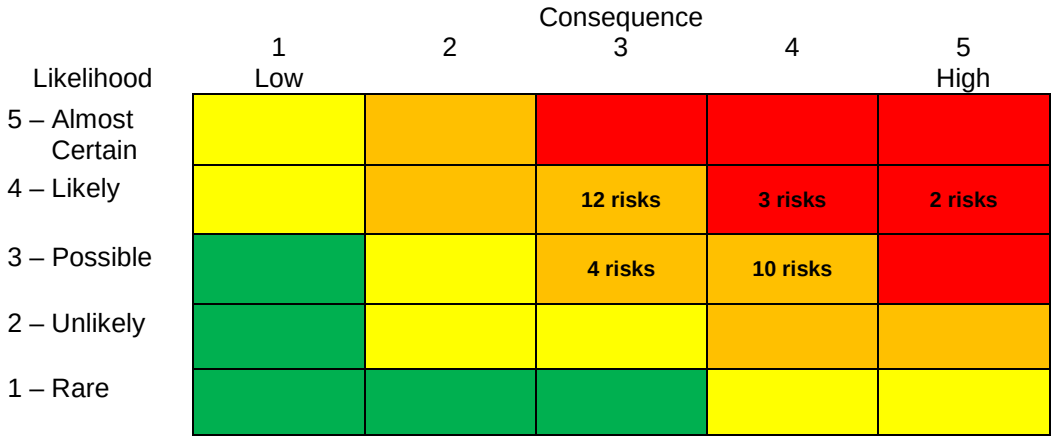
Risk updates for November 18 is shown in Appendix A.

Within the TRR (Appendix B), a number of risks are graded below the TRR escalation trigger of 12 and should be reviewed with consideration for retention on the TRR, de-escalation to local risk registers or closure (with rationale).
2719 – COO – page 1, 4794 – CFO – page 7, 4955 – CFO – page 9 and 3644 – CNO – page 16.

Following updates the split of the Trust Risk Register is:

Risks currently being managed (on-going)	31
Risks managed to target level	0

There are currently 31 risks contained within the Trust Register which are distributed across the Trust's (5x5) categorisation matrix as below:



Utilising the Trust categorisation matrix (risk plot above) as a way of 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	2		
6) Create a culture of compassion, safety & quality	2	16		

2

Red Incidents – Non SUI

Red incidents reported to Datix are shown in appendix C. Since the last report all Corporate red incidents have been reviewed and downgraded/closed, leaving 11 open red incidents across Div 1, 2 and 3. Six incidents require review and downgrade and 5 are awaiting further investigation and redress. All but one (202119) is within the target timescale for closure which is an improvement on the last report.

3

Serious Untoward incident (SUI) Performance

See progress/performance analysis below in table. Progress on the closure of overdue SUI action fluctuates but is on a decreasing trend. Monitoring continues at QSIG.

Month	Ongoing /Open incidents (stop clock)	New Reported to STEIS	Closure Request to Commrs	Closure Agreed by Commrs	Over 60 day breaches - running total	Potential breaches in month
June	71 (6)	31	14	5	5	1
July	55 (6)	15	15	10	9	4
Aug	42 (4)	8	13	25	13	6
Sept	30 (3)	5	11	12	6	2
Oct	21 (2)	7	13	13	7	5
Analysis	Good progress being made on the completion and closure of SUIs.	Reduction in SUIs numbers impacted by agreement with commissioners to work to the National SUI reporting framework.	Fewer queries received from commissioners re RCA reports.	A reasonably good closure rate continues with commissioners.	Weekly reports to CCG continue for overdue RCAs.	Progress helped by a weekly focus on RCA due dates.

4

Information Governance work plan

	The changes since April 18 falling from GDPR and the move to the new Data Security and Protection Toolkit has led to significant reliance on the IG manager/DPO & IG Officer to interpret and implement new guidance, to transfer toolkit evidence and new requirements alongside routine work items (including training, audit, FOI, policy review). To maintain work streams on a risk based approach, a priority plan has been developed for IG delivery between now and the end of the financial year. The Trust wide work streams include: • Data flow mapping (prioritised areas) • Spot Audits • Fair Processing Notices for high risk areas (Sexual Health/Children's/VI/Charities) • Privacy Impact Assessments (prioritised areas) • Training/Awareness/Communication – all sites • IG Incident review/Investigation • FOI • IG Toolkit • Policy maintenance • IG Enquiries • Advisory Project support – Shared Care, Pathology, BCF, 0-19, MASH • IG Meetings and Reporting • Caldicott function support Where large/new projects occur over and above those prioritised it will require identified funding to 'buy in' IG expertise. In addition, to manage IG workload moving forward, it has been requested that any new projects/business cases must identify/consider the IG expertise/support required at the point of development, so these can be approved as part of the case. A risk graded Amber (12) has been identified re Capacity for IG/GDPR compliance (Datix 4769) and the impact on the IG regulatory and toolkit compliance. The risk is awaiting approval for escalation to TRR.
5	**Governance staffing** Recruitment continues with consideration to necessary role changes. A new role (Investigation and Learning Specialist) is soon to be advertised and will support the RCA workload and an increased work focus on investigation, learning and improvement.
6	**Local Policy Governance** Interim resources are identified to develop a framework for Local Policy Governance. A project plan is being developed in order to begin implementation of this work and will include: • identifying priority areas to begin policy scoping, • populating a register of local policy and procedural documents • clarify local development and approval process • creating intranet space for local policy and procedural documents

	Nov 18 Update: • SOP revised for Local Policy and procedural documents (flowcharts for Nursing, Medical and AHP documents) • Local Policy Framework in development (will detail work to be done in each area to implement Policy Governance) • Planning meeting with Web Services to develop a Local Policy/Procedural document page • Population of local policies spreadsheet from intranet • Prioritised Directorates ED, Critical Care, Theatres, Maternity, Ophthalmology • Health Assure template reports for policy tracking being sourced To confirm the local Policy register and roll out the local policy governance system, Divisions and Directorates will be asked to provide key contacts within Directorates to work with the Project Manager on information gathering/confirmation. Divisions will be consulted to identify further areas to prioritise roll out.
7	**Mortality** Mortality review returns from Divisions continues to improve, status reported on 1st November were: • % completion Oct 17 – April = 93% (previously 89%) with 105 outstanding • % completion May 18 to date = 51% (previously 48%) with 403 outstanding New criterion is agreed for selecting cases for SJR 1 review, and is to be applied for all outstanding review (including figures above). The criteria below will reduce the number of SJR 1 reviews identified: Criteria for selecting allocated cases for stage-1 SJR review: 1. Learning Disability deaths (Mortality Lead to continue to be uploaded to the LeDER website) 2. Mental Health deaths (based on ICD code and identified during allocation) 3. DATIX incident or complaints (identified during allocation) 4. Elective admissions (identified during allocation) 5. Maternity, neonatal and child deaths (National programme) 6. Unexpected deaths (defined as death occurring rapidly and earlier than anticipated) 7. Random selection of 10% of all other allocated deaths Figures for outstanding SJR 1s as at 19/11/18 has reduced to 24 total with the new criteria applied. It is anticipated that backlog will be cleared by December 18. A learning log is in development to capture themes from SJRs and alert investigations.

Appendices	
1	Appendix A – TRR tracked changes Appendix B – TRR Appendix C – Red Incidents – non SUI

Appendix A: Tracked changes within Trust Risk Register (November 2018)

Lead Director	Risk	Risk Title	Field updated	Update made
Chief Operating Officer	4916	Dietetic Staffing		
			New risk	If the Dietetics team are under-recruited to in October 18, due to vacancies and maternity leave (2.5 vacant posts) within the Paediatric dietetics service, then this will result in the inability to provide the expected service to patients. There is a risk of reduced/no service resulting in poor outcomes and patient experience, unnecessary hospital admission and delayed discharge, inability meet SLAs and BPT resulting in a substantial loss of income to the Trust and increased staff stress.
	2080	Risk to quality of patient care: reduced manpower		
			Positive Assurance – **New**	Shortlisting for nursing clinical fellows roles
			Positive Assurance – **New**	29.62 wte trained nursing vacancies remain, 37.78 roles offered, but not in post
			Positive Assurance – **New**	9.29 HCA vacancies remain, 22.9 posts offered
			Positive Assurance – **New**	HoN Div 1 appointed as Professional lead for Nurse Bank
			Gap in Assurance - **New**	All wards are 'Amber' re safe staffing levels on daily basis
			Gap in Assurance - **New**	Issue in relation to ability to provide accurate staffing figures
			Action Plan - **New**	HoN's requesting staffing blueprints to allow them to monitor staffing levels more accurately
			Action Plan - **New**	Task and finish group set up to review operational delivery of nurse staffing
	4599	Emergency Services Governance Arrangements		
			Gap in Assurance - **New**	Matron currently off sick
			Gap in Assurance - **New**	Increase noted in number of both potential and reported SUI's
	4761	Cardiothoracic Surgical / Anaesthetic vacancies		
			Positive Assurance – **New**	No incidents have occurred to date (1-5 There have been 3 patients infected historically (none from Nov/Dec 17) to date - these infections take up to 5 years (as far as we know) to manifest
			Positive Assurance – **New**	Recruited to all available posts
			Positive Assurance – **New**	Training of ACCP's continues and will take a further 18 months (1-5 There have been 3 patients infected historically (none from Nov/Dec 17) to date - these infections take up to 5 years (as far as we know) to manifest
	4161	Shortage of Qualified Nurses across the Division		
			Positive Assurance – **New**	Reduction in overall Divisional vacancies (Sept 18: 31.7 WTE registered nurse

				vacancies with 28.48WTE awaiting a start date, 0 HCA vacancies)
			Action Plan - **New**	Reviewing Department Stress Risk Assessments for areas with high turnover
	4528	Incomplete Health Records on Clinical Web Portal		
			Action Plan - **New**	Non-STEIS investigation being undertaken Datix: 185209 - report to be finalised and approval process to be complete and outcomes updated into this risk
	4903	Risk of non-compliance with Thoracic Service Specification		
			Positive Assurance – **New**	Locum in post and contract has been extended for a further 6 months
			Positive Assurance – **New**	Continue to approach other Trusts for referrals and attending Walsall and Worcester MDT
Chief Nursing Officer	3644	Failure to make an improvement in compliance gaps with CQC standards.		
			Positive Controls – **New**	Monitoring of the Nursing System Framework monthly via TMC
			Positive Controls – **New**	EOL strategy with TOR has been developed and milestones monitored via the EOL group monthly
			Positive Controls – **New**	Mortality QI plan is monitored via Programme Board monthly and learning outcomes via MRG
			Positive Assurance – **New**	Divisions monitor performance via monthly Governance meetings
	2952	Patient developing a pressure ulcer due to inadequacies of pressure ulcer prevention equipment		
			Action Plan - **New**	Adult community services collating trends of failed deliveries and fault management of mattresses to submit via contracting to the CCG re filed attempts for delivery or repairs monthly

Appendix C

Red Incidents – Non SUI

Incident date (Datix ID)	Incident Description	Action taken	Update	Specialty (harm)
18/7/18 (202119)	Incident reported 7/9/18 10 year old brought in with right sided weakness and slurred speech. CT scan raised suspicion of stroke. However MRI could not be performed urgently. Delayed CT angiogram demonstrated cause for stroke. Opportunity to treat and cure patient was lost. Not clear why patient not immediately transferred to stroke centre. Not clear why paediatrician did not chase the pathway.	Informed all radiologists that we should expedite clinically urgent cases at the cost of cancelling outpatients or other in patients particularly if time is of the essence as it is in stroke imaging.	21.09.2018 Discussed at Radiology Clinical Governance Meeting Radiology CQM reported that the incident had been generated by Radiology and escalated as a potential SUI regarding delayed MRI/ treatment for stroke. Discussions ongoing. 19.10.2018 Discussed at Radiology Clinical Governance Meeting Radiology CD advised attendees' incident had been discussed with Divisional Medical Director D3/ Consultant Paediatrician and Divisional Medical Director D2/ Clinical Associate not considered a SUI as the tertiary centre contacted in a timely manner and their guidance followed. However, Radiology CD raised concerns that MRI should have been prioritised. In response, Deputy Superintendent Radiographer CT advised if a Consultant Radiologist requested an urgent in-patient MRI this would be accommodated. Radiology CQM enquired how to proceed with incident? Awaiting Radiology feedback	MRI Scanning (Mod)
21/9/18 (203261)	Reported 28/9/18 Patient in recovery B emerged from general anaesthesia whilst muscle relaxant agent was	Needed to leave the anaesthetist alone with the patient whilst I searched for the drug elsewhere in the theatre department.	Advised Directorate to review and downgrade	Theatres – H&N (none)

	still in effect. The anaesthetist requested some reversal agent in order to relieve the patient's distress however pharmacy had removed the Neostigmine from the drugs cupboard without notifying anyone of this action.			
30/10/18 (205314)	Overdue red observation from evening. Doctors notes all piled on chair at nurses station after the day shift	Files placed into locked cabinet Red observation done.	Advised Directorate to review and downgrade	Diabetes (none)
5/11/18 (205592)	Patient was handed over to c16, Staff nurse handed patient over that patient is not confused. Once the patient came to c16 he started to become aggressive with staff and is VERY confused, wondering around the ward disturbing all the patients, wondering into the females bays.	Spoke with AMU staff nurse who handed patient over. Datix done, security involved.	Advised Directorate to review and downgrade	Diabetes (none)
5/11/18 (205577)	0 scan slots this week in the emergency clinic due to short staffing within the maternity scan department	Datix completed	Advised Directorate to review and downgrade	Gynae (none)
6/11/18 (205628)	Email received from Lloyds homecare saying a delivery had been booked for a patient but no prescription received. Yet again Lloyds had not requested a prescription to the correct Dept as we were not aware that a prescription was needed	Urgent prescription organised and signed and sent to pharmacy for urgent processing Homecare Pharmacist (D Peddie) and Lloyds manager informed of this	Advised Directorate to review and downgrade	Rheum (none)
8/11/18 (205756)	Patient was seen in OPD on 16/12/16	An urgent appointment was arranged	Ongoing investigation to assess impact.	Derm (none)

	Blood test and biopsy was arranged. Due to lack of review slots she was seen today 8/11/18 about 2 years later			
8/11/18 (205738)	13 patients waiting outside for same day appointments - unable to offer appointments to patients who were ringing in. Only had 11 appointments to offer to patients.	we took decision to use the urgent slots appointments for routines.	Advised Directorate to review and downgrade	Thornley Street Surgery
9/11/18 (205865)	Patient complained about his relative receiving phone calls relating to his visit to the walk in centre. Said feels his confidentiality has been breached.	Reassured patient that this will be looked in to, and that the phone calls are not actually from the walk in centre, but will investigate further.	Ongoing investigation to assess.	Walk in Centre team
9/11/18 (205876)	"incompatible systems epma and web portal no cross allergy checking resulting in possible fatal errors"	Reported	Ongoing investigation to assess and address.	Anaes (none)
13/11/18 (206116)	Ward manager highlighted that there was a morphine sulphate 250mg/250ml PCA bag that was out of date on the ward. On removing the 3 x PCA infusion bags I discovered that there were two expiry dates on the PCA infusion bags - one of which was a lot shorter than the other. The shorter expiry date was also further covered on the outer packaging by the dispensing label. The risk of this is that the expiry could be missed at point of checking and administering the	The expired PCA bags have been removed from the ward. The event was highlighted to dispensary manager. Concern was raised that there could be other PCA bags around the hospital with two expiry dates, where confusion could occur.	Ongoing investigation to assess and address.	Pharm (none)

	infusion bag.			

The Royal Wolverhampton NHS Trust

Trust Risk Register

November-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 Risk Lead: COO	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	Nov-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 Risk Lead: General Surgery and Urology Group Manager	4 x 3 = 12 AMBER	1. CEPOD list to deal with these cases (Aug 2016) 2. SLA with Stoke reversed to bring additional resources from current RWT Consultant and buy service from Stoke (Feb 2018) 3. One slot on elective list for UGI Consultant Surgeon to accommodate 'hot gallbladder' from emergency admission commenced (Oct 2018)	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 1-3 (05.10.18) Highlight as a 'service at risk' to Division and as part of Medical Workforce Report 1-3 (05.10.18) Unable to appoint to the 3rd UGI Consultant post	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	Dec-18 Dec-18	2 x 2 = 4 YELLOW	Nov-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 Risk Lead: Emergency Department Group Manager	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 (Nov 18) 1) Bd7 nursing forums taking place regularly and working well (Nov 18) 3) Local audit around documentation of senior review and ECG is showing good compliance (Nov 18) 8) Significant improvement in middle grade workforce (Nov 18) 8) New ED management plan agreed, will include Quality Improvment Lead (Nov 18) 2) Backlog of unnapproved incidents reduced (Nov 18)	3) Significant number of SUI actions overdue/dates amended (Nov 18) 3) Some actions not relating to ED are taking a considerable amount of time to implement/ close (Nov 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 (Nov 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 (Nov 18) 3) Discharge checklist and adult safeguarding documentation still showing poor compliance (Nov 18) 13) Historic incidents need reviewing (Nov 18) 90 Pre Governance meetings have not taken place (Nov 18) 1) Matron currently off sick (Nov 18) 3) Increase noted in number of both potential and reported SUI's (Nov 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	Jan-19 Jan-19 Dec-18 Dec-18	2 x 3 = 6 YELLOW	Nov-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 Risk Lead: Cardiac Group Manager	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 (1-5 There have been 3 patients infected historically (none from Nov/Dec 17) to date - these infections take up to 5 years (as far as we know) to manifest (18 Oct 18) 1-3 Recruited to all available posts (18 Oct 18) 1-3 Training of ACCP's continues and will take a further 18 months (1-5 There have been 3 patients infected historically (none from Nov/Dec 17) to date - these infections take up to 5 years (as far as we know) to manifest (18 Oct 18) 1-3 Agency locums in place for surgery and anaesthetics to ensure safe cover whilst gaps remain (18 Oct 18)	1 & 2. Anaesthetics - x2 posts awaiting further documentation (visa's, exam results, scholarship) (18 Oct 18) 1 & 3. Surgery - awaiting confirmed start date for x1 post (18 Oct 18) 2. It takes two years to train ACCP's (18 Oct 2018)	2. Training of ACCP's	Aug-19	2 x 3 = 6 YELLOW	Nov-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	5083	IF staff do not understand their roles/ role boundaries and receive training and maintain competency needed to accurately identify dysphagia needs and manage these appropriately, THEN patients' needs may not be assessed (or inadequately assessed) RESULTING IN aspiration of oral intake and the potential negative effect on the patient's health. This can lead to increased antibiotic usage, increased length of hospital stay, increased likelihood of readmission and - in the most severe cases - the patient's death. Additional potential outcomes could be increased exposure to medical negligence actions for both staff and the Trust. Date of origin: August 2018 Accepted onto Divisional Risk Register: August 2018 Accepted onto Trust Risk Register: 08/10/18 Risk Lead: Head of Therapy Services	4 x 3 = 12 AMBER	(3) Care Pathway and initial guidance published on intranet (SALT pages) for wards to manage initial presentation of patients with swallowing problems (Aug 2018) (2) Use of swallow screening tool is now for trained/ competent Stroke nurses only (Aug 2018) (1) Working towards full implementation of IDDSI (International Dysphagia Diet Standardisation Initiative) required to be embedded across Trust by April 2019 (Aug 2018)	(1) IDDSI implementation progress on track and being led/ monitored via Nutrition and Hydration Steering Group (Aug 2018)	(1) PHSO C203652 aspiration pneumonia (Mar 18) (1) RCA 2017/30312 aspiration pneumonia (Nov 17) (1) 20 x related datix incidents in 2017; 15 x related datix incidents to date in 2018 - and it is possible that not ALL low harm/ near misses are being reported (Sept 18) (2) Staff who are untrained/ no competency cannot use swallow screening tool (all areas outside Stroke) (Aug 18)	(1-3) Develop and implement Trustwide Dysphagia framework - initially to implement Dysphagia Policy (to Dysphagia Policy Working Group in Sept 18 then aim for Policy Group November 2018) (SALT Service Manager)	Nov-18	x =	Nov-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 is 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 Risk Lead: Div 1 Deputy COO	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 (Oct18).	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	Nov-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 Risk Lead: CFO	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 Risk Lead: Cardiac Group Manager	4 x 5 = 20 RED	1. 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) 4. Group Manager and Thoracic Consultant have met with Worcester colleagues and pathways agreed (Sept 18) 5. Thoracic specification states that a Thoracic ANP and Consultant should be employed (Sept 18)	5. Thoracic ANP has been recruited and in post (18 Oct 18) 5. Consultant Thoracic Surgeon recruited and in post (18 Oct 18) 1-3 Additional meeting held with Worcester colleagues in September 2018 and pathway agreed (18 Oct 18) 3. Compliant with frozen sections following audit (18 Oct 18) 5. Locum in post and contract has been extended for a further 6 months (18 Oct 18) 1-5 Continue to approach other Trusts for referrals and attending Walsall and Worcester MDT (18 Oct 18)	1. Referrals have not increased, this has been escalated to DCOO and COO (18 Oct 18)		1 x 5 = 5 YELLOW	Nov-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	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 Risk Lead: CFO	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	
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 position. Date of origin: 20/07/18 Date of escalation: 20/07/18 Risk Lead: CFO	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 Risk Lead: COO	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	Nov-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 Risk Lead: Div 2 Deputy COO On BAF	4 x 4 = 16 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 (10/18) 3) Safe staffing levels are being maintained across acute wards (10/18) 1) Proactive recruitment approach continuing (10/18) 1-10) Monthly workforce group reviewing nurse recruitment and retention (10/18) 1) Electronic VCP process in place for Bd 2 and 5 substantive direct role replacement - working well (10/18) 1) Shortlisting for nursing clinical fellows roles (10/18) 1) 29.62 wte trained nursing vacancies remain, 37.78 roles offered, but not in post (10/18) 1) 9.29 HCA vacancies remain, 22.9 posts offered (10/18) 1-10) HoN Div 1 appointed as Professional lead for Nurse Bank (10/18)	8) Insufficient RN's available on Bank, backfilled by HCA (10/18) 1) Nationallly we are an outlier re safe staffing levels (10/18) 1) Recruited staff are newly qualified which can lead to mentorship and training pressures (10/18) 1) All wards are 'Amber' re safe staffing levels on daily basis (10/18) 3) Issue in relation to ability to provide accurate staffing figures (10/18)	1) Nursing strategy in development - outline draft produced 1) continue with proactive recruitment approach 1) Plan for overseas recruitment for Clinical Nurse Fellow posts 1) HoN's requesting staffing blueprints to allow them to monitor staffing levels more accurately 3) Task and finish group set up to review operational delivery of nurse staffing	Sep-18 Oct-18 Dec-18 Dec-18 Nov-18	4 x 3 = 12	Nov-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 Risk Level: Div 1 Deputy COO	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 8.47% (Oct 18) 1-5) Locum Expenditure decreased continually in May June and July (Sept 18)	1-5) Number of vacancies remain across the Division (Oct 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	Nov-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 Nov 18. Impact: This may lead to patient harm. Date of origin: 10.05.2012 Date of escalation 19/03/18 Risk Lead: Head of Corporate Nursing Date of expected closure 01/4/19 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. Adult 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 Nov 18 2) Community services can access surface selection guide for mattress selection based on risk and holistic needs Nov 18 2) A £55,000 budget for the out-of-hours pressure relieving mattress service in Community (Nov 18) 2) SLA in place with Independent Living Service and monitored Nov 18) 2) ILS service community equipment supplied by them on return (Nov 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 Nov 18 1) Process in place to reassess patients on Symmetrikit Chairs (OT posture managment Chairs) Nov 18 3) Notice of concern issued to current provider (Nov 18)	2) Accountability pressure injury process reviewed, October 17 & January 18 (Nov 18) 1) Suitable trolley mattresses in use for A&E ((Nov18) 3) West Park, CCH and New Cross supplied with Hybrid Mattresses - (Nov 18) 2) CCG Contracting Team/souial services are leading the tender process for community equipment including th TV Team - Nov 18 1) Process in place for wards to monitor integrity of hybrid mattress (Nov 18) 3) Adult community services collating a report to submit to the CCG regarding mattresses delivery and fault management delays (Nov 18)	2) RWT is not resourced to follow processes for specialist equipment request/order (Nov 18) 1) High demand on mattresses from ILS, no assurance on timely delivery (Nov 18) 1) Delays in delivering equipment from ILS (Nov 18)	6) Adult community services collating trends of failed deliveries and fault management of mattresses to submit via contracting to the CCG re filed attempts for delivery or repairs monthly 1, 6, 8 CCG are commencing the tender process with a view for successful service shadowing ILS from Jan- mar and commence new service from 1/4/19	Mar-19 Mar-19	1 x 3 = 3 GREEN	Nov-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 Risk Level: Div 1 Deputy COO	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 Sept 18 (Oct 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 Sept 18 (Oct 2018)	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) (Oct 2018) 3. Obstetrics (Fetal Blood Sampling) - Nil return on WHO checklists - Badgernet system to be updated in order to collect data (Oct 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 2. AfPP training is scheduled to take place in October 2018 and January 2019 1-12. Last 2 x NE deferred by the Commissioners - action plan to be updated	Sep-18 Mar-19 Mar-19 Mar-19 Oct-18 Nov-18 Nov-18 Jan-19 Oct-18	2 x 4 = 8 AMBER	Nov-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)	1-12. No further NE reported since June 2018- 4 months (October 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 Risk Lead: Deputy CNO	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 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. 10) 2018 CQC Action Plan is monitored via the Divisional Performance monitoring process and relevant sub board speciality groups reporting to TMC on a quarterly basis 12) Mortality QI plan is monitored via Programme Board monthly and learning outcomes via MRG 11) EOL strategy with TOR has been developed and milestones monitored via the EOL group monthly	5) Nursing and Midwifery KPIs are on 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 undertaken annually and reported to Board 3) Lord Carter metrics monitored monthly via Divisional Performance meetings 6) Vacancies continue to reduce month on month and are reported to Board monthly Divisions monitor performance via monthly Governance meetings	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. 2) Sickness absence has seen an increase over Summer 2018 in the Nursing workforce	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 Develop PLACE action plan in response to recent audit outcome Implement Safer Care Software and roll out Refurbishment and expansion of existing Discharge Lounge Implementation and roll out of NEWS 2 Review baseline of Nurse sensitive indicators	 Nov-18 Jan-19 Jan-19 Jan-19 Dec-18	2 x 2 = 4 YELLOW	Nov-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?
				Monitoring of the Nursing System Framework monthly via TMC						

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 Risk Lead: Div 1 Deputy COO	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 (Oct 18) 1. Reduction in overall Divisional vacancies (Sept 18: 31.7 WTE registered nurse vacancies with 28.48WTE awaiting a start date, 0 HCA vacancies) (Oct 2018)	5. Peak annual leave seasons challenge to cover bank shifts (Sept 18) 13. Most areas are working on amber levels (Sept 18)	1.Recruitment Calendar agreed re: events for the next year 1. Recruit Clinical Nurse Fellows (currently out to advert) 1-11. Reviewing Department Stress Risk Assessments for areas with high turnover	Mar-19 Dec-18 Dec-18	2 x 2 = 4 YELLOW	Nov-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 Risk Lead: Estates and Facilities Divisional Manager	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 September 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 9) Automatic Fire Detection (AFD) in identified areas has been upgraded with Tri-State Detectors. Areas identified from UwFS	10) 2 Unwanted Fire Signals within September 2018 (HPV Cleaning)	9) Compartmentation survey to be completed (commenced) 7) Further Evacuation Exercises to be completed for Wards 1-10) Remove all ACM cladding attached to the building. Funding secured from NHSI (PDC). However design specifications have yet to be finalised and approved.	2 x 2 = 4 YELLOW	Nov-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 Risk Lead: Estates and Facilities Divisional Manager	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 4. Implementation of robust waste management controls to reduce the risk of a fire occurring. 7.Basement area (Tugway) now being monitored following the Installation of CCTV.	1. 0 Unwanted Fire Signals within September 2018 1. 0 incidents relating to Reportable Fire's within September 2018 2. Combustible items located in the Tugway have been removed. The area is being monitored by Estates Department via the Tugway Group 7. Structural fire safety repairs carried out to minimise risk fire spread from the Basement (Tugway) into the building above. 7. Implementation of robust management controls		2. Departmental Business Continuity Plans need to be updated 4. Tugway Safety Environmental Audit Group monitoring action plan	2 x 2 = 4 YELLOW	Nov-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 Risk Lead: Emergency Departement Group Manager	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 (Nov 18) 15) New starters are familiar with the department and its processes/ policies when they start(Nov 18) 4-5) Reallocation of staff working well to help reduce wait times during pressured times (Nov 18) 7,17) Reduced reliiance on agency staff. Locums used are long term locums(Nov 18) 16) Urgent treatment doctor is making an improvement to patients recieving appropiate emergency treatment (Nov 18) 18) Additional triage room has helped reduce triage wait times(Nov 18) 19) Escalation tool in use in the dept (Nov 18)	1, 2) Inability to achieve 2 hour assessment and 15 minute triage consistently (Nov 18) 4,5) Staff not always available to be reallocated (Nov 18) 6) Delays in ED linked to bed availability (Nov 18) 7) Medical and nursing vacancies and sickness/ annual leave resulting in gaps in rota. Link to risk 4496 and 2374 (Nov 18) 8) Consistently at 2 hour wait by evening (Nov 18) 9) UCC not impacting on pt numbers and delays in assessments (Nov 18)	7)Continue with recruitment of medical staff - ECIP tool has identified need for more staff in the morning 1) Scoping exercise by industry staff to review systems to improve timeliness of reviews 7) Adverts out for speciality Doctors. Awaiting outcome of interviews.	Dec-18 Dec-18 Dec-18	1 x 4 = 4 YELLOW	Nov-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 Risk Lead: Div 1 Deputy COO	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 (Oct 2018) 1. Further incident identified 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 legal services work (June 2018)	1-2. Monitor ongoing incidents 1-2. Non-STEIS investigation being undertaken Datix: 185209 - report to be finalised and approval process to be complete and outcomes updated into this risk	Nov-18 Nov-18	2 x 2 = 4 YELLOW	Nov-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 Risk Lead: Emegency Department Group Manager	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 Dec-18 Dec-18	1 x 2 = 2 GREEN	Nov-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 having insufficient supply of staff at the correct seniority and experience) 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 Risk Lead: Div 1 Deputy COO	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	Nov-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 Risk Lead: Medical Director	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 6) ICE system is now fully functional from 1st April 2018 and reviewing filing of Pathology results and Radiology reports is available and auditable.	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) 6) In both August and September 2018, 20% of Pathology and Radiology reports were filed.(Oct 18)	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) 6) In both August and September 2018, 80% of reports were not filed.(Oct 18)	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 6) To ensure local SOP's are in place across all Directorates with mandatory reviewing and filing of results with audit of compliance by Directorate and Consultant.	Nov-17 Oct-18 Oct-18 Dec-18 Dec-18	x =	Nov-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 Risk Lead: Radiology Group Manager	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) 3) Parts still available for repair. Good rapport with service team so there is a rapid response (Oct	1) Breakdowns are usually fixed under a 'fix as you go' contract. (Nov 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. (Nov 2018) 1) & 2) Equipment replacement confirmed on capital replacement programme 18-19 (Nov 2018) 1) Equipment is due for replacement Q4 18-19 (Nov 2018)	1) Any breakdown causes disruption to the service offered to patients. Breakdowns encountered with CR readers 7; X-ray equipment 4 (Nov 2018) 2) No focus choice on mobile X-ray unit and reliance on ageing CR processing equipment (Nov 2018) 2) X-ray service will not be available if CR processing facilites fail (Nov 2018) 1) There is an increase in the number of breakdowns (Nov 2018)	1) & 2) To continue to monitor any equipment breakdown 1) & 2) Replacement of equipment planned for 18/19 3) On-going procurement process	Dec-18 Apr-19	2 x 2 = 4 YELLOW	Nov-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 Risk Lead: Radiology Group Manager	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) Use of outsourcing (Oct 2018)	3) Clinical Fellows have been appointed (3 in place) (Nov 2018) 4) Review meetings are happening fortnightly (Nov 2018) 1) Backlog has reduced from 7332 May 2017 to less than 2878 in Oct 2018 (Nov 2018) 3) Office space sourced (Nov 2018) 1) The backlog is actively monitored by Group Manager (Nov 2018)	1) Approximately 2878 non-urgent imaging studies unreported Oct 2018 (inclusive of 354 CT scans and 1061 MRI scans). Over 20 days there are 1026 in total (inclusive of 101 CT scans and 350 MRI scans) (Nov 2018) 1) Poor patient experience if patients and doctors are unsure when their scans are reported (Nov 2018) 3), 4) & 5) Demand for reporting imaging studies is higher than expanded reporting capacity (Nov 2018) 3) Infrastructure in terms of equipment and office space not currently available for the additional clinical fellows (Nov 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 1) Continue to monitor	Dec-18 Dec-18 Dec-18 Dec-18 Dec-18	2 x 4 = 8 AMBER	Nov-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 - re-opened 08/10/18 following incident 2. Drainage system - addressed 2. Electrical infrastructure - 3. Fire safety 4. Operating lights - addressed 5. Air-flow/ventilation - addressed 6. Storage 7. Infestations - 08/10/18 reopened - 2 incidents since 01/06/18 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 Risk Lead: Critical Care Group Manager	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) 08/10/18 - Now updated and opened . 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 have been 2 incidents (Datix 192843 - 10/03/2018, Datix 202440 - 13/09/18) of sewage ingress into Theatres (Oct 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. From June - Oct 2018 there were 2 incidents reported on Datix of insects in Theatres, both during operations with no known patient consequences (Oct 18) 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	Nov-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	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 Risk Lead: Obs and Gynae Group Manager	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 (9.11.18) 2) Close observation of activity in relation to number of predicted births (9.11.18) 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 (9/11/18)	1,2) Activity levels are variable and uncontrollable due to births occurring at varying gestations and women transferring in from other units (9.11.18)	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 1:27 Birthrate Plus ratio 1,2) Continue to monitor activity via dashboard 3) Continue to monitor birth activity as a result and decline inappropriate bookings	Mar-19 Mar-19 Mar-19 Mar-19	3 x 2 = 6 YELLOW	Nov-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	4916	If the Dietetics team are under-recruited to in October 18, due to vacancies and maternity leave (2.5 vacant posts) within the Paediatric dietetics service, then this will result in the inability to provide the expected service to patients. There is a risk of reduced/no service resulting in poor outcomes and patient experience, unnecessary hospital admission and delayed discharge, inability meet SLAs and BPT resulting in a substantial loss of income to the Trust and increased staff stress. Date of origin: July 2018 Escalated to Divisional Risk Register: August 2018 Escalated to Trust Risk Register: October 2018	3 x 4 = 12 AMBER	4) Team leader going on mat leave has agreed to be paid in lieu of A/L to induct locum/temp staff member in Sept 2018 [Aug 18] 3) Band 4 running review clinic for overweight and CMPI [Aug 18] 2) Cannock Clinics on hold [Aug 18] 1) Retired Band 7 has agreed to do 2 days per week bank work to cover dietetic clinics at NXH (Aug 18) 5) Currently at near 3.0 WTE through temp staffing / contracts and secondment [Sept 18]	1-4) No cancelled clinics to date in month [Sept 18] 1-4) No service user complaints received to date in month [Sept 18] 5) Staff in post [Sept 18]	5) Temporary staff lack experience of permanent staff, so additional support is required of the rest of the team [Sept 18] 5) Risk of failing to retain temp locum B6 - currently agreed 6 months [Sept 18] 1-3) No formal monitoring of impact on workload (e.g. cancelled clinics etc) but anecdotal evidence of this occurring (no cover for Paeds Diabetes on 07/09/18 [Sept 18]	1-4) Complete the training of Band 5 RD in paeds to provide 0.5 WTE support 1-4) Seek support from BCH in terms of training and possible CF SLA 1-4) If unable to increase to near 3.0 WTE review service/Trust priorities - clinical and financial 1-4) Advise Dietetics team to Datix report any incidents of service failure (e.g. cancelled clinics) in order to monitor impact	Oct-18 Oct-18 Oct-18 Oct-18	3 x 2 = 6 YELLOW	Nov-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	5031	If sub-optimal staffing (reduction in 39%) continues within the ultrasound scan department then it will impact on required compliance with national screening standards - this includes submitting required data and proving quality of work is assessed continually for obstetric patients. Neonatal Hip and cranial scans also need to comply with national standards and this may be affected. Training will also be impeded affecting the future of service provision. There may be a rise in litigation cases and disability. Delayed access to emergency gynae assessment unit / Fast Track clinics may lead to misdiagnosis of urgent care / life threatening conditions such as ectopic pregnancy and gynae cancers, and failure to meet national 2 week targets. There is potential for late discharges or treatments for obstetric, gynae and paediatric patients. Delayed access to ultrasound scans such as in August increases the risk of misdiagnosis of some high risk obstetric patients. Date of origin: 17/05/18 Date of escalation: 04/10/18 Risk Lead: Head of Midwifery	3 x 4 = 12 AMBER	1) Dating and Fetal Anomaly scans are given priority over Gynaecology scans to ensure women have their scan performed in accordance with the national programme standards. 17/5/18 2) Community Midwives have the facility to telephone the Maternity Unit and organise an urgent priority scan if a woman is thought to have booked late (17/5/18) 3) Midwife Sonographers in fetal medicine (FMU) are being asked to assist with scanning both obstetric and gynae scans in the main scan department when staffing in FMU allows (17/5/18) 4) Staff in maternity scan dept.are continually reviewing their staffing levels to escalate their concerns appropriately (17/5/18) 5) Agreement for Sonographers to volunteer to run weekend clinics and exteneded days to increase available scanning slots. (03/08/2018) 6) Current adhoc support from Midwife sonographers enables the sonographers to undertake hip, cranial and emergency gynae scans which have been prioritised. (03/08/2018)	1-4) There are no reported incidents whereby a woman has missed the opportunity to have her dating or anomaly scan as a direct result of sub standard staffing within main scan (21/09/18) 1-3) The Antenatal Screening Coordinator (Midwife) has not received any notifications from any community midwives to inform of a delay in scan (21/09/18) 1-8) Prioritisation of urgent patients e.g ectopics from ward and EPAU (21/09/2018) 1-8) Patients may be admitted to ward if unable to perform scan and confirm diagnosis (21/09/2018) 1-8) Currently, due to the prioritisation of work, sonographers are attempting to perform scans within standards stipulated for babies and mothers.(21/09/2018) 13) Staff have worked additional hours on the enhanced rate (21/9/18) 1-11) Currently all Obstetric patients still being offered screening and Anomaly scans within the time standard (09/10/18)	1-4 Datix incident reports have been received concerning staff shortages resulting in no scan service in the EPAU (21/09/2018) 1-8) Delayed diagnosis/treatment for patients and risk of mis-diagnosis (21/9/18) 1-8) Scans are currently being done out of standard for babies and mothers, as seen by the DATIX incidents. Hip Scans are out standard currently and done at 7 weeks plus - 11 babies just over 6 weeks screening standard (09/10/2018) 13) Whilst staff have worked some additional hours on the enhanced rate of pay there are still significant gaps within the scan service (21/9/18) 1-11) Routine gynae patients - currently 147 patients waiting without appointments (fully booked) - now starting to breach the 6 week wait (09/10/18) 1-11) There are no slots available for routine gynae before November and priority of the few slots we have left in November will have to be prioritised for Fast Track and Obstetrics or Paediatrics (09/10/18)	1) Increase staffing of sonographers in main scan 2) Resolve HR issues 3) Training for X2 Midwife sonographers 0.4WTE 3rd Trinester scans	Feb-19 Nov-18 Oct-19	1 x 3 = 3 GREEN	Nov-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?
				7) Selected Low Risk Gynae patients have been referred to Radiology (06/08/2018) 8) Doctors training cancelled as a temporary measure in women and children's to maximise the patients being scanned in a list. (07/08/2018) 9) x2 Sonographers employed via the bank - booked if they are available (07/08/2018) 10) x2 members of staff have increased their hours on a permanent basis (07/08/2018) 11) Enhanced Bank Rates £45/hr are being offered for any part time current staff (09/10/2018)		1-11) 6 EPAU clinics currently cancelled for October (impact - delayed diagnosis of ectopics and miscarriage and increase of ward referrals) (09/10/18) 1-11) 9 Gynae Fast Track appointments still outstanding (09/10/18)				

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 Risk Lead: Medical Director	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) Testing and roll out of electronic NEWs solution commencing Jan 19 Advertise and recruit two Sepsis nurses.	Mar-19 Dec-18	x =	Nov-18	