

Chief Nurse's Governance Report

7 October 2019

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Agenda Item No: 6.2

Trust Board Report

Meeting Date:	7th October 19
Title:	CNO Governance Report
Executive Summary:	<p>1.Trust Risk register (TRR) update – September19 The TRR update is provided with areas for attention highlighted below.</p> <p>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 expected is still awaited. This will bring a number of changes to the management of investigations by providers and Clinical Commissioning Groups (CCG). Preliminary changes include:</p> <ul style="list-style-type: none"> • 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) <p>There will be a 12 – 18 month transition period to implement the changes.</p> <p>4. Information Governance (IG) work plan and risk A second IG Officer has joined the team in August 19 and the IG team continue to work to a prioritised work plan to manage commitments within resources. A local IG resource risk exists on the Department risk register to ensure monitoring of FOI performance, audit, training, incident management etc.</p> <p>5. Governance staffing Prioritised work plans are in place for Health and Safety and Information Governance whilst recruitment processes continue.</p> <p>6. Governance of local Procedural Documents (ie Clinical Procedures, Guidelines, Protocols etc) Local procedure reports to Directorates and Divisions have been issued for August 19. Directorates and Divisions are required to monitor a programme of update for all local procedural documents.</p> <p>7. Mortality returns All Mortality reviewers are now appointed (mix of nurses and medical staff) and a plan is established to complete all outstanding SJR 1 and 2 reviews. Moving forward Mortality Reviewers will undertake SJRs (stage1 and stage 2) for adult deaths identified for review based on the criteria outlined in the Learning from Death policy (OP87). There is a separate process for Child</p>

	<p>Death review overseen by the CDOP (Child Death Overview panel). Further developments of the mortality process include the identification of 2 Specialist advisors per Directorate to support Mortality Reviewers in their role.</p> <p>Directorate Mortality Leads will continue to receive for their areas:</p> <ul style="list-style-type: none"> • Monthly lists of deaths for SJR1 review by Mortality reviewers (according to policy criteria) and Directorates can undertake additional reviews over and above the criteria. These must be entered onto the sharepoint repository. • The outcome of all SJRs completed. Directorate packs with review outcomes and outstanding actions will be circulated. <p>For oversight Divisions will receive a monthly report to include Directorate performance on SJR completions as well as SJR review outcomes and actions for redress. Divisions are asked to monitor progress of Directorate Mortality performance at Divisional Performance meetings.</p> <p>A learning framework is in development to include the use of a learning log to capture and share learning themes as well as to analyse themes to devise actions for improvement. Proposal will be reported to Mortality Review Group (MRG) in October 19.</p> <p>8. Learning and Improvement The Change Implementation Review framework is to be tested on selected recurrent themes. An evaluation of the pilot will be reported.</p> <p>9. CQC Well Led Inspection Following a 4 week period of CQC inspections across 6 of the 9 core services, the Trust continues to receive and respond CQC information requests. Processes for the issue and return of information continue to work well. Huge thanks is owed to staff for their engagement and responsiveness in providing information requested within short timescales. Further requests are expected prior to and during the planned Well Led review visit on the 18th to 20th September 19.</p>
Action Requested:	Receive and note,
For the attention of the Board	
Assure	<ul style="list-style-type: none"> • ESERG review all serious incident investigation, serious complaints and Radiation incidents. • TRR updates requested monthly • TRR process strengthened to drive appropriate risk escalation.
Advise	<ul style="list-style-type: none"> • Areas are requested to place targeted efforts on the review/update of local procedural documents • Areas are asked to maintain focus on the update risk registers prompt escalation of risks graded 12 or above to 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.
Alert	A revised National SUI Framework is expected to include significant changes to be adopted by the Trust. Preliminary indications being considered in line with the Trust Investigation process may require further review of the Trust Risk Management Reporting Policy (OP10).
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Links to Trust Strategic Objectives	<ol style="list-style-type: none"> 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	<p>Safe: patients, staff and the public are protected from abuse and avoidable harm.</p> <p>Effective: care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence.</p> <p>Caring: staff involve and treat everyone with compassion, kindness, dignity and respect.</p> <p>Responsive: services are organised so that they meet people's needs.</p> <p>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.</p>
Equality and Diversity Impact	No adverse impact on PPCs
Risks:	<p>See TRR risk detail below plus</p> <p>Governance Dept RR:</p> <p>3285 Non Compliance with FOI timescale – grade 9 amber</p> <p>4769 Capacity IG/GDPR – grade 9 amber</p> <p>4663 Capacity Health and Safety – grade 9 amber</p>
Public or Private:	
Other formal bodies involved:	
References	
NHS Constitution:	<p>In determining this matter, the Board should have regard to the Core principles contained in the Constitution of:</p> <ul style="list-style-type: none"> • 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	<p>1. <u>Trust Risk Register</u></p> <p>5 new risks:</p> <p>5119 - Falsified Medicines Directive (COO)</p> <p>5246 - Lack of Consultant cover within Cancer Services (COO)</p> <p>5284 - EPMA - system and operational use (overarching risk) (COO)</p> <p>5031 - Potential Non Compliance with The Fetal Anomaly, Paediatric Hips, Downs Patau, Edwards screening standards (COO)</p> <p>5253 - Dell Tablets on ePMA wards damage and unsupported warranty (COO)</p> <p>1 risk removed:</p> <p>5198 - Inability of Community Midwives to complete Early Help Assessments for the Unborn/Newborn babies (COO)</p> <p>4761 (Note on Datix 11/9/19) – Indicated for closure after discussion at Directorate Governance meeting.</p> <p>4 red risks:</p>

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

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

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

Attention is required to the following risks:

- 2719 COO – action update, grade under threshold – confirm decision to remain on TRR
- 5083 COO – action update
- 4113 COO – action update
- 1713 COO – action update
- 4529 COO – action update
- 4382 COO – no date on action
- 4411 COO – no date on action
- 5045 MD – action update required

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' (PIC) assessment and judgement made by the RCA lead and signed off at ESERG. Investigators are reminded to complete a PIC assessment for all RCA investigations into death.

Data below shows reporting 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
July 19	16(0)	7	2	3	0	0
Aug 19	17(0)	7	5	5	1	1
Analysis	Sustained progress	Reduction in SUI		Fewer queries from	RCA breach due	

	in closure of SUIs within timescale.	numbers aligns with the National SUI framework 2015.		commissioners re RCA reports.	to challenges in identifying RCA lead – RCA is expected in the next 2 weeks.	
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3. Information Governance work plan

The IG team continue to work to a priority work plan that includes:

- Re mapping evidence and requirements to the new Data Protection and Security Toolkit (DPST) – for Oct 19 and Mar 20 submissions.
- Audits – internal spot audits as well as independent audits by Grant Thornton
- Training – Information Asset Owners and all staff
- Staff awareness week – shared learning on themes and IG focus areas
- Policy review
- IG incident reporting and investigations
- DPIA/Information asset processes
- Data flow mapping processes

The top IG risks to the organisation were identified as below. Work is to continue via the IG Operational and Steering Groups to further define/refine and mitigate these risks in line with Risk Management processes.

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 event 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 ensuring 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

New Information Governance Officer commence in post in August is undergoing induction. Recruitment continues for H&S and Divisional Governance portfolios.

5. Local Procedures and Guidelines – Governance

The issue of monthly local procedure reports commenced in July 19 and have been issued for Aug 19. The reports indicate a need for targeted efforts and a monitored programme of review of local procedures. Areas are asked to ensure that local procedure reports are reviewed at local Governance meetings.

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

6. Mortality process summary

The current outstanding SJR reviews (163 as at 4/8/19) are to be completed as follows:

- 69 reviews (pre April 19) to be completed by Directorate. These reviews have been issued to Directorate mortality leads for completion.
- 94 reviews (post April 19) to be completed by Mortality reviewers. These reviews are being allocated to Mortality reviewers.

Each Directorate will have two 'Speciality Advisors' who the Mortality Reviewers can contact for independent specialist advise/clarification.

It is essential to the Mortality management process that:

- Mortality leads communicate within the Directorate the outcomes of SJRs and liaise between the Directorate and MRG a progress/action update.
- Directorates Mortality performance and outcomes are reported to Directorate governance in order that actions and findings are progresses and monitored. This must include the completion of required SJR, the reporting and discussion of outcomes (from alert investigations and SJRs) and SMART action planning.
- Divisional performance meetings oversee the performance and progress of mortality review outcomes and quality improvement (as appropriate).

A dedicated Mortality intranet page developed containing relevant information (eg MRG agendas minutes, reports, Mortality Quality Improvement plan, Mortality Dashboard, learning log etc.) is to be communicated to all staff imminently. The MRG continues to review oversight reports on Trust processes for managing mortality.

7. Learning and Improvement

A draft Change Implementation Review Framework is to be tested on identified themes in the Trust.

Discussions continue with CQI leads to ensure alignment between the CQI function/programme and governance and risk management processes/outputs.

A Learning page on the intranet is undergoing further refinement work (at the end of Sept 19) around the format and presentation of the information to ensure that learning and redress actions can be easily extracted for wider consideration/application in the Trust. 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.

A Trust wide learning framework will identify the mechanisms and processes the trust will use to identify, apply and learning from all sources. The framework will be applicable to all areas (Clinical Divisions and Corporate Services) and require broad engagement to achieve its aim.

8. CQC Well Led Inspection

As per summary above.

Appendices

Appendix 1 - Trust Risk Register (TRR)

Appendix 2 – Tracked changes to risks

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

Lead Director	Risk	Risk Title	Field updated	Update made
Chief Operating Officer	4665	X-RAY CANNOCK		
			Risk changed from AMBER to YELLOW	
			Positive Assurance – New	Remaining static X-ray room (Rm 3), mobile X-ray unit (AMX 4) and associated CR system decommissioned 05.08.2019
			Positive Assurance – New	Operational static and mobile X-ray units utilise DR systems only
			Gap in Assurance - New	Remaining static X-ray room (Rm 3) in process of being replaced
	5173	IT infrastructure in Audiology clinics		
			Action Plan - New	Present business case to Divisional Management Team
			Action Plan - New	Procure equipment
			Action Plan - New	Liaise with IT to install equipment
	5112	ICCU Staffing (Nursing)		
			Positive Control – New	Band 8a Operational Nurse Manager is now in post
			Positive Control – New	Centralised sickness management ensures that trends are identified and action taken. Monthly sickness workshops are held with HR ensuring appropriate escalation via Trust Policy
			Positive Control – New	Staff are paid at enhanced rate for overtime to cover the unit
			Positive Assurance – New	e-Roster utilised resulting in a decrease in staff dissatisfaction
			Positive Assurance – New	Shifts are being covered and disruption to services minimised
5198	Inability of Community Midwives to complete Early Help Assessments for the			
		Risk closed	Assurance received from Local Authority re: training and access to the Eclipse System.	

	Unborn/Newborn babies		
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 - 90% for full completion (documentation) in Aug 2019
		Positive Assurance – New	Monthly monitoring and compliance with WHO checklist use - There has been 100% compliance achieved during Aug 19
4529	Vacancies in Medical Staffing/Agency and Locum staffing in Division 1	Positive Assurance – New	Ongoing T&O medical vacancies sent 20 CVs as were struggling to recruit, 4 T&O Jnr Med appointments recruited
		Positive Assurance – New	4 x O&G Consultants recruited
		Positive Assurance – New	Recruitment has been successful to most established medic positions, for those where recruitment is on hold pending sign off of business cases Divisional HR Manager is linking in with the medical resourcing lead to discuss recruitment strategies
		Positive Assurance – New	Streamlining Group to be lead by lead Employers (only RWT speciality is Palliative)
		Positive Assurance – New	Agency usage in early 2019/20 months has nearly halved what it was at the start of 2018/9 financial year
		Action Plan - New	Divisional HR Manager to share an update on Locum list at DMT later this month
		4170	Lack of capacity - OPD, Snowdrop Suite and Durnall Unit
	Positive Assurance – New	PEF advert closed - await outcome of interviews	
4596	QS104 - Gallstone		

	Disease	Positive Control – New	Involvement with the Surgical Ambulatory Emergency Care Network
		Positive Control – New	Additional all day list allocated from 5th March
		Positive Control – New	There has been additional recruitment and training of staff for another half list per week
4472	Delays in triage in ED		
		Positive Assurance – New	Interviews underway for Bd 7 - 2nd cohort interviewed, 3 appointed
		Positive Assurance – New	Plan for Bd 7 to cover Zone A&B during day to be trialled
4903	Risk of non-compliance with Thoracic Service Specification		
		Positive Assurance – New	Continue to approach other Trusts for referrals
		Action Plan - New	Thoracic Surgeons have Robotic training booked for Sept/Oct19. We are in process of arranging a week of proctored training in the hope of attracting new work to RWT.
4523	Failing Heater Cooler Units		
		Positive Control – New	HCU's are cleaned and water changed with hydrogen peroxide daily and recorded
		Positive Control – New	HCU's disinfected every 2 weeks as per protocol
		Positive Control – New	HCU's are tested for infection monthly
		Positive Control – New	All HCU's used on patients are identified and recorded
		Positive Assurance – New	There have been 4 patients infected historically. There have been no further cases since 2016. These infections take up to 5 years (as far as we know) to manifest
		Positive Assurance – New	Potential for list cancellation - None cancelled to date
4761	Cardiology, Cardiothoracic & Anaesthetic JMS vacancies		
		Positive Control – New	Cardiology - 5 new Registrars started in Sept 2019 leaving only 1

			gap
		Positive Assurance – New	2 ACCP's have completed training and will be on the day time rota from Aug 19 and Oct 19 respectively. There will be 6 people on the rota then. They will then do some weekends and then in 6 months time some night shifts.
		Positive Assurance – New	Anaesthetics - 1 gap, 2 doctors coming from general side in Nov 2019
5119	Falsified Medicines Directive		
		New Risk	If the Trust does not comply with the EU Falsified Medicines Directive then we will be subject to penalties/fines and could expose patients to counterfeit medicines, resulting in financial damages to the Trust and potential harm to patients. In addition we will not be able to provide assurance to CQC that we are protecting patients from harm from falsified medicines.
5246	Lack of Consultant cover within Cancer Services		
		New Risk	If there is insufficient Consultant cover for H&N, colorectal, sarcoma and upper GI cancer sites (currently only 1 Cons for each of these sites due to inability to successfully recruit), then this will impact on the ability of the service to provide appropriate and timely care to patients at times of additional vacancies, staff sickness and annual leave. This will lead to a risk of compromised patient care, inability to treat specific cancer site patients at RWT, delays in treatment, inability to achieve cancer targets and increased workload/stress for existing Cons staff.
5284	EPMA - system and operational use (overarching risk)		
		New Risk	If the issues relating to EPMA are not resolved then healthcare professionals involved in the prescribing and administration of medicines may not be able to prescribe or administer medicines in a safe or timely manner. As a

			<p>consequence this may result in patient harm due to incorrect prescribing or administration of medicines, or missed or delayed doses. The issues relating to EPMA that contribute towards this risk can be categorised into:</p> <p>Lack of functionality or errors associated with the software.</p> <p>Lack of or errors associated with interfaces with other Trust systems (electronic and paper).</p> <p>Staff using the system incorrectly or suboptimally.</p> <p>Lack of and poor suitability of hardware for EPMA.</p> <p>This is an overarching risk and replaces risks 5190 and 5038.</p>
5031	Potential Non Compliance with The Fetal Anomaly, Paediatric Hips, Downs Pataus, Edwards screening standards	***New Risk***	This risk was deescalated in Jul 19 but has now been escalated back onto the TRR
4696	Unreported Imaging Studies	Gap in Assurance - New	Approximately 4944 non-urgent imaging studies unreported August 2019 (inclusive of 768 CT scans and 2335 MRI scans). Over 20 days there are 2233 in total (inclusive of 295 CT scans and 1232 MRI scans)
4528	Incomplete Health Records on Clinical Web Portal	Action Plan - New	Continue to monitor incidents
5069	Dermatology Fast Track Capacity	Positive Assurance – New	Two week wait referrals now at 84.4% in August 2019 from 87.6% in July 2019
4113	Divisions inability to achieve CIP	Positive Assurance	YTD financial position for Division 2 is £0.95m favourable due to patient

		– New	income over performance
		Positive Assurance – New	Division 1 - £65k worth of CIP was taken in month three
		Positive Assurance – New	Division 3 - £808k CIP achieved (£278k recurrently)
		Positive Assurance – New	Division 2 - £0.9m CIP achieved to date, against a target of £6.5 for Division 2 CIP
4382	NX55 Main Theatres, Wards A12, A14, Admin, Plant Rooms) - Fire Safety		
		Positive Assurance – New	0 incidents relating to Reportable Fire's within Aug 2019
		Positive Assurance – New	0 Unwanted Fire Signals within Aug 2019
4411	NX08/NX09 McHale Building - Fire Safety		
		Positive Assurance – New	0 incidents relating to Reportable Fire's within July to Aug 19
		Positive Assurance – New	0 Unwanted Fire Signals within Aug 19
4375	NX87 Heart Centre - Fire Safety		
		Positive Assurance – New	0 incidents relating to Reportable Fire's within Aug 19
		Positive Assurance – New	0 unwanted fire signals during Aug 2019
5197	Unacceptable waiting times for Cardiology follow-up appointments		
		Positive Control – New	We are adding an additional box to the RTT form so that Consultants can indicate if a patient needs to be seen by a specified date.
		Positive Control – New	We are asking the Registrars to review patients who are red on follow-up OWL starting with the Consultants who have the most to pull out clinically urgent.
		Gap in Assurance - New	Red FU OWL = total waits 2417. 1 x Consultant has 687
		Gap in Assurance - New	Amber FU OWL = total waits 596
		Gap in Assurance - New	Green FU OWL = total waits 2444

			Action Plan - New	Identify patients that do not require a Consultant review for a pacemaker check to ease waiting list times
			Action Plan - New	Monthly meeting with Arrhythmia Nurses/Cardiology ANP to undertake additional clinics to support.
	4706	Infrastructure/en vironment in Nucleus Theatres		
			Positive Assurance – New	1 x reported incident of power outage or back-up power failure in Theatre 7 during August
			Positive Assurance – New	No reported incidents of insect infestation for last 9 months
	2080	Risk to quality of patient care: reduced manpower		
			Positive Assurance – New	77.05 wte trained nursing vacancies remain
			Action Plan - New	Requesting recruitment for Bd2 staff to be done locally
			Action Plan - New	Developing local blueprints to be reviewed weekly
Chief Nursing Officer	3644	CQC risk		
			Action Plan – New	Undertake a gap analysis of mental health oversight and systems and process in place.
Medical Director	4661	Lack of robust system for review and communication of test results		
			Positive Assurance – New	Small increase in filed results from 20% to 23% (74% unfiled) however a plan is progressing with the migration of Cytology services to ICE on the 17th of September, followed by all new Histopathology results via ICE from 23/9/19 and Blood Sciences (Biochemistry, Haematology and Transfusion) and Microbiology results only being available via ICE aimed for February 2020. At the point of migration of reports to ICE, TD web will only be available to view historical reports (preceding the date of data transfer.)
			Gap in Assurance - New	76% of results on ICE are unfiled, 23% of results are filed

	5045	Sepsis		
			Action Plan - New	Generating weekly sepsis report from sepsis module and sharing it with the directorates.
	5182	Lack of Network support for Vascular Services at RWT.		
			Positive Assurance – New	Since May - 2 x TAVI lists have been cancelled due to lack of vascular cover
Chief Financial Officer	5253	Dell Tablets on ePMA wards damage and unsupported warranty		
			New risk	<p>Dell Latitude tablet computers were purchased for use on ePMA wards to enable drug rounds.</p> <p>Significant numbers have been damaged around the charging ports and are either difficult to charge and/or rendering the device unchangeable. The supplier has identified excessive use in a ward environment and the fact that they are not used on a one user to one device basis as the root cause. The supplier has therefore stated that these device failures are not supported under the 3 year warranty because the damage is due to user misuse.</p> <p>The devices are vital to administering drugs at the patient's bedside. If insufficient devices are available the wards will have to use computers on wheels or desktops for administration. This would be acceptable for business continuity in the short term whilst Wi-Fi issues are resolved however for unspecified and ongoing durations it introduces significant risks. The risks are that patients may receive the wrong drugs or doses.</p>

The Royal Wolverhampton NHS Trust

Trust Risk Register

September-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, rescheduled appointments and failure to save documents and audiograms (82 incidents reported via Datix since December 2018) (Sept 2019) 1) Multiple complaints from staff re: slow and hanging computers, often necessitating forced shut down of computers (Sept 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 (Sept 2019)	1-2) Present business case to Divisional Management Team 1-2) Procure equipment 1-2) Liaise with IT to install equipment	Sep-19 Nov-19 Dec-19	1 x 1 = 1 GREEN	Sep-19
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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	Sep-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	<p>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. If multiple HCUs fail on any day, then there is a risk of patient harm. Also if list cancellations become necessary then this could result in financial loss to the Trust.</p> <p>Date of origin: 28/04/2016 Date of escalation = 17/06/2016</p> <p>Date of re-escalation = 27/03/2019</p> <p>Risk Lead: Cardiac Group Manager</p>	3 x 4 = 12 AMBER	<p>1. A comprehensive service contract is in place, which provides a loan machine on breakdown of our machines (May 2016)</p> <p>2. 6 monthly service within comprehensive service (May 2016)</p> <p>3. Patients are informed before every case of the risk and it is documented on the consent form (March 2016)</p> <p>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)</p> <p>5. Directorate currently has 4 HCU machines. (Mar 19)</p> <p>6. HCU's are cleaned and water changed with hydrogen peroxide daily and recorded (28/03/2019)</p> <p>7. HCU's disinfected every 2 weeks as per protocol (08/05/2019)</p> <p>8. HCU's are tested for infection monthly (08/05/2019)</p> <p>9. All HCU's used on patients are identified and recorded (08/05/2019)</p>	<p>3 & 4. No patients have declined the procedure as a result of being open about the risk (Sept 2019)</p> <p>1-5 There have been 4 patients infected historically. There have been no further cases since 2016. These infections take up to 5 years (as far as we know) to manifest (Sept 2019)</p> <p>5. Potential for list cancellation - None cancelled to date (Sep 2019)</p>	<p>5) 3 out of 6 HCU machine have failed recently, 2 of which are irreparable (Sept 2019)</p> <p>5) A gap in HCU availability from manufacturer due to demand nationally (Sept 2019)</p> <p>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. (Sept 2019)</p>	<p>5) Approval of Business Case - 4 machines required, payment plan agreed with company</p>	Sep-19	1 x 3 = 3 GREEN	Sep-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	<p>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.</p> <p>Date of origin: 09/08/16</p> <p>Date of escalation = 06/02/17</p> <p>Risk Lead: General Surgery and Urology Group Manager</p>	4 x 3 = 12 AMBER	<p>2. SLA with Stoke reversed to bring additional resources from current RWT Consultant and buy service from Stoke (Feb 2018)</p> <p>3. Additional all day list allocated from 5th March 2019</p> <p>4. SOP agreed including agreed consent criteria and booking form</p> <p>1. Involvement with the Surgical Ambulatory Emergency Care Network (Sept 19)</p> <p>5. There has been additional recruitment and training of staff for another half list per week (Sept 19)</p>	<p>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)</p> <p>1-3 (03.06.19) Hot gallbladders undertaken on the CEPOD list by both UGI and non UGI Surgeons</p>	<p>1 (08.05.19) Patients are presenting with complications of gallstones</p> <p>1 (05.07.18) Local audit showing recurrent admissions</p> <p>1-3 (08.05.19) Highlight as a 'service at risk' to Division and as part of Medical Workforce Report</p> <p>1-3 (08.05.19) Unable to appoint to the 4th UGI Consultant post</p> <p>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.</p>	<p>(14.06.19) Re-locate UHNM staging lap list on Friday morning to give weekly 3rd session (Critical Care Services Directorate)</p> <p>(14.06.19) Recruit 4th UGI surgeon to enable full utilisation of allocated capacity. Currently being undertaken as additional to job plan</p> <p>(21.03.19) Purchase bile duct exploration kit</p>	<p>2 x 2 = 4 YELLOW</p> <p>Mar-20</p> <p>Oct-19</p>	Sep-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	<p>(*Risk for Closure by Directorate*) 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 locum's 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: As of July 2019 there are 5 Cardiology vacancies, 1 Cardiothoracic vacancy and 3 for Anaesthetics.</p> <p>Date of origin: May 17</p> <p>Date of escalation: May 18</p> <p>Risk Lead: Cardiac Group Manager</p>	3 x 4 = 12 AMBER	<p>2. Anaesthetics - Agreed we can recruit 2 training ACCPs (4.4.18)</p> <p>1. Job Vacancies are being advertised in BMJ as well as on NHS Jobs. (09.17)</p> <p>4. Cardiothoracic - 2 agency locums in place. (4.4.18)</p> <p>5. Anaesthetics - Consultants have had to cover middle grade night shifts. (25.4.19)</p> <p>6. Anaesthetics - 1 junior doctor starting 29.4.19 and another in 2 weeks time. (25.4.19)</p> <p>7. Cardiology - Recruitment on-going but slow. (18.4.19)</p> <p>8. Cardiology: 1 doctor recruited 3+ months ago still not in post, potential to be here in May 2019. (18.4.19)</p> <p>3. Anaesthetics: Dr Ahuja has agreed we can have some doctors to rotate around. (3.5.19)</p> <p>9. Cardiology - 5 new Registrars started in Sept 2019 leaving only 1 gap (11/09/2019).</p>	<p>1-6 There have been no incidents recorded to date (September 2019)</p> <p>2. Training of ACCP's continues and will take a further 12 months (September 2019)</p> <p>7. Cardiology: 2 candidates coming soon via the Clinical Fellowship Programme (September 2019)</p> <p>2. One ACCP going on rota mid August 2019 and the second one going on rota beginning of Oct 2019 (September 2019)</p> <p>4. Cardiothoracic Surgery - Fully staffed with a Trust locum in place until September 2019 when new person starts - no gaps (September 2019)</p> <p>2. 2 ACCP's have completed training and will be on the day time rota from Aug 19 and Oct 19 respectively. There will be 6 people on the rota then. They will then do some weekends and then in 6 months time some night shifts. (September 2019)</p> <p>2. Anaesthetics - 1 gap, 2 doctors coming from general side in Nov 2019 (September 2019).</p>	<p>1 & 2. Anaesthetics - x5 vacancies - delays on getting paperwork, GMC through since July 2018)08/05/2019)</p> <p>2. ACCP's x2 being trained, training will take a further 12 months to complete (08/05/2019)</p> <p>6. Cardiology: Very few suitable candidates available. 1 doctor recruited into MTI post has failed IELTS and must resit next month (08/05/2019)</p> <p>6. Cardiology: Staff generally recruited from abroad need IELTS, GMC and visa (08/05/2019)</p>	2 x 3 = 6 YELLOW	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	5083	<p>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.</p> <p>Date of origin: August 2018 Accepted onto Divisional Risk Register: August 2018 Accepted onto Trust Risk Register: 08/10/18</p> <p>Risk Lead: Head of Therapy Services</p>	4 x 3 = 12 AMBER	<p>(3) Care Pathway and initial guidance published on intranet (SALT pages) for wards to manage initial presentation of patients with swallowing problems (Aug 2018)</p> <p>(2) Use of swallow screening tool is now for trained/ competent Stroke nurses only (Aug 2018)</p> <p>(1) IDDSI (International Dysphagia Diet Standardisation Initiative) fully implemented across Trust (May 19)</p> <p>(4) Under Care Pathway, wards manage initial presentation and then refer to SALT who see patients within 2 working days (Nov 2018).</p> <p>(5) Implementation in progress with NHS/PSA/RE/2018/004 (May 19)</p>	<p>(1) Full implementation of IDDSI across Trust (July19)</p> <p>(5) Mainly compliant with Patient Safety Alert (NHS/PSA/RE/2018/004) - few remaining local actions being monitored via Nutrition & Hydration Steering Group (July19)</p>	<p>(1) PHSO C203652 aspiration pneumonia in Mar 18 [July19]</p> <p>(1) RCA 2017/30312 aspiration pneumonia in Nov 17 [July19]</p> <p>(1) 20 x related datix incidents in 2017; 15 x related datix incidents to Nov 2018 [datix reports Nov18-Apr19 under review] [July19]</p> <p>(2) Staff who are untrained/ no competency cannot use swallow screening tool (all areas outside Stroke) [July 19]</p> <p>(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 [July 19]</p>	<p>(4) Investigate the possibility of extending the SALT service beyond working days only - business case to be completed</p>	Jul-19	2 x 2 = 4 YELLOW	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?
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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 Divisions (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-design 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) YTD financial position for Division 2 is £0.95m favourable due to patient income over performance (08/19) 1-10) Division 1 - £65k worth of CIP was taken in month three (07/19) 1-10) Division 1 - CIP target for 19/20 is £9.3m, the Division has achieved £618k YTD (7% of the target in year). Recurrently £588k has been achieved (07/19) 1-10) Division 3 - £808k CIP achieved (£278k recurrently) (07/19) 1-10) Division 2 - £0.9m CIP achieved to date, against a target of £6.5 for Division 2 CIP (08/19)	2 & 3. Unidentified CIP still remains across the divisions (09/19)	1-10) Continue with process to identify and deliver efficiencies 2) Continue to review year to date underspends with a view to take non-recurrent to CIP 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) Endoscopy PID scheme for increased utilisation of Endoscopy rooms	3 x 3 = 9 AMBER	Nov-19 Nov-19 Apr-19 Nov-19 Apr-19 Oct-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	1-10) Endoscopy PID scheme extended. Expect to acheive Oct-March. 60% RAG rated yellow, 40 rated amber (09/19)					
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)	2. Thoracic ANP has been recruited and in post (September 2019) 2. Consultant Thoracic Surgeon recruited and in post (September 2019) 1-3 Continue to approach other Trusts for referrals (September 2019) 2. Locum Thoracic Surgeon recruited and will be in post Nov 2019 (September 2019)	1. Referrals have not increased, this has been escalated to DCOO and COO (September 19) 1. Despite agreed referral pathway with Walsall they are unwilling to move forward at present (September 2019)	1. Plan further approaches to Walsall Hospital 2. Thoracic Surgeons have Robotic training booked for Sept/Oct19. We are in process of arranging a week of proctored training in the hope of attracting new work to RWT.	Sep-19 Sep-19	1 x 5 = 5 YELLOW	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?
Trust Objective: Attract, retain & develop our staff & improve employee engagement										
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	Sep-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 Svcs, 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 (09/19) 1) Proactive recruitment approach continuing (09/19) 1) 77.05 wte trained nursing vacancies remain (09/19) 1) Continued recruitment to nursing clinical fellows (09/19) 1-10) Matrons meeting every Friday to ensure hospital is staffed over the weekend (09/19) 3) Snr Srs and Charge nurses meeting daily to ensure wards are safe (09/19) 3) 30 students offered roles to start in Sept 19 - awaiting confirmation of acceptance numbers (09/19) 3) 1 bay closed on C25 and C19 - having a beneficial impact (09/19) 1) Recruitment for Bd5's has now come back to local areas (09/19) 3) Weekly meetings to address vacancies as part of the Renal action plan - Twitter/Facebook campaign (09/19) 3) Bd6 allocated to C16 to complete D2A's to improve flow (09/19)	8) Insufficient RN's available on Bank, backfilled by HCA (09/19) 1) Nationally we are an outlier re safe staffing levels (09/19) 1) Recruited staff are newly qualified which can lead to mentorship and training pressures (09/19) 1) All wards are 'Amber' re safe staffing levels on daily basis (09/19) 3) Issue remains in relation to ability to provide accurate staffing figures (09/19) 3) Breaches in minimum safe staffing levels (09/19) 3) Significant nursing shortages on C16, C19, C24 and C25, working with 50% vacancies at Bd 5 level. (09/19)	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 1) Requesting recruitment for Bd2 staff to be done locally 3) Developing local blueprints to be reviewed weekly	4 x 3 = 12 AMBER	Sep-19	Yes

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?	
Chief Operating Officer	4529	<p>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.</p> <p>Please note: Risk 4239 (Obs & Gynae) staffing risk has been linked to this overarching Divisional medical staffing risk.</p> <p>Date of origin: 23/04/16</p> <p>Date of escalation = 17/05/16</p> <p>Risk Level: Div 1 Deputy COO</p>	4 x 3 = 12 AMBER	<p>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)</p> <p>3. Trust continues to be part of West Mid's Project to reduce Locum Agency use and pay (Dec 2017)</p> <p>4. Trust part of Junior Doctors in-training streamlining group (Dec 2017)</p> <p>1. Recruitment Strategy in place for Consultant and Middle Grade vacant posts - this is ongoing (Dec 17)</p> <p>5. Acces to overseas recruitment continuing membership to Clinician's Connected (June 18)</p> <p>6. Utilisation of the Fellowship Programme (Sept 18)</p> <p>7. Agency spend reviewed monthly at Directorate/Divisional meetings via the dashboard (Dec 18)</p>	<p>1-7) Medical staffing spend - increasing positive - filling posts (Aug 19)</p> <p>1-7) Medical staffing divisional vacancy rate - 11.67 consultants vacant, August data is expected to be much better as most of our DiT vacancies were filled by the deanery and gaps covered by the CFP programme (Aug 19)</p> <p>7) There continues to be no agency used in nursing (Aug 19)</p> <p>7) Achieved forecasted year end agency cap set for April 19 new cap set for April 20 (Aug 19)</p> <p>2) Baseline meetings are still continuing on-going on a regular basis (Aug 19)</p> <p>3) Project ongoing - reengagement day due to be held with Agencies in Sept (Aug 19)</p> <p>1) Recruitment is ongoing (Aug 19)</p> <p>1-7) Ongoing T&O medical vacancies sent 20 CVs as were struggling to recruit, 4 T&O Jnr Med appointments recruited (Aug19)</p> <p>1-7) 4 x O&G Consultants recruited (Aug 19)</p> <p>1-7) Agency usage in early 2019/20 months has nearly halved what it was at the start of 2018/9 financial year (Aug 19)</p>	<p>1-7) Number of vacancies remain across Division 1 (Aug 19)</p> <p>1-7) Locum spend continues but at a lower rate than previous (Aug 19)</p>	<p>5. Fellowship Programme ongoing</p> <p>1. Continuing campaign with regular adverts</p> <p>1. Continuing to develop roles to support medical rota (ANPs and ACCPs)</p> <p>6. Review of CVs by Clinician's Connected to fill Consultant vacancies</p> <p>1. Continue to implement recruitment strategy</p> <p>8. HR to work with Directorates to discuss annualised contracts to explore bringing locums onto permanent contracts.</p> <p>2. HR working with Anaesthetics and Ophthalmology to optimise rota configuration</p> <p>7. Divisional HR Manager to share an update on Locum list at DMT later this month</p>	<p>2 x 2 = 4 YELLOW</p>	<p>Dec-19</p> <p>Oct-19</p> <p>Oct-19</p> <p>May-19</p> <p>Dec-19</p> <p>Oct-19</p> <p>Oct-19</p> <p>Oct-19</p>	<p>Sep-19</p>	<p>Yes</p>

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?
					<p>1) Recruitment has been successful to most established medic positions, for those where recruitment is on hold pending sign off of business cases Divisional HR Manager is linking in with the medical resourcing lead to discuss recruitment strategies (Aug 19)</p> <p>7) Divisional HR Manager has a locum usage list and this has discussed the lists with directorates to gain an understanding of when we will stop using these persons (Aug 19)</p> <p>4) Steamlining Group to be lead by lead Employers (only RWT speciality is Palliative) (Aug 19)</p>					

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?
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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 (Sept 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 have been presented to Division before presentation at QSIG (Aug 19) 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 (Sept 19) 3. Monthly monitoring data of compliance with WHO checklist and Procedural Safety Checklist - 90% for full completion (documentation) in Aug 2019 (Sept 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. Ophthalmology (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) occurred 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) 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) (Sept 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	2 x 4 = 8 AMBER	Sep-19	Yes

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				<p>7. Policy for the management of retained swabs in place</p> <p>10. New qualitative and observational WHO checklist being used in Theatres (Oct 17)</p> <p>11. Continue to support the Sign up to Safety campaign - T&O and Maternity participation (Oct 17)</p> <p>12. LocSSIPs developed by Directorates auditing underway and presented to Division and QSIG (Jan 2018)</p> <p>13. AFFP Peer Review and Training undertaken</p>	<p>3. Monthly monitoring and compliance with WHO checklist use - There has been 100% compliance achieved during Aug 19 (Sept 19)</p> <p>1-13 There has been no new never events reported for two consecutive months (Sept 19)</p>					

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 Undertake a gap anaysis of mental health oversight and systems and process in place.	Nov-19 Sep-19 Sep-19	2 x 2 = 4 YELLOW	Sep-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?
				<p>1) Monitoring via Quality review visit and re-visit programme to assess CQC compliance (July 19)</p> <p>1) NEWS2 implemented Trust-wide (July 19)</p> <p>1) Information provided in PIR according to timescales (July 19)</p> <p>1) Series of Board development sessions sharing learning from other inspections and risks completed (July 19)</p> <p>1) communication of Trust Strategy including visions and values commenced (July 19)</p> <p>1) Evidence on PIR triangulated with KLOEs (July 19)</p>						

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	<p>(NX87) Heart Centre - Fire Safety:</p> <p>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.</p> <p>Date of origin: July 2017</p> <p>Date of escalation: Sep 17</p> <p>Risk Lead: Estates and Facilities Divisional Manager</p>	3 x 4 = 12 AMBER	<p>Implementation of a 4 Stage Risk Mitigation Plan; details include</p> <p>1) Restricted parking of vehicles to 6m</p> <p>2) Management of waste in the external compound</p> <p>3) Increased security and surveillance</p> <p>4) Augmented Fire Service reponse</p> <p>5) Increased Trust Fire Response</p> <p>6) Additional Fire Wardens trained</p> <p>7) Additional fire exercises and drills</p> <p>8) Review of fire risk assessments (15 completed, local risks managed by Directorates)</p> <p>9) Building & Maintenance risks managed by Estates via Planet FM</p> <p>10) Statutory fire alarm testing (weekly), Fire Damper Testing (Annual)</p>	<p>10) 0 incidents relating to Reportable Fire's within Aug 2019</p> <p>3) Additional Security Fire Patrols undertaken and recorded</p> <p>9) Priority Planned Preventative Maintenance undertaken</p> <p>2) Waste compound has been relocated</p> <p>7) Third Floor Fire Evacuation Exercise on 31.05.18</p> <p>9) Automatic Fire Detection (AFD) in identified areas has been upgraded with Tri-State Detectors. Areas identified from UwFS</p> <p>10) Break-glass over-ride facility for 3rd floor installed to enable lifts to be used in the event of an evacuation.</p> <p>1-10) Construction work underway in removing ACM cladding. Approx 70% has been removed from outer building. Inner courtyards had been resolved.</p> <p>4) WMFSvisited site, agreed security patrols and WMFS attendance to continue</p> <p>10) 0 unwanted fire signals during Aug 2019</p>	<p>9) Outstanding fire stopping required following compartmentation survey</p>		2 x 2 = 4 YELLOW	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	4382	<p>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.</p> <p>Date of Origin: 09/12/2015</p>	3 x 4 = 12 AMBER	<p>1. Statutory fire alarm testing (weekly), fire damper testing (annual)</p> <p>2. Departmental Fire Risk Assessments undertaken. Main Theatres frequency increased to 6 monthly due to risk</p> <p>3. Statutory Planned Preventative</p> <p>4. Bespoke Fire Warden Training</p> <p>5. Additional Fire Exercises and Drills</p> <p>7. Revised Management of External Waste in the Compound</p> <p>6. Departmental Fire Warden Daily Checks undertaken</p>	<p>1. 0 incidents relating to Reportable Fire's within Aug 2019</p> <p>3. Fire strategy has been approved and money set aside.</p> <p>1. 0 Unwanted Fire Signals within Aug 2019</p> <p>1. Fire Alarm is being upgraded to L1. Being monitored via Fire Safety Group</p>	<p>2. Compartmentation Survey to be completed</p> <p>3. Operational issues have meant the fire strategy work will take longer to complete with some work on hold</p> <p>1. Fire alarm & ancillary systems do not comply with current regulations</p>	<p>1. monitor and work towards completion of fire strategy for block</p>	Mar-20 2 x 2 = 4 YELLOW	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	4411	<p>(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.</p> <p>Date of origin : 14/02/2018</p> <p>Date of escalation: Sep 17</p> <p>Risk Lead: Estates and Facilities Divisional Manager</p>	3 x 4 = 12 AMBER	<p>1. Statutory fire alarm testing (weekly)</p> <p>2. Departmental Fire Risk Assessments undertaken</p> <p>3. Statutory Planned Preventative</p> <p>4. Waste Management</p> <p>6. Fire Evacuation Drill taken place on 4th July 2019. Fire drill is on a rolling programme</p> <p>5. Departmental Fire Warden Daily Checks undertaken</p> <p>7. Tugway Safety & Environmental Group commenced May 2018</p> <p>4. Implementation of robust waste management controls to reduce the risk of a fire occurring.</p> <p>7. Basement area (Tugway) now being monitored following the Installation of CCTV.</p>	<p>1. 0 Unwanted Fire Signals within August 2019</p> <p>1. 0 incidents relating to Reportable Fire's between July to August 2019</p> <p>2. Combustible items located in the Tugway have been removed. The area is being monitored by Estates Department via the Tugway Group</p> <p>7. Structural fire safety repairs carried out to minimise risk fire spread from the Basement (Tugway) into the building above.</p> <p>7. Implementation of robust management controls</p> <p>4. Environmental Audit Group carry out 3 monthly audits of Tugway</p>	<p>1. 1 Unwanted Fire Signals within July 2019 - due to system fault</p>	<p>2. Departmental Business Continuity Plans need to be updated</p>	2 x 2 = 4 YELLOW	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	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 (09/19) 4-5) Reallocation of staff working well to help reduce wait times during pressured times (09/19) 15) Urgent treatment doctor is making an improvement to patients receiving appropriate emergency treatment (09/19) 17) Additional triage room helping to reduce triage wait times (09/19) 1,2,7) Interviews underway for Bd 7 - 2nd cohort interviewed, 3 appointed (09/19) 1,2,7) Plan for Bd 7 to cover Zone A&B during day to be trialled (09/19)	1, 2) Inability to achieve 15 minute triage consistently breaches mainly in minors, at 1.5hrs at points in month (09/19) 4,5) Staff not always available to be reallocated (09/19) 7) Medical and nursing vacancies and sickness/annual leave resulting in gaps in rota. Link to risk 4496 and 2374 (09/19) 9) UCC minimum impact on pt numbers and delays in assessments (09/19) 7) Continued use of long term locums (09/19) 1) Inability to acheive 2 hr target in month, significant delays experienced (09/19)	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	Sep-19 Sep-19 Sep-19 Sep-19 Sep-19	1 x 4 = 4 YELLOW	Sep-19	Yes

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				11) Human factors review completed and resulted in department restructure. All staff provided with human factors training and rapid improvement events [6/3/19]						
				12) Medical and nurse staffing managed via the risk register (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)						

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				<p>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)</p> <p>21) Every member of staff has additional training 1 day per year (6/3/19)</p>						

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 clinicians 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 as well 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 (Sept19) 3. The Badgernet System remains embedded within the Maternity department (Sept 19) 2. Procedures continue to be in place to access paper records/request scanning of records onto portal (Sept 19)	1. Datix Incident reported - Non STEIS RCA 185209. There has been identification that the information included in hospital notes not available via clinical web-portal (Sept 19) 1. Records are not always available for elective clinics, even if they are available this creates a time lag within the clinic (Sept 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 (Sept 19) 3. Restricted access to the Badgernet System - no immediate access to Maternity notes (Sept 19) 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. Continue to monitor incidents	Jan-20	2 x 2 = 4 YELLOW	Sep-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	<p>Longstanding maintenance challenge around infrastructure/environment in Nucleus Theatres, which includes:</p> <ol style="list-style-type: none"> 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) <p>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.</p> <p>Date of origin: Feb 17 Date of escalation to Divisional Management: Sep 17 Risk Lead: Critical Care Group Manager</p>	4 x 3 = 12 AMBER	<ol style="list-style-type: none"> 1. Existing programme of theatre works in place (3 phase refurbishment is underway) - (Aug 2019) 2. All leakage/flooding/insect infestations incidents reported to management are immediately escalated to Hotel Services 3. Theatre 5 was closed for refurb between April 17 - Oct 18 - This is now open and is fully utilised. 	<p>1 - 7 No procedure cancellations due to any of the above issues for 8 months (Sept 19)</p> <p>1 - 1 x reported incident of Sewage ingress/water leaks since May 2019 - no further incidents reported (Sept 19)</p> <p>2 - 1 x reported incident of power outage or back-up power failure in Theatre 7 during August (Sept 19)</p> <p>7 - No reported incidents of insect infestation for last 9 months (Sept 19)</p>	<p>3) 3 x recent incidents of fire alarms sounding in theatres - of unknown cause between 01/01/19 and 15/08/19 - no further incidents reported (Sept 19)</p>	<p>1 - 4. Reconfiguration of Theatre reception and storage currently in progress</p> <p>1 - Work to commence this financial year for fire compartmentalisation in clinical areas</p>	<p>Mar-20 2 x 1 = 2 GREEN</p> <p>Mar-20</p>	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	5031	<p>If sub-optimal staffing (reduction in 39%) continues within the Ultrasound Scan Department, then it will impact on required compliance with national screening standards - this includes submitting the required data and proving quality of work is assessed continually for obstetric patients. Neonatal hip and cranial scans also need to comply with national standards and this may be affected. Training will also be impeded affecting the future of service provision. There may be a rise in litigation cases and disability, amongst other issues.</p> <p>Date of origin: 17/05/18 Date of escalation: 05/09/19 Risk Lead: Head of Midwifery</p>	3 x 4 = 12 AMBER	<p>1) Dating and Fetal Anomaly scans are given priority over Gynaecology scans to ensure women have their scans performed in accordance with the national programme standards. 9/4/19</p> <p>2) Community Midwives have the facility to telephone the Maternity Unit and organise an urgent priority scan if a woman is thought to have booked late (9/4/19)</p> <p>3) Midwife Sonographers in fetal medicine (FMU) are being asked to assist with scanning both obstetric and gynae scans in the main scan department when staffing in FMU allows (9/4/19)</p> <p>4) Staff in Maternity Scan Dept. are continually reviewing their staffing levels to escalate their concerns appropriately (9/4/19)</p> <p>5) Agreement for sonographers to volunteer to run weekend clinics and extended days to increase available scanning slots. (09/04/2019)</p> <p>6) Current adhoc support from midwife sonographers enables the sonographers to undertake hip, cranial and emergency gynae scans which have been prioritised. (9/04/2019)</p>	<p>1-4) There are no reported incidents whereby a woman has missed the opportunity to have her dating or anomaly scan as a direct result of sub standard staffing within main scan (10/9/19)</p> <p>1-3) The Antenatal Screening Coordinator (Midwives) has not received any notifications from any community midwives to inform of missed antenatal screening (10/9/19)</p> <p>1-15) Prioritisation of urgent patients, e.g., ectopics from ward and EPAU (10/9/2019)</p> <p>1-15) Patients may be admitted to ward if unable to perform scan and confirm diagnosis (10/9/2019)</p> <p>1-15) Currently, due to the prioritisation of work, sonographers are attempting to perform scans within standards stipulated for babies and mothers.(10/9/2019)</p> <p>11) Staff have worked additional hours on the enhanced rate (10/9/19)</p> <p>1-15) Still working weekend sessions to keep hip scans within 6 weeks (10.9.19)</p> <p>1-15) Currently, all obstetric patients are being offered screening and anomaly scans within the screening standard and no incidents have been reported (10/9/19)</p>	<p>1-4) Datix incident reports have been received concerning staff shortages resulting in no scan service in the EPAU - none received since 07.01.19 (10/9/19)</p> <p>15) Whilst weekend clinics are ensuring hip scans are not breached, there are still a number of gynae women who are not scanned within the national standard for emergency gynae fast track.(10/9/2019)</p> <p>11) There remains a vacancy for a WTE sonographer, due to commence Oct 2019 and a sonographer who remains on garden leave (1WTE) (10/9/19)</p> <p>1-3) Whilst patients aren't missing screening there have been incidences where women have not been offered the combined screening (Downs, syndrome, Edwards and Patau syndromes) at 11+2 - 14+1 weeks gestation which is the optimal screening test. Patients have gone on to have the QUAD test which is a less accurate screening test and is for Downs syndrome screening only (10/9/19).</p>	<p>1) Increase staffing of sonographers in main scan Dec-19</p> <p>2) Resolve HR issues Dec-19</p> <p>1) Re-advertise for permanent sonographers Dec-19</p> <p>1) Ultrasound Superintendent Manager to be advertised and recruited. Apr-20</p> <p>1) Further training of midwife to undertake full sonography role Jun-20</p>	1 x 3 = 3 GREEN	Sep-19	

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				7) Selected low risk gynae patients have been referred to Radiology (09/04/2019)	13) One midwife has completed her training and one midwife is due to complete her training (10/9/19)					
				8) Doctors training cancelled as a temporary measure in Women and Children's to maximise the patients being scanned in a list. (9/04/2019)	12) Nurse started University in February 2019 (10/9/19)					
				9) x2 sonographers have been employed via the Bank - booked if they are available (09/04/2019)	15) Weekends are being utilised to adhere to Gynae and Hip scan standards (10/09/19)					
				10) x2 members of staff have increased their hours on a permanent basis (09/04/2019)						
				11) Enhanced Bank Rates £45/hr are being offered for any part time current staff (09/4/2019)						
				12) Plans to train a nurse from EGAU to do scanning (9/4/2019)						
				13) Training two midwives to scan 3rd trimester scans (9/4/19)						
				14) Health & Safety assessment from Occupational Health undertaken (9/4/19)						
				15) Agency sonographer started on the 07.01.19 - 0.4 WTE (9/4/19)						
				16) Recruitment drive for both agency sonographers and permanent staff continues. 1WTE appointed (started April 19) and 1 WTE due to start October 2019. 20/8/19						

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	<p>Sepsis and severe infection are perhaps the most common reasons for admission to hospital and cause of inpatient deterioration.</p> <p>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.</p> <p>Date of origin: Jun 18</p> <p>Date of escalation: Jun 18</p> <p>Risk Lead: Medical Director</p>	4 x 3 = 12 AMBER	<p>4) Training staff in the recognition and management of sepsis - ongoing monitoring.</p> <p>2) Early warning systems for paediatric, maternal and adult patients assist in the detection of deteriorating patients - many of whom will have sepsis.</p> <p>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.</p> <p>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.</p> <p>5) Two sepsis nurses have been recruited (1 band 7 and 1 Band 6) (Feb 19)</p> <p>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.</p> <p>7) Generating weekly sepsis report from sepsis module and sharing it with the directorates (Sep 19)</p>	<p>4) Mandatory training compliance in IP and Sepsis is monitored at directorate governance</p> <p>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</p> <p>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</p> <p>1) Antimicrobial prescribing compliance. To ensure that antimicrobial prescribing is compliant with trust guidance and that antimicrobials are reviewed to reduce antimicrobial resistance</p> <p>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)</p>	<p>4) Mandatory training performance report.</p> <p>2) Non-Compliance with EWS audit.</p> <p>1) Non-compliance with Antimicrobial audit.</p>	<p>Consolidate sepsis awareness across the trust with the help of newly appointed sepsis nurses.</p> <p>Conducting regular sepsis compliance audits in ED, Inpatients, Haemat-oncology, Paediatrics and Obstetrics. The results of these are fed back to the DPG monthly.</p> <p>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.</p> <p>Generating weekly sepsis report from sepsis module and sharing it with the directorates. (Sep 19)</p>	Mar-19 x =	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	5069	<p>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.</p> <p>Date of Risk: 19/07/2018 Accepted onto Divisional RR: 16/11/2018 Accepted onto Trust RR: 15/02/2019</p>	4 x 3 = 12 AMBER	<p>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)</p> <p>3) Nursing resource allocated to support additional clinics - using bank where necessary (e.g. substantive staff sickness) (Nov 18)</p> <p>4) Weekly Dermatology PTL meeting with MDT Co-ordinator to review capacity for subsequent biosies (July 2018)</p> <p>5) New process implemented for nurses to undertake biopsies alongside FT clinics (Feb 19)</p> <p>6) Monitoring of two week wait referrals (June 19)</p>	<p>3) 0 FT patients outstanding for subsequent procedures to be booked (Sept 19)</p> <p>1) 0 FT patients outstanding for first appointment (Sept 19)</p> <p>6) Two week wait referrals now at 84.4% in August 2019 from 87.6% in July 2019 (Sept 19)</p>	<p>3) Currently have 4 WTE Consultants working, 1 not working, deficit 2 WTE (Sept 19)</p> <p>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%. This has since fallen to 86.6% in July 2019 (Sept 19)</p>	<p>1-4) Implement recommendations from Dermatology external review</p> <p>1-6) Directorate Manager to present updated action plan on monthly basis to Divisional Oversight Group</p>	<p>Sep-19 2 x 3 = 6 YELLOW</p> <p>Sep-19</p>	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	5112	<p>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.</p> <p>Date of Origin: Oct 18 updated July 2019</p> <p>Date of escalation: Dec 18</p> <p>Risk Lead: Critical Care Group Manager</p>	3 x 4 = 12 AMBER	<p>1- Band 8a Operational Nurse Manager is now in post (Aug 2019)</p> <p>2- New PDN is in post (Aug 2019)</p> <p>3- All new staff have a supernumerary period of 6 weeks, adjusted to meet individual staff requirements, dependant on previous critical care exposure (Aug 2019)</p> <p>4- Inexperienced staff have a 6 week intensive programme of clinical study days, with engagement from the post registration education team (Aug 2019)</p> <p>5- There is a documented weekly review for new member of staff with the PDN Team, to ensure training needs are achieved (Aug 2019)</p> <p>6- Each new member of staff is allocated to 2 experienced ICCU nurse to support them during the supernumerary period (Aug 2019)</p> <p>7-For inexperienced staff 75% of their shifts are worked Monday to Friday days. Continue with educational support for 4 months (Aug 2019)</p> <p>8- Education and Admin support posts are in place(Aug 2019)</p> <p>9- Exit interviews are carried out with leavers to ensure improvements for retaining staff (Aug 2019)</p>	<p>1- Band 8a Operational Nurse Manager in post and has overall responsibility for the service (Sept 2019)</p> <p>6,7,12 - e-Roster utilised resulting in a decrease in staff disatissfaction (Sept 2019)</p> <p>8-17 - Meeting notes and minutes, and Datix reports have indicated that staff are aware that they are being listened to and their suggestions considered (Sept 2019)</p> <p>2-7 - Education team have changed their training delivery method - this is now undertaken at the bedspace (Sept 2019)</p> <p>2-7- PDN is in post and providing training (Sept 2019)</p> <p>18 - Shifts are being covered and disruption to services minimised (Sept 19)</p>	<p>10,14 - 5 out of 10 vacancies remain unfilled - Vacancies recruited to will take up posts between 01/07/19 and 30/09/19 (Sept 2019)</p>	<p>9 - Recruit to Band 6 and 7 posts</p> <p>14 - Monitor Datix reports concerning staff shortages and skill mix</p>	<p>2 x 3 = 6 YELLOW</p>	<p>Sep-19</p> <p>Oct-19</p>	

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- All posts are advertised and recruited into on a continuing basis(Aug 2019)						
				11- 'You said, We Said' Wall is in place (Aug 2019)						
				12- E-rostering is fully utilised (Aug 2019)						
				13- Divisional Management Team is appraised of progress against the agreed action plan for the unit (Aug 2019)						
				14- Staff and sickness levels are monitored daily (Aug 2019)						
				15- New members of staff are allocated evenly across the unit to ensure that neither speciality is saturated with too many supervised staff (Aug 2019)						
				16- Inexperienced Staff have their own Team on e-roster (Aug 2019)						
				17- Centralised sickness management ensures that trends are identified and action taken. Monthly sickness workshops are held with HR ensuring appropriate escalation via Trust Policy (Aug 2019)						
				18- Staff are paid at enhanced rate for overtime to cover the unit (Aug 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?
Chief Operating Officer	5119	<p>If the Trust does not comply with the EU Falsified Medicines Directive then we will be subject to penalties/fines and could expose patients to counterfeit medicines, resulting in financial damages to the Trust and potential harm to patients. In addition we will not be able to provide assurance to CQC that we are protecting patients from harm from falsified medicines.</p> <p>Date of Risk: October 2018 Accepted onto Divisional RR: 16/11/2018 Accepted onto Trust RR: 22/7/2019</p>	4 x 3 = 12 AMBER	<p>6. HTE asked to develop framework for purchase of required kit which will support a competitive purchasing process(18/12/18)</p> <p>5. National email address from MHRA for FMD.(18/12/18)</p> <p>4. Black Country STP meetings. (18/12/18)</p> <p>3. Group action from chief pharmacists. (18/12/18)</p> <p>2. Attended regional study day which explored different options to achieve compliance (22/01/19)</p> <p>1. Regional review of FMD software undertaken. (18/12/18)</p> <p>7. Information for HTE framework made available through regional purchasing lead (4.2.19)</p> <p>8. Business case written to go to core team (Div3) (18.2.19)</p> <p>9. Pharmacy stakeholders meeting around option appraisal and action plan (14/01/19)</p>	<p>4. Able to use for networking and knowledge. (Aug 19)</p> <p>8. Business case approved by Division and C&C (Aug 19)</p>	<p>2. Implementation plan and date not agreed. (Aug 19)</p> <p>1. Software, hardware and licences not purchased (Aug 19)</p> <p>3. Post-Brexit position with regard to long term compatibility of software/hardware across Europe remains unclear (Aug 19)</p> <p>8. Business case for staffing, hardware and software to be approved by TMC (Aug 19)</p>	<p>1-9. Business case required for implementation - approval is subject to compliance with legislation regarding outsourced outpatient service</p>	Oct-19 2 x 3 = 6 YELLOW	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?
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 result on 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 occurring at RWT (Mar 19)	1-2 Since May - 2 x TAVI lists have been cancelled due to lack of vascular cover (Sept 19)	1-2 Frozen Elephant Trunk (FET) Device is not yet approved (Sept19)	1-2 Further evidence becoming available to enable approval of FET device.	Sep-19 2 x 2 = 4 YELLOW	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	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 result in patient harm due to delays in further diagnosis and treatment if required.	4 x 3 = 12 AMBER	<p>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</p> <p>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.</p> <p>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</p> <p>5. Assistant Directorate Manager regularly reviews slot utilisation report to ensure that all review slots are used</p> <p>1. Recruitment Strategy in place</p> <p>6. We are adding an additional box to the RTT form so that Consultants can indicate if a patient needs to be seen by a specified date.</p> <p>7. We are asking the Registrars to review patients who are red on follow-up OWL starting with the Consultants who have the most to pull out clinically urgent.</p>	<p>2. Extra clinics continue to run when consultants/ANPs agree to do so (Sept 2019)</p> <p>3. Partial booking process remains in place (Sept 2019)</p> <p>4 & 5. Deloitte's KPI report showed high level of slot utilisation for review clinics (Sept 2019)</p>	<p>2, 4, 5. Numbers of review patients on FU OWL and overdue continuing to rise despite additional clinics and other controls (Sept 2019)</p> <p>1-5 Red FU OWL = total waits 2417. 1 x Consultant has 687 (Sept 2019)</p> <p>1-5 Amber FU OWL = total waits 596 (Sept 2019)</p> <p>1-5 Green FU OWL = total waits 2444 (Sept 2019)</p>	<p>Extra consultant posts being recruited into to increase OP capacity across whole of cardiology</p> <p>Review capacity and demand.</p> <p>A further business case will be required which is in line with years 2-3 of the 10 year plan.</p> <p>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.</p> <p>Identify patients that do not require a Consultant review for a pacemaker check to ease waiting list times</p> <p>Monthly meeting with Arrhythmia Nurses/Cardiology ANP to undertake additional clinics to support.</p>	<p>Feb-20 4 x 2 = 8 AMBER</p> <p>Feb-20</p> <p>Nov-19</p> <p>Nov-19</p> <p>Sep-19</p> <p>Oct-19</p>	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	5246	If there is insufficient Consultant cover for H&N, colorectal, sarcoma and upper GI cancer sites (currently only 1 Cons for each of these sites due to inability to successfully recruit), then this will impact on the ability of the service to provide appropriate and timely care to patients at times of additional vacancies, staff sickness and annual leave. This will lead to a risk of compromised patient care, inability to treat specific cancer site patients at RWT, delays in treatment, inability to achieve cancer targets and increased workload/stress for existing Cons staff.	3 x 4 = 12 AMBER	<ul style="list-style-type: none"> 1) Palliative Consultant Radiologist reviewing Palliative care patients (07/19) 2) Prioritisation of existing patients (07/19) 3) On- going monitoring of service performance against national cancer targets (07/19) 4) Clinical Director trained in managing thyroid cancer patients (07/19) 5) 104 day harm reviews to identify harm (09/19) 6) Senior Clinical Fellow programme is providing support to the existing service 	<ul style="list-style-type: none"> 1,2,4) No medical staffing Datix incidents (07/19) 6) Senior clinical Fellows are being supported through the CESR programme (09/19) 2&3) Discussions are ongoing with other healthcare providers (09/19) 	<ul style="list-style-type: none"> 1 & 4) Consultant consistently raising concerns regarding lack of cover during periods of leave (07/19) 	<ul style="list-style-type: none"> 2&3) Discussions with other healthcare providers for support 1-4) Development of current Clinical Fellowship programme to identify medical staff of suitable calibre 1-4) Development of additional Cons Radiographer posts following commencement of current 2 new posts 1-4) Active recruitment to vacant colorectal posts 1-4) Active recruitment to vacant H&N post 1-4) Active recruitment to vacant upper GI post 1-6) Identify locum Cons cover 	<ul style="list-style-type: none"> Nov-19 2 x 4 = 8 AMBER Oct-19 Oct-19 Dec-19 Dec-19 Dec-19 Oct-19 	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 Financial Officer	5253	Dell Latitude tablet computers were purchased for use on ePMA wards to enable drug rounds. Significant numbers have been damaged around the charging ports and are either difficult to charge and/or rendering the device unchangeable. The supplier has identified excessive use in a ward environment and the fact that they are not used on a one user to one device basis as the root cause. The supplier has therefore stated that these device failures are not supported under the 3 year warranty because the damage is due to user misuse. The devices are vital to administering drugs at the patient's bedside. If insufficient devices are available the wards will have to use computers on wheels or desktops for administration. This would be acceptable for business continuity in the short term whilst Wi-Fi issues are resolved however for unspecified and ongoing durations it introduces significant risks. The risks are that patients may receive the wrong drugs or doses.	4 x 3 = 12 AMBER	<p>1) Continue to attempt to send devices to Dell for repair (June 19)</p> <p>2) Extra kit re-purposed for deployment as EPMA tablets (36 additional devices) (June 19)</p> <p>3) Magnetic adapters used on new devices to relieve pressure on charging ports and help durability of devices.(June 19)</p> <p>4) Redeployment of kit (June 19)</p>	<p>2) Extra kit re-purposed for deployment as EPMA tablets (36 additional devices) (June 19)</p> <p>3) Magnetic adapters used on new devices to relieve pressure on charging ports and help durability of devices.(June 19)</p>	<p>1) Not all devices will be fixed under warranty</p> <p>2) Durability of devices still questionable and even replacements exhibit same weaknesses as those devices which are being replaced. Eventually we will run out of replacement devices</p> <p>3) May provide some additional durability to new devices being redeployed but will not provide any durability to devices already weakened by use.</p> <p>4) Has reduced overall number of devices on each ward.</p>	<p>2) Identify funding to procure replacement devices. Sufficient devices are required to mitigate issues based on current reduction in numbers.</p> <p>2) Procure additional devices and build for deployment.</p> <p>4) Monitor number of replacement devices available and report count to Head of Technical Services, Dell have been able to repair and return some devices (Sep 19)</p> <p>2) Business case drafted for more devices but awaiting outcome of device trial before submission</p> <p>2) Site visits being conducted for durability of alternative machines now suitable machines and supplier identified.Devices being trialled on 3 wards. Due diligence regarding supplier being undertaken.</p>	<p>Oct-19 4 x 1 = 4 YELLOW</p> <p>Oct-19</p> <p>Oct-19</p> <p>Sep-19</p> <p>Sep-19</p>	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	5284	<p>If the issues relating to EPMA are not resolved then healthcare professionals involved in the prescribing and administration of medicines may not be able to prescribe or administer medicines in a safe or timely manner. As a consequence this may result in patient harm due to incorrect prescribing or administration of medicines, or missed or delayed doses. The issues relating to EPMA that contribute towards this risk can be categorised into:</p> <p>Lack of functionality or errors associated with the software.</p> <p>Lack of or errors associated with interfaces with other Trust systems (electronic and paper).</p> <p>Staff using the system incorrectly or suboptimally.</p> <p>Lack of and poor suitability of hardware for EPMA.</p> <p>This is an overarching risk and replaces risks 5190 and 5038.</p> <p>Date of origin:20.8.19</p> <p>Accepted onto Divisional Risk Register:</p> <p>Accepted onto Trust Risk Register:</p>	4 x 3 = 12 AMBER	<p>1. There is an EPMA Steering Group chaired by the Medical Director which provides Executive level oversight and strategic direction for EPMA. (Aug 19)</p> <p>2. Establishment of the EPMA Operational Group to address the issues with EPMA. This group reports into the Steering Group and links with the Trust Medicines Management Group. (Aug 19)</p> <p>3. A meeting was held with the system suppliers Emis to secure ongoing engagement to resolve system issues 10.7.19. List of priority system issues was presented to Emis. (Aug 19)</p> <p>4. A list of priority system issues has been produced by the EMPA Steering Group. (Aug 19)</p> <p>5. An assessment of all Datix relating to EPMA since go-live has been produced and will be shared with the Steering Group and Operational Group in August. This will continue to be monitored and reported on. (Aug 19)</p> <p>6. A business case for additional resource to support EPMA has been approved and the posts are being recruited to (Datix 5204), this includes additional posts to support training.. (Aug 19)</p>	<p>1. The EPMA Steering Group meets monthly and minutes are available. (Aug 19)</p> <p>2. The first meeting for the EPMA Operational Group is scheduled for September. A Chair has been appointed. (Aug 19)</p> <p>4. Emis has responded in writing to the priority list and will be undertaking a site visit in September. (Aug 19)</p> <p>5. Datix reports relating to EPMA are monitored monthly. (Aug 19)</p> <p>6. The business case is approved and posts being recruited to. (Aug 19)</p> <p>9. Emis are actively managing the intermittent issue where the system freezes and this is preventing it from occurring. (Aug 19)</p>	<p>5.6. User error is a cause of incidents reported via Datix, this could be improved with better training for EPMA. (Aug 19)</p> <p>7. Hardware is being reported as broken and monies need to be identified to replace. (Aug 19)</p> <p>5. The Datix assessment shows 231 incidents directly relating to EPMA March 18 - July 19. System user errors are the greatest source of incidents (121 reports). There is 1 report of moderate patient harm, 64 reports of no patient harm and 166 reports do not have harm recorded. (Aug 19)</p> <p>4.9. System down time is still occurring (need to add report of incidence). (Aug 19)</p> <p>4.9. No issues on the priority list have been resolved. (Aug 19)</p> <p>1,2. The Medical Director is receiving complaints from Consultants regarding EPMA. (Aug 19)</p> <p>7. IT report that 90 devices have been returned to IT as not working. Reports that nursing staff not using EPMA hardware and are using desktop PC's. (Aug 19)</p>	<p>Emis to visit site in September to review issues raised.</p> <p>Business case for IT hardware support</p> <p>Review and improve user training</p> <p>Replace broken hardware</p> <p>Continue to engage with Emis</p>	<p>Sep-19</p> <p>Sep-19</p> <p>Oct-19</p> <p>Oct-19</p> <p>Sep-19</p>	1 x 3 = 3 GREEN	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?	
				<p>7. IT are undertaking a trial of alternative hardware solutions and requesting that wards report all hardware issues to IT. (Aug 19)</p> <p>8. The Medicines Management Group and Steering Group approved an SOP which means that EPMA will not be used for day case surgery and will not be used on admission for elective surgery. This will be reviewed if Emis can make system changes to improve the use of EPMA in patients following the surgical pathway. (Aug 19)</p> <p>9. There is an issues (hazards log) which records all EPMA issues and actions. This is maintained by the EPMA Team and managed by the EPMA Operational Group. (Aug 19)</p> <p>10. The EPMA Steering Group has agreed not to extend the current EPMA system to new areas until current issues are resolved. This means it will not be extended to paediatrics, neonates and maternity at the current time. (Aug 19)</p>							
Risk Managed to Target Level											

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
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Trust Objective: Create a culture of compassion, safety & quality

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	2 x 2 = 4 YELLOW	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)	5) Equipment replacement programme commenced 18.03.2019. First static DR X-ray room (Rm 1) fully operational 03.06.2019, second static DR X-ray Room (Rm 2) fully operational 05.08.2019. (Sept 2019). 1), 2) & 3) Remaining static X-ray room (Rm 3), mobile X-ray unit (AMX 4) and associated CR system decommissioned 05.08.2019 (Sept 2019) 4) & 5) Operational static and mobile X-ray units utilise DR systems only (Sept 2019)	5) Remaining static X-ray room (Rm 3) in process of being replaced (Sept 2019)	5) Replacement of equipment planned for 19/20	Sep-19 2 x 2 = 4 YELLOW	Sep-19	Yes
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