The Royal Wolverhampton NHS Trust

Chief Nurse's Governance Report
1 July 2019

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	1st July 19
Title:	**CNO Governance Report**
Executive Summary:	**1.Trust Risk register (TRR) update – June 19** June TRR update provided with areas for attention highlighted below. **2. Risk Management process** The risk escalation process (where grade is 12+) is amended in Policy (OP10) to allow 3 months for a decision to escalate before the risk grade must be either reviewed or confirmed by the lead manager. **3. Serious Untoward incident (SUI) Performance** Sustained good performance on meeting SUI reporting and investigation timescales, although 1 historic breached continued during May 19 (see section 3). The Executive Significant Event Review Group (ESERG) has expanded its remit to reviewing serious/significant complaints and monitoring Radiation incidents externally reported to the CQC. **4. Information Governance (IG) work plan and risk** CQC is working with NHS Digital to assess compliance with Data Security and Protection Toolkit (DSPT) as part of Well Led reviews. Their assessment will include a review of progress against action plans for non-compliance as well as a sample of areas declared compliant. **5. Governance staffing** Recruitment efforts continue to appoint to Health and Safety vacancy – having regard to apprentice opportunities. Prioritised work plans are in place with some impact routine work plans. An annual report being prepared for July TMC and will highlight work achievements and areas for development. **6. Local Procedures Governance** Data cleans and collation to upload local procedure register to Health Assure in progress. First draft reports expected to be produced end of June. **7. Mortality returns** Slowly progress on SJR 1 and 2 completions. Interviews for SJR reviewers are in progress to support this work. **8. Learning and Improvement** Good feedback received from consultation on the Change Improvement Review framework which will go to Policy Group for approval in July. **9. CQC Well Led Inspection** The Trust submitted the CQC Provider Information Request (PIR) and requested documents by the deadline (29th May). Further requests and queries continue during the inspection window with short response timescales. Recognition and thanks is reiterated to staff for their engagement and support to the Inspection process and CQC timelines.

	10. Health and Safety Compliance Recruitment of H&S staff to deliver work plan continues. Annual programme of audits for 2019/20 developed to prioritise those not seen in the preceding 12 months, nil returns on self-assessments and those with poor compliance (including those stated in section 10 below). Non-compliant findings include out of date risk assessments, open action from previous audit, local inspections not undertaken etc
Action Requested:	**Receive and note,**
For the attention of the Board	
Assure	• ESERG extending its oversight to serious complaints and Radiation incidents • TRR updates requested monthly • TRR process strengthened to drive appropriate risk escalation.
Advise	• CQC Well Led monitoring, oversight and planning work continues.
Alert	• SUI management – one (pre dated) breach to 60 day target continued in May 19.
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Links to Trust Strategic Objectives	1. Create a culture of compassion, safety and quality 2. Proactively seek opportunities to develop our services 3. To have an effective and well integrated local health and care system that operates efficiently 4. Attract, retain and develop our staff, and improve employee engagement 5. Maintain financial health – Appropriate investment to patient services 6. Be in the top 25% of all key performance indicators
Resource Implications:	None
Report Data Caveats	This is a standard report using the previous month's data and updates within a live Datix system. It may therefore be subject to cleansing and revision.
CQC Domains	**Safe:** patients, staff and the public are protected from abuse and avoidable harm. **Effective:** care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence. **Caring:** staff involve and treat everyone with compassion, kindness, dignity and respect. **Responsive:** services are organised so that they meet people's needs. **Well-led:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.
Equality and Diversity Impact	No adverse impact on PPCs
Risks:	See TRR risk detail below plus 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

1 **1. Trust Risk Register**

1 new risk:

5198 - Inability of Community Midwives to complete Early Help Assessments for the Unborn/Newborn babies (COO)

3 risks removed:

4161 - Shortage of Qualified Nurses across the Division (COO)

4547 – Safeguarding (COO)

4955 - MRET/Readmissions/Fines monies (CFO)

4 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)

4113 - Divisions inability to achieve CIP (COO)

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

There are currently 31 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				1 risk	
4 – Likely			10 risks	2 risks	1 risks
3 – Possible			2 risks	14 risks	
2 – Unlikely				1 risk	
1 – Rare					

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

A majority of risks have received updates in June 19, attention is required to the following:

2719 COO – update required, grade under threshold – confirm decision to remain on TRR (p2)
4523 COO – update required (p3)
4761 COO - update required (p7)
4903 COO - update required (p11)
1713 COO - update required (p12)
4529 COO - update required (p14)
3069 COO - update required (p17)

4528 COO - update required (p26)
5112 COO – May update required (p38)

2. Risk Management Incident reporting and Risk Register management

The risk register review and escalation process requires that all grades of 12+ are escalated and approved for admittance to the Trust risk register.
A number of risks on Datix graded 12 and above have not been escalated (with Exec approval) to the Trust Risk Register. The process for risk escalation has been strengthened in Risk Management Reporting Policy (OP10). Risks graded 12+ will be followed up with the Lead manager for either escalation approval or for review and downgrade. Risks that have not been either accepted onto the Trust risk register or revised to local registers after 3 months will be downgraded to be managed at local level and communicated to the area for any necessary correction.

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
May 19	9 (0)	4	3	5	1	0
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.	No Breaches in month for May. One breach continues from previous months.	

4. Information Governance work plan

Indications from NHS Digital Pilots and feedback from Trusts having recently completed Well Led reviews indicate a specific focus on Information Governance (IG) compliance. Trusts were asked to demonstrate progress against Data Security and Protection Toolkit (DPST) action plans and sample check were undertaken for some standards declared compliant in the March 19 DSPT submission. Routine monitoring of DPST action plans occurs at IG Action Group and Steering Group. Internal checks on DPST evidence provided is being conducted. A Band 6 IG Officer role has been offered, pre-employment check and start date awaited. It’s likely to be 2-3 months before this role commences in the Trust, in the interim a reduced priority work plan continues until resource is improved.

5. **Governance staffing**

Recruitment still in progress for H&S and Divisional Governance portfolios.

6. **Local Procedures and Guidelines – Governance (June 19)**

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. Once reports begin to be produced, further data cleans and update will be required from Directorates to maintain an up to date register.

7. **Mortality process**

NB. SJR figures below are as at the 3rd June 19 and will change daily.

SJR1 review process
92 SJR1 reviews are outstanding.
36 SJR2 reviews are outstanding.

All have routine monthly follow up via Mortality leads. Progress is reported to QSIG via the Divisional Highlight reports.

As at 5th June 19, SJR2 judgements of overall care show predominantly adequate and good care. Interviews are in progress for SJR reviewers to assist completion.

SJR2 findings where poor care was judged indicate:
Ongoing care - Inadequate monitoring, escalation – RCA investigation commenced
EoL care – Failure to palliate/ recognise poor prognosis/DNACPR documentation – fed back for learning to area.

8. **Learning and Improvement**

A draft Change Implementation Review Framework will go to July Policy group. A discussion in progress with CQI leads will ensure alignment with CQI functions and the appropriate use of the review framework.

9. **CQC Well Led Inspection**

With the CQC PIR document request submitted, the weekly Well Led meeting continues to plan for the upcoming Well Led review and monitor requirements within business as usual. A gap analysis and action plan is created highlighting areas for ongoing work.

Oversight of the 2018 CQC action plan is monitored at COG.

10. **Health and Safety Compliance**

All areas are required to complete and return a self-assessment audit twice yearly. The return rate for year period 18/19 is below:

- Self-Assessment 1 = 136/225 – 60% returned
- Self-Assessment 2 = 118/225 – 52% returned

Non-returns are reported to Division via the quarterly Divisional Health and Safety report as well as direct follow up made between H&S staff and Directorates. Divisions and Directorates are asked to prioritise the monitoring of H&S returns since this can adversely affect assurance and complete reporting for Health and Safety.

Due to staffing resource, areas audited by H&S team over the past 12 months are detailed below. Recruitment to H&S role continues.

Division 1 - 73% audited
Division 2 – 40% audited
Division 3 – 53% audited
E&F – 40% audited
Corporate – 89% audited

Routine H&S compliance audits have given an overall rating is RED (RED – significant gaps to address) in the departments listed below.

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

The 2019/20 audit programme will prioritise areas not seen in the preceding 12 months, those with poor compliance and nil returns of self-assessments.

Appendices

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

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

Lead Director	Risk	Risk Title	Field updated	Update made
Chief Operating Officer	5198	Inability of Community Midwives to complete Early Help Assessments for the Unborn/Newborn babies		
			New risk	If the Local Authority are unable to provide training to maternity staff on the Eclipse System which is required for the completion of the Early Help Assessments (when unborn/newborn babies in need do not meet the Local Authority threshold for risk of significant harm) then then there is potential for escalation for a child in need to become a child at risk of significant harm. This will result in an increase in multi-agency referral forms (MARF) being sent to the Wolverhampton Multi Agency Safeguarding Hub (MASH). Currently MARF forms are being rejected by the MASH if they do not meet the threshold for child protection.
	4170	Lack of capacity - OPD, Snowdrop Suite and Durnall Unit		
			Positive Assurance – **New**	Staff transfer has not been required in this month
			Positive Assurance – **New**	1st and 2nd process map of patient journey through the Durnall Unit undertaken
			Positive Assurance – **New**	Increase in patients treated within "Golden Hour"
			Gap in Assurance - **New**	Recent RCA investigation has highlighted human factors linked to capacity and environment
			Action Plan - **New**	Undertake 3rd process mapping exercise
			Action Plan - **New**	Implement actions from RCA re documentation in Durnall and development of SOP for direct ward admissions
			Action Plan - **New**	VCP required for additional AOS nurses
			Action Plan - **New**	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
	4472	Delays in triage in ED		
			Risk level downgraded	Was RED now AMBER
			Gap in Assurance - **New**	Inability to achieve 2 hr target in month, significant delays experienced
	5083	Lack of trustwide dysphagia framework		
			Positive Control – **New**	IDDSI (International Dysphagia Diet Standardisation Initiative) fully implemented across Trust
			Positive Control – **New**	Implementation in progress with NHS/PSA/RE/2018/004
			Positive Assurance – **New**	Full implementation of IDDSI across Trust
			Positive Assurance – **New**	Mainly compliant with Patient Safety Alert (NHS/PSA/RE/2018/004) - few remaining local actions being monitored via Nutrition & Hydration Steering Group
	5173	IT infrastructure in Audiology clinics		
			Gap in Assurance - **New**	Interrupted, incomplete and rescheduled appointments (12 incidents reported via Datix since December 2018)
	4599	Emergency Services Governance Arrangements		
			Positive Control – **New**	Directorate appointment of Quality and Compliance officer in post
			Positive Control – **New**	Second Matron in post
			Positive Assurance – **New**	Backlog of unapproved incidents reduced
			Action Plan - **New**	Implement new process of all incidents
	4596	QS104 - Gallstone Disease		
			Positive Assurance – **New**	From 05/03/19 to 21/05/19, 11 patients admitted with cholecystitis have been operated on during their

				index admission on the hot gallbladder list (If there are no hot gallbladders for that day, then the rest of the list has been filled with elective gall bladders or other emergency patients)
			Positive Assurance – **New**	Hot gallbladders undertaken on the CEPOD list by both UGI and non UGI Surgeons
			Gap in Assurance - **New**	From 05/03/19 to 21/05/19, there have been 6 other patients listed who were unfit for surgery.
	4113	Divisions inability to achieve CIP		
			Positive Assurance – **New**	CIP partner now in post
			Positive Assurance – **New**	£6.4m CIP target now received for Div 2
			Positive Assurance – **New**	Division 2 over performance in Mth 1 of £1.1m
			Positive Assurance – **New**	Division 1 - Against a target of £192k, £48k of CIP has been achieved in month
			Positive Assurance – **New**	Division 1 CIP target for 19/20 is £9.3m, the Division has achieved £443k in month (5% of the target in year). Recurrently £185k has been achieved
			Action Plan - **New**	Activity data to come to Div 2 Core Team Meetings
	4382	NX55 Main Theatres, Wards A12, A14, Admin, Plant Rooms) - Fire Safety		
			Positive Assurance – **New**	0 incidents relating to Reportable Fire's within May 2019
			Positive Assurance – **New**	0 Unwanted Fire Signals within May 2019
	4411	NX08/NX09 McHale Building - Fire Safety		
			Positive Assurance – **New**	0 incidents relating to Reportable Fire's within May 19
			Positive Assurance – **New**	0 Unwanted Fire Signals within May 19
	4375	NX87 Heart Centre - Fire Safety		
			Positive Assurance	0 incidents relating to Reportable

			– **New**	Fire's within May 19
			Gap in Assurance - **New**	2 unwanted fire signal during May 2019 (Cooking on ward)
			Action Plan - **New**	WMFS to approve 4 stage Plan following
	5069	Dermatology Fast Track Capacity		
			Positive Control – **New**	Monitoring of two week wait referrals
			Positive Assurance – **New**	Two week wait referrals now increased to 88.5% from 64%
			Action Plan - **New**	Directorate Manager to present updated action plan on monthly basis to Divisional Oversight Group
	4547	Safeguarding		
			Downgraded from 12 to 9. Now managed on Directorate risk register.	
	4161	Shortage of Qualified Nurses across the Division		
			Downgraded from 12 to 9. Now managed on Divisional risk register.	
	4706	Infrastructure/environment in Nucleus Theatres		
			Positive Assurance – **New**	No reported incidents of insect infestation for last 6 months
			Gap in Assurance - **New**	Three recent incidents of fire alarms sounding in theatres - of unknown cause.
	2080	Risk to quality of patient care: reduced manpower		
			Positive Assurance – **New**	72.65 wte trained nursing vacancies remain, 39 roles offered, but not in post
			Positive Assurance – **New**	30 students offered roles to start in Sept 19
			Positive Assurance – **New**	1 bay closed on C25

			Action Plan - **New**	Local recruitment in place - await outcome
			Action Plan - **New**	Investigate use of Pharmacists in drug admin to free up trained nurses
Chief Nursing Officer	3644	If the Trust fails to sustain improved compliance with CQC standards the rating of Good will could decline and progress will not be made towards Outstanding.		
			Positive Control – **New**	Information provided in PIR according to timescales
			Action Plan – **New**	Collate examples of outstanding and circulate.
			Action Plan – **New**	Deliver comms plan
			Action Plan – **New**	Provide evidence and gaps around KLOES
Medical Director	4661	Lack of robust system for review and communication of test results		
			Positive Assurance – **New**	TD Web requesting facility is disabled, allowing only for the review of historic results. This will continue with monitoring of usage until further notice (May 19).
			Positive Assurance – **New**	From 3rd September 19 histology results will be available via ICE. Moving closer towards the use of ICE for results reporting (June 19)
			Gap in Assurance - **New**	Currently unable to" freeze" TD Web which means it is still available for reviewing results in conjunction with ICE
			Gap in Assurance - **New**	ICE filing compliance remains low across all reporting (circa 20%)
			Action Plan – **New**	Task and finish group to tailor the rebuild of ICE in readiness for new BCPS system in Feb 20 (only available via ICE).
			Action Plan – **New**	Trustwide SOP for use to be developed alongside rebuild of ICE system
Chief Financial Officer	4955	MRET/Readmissions/Fines monies		
			*****Risk closed*****	The Trust received the MRET/ readmission money therefore risk is to be closed.

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 (12 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)	Aug-19 Aug-19	1 x 1 = 1 GREEN	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?
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 (08/05/2019) 3 & 4. No patients have declined the procedure as a result of being open (08/05/2019) 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 (08/05/2019) 1-5 HCU's are tested for infection monthly (08/05/2019) 3 & 4 All HCU use on patients are recorded (08/05/2019) 1-5 All HCU cleaning is recorded (08/05/2019) 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 (08/05/2019)	5) Potential for list cancellation - None cancelled to date (08/05/2019) 5) 3 out of 6 HCU machine have failed recently, 2 of which are irreparable (08/05/2019) 5) A gap in HCU availability from manufacturer due to demand nationally (08/052019)	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 company's new 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	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	1-3 (03.06.19) From 05/03/19 to 21/05/19, 11 patients admitted with cholecystitis have been operated on during their index admission on the hot gallbladder list (If there are no hot gallbladders for that day, then the rest of the list has been filled with elective gall bladders or other emergency patients) 1-3 (03.06.19) Hot gallbladders undertaken on the CEPOD list by both UGI and non UGI Surgeons	1 (08.05.19) Patients are presenting with complications of gallstones 1 (05.07.18) Local audit showing recurrent admissions 1-3 (08.05.19) Highlight as a 'service at risk' to Division and as part of Medical Workforce Report 1-3 (08.05.19) Unable to appoint to the 4th UGI Consultant post 1-3 (03.06.19) From 05/03/19 to 21/05/19, there have been 6 other patients listed who were unfit for surgery.	(14.06.19) Additional recruitment and training of staff for another half day list per week (Critical Care Services Directorate) (14.06.19) Re-locate UHNM staging lap list on Friday morning to give weekly 3rd session (Critical Care Services Directorate) (14.06.19) Recruit 4th UGI surgeon 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 (14.06.19) Involvement with Surgical Ambulatory Emergency Care Network.	Jul-19 Jul-19 Mar-20 Sep-19 Sep-19 Mar-20	2 x 2 = 4 YELLOW	Jun-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 (08/16) 2) Review of Governance work streams at the Divisional Governance meetings, incuding NICE, External guidance, Audit, Risk (08/16) 3) Monitoring of all SUI/Audit actions through to completion. SUI actions are easily accessable on W Drive and reviewed on a monthly basis in a meeting (08/16) 4) Performance meetings in place (08/16) 5) Directorate Governance meeting in place and attended by Directorate Management Team (08/16) 6) Directorate appointment of Quality and Compliance officer in post (05/19) 7) Process in place to review re-attendances for potential SUI's proactively (08/16) 8) Ongoing recruitment (links to risk 2374 (medics) and 4496 (nursing) [09/17] 9) Governance pre meets in place (11/16) 10) Incident reporting and governance covered as part of junior doctors induction (12/17]	1) Bd7 nursing forums taking place regularly and working well (05/19) 3) Local audit around documentation of senior review and ECG is showing good compliance (05/19) 8) Quality Improvment Lead started (05/19) 8) 2nd Matron in post (05/19) 3) Reviewed weekly by Clinical lead in the Consultants meeting and Documentation review done by Junior Doctor's mentors(05/19) 2) Backlog of unnaproved incidents reduced (06/19)	3) Some actions not relating to ED are taking a considerable amount of time to implement/ close (05/19) 12) Historic incidents under review (06/19)	3) Meeting to explore more established clinical engament with Governance Process	Jul-19	2 x 3 = 6 YELLOW	Jun-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 [12/17] 12) Quality and compliance officer to agree new incident reviewing process within 2 matrons and group manager (6/19) 13) Substantive consultant establisment to 5 paeds and 9 adults (with 2 additional locums) [07/18] 14) HOT reporting of radiological results in place (07/18] 15) Second Matron in post (03/19)						

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. This will result in a risk to patient safety because the quality of care provided by locums can be variable and also to the health and well being of our existing staff because they are being regularly asked to work more and more extra shifts. Current position: there are 5 Cardiology vacancies, 1 Cardiothoracic vacancy and 3 for Anaesthetics. 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 (08/05/2019) 1-3 Training of ACCP's continues and will take a further 12 months (08/05/2019) 6. Cardiology: 2 candidates soon, Clinical Fellowship Programme. (08/05/2019)	1 & 2. Anaesthetics - x5 vacancies - delays on getting paperwork, GMC through since July 2018)08/05/2019) 1. Cardiothoracic vacancy from 1st March 2019 (08/05/2019) 2. ACCP's x2 being trained, training will take a further 12 months to complete (08/05/2019) 6. Cardiology: Very few suitable candidates available. 1 doctor recruited into MTI post has failed IELTS and must resit next month (08/05/2019) 6. Cardiology: Staff generally recruited from abroad need IELTs, GMC and visa (08/05/2019)	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) IDDSI (International Dysphagia Diet Standardisation Initiative) fully implemented across Trust (May 19) (4) Under Care Pathway, wards manage initial presentation and then refer to SALT who see patients within 2 working days (Nov 2018). (5) Implementation in progress with NHS/PSA/RE/2018/004 (May 19)	(1) Full implementation of IDDSI across Trust (May 19) (5) Mainly compliant with Patient Safety Alert (NHS/PSA/RE/2018/004) - few remaining local actions being monitored via Nutrition & Hydration Steering Group (May 19)	(1) PHSO C203652 aspiration pneumonia in Mar 18 [May 19] (1) RCA 2017/30312 aspiration pneumonia in Nov 17 [May 19] (1) 20 x related datix incidents in 2017; 15 x related datix incidents to Nov 2018 [datix reports Nov18-Apr19 under review] [May 19] (2) Staff who are untrained/ no competency cannot use swallow screening tool (all areas outside Stroke) [May 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 [May 19]	(4) Investigate the possibility of extending the SALT service beyond working days only - business case to be completed	Jul-19	x =	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?

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 2019/2020 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 (06/19) 3. VCP meetings held weekly and posts go through this process for all Divsions (06/19) 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. (06/19) 1-10) CIP partner now in post (06/19) 1-10) £6.4m CIP target now recieved for Div 2 (06/19) 1-10) Division 2 overperformance in Mth 1 of £1.1m (05/19) 1-10) Division 1 - Against a target of £192k, £48k of CIP has been achieved in month (May 2019) 1-10) Division 1 CIP target for 19/20 is £9.3m, the Division has achieved £443k in month (5% of the target in year). Recurrently £185k has been achieved (May 2019)	2 & 3. Unidentified CIP still remains across the divisions (06/19)	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) Division 1 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 1-10) Activity data to come to Div 2 Core Team Meetings	Apr-19 Apr-19 Apr-19 Apr-19 Apr-19 Apr-19 Jul-19 Jul-19	3 x 3 = 9 AMBER	Jun-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 (08/05/2019) 5. Consultant Thoracic Surgeon recruited and in post (08/05/2019) 5. Locum in post and contract has been extended for a further 6 months (08/05/2019) 1-4 Continue to approach other Trusts for referrals (08/05/2019) 1-4 Walsall plan to agree SLA with RWT (08/052019)	1. Referrals have not increased, this has been escalated to DCOO and COO (08/05/19)	1-4 Plan further approaches to Walsall Hospital	May-19	1 x 5 = 5 YELLOW	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:	**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	5 x 4 = 20 RED	1) Ongoing active recruitment exercises - including overseas (Jul 2018) 8) Use of Nurse Bank when required (Jan 16) 3) Defined minimum safe staffing levels now in place revised October 2017 5) Modified dependency tool for inpatient areas commenced (Jan 16) 9) Staffing incidents reviewed on monthly basis (Jan 16) 10) Closed Ward 3 at West Park Hospital (June 16) 4) Closed ward B7 (June 2017)	8) HCA's are available via Bank (06/19) 1) Proactive recruitment approach continuing (06/19) 1-10) Monthly workforce group reviewing nurse recruitment and retention (06/19) 1) 72.65 wte trained nursing vacancies remain, 39 roles offered, but not in post (06/19) 1) Continued recruitment to nursing clinical fellows (06/19) 1-10) Matrons meeting every Friday to ensure hospital is staffed over the weekend (06/19) 3) Snr Srs and Charge nurses meeting daily to ensure wards are safe (06/19) 1) 12 offers made following Phillipines recruitment, 20 from SA and 4 from Nigeria (06/19) 3) 30 students offered roles to start in Sept 19 (06/19) 3) 1 bay closed on C25 (06/19)	8) Insufficient RN's available on Bank, backfilled by HCA (06/19) 1) Nationallly we are an outlier re safe staffing levels (06/19) 1) Recruited staff are newly qualified which can lead to mentorship and training pressures (06/19) 1) All wards are 'Amber' re safe staffing levels on daily basis (06/19) 3) Issue remains in relation to ability to provide accurate staffing figures (06/19) 3) Breaches in minimum safe staffing levels (06/19) 3) Significant nursing shortages on C16, C24 and C25, working with 50% vacancies at Bd 5 level. C19 also a concern (06/19)	1) Continue with proactive recruitment approach 1) UK recruitment for Clinical Nurse Fellow posts - ongoing recruitment 3) Local recruitment in place - await outcome 1-10) Investigate use of Pharmacists in drug admin to free up trained nurses	Jun-19 Jun-19 Aug-19 Aug-19	4 x 3 = 12 AMBER	Jun-19	Yes

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

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
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 (May 19) 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 (May 19)	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 (June 19) 1) Monitor monthly performance through the nursing midwifery KPIs reported to QSIG (June 19) 1) Environmental Standards are monitored via the environmental group monthly (June 19) 1) Daily staffing (safe staffing, Skill mix) is monitored via the Divisional ops meetings (June 19) 1) Fundamental standards are reviewed & monitored by the designated specialist groups and bi annually by the sponsor which then reports to COG (June 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 (June 19) 1) Mortality QI plan is monitored via Programme Board monthly and learning outcomes via MRG (June 19) 1) EOL strategy with TOR has been developed and milestones monitored via the EOL group monthly (June 19)	1) Nursing and Midwifery KPIs are on Health Assure reporting and emailed out to ward sisters/matrons and HoNs monthly. (June 19) 1) QRV process is now embedded and refined, plan formulated for ongoing inspections 2019/20 (June 19) 1) Lord Carter metrics monitored monthly via Divisional Performance meetings (June 19) 1) Registered nurse vacancies for May have reduced from 31.88 to 9.05 WTE when compared with April's data. (June 19) 1) Divisions monitor performance via monthly Governance meetings (June 19) 1) Improved staff survey results ((June 19) 1) There is a system of nursing audits taking place monthly (June 19)	1) Vacancy rates remain high in some areas (June 19) 1) Safer staffing fill rates remain transient particularly for nights (June 19) 1)Outliers for Mortality HSMR and SHMI rates in National data sets (June 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 (June 19) 1) System change to Health Assure meant delay with nursing audit data was not available until March 2019 (June 19) 1) HCA vacancies have increased from -5.26 to 13.83 WTE	Review Intranet to ensure current content Collate examples of outstanding and circulate. Deliver comms plan provide evdence and gaps around KLOES	Nov-19 Jun-19 Jun-19 Sep-19	2 x 2 = 4 YELLOW	Jun-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 of the Nursing System Framework monthly via TMC (June 19) 1) Monitoring via Quality review visit and re-visit programme to assess CQC compliance (June 19) 1) NEWS2 implemented Trust-wide (June 19) 1) Information provided in PIR according to timescales (June 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 (14/06/19) 5. Morbidity & Mortality Reviews (14/06/19) 7. Capacity Reviews, Weekly Community clinics (Weds weekly, Fri alternate weeks) (14/06/19) 3. Staff from ward and Educational facilitators used to provide support at times of increased demand (14/06/19) 1. Door to needle times monitored for sepsis patients. Summary of 2 monthly Sepsis Audit findings (14/06/19) 2. Actively monitoring PALS feedback about the Durnall Unit (14/06/19) 9. Facilitate transfer to Deanesly and CHU within department opening times (14/06/19)	6) Approx 40% of nurses now trained to take blood cultures (06/19) 1-9) Service Improvement Team undertaking demand v activity v capacity (06/19) 7) Positive feedback from patients about the weekly community clinics (06/19) 1-7) 1st and 2nd process map of patient journey through the Durnall Unit undertaken (06/19) 2. No Further PALS concerns this month (06/19)	7) Overspend for Directorate (06/19) 7) Capacity review means some patients may have to attend hospital every other week (06/19) 6) Approx 60% of nurses still to be trained to take blood cultures. Training postponed (06/19) 9) Inadequate floor space found by H&S Health Building Note 00-03 review. This stated that 1.5m2 should be provided for ambulant persons and 3.0m2 for wheelchair users. Effectively the space currently seating 15 should realistically seat 6 ambulant and may be 1 wheelchair (06/19) 5) Recent RCA investigation has highlighted human factors linked to capacity and environment (06/19) 8. SEPSIS 6 Rolled out in dept reduction in door to needle time complainace and compatability with vitalpac(14/06/19) 6. Nurses trained to take blood cultures (14/06/19) 10) Decrease in patients treated within "Golden Hour" . (06/19) 9) Patients stranded on Durnall Unit after 7pm in month (06/19) 3,4) Staff transfer has been required in this month (06/19) 6) Nurse training on hold	1)Training for PGD antibiotics and competencies, PEF's to be included in competency training, facilitator. Currently with MMC. No suitable facilitator due to poor sepsis compliance 7) 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-ongoing 1-9) Update for demand and capacity project ongoing. - Manx Baker Servive Improvement 6) Ongoing training for nurses to take blood cultures- 13/06 on hold until workforce more stable 7) Risk Assessment re Durnall patient capacity to be completed, to be updated DBK - new Risk 5240 RA AHSCT+1 completed 13.06.2019 5240 9) Utilising Discharge Lounge for appropriate patients 9) Monitoring of Patient waits on Durnall 9) Scheduling of patients attending Durnall Review	Sep-19 Jul-19 Sep-19 Sep-19 Sep-19 Jul-19 Sep-19 Sep-19 Sep-19	3 x 3 = 9 AMBER	Jun-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?
							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 Sep-19			
							1-8) 95% staff to attend sepsis study day and online training - study day 11.06.2019 well attended remainder of staff to be captured Aug-19			
							1-8) Post non compliance sepsis investigation staff to reflect on findings - ongoing Sep-19			
							1-7) Undertake 3rd process mapping exercise Jul-19			
							5) Implement actions from RCA re documentation in Durnall and development of SOP for direct ward admissions from end of PCM process Aug-19			
							7) VCP required for additional AOS nurses requires BC Jul-19			
							1-9) Audit underway of coding and capturing of patient activity - ongoing Sep-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 May 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 from outer building. Inner courtyards had been resolved. 4) WMFS Informed of progress with regards to removal of ACM Cladding	9) Outstanding fire stopping required following compartmentation survey 10) 2 unwanted fire signals during May 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 1) WMFS to approve 4 stage Plan following	2 x 2 = 4 YELLOW	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	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 May 2019 3. Fire strategy has been approved and money set aside. 1. 0 Unwanted Fire Signals within May 2019 1. Fire Alarm is being upgraded to L1. Being montiored via Fire Safety Group	2. Compartmentation Survey to be completed 3. Operational issues have meant the fire strategy work will take longer to complete with some work on hold 1. Fire alarm & ancilliary systems do not comply with current regulations	1. monitor and work towards completion of fire stategy for block	2 x 2 = 4 YELLOW	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	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 May 2019 1. 0 incidents relating to Reportable Fire's within AMay 2019 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	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	4472	If patients wait over 15 minutes for triage and 2 hours for assessment by a Dr 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	3 x 4 = 12 AMBER	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 (06/19) 4-5) Reallocation of staff working well to help reduce wait times during pressured times (06/19) 15) Urgent treatment doctor is making an improvement to patients recieving appropiate emergency treatment (06/19) 17) Additional triage room helping to reduce triage wait times (06/19)	1, 2) Inability to achieve 15 minute triage consistently breaches mainly in minors (06/19) 4,5) Staff not always available to be reallocated (06/19) 7) Medical and nursing vacancies and sickness/ annual leave resulting in gaps in rota. Link to risk 4496 and 2374 (06/19) 9) UCC minimum impact on pt numbers and delays in assessments (06/19) 7) Continued use of long term locums (06/19) 1) Inability to acheive 2 hr target in month, significant delays experienced (06/19)	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	Jul-19 Jul-19 Jul-19	1 x 4 = 4 YELLOW	Jun-19	Yes

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
				11) Human factors review completed and resulted in department restructure. All staff provided with human factors training and rapid improvement events [6/3/19] 12) Medical and nurse staffing managed via the risk regsiter (risk 2374 & 4496) [5/3/19] 13) Nurse led RAT and SOP ratified and in place (5/3/19) 14) Where possible, newly qualified starters have their last student placement transferred to RWT ED [5/3/19] 15) System in place to ensure that Cat 2 patients are shown red at 15 minutes. Urgent treatment Doctor role developed to see cat 2 patients [5/3/19] 16) Use of internal bank rather than locum agencies where possible [5/3/19] 17) Extra Triage room and escalation process in place [5/3/19] 18) Escalation tool developed and identifies pressure points with agreed action [5/3/19] 19) Appointed Specialty Doctor in November 18 (5/3/19) 20) GIRFT Visit to be reviewed by end of July (7/19)						

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
				3) A management consultant from Industry visited the Trust at the beginning of February to look at flow in Minors awaiting feedback (6/3/19) 21) Every member of staff has additional training 1 day per year (6/3/19)							
Chief Operating Officer	4528	If Clinical Web Portal does not contain full copies of patient's notes/health records (if seen before 2013) as well as all Paediatric admissions/Badgernet information then clincians will only have access to an incomplete health record for inpatient and outpatient encounters. Lack of a comprehensive record may impact on the accuracy and/or timeliness of clinical decision making. NHSI link NE's to lack of complete clinical records in OPD clinics. Date of origin: 29/04/16 Date of escalation = 17/05/16 Risk Lead: Div 1 Deputy COO	4 x 3 = 12 AMBER	1. Ability to request paper notes (May 16) 2. Process for both access to patient records aswell as the process for when there is a need to have a complete patient scanned has been circulated by Patient Access (Dec 16) 3. Badgernet System in place in Maternity (Feb 19)	1) No continuous Datix incidents (May 19) 3) Badgenet System embedded within the Maternity department (May19) 2) Procedures in place to access paper records/request scanning of records onto portal (May 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 (May 19) 1. Records are not always available for elective clinics, even if they are available this creates a time lag within the clinic (May 19) 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 (May 19) 3) Restricted access to the Badgernet System - no immediate access to Maternity notes (May19)	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?
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 6) TD Web requesting facility is disabled, allowing only for the review of historic results. This will continue with monitoring of usage until further notice (May 19). 6) From 3rd September 19 histology results will be available via ICE. Moving closer towards the soe use of ICE for results reporting (June 19)	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) 3,6) Currently unable to" freeze" TD Web which means it is still available for reviewing results in conjunction with ICE (June 19) 6) ICE filing compliance remains low across all reporting (circa 20%) (June 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. 1-6) Task and finish group to tailor the rebuild of ICE in readiness for new BCPS system in Feb 20 (only available via ICE). 6) Trustwide SOP for use to be developed alongside rebuild of ICE system	Aug-19 Sep-19 Feb-20 Feb-20	x =	Jun-19	Yes

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	4665	If the X-ray and CR processing equipment at Cannock Hospital (which is over 13 years old) is not replaced within the Capital Programme then due to the age of the equipment there is an increased possibility that there will be equipment breakdowns/failures which could then directly impact the service offered. Also, patients are currently not in receipt of the advances in technology which a new machine could offer them i.e. lower doses of radiation and a speedier/quicker service. Date of origin: 17 November 2016 Date of escalation: 26 April 2017 Risk Lead: Radiology Group Manager	3 x 4 = 12 AMBER	1) Maintenance contract in place 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. (Jun 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 (Jun 2019 5) Equipment replacement programme commenced 18.03.2019 (Jun 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 (Jun 2019)	1) Any breakdown causes disruption to the service offered to patients. Breakdowns encountered with CR readers 11; X-ray equipment 3 (Jun 2019) 2) No focus choice on Mobile X-ray Unit and reliance on ageing CR processing equipment (Jun 2019) 4) X-ray service will be limited if CR processing facilites fail (Jun 2019) 1) Since Jan 2018 there have been a 5 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 (Jun 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	Jun-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 (2 in place) (Jun 2019) 4) Review meetings are happening fortnightly (Jun 2019) 1), 5) & 6) Backlog has reduced from 7332 May 2017 to less than 4021 in May 2019 (Jun 2019) 3) Office space sourced (Jun 2019) 1) The backlog is actively monitored by Group Manager (Jun 2019)	1) Approximately 4021 non-urgent imaging studies unreported May 2019 (inclusive of 594 CT scans and 1901 MRI scans). Over 20 days there are 1515 in total (inclusive of 231 CT scans and 880 MRI scans) (Jun 2019) 1) Poor patient experience if patients and doctors are unsure when their scans are reported (Jun 2019) 3), 4), 5) & 6) Demand for reporting imaging studies is higher than expanded reporting capacity (Jun 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	Jun-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 - usually in the form of water leaking through ceilings 2. Electrical infrastructure - emergency power back-up in theatres 3. Fire safety - storage of equipment and consumables compromising emergency evac routes 4. Operating lights - (addressed) 5. Air-flow/ventilation - (addressed) 6. Storage - not enough dedicated storage space in theatres for equipment and consumables 7. Insect infestation - flies and bugs being seen in theatres All of the above could lead to 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 to Divisional Management: 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) - COMPLETED 2. All leakage/flooding incidents reported to management are immediately escalated to Hotel Services 3. Theatre 5 was closed for refurb between April 2017 and Oct 18 - Now open and is fully utilised.	1 - 7 No procedure cancellations due to any of the above issues for 6 months. (April 2019) 1 - No reported incidents of Sewage ingress / water leaks since Nov 2018. (April 2019) 2 - No reported incidents of power outage or back-up power failure. (April 2019) 7 - No reported incidents of insect infestation for last 6 months. (April 2019)	3) Three recent incidents of fire alarms sounding in theatres - of unknown cause. (April 2019)	1 - Reconfiguration of Theatre Reception and Storage will be carried out this year 1 - Work to commence this financial year for fire compartmentalisation in clinical areas	Sep-19	2 x 1 = 2 GREEN	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	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	2 x 4 = 8 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 (08/05/2019) 2) Close observation of activity in relation to number of predicted births (08/05/2019) 3) The booking cap and out of area requests for births is still active (08/05/2019)	1,2) Activity levels are variable and uncontrollable due to births occurring at varying gestations and women transferring in from other units (08/05/2019)	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	Jun-19	Yes

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	5031	If sub-optimal staffing (reduction in 39%) continues within the ultrasound scan department then it will impact on required compliance with national screening standards - this includes submitting required data and proving quality of work is assessed continually for obstetric patients. Neonatal Hip and cranial scans also need to comply with national standards and this may be affected. Training will also be impeded affecting the future of service provision. There may be a rise in litigation cases and disability. Delayed access to emergency gynae assessment unit / Fast Track clinics may lead to misdiagnosis of urgent care / life threatening conditions such as ectopic pregnancy and gynae cancers, and failure to meet national 2 week targets. There is potential for late discharges or treatments for obstetric, gynae and paediatric patients. Delayed access to ultrasound scans such as in August increases the risk of misdiagnosis of some high risk obstetric patients. Date of origin: 17/05/18 Date of escalation: 04/10/18 Risk Lead: Head of Midwifery	3 x 4 = 12 AMBER	1) Dating and Fetal Anomaly scans are given priority over Gynaecology scans to ensure women have their scan performed in accordance with the national programme standards. 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 (5/6/19) 1-3) The Antenatal Screening Coordinator (Midwife) has not received any notifications from any community midwives to inform of a delay in scan (5/6/19) 1-15) Prioritisation of urgent patients e.g ectopics from ward and EPAU (5/6/2019) 1-15) Patients may be admitted to ward if unable to perform scan and confirm diagnosis (5/6/2019) 1-15) Currently, due to the prioritisation of work, sonographers are attempting to perform scans within standards stipulated for babies and mothers.(5/6/2019) 11) Staff have worked additional hours on the enhanced rate (5/6/19) 1-15) Currently all Obstetric patients still being offered screening and Anomaly scans within the time standard (5/6/19) 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. 5/6/19)	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 (5/06/19) 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 (5/6/2019) 11) There remains a vacancy for a WTE sonographer (5/6/19) 1-15) 9 Gynae Fast Track appointments still outstanding (5/6/19)	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	Oct-19 Oct-19 Oct-19 Oct-19	1 x 3 = 3 GREEN	Jun-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 (5.6.19) 1-15) Currently all Obstetric patients are being offered screening and Anomaly scans within the screening standard and no incidents have been reported (5/6/19) 13) Midwives training should complete this in June 2019 (5/6/19) 12) Nurse starts University in February 2019 (5/6/19) 1-15) No EPAU clinics cancelled since 07.01.19 (5/06/19) 15) Weekends being utilised to catch-up on Gynae and Hip scans (5/06/19)					

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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) LBR training funding for 19/20 is risk prioritised and includes Intermediate Life Support, Neonatal Life Support, Advanced Paediatric Life Support, ALERT training, ALS, Non Medical Prescribing etc. (May 19)	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 =	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	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) 6) Monitoring of two week wait referrals (June 19)	3) 0 FT patients outstanding for subsequent procedures to be booked (June 19) 1) 0 FT patients outstanding for first appointment (June 19) 6) Two week wait referrals now increased to 88.5% from 64% (June 19)	3) Currently have 4 WTE Consultants working, 1 not working, deficit 2 WTE (June 19) 1-3) May 19 compliance with 2 week wait below target at 88.5% due to increase in referrals (2nd highest number of referrals in 12 months) which is below the recommended target of 93% (June 19)	1-4) Implement recommendations from Dermatology external review 1-6) Directorate Manager to present updated action plan on monthly basis to Divisional Oversight Group	Jun-19 Sep-19	2 x 3 = 6 YELLOW	Jun-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- Band 8a Operational Nurse Manager in place 2- All new starters have a supernumerary period of up to 6 weeks , adjusted to meet their individual needs 3- All inexperienced ICCU staff have a 6 week intensive programme of clinical study days, supported by the Trust Education Team 4- All inexperienced ICCU staff have a weekly documented review, with the PDN, to ensure that training needs are being achieved 5- Each new member of staff is allocated to 2 experienced ICCU nurses for support during their supernumerary period 6- Each new member of staff works 75% of their shifts on Monday-Friday days for 4 months to allow continued educational support 7- Admin and Education Support post has been agreed to allow the PDN to focus on delivering clinical education and support 8- All leavers have an exit interview - feedback from this is used to retain existing staff 9- All staff vacancies are advertised and being recruited to 10- Staff Feedback is encouraged via a 'You said, We did' wall	1- Band 8a Operational Nurse Manager in place has overall responsibility for the service (April 2019) 2, 3, 4, 5, 6 - PDN documentation and e-roster which prevents inexperienced staff being unsupported in patient care. (April 2019) 6, 11, 12, 16, 17, 18 - e-Roster utilised resulting in a decrease in staff disatissfaction. (April 2019) 8, 10, 13, 14, 15 - Meeting notes and minutes, and Datix reports have indicated that staff are aware that they are being listened to and their suggestions considered. (April 2019) 7 - Education team have changed their training delivery method - this is now undertaken at the bedspace. (April 2019) 2, 5, 6, 12, 16, 17 - Currently we only have 2 staff who are supernumerary due to inexperience. This figure stood at 15 staff in Oct 2018. (April 2019)	9 - 5 out of 10 vacancies remain unfilled - further interviews are scheduled. (April 2019)	9 - Recruit to Band 6 and 7 posts 14 - Monitor Datix reports concerning staff shortages and skill mix	Jul-19 Oct-19	2 x 3 = 6 YELLOW	May-19	

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

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				11- Staff have individual rotation plans for CICCU and ICCU experience 12- E-rostering is fully utilised 13- Divisional Management Team has been made aware of the current staffing situation 14- All staff are encouraged to raise concerns and complete Datix reports 15- Staff meetings are held at all staff levels 16- New staff are allocated across the unit to prevent any area being oversaturated with inexperienced staff 17- Staff with less than 12 months experience have their own Team on e-roster 18- 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 (08/05/2019)	1-2 Frozen Elephant Trunk (FET) Device is not yet approved (08/05/2019)	1-2 Further evidence becoming available to enable approval of FET device.	Jun-19	2 x 2 = 4 YELLOW	Jun-19	

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Chief Operating Officer	5198	If the Local Authority are unable to provide training to maternity staff on the Eclipse System which is required for the completion of the Early Help Assessments (when unborn/newborn babies in need do not meet the Local Authority threshold for risk of significant harm) then then there is potential for escalation for a child in need to become a child at risk of significant harm. This will result in an increase in multi-agency referral forms (MARF) being sent to the Wolverhampton Multi Agency Safeguarding Hub (MASH). Currently MARF forms are being rejected by the MASH if they do not meet the threshold for child protection.	3 x 4 = 12 AMBER	1) When a MARF is rejected the community midwife communicates directly with the woman's named GP, health visitor and any other relevant healthcare professional involved in the family to make them aware of the needs of the unborn and newborn 12/4/19 2) When a MARF is rejected the community midwife informs the Named Midwife for Safeguarding who advises a datix to be completed. 12/4/19 3) The community midwife will document the rejected MARF on badger and any additonal information staff need to be aware of. This includes advice given from the Named Midwife for Safeguarding. 12/4/19 4) If a MARF is rejected and there is significant concern from the Named Midiwfe for Safeguarding she will advise resubmission of the MARF with advice on documentation. The named Midwife for Safeguarding will also in this instance contact the MASH and request a social worker assessment. 5) When a MARF is rejected the community midwife will advise the family to self refer to MASH for early help. 12/4/19	2) When a MARF is rejected the community midwife informs the named Midwife for Safeguarding who advises a datix to be completed. Datix to be added to risk register as documents (05/06/2019) 3)There are examples on Badger IT records whereby a community midwife has documented the rejected MARF and additonal information for staff to be aware of. This includes advice given from the Named Midwife for Safeguarding (05/06/2019) 4) Email correspondence to be added to the risk register when a MARF has been rejected and there is significant concern from the named Midiwfe for Safeguarding and she has contacted MASH to request a social worker assessment (05/06/2019)	1-5) Whilst there are controls in place there is still potential for a baby to come to significant harm through injury or death as a result of non-compliance with Health Authority requests for early help assessment (05/06/19) 1-5) There are now issues with training and access to the Local Authority Eclipse System (05/06/2019)	1) Selective members of staff within the community midwife teams to undergo early help assessment training. 1-5) Seek assurance from Local Authority re: training and access to the Eclipse System 1) Undertake an audit of rejected referrals and subsequent outcomes	Aug-19 Aug-19 Aug-19	1 x 4 = 4 YELLOW	Jun-19	