The Royal Wolverhampton
NHS Trust

CNO Governance Report
4 February 2019

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	4th February 19
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 8. Learning and improvement
Action Requested:	**Receive and note,**
For the attention of the Board	
Assure	• Improved review and prompt management of red incidents reported within the Datix system. • Timely completion and submission of SUI investigation reports has been sustained. Weekly Executive sign off meetings for RCAs to be formalised with TOR and reporting into Trust governance structure.
Advise	• A change to the Trust criteria for selecting deaths for the SJR process has reduced the total reviews due and should positively impact timely review completion.
Alert	• IG risk alerted in the last report has had further mitigating action agreed in the form of IG resource. A band 6 role is advertised to support delivery of the IG work plan.
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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:	None
Report Data Caveats	This is a standard report using the previous month's data and updates within a live Datix system. It may therefore 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 adverse impact on PPCs
Risks: BAF/ TRR	TRR 3644 – Failure to improve CQC Compliance gaps TRR 3069 – Risk of Never Events – Div 1 TRR 4599 – Emergency Services Governance arrangements TRR 4734 – Elevated Mortality Statistics
Public or Private:	
Other formal bodies involved:	
References	
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

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1. Trust Risk Register

2 new risks added:
5112 - ICCU Staffing (COO)
5116 - Provision of 24/7 Critical care Outreach Services (COO)

2 risks removed:
4916 - Dietetic Staffing (COO) – refer Appendix 2 for closure rationale
5097 - Implementing the new Agenda for Change pay deal (CFO)

5 existing 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)

The full TRR is shown in appendix 2 and tracked changes to risks in Appendix 1. Further progress narrative is provided for the following risks:
4665 – X-ray Cannock: The equipment programme is scheduled to start March 2019. Equipment is monitored on a daily basis and parts are still available to support the service.

4696 - Unreported imaging studies: Reporting numbers monitored by Group Manager on a daily basis. All oldest scans sent off site for reporting, and Waiting List Initiatives are performed in-house. Waiting time currently at 5 weeks.

A number of risks have received updates in January 19, reviews are required on the following:
2719 COO – grade under threshold for review
3644 CNO – grade under threshold for review
4375 COO – action dates required
4411 COO – action dates required
4661 MD – action update required

2. Red Incidents – Non SUI

Non to report this month, all incidents reviewed and reported/downgraded as appropriate.

3. Serious Untoward incident (SUI) Performance

Progress on the closure of overdue SUI action fluctuates but has improved with only one overdue at time of reporting. Monitoring continues at QSIG and weekly Executive review meetings.

Month	Ongoing /Open incidents (stop clock)	New Reported to STEIS	Closure Request to Commissioning	Closure Agreed by Commissioning	Over 60 day breaches - running total
June	71 (6)	31	14	5	5
July	55 (6)	15	15	10	9
Aug	42 (4)	8	13	25	13
Sept	30 (3)	5	11	12	6
Oct	21 (2)	7	13	13	7
Nov 18	19 (2)	10	11	12	1
Dec 18	22 (1)	12	7	7	1
Analysis	Sustained progress made on the completion and closure of SUIs within timescale.	Reduction in SUI numbers impacted by agreement with commissioners to work to the National SUI reporting framework.	Fewer queries received from commissioners re RCA reports.	A good closure rate continues with commissioners.	Weekly reports to CCG continue for overdue RCAs.

4. Information Governance work plan

Delivery of requirements of the Data Security Protection Toolkit (DSP) continues to be a challenge given the changes following GDPR. The priority plan agreed and previously reported will continue to be monitored to identify areas of concern/gaps in compliance.

The focus for January for IG team will be on the IG Awareness week (31st Jan to 25th Jan) across all sites, there are a number of workshops planned; Data Sharing, Drafting a Privacy Notice, Conducting a Protection Impact Assessments (PIA), Information Asset Registers.

The Band 6 role allocated to IG will further support delivery of the priority plan. There will still be a requirement for large/new projects over and above the IG priority plan, to identify supplementary 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 escalated re Capacity for IG/GDPR compliance (Datix 4769) and the impact on the IG regulatory and toolkit compliance. The risk has been updated following the approval of the recruitment to Band 6 IG Officer, however the grade remains the same and will be reviewed once the post is filled and work progress can be assessed.

5. **Governance staffing**

Recruitment continues giving consideration to necessary role changes within the team. A new role (Investigation and Learning Specialist) is created and advertised to support the RCA workload and to increase work focus on investigation, learning and improvement. A joint Data Analyst role is appointed and shared between Governance and Patient Experience team to support development of Datix/Governance system, information and reports.

6. **Local Policy Governance**

Work has commenced to implement Local Policy Governance. Progress to date is below:

- ❖ Draft Local Policy Plan (Framework) – Developed. To be shared/submitted to Policy Group in Feb 2019.
- ❖ Divisional/Directorate SOP for Development of Local Procedures – Developed. To be shared/submitted to Policy Group Feb 2019
- ❖ Directorates/Depts for initial roll out:

- **Ophthalmology – Deferred by management request till later in the programme due to key staff absences.**
  - o Contact made with Directorate Trio.
  - o Local Policy Lead identified (Support Manager for Opthalmology)
  - o Local documents ground work completed by Governance. To be shared along with requirements going forward at meeting on 16th Jan, 2019.
- **Critical Care & Theatres**
  - o Contact with Trio made.
  - o Meeting with Trio to take place 10th Jan to discuss plan and requirements to identify lead to work with.
  - o Internal ground work on local documents completed by Governance
- **Paediatrics**
  - o Ground work on local documents in progress
  - o Contact with Trio to be made once ground work completed
  - o Local Policy Lead to be agreed
- **Maternity**
  - o Division 1 Management requested (10th Jan) Maternity work commences at a later stage due to impending Midwifery Review and recent RCOG visit/actions required
- **Emergency Department**
  - o Work to commence on Local Documents following completion of Paeds.
  - o No contact made as yet taking into account Winter Pressures
- **Head and Neck**
  - o Suggested Directorate from Division 1 Management
  - o Local documents ground work to commence
- **Dermatology**
  - o Suggested Directorate from Division 1 Management
  - o Local documents ground work to commence following completion of Paeds work.

Initial planning meeting has occurred with IT on the development of a local policies page for Directorates.

7. **Mortality**

The period Sept 18 to Dec 18 following the change of how cases are allocated saw a decrease in the death reviews identified, 85 of the 571 deaths (15%) met the criteria for receiving a SJR1 review. December deaths are to be allocated w/c 7/1/19. Of the reviews undertaken in the period, 6 (4%) identified a score poor care. These cases will receive an

independent review via SJR2 process.
The period of Oct 17 to Nov 18 identified 87 cases for SJR2 review, 45 (60%) completed at time of reporting. Of the 42 SJR2s outstanding 32 are outside of the 4 week timescale for completion. These are in progress and being followed up. The remaining 10 are due for allocation w/c 7/1/2019.
The following overall themes have been identified following all SJR2 reviews

- End of life care – earlier intervention with specialist palliative care team to improve the care provided
- Recognition of the deteriorating patient – initiation of Sepsis 6 could be improved along with identification of deteriorating patient
- Safeguarding – improved knowledge of MCA/DoLs to improve care
- Documentation – primary diagnosis unclear in patient record

The above themes are being managed via the Quality Improvement Programme for Mortality reported separately. Directorate themes have been circulated for mortality leads to review and provide a summary of learning. The response to these will be reported to Mortality Review Group.

8. <u>Learning and Improvement</u>

A Shared learning page on the Trust intranet is under development to communicate lessons, themes and improvements identified from various sources (incidents, complaints, claims, specialist subject leads etc). The site will also share best practice from other organisations, publish links to tools and resources from national and international sites that lead in patient safety and improvement. To harvest local lessons for improvement a communication framework is being developed on sharepoint to allow key services PET, Legal, IP etc) and lead specialists (MSO, Safeguarding) to feed learning and improvement information into a central communication platform. This will assist with the timely capture of learning information relative to RWT to be publicised/alerted. This feed will also inform current communications through Risky Business and Making it better alerts.

9. **<u>SUI themes from 2018/19</u>**

Themes identified for redress were:
Results reporting – Wards/Depts are required to develop local Results reporting SOP in compliance with Trust policy. These are being collated within Divisions. Audit of compliance to CP 50 (Management of Pathology and Radiology Clinical Diagnostic and Screening tests) is planned, an audit tool is in development.
Local Policy Governance – Refer item 3 above Local Policy Governance
Communication/Handover – Work planned to commence in Q4. Governance to work alongside Quality PEF to address SUI findings.

Appendices

Appendix 1 - Tracked changes to risks
Appendix 2 – Trust Risk Register (TRR)

Appendix 1: Tracked changes within Trust Risk Register (January 2019)

Lead Director	Risk	Risk Title	Field updated	Update made
Chief Operating Officer	4916	Dietetic Staffing		
			Risk downgraded from 12 Amber to 9 Amber.	Risk is now being managed on local risk register. Capacity has improved to allow Cannock clinics to be reinstated. Band 4 running review clinics for overweight and CMPI now has HCPC registration, is now B5 and progressing through paediatric competencies
	5112	ICCU Staffing		
			New risk	If the 13% inexperienced staff on ICCU do not receive adequate support and educational input then they will not gain the experience to work unsupervised resulting in increased stress and sickness within the experienced staff population and potential patient harm.
	5116	Provision of 24/7 Critical care Outreach Services		
			New risk	If the Critical Care Outreach Team (CCOT) is unable to support the hospital, then seriously ill and deteriorating patients will not receive the support they require, resulting in patient harm or ICCU may experience avoidable admissions.
	4696	Unreported imaging studies		
			Positive Assurance – **New**	Backlog has reduced from 7332 May 2017 to less than 3389 in Dec 2018
			Gap in Assurance - **New**	Poor patient experience if patients and doctors are unsure when their scans are reported
			Gap in Assurance - **New**	Approximately 3386 non-urgent imaging studies unreported Dec 2018 (inclusive of 373 CT scans

				and 1080 MRI scans). Over 20 days there are 965 in total (inclusive of 131 CT scans and 359 MRI scans)
	4411	NX08/NX09 McHale Building - Fire Safety		
			Positive Assurance – **New**	0 incidents relating to Reportable Fire's within December 2018
			Positive Assurance – **New**	0 Unwanted Fire Signals within December 2018
	4547	Safeguarding		
			Positive Assurance – **New**	CPIS system now rolled out to Cannock
			Positive Assurance – **New**	Safeguarding referral form reduced to 5 pages
			Gap in Assurance - **New**	Q2 audit results for safeguarding scored poorly for adults 50%
			Gap in Assurance - **New**	Wolverhampton Council have advised the e-referral system will not be in place for at least another 12 mths
	4472	Delays in Cubicle Assessment and Triage		
			Positive Assurance – **New**	ACP's now included on the medical rota and trialled weekly
			Positive Assurance – **New**	Consultants work on busiest days - in place
			Action Plan - **New**	Further work to be undertaken with Industry staff with view to reducing non admitted breaches
			Action Plan - **New**	GIRFT Visit completed September 2018. Report received, Group Manager reviewing report (Winter pressures July completion date)
	4375	NX87 Heart Centre - Fire Safety		
			Positive Assurance – **New**	0 unwanted fire signals during December 2018
			Positive Assurance – **New**	0 incidents relating to Reportable Fire's within December 2018
			Positive Assurance – **New**	Break-glass over-ride facility for 3rd floor installed to enable lifts to be used in the event of an evacuation.

			Gap in Assurance - **New**	Outstanding fire stopping required following compartmentation survey
			Action Plan - **New**	Approval for ACM to be removed from designated areas. This will commence January 2019 with a programme of works being agreed by Trust Management
	2080	Risk to quality of patient care: reduced manpower		
			Positive Assurance – **New**	9 nursing clinical fellows posts offered
			Positive Assurance – **New**	60.25 wte trained nursing vacancies remain, 32.27 roles offered, but not in post
			Positive Assurance – **New**	Nursing strategy rolled out
			Gap in Assurance - **New**	Breaches in minimum safe staffing levels
			Gap in Assurance - **New**	Significant nursing shortages on C16, amber action plan in place
			Action Plan - **New**	Div 2 HoN to discuss with Cons Nurse for Quality re improving accuracy of blueprints, including use of live system
	4599	Emergency Services Governance Arrangements		
			Positive Control – **New**	New post for Quality and Compliance advertised - interviews to take place next week Friday
			Positive Assurance – **New**	Interviews for Matron post taking place in Jan. Appointment made - await start date
			Positive Assurance – **New**	Reviewed weekly by Clinical lead in the Consultants meeting and Documentation review done by Junior Doctor's mentors
	4596	QS104 - Gallstone Disease		
			Positive Assurance – **New**	Hot gallbladder list now expected to commence end of February 2019 (dependent on theatre staffing)
			Positive Assurance – **New**	Clinical Director to draft SOP for discussion / agreement within Directorate.
	4761	Cardiothoracic Surgical /		

		Anaesthetic vacancies	Action Plan - **New**	Explore Clinical Fellowship Programme, Physician Assistants and Advanced Nurse Practitioners
	3069	Risk of Never Events within Division 1: Risks to Patient Safety and Trust reputation		
			Gap in Assurance - **New**	Monthly monitoring data of compliance with WHO checklist and Procedural Safety Checklist - 89% for full completion in Dec 18
			Gap in Assurance - **New**	Monthly monitoring and compliance with WHO checklist use - There has been 80% compliance achieved during Dec 18
			Action Plan - **New**	Action Plan to be developed following NE Leicester Conference
			Action Plan - **New**	Revamp/refresh the WHO Checklists
	4161	Shortage of Qualified Nurses across the Division		
			Gap in Assurance - **New**	Wards A12, SEU, A23, A5 and A6 are under recruited
			Action Plan - **New**	Continue to recruit Clinical Nurse Fellows
			Action Plan - **New**	Continue to run specialist adverts for high risk areas such as ICCU and Theatres
			Action Plan - **New**	Plans being worked up to utilise closed bay on Ward A6
	5083	Lack of trustwide dysphagia framework		
			Positive Control – **New**	Under Care Pathway, wards manage initial presentation and then refer to SALT who see patients within 2 working days
			Gap in Assurance - **New**	SALT only available on working days, so at Bank Holiday times there could gaps of up to 4 additional days (on top of 2 day response target) before SALT assess the patient [
			Action Plan - **New**	Investigate the possibility of extending the SALT service beyond working days only
	5031	Potential Non Compliance with The Fetal Anomaly,		
			Gap in Assurance	6 EPAU clinics currently cancelled for October (impact - delayed

		Paediatric Hips, Downs Pataus, Edwards screening standards	– **New**	diagnosis of ectopics and miscarriage and increase of ward referrals)
			Gap in Assurance – **New**	One of the long term sonographers has started a graduated return to work on a limited basis , but another full time sonographer has gone off long term sick
			Gap in Assurance – **New**	No suitable applicants for the permanent and bank sonographer adverts
			Gap in Assurance – **New**	Currently have no available slots until the 10th January for urgent patients
			Gap in Assurance – **New**	Currently have 225 patients waiting for gynae scans in January
			Gap in Assurance - **New**	H&S Report awaited
			Action Plan - **New**	Out to advert for a bank sonographer and permanent sonographer
	1713	Productivity		
			Risk Description - **altered**	Now has Deputy Medical Director responsible for risk (as well as COO)
			Positive Control – **New**	Business case for Allocate approved. Implementation plan agreed at Workforce group (Jan 18). Implementation expected Apr/May 19
			Action Plan - **New**	Continue to work with NHSI on development of job planning tools and sign off processes.
	2719	Timeliness of PAS Admission		
			Positive Control – **New**	Ward clerk review completed. Pilot for weekend working commences Feb 18. Additional ward clerks in Paediatrics and SAU agreed (Nov 18)
	4113	Inability to achieve CIP		
			Risk Description - **altered**	Now incorporates all Divisions rather than just Division 1.
			Positive Control –	Outpatient efficiencies continue to be identified via OPEG (Outpatient)

			New	Dec 18
			Action Plan - **New**	Revised structure for delivery of CIP present to TMC/Trust Board. Recruitment commencing Dec 18 - Jan 19.
			Risk after actions - **upgraded**	Was YELLOW now AMBER
	4903	Risk of non-compliance with Thoracic Service Specification		
			Positive Assurance – **New**	Continue to approach other Trusts for referrals
			Positive Assurance – **New**	Walsall plan to agree SLA with RWT
			Action Plan - **New**	Divisional Management Team to meet with Directorate to discuss progress
			Action Plan - **New**	Plan further approaches to Walsall
Chief Nursing Officer	3644	Failure to make an improvement in compliance gaps with CQC standards.		
			Positive Assurance – **New**	Nursing vacancies are at 34WTE with 85.71 WTE waiting to start. The position is maintained compared to November
	2952	Patient developing a pressure ulcer due to inadequacies of pressure ulcer prevention equipment		
			Action Plan - **New**	Night comfort service accessible from Nov 2018 by Adult Community Services -ongoing monitoring of service.
Chief Financial Officer	5097	Implementing the new Agenda for Change pay deal		
			*****Risk closed*****	The Trust calculated an unfunded pressure of £0.7m which then reduced to £0.55m as some more funding materialised from the centre. The pressure was funded using Trust contingency as there was no way to mitigate the cost.
	4955	MRET/Readmissions/Fines monies		
			Risk after actions - **downgraded**	Was AMBER now YELLOW
			Positive Control – **New**	The Trust now has an aligned incentives contract agreed with Wolverhampton CCG which fixes

				the value of MRET and readmissions. The MRET funding has been added to the winter funding budget controlled by the A&E Delivery Board and the Trust is satisfied as all bids against this budget to support with winter costs have been approved.
			Positive Control – **New**	The readmissions funding has similarly been added to the A&E Delivery Board budget but this funding has been ring fenced to return to RWT on production of a winter plan. This exercise is being progressed internally and will be shared with the CCG shortly.
			Positive Assurance – **New**	Agreed mechanism with the CCG for the return of funding.
			Action Plan - **New**	Prioritise completing the winter plan with updated forecast expenditure to take into account opening additional beds but not a ward.
	4794	The 2016/17 year end invoice		
			Risk after actions - **downgraded**	Was AMBER now YELLOW
			Positive Control – **New**	The Trust has entered into direct negotiations with the CCG since the NHSI arbitration process was halted.
			Positive Assurance – **New**	The Trust is confident that a resolution can be reached due to the continuing and constructive dialogue between the respective CFOs.

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. Additional ward clerks in Paediatrics and SAU agreed (Nov 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	2) Business Case for additional Ward Clerks.	Apr-19	2 x 3 = 6 YELLOW	Jan-19	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	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. (09.01.19) Hot gallbladder list now expected to commence end of February 2019 (dependent on theatre staffing)	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) Further discussions to take place re: UGI pathway with Gastroenterology re Acute Pancreatitis patients 1.Clinical Director to draft SOP for discussion / agreement within Directorate.	Jan-19 Feb-19	2 x 2 = 4 YELLOW	Jan-19	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 (Band 7 meetings) to ensure all nursing actions are addressed and learning is shared across the team (12/18) 2) Review of Governance work streams at the Divisional Governance meetings, incuding NICE, External guidance, Audit, Risk (12/18) 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 (12/18) 4) Performance meetings in place (12/18) 5) Directorate Governance meeting in place and attended by Directorate Management Team (12/18) 6) Staff member identified to provide Governance support 2 days per week (12/18) 7) Process in place to review re-attendances for potential SUI's proactively (12/18) 8) Ongoing recruitment (links to risk 2374 (medics) and 4496 (nursing) [12/18] 9) Governance pre meets in place (12/18 10) Incident reporting and governance covered as part of junior doctors induction [12/18]	3) Number of SUI and SUI actions is reducing (Dec 18) 1) Bd7 nursing forums taking place regularly and working well (Dec 18) 3) Local audit around documentation of senior review and ECG is showing good compliance (Dec 18) 8) Significant improvement in middle grade workforce (Dec 18) 8) Quality Improvment Lead advert closed, applicants shortlisted (Jan 19) 2) Backlog of unnapproved incidents reduced (Dec 18) 8) Interviews for Matron post taking place in Jan. Appointment made - await start date (Jan 19) 3) Reviewed weekly by Clinical lead in the Consultants meeting and Documentation review done by Junior Doctor's mentors (1/19)	3) Significant number of SUI actions overdue/dates amended (Dec 18) 3) Some actions not relating to ED are taking a considerable amount of time to implement/ close (Dec 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 (Dec 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 (Dec 18) 3) Discharge checklist and adult safeguarding documentation still showing poor compliance (Dec 18) 13) Historic incidents need reviewing (Dec 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 - Shortlisting complete	Jan-19 Jan-19	2 x 3 = 6 YELLOW	Jan-19	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 [12/18] 13) Band 7s to pick up incidents so Governance lead can focus on true incidents [12/18] 14) Substantive consultant establisment to 5 paeds and 9 adults (with 2 additional locums) [12/18] 15) HOT reporting of radiological results in place (12/18] 16) 1-13 New post for Quality and Compliance advertised - interviews to take place next week Friday(Jan 19) 8) Matron interviews taken place and appointment made await start date (Jan 19)						

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	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 There have been no incidents recorded to date (12 Dec 2018) 1-3 Training of ACCP's continues and will take a further 18 months (12 Dec 2018) 1-3 Agency locums in place for surgery and anaesthetics to ensure safe cover whilst gaps remain (12 Dec 2018)	1 & 2. Anaesthetics - x4 gaps (12 Dec 2018) 1 & 3. Surgery - x2 locums in place (12 Dec 2018) 2. ACCP's x2 being trained, training will take a further 12 months to complete. (12 Dec 2018)	2. Training of ACCP's 1-3 Explore Clinical Fellowship Programme, Physician Assistants and Advanced Nurse Practitioners	Aug-19 Feb-19	2 x 3 = 6 YELLOW	Jan-19	

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	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) (4) Under Care Pathway, wards manage initial presentation and then refer to SALT who see patients within 2 working days (Nov 2018).	(1) IDDSI implementation progress on track and being led/ monitored via Nutrition and Hydration Steering Group [JAN 19]	(1) PHSO C203652 aspiration pneumonia [JAN 19] (1) RCA 2017/30312 aspiration pneumonia [JAN 19] (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 [JAN 19] (2) Staff who are untrained/ no competency cannot use swallow screening tool (all areas outside Stroke)[JAN 19] (4) SALT only available on working days, so at Bank Holiday times there could gaps of up to 4 additional days (on top of 2 day response target) before SALT assess the patient [JAN 19]	(4) Investigate the possibility of extending the SALT service beyond working days only	Feb-19	x =	Jan-19	

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**

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	4113	If the Divisions are unable to achieve the identified CIP target for 2018/2019 then there are implications for the financial position of the Trust Linked to BAF risk SR8. Date of origin: 11/01/19 Date of escalation = Dec 18 Risk Lead: All Deputy COO's	4 x 5 = 20 RED	3. Vacancy control panel in place (Oct 2015) and higher restrictions 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 Divisional Programmes 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 £100 P.H to be approved by COO/CEO 8. Divisions involved in Financial Recovery Board chaired by CEO (Nov 2017) 9. PIDs are forthcoming to the Finance team (Dec 2018)	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) for all Divsions 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)	2 & 3. Unidentified CIP still remains across the divisions(Jan 19).	1-10) 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 1-10) Progress to be made with LOS - drive across all areas 1-10) Revised structure for delivery of CIP present to TMC/Trust Board. Recruitment commencing Dec 18 - Jan 19.	Mar-19 Mar-19 Mar-19 Mar-19 Mar-19 Apr-19	3 x 3 = 9 AMBER	Jan-19	Yes

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
				10. Outpatient efficiencies continue to be identified via OPEG (Outpatient) Dec 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	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) 3) The Trust has entered into direct negotiations with the CCG since the NHSI arbitration process was halted.	1) The Trust is confident that a resolution can be reached due to the continuing and constructive dialogue between the respective CFOs.	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	2 x 3 = 6 YELLOW	Jan-19	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. Recruitment strategy in place (April 2018) 3. Group Manager and Thoracic Consultant have met with Worcester colleagues and pathways agreed (Sept 18) 4. Thoracic specification states that a Thoracic ANP and Consultant should be employed (Sept 18)	5. Thoracic ANP has been recruited and in post (12 Dec 18) 5. Consultant Thoracic Surgeon recruited and in post (12 Dec 18) 5. Locum in post and contract has been extended for a further 6 months (12 Dec 18) 1-4 Continue to approach other Trusts for referrals (12 Dec 18) 1-4 Walsall plan to agree SLA with RWT (12 Dec 18)	1. Referrals have not increased, this has been escalated to DCOO and COO (12 Dec 18)	1-4 Divisional Management Team to meet with Directorate to discuss progress 1-4 Plan further approaches to Walsall	Jan-19 Jan-19	1 x 5 = 5 YELLOW	Jan-19	

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	The Trust now has an aligned incentives contract agreed with Wolverhampton CCG which fixes the value of MRET and readmissions. The MRET funding has been added to the winter funding budget controlled by the A&E Delivery Board and the Trust is satisfied as all bids against this budget to support with winter costs have been approved. The readmissions funding has similarly been added to the A&E Delivery Board budget but this funding has been ring fenced to return to RWT on production of a winter plan. This exercise is being progressed internally and will be shared with the CCG shortly	Ongoing dialogue and planning assumption from Wton CCG of intent to pay. Agreed mechanism with the CCG for the return of funding.	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. Prioritise completing the winter plan with updated forecast expenditure to take into account opening additional beds but not a ward.	2 x 2 = 4 YELLOW	Jan-19	

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/Deputy Medical Director	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). 7) Business case for Allocate approved. Implementation plan agreed at Workforce group (Jan 18). Implementation expected Apr/May 19	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 18. 1) Increase in number of 'signed off' job plans October 2017 + April 2018 + Sep 18	1) Sign off of all job plans not complete (Dec 2018) 1) Audit review still raised concerns - closed Dec 17	1) Internal audit to review progress made on job planning 19/20 5) Further update to Audit Committee in progress. 1) Continue to work with NHSI on development of job planning tools and sign off processes	Sep-19 Feb-19 Apr-19	3 x 2 = 6 YELLOW	Jan-19	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 (01/19) 1) Proactive recruitment approach continuing (01/19) 1-10) Monthly workforce group reviewing nurse recruitment and retention (01/19) 1) 9 nursing clinical fellows posts offered (01/19) 1) 60.25 wte trained nursing vacancies remain, 32.27 roles offered, but not in post (01/19) 1) Nursing strategy rolled out (01/19)	8) Insufficient RN's available on Bank, backfilled by HCA (01/19) 1) Nationallly we are an outlier re safe staffing levels (01/19) 1) Recruited staff are newly qualified which can lead to mentorship and training pressures (01/19) 1) Majority of wards are 'Amber' re safe staffing levels on daily basis (01/19) 3) Issue in relation to ability to provide accurate staffing figures (01/19) 3) Breaches in minimum safe staffing levels (01/19) 3) Significant nursing shortages on C16, amber action plan in place (01/19)	1) continue with proactive recruitment approach 1) UK recruitment for Clinical Nurse Fellow posts - ongoing recruitment 1) Business case produced for further funding for overseas recruitment 1) Div 2 HoN to discuss with Cons Nurse for Qulaity re improving accuracy of blueprints, including use of live system	Feb-19 Jan-19 Feb-19 Feb-19	4 x 3 = 12	Jan-19	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 reduced 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 (Jan 19)	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	Mar-19 Mar-19 Mar-19 Mar-19	2 x 2 = 4 YELLOW	Jan-19	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 Dec 18 2) Community services can access surface selection guide for mattress selection based on risk and holistic needs Dec 18 2) A £55,000 budget for the out-of-hours pressure relieving mattress service in Community (Dec 18) 2) SLA in place with Independent Living Service and monitored Dec 18) 2) ILS service community equipment supplied by them on return (Dec 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 Dec 18 1) Process in place to reassess patients on Symmetrikit Chairs (OT posture managment Chairs) Dec 18 3) Notice of concern issued to current provider (Dec 18)	2) Accountability pressure ulcer process reviewed, October 17 & January 18 (Dec 18) 1) Suitable trolley mattresses in use for A&E (Dec18) 3) West Park, CCH and New Cross supplied with Hybrid Mattresses - (Dec 18) 2) CCG Contracting Team/souial services are leading the tender process for community equipment including th TV Team - Dec 18 1) Process in place for wards to monitor integrity of hybrid mattress (Dec 18) 3) Adult community services collating a report to submit to the CCG regarding mattresses delivery and fault management delays (Dec 18)	2) RWT is not resourced to follow processes for specialist equipment request/order (Dec 18) 1) High demand on mattresses from ILS, no assurance on timely delivery (Dec 18) 1) Delays in delivering equipment from ILS (Dec 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 Night comfort service accessible from Nov 2018 by Adult Community Services - ongoing monitoring of service.	Mar-19 Mar-19	1 x 3 = 3 GREEN	Jan-19	

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) 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) 1-12. No further NE reported since June 2018 - 6 months (Jan 19) 13. Over 5 AfPP training days - approx. 240 staff members have been trained (Jan 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)	1-13. 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 1-13 Action Plan to be developed following NE Leicester Conference 3. Revamp/refresh the WHO Checklists	Mar-19 Mar-19 Mar-19 Mar-19 Jan-19 Mar-19	2 x 4 = 8 AMBER	Jan-19	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 and presented to Division and QSIG (Jan 2018) 13. AFFP Peer Review and Training undertaken		3. Monthly monitoring data of compliance with WHO checklist and Procedural Safety Checklist - 89% for full completion in Dec 18 (Jan 19) 3. Monthly monitoring and compliance with WHO checklist use - There has been 80% compliance achieved during Dec18 (Jan 19)				

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	If the Trust fails to make an improvement in compliance gaps with CQC standards the rating of Good will not be sustained and progress will not be made towards Outstanding. 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 (Jan 19) 3) Monitor monthly performance through the nursing midwifery KPIs for signs of deterioration (Jan 19) 4) Environmental Standards are monitored via the environmental group monthly (Jan 19) 6) Daily staffing is monitored via the Divisional QSIG ops meetings (Jan 19) 8) Fundamental standards are reviewed & monitored by the designated specialist groups and bi annually by the sponsor which then reports to COG (Jan 19) 9) HON/M monitor quality performance metrics on a monthly basis for trends and themes, these are further analysed via QSIG (Jan 19) 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 (Jan 19) 12) Mortality QI plan is monitored via Programme Board monthly and learning outcomes via MRG (Jan 19)	5) Nursing and Midwifery KPIs are on Health Assure reporting and emailed out to ward sisters/matrons and HoNs monthly. (Jan 19) 2) QRV process is now embedded and refined, plan formulated for ongoing inspections 2019/20 (Jan 19) 7) CQC insight report shared with Divisions for information (Jan 19) 7) Biannual skill mix review undertaken annually and reported to Board (Jan 19) 3) Lord Carter metrics monitored monthly via Divisional Performance meetings (Jan 19) 6) Nursing vacancies are at 34WTE with 85.71 WTE waiting to start. the posiiton is maintained compared to November (Jan 19) 7) Divisions monitor performance via monthly Governance meetings (Jan 19)	3) Vacancy rates remain high in some areas (Jan 19) 3) Phase 1 skill mix review for Adult inpatients shows a deficit (Jan 19) 4) Safer staffing fill rates remain transient particularly for nights (Jan 19) 9) Rising Mortality HSMR and SHMI rates are being reported in National data sets (Jan 19) 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 (Jan 19) 2) Sickness absence has seen an increase over Summer 2018 in the Nursing workforce	6) Implement Safer Care Software and roll out 4) Refurbishment and expansion of existing Discharge Lounge 5) Implementation and roll out of NEWS 2	Feb-19 Apr-19 Feb-19	2 x 2 = 4 YELLOW	Jan-19	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) EOL strategy with TOR has been developed and milestones monitored via the EOL group monthly (Jan 19) Monitoring of the Nursing System Framework monthly via TMC (Jan 19)						

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) 14. Continuing to recruit a new department every quarter as a minimum to Shared Governance (Jan 19) 1. Division 1 participating in the Corporate Recruitment Plan (Oct 18) 1.43.67 WTE vacancies of which 32.57 have been offered and await start dates. Leaving 11.10 WTE vacancies. Further business cases have been approved for additional staffing resulting in more positions to be recuited to (Jan 19)	5. Peak annual leave seasons will continue to be a challenge to cover (Jan 19) 13. Most areas are working on amber levels (Jan 19) 1+11. Wards A12, SEU, A23, A5 and A6 are under recruited (Jan 19)	1.Recruitment Calendar agreed re: events for the next year 1. Continue to recruit Clinical Nurse Fellows 1. Continue to run specialist adverts for high risk areas such as ICCU and Theatres 3. Plans being worked up to utilise closed bay on Ward A6	Mar-19 Apr-19 Apr-19 Apr-19	2 x 2 = 4 YELLOW	Jan-19	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 Trustwide (Jan 19)						

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 December 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) 0 unwanted fire signals during December 2018 10) Break-glass over-ride facility for 3rd floor installed to enable lifts to be used in the event of an evacuation.	9) Outstanding fire stopping required following compartmentation survey	7) Further Evacuation Exercises to be completed for Wards 1-10) Approval for ACM to be removed from designated areas. This will commence January 2019 with a prorgramme of works being agreed by Trust Management	2 x 2 = 4 YELLOW	Jan-19	

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 December 2018 1. 0 incidents relating to Reportable Fire's within December 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	Jan-19	

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	4472	If patients wait over 2 hours for assessment in cubicles in the Emergency Department and wait over 15 minutes for triage, then an urgent clinical need may not be identified within appropriate timescale's, which could compromise patient care. Date of Origin: 24/02/2016 Date of escalation = 15/04/16 Risk Lead: Emergency Department Group Manager	4 x 4 = 16 RED	1) National guidance in place (15 minutes for triage & 2 hours for assessment) (12/18) 2) Use of MSS to monitor times for triage and assessment (12/18) 4) Reallocation of doctors to areas with high waiting times if appropriate (12/18) 5) Reallocation of nurse to support triage nurse (12/18) 6) Bed meetings held 3 times a day everyday where status of Emergency Department is discussed with representatives of both Divisions to facilitate flow (12/18) 7) Monitoring staffing ratios and man-power plans regularly reviewed (12/18) 8) Acute Physician team available to support department from 10am until 21.30 every day (12/18) 9) UCC opened on 1st April 2016 and joint triage model in place. (12/18) 10) Powerpoint presentation around National ED standards included in new starters induction and within annual mandatory training sessions (12/18)	8) Acute Physician support continues to work well (12/18) 15) New starters are familiar with the department and its processes/ policies when they start (12/18) 4-5) Reallocation of staff working well to help reduce wait times during pressured times (12/18) 7,17) Reduced reliiance on agency staff. Locums used are long term locums (12/18) 16) Urgent treatment doctor is making an improvement to patients recieving appropiate emergency treatment (12/18) 18) Additional triage room has helped reduce triage wait times (12/18) 4) ACP's now included on the medical rota and trialled weekly (1/19) 1) Industry expert has undertaken intial scoping exercise (12/18) 8) Consultants work on busiest days - in place (1/19)	1, 2) Inability to achieve 2 hour assessment and 15 minute triage consistently (12/18) 4,5) Staff not always available to be reallocated (12/18) 6) Delays in ED linked to bed availability (12/18) 7) Medical and nursing vacancies and sickness/ annual leave resulting in gaps in rota. Link to risk 4496 and 2374 (12/18) 8) Consistently at 2 hour wait by evening (12/18) 9) UCC not impacting on pt numbers and delays in assessments (12/18)	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 1) Further work to be undertaken with Industry staff with view to reducing non admitted breaches 1) GIRFT Visit completed September 2018. Report received, Group Manager reviewing report (Winter pressures July completion date)	Feb-19 Feb-19 Feb-19 Jul-19	1 x 4 = 4 YELLOW	Jan-19	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 [12/18] 13) Medical and nurse staffing managed via the risk regsiter (risk 2374 & 4496) [12/18] 14) Nurse led RAT and SOP ratified and in place (12/18) 15) Where possible, newly qualified starters have their last student placement transferred to RWT ED [12/18] 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 [12/18] 17) Use of internal bank rather than locum agencies where possible [12/18] 18) Extra Triage room and escalation process in place [12/18] 19) Escalation tool developed and identifies pressure points with agreed action [12/18] 7) Appointed Specialty Doctor in November 18 (11/18) 1) GIRFT Visit to be reviewed by end of July (7/19)						

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?
				1) A management consultant from Industry will be coming at the beginning of February to look at flow in Minors (1/19)						
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. NHSI link NE's to lack of complete clinical records in ODP clinics. 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: awaiting Directorate level approval. There has been identification that the information included in hospital notes not available via clinical web-portal (Nov 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: 186645 - Unexpected Injury/Extravasation injury to neonate - removed from STEIS (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 Mar-19 1-2. Non-STEIS investigation being undertaken Datix: 185209 - approval process commenced/awaiting finalised report. Jan-19	2 x 2 = 4 YELLOW	Jan-19	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 [12/18] 1) Incidents reported and monitored through Datix. Datix emailed to appropiate leads and reviewed [12/18] 3) Referrals currently printed, completed and scanned in to be sent to secure email address [12/18] 4) One PC has been set up in base B for safeguarding referrals [12/18] 5) Safeguarding attend the department daily to identify any referrals overnight/ not communicated yet. Named Safeguarding support identified to support ED [12/18] 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 [12/18] 7) ED Safeguarding champions x 5 in place [12/18] 8) Monthly operational safeguarding meeting in place. Attended by champions + Matron [12/18]	1-18) Safeguarding incidents have decreased [01/19] 14) Electronic system in place for Paeds (01/19) 16) CPIS system now rolled out to Cannock (01/19). 1-18) Safeguarding referral form reduced to 5 pages (01/19)	3) Scanned documents are of a poor quality and information is not easy to read [01/19] 11) Paediatric and adults audit results have highlighted poor documentation [01/19] 9) Training records show that not all staff have received training (medical staffing are the major concern and clinical lead aware) [01/19] 14) No electronic system in place for adult safeguarding or DV referrals. There is one for Paeds but it is not fully electronic [01/19] 16) CPIS identifies under 18 who are on a plan however w-ton council are not currently live with this process [01/19] 11) Q2 audit results for safeguarding scored poorly for adults 50%. [01/19] 1-18) Wolverhampton Council have advised the e-referral system will not be in place for at least another 12 mths (01/19)	1-18) waiting for wolverhampton Council to set up live e-referrals. Original timeframe delayed significantly — Dec-19 1-18) HoN Div 2 to meet with Chief Nurse to discuss other options — Feb-19	1 x 2 = 2 GREEN	Jan-19	

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 [12/18] 12) Letters are being sent to the individuals involved in missed safeguarding incidents [12/18] 14) See and treat sheet includes paeds safeguarding proforma - used for patients coming through see and treat [12/18] 15) New training programme for new starters implemented [12/18] 16) CPIS system in place [12/18] 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 (Dec 18) 4) Establishment of workforce group to review/monitor use of medical locums/agency (Oct 16) Revised TOR Jan 19 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 2018) 6) Use of agency reported at Ops Finance + Finance + Performance meeting + directorates via the dashboard (Dec 2018) 9) Business cases being developed for overseas recuitment (Sept 18)	1-9) Significant decrease in Locum expenditure overall (Dec 18) 1-9) There has been no agency used in nursing for the last 13 months (Jan 19) 1-9) Achieved forecasted year end agency cap for April 18, new cap set for April 19 (Dec 18)	1-9) Locum expenditure has increased for some specialties (Dec 18) 6) Orthotist and 2 x Cardiac Investigations HCP in place (Dec 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	Mar-19 Mar-19 Mar-19 Mar-19 Mar-19 Mar-19	2 x 2 = 4 YELLOW	Jan-19	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 =	Jan-19	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. (Jan 2019) 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. (Jan 2019 1) & 2) Equipment replacement confirmed on capital replacement programme 18-19 (Jan 2019) 1) Equipment is due for replacement Q4 18-19 (Jan 2019)	1) Any breakdown causes disruption to the service offered to patients. Breakdowns encountered with CR readers 2; X-ray equipment 3 (Jan 2019) 2) No focus choice on mobile X-ray unit and reliance on ageing CR processing equipment (Jan 2019) 2) X-ray service will not be available if CR processing facilites fail (Jan 2019)	1) & 2) To continue to monitor any equipment breakdown 1) & 2) Replacement of equipment planned for 18/19	Mar-19 Apr-19	2 x 2 = 4 YELLOW	Jan-19	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) (Jan 2019) 4) Review meetings are happening fortnightly (Jan 2019) 1) Backlog has reduced from 7332 May 2017 to less than 3389 in Dec 2018 (Jan 2019) 3) Office space sourced (Jan 2019) 1) The backlog is actively monitored by Group Manager (Jan 2019)	1) Approximately 3386 non-urgent imaging studies unreported Dec 2018 (inclusive of 373 CT scans and 1080 MRI scans). Over 20 days there are 965 in total (inclusive of 131 CT scans and 359 MRI scans) (Jan 2019) 1) Poor patient experience if patients and doctors are unsure when their scans are reported (Jan 2019) 3), 4) & 5) Demand for reporting imaging studies is higher than expanded reporting capacity (Jan 2019)	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) Monitor outsourcing work and assess impact on reducing outstanding numbers 1,3,4 & 5) Continue to utilise waiting list initiatives	Mar-19 Feb-19 Feb-19	2 x 4 = 8 AMBER	Jan-19	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-clinical areas	Sep-19 Mar-19	2 x 1 = 2 GREEN	Jan-19	

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 (Dec 18) 2) The number of women booking at RWT is being monitored by Antenatal Payment By Results (PBR) Dec 18 3) 13/11/2017 Birth Activity capped (24/1/18) and reviewed Oct 18. Remain in place.	1) Predicted births/booking are recorded on the Maternity Dashboard, RAG-rated and discussed at monthly Governance & Risk Management meeting (5.12.18) 2) Close observation of activity in relation to number of predicted births (5.12.18) 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 (5/12/18)	1,2) Activity levels are variable and uncontrollable due to births occurring at varying gestations and women transferring in from other units (5.12.18)	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	Jan-19	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	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) 1-14) Prioritisation of urgent patients e.g ectopics from ward and EPAU (21/09/2018) 1-14) Patients may be admitted to ward if unable to perform scan and confirm diagnosis (21/09/2018) 1-14) Currently, due to the prioritisation of work, sonographers are attempting to perform scans within standards stipulated for babies and mothers.(21/09/2018) 11) Staff have worked additional hours on the enhanced rate (21/9/18) 1-14) 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) 1-14) Delayed diagnosis/treatment for patients and risk of mis-diagnosis (21/9/18) 1-14) 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) 11) 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) 1-14) There have been 50 cancelled EGAU slots since mid November (Dec 2018) 1-14) 6 EPAU clinics currently cancelled for October (impact - delayed diagnosis of ectopics and miscarriage and increase of ward referrals) (09/10/18) 1-14) 9 Gynae Fast Track appointments still outstanding (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 1. Out to advert for a bank sonographer and permanent sonographer	Feb-19 Jan-19 Oct-19 Feb-19	1 x 3 = 3 GREEN	Jan-19	

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) 12) Plans to train a nurse from EGAU to do scanning (Dec 2018) 13) Training 2 midwives to scan 3rd trimester scans (Dec 18) 14) Health & Safety assessment from Occupational Health undertaken (Dec 2018)	1-14) One agency sonographer who can only do 4 days throughout January and a second possible agency sonographer starting in January (Dec 18) 1-14) Still working weekend sessions to keep hip scans within 6 weeks (02.11.18) 1-14) Currently all Obstetric patients are being offered screening and Anomaly scans within the screening standard and no incidents have been reported (02/11/18) 1-14) Still covering Saturday clinics for hips and gynae scans but with the limited lists over Christmas and staff sickness and holiday (Dec 2018) 13) Midwives training should complete this in June 2019 (Dec 2018) 12) Nurse starts University in February 2019 (Dec 2018)	1-14) There has been no sonographer cover for 8 Emergency gynae clinics (impact - delayed diagnosis of ectopic and miscarriage and increase of ward referrals). (02/11/18) 1-14) There are no slots available for routine gynae before December and the few slots we have left in November will have to be prioritised for Fast Track and Obstetrics or Paediatrics (02/11/18) 1-14) One of the long term sonographers has started a graduated return to work on a limited basis , but another full time sonographer has gone off long term sick (Dec 2018) 1-14) No suitable applicants for the permanent and bank sonographer adverts (Dec 2018) 1-14) Currently have no available slots until the 10th January for urgent patients (Dec 2018) 1-14) Currently have 225 patients waiting for gynae scans in January (Dec 2018) 14) H&S Report awaited (Dec 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 =	Jan-19	

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	5112	If the 13% inexperienced staff on ICCU do not receive adequate support and educational input then they will not gain the experience to work unsupervised resulting in increased stress and sickness within the experienced staff population and potential patient harm. Date of Origin: Oct 18 Date of escalation: Dec 18 Risk Lead: Critical Care Group Manager	3 x 4 = 12 AMBER	1- 08/10/18 Band 8a Operational Nurse Manager in place 2- 08/10/18 All new starters have a supernumerary period of up to 6 weeks , adjusted to meet their individual needs 3- 08/10/18 All inexperienced ICCU staff have a 6 week intensive programme of clinical study days, supported by the PDN Team 4- 08/10/18 All inexperienced ICCU staff have a weekly documented review, with the PDN Team, to ensure that training needs are being achieved 5- 08/10/18 Each new member of staff is allocated to 2 experienced ICCU nurses for support during their supernumerary period 6- 08/10/18 Each new member of staff works 75% of their shifts on Monday-Friday days for 4 months to allow continued educational support 7- 08/10/18 Admin and Education Support post has been agreed to allow PDN team to focus on delivering clinical education and support 8- 08/10/18 All leavers have an exit interview - feedback from this is used to retain existing staff	1- 08/10/18 Band 8a Operational Nurse Manager in place has overall responsibility for the service 2, 3, 4, 5, 6- 08/10/18 PDN documentation and e-roster which prevents inexperienced staff being unsupported in patient care 6, 11, 12, 16, 17, 18 - 08/10/18 e-Roster resulting in a decrease in staff disatissfaction with their rostering 8, 10, 13, 14, 15 - 08/10/18 Meeting notes and minutes ,Datix reports have indicated that staff are aware that they are being listened to and their suggestions concisdered 7 - Education team have changed their training delivery method - this is now undertaken at the bedspace (Dec 2018)	9 - 07/12/18 - Some vacancies remain unfilled - further interviews scheduled for 17/12/18	9-08/10/18 Recruit to Band 6 and 7 posts 14- 08/10/18 Monitor Datix reports concerning shortages and skill mix	Jan-19 Oct-19	2 x 3 = 6 YELLOW	Jan-19	

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- 08/10/18 All staff vacancies are advertised and being recruited to 10- 08/10/18 Staff Feedback is encouraged via a 'You said, We did' Wall is in place 11- 08/10/18 Staff have individual rotation plans for CICCU and ICCU experience 12- 08/10/18 E-rostering is in place 13- 08/10/18 Divisional Management Team is aware of the current situation 14- 08/10/18 All staff are encouraged to raise concerns and complete Datix reports 15- 08/10/18 Staff meetings are held at all staff levels 16- 08/10/18 New staff are allocated across the unit to prevent any area being oversaturated with inexperienced staff 17- 08/10/18 Staff with less than 12 months experience have their own Team on e-roster 18- 08/10/18 A SOP is in place to ensure patient safety and accuracy when a request is made to a floor leader to move staff to another clinical area.						

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	5116	If the Critical Care Outreach Team (CCOT) is unable to support the hospital, then seriously ill and deteriorating patients will not receive the support they require, resulting in patient harm, or ICCU may experience avoidable admissions. Date of origin: Oct 18 Date of escalation: Dec 18 Risk Lead: Critical Care Group Manger	3 x 4 = 12 AMBER	2- (18-10-18) Current staffing model consists of: 1.0wte - Band 7, 4.29wte – Band 6, Vacancy = 0.21wte Band 6 3- (18-10-18) When there are gaps in CCOT staffing - a Bleep is held by ICCU staff 1 - (30.11.18) Recuitment plan in place	1. Active recruitment underway (Dec 18)	2. (18-10-18) Current staffing not sufficient to provide safe 24/7 service. Each episode is recorded on Datix 3. (18-10-18) This only provides telephone advice and not a physical assessment of the patient by an experienced ICCU nurse, each episode is recorded on datix 1. (30-11-18) Active recruitment underway however due to staffing constraints on ICCU, Outreach will be on occasions be pulled to support emergency capacity on the unit reulting in a loss of cover for CCOT (Dec 18) 1-3 (30-11-18) Sept-Nov 2018 = 15 shifts (12hr shifts) have had no Outreach cover (Dec 18)	1, 2 - Continue to recruit in line with business case	Jan-19	2 x 3 = 6 YELLOW	Jan-19	