The Royal Wolverhampton NHS Trust

Chief Nurse's Governance Report
5 August 2019

Agenda Item No: 7.2

Safe & Effective | Kind & Caring | Exceeding Expectation

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	5 August 19
Title:	**CNO Governance Report**
Executive Summary:	**1.Trust Risk register (TRR) update – July 19** June TRR update provided with areas for attention highlighted below. **3. Serious Untoward incident (SUI) Performance** Sustained good performance on meeting SUI reporting and investigation timescales is reported below. A new National Serious Incident Framework is expected to be published in July 19. This will bring a number of changes to the management of investigations by providers and Clinical Commissioning Groups (CCG). Preliminary changes include: • Responsibility for closure / sign-off of a Serious Incident to transfer to Trust • CCGs to be consulted and assured of the provider's investigation strategy and infrastructure • Investigations to be undertaken by a specific level of staff • Flexibility to be agreed between provider and CCGs about the incidents that require investigation and those that should be subject to alternative routes of review eg. Quality Improvement project • Introduction of a national framework for investigation training and methodology • Introduction of a mandated standard investigation report template • Flexibility around agreeing the timescale for investigation (typically 3 months but no more than 6 months) There will be a 12 – 18 month transition period to implement the changes. **4. Information Governance (IG) work plan and risk** Significant changes to the DPST require re mapping in order to provide a Trust baseline submission in October 19 – work has commenced. Information Governance incident themes for 2018/19 is detailed below as well as the Trust top IG risks. A detailed IG annual report is produced separately for TMC and TB. **5. Governance staffing** Prioritised work plans are in place for Health and Safety and Information Governance whilst recruitment processes are continue. **6. Governance of local Procedural Documents (ie Clinical Procedures, Guidelines, Protocols etc)** Local procedure reports to Directorates and Divisions will commence wc 22nd July preceded by an all user communication and Health Assure user guide wc 15th July. Areas will be required to update and maintain local procedure registers and ensure compliance with the local document review and approval process. **7. Mortality returns** All Mortality reviewers are now appointed (mix of nurses and medical staff). Themes from internal LeDer reviews are being reported through MRG and a report on wider themes within the region is due in August will provide a

	benchmark as well as independent review of Wolverhampton LeDer deaths. **8. Learning and Improvement** The Change Implementation Review framework is due to Policy Group for approval in Aug due to meeting capacity. **9. CQC Well Led Inspection** Good progress is reported on the closure of previous CQC actions. Inspection planning continues with Board briefings and management and staff communication and engagement.
Action Requested:	**Receive and note,**
For the attention of the Board	
Assure	• ESERG review all serious incident investigation reports and have extending its oversight to serious complaints and Radiation incidents. • TRR updates requested monthly • TRR process strengthened to drive appropriate risk escalation.
Advise	• A New National Serious Incident framework expected to be published in July 19 will require a review of the Trust strategy and arrangements for serious incident investigation. • Areas are asked to maintain focus on the update and maintenance of risk registers across the Trust. • For year period 2019/20, 'Problems in case' assessments and judgements are made by RCA lead and approved at ESERG for all serious incident deaths. • CQC Well Led monitoring, oversight and planning work continues.
Alert	
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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 9 amber 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:

5197 - Unacceptable waiting times for Cardiology follow-up appointments (COO)

3 risks removed:

4599 - Emergency Services Governance Arrangements (COO)

4756 – Increased Activity in Relation to Forecasted Number of Births (COO)

5031 - Potential Non Compliance with The Fetal Anomaly, Paediatric Hips, Downs Pataus, Edwards screening standards (COO)

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

	Consequence				
Likelihood	1 Low	2	3	4	5 High
5 – Almost Certain				1 risk	
4 – Likely			10 risks	2 risks	1 risks
3 – Possible			2 risks	13 risks	
2 – Unlikely					
1 – Rare					

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

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

2719 COO – action update, grade under threshold – confirm decision to remain on TRR
4113 COO – action update
1713 COO – action update
4529 COO – action update
4375 COO – no date on action
4382 COO – no date on action
4411 COO – no date on action
5069 COO – action update
5182 MD – Update required - to follow
5045 MD – Update required – to follow

2. Serious Untoward incident (SUI) Performance

Monitoring of SUI investigation completion to timescale continues at QSIG and the weekly Executive Significant Event Review Group (ESERG). RCA investigation reports are reviewed for final Executive sign off with specific and wider learning/action identified. All serious incident deaths are subject to a 'problems in care' assessment and judgement made by the RCA lead and signed off at ESERG.
The period May 18 to May 19 showed progressive and sustained compliance with SUI timescales, data below will not be reported for financial year 2019/20.

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
April 19	12 (0)	1	6	6	2	2
May 19	9 (0)	4	3	5	1	0
June 19	14(0)	7	3	1	0	0
Analysis	Sustained progress in closure of SUIs within timescale.	Reduction in SUI numbers aligns with the National SUI framework 2015.		Fewer queries from commissioners re RCA reports.	No Breaches in month for June. No breach or outstanding RCAs from previous months.	

3. Information Governance work plan

IG Officer role is due to commence early August. A priority work plan continues until resource is improved. Indications from NHS Digital Pilots and feedback from Trusts having recently completed Well Led reviews indicate a specific focus on Information Governance (IG) compliance will include testing of standards declared compliant and progress review of action plans for non-compliant submissions. Internal checks on Data Security and Protection Toolkit (DPST) evidence provided continues. The 2019/20 DPST has seen a significant change in scope since the last submission; nearly 80% of toolkit assertions have changed. The IG team are mapping the new requirements and evidence against last year's submission as the Trust prepares to make a baseline submission in October 19.

IG Incident patterns for 2018/19:
Lost and stolen paperwork – lost ward handover sheets
Disclosure in error – emails, verbal, fax and other
Data quality – various data errors, failures in data checks
Security failings (organisational and procedural) – safe storage checks, third party contract monitoring.

IG Serious Incident patterns for 2018/19:
Serious unauthorised access
Disclosure in error
Non secure disposal (electronic devices and paper)

Top IG risks to the organisation:

People and process risk – through IG incident monitoring we can see that disclosed in error via various means (verbal, email, post, fax and in person), is a risk to the organisation in terms of the way in which people work. This is always a risk in large organisations such as health. Lost ward handovers continue to be an issue, with paper handovers being a contributory factor to the issue. Unauthorised access has also risen as a theme again in the last financial year due to the open access approach to systems supporting the way we work; proactive monitoring of user access continues to be a challenge for a Trust our size.

Protecting information assets (cyber risk) – due to the increase cyber risk seen to the health sector , knowing what the organisation holds and how this should be protected continues to be a challenge for an organisation the size of the Trust. As well as protecting against threats to large scale assets such as CWP portal and MMS for example, we also need to understand what local information assets are held, how these are managed and protected and what happens in the even they are compromised. A Trust wide information asset mapping exercise is taking place to better understand this issue through the GDPR and DSPT toolkit assurance work.

Third party/ supplier assurance – whilst the Trust has worked to better understand which data processors are handling data on behalf of the Trust, there is still more work to be done ensuing that there are clear contractual stipulations in place to ensure there is explicit instructions in place between the Trust and a third party. This should be supplemented by data sharing/ processing agreements. Robust contract monitoring to ensure these instructions are being followed continues to be a risk, and the Trust currently have a reactive approach to contract monitoring in the event of a data incident. This work also forms part of the DSPT toolkit assurance and GDPR work streams.

4. Governance staffing

Recruitment continues for H&S and Divisional Governance portfolios. New Information Governance Officer due to start early August.

5. Local Procedures and Guidelines – Governance (June 19)

Following the data cleansing a majority of registers have been uploaded to Health Assure. Radiology and Neonate uploads will be completed by the technical team w/e 19th July, ED and AMUs register returns are still outstanding. Draft reports were completed at the end of June 19 and final Directorate and Divisional status reports will be ready for issuing wc 22nd July.

Health Assure User Guides have been developed for Directorate staff responsible for Procedures and Guidelines. Staff communication about the issue of local procedure reports and the use of the Health assure system will begin w/c 15th July 19 and reports to follow wc 22nd July. Following the first reporting in July, the Health Assure system will issue local procedure reports monthly on the 11th of each month to Directorates and Divisions.

Governance continues to support Directorates in adopting the arrangements for local procedures as per OP1.

6. Mortality process summary

The Structured Judgement Review (SJR) is the methodology the Trust uses when completing a review for those deaths that meet the Learning from Deaths policy criteria and is different to the methodology that is used by LeDER national programme. The LeDeR Steering Group for the Black Country are collating the themes from across Dudley, Walsall, Sandwell and Wolverhampton. Wolverhampton specific learning from LeDER reviews is planned to be reported to MRG in August 2019.

NB. SJR figures below are as at the 9th July and will change daily.

SJR1 review process
107 SJR1 reviews are outstanding.
46 SJR2 reviews are outstanding.

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

Mortality Reviewers are now appointed and all SJR2s have been re-allocated for completion.

Learning – SJR1 Reviews:
SJR 1 reviews for the period of 01/04/2019 to 31/05/2019 showed a majority of 'poor care' findings were in Phase 2 'ongoing care' and Phase 6 'overall care'. For context these related to 2 cases.

SJR 1 Analysis – Patients with Learning Disabilities:
An analysis of those SJR1s where a patient has learning disabilities has been undertaken and reported to Mortality Review Group. 19 Deaths have been identified (as at 25th June). The highlights from the analysis are:

- 42% (8) of all the SJR1 are related to Respiratory Medicine, followed by Care of Elderly Medicine) and Renal Medicine specialties
- Poor care judgements cross into three phases: Ongoing Care, Care during a procedure & Overall assessment. The themes relate to medication, communication and paperwork.
- The excellent care themes relate to: speed of treatment, great communication, and medical practice.

Examples of positive themes:

- Phase of care: 1 - Good medical practice & Care - Good initial care with recognition of pneumonia and antibiotics given in timely fashion
- Phase of care 2 - Good medical practice & Care - patient seen by oncologist within 24 hours of admission and received good care.
- Phase of care 5 -Communication - Overall care was good, family kept well informed with good documentation

Examples of negative themes:

- Phase of care 5 -Documentation - Resuscitation discussion not clear in notes, DNAR mentions LD specifically.
- Phase of care 5 -Documentation - No documentation in notes regarding certification of death or possibly this has not been filed properly
- Phase 1 - Discharge - Patient with learning disability admitted from nursing home with aspiration pneumonia
- Phase 2 - General lack of care & medical practice - Deteriorating patient and communication with relatives.

Mortality Review group receive monthly reports on mortality review themes and mortality process performance for action management.

7. Learning and Improvement

A draft Change Implementation Review Framework will go to August Policy group for approval. Discussions continue with CQI leads to ensure alignment between the CQI function/programme and governance and risk management processes/outputs. A Learning page is developed on the Trust intranet as a central place for staff to visit and review information on lessons identified, redress actions, making it better alerts, useful patient safety links and material. The site is still evolving including the use of SharePoint as a means to gather themes and learning from key areas eg national guidance, incident investigations and trends, complaints, claims etc. The site is located on the home page of the intranet and via the link below:
http://intranet.xrwh.nhs.uk/patient_safety_improvement/index.html

8. CQC Well Led Inspection

The weekly Well Led meetings continue with planning and oversight of the gap analysis and action plan of ongoing work. A number of Board Development Sessions have taken place and staff support briefing packs circulated across the organisation, with each area encouraged to complete proud, innovation and improvement posters for their local areas.

Oversight of the previous CQC action plan is monitored at COG and TMC on a monthly basis. Good progress is made on the progress of actions with 11 actions open pertaining to GP practice visits and only one action open relating to other areas.

Appendices

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

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

Lead Director	Risk	Risk Title	Field updated	Update made
Chief Operating Officer	4665	Inability of Community Midwives to complete Early Help Assessments for the Unborn/Newborn babies		
			Positive Assurance – **New**	Equipment replacement programme commenced 18.03.2019. First static DR X-ray Room (Rm 1) fully operational 03.06.2019. Work commenced on second static X-ray Room (Rm 2) projected date of completion 05.09.2019
	3069	Risk of Never Events within Division 1: Risks to Patient Safety and Trust reputation		
			Positive Assurance – **New**	Monthly monitoring data of compliance with WHO checklist and Procedural Safety Checklist - 100% for full completion (documentation) in June 2019
			Gap in Assurance - **New**	Monthly monitoring and compliance with WHO checklist use - There has been 90% compliance achieved during June 19
			Gap in Assurance - **New**	1 x NE in 19/20 reported to CCG (June 2019) - 1 x Wrong Site Surgery - Wrong Side Fascia Iliaca Block (T&O/Theatres Datix 218936)
	4529	Vacancies in Medical Staffing/Agency and Locum staffing in Division 1		
			Action Plan - **New**	HR working with Anaesthetics and Ophthalmology to optimise rota configuration
	4170	Lack of capacity - OPD, Snowdrop Suite and Durnall Unit		
			Positive Assurance – **New**	New Band 7 started
	4472	Delays in triage in ED		
			Action Plan - **New**	LEAN Project (28/06/19 & 19/07/19) to look at processes and flow in Zone B
			Action Plan - **New**	Awaiting outcome of internal interviews for Bd 7 development programme

			Action Plan - **New**	Await outcome of plan for second Bd 7 for Zone B
	4903	Risk of non-compliance with Thoracic Service Specification		
			Gap in Assurance - **New**	Despite agreed referral pathway with Walsall they are unwilling to move forward at present
			Action Plan - **New**	Locum Thoracic Surgeon post out to advert
	4523	Failing Heater Cooler Units		
			Gap in Assurance - **New**	There has been a delay in trialling the company's demo machine - as the company will not loan out the demo machine until we have clear tests from our water sources. May not be allowed to use it clinically for another week until the latest samples are back
	4761	Cardiology, Cardiothoracic & Anaesthetic JMS vacancies		
			Positive Assurance – **New**	One ACCP going on rota mid-August 2019 and the second one going on rota beginning of Oct 2019 (01/07/2019)
			Positive Assurance – **New**	Cardiothoracic Surgery - Fully staffed with a Trust locum in place until September 2019 when new rotation starts (01/07/2019)
			Positive Assurance – **New**	Cardiology - Awaiting start date for 1 candidate, Clinical Fellow Programme (01/07/2019)
			Positive Assurance – **New**	Cardiology - Continuing to advertise posts (01/07/2019)
			Action Plan - **New**	Directorate to present case to the Divisional Management Team that this risk should remain as a high amber risk
	4756	Increased Activity in Relation to Forecasted Number of Births		
			Risk removed from TRR	Now managed on local risk register.
	5031	Potential Non Compliance with The Fetal Anomaly, Paediatric Hips,		
			Risk removed from TRR	Now managed on local risk register. Deputy COO P highlighted that this has significantly improved

		Downs Pataus, Edwards screening standards		now; accepting the small number of vacancies.
	4696	Unreported Imaging Studies		
			Positive Assurance – **New**	Backlog against a backdrop of increased referrals has reduced from 7332 May 2017 to less than 3648 in June 2019
			Gap in Assurance - **New**	Approximately 3648 non-urgent imaging studies unreported June 2019 (inclusive of 706 CT scans and 1472 MRI scans). Over 20 days there are 1400 in total (inclusive of 268 CT scans and 582 MRI scans)
	4528	Incomplete Health Records on Clinical Web Portal		
			Action Plan - **New**	Approval process commenced for Non-STEIS investigation being undertaken Datix: 185209
	4599	Emergency Services Governance Arrangements		
			Risk removed from TRR	Now managed on local risk register. Concerns and issues reduced since 2nd Matron and Quality/ Compliance Officer in post
	4113	Divisions inability to achieve CIP		
			Positive Assurance – **New**	Division 1 - Against a target of £192k, £64k of CIP has been achieved in month
			Positive Assurance – **New**	Division 2 - £0.5m CIP achieved
			Positive Assurance – **New**	Div 3 position at month 2 - £309k achieved against plan of £91k
			Action Plan - **New**	Endoscopy PID scheme for increased utilisation of Endoscopy rooms
	4382	NX55 Main Theatres, Wards A12, A14, Admin, Plant Rooms) - Fire Safety		
			Positive Assurance – **New**	0 incidents relating to Reportable Fire's within Jun 2019
			Positive Assurance – **New**	0 Unwanted Fire Signals within Jun 2019
	4411	NX08/NX09 McHale Building		

		- Fire Safety	Positive Assurance – **New**	0 incidents relating to Reportable Fire's within Jun 19
			Positive Assurance – **New**	0 Unwanted Fire Signals within Jun 19
	4375	NX87 Heart Centre - Fire Safety		
			Positive Assurance – **New**	0 incidents relating to Reportable Fire's within Jun 19
			Positive Assurance – **New**	0 unwanted fire signals during Jun 2019
	5197	Unacceptable waiting times for Cardiology follow-up appointments		
			New risk	The Cardiology Directorate does not have enough outpatient capacity to see review patients by the date the doctor has requested. If there continues to be inadequate capacity then this may lead to patient harm due to delays in further diagnosis and treatment if required.
	4706	Infrastructure/environment in Nucleus Theatres		
			Gap in Assurance - **New**	3 x recent incidents of fire alarms sounding in theatres - of unknown cause between 01/01/19 and 08/07/19
			Action Plan – **New**	Operating Lights in Theatre 7 to be replaced
	2080	Risk to quality of patient care: reduced manpower		
			Positive Assurance – **New**	Recruitment for Bd5's has now come back to local areas - 4 places offered for C19
			Positive Assurance – **New**	Weekly meetings to address vacancies as part of the Renal action plan - Twitter/Facebook campaign
			Positive Assurance – **New**	Renal open day taking place 11th July
Chief Nursing Officer	3644	CQC risk		
			Positive Control – **New**	Series of Board development sessions sharing learning from other inspections and risks completed
			Positive Control –	Communication of Trust Strategy including visions and values

			New	commenced
			Positive Control – **New**	Evidence on PIR triangulated with KLOEs
			Positive Assurance – **New**	There an no Registered Midwife Vacancies
			Positive Assurance – **New**	The number of nursing staff leavers is low 13 RN/RM and 7 unregistered members in June 19
			Gap in Assurance - **New**	Registered Nurse vacancies are 123.66 and HCA's 32.56
			Action Plan – **New**	Undertake ongoing recruitment campaign
			Action Plan – **New**	Ratify & publish Patient Quality and safety strategy

The Royal Wolverhampton NHS Trust

Trust Risk Register

July-2019

5	10	15	20	25
4	8	12	16	20
3	6	9	12	15
2	4	6	8	10
1	2	3	4	5

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Risk Lead	ID	Principal Risk		Controls	Positive Assurances	Gaps in Assurance/Control	Action Plan that addresses Gaps in Control		Residual Risk Level		
Risks Currently Being Managed											
Trust Objective:		**Proactively seek opportunities to develop our services**									
Chief Operating Officer	5173	If the information technology infrastructure is inadequate within the Audiology Clinics then patient appointments will frequently be interrupted due to lack of necessary IT to support delivery of service, resulting in a poor patient experience as occasionally this necessitates patients being recalled to future appointments. Date of origin: 20 February 2019 Date of escalation: 28 March 2019 Risk Lead: Head of Audiology	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) (July 2019) 1) Multiple complaints from staff re: slow and hanging computers, often necessitating forced shut down of computers (July 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 (July 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	Jul-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	Jul-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 Risk Lead: Cardiac Group Manager	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 (08/05/2019) 5) There has been a delay in trialling the company's demo machine - as the company will not loan out the demo machine until we have clear tests from our water sources. May not be allowed to use it clinically for another week until the latest samples are back (16/07/2019)	5) Approval of Business Case - Need to consider replacement of some if not all machines - minimum of 5 machines required 1-5) Currently undertaking a trial of company's new demo machine (using 200 bottles of sterile water)	Sep-19 Sep-19	1 x 3 = 3 GREEN	Jul-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	Jul-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	4761	If there is an inability 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 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) 4. Cardiothoracic - 2 agency locums in place. (4.4.18) 5. Anaesthetics - Consultants have had to cover middle grade night shifts. (25.4.19) 6. Anaesthetics - 1 junior doctor starting 29.4.19 and another in 2 weeks time. (25.4.19) 7. Cardiology - Recruitment on-going but slow. (18.4.19) 8. Cardiology: 1 doctor recruited 3+ months ago still not in post, potential to be here in May 2019. (18.4.19) 3. 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) 1-3 One ACCP going on rota mid August 2019 and the second one going on rota beginning of Oct 2019 (01/07/2019) 1. Cardiothoracic Surgery - Fully staffed with a Trust locum in place until September 2019 when new rotation starts (01/07/2019) 6. Cardiology - Awaiting start date for 1 candidate, Clinical Fellow Programme (01/07/2019) 6. Cardiology - Continuing to advertise posts (01/07/2019)	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 1-8 Directorate to present case to the Divisional Management Team that this risk should remain as a high amber risk	Aug-19 Aug-19	2 x 3 = 6 YELLOW	Jul-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 =	Jul-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) Division 2 overperformance YTD of £0.58m (07/19) 1-10) Division 1 - Against a target of £192k, £64k of CIP has been achieved in month (06/19) 1-10) Division 1 - CIP target for 19/20 is £9.3m, the Division has achieved £602k YTD. 6% of the target in year). Recurrently £579k has been achieved (06/19) 1-10) Div 3 position at month 2 - £309k achieved against plan of £91k 1-10) Division 2 - £0.5m CIP acheived (07/19)	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) Endoscopy PID scheme for increased utilisation of Endoscopy rooms	Apr-19 Apr-19 Apr-19 Apr-19 Apr-19 Apr-19 Jul-19 Oct-19	3 x 3 = 9 AMBER	Jul-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 (08/05/2019)	1. Referrals have not increased, this has been escalated to DCOO and COO (08/05/19) 1-4. Despite agreed referral pathway with Walsall they are unwilling to move forward at present (01/07/2019)	1-4 Plan further approaches to Walsall Hospital 2. Locum Thoracic Surgeon post out to advert 01/07/2019	Aug-19 Aug-19	1 x 5 = 5 YELLOW	Jul-19	

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Trust Objective:		**Attract, retain & develop our staff & improve employee engagemen**									
Chief Operating Officer	1713	Failure to effectively maximise workforce productivity; failure to routinely review consultant job plans. Date of origin: 03/06/08 Date of escalation = 11/05/11 Risk Lead: COO/Deputy Medical Director	4 x 3 = 12 AMBER	2) Areas to be contained with SPA allocation have been agreed 4) Usage reports for medical bank - Dec 17 3) RAG rated tool to monitor compliance against Job Plans has been developed and now shared with directorates Sept 17. 1) Job plans continue to be reviewed and sign off by DMD / MD- sign off committee established (Apr-Aug18) 1) New Job Planning Policy agreed by LNC Mar 17 5) Job Planning updates to be presented to clinical excellence group (Jan 18) 6) Job Planning Consistency Panel established 18/19 (May 18 first one). 7) Business case for Allocate approved. Implementation plan agreed at Workforce group (Jan 18). Implementation expected Apr/May 19	1) Job Planning Audit indicated a number of actions now addressed 1) Training commenced on new job planning process - Feb 16 4) Medical agency costs reducing Dec 18. 1) Increase in number of 'signed off' job plans October 2017 + April 2018 + Sep 18	1) Sign off of all job plans not complete (Dec 2018) 1) Audit review still raised concerns - closed Dec 17	1) Internal audit to review progress made on job planning 19/20 5) Further update to Audit Committee in progress. 1) Continue to work with NHSI on development of job planning tools and sign off processes	Sep-19 Feb-19 Apr-19	3 x 2 = 6 YELLOW	Jul-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 (07/19) 1) Proactive recruitment approach continuing (07/19) 1) 72.65 wte trained nursing vacancies remain, 39 roles offered, but not in post (07/19) 1) Continued recruitment to nursing clinical fellows (07/19) 1-10) Matrons meeting every Friday to ensure hospital is staffed over the weekend (07/19) 3) Snr Srs and Charge nurses meeting daily to ensure wards are safe (07/19) 1) 12 offers made following Phillipines recruitment, 20 from SA and 4 from Nigeria - seeking clarity re acceptance numbers and arrival dates (07/19) 3) 30 students offered roles to start in Sept 19 - awaiting confirmation of accptance numbers (07/19) 3) 1 bay remains closed on C25 - this is having a beneficial impact (07/19) 1) Recruitment for Bd5's has now come back to local areas - 4 places offered for C19 (07/19) 3) Weekly meetings to address vacancies as part of the Renal action plan - Twitter/Facebook campaign (07/19)	8) Insufficient RN's available on Bank, backfilled by HCA (07/19) 1) Nationallly we are an outlier re safe staffing levels (07/19) 1) Recruited staff are newly qualified which can lead to mentorship and training pressures (07/19) 1) All wards are 'Amber' re safe staffing levels on daily basis (07/19) 3) Issue remains in relation to ability to provide accurate staffing figures (07/19) 3) Breaches in minimum safe staffing levels (07/19) 3) Significant nursing shortages on C16, C24 and C25, working with 50% vacancies at Bd 5 level. C19 also a concern (07/19)	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 Aug-19 Aug-19 Aug-19	4 x 3 = 12 AMBER	Jul-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) Renal open day taking place 11th July (07/19)					

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	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 (June 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 reduced in May 19 - In month bank spend reduced by 200k since May 2018 (June 19) 7) There has been no agency used in nursing for the last 19 months (June 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 (June 19) 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 (June 19)	1-5) Number of vacancies remain across Division 1 (June19) 1-8) Still vacancies and locum expenditure remains high (June 19) 4) Last Meeting March 2019 - 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 continuous locum and agency spend HR to review monthly workforce report and discuss with directorates 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) 2. HR working with Anaesthetics and Ophthalmology to optimise rota configuration	Sep-19 Sep-19 Sep-19 May-19 Jul-19 Jul-19 Sep-19 Oct-19	2 x 2 = 4 YELLOW	Jul-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) 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 (June 19) 1-8) 4 x O&G Consultants posts have been accepted, the first one is due to commence in July 2019 (June 19) 1-8) Agency usage in early 2019/20 months has nearly halved what it was at the start of 2018/9 financial year (June 19) 3) Have not met with any further agencies since the two in April 2019 however received better rates from one of the agencies following the meeting (June 2019)					

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 (July 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) 13. Over 5 AfPP training days - approx. 240 staff members have been trained (July 19) 3. Monthly monitoring data of compliance with WHO checklist and Procedural Safety Checklist - 100% for full completion (documentation) in June 2019 (July 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. 4 x NE in 18/19 reported to CCG - 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) (June 19) 3. Monthly monitoring and compliance with WHO checklist use - There has been 90% compliance achieved during June 19 (July 19)	2. Programme of Human Factors Training for Theatre Staff under-development 1-11. Staff continue to undertake PCM training 1-13 Implementation of remaining x 2 actions (10,000ft and Human Factors training) as identified on the action plan following the NE Leicester Conference 6. RCA Investigation to be undertaken into the NE Wrong Site Surgery - Wrong Side Fascia Iliaca Block (Datix 218936)	Oct-19 Oct-19 Oct-19 Sep-19	2 x 4 = 8 AMBER	Jul-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		4. 1 x NE in 19/20 reported to CCG (June 2019) - 1 x Wrong Site Surgery - Wrong Side Fascia Iliaca Block (T&O/Theatres Datix 218936) (July 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 (July 19) 1) Monitor monthly performance through the nursing midwifery KPIs reported to QSIG (July 19) 1) Environmental Standards are monitored via the environmental group monthly (July 19) 1) Daily staffing (safe staffing, Skill mix) is monitored via the Divisional ops meetings (July 19) 1) Fundamental standards are reviewed & monitored by the designated specialist groups and bi annually by the sponsor which then reports to COG (July 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 (July 19) 1) Mortality QI plan is monitored via Programme Board monthly and learning outcomes via MRG (July 19) 1) EOL strategy with TOR has been developed and milestones monitored via the EOL group monthly (July 19) 1) Monitoring of the Nursing System Framework monthly via TMC (July 19)	1) Nursing and Midwifery KPIs are on Health Assure reporting and emailed out to ward sisters/matrons and HoNs monthly. (July 19) 1) QRV process is now embedded and refined, plan formulated for ongoing inspections 2019/20 (July 19) 1) Lord Carter metrics monitored monthly via Divisional Performance meetings (July 19) 1) Divisions monitor performance via monthly Governance meetings (July 19) 1) Improved staff survey results ((July 19) 1) There is a system of nursing audits taking place monthly (July 19) 1) There an no Registered Midwife Vacancies (July 19) 1) The number of nursing staff leavers is low 13 RN/RM and 7 unregistered members in June 19 (July 19)	1) Vacancy rates remain high in Medinine (July 19) 1) Safer staffing fill rates remain transient particularly for nights (July 19) 1)Outliers for Mortality HSMR and SHMI rates in National data sets (July 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 (July 19) 1) System change to Health Assure meant delay with nursing audit data was not available until March 2019 (July 19) 1) Registerd Nurse vacancies are 123.66 and HCA's 32.56 (July19)	Review Intranet to ensure current content Undertake ongoing recruitment campaign Ratify & publish Patient Quality and safety strategy	Nov-19 Jul-19 Aug-19	2 x 2 = 4 YELLOW	Jul-19	Yes

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
				1) Monitoring via Quality review visit and re-visit programme to assess CQC compliance (July 19) 1) NEWS2 implemented Trust-wide (July 19) 1) Information provided in PIR according to timescales (July 19) 1) Series of Board development sessions sharing learning from other insepections and risks completed (July 19) 1) comunication of Trust Stragey including visions and vaultes commenced (July 19) 1) Evidence on PIR triangulated with KLOEs (July 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 (07/19) 5. Morbidity & Mortality Reviews (07/19) 7. Capacity Reviews, Weekly Community clinics (Weds weekly, Fri alternate weeks) (07/19) 3. Staff from ward and Educational facilitators used to provide support at times of increased demand (07/19) 1. Door to needle times monitored for sepsis patients. Summary of 2 monthly Sepsis Audit findings (07/19) 2. Actively monitoring PALS feedback about the Durnall Unit (07/19) 9. Facilitate transfer to Deanesly and CHU within department opening times (07/19)	6) Approx 40% of nurses now trained to take blood cultures (07/19) 1-9) Service Improvement Team undertaking demand v activity v capacity (07/19) 7) Positive feedback from patients about the weekly community clinics (07/19) 1-7) 1st and 2nd process map of patient journey through the Durnall Unit undertaken (07/19) 2. No Further PALS concerns this month (07/19) 1-9) New Band 7 started (07/19)	7) Overspend for Directorate (07/19) 7) Capacity review means some patients may have to attend hospital every other week (07/19) 6) Approx 60% of nurses still to be trained to take blood cultures. Training postponed (07/19) 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 (07/19) 5) Recent RCA investigation has highlighted human factors linked to capacity and environment (07/19) 8. SEPSIS 6 Rolled out in dept reduction in door to needle time compliance and compatability with vitalpac (07/19) 6. Nurses trained to take blood cultures (07/19) 10) Decrease in patients treated within "Golden Hour" . (07/19) 9) Patients stranded on Durnall Unit after 7pm in month (07/19) 3,4) Staff transfer has been required in this month (07/19) 6) Nurse training on hold (07/19)	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 9) Utilising Discharge Lounge for appropriate patients 9) Monitoring of Patient waits on Durnall 9) Scheduling of patients attending Durnall Review 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 1-8) Trust AOS Low risk sepsis service to consider community reviews, daily follow ups and weekend follow ups	Sep-19 Sep-19 Sep-19 Sep-19 Sep-19 Sep-19 Sep-19 Sep-19 Mar-21 Sep-19	3 x 3 = 9 AMBER	Jul-19	

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
							1-8) 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			
							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	Sep-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 June 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 70% has been removed from outer building. Inner courtyards had been resolved. 4) WMFSvisited site, agreed security patrols and WMFS attendance to continue 10) 0 unwanted fire signals during June 2019	9) Outstanding fire stopping required following compartmentation survey	7) Further Evacuation Exercises to be completed for Wards 1-10) Approval for ACM to be removed from designated areas. This will commence January 2019 with a prorgramme of works being agreed by Trust Management 1) WMFS to approve 4 stage Plan following	2 x 2 = 4 YELLOW	Jul-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 June 2019 3. Fire strategy has been approved and money set aside. 1. 0 Unwanted Fire Signals within June 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	Jul-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 June 2019 1. 0 incidents relating to Reportable Fire's within June 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	Jul-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 (07/19) 4-5) Reallocation of staff working well to help reduce wait times during pressured times (07/19) 15) Urgent treatment doctor is making an improvement to patients recieving appropiate emergency treatment (07/19) 17) Additional triage room helping to reduce triage wait times (07/19)	1, 2) Inability to achieve 15 minute triage consistently breaches mainly in minors, at 1.5hrs at points in month (07/19) 4,5) Staff not always available to be reallocated (07/19) 7) Medical and nursing vacancies and sickness/annual leave resulting in gaps in rota. Link to risk 4496 and 2374 (07/19) 9) UCC minimum impact on pt numbers and delays in assessments (07/19) 7) Continued use of long term locums (07/19) 1) Inability to acheive 2 hr target in month, significant delays experienced (07/19)	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 1-21) LEAN Project (28/06/19 & 19/07/19) to look at processes and flow in Zone B 1-20) Awaiting outcome of internal interviews for Bd 7 development programme 5) Await outcome of plan for second Bd 7 for Zone B	Jul-19 Jul-19 Jul-19 Sep-19 Aug-19 Aug-19	1 x 4 = 4 YELLOW	Jul-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)						

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	4528	If Clinical Web Portal does not contain full copies of patient's notes/health records (if seen before 2013) as well as all Paediatric admissions/Badgernet information then clincians will only have access to an incomplete health record for inpatient and outpatient encounters. Lack of a comprehensive record may impact on the accuracy and/or timeliness of clinical decision making. NHSI link NE's to lack of complete clinical records in OPD clinics. Date of origin: 29/04/16 Date of escalation = 17/05/16 Risk Lead: Div 1 Deputy COO	4 x 3 = 12 AMBER	1. Ability to request paper notes (May 16) 2. Process for both access to patient records aswell as the process for when there is a need to have a complete patient scanned has been circulated by Patient Access (Dec 16) 3. Badgernet System in place in Maternity (Feb 19)	1. No continuous Datix incidents (July 19) 3. The Badgenet System reamins embedded within the Maternity department (July 19) 2. Procedures continue to be in place to access paper records/request scanning of records onto portal (July 19)	1. Datix Incident reported - Non STEIS RCA 185209: 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 (July 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 (July 19) 3. Restricted access to the Badgernet System - no immediate access to Maternity notes (May19) 1. Another incident identified Non STEIS RCA 215719 Treatment Procedure - Leadless pacemaker not required - Old paper notes of relevance were not available (June 19)	1-2. Monitor ongoing incidents 1-2. Approval process commenced for Non-STEIS investigation being undertaken Datix: 185209	Dec-19 Jul-19	2 x 2 = 4 YELLOW	Jul-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 =	Jul-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. (Jul 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 (Jul 2019 5) Equipment replacement programme commenced 18.03.2019. First static DR X-ray Room (Rm 1) fully operational 03.06.2019. Work commenced on second static X-ray Room (Rm 2) projected date of completion 05.09.2019. (Jul 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 (Jul 2019)	1) Any breakdown causes disruption to the service offered to patients. Breakdowns encountered with CR readers 2; X-ray equipment 2 (Jul 2019) 2) No focus choice on Mobile X-ray Unit and reliance on ageing CR processing equipment (Jul 2019) 4) X-ray service will be limited if CR processing facilites fail (Jul 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 (Jul 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	Jul-19	Yes

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	4696	If non-urgent imaging studies are not reported within the timescale of 3 - 6 weeks, delays may have an impact on timely patient management. Ideally, imaging should be reported as soon as they are undertaken but this is not possible given the national shortage of staff. Date of origin: 5 January 2017 Approved by Division: 28 December 2016 Accepted onto Trust Risk Register: 5 January 2017 Risk Lead: Radiology Group Manager	3 x 4 = 12 AMBER	1) Monitoring of unreported scans/imaging studies on a weekly basis (Jan 2017) 3) Clinical Fellows are being employed (Jan 2017) 4) Regular meetings between Clinical Director and Group Manager (Jan 2017) 5) Waiting list initiatives for Trust Radiologists on going (Jan 2017) 6) Use of outsourcing (Oct 2018)	3) Clinical Fellows have been appointed (3 in place) (Jul 2019) 4) Review meetings are happening fortnightly (Jul 2019) 1), 5) & 6) Backlog against a backdrop of increased referrals has reduced from 7332 May 2017 to less than 3648 in June 2019 (Jul 2019) 3) Office space sourced (Jul 2019) 1) The backlog is actively monitored by Group Manager (Jul 2019)	1) Approximately 3648 non-urgent imaging studies unreported June 2019 (inclusive of 706 CT scans and 1472 MRI scans). Over 20 days there are 1400 in total (inclusive of 268 CT scans and 582 MRI scans) (Jul 2019) 1) Poor patient experience if patients and doctors are unsure when their scans are reported (Jul 2019) 3), 4), 5) & 6) Demand for reporting imaging studies is higher than expanded reporting capacity (Jul 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	Jul-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 - This has been addressed with the creation of storage in the basement. (July 2019) 4. Operating lights - (Theatre 7 require light replacement - July 2019) 5. Air-flow/ventilation - (addressed) 6. Storage - not enough dedicated storage space in theatres for equipment and consumables (addressed) 7. Insect infestation - flies and bugs being seen in theatres - (addressed No incidents reported 01/01/19 to 08/-7/19) 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 (July 2019) 1 - 1 x reported incident of Sewage ingress/water leaks since May 2019 (July 2019) 2 - No reported incidents of power outage or back-up power failure (July 2019) 7 - No reported incidents of insect infestation for last 7 months (July 2019)	3) 3 x recent incidents of fire alarms sounding in theatres - of unknown cause between 01/01/19 and 08/07/19 (July 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 1. Operating Lights in Theatre 7 to be replaced	Sep-19 Oct-19 Aug-19	2 x 1 = 2 GREEN	Jul-19	

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Medical Director	5045	Sepsis and severe infection are perhaps the most common reasons for admission to hospital and cause of inpatient deterioration. If patients do not receive high quality and timely sepsis care through detection, recognition and management of the deteriorating patient then patient harm or death could result. Date of origin: Jun 18 Date of escalation: Jun 18 Risk Lead: Medical Director	4 x 3 = 12 AMBER	4) Training staff in the recognition and management of sepsis - ongoing monitoring. 2) Early warning systems for paediatric, maternal and adult patients assist in the detection of deteriorating patients - many of whom will have sepsis. 3) Sepsis screening tools exist for paediatric, maternal and adult patients who deteriorate and may have sepsis. Optimal utilisation of these tools help reduce the mortality and morbidity from sepsis. 1) A trust antimicrobial guideline has been developed to advise appropriate antibiotics for given indications. This is available as an app and on the intranet and is subject to audit. 5) Two sepsis nurses have been recruited (1 band 7 and 1 Band 6) (Feb 19) 6) Vital PACS upgrade with sepsis module have been implemented on 28th March. Captured data will measure compliance and improvement in identification and timely management of sepsis.	4) Mandatory training compliance in IP and Sepsis is monitored at directorate governance 2) Early Warning Score audit compliance. Auditing medical records to ensure the processes of detection, recognition and management of deteriorating patients is robust with feedback of performance to directorates and the development of action plans to achieve compliance 3) Compliance with sepsis screening and sepsis 6 delivery. Auditing the use of the sepsis screening tool and delivery of the sepsis 6 with feedback of performance to directorates and the development of action plans to achieve compliance 1) Antimicrobial prescribing compliance. To ensure that antimicrobial prescribing is compliant with trust guidance and that antimicrobials are reviewed to reduce antimicrobial resistance 4) 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) June 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	Jul-19	

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	5112	18/07/19 - If the number of staff who are not able to work on the ICCU or who require supervision continues at a high level (13% in 2018- 21% at 18/07/19) then there are insufficient experienced skilled Band 5 nurses in the ICCU setting resulting in an increase in staff stress and potential harm for patients. Date of Origin: Oct 18 updated July 2019 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 (July 2019) 6, 11, 12, 16, 17, 18 - e-Roster utilised resulting in a decrease in staff disatissfaction. (July 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. (July 2019) 7 - Education team have changed their training delivery method - this is now undertaken at the bedspace. (July 2019)	9 - 5 out of 10 vacancies remain unfilled - Vacancies recruited to will take up posts between 01/07/19 and 30/09/19 (July 2019)	9 - Recruit to Band 6 and 7 posts 14 - Monitor Datix reports concerning staff shortages and skill mix	Oct-19 Oct-19	2 x 3 = 6 YELLOW	Jul-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?
				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.					

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Medical Director	5182	If RWT does not meet NHSE requirements of having Cardiac Thoracic and Aortic Services co-located with Vascular services on RWT site, then the Aortic service specification will not be met and RWT may not be authorised for Aortic services, this will adversely impacting patient service provision at RWT. 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	

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	5197	The Cardiology Directorate does not have enough outpatient capacity to see review patients by the date the doctor has requested. If there continues to be inadequate capacity then this may lead to patient harm due to delays in further diagnosis and treatment if required.	4 x 3 = 12 AMBER	2. Consultants and ANP's being offered WLI rates/overtime to do additional clinics in areas where there are a particularly large number of patients overdue their review appointment 3. As we use partial booking the review appointments are actively managed and not booked up too far in advance so if a patient contacts the Directorate with any concerns we are able to give them an appointment within a reasonable timescale and will speak to the consultant about overbooking if a patient needs to be seen urgently. 4.Patients on FU OWL are validated by the FU OWL coordinator to ensure that they are appropriately booked so that slots aren't wasted 5. Assistant Directorate Manager regularly reviews slot utilisation report to ensure that all review slots are used 1. Recuitment Stategy in place	1-5. Extra clinics continue to run when consultants/ANPs agree to do so (July 2019) 1-5. Partial booking process remians in place (July 2019) 5. Deloittes KPI report showed high level of slot utilisation for review clinics (June 2019)	1-5. Numbers of review patients on FU OWL and overdue continuing to rise despite additional clinics and other controls (July 2019) 1-5 Red FU OWL, total waits 1850. I x Consultant has 617 (July 2019)	1. Continuing efforts to recruit into vacant registrar/middlegrade posts will increase review capacity within standard job plans 1. Extra consultant posts being recruited into to increase OP capacity across whole of cardiology 1. Review capacity and demand. 1. A further business case will be required which is in line with years 2-3 of the 10 year plan. 1. Business Case - agreed and jobs out to advert at present. 1. Arrange a review of the long waiters/urgency in the first instance by one of the middlegrades using notes on portal and arrange for any clinically significant patients to be seen. 1. Patients who need a pacemaker check need to be moved to the pacemaker clinic	Aug-19 Aug-19 Aug-19 Aug-19 Aug-19 Aug-19 Aug-19	4 x 2 = 8 AMBER	Jul-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	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 (04/07/2019) 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 (04/07/2019) 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 (04/07/2019)	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 (04/07/19) 1-5) There are now issues with training and access to the Local Authority Eclipse System (04/07/2019)	1-5) 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 1-5) Undertake an audit of rejected referrals and subsequent outcomes	Sep-19 Aug-19 Aug-19	1 x 4 = 4 YELLOW	Jul-19	