The Royal Wolverhampton NHS Trust

Chief Nurse's Governance Report
6 November 2019

Agenda Item No: 11.2

Safe & Effective | Kind & Caring | Exceeding Expectation

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	6th November 2019
Title:	**CNO Governance Report**
Executive Summary:	**1.Trust Risk register (TRR) update – October 19** The TRR update is provided with areas for attention highlighted below. **2. Serious Untoward incident (SUI) Performance** Largely good performance in meeting RCA investigation timescales. One investigation report brought forward from Sept is subject to final adjustment prior to submission. Recent delays in RCA completion has been due to difficulty in identifying RCA leads. Divisions are encouraged to identify individuals to receive investigator training. September saw a notable increase in reported SUIs. **3. Information Governance (IG) work plan** By March 2020 all Health and Adult Social Care organisations are required to comply with the National data opt-out policy. This involves the application of the National Opt out standard in circumstances where confidential patient information is used for purposes beyond an individual's care and treatment. A program of work is required involving Information Services/Research & Development (include advice to NIHR/CRN) in the first instance. The mid-year submission for the Data Protection and Security Toolkit (DPST) identifies 99 completed mandatory elements with 17 outstanding for RL4, and for GP practices 32 completed with 10 outstanding mandatory elements. An action plan is in progress to ensure full compliance by March 2020. **4. Governance Department staffing** The Health and Safety (H&S) team structure is under review owing to difficulties in recruiting to a band 5 H&S officer. A prioritised H&S work plan remains in place. **5. Governance of local Procedural Documents (ie Clinical Procedures, Guidelines, Protocols etc)** Routine local procedure reports have been issued including LocSSIPs known to exist. Directorates are asked to update the local register with any additional procedures and guidelines that exist. Divisions are required to monitor a programme of update for all local procedural documents. **6. Mortality Review Process** For the period of October 2018 to 31st July 19 the number of outstanding SJR 1 reviews equalled 123 cases (as at 12th Sept 19). Outstanding SJR1 will be reviewed as follows: • Directorates to complete cases before 1st April 2019 • Mortality Reviewers to complete cases on or after 1st April 2019 As at the October report to MRG, the top category selected by reviewers for 'problems in care' was: Problem in assessment, investigation or diagnosis (Inc. assessment of pressure ulcer risk, VTE risk, history of falls. (38%) Followed by: Problem related treatment and management plan. (28%)

	7. Learning and Improvement A Learning Framework is in development for consultation and presentation in Nov 19. **8. CQC Well Led Inspection** Document requests and queries continue to be received from CQC, and are being responded within requested timeframes. A significant number relate to Community Services, ED, Children Young Persons, Well led queries (eg. policies and strategies), Medication audits and Safeguarding.
Action Requested:	**Receive and note,**
For the attention of the Board	
Assure	• TRR updates requested monthly, up to date risk is maintained. • The number of risk scoring 12 or above and awaiting approval to TRR has reduced.
Advise	• Areas are requested to place targeted efforts on the review/update of local procedural documents, with confirmation of LocSSIPs in use. • Areas are asked to maintain focus on the update risk registers prompt escalation of risks graded 12 or above to the Trust.
Alert	• It is essential that elements identified in the DPST actions plan are completed by March 2020. • A revised National SUI Framework is expected to include significant changes to be adopted by the Trust. Early adopters are piloting the new requirements. 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	1. Create a culture of compassion, safety and quality 2. Proactively seek opportunities to develop our services 3. To have an effective and well integrated local health and care system that operates efficiently 4. Attract, retain and develop our staff, and improve employee engagement 5. Maintain financial health – Appropriate investment to patient services 6. Be in the top 25% of all key performance indicators
Resource Implications:	None
Report Data Caveats	This is a standard report using the previous month's data and updates within a live Datix system. It may therefore be subject to cleansing and revision.
CQC Domains	**Safe:** patients, staff and the public are protected from abuse and avoidable harm. **Effective:** care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence. **Caring:** staff involve and treat everyone with compassion, kindness, dignity and respect. **Responsive:** services are organised so that they meet people's needs. **Well-led:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.
Equality and Diversity Impact	No adverse impact on PPCs
Risks:	See TRR risk detail below plus Governance Dept RR: 3285 Non Compliance with FOI timescale – grade 9 amber 4769 Capacity IG/GDPR – grade 9 amber 4663 Capacity Health and Safety – grade 9 amber

Public or Private:	
Other formal bodies involved:	
References	
NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Report Details

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1. Trust Risk Register

2 new risks:

5285 - Urgent access to Stroke CTAs 24 hours a day 7 days a week (COO)

5249 - Cerebral Function Monitoring Machine failure Services (COO)

3 risks removed:

4665 - X-RAY CANNOCK (COO)

4761 - Cardiology, Cardiothoracic & Anaesthetic JMS vacancies (COO)

5069 - Dermatology Fast Track Capacity (COO)

4 red risks:

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

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

4113 - Divisions inability to achieve CIP (COO)

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

There are currently 32 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			**3 risks**	**12 risks**	
2 – Unlikely					
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
4170 COO – action update
4375 COO – risk update, assurance, action progress
4382 COO – assurance dates required and update
4411 COO – no date on action, assurance and action update required
5045 MD – risk and action update required
5119 COO – mitigating action required
5197 COO – action update
5284 COO – action update
5285 COO – mitigating action 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
Sept 19	25 (2)	17	7	5	0	1
Analysis		Increase in SUIs reported in Sept include Diagnostic incidents x 6, Suboptimal care x 2, Unexpected death x 2, VTE x 1, Attempted Suicide, 2 PU.		Fewer queries from commissioners re RCA reports.		RCA breach due to challenges in identifying RCA lead. ESERG approved the RCA on 7/10/19 subject to agreed changes - underway. Report planned for CCG submission by 16/10/19.

3. Information Governance work plan

The work has been scoped in line with the NHS Digital guidance and has confirmed that a project type support role (Band 5) for a period of 5 - 6 months is required comply with the Information Standard DCB3058 AMD 91/2018. The project will involve scoping data held

and its uses, setting up and implementing technical solutions, the update of Trust and local policies and procedures for the application of opt-outs and external communications to declare compliance. Resources are being considered for conducting this work.

4. **Governance Department staffing**

The final vacant Governance Officer post has been offered and a start date is awaited. The H&S Officer function is under review due to continued challenges in recruitment.

5. **Governance of Local Procedures and Guidelines**

As per summary above.

6. **Mortality Review process**

As per summary above.

7. **Learning and Improvement**

As per summary above.

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 (Oct 2019)

Lead Director	Risk	Risk Title	Field updated	Update made
Chief Operating Officer	4665	X-RAY CANNOCK		
			Risk closed	Discussed at QGAC to close risk with regards to equipment at Cannock
	5285	Urgent access to Stroke CTAs 24 hours a day 7 days a week		
			New risk	Mandatory rapid 24/7 access to CT angiograms from Arch of Aorta to Vertex is required for Hyperacute Stroke patients to ensure they have rapid imaging assessment to access urgent thrombectomy. The risk from this is obviously a poorer outcome for the patient but also exposes the Trust to legal avenues of contest why an urgent scan could not be carried out. That could carry a financial risk into a 6 figure sum every time a patient was pushed outside the thrombectomy window due to scan delay. During working hours (0900 to 1700hrs) there is good access to CTA in ED and risk is low of delayed CTA access Between 0800 to 0900 and 1700 to 2000hrs then there is access to CTA in Main CT that will involve a 20 - 30 minute delay in the overall treatment of patient with inter department transfer from ED to Main CT. Risk of delay is low to moderate for patient. Moderate risk if patient is unstable. Between 2000hrs and 0800hrs access to CTA is via on call CT radiographer who will have to come in from home. This can result in a 30-60 minute delay in treatment awaiting the on call CT radiographer to come into hospital. This exposes patient to moderate risk Risk is substandard access to CTA overnight to deliver timely hyperacute Stroke care. CTA access risk was identified at

				the recent WMQRS review in May 2019.
	5173	IT infrastructure in Audiology clinics		
			Gap in Assurance - **New**	Upgrade of Auricals to Windows Version 10 is not achievable
	5112	ICCU Staffing (Nursing)		
			Positive Assurance – **New**	32 Datix incidents reported (April to Oct 2018) reduced to 14 for same time period 2019
	3069	Risk of Never Events within Division 1: Risks to Patient Safety and Trust reputation		
			Positive Assurance – **New**	Monthly monitoring data of compliance with WHO checklist and Procedural Safety Checklist - 100% for full completion (documentation) in Sept 2019
			Positive Assurance – **New**	Monthly monitoring and compliance with WHO checklist use - There has been 100% compliance achieved during Sept 19
	4529	Vacancies in Medical Staffing/Agency and Locum staffing in Division 1		
			Positive Assurance – **New**	Vacancy Rate Medical Staff 4.93%, Cardiothoracic and Ophthalmology each carrying circa 20% vacancy
			Positive Assurance – **New**	Continue to achieve the agency cap
			Positive Assurance – **New**	Agency Spend in August dipped under 100k for the first time in over 18 months
	4170	Lack of capacity - OPD, Snowdrop Suite and Durnall Unit		
			Positive Assurance – **New**	Positive QRV report for Durnall
	4472	Delays in triage in ED		
			Action Plan - **New**	3 internal band 7 appointments closed
			Action Plan - **New**	Establish task force to develop 5 year plan
	4903	Risk of non-compliance with Thoracic Service Specification		
			Positive Assurance – **New**	Thoracic Surgeons have undertaken proctored Robotic training sessions in the hope of

				attracting new work to RWT
	4523	Failing Heater Cooler Units		
			Action Plan - **New**	Procure equipment
	4761	Cardiology, Cardiothoracic & Anaesthetic JMS vacancies		
			Risk closed	5 new Registrars started in Sept 2019 leaving only 1 gap
	5246	Lack of Consultant cover within Cancer Services		
			Gap in Assurance - **New**	1 Cons retiring resulting in further shortfall of staff
	5249	Cerebral Function Monitoring Machine failure		
			New risk	If the current x2 CFM machines used to record EEG tracing during cooling treatment delivery continue to frequently fail (machines not holding charge and therefore failing to capture ongoing clinical tracing) then we will not be able to deliver the required treatment. This may result in loss of Unit Level 3 status as NX is a designated Cooling Centre. The Trust will also not be able to defend care delivery in legal cases as evidence of EEG trace may have been lost during recording. This could potentially lead to increase in compensations if cases become legal. There is no contract cover for company to provide backup if machine fails
	4696	Unreported Imaging Studies		
			Gap in Assurance - **New**	Approximately 5299 non-urgent imaging studies unreported September 2019 (inclusive of 787 CT scans and 2499 MRI scans). Over 20 days there are 2644 in total (inclusive of 418 CT scans and 1446 MRI scans)
	5069	Dermatology Fast Track Capacity		
			Risk removed from TRR	Now being managed on Directorate risk register as score is 9
			Positive Control – **New**	Directorate manager presents combined action plan update to Divisional Governance on a monthly basis

			Negative Assurance – **New**	GP's not informing their patients they are being referred via the cancer pathway so patient is not aware of the urgency of these appointments
	4113	Divisions inability to achieve CIP		
			Positive Assurance – **New**	Division 1 - £123k worth of CIP was achieved in month 5. A further £280k income CIP is within reserves to be transacted in month 6
			Positive Assurance – **New**	Division 1 - The Division One CIP Target for 19/20 is £9.3m. The Division has achieved £815k YTD (9% of the target in year). Recurrently £657k has been achieved
			Positive Assurance – **New**	Division 3 - at month 5: £938k CIP achieved against YTD target ot £838k
	4411	NX08/NX09 McHale Building - Fire Safety		
			Positive Assurance – **New**	0 incidents relating to Reportable Fire's within Sep 19
			Positive Assurance – **New**	0 Unwanted Fire Signals within Sep 19
	5197	Unacceptable waiting times for Cardiology follow-up appointments		
			Positive Assurance – **New**	Appointed a new EP Consultant due to start 20 January 2020
			Gap in Assurance - **New**	Red FU OWL (Follow-up Out Patient Waiting list) = total waits 2546 **Red** – as of today the patient is overdue their appointment
			Gap in Assurance - **New**	Amber FU OWL = total waits 607 **Amber** – as of tomorrow, the patient will be due their appointment within the next 6 weeks *(note, any patients on this list for tomorrow will then move over to the red list)*
			Gap in Assurance - **New**	Green FU OWL = total waits 2465 **Green** – the patient is due their appointment in more than 6 weeks
			Action Plan - **New**	Pooling internal referrals for EP

	2080	Risk to quality of patient care: reduced manpower		
			Positive Assurance – **New**	75.74 wte trained nursing vacancies remain
			Positive Assurance – **New**	Awaiting arrival of newly qualified and overseas nurses
			Positive Assurance – **New**	Local recruitment for Bd5's ongoing
			Gap in Assurance - **New**	Starting to see an increase in HCA vacancy numbers
			Action Plan - **New**	Electronic solution in development for local monitor/management of vacancy numbers and recruitment
Chief Nursing Officer	3644	CQC risk		
			Positive Assurance – **New**	SHIMI coming down in lines with national expectation. 1.15 in September 2019
			Positive Assurance – **New**	Nursing Audit data available and reported for July 19
			Positive Assurance – **New**	Verbal feedback from CQCQ is largely positive, all points raised responded to and in action plan
			Gap in Assurance - **New**	CQC final report unpublished
			Action Plan - **New**	Develop Mental Health act training plan
			Action Plan - **New**	Develop Mental Health Act Use Policy
Medical Director	5182	Lack of Network support for Vascular Services at RWT		
			Positive Assurance – **New**	A regional meeting has taken place in September 2019 to discuss the regional aortic dissection rota and RWT will be a part of this rota. A meeting of SCTS on 8 October 2019 agreed that all centres who are part of the regional dissection rota should have FET on the shelf and we are hopeful that commissioners will recognise this. A further regional meeting to nail down the workings of the rota etc is planned in November 2019. Vascular cover is provided by RHH as the Regional Hub and the Vascular surgeons have been invited to the next regional aortic

				meeting.
	4661	Lack of robust system for review and communication of test results		
			Positive Assurance – **New**	From 23/9/19 Histology results available on ICE only. Only historic Histology results are viewable via TD Web
Chief Financial Officer	5253	Dell Tablets on ePMA wards damage and unsupported warranty		
			Positive Control – **New**	Trial is running using alternative Getac tablet devices in 3 clinical areas for 8 weeks until Oct 19, currently going well
			Positive Control – **New**	IT to raise business case for requirement of further devices in all clinical areas
			Gap in Assurance - **New**	Dell pushback regarding warranty as no manufacturing fault found with devices, Dell state no other customers with issues and all industry testing was successful
			Action Plan - **New**	Once trial ended to gain agreement from clinical areas and IT to go ahead with new Getec devices
			Action Plan - **New**	Order to be raised for devices required
			Action Plan - **New**	IT to work on a roll out plan
			Action Plan - **New**	IT to raise business case for further devices

The Royal Wolverhampton NHS Trust

Trust Risk Register

October-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 the risk? Risk	How are we managing Controls	Evidence that it is working. Positive Assurances	Any Evidence that it is not working. Gaps in Assurance/Control	What else can we do? Action Plan that addresses Gaps in Control	Risk after actions Residual Risk Level	Date Last Reviewed	TB Accept Risk?
Risk Lead	ID	Principal Risk								
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) (Oct 2019) 1) Multiple complaints from staff re: slow and hanging computers, often necessitating forced shut down of computers (Oct 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 (Oct 2019) 1) Upgrade of Auricals to Windows Version 10 is not achievable (Oct 2019)	1-2) Procure equipment 1-2) Liaise with IT to install equipment	Dec-19 Jan-20	1 x 1 = 1 GREEN	Oct-19	

Director	Cross Ref	What is the Risk?	Current Level of the risk? 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	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?
Chief Operating Officer	4523	Heater Cooler Units (HCU) used in cardiac surgery can harbour Mycobacterium chimaera (national and international incident). The upgraded cleaning protocol for the HCUs involves powerful bleach, which progressively damages the internal components of the machines. Surgery without an HCU would be very hazardous, so there is a need for at least one spare HCU on any operating day, in case of HCU failure during a case. 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. Date of origin: 28/04/2016 Date of escalation = 17/06/2016 Date of re-escalation = 27/03/2019 Risk Lead: Cardiac Group Manager	3 x 4 = 12 AMBER	1. A comprehensive service contract is in place, which provides a loan machine on breakdown of our machines (May 2016) 2. 6 monthly service within comprehensive service (May 2016) 3. Patients are informed before every case of the risk and it is documented on the consent form (March 2016) 4. All patients who have had valve surgery since January 2013 have been contacted and told of the risk of contracting Mycobacterium Chimera. There is a dedicated national helpline for patients to contact should they have any queries (March 2017) 5. Directorate currently has 4 HCU machines. (Mar 19) 6. HCU's are cleaned and water changed with hydrogen peroxide daily and recorded (28/03/2019) 7. HCU's disinfected every 2 weeks as per protocol (08/05/2019) 8. HCU's are tested for infection monthly (08/05/2019) 9. All HCU's used on patients are identified and recorded (08/05/2019)	3 & 4. No patients have declined the procedure as a result of being open about the risk (Oct 19) 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 (Oct 19) 5. Potential for list cancellation - None cancelled to date (Oct 19)	5) 3 out of 6 HCU machine have failed recently, 2 of which are irrepairable (Oct 19) 5) A gap in HCU availability from manufacturer due to demand nationally (Oct 19) 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. (Oct 19)	1-5) Procure equipment	Dec-19	1 x 3 = 3 GREEN	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?
Chief Operating Officer	4596	If a patient with acute cholecystitis does not have cholecystectomy within 1 week (as recommended by NICE QS104) and a patient with acute gallstone pancreatitis is does not have cholecystectomy within 2 weeks (as recommended by NCEPOD in Treat the Cause) the patient is at increased risk of recurrent admissions with complications of gallstones, potentially serious morbidity and an increased risk of mortality. Date of origin: 09/08/16 Date of escalation = 06/02/17 Risk Lead: General Surgery and Urology Group Manager	4 x 3 = 12 AMBER	2. SLA with Stoke reversed to bring additional resources from current RWT Consultant and buy service from Stoke (Feb 2018) 3 Additional all day list allocated from 5th March 2019 4. SOP agreed including agreed consent criteria and booking form 1. Continued involvement with the Surgical Ambulatory Emergency Care Network (Oct19) 5. There has previously been additional recruitment and training of staff for another half list per week (Oct 19)	1-3 (03.06.19) From 05/03/19 to 21/05/19, 11 patients admitted with cholecystitis have been operated on during their index admission on the hot gallbladder list (If there are no hot gallbladders for that day, then the rest of the list has been filled with elective gall bladders or other emergency patients) 1-3 (03.06.19) Hot gallbladders undertaken on the CEPOD list by both UGI and non UGI Surgeons	1 (08.05.19) Patients are presenting with complications of gallstones 1 (05.07.18) Local audit showing recurrent admissions 1-3 (08.05.19) Highlight as a 'service at risk' to Division and as part of Medical Workforce Report 1-3 (08.05.19) Unable to appoint to the 4th UGI Consultant post 1-3 (03.06.19) From 05/03/19 to 21/05/19, there have been 6 other patients listed who were unfit for surgery.	(14.06.19) Re-locate UHNM staging lap list on Friday morning to give weekly 3rd session (Critical Care Services Directorate) (14.06.19) Recruit 4th UGI surgeon to enable full utilisation of allocated capacity. Currently being undertaken as additional to job plan (21.03.19) Purchase bile duct exploration kit	Oct-19 Mar-20 Oct-19	2 x 2 = 4 YELLOW	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?
Chief Operating Officer	5083	IF staff do not understand their roles/ role boundaries and receive training and maintain competency needed to accurately identify dysphagia needs and manage these appropriately, THEN patients' needs may not be assessed (or inadequately assessed) RESULTING IN aspiration of oral intake and the potential negative effect on the patient's health. This can lead to increased antibiotic usage, increased length of hospital stay, increased likelihood of readmission and - in the most severe cases - the patient's death. Additional potential outcomes could be increased exposure to medical negligence actions for both staff and the Trust. Date of origin: August 2018 Accepted onto Divisional Risk Register: August 2018 Accepted onto Trust Risk Register: 08/10/18 Risk Lead: Head of Therapy Services	4 x 3 = 12 AMBER	(3) Care Pathway and initial guidance published on intranet (SALT pages) for wards to manage initial presentation of patients with swallowing problems (Aug 2018) (2) Use of swallow screening tool is now for trained/ competent Stroke nurses only (Aug 2018) (1) IDDSI (International Dysphagia Diet Standardisation Initiative) fully implemented across Trust (May 19) (4) Under Care Pathway, wards manage initial presentation and then refer to SALT who see patients within 2 working days (Nov 2018). (5) Implementation in progress with NHS/PSA/RE/2018/004 (May 19)	(1) Full implementation of IDDSI across Trust (Oct 19) (5) Mainly compliant with Patient Safety Alert (NHS/PSA/RE/2018/004) - few remaining local actions being monitored via Nutrition & Hydration Steering Group (Oct 19)	(1) PHSO C203652 aspiration pneumonia in Mar 18 (Oct 19) (1) RCA 2017/30312 aspiration pneumonia in Nov 17 [(Oct 19) (1) 20 x related datix incidents in 2017; 15 x related datix incidents to Nov 2018 [datix reports Nov18-Apr19 under review] (Oct 19) (2) Staff who are untrained/ no competency cannot use swallow screening tool (all areas outside Stroke) [(Oct 19) (4) SALT only available on working days, so at Bank Holiday times there could gaps of up to 4 additional days (on top of 2 day response target) before SALT assess the patient (Oct 19)	(4) Investigate the possibility of extending the SALT service beyond working days only - business case to be completed	Oct-19	2 x 2 = 4 YELLOW	Oct-19	

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Trust Objective:		**Maintain financial health - appropriate investment enhancement**								

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	4113	If the Divisions are unable to achieve the identified CIP target for 2019/2020 then there are implications for the financial position of the Trust Linked to BAF risk SR8. Date of origin: 11/01/19 Date of escalation = Dec 18 Risk Lead: All Deputy COO's	4 x 5 = 20 RED	3. Vacancy control panel in place (Oct 2015) and higher restrictions applied (Jan 17) 2. Financial Forecasting meetings now include Confirm & Challenge CIP so that there is a consistent approach to Directorate financial position/challenge (Sept 17) 1. Increased PMO resources to support delivery of the Trusts efficiency programme (June 16) 4. Monitored by the Financial Recovery Board (FRB) (Oct 2017) 5. Member of Service Re-design Team aligned to Divisional Programmes to provide structure and targeted support to operational teams in their delivery of CIP 6. Operating Theatre Efficiency Group (OTEG) set-up and running for 12 months. Each Directorate has 'Local' sub-groups (Sept 17) 7. All agency requests above £100 P.H to be approved by COO/CEO 8. Divisions involved in Financial Recovery Board chaired by CEO (Nov 2017) 9. PIDs are forthcoming to the Finance team (Dec 2018)	2, 3 & 4. Structure in place to discuss and identify opportunities to create efficiencies and business growth (06/19) 3. VCP meetings held weekly and posts go through this process for all Divsions (06/19) 5. If there is a risk that impacts on a team's ability to deliver their CIP schemes then the member of Service Re-deisgn Team would be available to support as and when required at the Quality Meetings. (06/19) 1-10) CIP partner now in post (06/19) 1-10) YTD financial position for Division 2 is £0.95m favourable due to patient income over performance (08/19) 1-10) Division 1 - £123k worth of CIP was achieved in month 5. A further £280k income CIP is within reserves to be transacted in month 6 (09/19) 1-10) Division 1 - The Division One CIP Target for 19/20 is £9.3m. The Division has achieved £815k YTD (9% of the target in year). Recurrently £657k has been achieved (09/19) 1-10) Division 3 - at month 5: £938k CIP achieved against YTD target ot £838k (09/19)	2 & 3. Unidentified CIP still remains across the divisions (10/19)	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	Nov-19 Nov-19 Apr-19 Nov-19 Apr-19 Oct-19	3 x 3 = 9 AMBER	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) Division 2 - £0.9m CIP achieved to date, against a target of £6.5 for Division 2 CIP (08/19) 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 (Oct 19) 2. Consultant Thoracic Surgeon recruited and in post (Oct 19) 1-3 Continue to approach other Trusts for referrals (Oct 19) 2. Locum Thoracic Surgeon recruited and will be in post Nov 2019 (Oct 19) 2. Thoracic Surgeons have undertake proctored Robotic training sessions in the hope of attracting new work to RWT (Oct 19)	1. Referrals have not increased, this has been escalated to DCOO and COO (Oct 19) 1. Despite agreed referral pathway with Walsall they are unwilling to move forward at present (Oct 19)	1. Plan further approaches to Walsall Hospital	Dec-19	1 x 5 = 5 YELLOW	Oct-19	

Director	Cross Ref	What is the Risk?	Current Level of the risk? Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Trust Objective:		**Attract, retain & develop our staff & improve employee engagemen**									
Chief Operating Officer	1713	Failure to effectively maximise workforce productivity; failure to routinely review consultant job plans. Date of origin: 03/06/08 Date of escalation = 11/05/11 Risk Lead: COO/Deputy Medical Director	4 x 3 = 12 AMBER	2) Areas to be contained with SPA allocation have been agreed 4) Usage reports for medical bank - Dec 17 3) RAG rated tool to monitor compliance against Job Plans has been developed and now shared with directorates Sept 17. 1) Job plans continue to be reviewed and sign off by DMD / MD- sign off committee established (Apr-Aug18) 1) New Job Planning Policy agreed by LNC Mar 17 5) Job Planning updates to be presented to clinical excellence group (Jan 18) 6) Job Planning Consistency Panel established 18/19 (May 18 first one). 7) Business case for Allocate approved. Implementation plan agreed at Workforce group (Jan 18). Implementation expected Apr/May 19	1) Job Planning Audit indicated a number of actions now addressed 1) Training commenced on new job planning process - Feb 16 4) Medical agency costs reducing Dec 18. 1) Increase in number of 'signed off' job plans October 2017 + April 2018 + Sep 18	1) Sign off of all job plans not complete (Dec 2018) 1) Audit review still raised concerns - closed Dec 17	1) Internal audit to review progress made on job planning 19/20 5) Further update to Audit Committee in progress. 1) Continue to work with NHSI on development of job planning tools and sign off processes	Sep-19 Feb-19 Apr-19	3 x 2 = 6 YELLOW	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?
Chief Operating Officer	2080	If the Trust is unable to recruit and retain sufficient nursing staff across Division 2 then there will be reduced quality of care for patients, including increased risk of harm, late observations and treatment. As well as increased levels of staff stress and complaints. (Linked to local risks 2780 CHU, 4164 Renal, 4272 Therapy Svs, 4321 DN's, 3431 CofE) Date of origin: 02/01/09 Date of escalation = 12/01/16 Risk Lead: Div 2 Deputy COO On BAF	5 x 4 = 20 RED	1) Ongoing active recruitment exercises - including overseas (Jul 2018) 8) Use of Nurse Bank when required (Jan 16) 3) Defined minimum safe staffing levels now in place revised October 2017 5) Modified dependency tool for inpatient areas commenced (Jan 16) 9) Staffing incidents reviewed on monthly basis (Jan 16) 10) Closed Ward 3 at West Park Hospital (June 16) 4) Closed ward B7 (June 2017)	8) HCA's are available via Bank (10/19) 1) Proactive recruitment approach continuing (10/19) 1) 75.74 wte trained nursing vacancies remain (10/19) 1) Continued recruitment to nursing clinical fellows (10/19) 1-10) Matrons meeting every Friday to ensure hospital is staffed over the weekend (10/19) 3) Snr Srs and Charge nurses meeting daily to ensure wards are safe (10/19) 3) Awaiting arrival of newly qualified and overseas nurses (10/19) 3) 1 bay closed on C25 and C19 - having a beneficial impact (10/19) 1) Local recruitment for Bd5's ongoing (10/19) 3) Weekly meetings to address vacancies as part of the Renal action plan - Twitter/Facebook campaign (10/19) 3) Bd6 allocated to C16 to complete D2A's to improve flow (10/19)	8) Insufficient RN's available on Bank (10/19) 1) Nationallly we are an outlier re safe staffing levels (10/19) 1) Recruited staff are newly qualified which can lead to mentorship and training pressures (10/19) 1) All wards are 'Amber' re safe staffing levels on daily basis (10/19) 3) Issue remains in relation to ability to provide accurate staffing figures (10/19) 3) Breaches in minimum safe staffing levels (10/19) 3) Significant nursing shortages on C16, C19, C24 and C25, working with 50% vacancies at Bd 5 level.(10/19) 3) Starting to see an increase in HCA vacancy numbers (10/19)	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 3) Electronic solution in development for local monitor/management of vacancy numbers and recruitment	Nov-19 Nov-19 Nov-19 Nov-19 Nov-19	4 x 3 = 12 AMBER	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?
Chief Operating Officer	4529	If there continues to be vacancies in consultant and training grade medical posts across Division 1 alongside an increase in elective activity (in some directorates) then this will result in the need to engage agency and locum staff in order to deliver a safe and effective elective service and to safely staff on-call rotas. Agency and locum staff are often engaged at premium rates which places an enhanced pressure on the divisional staffing budget; it is also recognised that locum/agency staff may not be familiar with the Trust procedures and that this unfamiliarity may have a detrimental impact on the quality and continuity of patient care. Please note: Risk 4239 (Obs & Gynae) staffing risk has been linked to this overarching Divisional medical staffing risk. Date of origin: 23/04/16 Date of escalation = 17/05/16 Risk Level: Div 1 Deputy COO	4 x 3 = 12 AMBER	2. Baseline resourcing meetings continue to be held to review vacancies and expenditure, identify recruitment opportunities within Directorates explore alternative solutions including future workforce planning and forecasting (Sept 17) 3. Trust continues to be part of West Mid's Project to reduce Locum Agency use and pay (Dec 2017) 4. Trust part of Junior Doctors in-training streamlining group (Dec 2017) 1. Recruitment Strategy in place for Consultant and Middle Grade vacant posts - this is ongoing (Dec 17) 5. Acces to overseas recruitment continuing membership to Clinician's Connected (June 18) 6. Utilisation of the Fellowship Programme (Sept 18) 7. Agency spend reviewed monthly at Directorate/Divisional meetings via the dashboard (Dec 18)	1-7) Vacancy Rate Medical Staff 4.93%, Cardiothoracic and Ophthalmology each carrying circa 20% vacancy (Sept 19) 7) There continues to be no agency used in nursing (Sept 19) 7) Continue to achieve the agency cap (Sept 19) 2) Baseline meetings are still continuing on-going on a regular basis (Sept19) 3) Project ongoing - rengagement day due to be held with Agencies in Sept (Sept 19) 1) Recruitment is ongoing (Oct 19) 1-7) Ongoing T&O medical vacancies sent 20 CVs as were struggling to recruit, 4 T&O Jnr Med appointments recuited (Aug 19) 1-7) 4 x O&G Consultants recruited (Aug 19) 1-7) Agency Spend in August dipped under 100k for the first time in over 18 months (Sept 19) 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 (Sept 19)	1-7) Number of vacancies remain across Division 1 (Oct 19) 1-7) Locum spend continues but at a lower rate than previous (Sept 19)	5. Fellowship Programme ongoing 1. Continuing campaign with regular adverts 1. Continuing to develop roles to support medical rota (ANPs and ACCPs) 6. Review of CVs by Clinician's Connected to fill Consultant vacancies 1. Continue to implement recruitment strategy 8. HR to work with Directorates to discuss annualised contracts to explore bringing locums onto permanent contracts. 2. HR working with Anaesthetics and Ophthalmology to optimise rota configuration 7. Divisional HR Manager to share an update on Locum list at DMT later this month	Dec-19 Oct-19 Oct-19 Oct-19 Dec-19 Oct-19 Oct-19 Oct-19	2 x 2 = 4 YELLOW	Oct-19	Yes

Director	Cross Ref	What is the Risk?	Current Level of the risk?	How are we managing Risk	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
					7) 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) 4) Steamlining Group to be lead by lead Employers (only RWT speciality is Palliative) (Aug 19)					

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

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	3069	If a Never Event occurs within Division 1 this may result in an adverse outcome, there is potential for severe harm and/or patient death and also reputational impact including increased external monitoring Date of origin: 19/07/12 Date of escalation = 17/11/15 Risk Level: Div 1 Deputy COO	3 x 4 = 12 AMBER	5. Monitoring and circulation of incident notification reports to all senior staff for review 6. Trustwide learning via a "Lessons Learned" sheet in the monthly IGR, Risky Business Newsletter and the CLIP Group. 8. Regular scrutiny of Directorate risk registers and minutes of Directorate governance meetings at the Quality Meetings 2. Review completed of all documentation and Theatre protocols/procedures amalgamating where possible 1. Perioperative care plans are in place across the Trust 9. Agreed communication strategy with Division 2 to share/raise awareness of never events and lessons learnt 3. Monitoring of Policy OP100 and monthly audit of WHO Checklist for agreed procedures. Directorates providing assurance of the shortfalls in performance at Directorate Governance Meetings and Quality Meetings. 4. New NE Guidance (published Jan 2018) being used for NE classification	10. Human Factors continues to be recgonised as a trend (Oct 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 19) 11. Staff across the Division are supported to undertake PCM training (Oct 19) 12. Audit of LocSSIPs have been presented to Division before presentation at QSIG (Oct 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 - 100% for full completion (documentation) in Sept 2019 (Oct 19)	4. There have been 3 x Never Event incidents 2 x Wrong Site Surgery and 1 x Retained foreign object) reported and investigated during 2015 4. 5 x NE in 16/17 reported to CCG - 1. Maternity NE (retained tampon) reported (Datix ID: 158830), 2. Radiology NE (wrong ankle injected) reported (Datix 165455), 3. Opthalmology (wrong eye injected) reported (Datix 166680) 4. Theatres (retained foreign object) reported (Datix ID: 169339) 5. Theatres/T&O Cannock (wrong prosthesis) reported (Datix ID: 174038) occured Mar 2017 4. 5 x NE incidents reporting in 17/18 reported to CCG from April 2017 (175581,179911,181941,185875 186479) (Dec 17) 4. 4 x NE in 18/19 reported to CCG - 2 x Wrong Site Surgery incidents (Neonates Datix 194205 and H&N Datix 194977 - both in April 2018). There has been and 2 Retained Foreign Object incidents (Theatres 197654 and Obstetrics 197996 - both in June 2018) (June 19) 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 Ongoing implementation of remaining x 2 actions (10,000ft and Human Factors training) as identified on the action plan following the NE Leicester Conference	Dec-19 Dec-19 Dec-19	2 x 4 = 8 AMBER	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?
				7. Policy for the management of retained swabs in place 10. New qualitative and observational WHO checklist being used in Theatres (Oct 17) 11. Sign up to Safety campaign was supported - T&O and Maternity participation (Oct 17) 12. LocSSIPs developed by Directorates auditing underway and presented to Division and QSIG (Jan 2018) 13. AFFP Peer Review and Training undertaken	3. Monthly monitoring and compliance with WHO checklist use - There has been 100% compliance achieved during Sept 19 (Oct 19) 1-13 There has been no new never events reported for three consecutive months within Division 1 (Oct 19)				

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Nursing Officer	3644	If the Trust fails to sustain improved compliance with CQC standards the rating of Good could decline and progress will not be made towards Outstanding. Date of origin: 14/01/14 Date of escalation = 14/01/14 Risk Lead: Deputy CNO	3 x 3 = 9 AMBER	1) Monitor recruitment and retention via WODG and Board monthly (Oct 19) 1) Monitor monthly performance through the nursing midwifery KPIs reported to QSIG (Oct 19) 1) Environmental Standards are monitored via the environmental group monthly (Oct 19) 1) Daily staffing (safe staffing, Skill mix) is monitored via the Divisional ops meetings (Oct 19) 1) Fundamental standards are reviewed & monitored by the designated specialist groups and bi annually by the sponsor which then reports to COG (Oct 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 (Oct 19) 1) Mortality QI plan is monitored via Programme Board monthly and learning outcomes via MRG (Oct 19) 1) EOL strategy with TOR has been developed and milestones monitored via the EOL group monthly (Oct 19) 1) Monitoring of the Nursing System Framework monthly via TMC (Oct 19)	1) Nursing and Midwifery KPIs are on Health Assure reporting and emailed out to ward sisters/matrons and HoNs monthly. (Oct 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 (Oct 19) 1) Divisions monitor performance via monthly Governance meetings (Oct 19) 1) Improved staff survey results (Oct 19) 1) There is a system of nursing audits taking place monthly (Oct 19) 1) There are no Registered Midwife Vacancies Oct 19) 1) SHIMI coming down in lines with national expectation. 1.15 in September 2019 (Oct 19) 1) Nursing Audit data avaiaible and reported for July 19 (Oct 19) 1) Verbal feedback from CQCQ is largerly positive, all points raised responded to and in action plan (Oct 19)	1) Vacancy rates remain high in Medinine (Oct 19) 1) Safer staffing fill rates remain transient particularly for nights (Oct 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 (Oct 19) 1) Registerd Nurse vacancies are 123.66 and HCA's 32.56 in Sept 19 (Oct 19) 1) CQC final report unpublished (Oct 19)	Review Intranet to ensure current content Develop Mental Health act training plan Develop Mental Health Act Use Policy	Nov-19 Nov-19 Nov-19	2 x 2 = 4 YELLOW	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?
				1) Monitoring via Quality review visit and re-visit programme to assess CQC compliance (Oct 19) 1) NEWS2 implemented Trust-wide (Oct 19) 1) Information provided in PIR according to timescales (Oct 19) 1) Series of Board development sessions sharing learning from other insepections and risks completed (Oct 19) 1) comunication of Trust Stragey including visions and vaultes commenced (Oct 19) 1) Evidence on PIR triangulated with KLOEs (Oct 19)					

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	4170	If there is a lack of physical and staffing capacity in the Durnall unit, then this will impact on the ability to effectively triage and treat sick patients. This will result in neutropenic sepsis patients not receiving treatment within the 'golden hour', patients receiving line care and other interventions having significant delays and long waiting times, including pts with life limiting conditions. Clinics over running significantly leading to poor patient experience. Date of origin: May 2015 Date of escalation: April 2019 Risk lead: Group Manager for Oncology and Haematology	3 x 4 = 12 AMBER	4. Staff in unit actively support triage area staff (07/19) 5. Morbidity & Mortality Reviews (07/19) 7. Capacity Reviews, Weekly Community clinics (Weds weekly, Fri alternate weeks) (07/19) 3. Staff from ward and Educational facilitators used to provide support at times of increased demand (07/19) 1. Door to needle times monitored for sepsis patients. Summary of 2 monthly Sepsis Audit findings (07/19) 2. Actively monitoring PALS feedback about the Durnall Unit (07/19) 9. Facilitate transfer to Deanesly and CHU within department opening times (07/19)	6) Approx 40% of nurses now trained to take blood cultures (10/19) 1-9) Service Improvement Team undertaking demand v activity v capacity - await outcome (10/19) 7) Positive feedback from patients about the weekly community clinics (10/19) 1-7) Ongoing progress with action plan following process mapping of patient journey (10/19) 1) PEF advert closed - await outcome of interviews (10/19) 1-9) Positive QRV report for Durnall (10/19)	7) Overspend for Directorate (10/19) 7) Capacity review means some patients may have to attend hospital every other week (10/19) 6) Approx 60% of nurses still to be trained to take blood cultures. Training postponed (10/19) 9) Inadequate floor space found by H&S Health Building Note 00-03 review. This stated that 1.5m2 should be provided for ambulant persons and 3.0m2 for wheelchair users. Effectively the space currently seating 15 should realistically seat 6 ambulant and may be 1 wheelchair (10/19) 8) SEPSIS 6 Rolled out in dept reduction in door to needle time compliance and compatability with vitalpac (10/19) 6) Gaps in numbers of nurses trained to take blood cultures (10/19) 10) Decrease in patients treated within "Golden Hour" (10/19) 9) Patients stranded on Durnall Unit after 7pm in month (10/19) 3,4) Staff transfer has been required in this month (10/19) 6) Nurse training on hold (10/19)	1)Training for PGD antibiotics and competencies, PEF's to be included in competency training, facilitator. Currently with MMC. No suitable facilitator due to poor sepsis compliance 7) Business Case to be finalised by Group Manager and to be formalised for increased nursing allowing for Community clinics and increased staffing in Durnell-13.05.2019 to be finalised post process mapping 1) AOS nurse to undertake RCA to review 'golden hour' patients. For any patients who do not get antibiotis within the hour AOS nurse to review-ongoing 1-9) Update for demand and capacity project ongoing. - Manx Baker Servive Improvement 6) Ongoing training for nurses to take blood cultures- 13/06 on hold until workforce more stable 9) Utilising Discharge Lounge for appropriate patients 9) Monitoring of Patient waits on Durnall 9) Scheduling of patients attending Durnall Review 1) Meeting with estates to access alternative areas to accommodate Durnall day case area. Various options discussed Group Manager to escalate to divisional management April 2019 1-8) Trust AOS Low risk sepsis service to consider community reviews, daily follow ups and weekend follow ups	Sep-19 Sep-19 Sep-19 Sep-19 Sep-19 Sep-19 Sep-19 Sep-19 Mar-21 Sep-19	3 x 3 = 9 AMBER	Oct-19	

Director	Cross Ref	What is the Risk?	Current Level of the risk?	How are we managing Risk	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
							1-8) 95% staff to attend sepsis study day and online training - study day 11.06.2019 well attended remainder of staff to be captured	Aug-19			
							1-8) Post non compliance sepsis investigation staff to reflect on findings - ongoing	Sep-19			
							5) Implement actions from RCA re documentation in Durnall and development of SOP for direct ward admissions from end of PCM process	Aug-19			
							7) VCP required for additional AOS nurses requires BC	Sep-19			
							1-9) Audit underway of coding and capturing of patient activity - ongoing	Sep-19			

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	4375	(NX87) Heart Centre - Fire Safety: As a consequence of shortfalls in structural fire protection (including emergency lighting) and the recent failure of external ACM cladding, fire could spread both externally and internally throughout the building , compromising life safety. Date of origin: July 2017 Date of escalation: Sep 17 Risk Lead: Estates and Facilities Divisional Manager	3 x 4 = 12 AMBER	Implementation of a 4 Stage Risk Mitigation Plan; details include 1) Restricted parking of vehicles to 6m 2) Management of waste in the external compound 3) Increased security and surveillance 4) Augmented Fire Service reponse 5) Increased Trust Fire Response 6) Additional Fire Wardens trained 7) Additional fire exercises and drills 8) Review of fire risk assessments (15 completed, local risks managed by Directorates) 9) Building & Maintenance risks managed by Estates via Planet FM 10) Statutory fire alarm testing (weekly), Fire Damper Testing (Annual)	10) 0 incidents relating to Reportable Fire's within Aug 2019 3) Additional Security Fire Patrols undertaken and recorded 9) Priority Planned Preventative Maintenance undertaken 2) Waste compound has been relocated 7) Third Floor Fire Evacuation Exercise on 31.05.18 9) Automatic Fire Detection (AFD) in identified areas has been upgraded with Tri-State Detectors. Areas identified from UwFS 10) Break-glass over-ride facility for 3rd floor installed to enable lifts to be used in the event of an evacuation. 1-10) Construction work underway in removing ACM cladding. Approx 70% has been removed from outer building. Inner courtyards had been resolved. 4) WMFSvisited site, agreed security patrols and WMFS attendance to continue 10) 0 unwanted fire signals during Aug 2019	9) Outstanding fire stopping required following compartmentation survey		2 x 2 = 4 YELLOW	Oct-19	

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	4382	NX55 (Main Theatres, Wards A12, A14, Admin, Plant Rooms) - Fire Safety: As a consequence of shortfalls in structural fire protection (including fire alarm), fire could spread uncontrolled through wards and departments, compromising life safety. Date of Origin: 09/12/2015	3 x 4 = 12 AMBER	1. Statutory fire alarm testing (weekly), fire damper testing (annual) 2. Departmental Fire Risk Assessments undertaken. Main Theatres frequency increased to 6 monthly due to risk 3. Statutory Planned Preventative 4. Bespoke Fire Warden Training 5. Additional Fire Exercises and Drills 7.Revised Management of External Waste in the Compound 6. Departmental Fire Warden Daily Checks undertaken	1. 0 incidents relating to Reportable Fire's within Aug 2019 3. Fire strategy has been approved and money set aside. 1. 0 Unwanted Fire Signals within Aug 2019 1. Fire Alarm is being upgraded to L1. Being montiored via Fire Safety Group	2. Compartmentation Survey to be completed 3. Operational issues have meant the fire strategy work will take longer to complete with some work on hold 1. Fire alarm & ancilliary systems do not comply with current regulations	1. monitor and work towards completion of fire stategy for block	Mar-20	2 x 2 = 4 YELLOW	Oct-19	

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	4411	(NX08/09) McHale - Fire Safety: As a consequence of shortfalls in structural fire protection and the identification of polystyrene foam insulation installed between metal cladding, fire could spread uncontrolled throughout the building effecting critical operational services that could compromise hospital business continuity. Date of origin : 14/02/2018 Date of escalation: Sep 17 Risk Lead: Estates and Facilities Divisional Manager	3 x 4 = 12 AMBER	1. Statutory fire alarm testing (weekly) 2. Departmental Fire Risk Assessments undertaken 3. Statutory Planned Preventative 4. Waste Management 6. Fire Evacuation Drill taken place on 4th July 2019. Fire drill is on a rolling programme 5.Departmental Fire Warden Daily Checks undertaken 7. Tugway Safety & Environmental Group commenced May 2018 4. Implementation of robust waste management controls to reduce the risk of a fire occurring. 7. Basement area (Tugway) now being monitored following the Installation of CCTV.	1. 0 Unwanted Fire Signals - September 2019 1. 0 incidents relating to Reportable Fire's - September 2019 2. Combustible items located in the Tugway have been removed. The area is being monitored by Estates Department via the Tugway Group 7. Structural fire safety repairs carried out to minimise risk fire spread from the Basement (Tugway) into the building above. 7. Implementation of robust management controls 4. Environmental Audit Group carry out 3 monthly audits of Tugway	1. 1 Unwanted Fire Signals within July 2019 - due to system fault	2. Departmental Business Continuity Plans need to be updated	2 x 2 = 4 YELLOW	Oct-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 (10/19) 4-5) Reallocation of staff working well to help reduce wait times during pressured times (10/19) 15) Urgent treatment doctor is making an improvement to patients recieving appropiate emergency treatment (10/19) 17) Additional triage room helping to reduce triage wait times (10/19) 1,2,7) Interviews underway for Bd 7 - 2nd cohort interviewed, 3 appointed (10/19) 1,2,7) Plan for Bd 7 to cover Zone A&B during day to be trialled (10/19)	1, 2) Inability to achieve 15 minute triage consistently breaches mainly in minors, at 1.5hrs at points in month (10/19) 4,5) Staff not always available to be reallocated (10/19) 7) Medical and nursing vacancies and sickness/annual leave resulting in gaps in rota. Link to risk 4496 and 2374 (10/19) 9) UCC minimum impact on pt numbers and delays in assessments (10/19) 7) Continued use of long term locums (10/19) 1) Inability to acheive 2 hr target in month, significant delays experienced (10/19)	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. 2nd lean meeting to be held 1-20) 3 internal band 7 appointments closed 5) Await outcome of plan for second Bd 7 for Zone B 1-20) Establish task force to develop 5 year plan	Dec-19 Dec-19 Dec-19 Dec-19 Dec-19 Dec-19 Dec-19	1 x 4 = 4 YELLOW	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?
				11) Human factors review completed and resulted in department restructure. All staff provided with human factors training and rapid improvement events [6/3/19] 12) Medical and nurse staffing managed via the risk regsiter (risk 2374 & 4496) [5/3/19] 13) Nurse led RAT and SOP ratified and in place (5/3/19) 14) Where possible, newly qualified starters have their last student placement transferred to RWT ED [5/3/19] 15) System in place to ensure that Cat 2 patients are shown red at 15 minutes. Urgent treatment Doctor role developed to see cat 2 patients [5/3/19] 16) Use of internal bank rather than locum agencies where possible [5/3/19] 17) Extra Triage room and escalation process in place [5/3/19] 18) Escalation tool developed and identifies pressure points with agreed action [5/3/19] 19) Appointed Specialty Doctor in November 18 (5/3/19) 20) GIRFT Visit to be reviewed by end of July (7/19)					

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
				3) A management consultant from Industry visited the Trust at the beginning of February to look at flow in Minors awaiting feedback (6/3/19) 21) Every member of staff has additional training 1 day per year (6/3/19)						

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	4528	If Clinical Web Portal does not contain full copies of patient's notes/health records (if seen before 2013) as well as all Paediatric admissions/Badgernet information then clincians will only have access to an incomplete health record for inpatient and outpatient encounters. Lack of a comprehensive record may impact on the accuracy and/or timeliness of clinical decision making. NHSI link NE's to lack of complete clinical records in OPD clinics. Date of origin: 29/04/16 Date of escalation = 17/05/16 Risk Lead: Div 1 Deputy COO	4 x 3 = 12 AMBER	1. Ability to request paper notes (May 16) 2. Process for both access to patient records aswell as the process for when there is a need to have a complete patient scanned has been circulated by Patient Access (Dec 16) 3. Badgernet System in place in Maternity (Feb 19)	1. No continuous Datix incidents (Oct 19) 3. The Badgenet System remains embedded within the Maternity department (Oct 19) 2. Procedures continue to be in place to access paper records/request scanning of records onto portal (Oct 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 (Oct 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 (Oct 19) 3. Restricted access to the Badgernet System - no immediate access to Maternity notes (Oct 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	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?
Medical Director	4661	Lack of robust effective system for the communication of high risk or abnormal/ unexpected investigation results, and evidence of receipt, review and actions taken by clinicians. Risk of delayed or missed opportunities for diagnoses and appropriate treatment for patients, which could result in Serious Incidents, litigation and complaints. Date of origin: 17/11/16 Date of escalation = 17/11/16 Risk Lead: Medical Director	4 x 4 = 16 RED	5) Monitoring via incident reporting 4) Directorate/ specialty local 'safety net' procedures to ensure results are received and reviewed 3) Pathology local procedure(s) for the escalation of abnormal results 2) Radiology local procedure(s) "Communication of Critical and/ or Unexpected Findings to Referring Doctors" 1) Trust wide Policy CP50 for the Management of Risks Associated with Clinical Diagnostic Tests and Screening 6) ICE system is now fully functional from 1st April 2018 and reviewing filing of Pathology results and Radiology reports is available and auditable.	5) Small proportion of incidents to number of investigations undertaken 2) Policy implemented for urgent and critical findings (June 2017) 2) A flag is also added to the report which will send in the subject matter of the e-mailed report ***Urgent Findings*** or Unexpected Significant Findings, this will alert the referring consultant (June 2017) 2) There is now also a Cancer Suspicious flag which can also be attached (June 2017) 3) There are a list of tests that fall into the urgent action category, the clinicans are telephoned about these. Other less urgent abnormal results are highlighted as such in TD Web when they are reviewed (June 2017) 6) As at 31st Dec 18 21% of Pathology and Radiology results were filed 6) TD Web requesting facility is disabled, allowing only for the review of historic results. This will continue with monitoring of usage until further notice (May 19). 6) From 3rd September 19 histology results will be available via ICE. Moving closer towards the soe use of ICE for results reporting (June 19)	1-4) Audit of local safety net procedures demonstrated significant gaps (Nov 16) 2) Size of Radiology reports is significant resulting in inbox limits being frequently exceeded (Nov 16) 5) Incidents continue to be reported where the reviewing if abnormal results has been delayed with significant consequences to patient outcome (May 17) 3) No further action can be taken by Pathology until ICE is implemented (June 2017) 6) As at 31st Dec 18 79% of Pathology and Radiology results were unfiled. (Feb 19) 6) As at 31st Jan 19, 20% of Pathology and Radiology results were filed which has slightly reduced from Dec 18 report; and 80% of Pathology and Radiology results were unfiled.(Mar 19) 3,6) Currently unable to" freeze" TD Web which means it is still available for reviewing results in conjunction with ICE (June 19) 6) ICE filing compliance remains low across all reporting (circa 20%) (June 19) 6) 76% of results on ICE are unfiled, 23% of results are filed (Sept 19)	1-4) Local SOPs for results reporting required from all areas with mandatory reviewing and filing of results with audit of compliance by Directorate and Consultant. Aim is to achieve full compliance with viewing and filing. 1-6) Task and finish group to tailor the rebuild of ICE in readiness for new BCPS system in Feb 20 (only available via ICE). 6) Trustwide SOP for use to be developed alongside rebuild of ICE system	Nov-19 Feb-20 Feb-20	x =	Oct-19	Yes

Director	Cross Ref	What is the Risk?	Current Level of the risk?	How are we managing 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?
					6) 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.) (Sept 19) 6) From 23/9/19 Histology results available on ICE only. Only historic Histology results are viewable via TD Web. (Oct 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	4696	If non-urgent imaging studies are not reported within the timescale of 3 - 6 weeks, delays may have an impact on timely patient management. Ideally, imaging should be reported as soon as they are undertaken but this is not possible given the national shortage of staff. Date of origin: 5 January 2017 Approved by Division: 28 December 2016 Accepted onto Trust Risk Register: 5 January 2017 Risk Lead: Radiology Group Manager	3 x 4 = 12 AMBER	1) Monitoring of unreported scans/imaging studies on a weekly basis (Jan 2017) 3) Clinical Fellows are being employed (Jan 2017) 4) Regular meetings between Clinical Director and Group Manager (Jan 2017) 5) Waiting list initiatives for Trust Radiologists on going (Jan 2017) 6) Use of outsourcing (Oct 2018)	3) Clinical Fellows have been appointed (3 in place) (Oct 2019) 4) Review meetings are happening fortnightly (Oct 2019) 1), 5) & 6) Backlog against a backdrop of increased referrals has reduced from 7332 May 2017 to less than 5299 in September 2019 (Oct 2019) 3) Office space sourced (Oct 2019) 1) The backlog is actively monitored by Group Manager (Oct 2019)	1) Approximately 5299 non-urgent imaging studies unreported September 2019 (inclusive of 787 CT scans and 2499 MRI scans). Over 20 days there are 2644 in total (inclusive of 418 CT scans and 1446 MRI scans) (Oct 2019) 1) Poor patient experience if patients and doctors are unsure when their scans are reported (Oct 2019) 3), 4), 5) & 6) Demand for reporting imaging studies is higher than expanded reporting capacity (Oct 2019)	1,3,4, & 5) Offer opportunities to Radiologists from other localities to work in our Trust. Radiology will liaise with HR about the possibility of head hunting Radiologists from other Trusts 1,3,4, 5 & 6) Monitor outsourcing work and assess impact on reducing outstanding numbers 1,3,4 & 5) Continue to utilise waiting list initiatives	Dec-19 Dec-19 Dec-19	2 x 4 = 8 AMBER	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?
Chief Operating Officer	4706	Longstanding maintenance challenge around infrastructure/environment in Nucleus Theatres, which includes: 1. Sewage - usually in the form of water leaking through ceilings 2. Electrical infrastructure - emergency power back-up in theatres 3. Fire safety - storage of equipment and consumables compromising emergency evac routes - This has been addressed with the creation of storage in the basement. (July 2019) 4. Operating lights - (Theatre 7 require light replacement - July 2019) 5. Air-flow/ventilation - (addressed) 6. Storage - not enough dedicated storage space in theatres for equipment and consumables (addressed) 7. Insect infestation - flies and bugs being seen in theatres - (addressed No incidents reported 01/01/19 to 08/-7/19) All of the above could lead to patient (and staff) safety being compromised, non-compliance with external regulations and/or internal standard/ audits and also adverse media publicity and increasing number of raising concerns via local policy. Date of origin: Feb 17 Date of escalation to Divisional Management: Sep 17 Risk Lead: Critical Care Group Manager	4 x 3 = 12 AMBER	1. Existing programme of theatre works in place (3 phase refurbishment is underway) - Currently in Stage 1 phase 3 (Oct 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.	1 - 7 No procedure cancellations due to any of the above issues for 9 months (Oct 19) 1 - 1 x reported incident of Sewage ingress/water leaks since May 2019 - no further incidents reported but sewers are blocked below the department (Oct 19) 2 - 1 x reported incident of power outage or back-up power failure in Theatre 7 during August No further reports (Oct 19) 7 - No reported incidents of insect infestation for last 10 months (Oct 19)	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 (Oct 19)	1 - 4. Reconfiguration of Theatre reception and storage currently in progress 1 - Work to commence this financial year for fire compartmentalisation in clinical areas	Mar-20 Mar-20	2 x 1 = 2 GREEN	Oct-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	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. Date of origin: 17/05/18 Date of escalation: 05/09/19 Risk Lead: Head of Midwifery	3 x 4 = 12 AMBER	1) Dating and Fetal Anomaly scans are given priority over Gynaecology scans to ensure women have their scans performed in accordance with the national programme standards. 9/4/19 2) Community Midwives have the facility to telephone the Maternity Unit and organise an urgent priority scan if a woman is thought to have booked late (9/4/19) 3) Midwife Sonographers in fetal medicine (FMU) are being asked to assist with scanning both obstetric and gynae scans in the main scan department when staffing in FMU allows (9/4/19) 4) Staff in Maternity Scan Dept.are continually reviewing their staffing levels to escalate their concerns appropriately (9/4/19) 5) Agreement for sonographers to volunteer to run weekend clinics and extended days to increase available scanning slots. (09/04/2019) 6) Current adhoc support from midwife sonographers enables the sonographers to undertake hip, cranial and emergency gynae scans which have been prioritised. (9/04/2019)	1-4) There are no reported incidents whereby a woman has missed the opportunity to have her dating or anomaly scan as a direct result of sub standard staffing within main scan (10/9/19) 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) 1-15) Prioritisation of urgent patients, e.g., ectopics from ward and EPAU (10/9/2019) 1-15) Patients may be admitted to ward if unable to perform scan and confirm diagnosis (10/9/2019) 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) 11) Staff have worked additional hours on the enhanced rate (10/9/19) 1-15) Still working weekend sessions to keep hip scans within 6 weeks (10.9.19) 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)	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) 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) 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) 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 Pataus 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).	1) Increase staffing of sonographers in main scan 2) Resolve HR issues 1) Re-advertise for permanent sonographers 1) Ultrasound Superintendent Manager to be advertised and recruited. 1) Further training of midwife to undertake full sonography role	Dec-19 Dec-19 Dec-19 Apr-20 Jun-20	1 x 3 = 3 GREEN	Oct-19	

Director	Cross Ref	What is the Risk?	Current Level of the risk? Risk	How are we managing	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
				7) Selected low risk gynae patients have been referred to Radiology (09/04/2019) 8) Doctors training cancelled as a temporary measure in Women and Children's to maximise the patients being scanned in a list. (9/04/2019) 9) x2 sonographers have been employed via the Bank - booked if they are available (09/04/2019) 10) x2 members of staff have increased their hours on a permanent basis (09/04/2019) 11) Enhanced Bank Rates £45/hr are being offered for any part time current staff (09/4/2019) 12) Plans to train a nurse from EGAU to do scanning (9/4/2019) 13) Training 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 permanant staff continues. 1WTE appointed (started April 19) and 1 WTE due to start October 2019. 20/8/19	13) One midwife has completed her training and one midwife is due to complete her training (10/9/19) 12) Nurse started University in February 2019 (10/9/19) 15) Weekends are being utilised to adhere to Gynae and Hip scan standards (10/09/19)				

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Medical Director	5045	Sepsis and severe infection are perhaps the most common reasons for admission to hospital and cause of inpatient deterioration. If patients do not receive high quality and timely sepsis care through detection, recognition and management of the deteriorating patient then patient harm or death could result. Date of origin: Jun 18 Date of escalation: Jun 18 Risk Lead: Medical Director	4 x 3 = 12 AMBER	4) Training staff in the recognition and management of sepsis - ongoing monitoring. 2) Early warning systems for paediatric, maternal and adult patients assist in the detection of deteriorating patients - many of whom will have sepsis. 3) Sepsis screening tools exist for paediatric, maternal and adult patients who deteriorate and may have sepsis. Optimal utilisation of these tools help reduce the mortality and morbidity from sepsis. 1) A trust antimicrobial guideline has been developed to advise appropriate antibiotics for given indications. This is available as an app and on the intranet and is subject to audit. 5) Two sepsis nurses have been recruited (1 band 7 and 1 Band 6) (Feb 19) 6) Vital PACS upgrade with sepsis module have been implemented on 28th March. Captured data will measure compliance and improvement in identification and timely management of sepsis. 7) Generating weekly sepsis report from sepsis module and sharing it with the directorates (Sep 19)	4) Mandatory training compliance in IP and Sepsis is monitored at directorate governance 2) Early Warning Score audit compliance. Auditing medical records to ensure the processes of detection, recognition and management of deteriorating patients is robust with feedback of performance to directorates and the development of action plans to achieve compliance 3) Compliance with sepsis screening and sepsis 6 delivery. Auditing the use of the sepsis screening tool and delivery of the sepsis 6 with feedback of performance to directorates and the development of action plans to achieve compliance 1) Antimicrobial prescribing compliance. To ensure that antimicrobial prescribing is compliant with trust guidance and that antimicrobials are reviewed to reduce antimicrobial resistance 4) LBR training funding for 19/20 is risk prioritised and includes Intermediate Life Support, Neonatal Life Support, Advanced Paediatric Life Support, ALERT training, ALS, Non Medical Prescribing etc. (May 19)	4) Mandatory training performance report. 2) Non-Compliance with EWS audit. 1) Non-compliance with Antimicrobial audit.	Consolidate sepsis awareness across the trust with the help of newly appointed sepsis nurses. Conducting regular sepsis compliance audits in ED, Inpatients, Haemat-oncology, Paediatrics and Obstetrics. The results of these are fed back to the DPG monthly. Regular QIP projects to improve the delivery of sepsis screening, awareness and antibiotic delivery within an hour in patients with sepsis or suspected sepsis. This will also help identify any barriers that influence the uptake of the sepsis screening. Generating weekly sepsis report from sepsis module and sharing it with the directorates. (Sep 19)	Mar-19	x =	Oct-19	

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	5112	If the number of staff who are not able to work on the ICCU or who require supervision continues at a high level (13% in 2018-21% at 18/07/19) then there are insufficient experienced skilled Band 5 nurses in the ICCU setting resulting in an increase in staff stress and potential harm for patients. Date of Origin: Oct 18 updated July 2019 Date of escalation: Dec 18 Risk Lead: Critical Care Group Manager	3 x 4 = 12 AMBER	1- Band 8a Operational Nurse Manager is now in post (Oct 2019) 2- New PDN is in post (Oct 2019) 3- All new stafff have a supernumerary period of 6 weeks, adjusted to meet individual staff requirements, dependant on previous critical care exposure (Oct 2019) 4- Inexperienced staff have a 6 week intensive programme of clinical study days, with engagement from the post registration education team (Oct 2019) 5- There is a documented weekly review for new member of staff with the PDN Team, to ensure training needs are achieved (Oct 2019) 6- Each new member of staff is allocated to 2 experienced ICCU nurse to support them during the supernumerary period (Oct 2019) 7-For inexperienced staff 75% of their shifts are worked Monday to Friday days. Continue with educational support for 4 months (Oct 2019) 8- Education and Admin support posts are in place(Oct 2019) 9- Exit interviews are carried out with leavers to ensure improvements for retaining staff (Oct 2019)	1- Band 8a Operational Nurse Manager in post and has overall responsibility for the service (Oct 2019) 6,7,12 - e-Roster utilised resulting in a decrease in staff disatissfaction (Oct 2019) 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 (Oct 2019) 2-7 - Education team have changed their training delivery method - this is now undertaken at the bedspace (Oct 2019) 2-7- PDN is in post and providing training (Oct 2019) 18 - Shifts are being covered and disruption to services minimised (Oct 19) 14- 32 Datix incidents reported (April to Oct 2018) reduced to 14 for same time period 2019	10,14 - 4.84 WTE B5 and 2.85 B6 vacancies remain unfilled - 14 B5 WTE have under 12 months experience and 6 new starters are not in the numbers at (08/10/19) (Oct 2019)	14 - Monitor Datix reports concerning staff shortages and skill mix	Apr-20	2 x 3 = 6 YELLOW	Oct-19	

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				10- All posts are advertised and recruited into on a continuing basis(Oct 2019) 11- 'You said, We Said' Wall is in place (Oct 2019) 12- E-rostering is fully utilised (Oct 2019) 13- Divisional Management Team is appraised of progress against the agreed action plan for the unit (Oct 2019) 14- Staff and sickness levels are monitored daily (Oct 2019) 15- New members of staff are allocated evenly across the unit to ensure that neither speciality is saturated with too many suppervised staff (Oct 2019) 16- Inexperienced Staff have their own Team on e-roster (Oct 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 (Oct 2019) 18- Staff are paid at enhanced rate for overtime to cover the unit (Oct 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	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. Date of Risk: October 2018 Accepted onto Divisional RR: 16/11/2018 Accepted onto Trust RR: 22/7/2019	4 x 3 = 12 AMBER	6. HTE asked to develop framework for purchase of required kit which will support a competitive purchasing process(18/12/18) 5. National email address from MHRA for FMD.(18/12/18) 4. Black Country STP meetings. (18/12/18) 3. Group action from chief pharmacists. (18/12/18) 2. Attended regional study day which explored different options to achieve compliance (22/01/19) 1. Regional review of FMD software undertaken. (18/12/18) 7. Information for HTE framework made available through regional purchasing lead (4.2.19) 8. Business case written to go to core team (Div3) (18.2.19) 9. Pharmacy stakeholders meeting around option appraisal and action plan (14/01/19)	4. Able to use for networking and knowledge. (Oct 19) 8. Business case approved by Division and C&C ((Oct 19)	2. Implementation plan and date not agreed. (Oct 19) 1. Software, hardware and licences not purchased ((Oct 19) 3. Post-Brexit position with regard to long term compatibility of software/ hardware across Europe remains unclear (Oct 19) 8. Business case for staffing, hardware and software to be approved by TMC (Oct 19)		2 x 3 = 6 YELLOW	Oct-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 occuring at RWT (Mar 19)	1-2 Since May - 2 x TAVI lists have been cancelled due to lack of vascular cover (Oct 19) 1-2 A regional meeting has taken place in September 2019 to discuss the regional aortic dissection rota and RWT will be a part of this rota. A meeting of SCTS on 8 October 2019 agreed that all centres who are part of the regional dissection rota should have FET on the shelf and we are hopeful that commissioners will recognise this. A further regional meeting to nail down the workings of the rota etc is planned in November 2019. Vascular cover is provided by RHH as the Regional Hub and the Vascular surgeons have been invited to the next regional aortic meeting (Oct 19)	1-2 Frozen Elephant Trunk (FET) Device is not yet approved (Oct 19)	1-2 Further evidence becoming available to enable approval of FET device. It has been agreed (September 2019) that a regional aortic dissection rota will be established and RWT will be part of this.	Dec-19	2 x 2 = 4 YELLOW	Oct-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	2. Consultants and ANP's being offered WLI rates/overtime to do additional clinics in areas where there are a particularly large number of patients overdue their review appointment 3. As we use partial booking the review appointments are actively managed and not booked up too far in advance so if a patient contacts the Directorate with any concerns we are able to give them an appointment within a reasonable timescale and will speak to the consultant about overbooking if a patient needs to be seen urgently. 4.Patients on FU OWL are validated by the FU OWL coordinator to ensure that they are appropriately booked so that slots aren't wasted 5. Assistant Directorate Manager regularly reviews slot utilisation report to ensure that all review slots are used 1. Recuitment Stategy in place 6. We are adding an an additional bex to the RTT form so that Consultants can indicate if a patient needs to be seen by a specified date. 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.	2. Extra clinics continue to run when consultants/ANPs agree to do so (Oct 2019) 3. Partial booking process remains in place (Oct 2019) 4 & 5. Deloittes KPI report showed high level of slot utilisation for review clinics (Oct 2019) 1. Appointed a new EP Consultant due to start 20 January 2020 (Oct 2019)	2, 4, 5. Numbers of review patients on FU OWL and overdue continuing to rise despite additional clinics and other controls (Oct 2019) 1-5 Red FU OWL = total waits 2546 (Sept 2019) 1-5 Amber FU OWL = total waits 607 (Sept 2019) 1-5 Green FU OWL = total waits 2465 (Sept 2019)	Extra consultant posts being recruited into to increase OP capacity across whole of cardiology Review capacity and demand. A further business case will be required which is in line with years 2-3 of the 10 year plan. 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. Identify patients that do not require a Consultant review for a pacemaker check to ease waiting list times Monthly meeting with Arrhythmia Nurses/Cardiology ANP to undertake additional clinics to support. Pooling internal referrals for EP	Feb-20 Feb-20 Nov-19 Nov-19 Sep-19 Oct-19 Oct-19	4 x 2 = 8 AMBER	Oct-19	

Director	Cross Ref	What is the Risk?	Current Level of the risk? 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	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	1,2,4) No medical staffing Datix incidents (10/19) 6) Senior clinical Fellows are being supported through the CESR programme (10/19) 2&3) Discussions are ongoing with other healthcare providers (10/19)	1 & 4) Consultant consistently raising concerns regarding lack of cover during periods of leave (10/19) 1-5) 1 Cons retiring resulting in further shortfall of staff (10/19)	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 follwoing 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	Nov-19 Oct-19 Oct-19 Dec-19 Dec-19 Dec-19 Oct-19	2 x 4 = 8 AMBER	Oct-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	5249	If the current x2 CFM machines used to record EEG tracing during cooling treatment delivery continue to frequently fail (machines not holding charge and therefore failing to capture ongoing clinical tracing) then we will not be able to deliver the required treatment. This may result in loss of Unit Level 3 status as NX is a designated Cooling Centre. The Trust will also not be able to defend care delivery in legal cases as evidence of EEG trace may have been lost during recording. This could potentially lead to increase in compensations if cases become legal. There is no contract cover for company to provide backup if machine fails. Accepted onto TRR: 16/09/2019	4 x 3 = 12 AMBER	2. 1 x CFM machine available and 1 x loan machine is currently in place (Oct 19) 4. Local printer set up to one CFM for printing of CFM trace (Oct 19) 3. Fast track charger available for failure during recording (Oct 19) 1. Current situation awareness for all Consultants and Senior nursing team. (Oct 19)		1-3) There is no assurance with the current set-up (07/10/2019)	1-5) Replace existing equipment 1-5) Business Case to be presented to support replacement of equipment 1-5) Trial to be undertaken of machines by both companies which will then inform the Business Case as to preferred product	Nov-19 Nov-19 Nov-19	1 x 1 = 1 GREEN	Oct-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	1) Continue to attempt to send devices to Dell for repair (June 19) 2) Extra kit re-purposed for deployment as EPMA tablets (36 additional devices) (June 19) 3) Magnetic adapters used on new devices to relieve pressure on charging ports and help durability of devices.(June 19) 4) Redeployment of kit (June 19) 5) Trial is running using alternative Getac tablet devices in 3 clinical areas for 8 weeks until Oct 19, currently going well 6) IT to raise business case for requirement of further devices in all clinical areas	2) Extra kit re-purposed for deployment as EPMA tablets (36 additional devices) (June 19) 3) Magnetic adapters used on new devices to relieve pressure on charging ports and help durability of devices.(June 19)	1) Not all devices will be fixed under warranty 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 3) May provide some additional durability to new devices being redeployed but will not provide any durability to devices already weakened by use. 4) Has reduced overall number of devices on each ward. 1) Dell pushback regarding warranty as no manufacturing fault found with devices, Dell state no other customers with issues and all industry testing was successful (Oct 19)	2) Identify funding to procure replacement devices. Sufficient devices are required to mitigate issues based on current reduction in numbers. 2) Procure additional devices and build for deployment. 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) 5) Once trial ended to gain agreement from clinical areas and IT to go ahead with new Getec devices 5) Order to be rawised for devices required 5) IT to work on a roll out plan 6) IT to raise business case for further devices	Oct-19 Oct-19 Oct-19 Oct-19 Oct-19 Nov-19 Nov-19	4 x 1 = 4 YELLOW	Oct-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	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: Lack of functionality or errors associated with the software. Lack of or errors associated with interfaces with other Trust systems (electronic and paper). Staff using the system incorrectly or suboptimally. Lack of and poor suitability of hardware for EPMA. This is an overarching risk and replaces risks 5190 and 5038. Date of origin:20/08/19 Accepted onto Divisional Risk Register: 20/09/19 Accepted onto Trust Risk Register: [via ePMA Steering Group and Trust Medical Director]	4 x 3 = 12 AMBER	1. There is an EPMA Steering Group chaired by the Medical Director which provides Executive level oversight and strategic direction for EPMA. (Aug 19) 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 Managment Group. (Aug 19) 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) 4. A list of priority system issues has been produced by the EMPA Steering Group. (Aug 19) 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) 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)	1. The EPMA Steering Group meets monthly and minutes are available. (Oct 19) 2. The first meeting for the EPMA Operational Group is scheduled for September. A Chair has been appointed. (Oct 19) 4. Emis has responded in writing to the priority list and will be undertaking a site visit in September. (Oct 19) 5. Datix reports relating to EPMA are monitored monthly. (Oct 19) 6. The business case is approved and posts being recruited to. (Oct 19) 9. Emis are actively managing the intermittent issue where the system freezes and this is preventing it from occurring. (Oct 19)	5,6. User error is a cause of incidents reported via Datix, this could be improved with better training for EPMA. (Oct 19) 7. Hardware is being reported as broken and monies need to be identified to replace. (Oct 19) 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. (Oct 19) 4,9. System down time is still occuring (need to add report of incidence). (Oct 19) 4,9. No issues on the priority list have been resolved. (Oct 19) 1,2. The Medical Director is receiving complaints from Consultants regarding EPMA. (Oct 19) 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. (Oct 19)	Emis to visit site in September to review issues raised. Business case for IT hardware support Review and improve user training Replace broken hardware Continue to engage with Emis	Sep-19 Sep-19 Oct-19 Oct-19 Sep-19	1 x 3 = 3 GREEN	Oct-19	

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
				7. IT are undertaking a trial of alternative hardware solutions and requesting that wards report all hardware issues to IT. (Aug 19) 8. The Medicines Managment 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) 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) 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)					

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	5285	*Awaiting Divisional Approval for Trust Board* Mandatory rapid 24/7 access to CT angiograms from Arch of Aorta to Vertex is required for Hyperacute Stroke patients to ensure they have rapid imaging assessment to access urgent thrombectomy. Rapid access is having door to scan time less than 30 minutes. Any time lost accessing Brain imaging will result in a poorer outcome for the patient. This has the inherent risk patients will miss out on thrombectomy. The risk from this is obviously a poorer outcome for the patient but also exposes the Trust to legal avenues of contest why an urgent scan could not be carried out. That could carry a financial risk into a 6 figure sum every time a patient was pushed outside the thrombectomy window due to scan delay. During working hours (0900 to 1700hrs) there is good access to CTA in ED and risk is low of delayed CTA access Between 0800 to 0900 and 1700 to 2000hrs then there is access to CTA in Main CT that will involve a 20 - 30 minute delay in the overall treatment of patient with inter department transfer from ED to Main CT. Risk of delay is low to moderate for patient. Moderate risk if	3 x 4 = 12 AMBER	1.We have met with radiology for review of this risk to ensure future 24/7 on site CTA cover. At present not deliverable due to skilled radiographer shortage to give full overnight cover. We are managing with current CT radiographer provision (aug 19)	1. Incidents reported via DATIX of potential missed thrombolysis or delayed thrombolysis overnight (sept19)	1. Unable to ensure future 24/7 on site CTA cover not deliverable due to skilled radiographer shortage to give full overnight cover. We are managing with current CT radiographer provision (sept19)		2 x 1 = 2 GREEN	Oct-19	

Director	Cross Ref	What is the Risk?	Current Level of the risk?	How are we managing 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?
		patient is unstable. Between 2000hrs and 0800hrs access to CTA is via on call CT radiographer who will have to come in from home. This can result in a 30-60 minute delay in treatment awaiting the on call CT radiographer to come into hospital. This exposes patient to moderate risk Risk is substandard access to CTA overnight to deliver timely hyperacute Stroke care. CTA access risk was identified at the recent WMQRS review in May 2019. Escalated to TRR: 30th Sep								