The Royal Wolverhampton NHS Trust

CNO Governance Report including Trust Risk Register

1 April 2019

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	1st April 19
Title:	CNO Governance Report
Executive Summary:	Headlines contained in this report: 1. Trust Risk register progress update 2. Red incidents – Non SUI – nil to report 3. Serious Untoward incident (SUI) Performance 4. Information Governance work plan and risk 5. Governance staffing 6. Local Procedures Governance (inc Clinical Guidelines, Protocols etc) 7. Mortality returns 8. Learning and improvement 9. SUI Themes
Action Requested:	**Receive and note,**
For the attention of the Board	
Assure	• Sustained progress with SUI management – one breach to 60 day target in February19 has been submitted. • TRR updates requested monthly are improving • TRR risks are reviewed by operational Divisions, subject leads, Specialist groups and QGAC.
Advise	• A change to the Trust criteria for selecting deaths for the SJR process has reduced the total reviews that are due. Figures indicate that reviews are undertaken over and above the minimum criteria however not always covering the mandatory minimum; therefore follow up is in progress. • As part of preparation and compliance to CQC Well Led requirements, work has commenced to assess a compliance position and action plan. This includes establishing governance arrangements for local procedural documents, revisiting a communication plan for Trust Vision, Values and Objectives and Trust strategy alignment.
Alert	• Further review of the IG risk is underway to consider the final IG toolkit compliance due 31st Mar 19.
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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

Trust Risk Register Key Issues

4 new risks:

5069 - Fast Track Capacity (COO)

5182 - Lack of Network support for Vascular Services at RWT (MD)

5190 - ePMA downtime / outage issues (MD)

4382 - NX55 Main Theatres, Wards A12, A14, Admin, Plant Rooms) - Fire Safety (COO)

0 risks removed

7 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)

5088 - Fragility of SaTH service (COO)

5182 - Lack of Network support for Vascular Services at RWT (MD)

5190 - ePMA downtime / outage issues (MD)

There are currently 36 risks contained within the Trust Register which are distributed across the Trust's (5x5) categorisation matrix as below:

Likelihood	Consequence 1 Low	2	3	4	5 High
5 – Almost Certain					
4 – Likely			13 risks	5 risks	2 risks
3 – Possible			4 risks	11 risks	
2 – Unlikely			1 risk		
1 – Rare					

The full TRR is shown in appendix 1 and tracked changes to risks in Appendix 2.

A majority of risks have received updates in March 19, attention is required to the following (in addition to update received):
2719 COO – grade under threshold – confirm decision to remain on TRR
3644 CNO – grade under threshold – decision confirmed to retain on TRR for monitoring
4794 CFO – grade under threshold (confirm decision to remain on TRR), update required
4375 COO – dates needed for actions
4411 COO - dates needed for actions
5045 MD – dates needed for actions (or transfer to controls if completed/underway)
5190 COO – dates needed for actions
5116 COO – under grade threshold - (confirm decision to remain on TRR)
4955 – CFO – grade under threshold ((confirm decision to remain on TRR)), 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

Good performance on completion of SUI investigations to timescale. 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
Jan 19	22 (2)	9	7	8	0
Feb 19	20 (2)	4	6	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. Closure may relate to previous months.	Feb overdue report now submitted as at 4/3/19	Progress helped by a weekly focus on RCA due dates.

4. **Information Governance work plan**

Delivery of the Data Security Protection Toolkit (DSPT) following GDPR continues to be a challenge. The priority work plan remains in place however some work areas are unaddressed until further IG resource is recruited.

A successful IG Awareness week (21st Jan to 25th Jan) was delivered by the IG team across all sites. Further follow up sessions are planned throughout the year. The patient campaign also raised awareness for members of the public on GDPR.

Recruitment to the Band 6 role to support delivery of the priority plan is proving challenging. Two cycles of interviews have been unsuccessful in identifying staff with the required experience, so the post has gone out to advert again. It is unlikely that this resource will be in post until late summer, even if a successful applicant is found the third time around.
A risk graded Amber (12) has been identified re Capacity for IG/GDPR compliance (Datix 4769) and the impact on the IG regulatory and toolkit compliance. The risk grade remains the same until additional IG resources are in post and areas of work on the priority plan can be commenced.

February's focus has been conducting spot audits and ensuring teams self-assess with unannounced follow ups from the IG team. The focus for the March will be the DSPT toolkit submission and ensuring a robust submission for the Trust and the VI practices. At this stage the Trust is still in a position where all mandatory requirements have not been met, so work is on-going with leads across the Trust to ensure robust action plans are in place for a successful submission.
Work to ensure Brexit plans consider data sharing and GDPR continues, and the DPO is working with the Trust Brexit task and finish group as a work priority.

5. **Governance staffing**

Shortlisting in progress for the 2nd round of interviews for an Investigation and Learning Specialist. This role will support the RCA workload including investigation, learning and improvement. Recruitment also continues for Governance Officer, Information Governance and Health and Safety roles. Cover arrangements and prioritised work schedules are in place in these work areas.

6. **Local Procedures and Guidelines - Governance**

Progress to date is below:

- ❖ Divisional/Directorate SOP for Development of Local Procedures ratified at Policy Group on 1/3/19 and is attachment 11 of OP1 Development and Control of Trust Policy and Procedural Documents. OP1 inc att 11 will go to TMC for final approval on 22nd Mar.

- ❖ All 3 clinical Divisions/Directorates have been issued with lists of local procedural documents to validate/update local documents in use. Timescale for returns requested for end of Mar early April 19.
- ❖ The returns will inform a register and tracking system for local documents.
- ❖ Lead for Medical (Adult Medical Guidelines) and Nursing guidelines are being engaged to align with new local processes.
- ❖ New arrangements and process shared with Dr O (Adult Medical Guideline Lead) to align processes. All Adult Medical Guidelines must be ratified and approved at the speciality local Governance Meetings or locally approved Group prior to sharing/publication. The majority of these guidelines are included in the relevant Directorate registers.
- ❖ All user bulletin issued to communicate channels for publishing local procedures and guidelines onto the intranet.
- ❖ A central page for publishing local procedures and guidelines will be created when the new intranet is launched end of April 19.
- ❖ Work with prioritised Directorates/Depts continues:

- **Ophthalmology – Deferred by management request till later in the programme due to key staff absences.**
    - Directorate working to above timescale for register update.

- **Critical Care & Theatres**
    - Meetings planned with CC Governance Facilitator 6/3/19.

- **Paediatrics**
    - Meeting with Clinical Lead scheduled for 20th March to work on register.

- **Maternity**
    - Directorate working to above timescale for register update.

- **Emergency Department**
    - Directorate working to above timescale for register update.

- **Head and Neck**
    - Directorate working to above timescale for register update.

- **Dermatology**
    - Directorate working to above timescale for register update.

To date Rheumatology and Renal have returned updated local document lists. Several Directorate enquiries received indicating awareness and work in progress. Authors have been in touch about the new arrangements for publishing on the intranet and governance requirements for development and approval of local documents. This will be supported further by dissemination of the revised OP01 and local SOP following approval in March.

7. Mortality process

NB. Records of figures below are as at the 6th March and will change daily. SJR1 allocations for Feb 19 will be issued in after 11th Mar and are excluded from below.

SJR1 review process

For the period Sept 18 to January 19, 153 SJR1 reviews were allocated for review and 86 showing as outstanding to date (ie. 6/3/19). SJR1 reviews have routine monthly follow up with Mortality leads, via reports to QSIG and will be added to Directorate Integrated Governance Reports for redress.

For the period pre Sept 18, eight SJR1 reviews are outstanding. In addition to the routine monthly follow up, MRG chair emailed follow up to the Medical leads assigned to complete these reviews.

SJR1 judgements of overall care for Jan 19 indicate adequate and good care only.

SJR2 review process
For the period Sept 18 to Jan 19, ten cases have been referred for SJR2 (having triggered poor or very poor care). Follow up is established as for SJR1 process.

SJR2 judgements of overall care for Jan 19 indicate adequate as well as poor care outcomes.

The themes for improvement following SJR2 are consistent:

1. Recognition of the deteriorating patient
2. Documentation
3. Safeguarding
4. End of Life Care

With the addition of a **new theme**:

5. **Delays (of diagnostic procedures e.g. CT/X-Ray/ECG/Biopsy) -** This relates to 'delay' of various diagnostic procedures and does not highlight one area in particular.

A further drill down is needed to establish the causes behind these themes.

8. Learning and Improvement

A number of learning resources are under development.

a) A Learning Log – a central database of organisational learning. The log used to record themes and learning outcomes from various subjects (eg medication safety, complaints, claims, SUI, Inquests, mortality, safeguarding etc) The log is currently made available to subject leads via SharePoint for their update. Once collated the log will be made available via the intranet learning web page.
b) Learning webpage – a resource developed to specifically targets patient safety improvements. The pages include international, national and local learning. A number of links to external patient safety improvement webpages are provided along with links to external conference and learning events. The webpage is currently available (but under continuous development) via a link within the Governance Dept webpage - http://intranet.xrwh.nhs.uk/patient_safety_improvement/index.html The morality learning webpages will be linked to this site and vice versa. Wider communication throughout the organisation of this webpage is scheduled.
c) Patient safety review framework – is a learning evaluation framework being developed to investigate themes and assess improvements in the care environment. It's intended to be used in areas where repeat incidents/never events/ serious incidents are seen. This process reviews the strength of remedial actions previously identified, and tests for sustainable improvement/change. The scope may include patient safety culture evaluation, leadership and team effectiveness and may suggest more system wide recommendations. The document is in the consultation stage of development.

9. SUI themes

Work arising from the 17/18 themes is being addressed and includes the following:

- Results reporting – Wards/Depts are required to develop local Results Reporting SOPs by April 19. These are being collated within Divisions. Audit of compliance to local SOPs is planned for 19/20 Clinical audit programme. Red risk 4661 (re Results reporting) is monitored on the Trust Risk register with controls and actions.
- Local Procedures Governance – Refer item 6 above Local Procedures Governance
- Communication/Handover – Work planned to commence in Q1 19/20.

	• A review of SUI themes for 18/19 will be reported in July 19 and will incorporate any residual actions from the previous year.
Appendices	
	Appendix 1 - Trust Risk Register (TRR) Appendix 2 – Tracked changes to risks

Appendix 1 TRR

Appendix 2

Appendix 2: Tracked changes within Trust Risk Register (February 2019)

Lead Director	Risk	Risk Title	Field updated	Update made
Chief Operating Officer	5082	Neonatal Workforce and Activity		
			New risk	There is a risk to the quality and safety of care delivered to babies on Neonatal Unit due to unpredictable levels of neonatal activity from within the Trust, South Staffordshire and Black Country Neonatal and Maternity Network (SSBCNMN) and wider national demands for tier 3 neonatal cots. This is compounded by vacancies following the establishment review / establishment recently funded to meet British Association of Perinatal Mortality (BAPM) standards. If, this is not resolved, then it could result in suboptimal care and potential increased mortality, together with unsafe staffing level leading to high staff stress and sickness levels, a poor reputation and inability to recruit and retain staff.
	4661	Lack of robust system for review and communication of test results		
			Gap in Assurance - **New**	As at 31st Dec 18 21% of Pathology and Radiology results were filed and 79% unfiled.
	4411	NX08/NX09 McHale Building - Fire Safety		
			Positive Assurance – **New**	0 incidents relating to Reportable Fire's within Jan 19
			Positive Assurance – **New**	0 Unwanted Fire Signals within Jan 19
	4903	Risk of non-compliance with Thoracic Service Specification		
			Risk Level now **downgraded**	Was RED now AMBER
	4547	Safeguarding		
			Positive Assurance – **New**	Concerns escalated to Trust Board and National Safeguarding Board

			Action Plan - **New**	Review medical/nursing establishment once Safeguarding requirement is ascertained
			Action Plan - **New**	HoN Div 2 and ED Matron to discuss how to maximise the effectiveness of the Safeguarding Champions role in ED
	4472	Delays in Cubicle Assessment and Triage		
			Gap in Assurance - **New**	Procurement delays re Zone B development
			Gap in Assurance - **New**	Significant increase in ambulance numbers in month
	4756	Increased Activity in Relation to Forecasted Number of Births		
			Positive Assurance – **New**	The booking cap and out of area requests for births is still active
	4375	NX87 Heart Centre - Fire Safety		
			Positive Assurance – **New**	0 unwanted fire signals during Jan 19
			Positive Assurance – **New**	0 incidents relating to Reportable Fire's within Jan 19
	2080	Risk to quality of patient care: reduced manpower		
			Positive Assurance – **New**	10 Clinical Nurse Fellow posts recruited to
			Positive Assurance – **New**	Business case for overseas recruitment approved
			Action Plan - **New**	Implement plan for overseas recruitment in the Philippines
	4599	Emergency Services Governance Arrangements		
			Positive Assurance – **New**	2nd Matron post appointment made - expected start date April 19
	4596	QS104 - Gallstone Disease		
			Gap in Assurance - **New**	No identified rota for surgeons who will operate
			Action Plan - **New**	All day HGB list available from 26.02.19 - Rota to be devised to ensure full utilisation.
			Action Plan - **New**	Additional recruitment and training of staff for another half day list per

				week
	4761	Cardiothoracic Surgical / Anaesthetic vacancies		
			Positive Assurance – **New**	No vacancies for cardiothoracic surgery at present
			Gap in Assurance - **New**	Anaesthetics - x4 vacancies - delays on getting paperwork, GMC through since July 2018
			Gap in Assurance - **New**	Cardiothoracic surgery vacancy from 1st March 2019
	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 - 90% for full completion in Jan 2019
			Gap in Assurance - **New**	Monthly monitoring and compliance with WHO checklist use - There has been 80% compliance achieved during Jan 19
			Action Plan - **New**	Implementation of action plan following NE Leicester Conference
	5031	Potential Non Compliance with The Fetal Anomaly, Paediatric Hips, Downs Pataus, Edwards screening standards		
			Positive Control – **New**	Agency Sonographer started on the 07.01.19 0.8 WT
			Positive Assurance – **New**	No EPAU clinics cancelled since 07.01.19
			Positive Assurance – **New**	2 Sonographers have now returned to work (1 on graduated return)
			Positive Assurance – **New**	Weekends being utilised to catch-up on Gynae and Hip scans
			Action Plan - **New**	Re-advertise for permanent sonographers
	5088	Fragility of SaTH service		
			New risk	If the fragility of neighbouring Trusts leads to a reduction of service provision by them and the need for RWT to provide support, then this will significantly impact on RWT capacity. This will result in increased pressure within ED, as well as the wider Trust, leading to compromised patient care and increased staff stress.

Chief Nursing Officer	3644	If the Trust fails to sustain improved compliance with CQC standards the rating of Good will could decline and progress will not be made towards Outstanding.		
			Risk Description - **altered**	Was - Failure to make an improvement in compliance gaps with CQC
			Action Plan - **New**	CQC Well Led gap analysis and action plan in development
			Action Plan - **New**	Launch quality of nursing care
	2952	Patient developing a pressure ulcer due to inadequacies of pressure ulcer prevention equipment		
			Positive Control – **New**	The tender process was completed mid -Dec 2018, and following the required period, a contract has been offered to an alternative service supplier. The new service will be commencing on 1st April 2019.
Medical Director	5045	Sepsis		
			Positive Control – **New**	Two sepsis nurses have been recruited (1 band 7 and 1 Band 6)
			Action Plan - **New**	Rolling out Vital Pac with sepsis module incorporated into it on 26 th Feb 2019. Following the roll out we plan to audit our sepsis performance in 3 month's time
			Action Plan - **New**	Consolidate sepsis awareness across the trust with the help of newly appointed sepsis nurses.

The Royal Wolverhampton NHS Trust

Trust Risk Register

March-2019

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 Risk Lead	Cross Ref ID	What is the Risk? Principal Risk	Current Level of Risk	How are we managing the risk? Controls	Evidence that it is working. Positive Assurances	Any Evidence that it is not working. Gaps in Assurance/Control	What else can we do? Action Plan that addresses Gaps in Control		Risk after actions Residual Risk Level	Date Last Reviewed	TB Accept Risk?
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	Mar-19	Yes

Director	Cross Ref	What is the Risk?	Current 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. (07.02.19) Hot gallbladder list to be introduced with effect from 26/02/2019 (1 day per week)	1. (05.07.18) Patients are presenting with complications of gallstones 1. (05.07.18) Local audit showing recurrent admissions 1-3 (05.10.18) Highlight as a 'service at risk' to Division and as part of Medical Workforce Report 1-3 (05.10.18) Unable to appoint to the 3rd UGI Consultant post 1. (19.1.19) No identified rota for surgeons who will operate	(25.01.19) All day HGB list available from 26.02.19 - Rota to be devised to ensure full utilisation. (25.01.19) Additional recruitment and training of staff for another half day list per week	Feb-19 Mar-19	2 x 2 = 4 YELLOW	Mar-19	Yes

Director	Cross Ref	What is the Risk?	Current 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	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 (5/3/19) 2) Review of Governance work streams at the Divisional Governance meetings, incuding NICE, External guidance, Audit, Risk (5/3/19) 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 (5/3/19) 4) Performance meetings in place (5/3/19) 5) Directorate Governance meeting in place and attended by Directorate Management Team (5/3/19) 6) Staff member identified to provide Governance support 2 days per week (5/3/19) 7) Process in place to review re-attendances for potential SUI's proactively (5/3/19) 8) Ongoing recruitment (links to risk 2374 (medics) and 4496 (nursing) [5/3/19] 9) Governance pre meets in place (5/3/19) 10) Incident reporting and governance covered as part of junior doctors induction [5/3/19]	1) Bd7 nursing forums taking place regularly and working well (03/19) 3) Local audit around documentation of senior review and ECG is showing good compliance (03/19) 8) Quality Improvment Lead appointed to - await start date (03/19) 8) 2nd Matron has started in post (03/19) 3) Reviewed weekly by Clinical lead in the Consultants meeting and Documentation review done by Junior Doctor's mentors(03/19)	3) Some actions not relating to ED are taking a considerable amount of time to implement/ close (03/19) 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 (03/19) 7) No agreed process in place within ED other than GO supporting, to ensure re-atteners report is reviewed in the absence of governance lead - risk accepted (03/19) 12) Historic incidents under review (03/19) 2) Backlog of unnaproved incidents remains static (03/19)	12) Governance lead to review and close historic incidents	Apr-19	2 x 3 = 6 YELLOW	Mar-19	Yes

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

Director	Cross Ref	What is the Risk?	Current 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 [5/3/19] 12) Band 7s to pick up incidents so Governance lead can focus on true incidents [5/3/19] 13) Substantive consultant establisment to 5 paeds and 9 adults (with 2 additional locums) [5/3/19] 14) HOT reporting of radiological results in place (5/3/19] 15) 1-13 New post for Quality and Compliance advertised - interviews to take place next week Friday(5/3/19) 16) Matron interviews taken place and appointment made and has commenced position (5/3/19)						

Director	Cross Ref	What is the Risk?	Current 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: 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 (20/02/19) 1-3 Training of ACCP's continues and will take a further 18 months (20/02/19)	1 & 2. Anaesthetics - x4 vacancies - delays on getting paperwork, GMC through since July 2018 (20/02/19) 1. Cardiothoracic surgery vacancy from 1st March 2019 (20/02/19) 2. ACCP's x2 being trained, training will take a further 12 months to complete (20/02/19)	2. Training of ACCP's	Aug-19	2 x 3 = 6 YELLOW	Mar-19	

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

Director	Cross Ref	What is the Risk?	Current 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	Apr-19	x =	Mar-19	

Director	Cross Ref	What is the Risk?	Current 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?	Current 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 (Feb 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	Mar-19	Yes

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

Director	Cross Ref	What is the Risk?	Current 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							
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	Feb-19	Yes

Director	Cross Ref	What is the Risk?	Current 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	3 x 4 = 12 AMBER	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 (20/02/19) 5. Consultant Thoracic Surgeon recruited and in post (20/02/19) 5. Locum in post and contract has been extended for a further 6 months (20/02/19) 1-4 Continue to approach other Trusts for referrals (20/02/19) 1-4 Walsall plan to agree SLA with RWT (20/02/19)	1. Referrals have not increased, this has been escalated to DCOO and COO (20/02/19)	1-4 Divisional Management Team to meet with Directorate to discuss progress 1-4 Plan further approaches to Walsall Hospital	Mar-19 Mar-19	1 x 5 = 5 YELLOW	Mar-19	

Director	Cross Ref	What is the Risk?	Current 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	Feb-19	

Director	Cross Ref	What is the Risk?	Current 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	Mar-19	Yes

Director	Cross Ref	What is the Risk?	Current 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 (03/19) 1) Proactive recruitment approach continuing (03/19) 1-10) Monthly workforce group reviewing nurse recruitment and retention (03/19) 1) 54.87 wte trained nursing vacancies remain, 40.65 roles offered, but not in post (03/19) 1) Nursing strategy rolled out (03/19) 1) Continued recruitment to nursing clinical fellows (03/19) 1) Stall at national nurse recruitment event on 12/03 (03/19) 1-10) D.Edwards in place as Matron lead of Clinical Nurse Fellowship (03/19)	8) Insufficient RN's available on Bank, backfilled by HCA (03/19) 1) Nationallly we are an outlier re safe staffing levels (03/19) 1) Recruited staff are newly qualified which can lead to mentorship and training pressures (03/19) 1) Majority of wards are 'Amber' re safe staffing levels on daily basis (03/19) 3) Issue in relation to ability to provide accurate staffing figures (03/19) 3) Breaches in minimum safe staffing levels (03/19) 3) Significant nursing shortages on C16, new ward mgr moved to C16 temporarily. Re-organisation of management of area (03/19)	1) Continue with proactive recruitment approach 1) UK recruitment for Clinical Nurse Fellow posts - ongoing recruitment 1) Implement plan for overseas recruitment in the Phillipines via Skype	Apr-19 Apr-19 Apr-19	4 x 3 = 12 AMBER	Mar-19	Yes

Director	Cross Ref	What is the Risk?	Current 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 (Dec 2017) 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	Mar-19	Yes

Director	Cross Ref	What is the Risk?	Current 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**

Director	Cross Ref	What is the Risk?	Current 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	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. There is a risk of increased pressure ulcer incidents due training needs associated with the switch of community equipment providers for provision of pressure ulcer prevention equipment from 1st April 2019 (ordering process, correct use of equipment and process for escalation of faulty equipment). 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 3) A £55,000 budget for the out-of-hours pressure relieving mattress service in Community (Dec 18) 4) SLA in place with Independent Living Service and monitored (Dec 18) 5) ILS service community equipment supplied by them on return (Dec 18) 6) 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 7) Process in place to reassess patients on Symmetrikit Chairs (OT posture managment Chairs) Dec 18 8) 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) 2,3,4,5,6,8) 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) 8) Adult community services collating a report to submit to the CCG regarding mattresses delivery and fault management delays (Dec 18) 6)Individual funding requests approved or declined by CCG. 7) OT issue advise patient/carer when prescribing to escalate to GP if needs change. At the prescribing stage this is confirmed in writing to the GP from OT. 11) There is a CCG contracting project team that monitors the outcomes of the Night comfort service	6) RWT is not resourced to follow processes for specialist equipment request/order (Dec 18) 8) High demand on mattresses from ILS, no assurance on timely delivery (Dec 18) 8) Delays in delivering equipment from ILS (Dec 18)		1 x 3 = 3 GREEN	Mar-19	

Director	Cross Ref	What is the Risk?	Current 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) The tender process was completed mid -Dec 2018, and following the required period, a contract has been offered to an alternative service supplier(Drive -DeVilbiss Healthcare). The new service will be commencing on 1st April 2019. (March 2019) 10) Adult Community Services collate trends of failed deliveries and fault management of mattresses to submit via contracting to the CCG re filed attempts for delivery or repairs monthly. (March 2019) 11) Night comfort service accessible from Nov 2018 by Adult Community Services -ongoing monitoring of service.(March 2019) 12)ILS are sending a patient information letter to all households that have pressure ulcer prevention equipment. (March 2019). 13) RWT are working with Drive and CCG to facilitate the transition process from old to new supplier. (March 2019) 14) Through liaison the TV team, the new supplier (Drive) will send communications to RWT to advise on switch which dicused standard bed sizes only.						

Director	Cross Ref	What is the Risk?	Current 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 - 7 months (Feb 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) 3. Monthly monitoring data of compliance with WHO checklist and Procedural Safety Checklist - 90% for full completion in Jan 2019 (Feb 19)	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 3. Revamp/refresh the WHO Checklists 1-13 Implementation of action plan following NE Leicester Conference	Mar-19 Mar-19 Mar-19 Mar-19 Apr-19	2 x 4 = 8 AMBER	Mar-19	Yes

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

Director	Cross Ref	What is the Risk?	Current 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 and compliance with WHO checklist use - There has been 80% compliance achieved during Jan 19 (Feb 19)				

Director	Cross Ref	What is the Risk?	Current 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 sustain improved compliance with CQC standards the rating of Good could decline 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 (Mar 19) 3) Monitor monthly performance through the nursing midwifery KPIs reported to QSIG (Mar 19) 4) Environmental Standards are monitored via the environmental group monthly (Mar 19) 6) Daily staffing (safe staffing, Skill mix) is monitored via the Divisional ops meetings (Mar 19) 8) Fundamental standards are reviewed & monitored by the designated specialist groups and bi annually by the sponsor which then reports to COG (Mar 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 (Mar 19) 12) Mortality QI plan is monitored via Programme Board monthly and learning outcomes via MRG (Mar 19) 11) EOL strategy with TOR has been developed and milestones monitored via the EOL group monthly (Mar 19) 13) Monitoring of the Nursing System Framework monthly via TMC (Mar 19)	Nursing and Midwifery KPIs are on Health Assure reporting and emailed out to ward sisters/matrons and HoNs monthly. (Mar 19) QRV process is now embedded and refined, plan formulated for ongoing inspections 2019/20 (Mar19) Lord Carter metrics monitored monthly via Divisional Performance meetings (Mar 19) Nursing vacancies are at 34WTE with 85.71 WTE waiting to start. the posiiton is maintained compared to November (Mar 19) Divisions monitor performance via monthly Governance meetings (Mar 19)	Vacancy rates remain high in some areas (Mar 19) Phase 1 skill mix review for Adult inpatients shows a deficit (Mar 19) Safer staffing fill rates remain transient particularly for nights (Mar 19) Rising Mortality HSMR and SHMI rates are being reported in National data sets (Mar 19) 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 (Mar 19) Sickness absence has seen an increase over Summer 2018 in the Nursing workforce (Mar 19) 1) Nursing audit data to assure quality is not available until March 2019 (Mar 19)	mplement Safer Care Software and roll out Refurbishment and expansion of existing Discharge Lounge mplementation and roll out of NEWS 2 Launch quality of nursing care audits (Feb 19)	Mar-19 Apr-19 Mar-19 Mar-19	2 x 2 = 4 YELLOW	Mar-19	Yes

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

Director	Cross Ref	What is the Risk?	Current 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) Monitoring via Quality review visit and re-visit programme to assess CQC compliance (Mar 19)						

Director	Cross Ref	What is the Risk?	Current 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: Head of Nursing - Division 1	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) 1.42.19 WTE vacancies of which 17.83 have been offered and await start dates. Leaving 24.36 WTE vacancies. Further business cases have been approved for additional staffing resulting in more positions to be recuited to (Feb 19) 15. Bay opens periodically throughout the week as staffing allows for ambulatory trauma patients (Feb 19) 1. Successful recruitment day - 15 offered further 27 to be offered an interview (Feb 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 15. Skill Mix reviews taking place including assessment of workforce required to open closed beds on A6	Mar-19 Apr-19 Apr-19 Apr-19	2 x 2 = 4 YELLOW	Mar-19	Yes

Director	Cross Ref	What is the Risk?	Current 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) 15. Plans being worked up to utilise closed bay on Ward A6 (Feb 19)						

Director	Cross Ref	What is the Risk?	Current 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 Feb 2019 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) Break-glass over-ride facility for 3rd floor installed to enable lifts to be used in the event of an evacuation. 1-10) Construction work underway in removing ACM cladding. Approx 50% has been removed 4) WMFS Informed of progress with regards to removal of ACM Cladding	9) Outstanding fire stopping required following compartmentation survey 10) 2 unwanted fire signals during Feb 2019 (HPV & Cooking on ward)	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	Mar-19	

Director	Cross Ref	What is the Risk?	Current 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	4382	NX55 (Main Theatres, Wards A12, A14, Admin, Plant Rooms) - Fire Safety: As a consequence of shortfalls in structural fire protection (including fire alarm), fire could spread uncontrolled through wards and departments, compromising life safety. Date of Origin: 09/12/2015	3 x 4 = 12 AMBER	1. Statutory fire alarm testing (weekly), fire damper testing (annual) 2. Departmental Fire Risk Assessments undertaken. Main Theatres frequency increased to 6 monthly due to risk 3. Statutory Planned Preventative 4. Bespoke Fire Warden Training 5. Additional Fire Exercises and Drills 7.Revised Management of External Waste in the Compound 6. Departmental Fire Warden Daily Checks undertaken	1. 0 Unwanted Fire Signals within January 2019 1. 0 incidents relating to Reportable Fire's within January 2019 3. Fire strategy has been approved and money set aside.	2. Compartmentation Survey to be completed 3. Operational issues have meant the fire strategy work will take longer to complete with some work on hold 1. Fire alarm & ancilliary systems do not comply with current regulations	1. monitor and work towards completion of fire stategy for block	2 x 2 = 4 YELLOW	Mar-19	

Director	Cross Ref	What is the Risk?	Current 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 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 Feb 19 1. 0 incidents relating to Reportable Fire's within Feb 19 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 4. Environmental Audit Group carry out 3 monthly audits of Tugway		2. Departmental Business Continuity Plans need to be updated 4. Tugway Safety Environmental Audit Group monitoring action plan	2 x 2 = 4 YELLOW	Mar-19	

Director	Cross Ref	What is the Risk?	Current 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) (6/3/19) 2) Use of MSS to monitor times for triage and assessment (6/3/19) 4) Reallocation of doctors to areas with high waiting times if appropriate (6/3/19) 5) Reallocation of nurse to support triage nurse (6/3/19) 6) Bed meetings held 3 times a day everyday where status of Emergency Department is discussed with representatives of both Divisions to facilitate flow (6/3/19) 7) Monthly review with Recruitment and Finance department of staffing ratios and man-power plans (6/3/19) 8) Acute Physician team available to support department from 10am until 21.30 every day (6/3/19) 9) UCC opened on 1st April 2016 and joint triage model in place. (6/3/19) 10) Powerpoint presentation around National ED standards included in new starters induction and within annual mandatory training sessions (6/3/19)	8) Acute Physician support continues to work well (03/19) 4-5) Reallocation of staff working well to help reduce wait times during pressured times (6/3/19) 15) Urgent treatment doctor is making an improvement to patients recieving appropiate emergency treatment (03/19) 17) Additional triage room helping to reduce triage wait times (03/19) 4) ACP's now included on the medical rota and trialled weekly (03/19) 18) Work has started on the Paeds waiting room (03/19) 14) Nurse led RAT has improved timeliness of triage (03/19)	1, 2) Inability to achieve 2 hour assessment and 15 minute triage consistently breaches mainly in minors (03/19) 4,5) Staff not always available to be reallocated (03/19) 7) Medical and nursing vacancies and sickness/ annual leave resulting in gaps in rota. Link to risk 4496 and 2374 (03/19) 8) Consistently at 2 hour wait by evening (03/19) 9) UCC minimum impact on pt numbers and delays in assessments (03/19) 1) Significant increase in ambulance numbers in month (03/19) 7) Continued use of long term locums (03/19)	7)Continue with recruitment of medical staff - ECIP tool has identified need for more staff in the morning 3) 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) monitoring actions through Governance meetings	Mar-19 Mar-19 Jul-19	1 x 4 = 4 YELLOW	Mar-19	Yes

Director	Cross Ref	What is the Risk?	Current 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 [6/3/19] 12) Medical and nurse staffing managed via the risk regsiter (risk 2374 & 4496) [5/3/19] 13) Nurse led RAT and SOP ratified and in place (5/3/19) 14) Where possible, newly qualified starters have their last student placement transferred to RWT ED [5/3/19] 15) 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 [5/3/19] 16) Use of internal bank rather than locum agencies where possible [5/3/19] 17) Extra Triage room and escalation process in place [5/3/19] 18) Escalation tool developed and identifies pressure points with agreed action [5/3/19] 19) Appointed Specialty Doctor in November 18 (5/3/19) 20) GIRFT Visit to be reviewed by end of July (7/19)						

Director	Cross Ref	What is the Risk?	Current 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?
				3) A management consultant from Industry visited the Trust at the beginning of February to look at flow in Minors awaiting feedback (6/3/19) 21) Every member of staff has additional training 1 day per year (6/3/19)						
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/Badgernet information then clincians will only have access to an incomplete health record 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 OPD 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 16) 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) 3. Badgernet System in place in Maternity (Feb 19)	1) No continuous Datix incidents (July 18) 3) Badgenet System embedded within the Maternity department (Feb 19) 2) Procedures in place to access paper records/request scanning of records onto portal (Feb 19)	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) 3) Restricted access to the Badgernet System - no immediate access to Maternity notes (Feb 19)	1-2. Monitor ongoing incidents May-19 1-2. Non-STEIS investigation being undertaken Datix: 185209 - awaiting Division 3 (Paediatric approval) Feb-19 3. Head of Midwifery to review the access permissions to Badgernet for Divisional Medical Director and Governance Manager Mar-19	2 x 2 = 4 YELLOW	Mar-19	Yes

Director	Cross Ref	What is the Risk?	Current 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 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] 9) Letters are being sent to the individuals involved in missed safeguarding incidents [12/18]	1-18) Safeguarding incidents have decreased [03/19] 14) Electronic system in place for Paeds (03/19) 16) CPIS system now rolled out to Cannock (03/19). 1-18) Safeguarding referral form reduced to 5 pages (03/19) 1-18) Concerns escalated to Trust Board and National Safegaurding Board (03/19) 7) Work continues towards amending the rota to allow 1 Safeguarding Chmpion on each shift (03/19)	3) Scanned documents are of a poor quality and information is not easy to read [03/19] 15) Training records show that not all staff have received training (medical staffing are the major concern and clinical lead aware) [03/19] 14) No electronic system in place for adult safeguarding or DV referrals. There is one for Paeds but it is not fully electronic [03/19] 16) CPIS identifies under 18 who are on a plan however w-ton council are not currently live with this process [03/19] 16) Wolverhampton Council have advised the e-referral system will not be in place til Dec 19 (03/19)	1-18) waiting for wolverhampton Council to set up live e-referrals. Original timeframe delayed significantly 1-18) Review medical/nursing establishment once Safeguarding requirement is ascertained 1-18) Safeguarding champions to identify process to identify any missed referrals in a timely manner	Dec-19 May-19 May-19	1 x 2 = 2 GREEN	Mar-19	

Director	Cross Ref	What is the Risk?	Current 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) See and treat sheet includes paeds safeguarding proforma - used for patients coming through see and treat [12/18] 11) New training programme for new starters implemented [12/18] 12) CPIS system in place [5/3/19] 13) Medical staff training reviewed and now includes level 3 [08/18] 14) Safeguarding training included at induction and more dates available for staff [08/18]						

Director	Cross Ref	What is the Risk?	Current 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 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	2 x 2 = 4 YELLOW	Mar-19	Yes

Director	Cross Ref	What is the Risk?	Current 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) Policy implemented 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) As at 31st Dec 18 21% of Pathology and Radiology results were filed	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) As at 31st Dec 18 79% of Pathology and Radiology results were unfiled. (Feb 19) 6) As at 31st Jan 19, 20% of Pathology and Radiology results were filed which has slightly reduced from Dec 18 report; and 80% of Pathology and Radiology results were unfiled.(Mar 19)	1-4) Local SOPs for results reporting required from all areas with mandatory reviewing and filing of results with audit of compliance by Directorate and Consultant. Aim is to achieve full compliance with viewing and filing. 6) Work is underway to trial the uploading of the "formal" histopathology reports into the ICE system. If successful it may be possible to start to upload all histopathology reports in the future. Timescale is to be confirmed - review/update monthly.	Apr-19 Apr-19	x =	Mar-19	Yes

Director	Cross Ref	What is the Risk?	Current 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 2018) 4) Access to DR Mobile should CR systems fail (Feb 2019)	1) & 3) Breakdowns are usually fixed under a 'fix as you go' contract. (Mar 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. (Mar 2019 1) & 2) Equipment replacement confirmed on capital replacement programme 18-19 (Mar 2019) 1) Equipment is due for replacement Q4 18-19 (Mar 2019) 4) There is a DR Mobile Unit at CCH should CR Processing systems fail (Mar 2019)	1) Any breakdown causes disruption to the service offered to patients. Breakdowns encountered with CR readers 3; X-ray equipment 9 (Mar 2019) 2) No focus choice on mobile X-ray unit and reliance on ageing CR processing equipment (Mar 2019) 2) X-ray service will not be available if CR processing facilites fail (Mar 2019) 1) Since Jan 2018 there have been a 4 radiation incidents involving exposure of patients as a result of equipment faults associated with ageing equipment externally reported to CQC IR(ME)R as systemic failure (Mar 2019)	1) & 2) To continue to monitor any equipment breakdown 1) & 2) Replacement of equipment planned for 18/19 4) DR Mobile to be made ready for use, training programme rolled out and ensure all staff are proficient with use	Jun-19 Jun-19 Jun-19	2 x 2 = 4 YELLOW	Mar-19	Yes

Director	Cross Ref	What is the Risk?	Current 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) (Mar 2019) 4) Review meetings are happening fortnightly (Mar 2019) 1) Backlog has reduced from 7332 May 2017 to less than 2974 in Feb 2019 (Mar 2019) 3) Office space sourced (Mar 2019) 1) The backlog is actively monitored by Group Manager (Mar 2019)	1) Approximately 2974 non-urgent imaging studies unreported Feb 2019 (inclusive of 474 CT scans and 896 MRI scans). Over 20 days there are 502 in total (inclusive of 84 CT scans and 174 MRI scans) (Mar 2019) 1) Poor patient experience if patients and doctors are unsure when their scans are reported (Mar 2019) 3), 4) & 5) Demand for reporting imaging studies is higher than expanded reporting capacity (Mar 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	Jun-19 Jun-19 Jun-19	2 x 4 = 8 AMBER	Mar-19	Yes

Director	Cross Ref	What is the Risk?	Current 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	Mar-19	

Director	Cross Ref	What is the Risk?	Current 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 (1.2.19) 2) Close observation of activity in relation to number of predicted births (1.2.19) 3) The booking cap and out of area requests for births is still active (1/2/19)	1,2) Activity levels are variable and uncontrollable due to births occurring at varying gestations and women transferring in from other units (1.2.19)	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	Mar-19	Yes

Director	Cross Ref	What is the Risk?	Current 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 (30/1/19) 1-3) The Antenatal Screening Coordinator (Midwife) has not received any notifications from any community midwives to inform of a delay in scan (30/1/19) 1-15) Prioritisation of urgent patients e.g ectopics from ward and EPAU (30/1/2019) 1-15) Patients may be admitted to ward if unable to perform scan and confirm diagnosis (30/1/2019) 1-15) Currently, due to the prioritisation of work, sonographers are attempting to perform scans within standards stipulated for babies and mothers.(30/1/2019) 11) Staff have worked additional hours on the enhanced rate (30/1/19) 1-15) Currently all Obstetric patients still being offered screening and Anomaly scans within the time standard (30/1/19)	1-4) Datix incident reports have been received concerning staff shortages resulting in no scan service in the EPAU - none received since 07.01.19 (30/01/19) 1-15) 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 (30/1/2019) 11) Whilst staff have worked some additional hours on the enhanced rate of pay there are still significant gaps within the scan service (30/1/19) 1-15) There have been 50 cancelled EGAU slots since mid November (30/1/19) 1-15) 9 Gynae Fast Track appointments still outstanding (30/1/19) 1-15) There has been no sonographer cover for 8 Emergency gynae clinics (impact - delayed diagnosis of ectopic and miscarriage and increase of ward referrals). (30/1/19) 1-15) 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 (30/1/19)	1) Increase staffing of sonographers in main scan — Apr-19 2) Resolve HR issues — Apr-19 3) Training for x2 Midwife sonographers 0.4WTE 3rd Trimester scans — Oct-19 1) Re-advertise for permanent sonographers — Apr-19	1 x 3 = 3 GREEN	Mar-19	

Director	Cross Ref	What is the Risk?	Current 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) 15) Agency Sonograher started on the 07.01.19 0.8 WTE (Jan 2019)	1-15) One agency sonographer who can only do 4 days throughout January and a second possible agency sonographer starting in January (30/1/19_ 1-15) Still working weekend sessions to keep hip scans within 6 weeks (30.1.19) 1-15) Currently all Obstetric patients are being offered screening and Anomaly scans within the screening standard and no incidents have been reported (30/1/19) 1-15) Still covering Saturday clinics for hips and gynae scans but with the limited lists over Christmas and staff sickness and holiday (30/1/19) 13) Midwives training should complete this in June 2019 (30/1/19) 12) Nurse starts University in February 2019 (30/1/19) 1-15) No EPAU clinics cancelled since 07.01.19 (30/01/19) 1-15) 2 Songraphers have now returned to work (1 on graduated return) (30/01/2019) 15) Weekends being utilised to catch-up on Gynae and Hip scans (30/01/19)	1-15) 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 (30/1/19) 1-15) No suitable applicants for the permanent and bank sonographer adverts (30/1/19) 1-15) Currently have no available slots until the 10th January for urgent patients (30/1/19) 1-15) Currently have 225 patients waiting for gynae scans in January (30/1/19) 14) H&S Report awaited - no report received as yet (30/1/19)				

Director	Cross Ref	What is the Risk?	Current 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. 5) Two sepsis nurses have been recruited (1 band 7 and 1 Band 6) (Feb 19)	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 VITAL PAC with sepsis module will be rolled out/implemented on 26 th March 2019. It will deliver comprehensive functionality to identify, risk-stratify and audit the delivery of appropriate care for patients with potential sepsis. Consolidate sepsis awareness across the trust with the help of newly appointed sepsis nurses. Conducting regular sepsis compliance audits in ED, Inpatients, Haemat-oncology, Paediatrics and Obstetrics. The results of these are fed back to the DPG monthly. Regular QIP projects to improve the delivery of sepsis screening, awareness and antibiotic delivery within an hour in patients with sepsis or suspected sepsis. This will also help identify any barriers that influence the uptake of the sepsis screening.	Mar-19 Mar-19	x =	Mar-19	

Director	Cross Ref	What is the Risk?	Current 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	5069	If there is insufficient workforce capacity to meet Fast Track demand then patients will not be seen within two week timeframe as per policy resulting in Cancer target breaches and delay in diagnosis and treatment. Date of Risk: 19/07/2018 Accepted onto Divisional RR: 16/11/2018 Accepted onto Trust RR: 15/02/2019	4 x 3 = 12 AMBER	1) Department receives daily reports re outstanding FT patients that cannot be booked within two weeks - governance lead reviews and identifies what additional FT clinics are required then contacts Consultants for availability (July 18) 2) Ad hoc establishment of additional clinics (WLI) (July 18) 3) Nursing resource allocated to support additional clinics - using bank where necessary (e,g. substantive staff sickness) (Nov 18) 4) Weekly Dermatology PTL meeting with MDT Co-ordinator to review capacity for subsequent biosies (July 2018) 5) New process implemented for nurses to undertake biopsies alongside FT clinics (Feb 19)	3) 0 FT patients outstanding for subsequent procedures to be booked (compared with 16 last month) (Feb 19)	3) Currently have 4 WTE Consultants working, 1 not working, deficit 2 WTE (Mar 19) 1-3) Feb 19 compliance with 2 week wait below target at 87% (compared with 94% last month (Mar 19) 3) Approx 30% increase in FT referrals since May 18 against a reduction in workforce of 1.0 WTE Consultant (Dec 18) 1) 58 FT patients outstanding for first appointment (compared with 0 last month) (Mar19)	1-4) Complete Consultant job plan review 1-4) Implement recommendations from Dermatology external review	Apr-19 Jun-19	2 x 3 = 6 YELLOW	Mar-19	

Director	Cross Ref	What is the Risk?	Current 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	5088	If the fragility of neighbouring Trusts leads to a reduction of service provision by them and the need for RWT to provide support, then this will significantly impact on RWT capacity. This will result in increased pressure within ED, as well as the wider Trust, leading to compromised patient care and increased staff stress. Date of origin: 5th Sep 2018 Date of escalation: 7th Feb 2019	4 x 4 = 16 RED	1) Daily quality call with NHSI re safety of ED (09/18) 2) Work with neighbouring Trusts to review any impact upon RWT (09/18)	2) Repatriation policy in development as part of Trustwide action plan (03/19) 1&2) Fit for Future plan developed for SaTH, proposing ED move from Telford to Shrewsbury (03/19) 1&2) Intelligent conveyancing being introduced to manage ambulance flow in region (03/19)	2) Draft plan to mobilise Bd 5's from stable wards to support C16 still being implemented (03/19) 2) Diverts from neighbouring have been recieved in month (03/19)	1&2) Map incremental increases in ED attendance for future planning	Apr-19	3 x 3 = 9 AMBER	Mar-19	

Director	Cross Ref	What is the Risk?	Current 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 Trust Education Team 4- 08/10/18 All inexperienced ICCU staff have a weekly documented review, with the PDN, 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 the PDN 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) 2, 5, 6, 12, 16, 17 - Currently (Feb 2019) only have 2 staff who are supernumerary due to inexperience. This figure stood at 15 staff in Oct 2018.	9 - 06/02/19 - 5 (out of 10) vacancies remain unfilled - further interviews scheduled for 12/02/19	9-08/10/18 Recruit to Band 6 and 7 posts 14- 08/10/18 Monitor Datix reports concerning shortages and skill mix	Mar-19 Oct-19	2 x 3 = 6 YELLOW	Mar-19	

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

Director	Cross Ref	What is the Risk?	Current 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?	Current 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	5182	If RWT does not meet NHSE requirements of having Cardiac Thoracic and Aortic Services co-located with Vascular services on RWT site, then the Aortic service specification will not be met and RWT may not be authorised for Aortic services, this will adversely impacting patient service provision at RWT.	4 x 4 = 16 RED	Vascular support in place for TAVI (Mar 19) Monthly aortic MDT occuring at RWT (Mar 19)	1-2 Have not had to cancel any surgical or TAVI lists for lack of cover (Mar 19)	1-2 Frozen Elephant Trunk (FET) Device is not yet approved (Mar 19)	1-2 Further evidence becoming available to enable approval of FET device. 1-2 Need to relocate Vascular Services at RWT.	Jun-19 Jun-19	2 x 2 = 4 YELLOW	Mar-19	
Medical Director	5190	Intermittent issue where the ePMA system freezes preventing nurses from ticking the drug administration box to indicate that a drug has been administered. During this time the drug chart remains available and can be viewed by everyone. If this system downtime issue occurs then there is a risk of patients receiving incorrect doses of medication with the potential for harm. Date of origin: 12/03/19 Accepted onto Divisional Risk Register: 15/03/19 For inclusion on Trust Risk Register	4 x 5 = 20 RED	(1) On receiving a report of a system issue IT and the supplier (EMIS) attempt to immediately resolve. If resolution is likely to occur within 1 hour Business Continuity is not invoked. The above incidents did not require the activation of the Business Continuity Plan which calls for drug charts to be printed. (Mar 19) (2) Attempted Fixes: 16/01/19 - An index was added to the database. 28/01/19 - ActiveX Sciptlets were enabled. 03/02/19 and 06/02/19 - system failed again so the supplier needed to capture relevant data. 18/02/19 - attempt to capture data. Following this the supplier has identified changes regarding Internet Explorer settings. (Mar 19)	(2) N/A. Fixes have not worked. EMIS have to manually resolve the issue once we've raised it with them (Mar 19)	(1-2) ePMA system has still gone down despite the fixes. 9 instances recorded between 19/11/18 and 01/03/19. Duration of incidents is approx. 30mins from report to resolution but on one occasion it was 55mins - [Datix for combined incidents W144595] (Mar 19) (1-2) The system has gone down 2 more occasions since 01/03/19 (Mar 19)	(2) Once implemented the system will need to be monitored to ensure no reoccurrence. (2) IT have raised this with EMIS to resolve. IT have reviewed and are applying emergency changes to implement the proposed settings.		x =	Mar-19	

Risk Managed to Target Level

Director	Cross Ref	What is the Risk?	Current 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 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	2 x 3 = 6 YELLOW	2- (21-02-19) Current staffing model consists of: 1 - Band 7, 9 - Band 6, Vacancy = 3 vacancies remaining 3- (21-02-19) In exceptional circumstances when CCOT staffing is reduced - a bleep is held by ICCU staff 1- (21-02-19) Recuitment plan in place	1. Active recruitment underway (Dec 18)	3. (21-02-19) This is only provision of telephone advice and not a physical assessment of the patient by an experienced ICCU nurse 1. (21-02-19) Active recruitment still underway - all vacancies not yet filled	1, 2 - Continue to recruit in line with business case Apr-19	2 x 3 = 6 YELLOW	Mar-19	