The Royal Wolverhampton NHS Trust

Chief Nursing Officer's Governance Report
4 June 2019

Agenda Item No:10.2

Safe & Effective | Kind & Caring | Exceeding Expectation

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	4th June 19
Title:	**CNO Governance Report**
Executive Summary:	**1.Trust Risk register (TRR) update – May 19** Monthly TRR review continues with generally good progress on risk management. Areas for attention are highlighted below. **2. Risk Management process** Some risks particularly in the Corporate Division have been graded 12+ (triggering escalation) but are not yet approved for entry onto TRR. Corporate leads have been chased for a decision re escalation/de-escalation. The risk register and escalation process has been reiterated and will be strengthened in policy (OP10). **3. Serious Untoward incident (SUI) Performance** Overall good performance on SUI reporting and investigation timescales continues, although 2 breaches occurred in May 19. The Executive Significant Event Review Group (ESERG) monitors this process weekly. **4. Information Governance (IG) work plan and risk** Further to submission of the Data Security and Protection Toolkit (DSPT) on 31st March 19 with some areas of partial compliant, the Trust is required to complete all action plans within 6 months (by end of Sept 19 latest). A review of all DSPT evidence is also underway as part of Well Led requirements. **5. Governance staffing** Recruitment to Health & Safety (H&S) and IG vacancies have proven challenging with a 3rd cycle of interviews planned and temporary staff being sourced. Prioritised work plans are in place for both areas as staffing has impacted routine work plans. **6. Local Procedures Governance** Good progress, 74% return to date of local procedure registers. **7. Mortality returns** Ongoing follow up of SJR returns shows a slowly reducing figure. Interviews for SJR reviewers are being held to progress this agenda further. **8. Learning and Improvement** A review framework is under consultation in liaison with Clinical Quality Improvement (CQI) leads. **9. CQC Well Led Inspection** The Trust has been issued with the CQC Provider Information Request (PIR). Strict timescales apply for the return of information and documents: Internal deadline is 16th May for submission to CQC by 29th May. **10. Health and Safety Compliance** H&S audits have identified red rated non-compliance in areas detailed in section 10 below. Non-compliant findings include out of date risk assessments, open action from previous audit, local inspections not

	undertaken etc. Areas have been informed and support offered for improvement. Reduced and variable resource for H&S over the past 12 months prevented all areas from being audited – Division 1 - 73% audited Division 2 – 40% audited Division 3 – 53% audited E&F – 40% audited Corporate – 89% audited A risk prioritised approach is taken having regard to new services and buildings utilised by the Trust.
Action Requested:	**Receive and note,**
For the attention of the Board	
Assure	• Weekly oversight of SUI RCA management via Executive Significant Event Review Group (ESERG) • TRR updates requested monthly • TRR risks are reviewed by operational Divisions, subject leads, Specialist groups and QGAC.
Advise	• The CQC Well Led Governance group continues to meet weekly. The focus continues to be on Well Led Inspection preparation including progressing the Well Led gap analysis actions, oversight of any outstanding CQC actions from previous visit and collation of the formally issued CQC PIR and documents requested for submission by the 29th May 2019. • The Health and Safety Executive (HSE) has increased its fee for intervention (FFI) hourly rate from £129 to £154.
Alert	• The Trust IG toolkit submission was made with some areas of partial compliance declared. The Information Commissioner Office (ICO) have accepted the Trust improvement plans which must be completed within a 6 month timescale (by end of Sept 19) (ICO mandated). • SUI management – two breaches to 60 day target in April19.
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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:	See detail below Governance Dept RR: 3285 Non Compliance with FOI timescale – grade 9 amber 4769 Capacity IG/GDPR – grade 12 amber (under review for escalation/de-escalation) 4663 Capacity Health and Safety – grade 9 amber
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

1 new risk:

4170 - Lack of capacity - OPD, Snowdrop Suite and Durnall Unit (COO)

2 risks removed:

5088 - Fragility of neighbouring services (COO)

5190 - ePMA downtime / outage issues (MD)

5 red risks:

2080 - Risk to quality of patient care: reduced manpower (COO)

4661 - Lack of robust system for review and communication of test results (MD)

4472 - Delays in Cubicle Assessment and Triage (COO).

4113 - Division 1 failure to achieve CIP target (COO)

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

There are currently 33 risks contained within the Trust Register which are distributed across the (5x5) categorisation matrix as below:

Likelihood	Consequence 1 Low	2	3	4	5 High
5 – Almost Certain					
4 – Likely			11 risks	4 risks	1 risks
3 – Possible			4 risks	13 risks	
2 – Unlikely					
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 May 19, attention is required to the following:

2719 COO – May update required, grade under threshold – confirm decision to remain on TRR (p2)
4596 COO – May update required (p4)
4599 COO – May update required (p5)
5083 COO – May update required (p8)
1713 COO - May update required (p13)
3644 CNO – Decision confirmed to retain on TRR for monitoring (p20)
4661 MD – May update required (p34)
4706 COO – May update required (p37)
4756 COO – May update required (p38)
5112 COO – May update required (p43)
5182 MD – May update required (p45)
5045 MD – Dates needed for actions (or transfer to controls if completed/underway) (p41)
4955 CFO – May update required, grade under threshold (confirm decision to remain on TRR) (p12)

2. Risk Management Incident reporting and Risk Register management

No red (non STEIS incidents) to report. The Trust has increased its scrutiny of operational risks that trigger escalation and reminding managers to regularly review and update local risk registers. All risks scoring 12+ must be escalated to the Head of Department in the first instance then to the Executive Director for acceptance onto the Trust Risk Register (TRR). This is to ensure that all high level risks are highlighted to Executive Directors and Trust Board and a comprehensive corporate register of risks is maintained. Where risks graded 12+ are not escalated or reviewed for a period of 3 months the risk will be downgraded and de-escalated to the risk/Dept lead for review.

3. Serious Untoward incident (SUI) Performance

Good performance on completion of SUI investigations to timescale. Monitoring continues at QSIG and weekly Executive Significant Event Review Group (ESERG).

Month	Ongoing /Open incidents (stop clock)	New Reported to STEIS	Closure Request to Commissioning	Closure Agreed by Commissioning	Over 60 day breaches - running total	Potential breaches in month
June 18	71 (6)	31	14	5	5	1
July 18	55 (6)	15	15	10	9	4
Aug 18	42 (4)	8	13	25	13	6
Sept 18	30 (3)	5	11	12	6	2
Oct 18	21 (2)	7	13	13	7	5
Nov 18	19 (2)	10	11	12	1	1
Dec 18	22 (1)	12	7	7	1	1
Jan 19	22 (2)	9	7	8	0	0
Feb 19	20 (2)	4	6	7	1	0
Mar 19	15 (1)	4	5	5	1	1
April 19	12 (0)	1	6	6	2	2
Analysis	Sustained progress in closure of SUIs within timescale.	Reduction in true SUI numbers aligns with the National SUI framework.		Fewer queries from commissioners re RCA reports.	Gen Surg - Statements and Interviews are still to take place Gynaecology – Report not	Weekly focus on RCA due dates via ESERG.

					approved by the Divisional Management Team	

4. Information Governance work plan

Data Security and Protection Toolkit (DSPT) submitted with partial compliance declared within some toolkit measures. May onward will focus on the implementation of action plans which must be completed in the next 6 months (end of Sept 19) (by ICO mandate). There will also be a focus on preparing for the Well Led inspection where Data Security and Protection will feature and Toolkits will be reviewed.

Privacy related training sessions will continue to support and embed principles of privacy into working practices.

The IG and Data Protection Policy and IG Strategy was approved at the May Policy Group, the next few months will focus on implementation and the update of supporting policies.

5. Governance staffing

An offer has been made to the role of Investigation and Learning Specialist, and going through pre-employment process. This role will support the RCA workload including investigation, learning and improvement. Vacancies still remain within H&S, Information Governance and Divisional Governance portfolios.

6. Local Procedures and Guidelines – Governance (May 19)

Good engagement from Directorates 26/35 Directorates responded (74%) to return local procedural document listing:

- **Division 1:** Returns received: Cardiology/Cardiothoracic, Urology, Pathology, Head & Neck, Special Care Dental Services, Audiology, T&O, Critical Care, Obstetrics, Gynaecology.
- **Division 1:** Returns awaited: *General Surgery, Ophthalmology, Neonates, Patient Services*
- **Division 2:** Returns received: Oncology & Haematology, Renal, Diabetes, Neurology, Gastro, CoE and Stroke
- **Division 2:** Returns awaited: *ED, AMU, The Maltings and Respiratory, Patient Access*
- **Division 3:** All returns received: Radiology, Primary Care, Paediatrics, Therapy Services (SALT, Dietetics), Adult Community, Rheumatology, Sexual Health, Pharmacy, Dermatology

Governance is currently reviewing registers and cleansing data for upload to the Health Assure system. Draft reports are expected to be available by/before the end of June 19.

7. Mortality process

NB. All figures below are as at the 11th April and will change daily.

SJR1 review process
94 SJR1s reviews are outstanding and have routine monthly follow up via Mortality leads. Progress is reported to QSIG and is added to Directorate Integrated Governance Reports for redress. For the period pre Sept 18, 11 SJR1 reviews are outstanding with targeted follow up in place. SJR1 judgements of overall care indicate predominantly adequate and good care.

SJR2 review process
51 SJR2 reviews (pertaining to pre-Sept 18) are outstanding. A further 10 case (identified from Sept 18 to 11th April 19) have been identified for SJR 2 review. SJR2 judgements of overall care show predominantly poor and adequate care.

Interviews are in progress for SJR reviewers to assist completion.

Themes of learning from SJR1 and 2 reviews include:

- Documentation
- Communication
- Care Pathway management

8. Learning and Improvement

A draft Change Implementation Review Framework is under consultation. Links are being made with the Trust CQI plans and function.

9. CQC Well Led Inspection

Divisions and specialist leads have been issued with the CQC PIR for completion by 16th May 2019. Documents requested by CQC must also be returned by this date in order to allow time for collation, quality assurance, follow up where needed and final Executive sign off. Heads of Department and/or Executive leads must be sighted on submissions being made and any concerns within the information provided.

Divisions must also ensure the progression/completion of the previous CQC action plan.

10. Health and Safety Compliance

Routine H&S compliance audits have identified some areas for attention below.

The departments listed below require follow up of audits as their overall rating is RED (RED – significant gaps to address).

Division 1	Division 2	Division 3	E&F
A9 SAU Maxillo-Facial Laboratory Maternity Reception Maternity Administration C55 AEC	C25 Renal	Coalway Road Health Centre Warstones Medical Centre	Housekeeping NX

Each of these areas received at least one visit from the H&S team to provide improvement support.

The H&S team continues to work with reduced capacity having been unsuccessful with several rounds of recruitment. Agency (now ended) and Bank workers have been employed and bank is being sought again. Workforce is down by 1wte Health and Safety (H&S) Officer, leaving a team consisting of the 1wte Trust Health, Safety and Improvement Co-ordinator, 1wte H&S Officer, 1 p/t H&S Officer (on bank) and 1 x wte Support Officer. Due to recruitment challenges the latter Support Officer role was created to trial a new model and to prevent further depletion of service.

As a result of staffing challenges a number of departments were not audited in the last 12 months:

Div 1	Div 2	Div 3	E&F	Corporate	GP's
17 of 63	28 of 47	19 of 40	12 of 20	15 of 44	1 of 9

	These areas have been prioritised for 19/20 financial year and although no audit formally undertaken they will have received a combination of H&S self-assessment follow up, H&S and support and/or advice upon request.
Appendices	
	Appendix 1 - Trust Risk Register (TRR) Appendix 2 – Tracked changes to risks

Appendix 1 TRR

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

Lead Director	Risk	Risk Title	Field updated	Update made
Chief Operating Officer	4761	Cardiology, Cardiothoracic & Anaesthetic JMS vacancies		
			Positive Control – **New**	Cardiothoracic - 2 agency locums in place.
			Positive Control – **New**	Anaesthetics - Consultants have had to cover middle grade night shifts
			Positive Control – **New**	Anaesthetics: Dr has agreed we can have some doctors to rotate around.
			Positive Control – **New**	Anaesthetics - 1 junior doctor starting 29.4.19 and another in 2 weeks' time.
			Positive Control – **New**	Cardiology - Recruitment on-going but slow.
			Positive Control – **New**	Cardiology: 1 doctor recruited 3+ months ago still not in post, potential to be here in May 2019.
			Positive Assurance – **New**	Cardiology: 2 candidates soon, Clinical Fellowship Programme.
			Gap in Assurance - **New**	Cardiology: Very few suitable candidates available. 1 doctor recruited into MTI post has failed IELTS and must resit next month.
			Gap in Assurance - **New**	Cardiology: Staff generally recruited from abroad need IELTs, GMC and visa
	4170	Lack of capacity - OPD, Snowdrop Suite and Durnall Unit		
			New risk	If there is a lack of physical and staffing capacity in the Durnall unit, then this will impact on the ability to effectively triage and treat sick patients. This will result in neutropenic sepsis patients not receiving treatment within the 'golden hour', patients receiving line care and other interventions having significant delays and long waiting times, including pts with life limiting conditions. Clinics over running significantly leading to poor patient experience.

	4523	Failing Heater Cooler Units		
			Action Plan - **New**	Approval of Business Case - Need to consider replacement of some if not all machines - minimum of 5 machines required
			Action Plan - **New**	Undertake a trial of new company's demo machine
	4113	Divisions inability to achieve CIP		
			Action Plan - **New**	Service Delivery & Design to develop plan in conjunction with Div 2
	4528	Incomplete Health Records on Clinical Web Portal		
			Action Plan - **New**	Send risk to Division 3 for their consideration
	4382	NX55 Main Theatres, Wards A12, A14, Admin, Plant Rooms) - Fire Safety		
			Positive Assurance – **New**	0 incidents relating to Reportable Fire's within Apr 2019
			Positive Assurance – **New**	3 Unwanted Fire Signals within Apr 2019
	4411	NX08/NX09 McHale Building - Fire Safety		
			Positive Assurance – **New**	0 incidents relating to Reportable Fire's within Apr 19
			Positive Assurance – **New**	0 Unwanted Fire Signals within Apr 19
	4375	NX87 Heart Centre - Fire Safety		
			Positive Assurance – **New**	0 incidents relating to Reportable Fire's within Apr 19
			Gap in Assurance - **New**	1 unwanted fire signal during Apr 2019 (Cooking on ward)
	4161	Shortage of Qualified Nurses across the Division		
			Positive Assurance – **New**	48.53 WTE vacancies of which 18.04 have been offered and await start dates. Leaving 30.49 WTE vacancies. Further business cases have been approved for additional staffing resulting in more positions to be recruited to
			Action Plan - **New**	Head of Nursing has requested to see staff leavers figures

	2080	Risk to quality of patient care: reduced manpower		
			Positive Assurance – **New**	Matrons meeting every Friday to ensure hospital is staffed over the weekend
			Positive Assurance – **New**	Snr Srs and Charge nurses meeting daily to ensure wards are safe
			Positive Assurance – **New**	2 offers made following Philippines recruitment
			Gap in Assurance - **New**	All wards are 'Amber' re safe staffing levels on daily basis
			Gap in Assurance - **New**	Significant nursing shortages on C16, C24 and C25, working with 50% vacancies at Bd 5 level. C19 also a concern
			Action Plan - **New**	Generic recruitment process being reviewed
	5088	Fragility of neighbouring services		
			Risk closed	COO has agreed risk can be closed
	4696	Unreported Imaging Studies		
			Gap in Assurance – **New**	Approximately 3569 non-urgent imaging studies unreported Apr 2019 (inclusive of 515 CT scans and 1675 MRI scans). Over 20 days there are 1240 in total (inclusive of 205 CT scans and 547 MRI scans)
	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 - 78% for full completion (documentation) in Apr 2019
			Gap in Assurance - **New**	Monthly monitoring and compliance with WHO checklist use - There has been 78% compliance achieved during Apr 19
			Action Plan – **New**	Obstetrics and Neonates to be attend Divisional Governance in May 2019 re: WHO checklist compliance
	4529	Vacancies in Medical		

		Staffing/Agency and Locum staffing	Positive Assurance – **New**	Medical staffing divisional vacancy rate - 9 consultants vacant, improving as 40 medical vacancies overall in Jan vacancy % reduced by 1.5% to 7.97% in March
			Positive Assurance – **New**	Agency and Locum spend Aug 120k rotation commence steady throughout Sep - Dec increase in Jan to 350K largely due to Cardiology and Orthopaedics where there have been increases in activity and medical vacancies. T&O recruitment is still ongoing at junior level, 4 appointed who should all start by July 19. Cardiology - 2 appointed starting in May 19, 2 ACCP's should be fully qualified by September 19
			Positive Assurance – **New**	Following a meeting in April, engagement with the top provider (Medacs) has increased and we are working closer with them, provision for locum workers via this agency has improved slightly
			Positive Assurance – **New**	Ongoing T&O medical vacancies sent 20 CVs as were struggling to recruit, 4 T&O Jnr Med appointments should be in place for July 2019
			Positive Assurance – **New**	4 x O&G Consultants posts have been accepted, the first one is due to commence in July 2019
			Gap in Assurance – **New**	Group not held for the last two months, due to re-scheduled again on the 21/05/2019
			Action Plan – **New**	Human Resources to work with directorates to discuss annualised contracts to explore bringing locums onto permanent contracts. (Meeting with ophthalmic Locum scheduled in April, Group Manager Cardiology to meet with locum to discuss)
Chief Nursing Officer	3644	If the Trust fails to sustain improved compliance with CQC standards the rating of Good will could decline and		
			Positive Assurance – **New**	Registered nurse vacancies are at 27.99WTE with 60.69 WTE waiting to start.
			Positive Assurance – **New**	There is a system of nursing audits taking place monthly

		progress will not be made towards Outstanding.	Action Plan – **New**	Commence comms plan on Strategy, visions and values
Medical Director	5190	ePMA downtime / outage issues		
			Risk now managed on Directorate Risk Register	Risk now graded as 8 AMBER

The Royal Wolverhampton NHS Trust

Trust Risk Register

May-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	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?
Risk Lead	ID	Principal Risk		Controls	Positive Assurances	Gaps in Assurance/Control	Action Plan that addresses Gaps in Control		Residual Risk Level		
Risks Currently Being Managed											
Trust Objective:		**Proactively seek opportunities to develop our services**									
Chief Operating Officer	5173	If the information technology infrastructure is inadequate within the Audiology Clinics then patient appointments will frequently be interrupted due to lack of necessary IT to support delivery of service, resulting in a poor patient experience as occasionally this necessitates patients being recalled to future appointments. Date of origin: 20 February 2019	4 x 3 = 12 AMBER	1) Manual rebooting of computers (Mar 2019) 2) Audit of all computers all all sites for specification checks (Mar 2019)		1) Interrupted, incomplete and rescheduled appointments (10 incidents reported via Datix since December 2018) (May 2019) 1) Multiple complaints from staff re: slow and hanging computers, often necessitating forced shut down of computers (May 2019) 2) All of the 33 computers have too little RAM - this has been confirmed by IT of which 8 computers across the department are obsolete (May 2019)	1) & 2) Liaise with IT to discuss specifications of the equipment needed to run the Audiology software necessary and solutions 1) & 2) Business Case for IT Infrastructure upgrade to be submitted (this should include any associated IG risks)	May-19 May-19	1 x 1 = 1 GREEN	May-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?
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	Apr-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	4523	Heater Cooler Units (HCU) used in cardiac surgery can harbour Mycobacterium chimaera (national and international incident). The upgraded cleaning protocol for the HCUs involves powerful bleach, which progressively damages the internal components of the machines. Surgery without an HCU would be very hazardous, so there is a need for at least one spare HCU on any operating day, in case of HCU failure during a case. Experience one year ago was that all HCUs being cleaned under the current protocol sustained similar damage and all failed over a short period. 3 of our 6 HCUs have failed recently, with only 1 being repairable. There is a risk of patient harm if multiple HCUs failed on any day, along with the risk of financial loss if list cancellations became necessary. Date of origin: 28/04/2016 Date of escalation = 17/06/2016 Date of re-escalation = 27/03/2019	3 x 4 = 12 AMBER	1. A comprehensive service contract is in place, which provides a loan machine on breakdown of our machines (May 2016) 2. 6 monthly service within comprehensive service (May 2016) 3. Patients are informed before every case of the risk and it is documented on the consent form (March 2016) 4. All patients who have had valve surgery since January 2013 have been contacted and told of the risk of contracting Mycobacterium Chimera. There is a dedicated national helpline for patients to contact should they have any queries (March 2017) 5. Directorate currently has 4 HCU machines. (Mar 19)	1. Company involved in the upgrading of the machines (28/03/2019) 3 & 4. No patients have declined the procedure as a result of being open (28/03/2019) 1-5 HCU's are cleaned and water changed with hydrogen peroxide daily (28/03/2019) 1-5 HCU's disinfected every 2 weeks as per protocol (28/03/2019) 1-5 HCU's are tested for infection monthly (28/03/2019) 3 & 4 All HCU use on patients are recorded (28/03/2019) 1-5 All HCU cleaning is recorded (28/03/2019) 1-5 There have been 3 patients infected historically (none from Nov/Dec 17) to date - these infections take up to 5 years (as far as we know) to manifest (28/03/2019)	5) Potential for list cancellation - None cancelled to date (28/03/2019) 5) 3 out of 6 HCU machine have failed recently, 2 of which are irreparable (28/03/2019) 5) A gap in HCU availability from manufacturer due to demand nationally (28/03/2019)	5) Approval of Business Case - Need to consider replacement of some if not all machines - minimum of 5 machines required 1-5) Undertake a trial of new company's demo machine	Jun-19 May-19	1 x 3 = 3 GREEN	May-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 (21/03/19) Additional all day list allocated from 5th March 2019 4 (21/03/19) SOP agreed including agreed consent criteria and booking form		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 (21.03.19) Unable to appoint to the 4th UGI Consultant post 1 (21.03.19) All day list introduced 5th March 2019. First 2 weeks only 1 patient per list (poor use of theatres)	(25.01.19) Additional recruitment and training of staff for another half day list per week (21.03.19) Re-locate UHNM staging lap list on Friday morning to give weekly 3rd session (21.03.19) Recruit 4th UGI surgeon - closing date 19th March 2019; to enable full utilisation of allocated capacity. Currently being undertaken as additional to job plan (21.03.19) Purchase bile duct exploration kit (21.03.19) Procedure specific consent form 1. Divisional Medical Director request for data re:"How many patients admitted with cholecystitis have been operated on?	May-19 May-19 May-19 May-19 May-19 May-19	2 x 2 = 4 YELLOW	May-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 (04/19) 3) Local audit around documentation of senior review and ECG is showing good compliance (04/19) 8) Quality Improvment Lead appointed to - await start date (04/19) 8) 2nd Matron in post (04/19) 3) Reviewed weekly by Clinical lead in the Consultants meeting and Documentation review done by Junior Doctor's mentors(04/19)	3) Some actions not relating to ED are taking a considerable amount of time to implement/ close (04/19) 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 (04/19) 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 (04/19) 12) Historic incidents under review (04/19) 2) Backlog of unnaproved incidents remains static (04/19)	12) Governance lead to review and close historic incidents	Apr-19	2 x 3 = 6 YELLOW	Apr-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) 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 recruit senior fellows then we will be unable to provide a service without reliance on expensive agency locum doctors and additional shifts at enhanced rates for our existing staff. As at 18.4.19 - There are 4 Cardiology vacancies and from 29.4.19 there will be 5, there is 1 Cardiothoracic vacancy and 3 for Anaesthetics. This is a risk to patient safety because the quality of care provided by locums can be variable. It is a risk to the health and well being of our existing staff because they are being regularly asked to work more and more extra shifts. Date of origin: May 17 Date of escalation: May 18 Addition made to risk: Cardiology added May 19 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. Cardiothoracic - 2 agency locums in place. (4.4.18) 4. Anaesthetics - Consultants have had to cover middle grade night shifts. (25.4.19) 5. Anaesthetics - 1 junior doctor starting 29.4.19 and another in 2 weeks time. (25.4.19) 6. Cardiology - Recruitment on-going but slow. (18.4.19) 6. Cardiology: 1 doctor recruited 3+ months ago still not in post, potential to be here in May 2019. (18.4.19) 2. Anaesthetics: Dr Ahuja has agreed we can have some doctors to rotate around. (3.5.19)	1-3 There have been no incidents recorded to date (28/03/2019) 1-3 Training of ACCP's continues and will take a further 12 months (28/03/2019) 6. Cardiology: 2 candidates soon, Clinical Fellowship Programme. (18.4.2019)	1 & 2. Anaesthetics - x5 vacancies - delays on getting paperwork, GMC through since July 2018 (28/03/2019) 1. Cardiothoracic vacancy from 1st March 2019 (28/03/2019) 2. ACCP's x2 being trained, training will take a further 12 months to complete (28/03/2019) 6. Cardiology: Very few suitable candidates available. 1 doctor recruited into MTI post has failed IELTS and must resit next month. (18.4.2019) 6. Cardiology: Staff generally recruited from abroad need IELTs, GMC and visa (18.4.2019).	2. Training of ACCP's	Aug-19	2 x 3 = 6 YELLOW	May-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	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 - business case to be completed	Jul-19	x =	Apr-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 (04/19) 3. VCP meetings held weekly and posts go through this process for all Divsions (04/19) 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. (04/19)	2 & 3. Unidentified CIP still remains across the divisions (04/19)	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. 1-10) Service Delivery & Design to develop plan in conjunction with Div 2	Apr-19 Apr-19 Apr-19 Apr-19 Apr-19 Apr-19 Jul-19	3 x 3 = 9 AMBER	May-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?
				10. Outpatient efficiencies continue to be identified via OPEG (Outpatient) Dec 18							
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 (28/03/2019) 5. Consultant Thoracic Surgeon recruited and in post (28/03/2019) 5. Locum in post and contract has been extended for a further 6 months (28/03/2019) 1-4 Continue to approach other Trusts for referrals (28/03/2019) 1-4 Walsall plan to agree SLA with RWT (28/03/2019)	1. Referrals have not increased, this has been escalated to DCOO and COO (28/03/19)	1-4 Plan further approaches to Walsall Hospital	May-19	1 x 5 = 5 YELLOW	Apr-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	Apr-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 harm, late observations and treatment. As well as increased levels of staff stress and complaints. (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 (05/19) 1) Proactive recruitment approach continuing (05/19) 1-10) Monthly workforce group reviewing nurse recruitment and retention (05/19) 1) 61.02 wte trained nursing vacancies remain, 17.73 roles offered, but not in post (05/19) 1) Continued recruitment to nursing clinical fellows (05/19) 1-10) Matrons meeting every Friday to ensure hospital is staffed over the weekend (05/19) 3) Snr Srs and Charge nurses meeting daily to ensure wards are safe (05/19) 1) 12 offers made following Phillipines recruitment (05/19)	8) Insufficient RN's available on Bank, backfilled by HCA (05/19) 1) Nationallly we are an outlier re safe staffing levels (05/19) 1) Recruited staff are newly qualified which can lead to mentorship and training pressures (05/19) 1) All wards are 'Amber' re safe staffing levels on daily basis (05/19) 3) Issue remains in relation to ability to provide accurate staffing figures (05/19) 3) Breaches in minimum safe staffing levels (05/19) 3) Significant nursing shortages on C16, C24 and C25, working with 50% vacancies at Bd 5 level. C19 also a concern (05/19)	1) Continue with proactive recruitment approach 1) UK recruitment for Clinical Nurse Fellow posts - ongoing recruitment 1-10) Potential recrutiment in South Africa - Team flying out to recruit staff 3) Awaiting decision from COO re proposal to close 1 bay each on C16 and C25 1) Generic recruitment process being reviewed	Jun-19 Jun-19 Jun-19 Jun-19 Jun-19	4 x 3 = 12 AMBER	May-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 continues to be vacancies in consultant and training grade medical posts across Division 1 alongside an increase in elective activity (in some directorates) then this will result in the need to engage agency and locum staff in order to deliver a safe and effective elective service and to safely staff on-call rotas. Agency and locum staff are often engaged at premium rates which places an enhanced pressure on the divisional staffing budget; it is also recognised that locum/agency staff may not be familiar with the Trust procedures and that this unfamiliarity may have a detrimental impact on the quality and continuity of patient care. Please note: Risk 4239 (Obs & Gynae) staffing risk has 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 continue 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. Recruitment Strategy in place for Consultant and Middle Grade vacant posts - this is ongoing (Dec 17) 5. Overseas recruitment continuing membership to Clinician's Connected (June 18) 6. Utilisation of the Fellowship- Programme (Sept 18) 7. Agency spend reviewed monthly at Directorate/Divisional meetings via the dashboard (Dec 18) 8. Business cases being developed for overseas recruitment (Sept 18)	1-8) Medical staffing spend - increasing positive - filling posts (May 19) 1-8) Medical staffing divisional vacancy rate - 9 consultants vacant, improving as 40 medical vacancies overall in Jan vacancy % reduced by 1.5% to 7.97% in March (Apr 19) 1-8) Agency and Locum spend Aug 120k rotation commence steady throughout Sep - Dec increase in Jan to 350K largely due to Cardiology and Orthopaedics where there have been increases in activity and medical vacancies. T&O recruitment is still ongoing at junior level, 4 appointed who should all start by July 19 . Cardiology - 2 appointed starting in May 19, 2 ACCP's should be fully qualified by September 19 (May 19) 7) There has been no agency used in nursing for the last 18 months (May 19) 7) Achieved forecasted year end agency cap set for April 19 new cap set for April 20 (Apr 19) 2) Baseline meetings are still continuing on-going on a regular basis (May 19)	1-5) Number of vacancies remain across Division 1 (May 19) 1-8) Still vacancies and locum expenditure remains high (May 19) 4) Still attending not achieving what it set out to, ease of transition - OH.training etc, finance work withdrawn more a forum for issues and concerns (Mar 19) 4) Group not held for the last two months, due to re-scheduled again on the 21/05/2019 (May 19)	5. Fellowship Programme ongoing 1. Continuing campaign with regular adverts 1. Continuing to develop roles to support medical rota (ANPs and ACCPs) 6. Review of CVs by Clinician's Connected to fill Consultant vacancies 7. Focus on reducing agency spend in non-clinical areas initially 1. Continue to implement recruitment strategy 8. Human Resources to work with directorates to discuss annualised contracts to explore bringing locums onto permanent contracts. (Meeting with ophthalmic Locum scheduled in April, Group Manager Cardiology to meet with locum to discuss)	Sep-19 Sep-19 Sep-19 May-19 May-19 Sep-19 Sep-19	2 x 2 = 4 YELLOW	May-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?
					3) Project ongoing - recent engagement meeting at Sandwell individual agencies are supplying at reasonable rates why preferential rates at other Trust, two meetings with agencies have been scheduled for April (Apr 19) 1) Recruitment is ongoing (May 19) 3) Following a meeting in April, engagement with the top provider (Medacs) has increased and we are working closer with them, provision for locum workers via this agency has improved slightly (May 19) 1-8) Ongoing T&O medical vacancies sent 20 CVs as were struggling to recruit, 4 T&O Jnr Med appointments should be in place for July 2019 (May 19) 1-8) 4 x O&G Consultants posts have been accepted, the first one is due to commence in July 2019 (May 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:		**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 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 in Division 1 since June 2018 - 10 months (May 19) 13. Over 5 AfPP training days - approx. 240 staff members have been trained (Jan 2018)	4. There have been 3 x Never Event incidents 2 x Wrong Site Surgery and 1 x Retained foreign object) reported and investigated during 2015 4. 5 x NE in 16/17 reported to CCG - 1. Maternity NE (retained tampon) reported (Datix ID: 158830), 2. Radiology NE (wrong ankle injected) reported (Datix 165455), 3. Opthalmology (wrong eye injected) reported (Datix 166680) 4. Theatres (retained foreign object) reported (Datix ID: 169339) 5. Theatres/T&O Cannock (wrong prosthesis) reported (Datix ID: 174038) occured Mar 2017 4. 5 x NE incidents reporting in 17/18 reported to CCG from April 2017 (175581,179911,181941,185875 186479) (Dec 17) 4. 2018/2019 There has been 4 x NEs reported since April 2018 - 2 x Wrong Site Surgery incidents (Neonates Datix 194205 and H&N Datix 194977 - both in April 2018). There has been and 2 Retained Foreign Object incidents (Theatres 197654 and Obstetrics 197996 - both in June 2018) (Oct 2018)	1-13. All theatre staff to undertake Human Factors Training from AFPP 2. Programme of Human Factors Training for Theatre Staff under-development 1-11. Staff continue to undertake PCM training 3. Revamp/refresh the WHO Checklists 1-13 Implementation of action plan following NE Leicester Conference 1-13 Divisional Management Team to discuss AfPP report 3. Obstetrics and Neonates to be attend Divisional Governance in May 2019 re: WHO checklist compliance	May-19 May-19 May-19 May-19 May-19 May-19 May-19	2 x 4 = 8 AMBER	May-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?
				7. Policy for the management of retained swabs in place 10. New qualitative and observational WHO checklist being used in Theatres (Oct 17) 11. Continue to support the Sign up to Safety campaign - T&O and Maternity participation (Oct 17) 12. LocSSIPs developed by Directorates auditing underway and presented to Division and QSIG (Jan 2018) 13. AFFP Peer Review and Training undertaken		3. Monthly monitoring data of compliance with WHO checklist and Procedural Safety Checklist - 78% for full completion (documentation) in Apr 2019 (May19) 3. Monthly monitoring and compliance with WHO checklist use - There has been 78% compliance achieved during Apr 19 (May 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	1) Monitor recruitment and retention via WODG and Board monthly (may 19) 1) Monitor monthly performance through the nursing midwifery KPIs reported to QSIG (May 19) 1) Environmental Standards are monitored via the environmental group monthly (May 19) 1) Daily staffing (safe staffing, Skill mix) is monitored via the Divisional ops meetings (May 19) 1) Fundamental standards are reviewed & monitored by the designated specialist groups and bi annually by the sponsor which then reports to COG (May 19) 1) 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 (May 19) 1) Mortality QI plan is monitored via Programme Board monthly and learning outcomes via MRG (May 19) 1) EOL strategy with TOR has been developed and milestones monitored via the EOL group monthly (May 19) 1) Monitoring of the Nursing System Framework monthly via TMC (May 19)	1) Nursing and Midwifery KPIs are on Health Assure reporting and emailed out to ward sisters/matrons and HoNs monthly. (May 19) 1) QRV process is now embedded and refined, plan formulated for ongoing inspections 2019/20 (May 19) 1) Lord Carter metrics monitored monthly via Divisional Performance meetings (May 19) 1) Registered nurse vacancies are at 27.99WTE with 60.69 WTE waiting to start. (May 19) 1) Divisions monitor performance via monthly Governance meetings (May 19) 1) Improved staff survey results (May 19) 1) There is a system of nursing audits taking place monthly (May 19)	1) Vacancy rates remain high in some areas (May 19) 1) Phase 1 skill mix review for Adult inpatients shows a deficit (May 19) 1) Safer staffing fill rates remain transient particularly for nights (May 19) 1)Outliers for Mortality HSMR and SHMI rates in National data sets (May 19) 1) 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 May19) 1) Nursing audit data to assure quality is not available until March 2019 (May 19)	Commence implemention of Safer Care Software and roll out Review Intranet to ensure current content Commence comms plan on Strategy, visisons and values	May-19 Apr-19 May-19	2 x 2 = 4 YELLOW	May-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?
				1) Monitoring via Quality review visit and re-visit programme to assess CQC compliance (May 19) 1) NEWS2 implemented Trust-wide (May 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. 48.53 WTE vacancies of which 18.04 have been offered and await start dates. Leaving 30.49 WTE vacancies. Further business cases have been approved for additional staffing resulting in more positions to be recruited to (Apr 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. The main areas of concern are Cardiothoracic, General Surgery and T&O (Apr 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 1. Head of Nursing has requested to see staff leavers figures	Apr-19 Apr-19 Apr-19 Apr-19 Apr-19	2 x 2 = 4 YELLOW	May-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	4170	If there is a lack of physical and staffing capacity in the Durnall unit, then this will impact on the ability to effectively triage and treat sick patients. This will result in neutropenic sepsis patients not receiving treatment within the 'golden hour', patients receiving line care and other interventions having significant delays and long waiting times, including pts with life limiting conditions. Clinics over running significantly leading to poor patient experience. Date of origin: May 2015 Date of escalation: April 2019 Risk lead: Group Manager for Oncology and Haematology	3 x 4 = 12 AMBER	4. Staff in unit actively support triage area staff 5. M&M Reviews 6. Nurses trained to take blood cultures 7. Capacity Reviews, Weekly Community clinics (Weds weekly, Fri alternate weeks) 3. Staff from ward and Educational facilitators used to provide support at times of increased demand 1. Door to needle times monitored for sepsis patients Summary of 2 monthly Sepsis Audit findings 2. PALS feedback 9. Facilitate transfer to Deanesly and CHU within department opening times 8. SEPSIS 6 Rolled out in dept	3) Not required in month to move staff (04/19) 6) Approx 40% of nurses now trained to take blood cultures (04/19) 3) Service improvement team undertaking demand v activity v capacity (04/19) 5) No adverse outcomes identified from M&M review. Current Trust mortality rate is 2.5 % compared to National range of 2 - 21%. (04/19) 9) No patients stranded on Durnall Unit after 7pm in month (04/19) 7) Positive feedback from patients (04/19) 1-7) Process map of patient journey through the Durnall Unit undertaken (05/19)	2) Negative PALS feedback in relation to waits (04/19) 7) Overspend for Directorate (04/19) 7) As only alternate friday weeks, pts still have to attend hospital every other week (04/19) 6) Approx 60% of nurses still to be trained to take blood cultures (04/19) 1) In Dec 0% of pts treated within 'golden hour' (12/18) 9) H&S the Health Building Note 00-03: Clinical and clinical support spaces states that 1.5m2 be provided for ambulant person and 3.0m2 for wheelchair users. Effectively the space you currently have seating for 15 should realistically seat 6 ambulant and may be 1 wheelchair (04/19)	1)Training for PGD antibiotics and competencies, PEF's to be included in competency training, facilitator. Currently with MMC. DB to contact Pharmacy to discuss progression 1) Business Case to be finalised by Group Manager and to be formalised for increased nursing allowing for Community clinics and increased staffing in Durnell-13.05.2019 to be finalised post process mapping 1) AOS nurse to undertake RCA to review 'golden hour' patients. For any patients who do not get antibiotis within the hour AOS nurse to review-13.05.2019 NR update request 1-7) Update for demand and capacity project ongoing. - final meeting 11.06.2019 1-7) Await outcome of external review of service to be circulated- recommended Durnal unfit for purpose - action plan developed 6) Ongoing training for nurses to take blood cultures-13.05.2019 on hold 7) Risk Assessment re Durnall patient capacity to be completed, to be updated DBK 13.05.2019 9) Utilising Discharge Lounge for appropriate patients 9) Monitoring of Patient waits on Durnall 9) Scheduling of patients attending Durnall Review	Jun-19 Jul-19 Jun-19 Jun-19 Jun-19 Jul-19 Jun-19 Jun-19 Jul-19 Jul-19	3 x 3 = 9 AMBER	May-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?
							1) Meeting with estates to access alternative areas to accommodate Durnall day case area. Various options discussed Group Manager to escalate to divisional management April 2019	Mar-21			
							1-8) Trust AOS Low risk sepsis service to consider community reviews, daily follow ups and weekend follow ups	Jun-19			
							1-8) 95% staff to attend sepsis study day and online training	Jun-19			
							1-8) Post non compliance investigation staff to reflect on findings	Jun-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 Apr 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) 1 unwanted fire signal during Apr 2019	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	May-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 incidents relating to Reportable Fire's within Mar 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. 3 Unwanted Fire Signals within Apr 2019	1. monitor and work towards completion of fire stategy for block	2 x 2 = 4 YELLOW	May-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 Aprr 19 1. 0 incidents relating to Reportable Fire's within Apr 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	May-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 15 minutes for triage in the Emergency Department, 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 (05/19) 4-5) Reallocation of staff working well to help reduce wait times during pressured times (05/19) 15) Urgent treatment doctor is making an improvement to patients recieving appropiate emergency treatment (05/19) 17) Additional triage room helping to reduce triage wait times (05/19) 14) Nurse led RAT has improved timeliness of triage (05/19)	1, 2) Inability to achieve 15 minute triage consistently breaches mainly in minors (05/19) 4,5) Staff not always available to be reallocated (05/19) 7) Medical and nursing vacancies and sickness/ annual leave resulting in gaps in rota. Link to risk 4496 and 2374 (05/19) 9) UCC minimum impact on pt numbers and delays in assessments (05/19) 1) Significant numbers through the dept in month (05/19) 7) Continued use of long term locums (05/19) 4) ACP's not included on the medical rota due to working hours issue (05/19) 1-21) Medic left dept recently (05/19)	7)Continue with recruitment of medical staff 1) GIRFT Visit completed September 2018. Report received, Group Manager reviewing report (Winter pressures July completion date) monitoring actions through Governance meetings 1) External agency to map rota against patient no's and develop workforce plan	Jun-19 Jul-19 Jun-19	1 x 4 = 4 YELLOW	May-19	Yes

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				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 Division 3 Medical Director's approval. There has been identification that the information included in hospital notes not available via clinical web-portal (Mar 19) 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 1-2. Non-STEIS investigation being undertaken Datix: 185209 - awaiting Division 3 Medical Director's approval 3. Head of Midwifery to review the access permissions to Badgernet for Divisional Medical Director and Governance Manager	Sep-19 May-19 May-19	2 x 2 = 4 YELLOW	May-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	3 x 3 = 9 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 [04/19] 1-18) Safeguarding referral form reduced to 5 pages (04/19) 1-18) Concerns escalated to Trust Board and National Safegaurding Board (04/19) 7) Work continues towards amending the rota to allow 1 Safeguarding Chmpion on each shift (04/19)	3) Scanned documents are of a poor quality and information is not easy to read [04/19] 15) Training records show that not all staff have received training (medical staffing are the major concern and clinical lead aware) [04/19] 14) No electronic system in place for adult safeguarding or DV referrals [04/19] 16) CPIS identifies under 18 who are on a plan however w-ton council are not currently live with this process [04/19] 16) Wolverhampton Council have advised the e-referral system will not be in place til Dec 19 (04/19)	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	May-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?
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 =	Apr-19	Yes

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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 for existing equipment (£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) 5) Equipment replacement due to commence Q4 18-19 (Mar 2019)	1) & 3) Breakdowns are usually fixed under a 'fix as you go' contract. (May 2019) 2) There is a Mobile X-ray Unit at CCH which can be used to maintain the X-ray service should the equipment in one of the X-ray rooms fail (May2019 5) Equipment replacement programme commenced 18.03.2019 (May 2019) 4) There is a DR Mobile Unit at CCH which can be used to maintain the X-ray service should CR Processing systems fail (May 2019)	1) Any breakdown causes disruption to the service offered to patients. Breakdowns encountered with CR readers 5; X-ray equipment 1 (May 2019) 2) No focus choice on Mobile X-ray Unit and reliance on ageing CR processing equipment (May 2019) 4) X-ray service will be limited if CR processing facilites fail (May 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 (May 2019)	1), 2) & 3) To continue to monitor any equipment breakdown 5) Replacement of equipment planned for 19/20	Jul-19 Jul-19	2 x 2 = 4 YELLOW	May-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 (1 in place) (May 2019) 4) Review meetings are happening fortnightly (May 2019) 1), 5) & 6) Backlog has reduced from 7332 May 2017 to less than 3569 in Apr 2019 (May 2019) 3) Office space sourced (May 2019) 1) The backlog is actively monitored by Group Manager (May 2019)	1) Approximately 3569 non-urgent imaging studies unreported Apr 2019 (inclusive of 515 CT scans and 1675 MRI scans). Over 20 days there are 1240 in total (inclusive of 205 CT scans and 547 MRI scans) (May 2019) 1) Poor patient experience if patients and doctors are unsure when their scans are reported (May 2019) 3), 4), 5) & 6) Demand for reporting imaging studies is higher than expanded reporting capacity (May 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 & 6) Monitor outsourcing work and assess impact on reducing outstanding numbers 1,3,4 & 5) Continue to utilise waiting list initiatives	Jul-19 Jul-19 Jul-19	2 x 4 = 8 AMBER	May-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 (refurb 1 theatre per year) - (Feb 17) - COMPLETE 2. All leakage/flooding incidents reported to management are escalated to Hotel Services - (Sept 17) 3. Theatre 5 was closed for refurb between April 2017 and Oct 18 - Now open and fully utilised.	1. Programme of works completed to refurb theatres (Apr 18) 4. No procedure cancellations due to any of the above estates issues (between Apr 18 and Apr 2019) (Apr 19) 3. Ceiling space above Theatre 5 has been surveyed regarding the sewage leaks (Mar 18) - no issues for over three months (April 2019) 3. Theatre 5 is now fully refurbished and in use (Oct 2018) 2. No incidents reported re. Sewage ingress / water leaks for over three months (April 2019)	1+2. There have been 2 incidents (Datix 192843 - 10/03/2018, Datix 202440 - 13/09/18) of sewage ingress into Theatres (Oct 18) Zero incidents to date (April 19) 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) - Zero incidents to date (April 2019) 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) - Zero incidents to date (April 2019) 1+2 From Jan-April 2018 there have been 4 incidents reported on Datix of insects in NucleusTheatres (April 18) - Zero incidents to date (April 2019) 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 - Zero incidents to date (April 2019)	1. Reconfiguration of the Reception Storage being planned by the Estates Dept 1. Work to commence this financial year for fire stopping in clinical areas	Sep-19	2 x 1 = 2 GREEN	May-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 (9/4/19) 2) The number of women booking at RWT is being monitored by Antenatal Payment By Results (PBR) (19/4/19) 3) 13/11/2017 Birth Activity capped (24/1/18) and reviewed Oct 18. Remain in place (9/4/19)	1) Predicted births/booking are recorded on the Maternity Dashboard, RAG-rated and discussed at monthly Governance & Risk Management meeting (9.4.19) 2) Close observation of activity in relation to number of predicted births (9.4.19) 3) The booking cap and out of area requests for births is still active (9/4/19)	1,2) Activity levels are variable and uncontrollable due to births occurring at varying gestations and women transferring in from other units (9.4.19)	1,2) Continue to monitor activity via dashboard 3) Continue to monitor birth activity as a result and decline inappropriate bookings	Jul-19 Jul-19	3 x 2 = 6 YELLOW	May-19	Yes

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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. 9/4/19 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 (9/4/19) 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 (9/4/19) 4) Staff in maternity scan dept.are continually reviewing their staffing levels to escalate their concerns appropriately (9/4/19) 5) Agreement for Sonographers to volunteer to run weekend clinics and exteneded days to increase available scanning slots. (09/04/2019) 6) Current adhoc support from Midwife sonographers enables the sonographers to undertake hip, cranial and emergency gynae scans which have been prioritised. (9/04/2019)	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 (9/4/19) 1-3) The Antenatal Screening Coordinator (Midwife) has not received any notifications from any community midwives to inform of a delay in scan (9/4/19) 1-15) Prioritisation of urgent patients e.g ectopics from ward and EPAU (9/4/2019) 1-15) Patients may be admitted to ward if unable to perform scan and confirm diagnosis (9/4/2019) 1-15) Currently, due to the prioritisation of work, sonographers are attempting to perform scans within standards stipulated for babies and mothers.(9/4/2019) 11) Staff have worked additional hours on the enhanced rate (9/4/19) 1-15) Currently all Obstetric patients still being offered screening and Anomaly scans within the time standard (9/4/19) 1-15) 2 WTE vacancy one of which has been recruited into, 1 WTE will be advertised with support from radiology in order to make the post more attractive. (9/4/19)	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 (9/04/19) 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 (9/4/2019) 11) There remains a vacancy for a WTE sonographer (9/4/19) 1-15) 9 Gynae Fast Track appointments still outstanding (9/4/19)	1) Increase staffing of sonographers in main scan 2) Resolve HR issues 3) Training for x2 Midwife sonographers 0.4WTE 3rd Trimester scans 1) Re-advertise for permanent sonographers	Jun-19 Jun-19 Jun-19 Jun-19	1 x 3 = 3 GREEN	May-19	

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				7) Selected Low Risk Gynae patients have been referred to Radiology (09/04/2019) 8) Doctors training cancelled as a temporary measure in women and children's to maximise the patients being scanned in a list. (9/04/2019) 9) x2 Sonographers employed via the bank - booked if they are available (09/04/2019) 10) x2 members of staff have increased their hours on a permanent basis (09/04/2019) 11) Enhanced Bank Rates £45/hr are being offered for any part time current staff (09/4/2019) 12) Plans to train a nurse from EGAU to do scanning (9/4/2019) 13) Training 2 midwives to scan 3rd trimester scans (9/4/19) 14) Health & Safety assessment from Occupational Health undertaken (9/4/19) 15) Agency Sonograher started on the 07.01.19 - 0.8 WTE (9/4/19)	1-15) Still working weekend sessions to keep hip scans within 6 weeks (9.4.19) 1-15) Currently all Obstetric patients are being offered screening and Anomaly scans within the screening standard and no incidents have been reported (9/4/19) 13) Midwives training should complete this in June 2019 (9/4/19) 12) Nurse starts University in February 2019 (9/4/19) 1-15) No EPAU clinics cancelled since 07.01.19 (9/04/19) 15) Weekends being utilised to catch-up on Gynae and Hip scans (9/04/19)					

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) 6) Vital PACS upgrade with sepsis module have been implemented on 28th March. Captured data will measure compliance and improvement in identification and timely management of sepsis.	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.	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	x =	May-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 in Dermatology 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) 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 (May 19) 1) 0 FT patients outstanding for first appointment (May 19)	3) Currently have 4 WTE Consultants working, 1 not working, deficit 2 WTE (May 19) 1-3) May 19 compliance with 2 week wait below target at 64% due to increase in referrals in April (2nd highest number of referrals in 12 months) (May 19)	1-4) Implement recommendations from Dermatology external review	Jun-19	2 x 3 = 6 YELLOW	May-19	

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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	Apr-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- 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.					

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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. Date of origin: 11/03/19 Date of escalation: 25/03/19	4 x 4 = 16 RED	1. Vascular support in place for TAVI (Mar 19) 2. Monthly aortic MDT occuring at RWT (Mar 19)	1-2 Have not had to cancel any surgical or TAVI lists for lack of cover (28/03/2019)	1-2 Frozen Elephant Trunk (FET) Device is not yet approved (28/03/2019)	1-2 Further evidence becoming available to enable approval of FET device.	Jun-19	2 x 2 = 4 YELLOW	May-19	