

# Chief Nurse's Governance Report 4 February 2020

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Agenda Item No: 8.2

## Trust Board Report

<b>Meeting Date:</b>	4 <sup>th</sup> February 2020
<b>Title:</b>	CNO Governance report
<b>Action Requested:</b>	<b>Receive for assurance and note</b>
<b>For the attention of the Board (note 3)</b>	
<b>Assure</b>	<ul style="list-style-type: none"> <li>TRR updates are requested monthly, with review/challenge on risk progress at Divisional and Trust level groups.</li> <li>The number of risks scoring 12 or above that are awaiting approval to TRR has reduced.</li> </ul>
<b>Advise</b>	<ul style="list-style-type: none"> <li>Good progress is being made on implementing Governance processes for local procedural documents (including document review). Regular reports are produced for Directorates and Divisions to maintain progress on document maintenance.</li> </ul>
<b>Alert</b>	<ul style="list-style-type: none"> <li>Resources have been identified to employ a full time band 5 project role to implement compliance processes for the National Data Opt out policy. Priority for and engagement with this work by all stakeholders will be crucial to meeting the deadline of the 31<sup>st</sup> March 20.</li> <li>Delays with identifying lead RCA investigators and/or staff availability for RCA work has been highlighted (increase seen in Dec 19) and discussions have commenced to consider resource requirements for dedicated investigators. A proposal is being prepared.</li> </ul>
<b>Author + Contact Details:</b>	Tel 01902 695114 Email maria.arthur@nhs.net
<b>Links to Trust Strategic Objectives</b>	<ol style="list-style-type: none"> <li>Create a culture of compassion, safety and quality</li> <li>Proactively seek opportunities to develop our services</li> <li>To have an effective and well integrated local health and care system that operates efficiently</li> <li>Attract, retain and develop our staff, and improve employee engagement</li> <li>Maintain financial health – Appropriate investment in patient services</li> <li>Be in the top 25% of all key performance indicators</li> </ol>
<b>Resource Implications:</b>	Opt out resource to be raised as cost pressure
<b>Report Data Caveats</b>	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.
<b>CQC Domains</b>	<b>Safe: Effective: Caring: Responsive: Well-led:</b>
<b>Equality and Diversity Impact</b>	No adverse impact on PPC.
<b>Risks: BAF/ TRR</b>	<p>Risks relate to capacity and resources to comply with Statutory and Regulatory requirements. See TRR risk detail below plus -:</p> <p>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</p>
<b>Risk: Appetite</b>	
<b>Public or Private:</b>	
<b>References</b>	If required/appropriate e.g. if addressing a national policy priority.
<b>NHS Constitution:</b>	<p>In determining this matter, the Board should have regard to the Core principles contained in the Constitution of:</p> <ul style="list-style-type: none"> <li>Equality of treatment and access to services</li> <li>High standards of excellence and professionalism</li> <li>Service user preferences</li> <li>Cross community working</li> <li>Best Value</li> <li>Accountability through local influence and scrutiny</li> </ul>

**Brief/Executive Report Details**

**Brief/Executive Summary Title:** This report provides update for work areas within the Governance portfolio. Some items are routine eg Trust Risk Register report, others are by exception. The report content is listed below:

1. Trust Risk register (TRR) update – December 19 and January 20
2. Serious Untoward incident (SUI) Performance
3. Information Governance (IG) work plan – Resources have been identified to complete the National data Opt-out requirements due by 31st March under GDPR.
4. Governance Department staffing – recruitment progress.
5. Governance structure review
6. Governance of local Procedural Documents (ie Clinical Procedures, Guidelines, Protocols etc)

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

**Item/paragraph 1.0** **1. Trust Risk Register update – December 19 and January 20**

Trust Risk Register Key Issues

**4 new risks:**  
**5316** - Risk of RTT breaches for Paediatric/Adult Patients (COO)  
**5260** - RWT CYT: Cytology reporting times not meeting target (COO)  
**5315** - DGFT/RWT Shortage of Consultant Microbiologist (COO)  
**3256** - Premises at West Park do not conform to professional standards for Audiology (COO)

**1 risks removed:**  
**5119** - Falsified Medicines Directive (COO)

**5 red risks:**  
**2080** - Risk to quality of patient care: reduced manpower (COO)  
**4661** - Lack of robust system for review and communication of test results (MD)  
**4113** - Divisions inability to achieve CIP (COO)  
**5182** - Lack of Network support for Vascular Services at RWT (MD)  
**5246** - Lack of Consultant cover within Cancer Services (COO)

There are currently 35 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			15 risks	3 risks	1 risk
3 – Possible			2 risks	13 risks	
2 – Unlikely					
1 – Rare					

Attention is required to the following risks:

4113 COO – Actions 1<sup>st</sup>, 2<sup>nd</sup> and 3<sup>rd</sup> actions to be considered as controls for ongoing monitoring.

1713 COO – Action and assurance update

4375 COO – Add actions in progress and a timescale for completion

4411 COO – Add action timescales

4472 COO – Consider GIRFT visit action plan progress as a control

5031 COO – Update on actions

5182 MD – Action update

5197 COO – Action update

5045 MD – Action update

5253 CFO – Action update

## 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
Oct 19	32 (6)	11	5	6	2	2
Nov 19	30(6)	7	5	6	1	1
Dec 19	26(5)	8	9	7	6	6
<b>Analysis</b>					20083 - Div 2 - Sub Op (difficulty appointing a lead) 20489 - Div 3 - Diagnostic (difficulty with dates with the division) 20607 - Div 1 - Sub Op (difficulty appointing a lead) 19722 - Div 1 - Diagnosis (awaiting approval / friday morning meeting was cancelled) 20979 - Div 1 - VTE (awaiting comments from pharmacy) 21323 - Div 3 - Diagnostic (awaiting input from other area)	

### **3. Information Governance (IG) work plan**

A full time band 5 post is to be recruited for 3 months to deliver a project that will meet the National data Opt out requirements by 31<sup>st</sup> March 20. A project plan will be developed to include scoping the data held and its uses, setting up systems and processes to apply the Opt out (possible technical solutions), the update of Trust and local policies and procedures for the application of opt-outs and external communications to declare compliance. This work will include a focus on research but may include other areas that hold and use patient data for reasons aside from direct care.

### **4. Governance Department staffing**

Divisional Governance Officers are fully recruited; H&S vacancy persists with a structural review and work re-allocation underway. A Governance manager post for Division 3 to cover Maternity leave has been recruited and due to commence early February with interim cover being provided by Division 1 and Division 2 Governance managers from mid-January to early February when the new post holder starts. During this time there will be prioritised Governance meeting attendance in Division 3. These arrangements have been communicated within the Division.

### **5. Governance Structure review**

As part of a routine structural review within Nursing and Quality Directorate, the Governance Department will be subject to a review of its department structure and related functions with further communication to follow.

### **6. Governance of local Procedural Documents**

From January 20 Divisions will receive a monthly report showing the status of local procedures management and to support performance monitoring of the review and maintenance of local procedures and guidelines. Progress will be reported via QSIG with process oversight via the Trust Policy group.

Division 2 and 3 have completed collation of local SOPs for CP50 (Results Reporting). Collation of SOPs is in progress within Division 1. Next steps are to communicate, publish and establish routine SOP audits.

Reference Pack CNO Governance Report 04/02/2020

Appendix 2: Tracked changes within Trust Risk Register (Jan 2020):

Lead Director	Risk	Risk Title	Field updated	Update made
Chief Operating Officer	5316	Risk of RTT breaches for Paediatric/Adult Patients		
			***New risk***	<p>The Ophthalmology department has a backlog of paediatric and adult patients awaiting squint surgery. This has occurred due to a combination of:</p> <p>(a) The Trust's decision to move paediatric surgery from Beynon Centre theatres to Nucleus theatres in 2017.</p> <p>(b) the subsequent retirement of the Ocular-motility Consultant (with no other consultant able to carry out this type of surgery for paediatric or adult patients)</p> <p>(c) a lack of paediatric bed capacity on the Paediatric Ward on the allocated day of Ophthalmology surgery in Nucleus theatre. I</p> <p>If the department is unable to access sufficient beds on a weekly basis for paediatric surgery and remains unable to recruit to the Ocular-motility vacancy, then both paediatric/adult waiting list will continue to rise and could result in waiting list breaches and financial penalties for the Trust.</p>
	5260	RWT CYT: Cytology reporting times not meeting target	***New risk***	<p>If cytology screening program high activity levels following the recent Tender award for Primary HPV screening continues, then reporting times will not meet the national target (98% in 10 days). Resulting in delays in cytology screening reporting for patients within the geographical area covered by the Tender (Midlands) and delays in patient management due to the late reporting.</p>
	5315	DGFT/RWT Shortage of Consultant Microbiologist	***New risk***	<p>If the only permanent Consultant Microbiologist at DGFT Microbiology is unexpectedly off work then clinical cover will be from</p>

			a Locum based at DGFT and supported from Microbiologists from RWT who already have vacancy due to the retirement of a Consultant Microbiologist in March 2020. Resulting in delayed support to clinicians which may adversely affect patient management.
3256	Premises at West Park do not conform to professional standards for Audiology		
		<b>***New risk***</b>	<p>If the premises at West Park Hospital are assessed by UKAS as unsuitable for clinical service delivery (lack of adequate soundproofing and an inability to maintain ambient temperatures in clinical rooms), then this leads to:</p> <ul style="list-style-type: none"> <li>- Compromised patient care in that we cannot perform diagnostic testing at very quiet levels, resulting in inaccurate testing, misdiagnosis and incorrect treatment in a variety of hearing conditions.</li> <li>- Potential complaints and litigation and a risk of loss of contract(s) from misdiagnosis and incorrect treatment.</li> <li>- Loss of UKAS accreditation (UKAS Visit 30th -31st July 2019 West Park removed from scope of practice in part to the ongoing concerns re sound treatment) due to major non-compliance with core standards under the inspection/audit/NICE Guidelines/NSF criteria.</li> </ul>
5173	IT infrastructure in Audiology clinics		
		Action Plan - <b>New</b>	Business case to be finally approved
4523	Failing Heater Cooler Units		
		Positive Assurance – <b>New</b>	A trail of a company's demo machine has been undertaken
		Action Plan - <b>New</b>	Equipment now on site. Awaiting equipment to be released from Stores.
4596	QS104 - Gallstone Disease		
		Positive Control –	Appointment of Locum Consultant.

		<b>New</b>	
		Positive Assurance – <b>New</b>	Hot gallbladder list undertaken every Tuesday by Locum Upper GI Consultant
4706	Infrastructure/environment in Nucleus Theatres		
		Positive Assurance – <b>New</b>	2 x reported incident of Sewage ingress/water leaks since May 2019 - Sewage leak reported January 2020
		Positive Assurance – <b>New</b>	1 x reported incident of power outage or back-up power failure in Theatre 7 during August 19 - no further reports
		Positive Assurance – <b>New</b>	1x Sewage leak behind Theatre 5, from the ward toilets in January
		Action Plan - <b>New</b>	1x Sewage leak behind Theatre 5, from the ward toilets in January
5243	Breast Service (General Surgery & Radiology)		
		Positive Assurance – <b>New</b>	As at the 09/01/20 the Trust has capacity to see patients within 14 days
		Gap in Assurance - <b>New</b>	Continued pressure on workload due to increased referrals
		Action Plan - <b>New</b>	Recruit Consultant Radiologist - one candidate in negotiation
		Action Plan - <b>New</b>	Review pathway for patients with pain. Joint working with EAG / CCG re criteria and initial GP management
		Action Plan - <b>New</b>	Implementation of new referral form and pain pathway across the West Midlands with an anticipated referral reduction of 15%
		Action Plan - <b>New</b>	Business Case for Consultant Nurse (Breast) to be presented to Division
		Action Plan - <b>New</b>	Introduction of stratified follow up of Breast patients with associated workforce
4472	Delays in triage in ED		
		Gap in Assurance - <b>New</b>	Significant increase in number of 8hr waits for first assessments in month due to no beds in Trust



		Gap in Assurance - <b>New</b>	Significant number of attendances through ED experienced
		Gap in Assurance - <b>New</b>	12hr wait experience in month
5119	Falsified Medicines Directive		
		<b>Risk now managed on local risk register</b>	Risk updated and score reduced. To be removed from Trust and Divisional RR. Risk reduced on basis that software, hardware and licenses now in place and number of notifications of falsified medicines received via CAS is very low
4170	Lack of capacity - OPD, Snowdrop Suite and Durnall Unit		
		Positive Control – <b>New</b>	Improvements made to increase space and improve signage
		Positive Control – <b>New</b>	Trust AOS Low risk sepsis service to consider community reviews, daily follow ups and weekend follow ups
		Positive Assurance – <b>New</b>	Business Case finalised by Group Manager for increased nursing allowing for Community clinics and increased staffing in Durnell
		Positive Assurance – <b>New</b>	AOS nurse has undertaken RCA to review 'golden hour' patients. For any patients who do not get antibiotics within the hour
		Positive Assurance – <b>New</b>	Utilising Discharge Lounge for appropriate patients
		Positive Assurance – <b>New</b>	95% staff to attend sepsis study day and online training - study day 11.06.2019 well attended remainder of staff to be captured
		Positive Assurance – <b>New</b>	Recruitment successful 2 x AOS Posts
		Action Plan - <b>New</b>	2 Band 8a and a Band 7 to be interviewed
3069	Risk of Never Events within Division 1: Risks to Patient Safety and Trust reputation		
		Positive Assurance – <b>New</b>	Monthly monitoring and compliance with WHO checklist use - There has been 100% compliance achieved during Dec 19
		Positive Assurance	Monthly monitoring data of compliance with WHO checklist

		– <b>New</b>	and Procedural Safety Checklist - 100% for full completion (documentation) in Dec 2019
4696	Unreported Imaging Studies		
		Positive Assurance – <b>New</b>	Backlog against a backdrop of increased referrals has reduced from 7332 May 2017 to less than 6275 in December 2019
		Gap in Assurance - <b>New</b>	Approximately 6275 non-urgent imaging studies unreported December 2019 (inclusive of 713 CT scans and 2708 MRI scans). Over 20 days there are 3257 in total (inclusive of 458 CT scans and 1599 MRI scans)
4113	Divisions inability to achieve CIP		
		Positive Control – <b>New</b>	Use of model hospital to identify opportunities for CIP
		Positive Control – <b>New</b>	Use of external support to challenge budget management and CIP opportunities
		Gap in Assurance - <b>New</b>	Low value of recurring CIP
		Action Plan - <b>New</b>	Project team for Zesty project to be established
		Action Plan - <b>New</b>	Development of STP schemes
		Action Plan - <b>New</b>	Development of schemes for 20/21
		Action Plan - <b>New</b>	Review ideas from other Trusts meeting with NHSI
2719	Timeliness of PAS Admission		
		Gap in Assurance - <b>New</b>	Risk in EMPA for Pharmacy prescribing (identified in 2019, included in RR Nov 19)
		Action Plan - <b>New</b>	Business Case for additional Ward Clerks for consideration in 20/21 cost pressures
4411	NX08/NX09 McHale Building - Fire Safety		
		Positive Assurance – <b>New</b>	0 incidents relating to Reportable Fire's within Dec 19
		Positive Assurance – <b>New</b>	0 Unwanted Fire Signals within Dec 19

4382	NX55 Main Theatres, Wards A12, A14, Admin, Plant Rooms) - Fire Safety		
		Positive Assurance – <b>New</b>	0 incidents relating to Reportable Fire's within Dec 2019
		Positive Assurance – <b>New</b>	0 Unwanted Fire Signals within Dec 2019
4375	NX87 Heart Centre - Fire Safety		
		Positive Assurance – <b>New</b>	0 unwanted fire signals during Dec 2019
		Positive Assurance – <b>New</b>	0 incidents relating to Reportable Fire's within Dec 2019
5246	Lack of Consultant cover within Cancer Services		
		Risk <b>upgraded</b>	Risk now RED. Was AMBER
		Positive Assurance – <b>New</b>	No harm identified from 104 day reviews
		Positive Assurance – <b>New</b>	Senior Clinical Fellows continue to provide significant support to service
		Positive Assurance – <b>New</b>	Dr who manages thyroid cancer patients will return from sabbatical in Feb 20
		Gap in Assurance - <b>New</b>	The service is severely compromised in its ability to provide adequate clinic appointments at the end of the 62 day target pathway
		Gap in Assurance - <b>New</b>	Currently no appropriate locum cover available
		Gap in Assurance - <b>New</b>	Increase in number of medical staffing incidents on Datix
		Action Plan - <b>New</b>	Identify locum Cons cover
		Action Plan - <b>New</b>	Discussions ongoing with SATH specifically including brachytherapy
		Action Plan - <b>New</b>	Discussions with SATH and UHNM with regards to brain and gynae service provision
		Action Plan - <b>New</b>	Senior Clinical Fellow job plan to be reviewed to provide support to existing gynae Cons
Action Plan - <b>New</b>	Work with Dudley to standardise the discharging process and subsequent radiotherapy referrals		

		Action Plan - <b>New</b>	Formalise competencies in the current Clinical Fellowship programme to identify medical staff of suitable calibre
4529	Vacancies in Medical Staffing/Agency and Locum staffing in Division 1		
		Positive Control – <b>New</b>	National NHSI Led programme continues
		Positive Assurance – <b>New</b>	Vacancy Rate Medical Staff 5.87%
		Positive Assurance – <b>New</b>	RWT only lead employer for palliative
		Action Plan - <b>New</b>	HR working with Anaesthetics and Ophthalmology to optimise rota configuration
5284	EPMA - system and operational use (overarching risk)		
		Action Plan - <b>New</b>	Upgrade software
		Action Plan - <b>New</b>	Develop SOP's to support user guide
		Action Plan - <b>New</b>	Address PAS issues impacting on ePMA
		Action Plan - <b>New</b>	Write a business case for additional BC machines
		Action Plan - <b>New</b>	Review BC SOP's and agree actions to be taken when EPMA is unavailable
5249	Cerebral Function Monitoring Machine failure		
		Positive Control – <b>New</b>	Directorate undertaking a trial of 2 x different machines in order to identify the preferred product
		Positive Assurance – <b>New</b>	Directorate have trialled the inspiration CFM. The other provider has not been evaluated
5197	Unacceptable waiting times for Cardiology follow-up appointments		
		Positive Assurance – <b>New</b>	Numbers of review patients on FU OWL and overdue continuing to rise despite additional clinics and other controls
		Positive Assurance – <b>New</b>	Red FU OWL = total waits 2872 (14.01.2020) the patient is overdue their appointment  <b>Red – as of today the patient is</b>

				overdue their appointment
			Positive Assurance – <b>New</b>	Amber FU OWL = total waits 687 (14.01.2020) the patient will be due their appointment within the next 6 weeks  <b>Amber</b> – 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)
			Positive Assurance – <b>New</b>	Green FU OWL = total waits 2403 (14.01.2020) the patient is due their appointment in more than 6 weeks  <b>Green</b> – the patient is due their appointment in more than 6 weeks
			Action Plan - <b>New</b>	Band 7 Arrhythmia Nurse advertised.
	2080	Risk to quality of patient care: reduced manpower		
			Positive Assurance – <b>New</b>	72.94 wte trained nursing vacancies remain
			Positive Assurance – <b>New</b>	Close beds re-opened on C24
			Positive Assurance – <b>New</b>	PEF's and Mentors in place to improve retention of new starters
			Positive Assurance – <b>New</b>	Division 2 real time electronic system in place to monitor vacancies
			Positive Assurance – <b>New</b>	27.62 HCA vacancies
			Gap in Assurance - <b>New</b>	Significant nursing shortages remain on C16, C19 and C25, working with 35% - 40% vacancies at Bd 5 level
Medical Director	5045	Sepsis		
			Action Plan - <b>Completed</b>	Consolidate sepsis awareness across the trust with the help of newly appointed sepsis nurses.
	4661	Lack of robust system for review and communication of test results		
			Action Plan - <b>New</b>	Aim is to achieve full compliance with mandatory reviewing and filing of results with audit of compliance by Directorate and Consultant.

	5182	Lack of Network support for Vascular Services at RWT.	Positive Control – New	Email sent from Professor Cotton on 8.12.19 to Dr Odum raising concerns over the current status of the TAVI service, with particular reference to "acute on chronic" problems gaining appropriate vascular cover
			Action Plan - New	To seek further evidence to enable approval of FET device.
Chief Financial Officer	5253	Dell Tablets on ePMA wards damage and unsupported warranty	Action Plan - <b>Completed</b>	Order to be raised for devices required
Chief Nursing Officer	3644	CQC risk	Action Plan - New	A Mental Health Act Use Policy is in development - being reviewed by independent agency
			Action Plan - New	Draft CQC action plan developed. Update CQC action plan on receipt of the draft CQC action plan.

th Act training  
se  
he Royal Wolverhampton NHS Trust  
Trust Risk Register  
January-2020

Action Plan - New

Develop Mental Health plan and business ca

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?	How are we managing the Risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Risk Lead	ID	Principal Risk		Controls	Positive Assurances	Gaps in Assurance/Control	Action Plan that addresses Gaps in Control	Residual Risk Level		

**Risks Currently Being Managed**

**Trust Objective: Be in the top 25% for key performance measures**

Chief Operating Officer	5260	If cytology screening program high activity levels following the recent Tender award for Primary HPV screening continues, then reporting times will not meet the national target (98% in 10 days). Resulting in delays in cytologyscreening reporting for patients within the geographical area covered by the Tender (Midlands) and delays in patient management due to the late reporting.	3 x 4 = 12 AMBER	1. Contingency plan- staff working additional hours to cover increased workload (Jan 20)  2. Plan to clear Primary HPV backlog by 28/2/2020 (Jan 20)	1. Turnaround times monitored weekly - 9-10 week backlog (Jan 20)  1. Backlogs within the process stages is routinely monitored (Jan 20)  1. Additional/overtime hours offered to staff members and bank staff ((Jan 20)  1. Regular updates given to Commissioners of the service regarding the delay (Jan 20)  1. National statistical returns for performance monitoring (Jan 20)	1. TAT not being met ((Jan 20)  1. Incidents raised: 228259, 228586 SAIF reportable: W156998, W159722, W159649, W160508 (Nov 2019)  1. Complaints received regarding delayed reporting 20389, 20498, 20531 and 20680 (Dec 2019)	1. Manage workload and liaise with commissioners regarding TAT  1. Increase overtime/bank hours to address backlog in booking in	Feb-20  Feb-20	2 x 3 = 6 YELLOW	Jan-20
		Accepted onto the Divisional RR = 13/12/2019 Accepted onto the TRR = 01/01/2020								

Director	Cross Ref	What is the Risk?	Current Level of the 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?
<b>Trust Objective: Proactively seek opportunities to develop our services</b>										
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.	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) (Jan 20)  1) Multiple complaints from staff re: slow and hanging computers, often necessitating forced shut down of computers (Jan 20)  2) All of the 33 computers had too little RAM - this has been confirmed by IT of which a total of 8 computers across the department were obsolete (Jan 20)  1) Upgrade of Auricals to Windows Version 10 is not achievable (Jan 20)	1-2) Procure equipment 1-2) Liaise with IT to install equipment 1-2) Business case to be finally approved	May-20 Feb-20 Feb-20	1 x 1 = 1 GREEN	Jan-20
		Date of origin: 20 February 2019								
		Date of escalation: 28 March 2019								
		Risk Lead: Head of Audiology								



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?
<b>Trust Objective: To have an effective &amp; well integrated health and care system th</b>										
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	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. Refreshed support from Teletracking in 2019. Upgrade due in 2020.  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) 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  1) Risk in EMPA for Pharmacy prescribing (identified in 2019, included in RR Nov 19)	2) Business Case for additional Ward Clerks for consideration in 20/21 cost pressures	Apr-20 2 x 3 = 6 YELLOW	Jan-20	Yes

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?	
Chief Operating Officer	4523	<p>Heater Cooler Units (HCU) used in cardiac surgery can harbour Mycobacterium chimaera (national and international incident). The upgraded cleaning protocol for the HCUs involves powerful bleach, which progressively damages the internal components of the machines. Surgery without an HCU would be very hazardous, so there is a need for at least one spare HCU on any operating day, in case of HCU failure during a case. If multiple HCUs fail on any day, then there is a risk of patient harm. Also if list cancellations become necessary then this could result in financial loss to the Trust.</p> <p>Date of origin: 28/04/2016 Date of escalation = 17/06/2016</p> <p>Date of re-escalation = 27/03/2019</p> <p>Risk Lead: Cardiac Group Manager</p>	4 x 3 = 12 AMBER	<p>1. A comprehensive service contract is in place, which provides a loan machine on breakdown of our machines (May 2016)</p> <p>2. 6 monthly service within comprehensive service (May 2016)</p> <p>3. Patients are informed before every case of the risk and it is documented on the consent form (March 2016)</p> <p>4. All patients who have had valve surgery since January 2013 have been contacted and told of the risk of contracting Mycobacterium Chimera. There is a dedicated national helpline for patients to contact should they have any queries (March 2017)</p> <p>5. Directorate currently has 4 HCU machines. (Mar 19)</p> <p>6. HCU's are cleaned and water changed with hydrogen peroxide daily and recorded (28/03/2019)</p> <p>7. HCU's disinfected every 2 weeks as per protocol (08/05/2019)</p> <p>8. HCU's are tested for infection monthly (08/05/2019)</p> <p>9. All HCU's used on patients are identified and recorded (08/05/2019)</p>	<p>3 &amp; 4. No patients have declined the procedure as a result of being open about the risk (Jan 20)</p> <p>1-5 There have been 4 patients infected historically. There have been no further cases since 2016. These infections take up to 5 years (as far as we know) to manifest (Jan 20)</p> <p>5. Potential for list cancellation - None cancelled to date (Jan 20)</p> <p>5. A trail of a company's demo machine has been undertaken (Jan 20)</p>	<p>5. 3 out of 6 HCU machines have failed recently, 2 of which are irreparable (Jan 20)</p> <p>5. A gap in HCU availability from manufacturer due to demand nationally ((Jan 20)</p>	<p>1-5) Equipment now on site. Awaiting equipment to be released from Stores.</p>	Jan-20	1 x 3 = 3 GREEN	Jan-20	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)  6. Appointment of Locum Consultant.	1-3 In first three months of commencing hot gallbladder list, 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) (January 2020)  1-3 (03.06.19) Hot gallbladders undertaken on the CEPOD list by both UGI and non UGI Surgeons  Hot gallbladder list undertaken every Tuesday by Locum Upper GI Consultant (January 2020)	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 substantive post	Re-locate UHNM staging lap list on Friday morning to give weekly 3rd session (Critical Care Services Directorate - no available theatre to relocate session) (January 2020)  (14.06.19) Recruit 4th substantive 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	2 x 2 = 4 YELLOW	Jan-20	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?
Chief Operating Officer	5083	<p>IF staff do not understand their roles/ role boundaries and receive training and maintain competency needed to accurately identify dysphagia needs and manage these appropriately, THEN patients' needs may not be assessed (or inadequately assessed) RESULTING IN aspiration of oral intake and the potential negative effect on the patient's health. This can lead to increased antibiotic usage, increased length of hospital stay, increased likelihood of readmission and - in the most severe cases - the patient's death. Additional potential outcomes could be increased exposure to medical negligence actions for both staff and the Trust.</p> <p>Date of origin: August 2018 Accepted onto Divisional Risk Register: August 2018 Accepted onto Trust Risk Register: 08/10/18</p> <p>Risk Lead: Head of Therapy Services</p>	4 x 3 = 12 AMBER	<p>(3) Care Pathway and initial guidance published on intranet (SALT pages) for wards to manage initial presentation of patients with swallowing problems (Aug 2018)</p> <p>(2) Use of swallow screening tool is now for trained/ competent Stroke nurses only (Aug 2018)</p> <p>(1) IDDSI (International Dysphagia Diet Standardisation Initiative) fully implemented across Trust (May 19)</p> <p>(4) Under Care Pathway, wards manage initial presentation and then refer to SALT who see patients within 2 working days (Nov 2018).</p> <p>(5) Implementation in progress with NHS/PSA/RE/2018/004 (May 19)</p>	<p>(5) Mainly compliant with Patient Safety Alert (NHS/PSA/RE/2018/004) - few remaining local actions being monitored via Nutrition &amp; Hydration Steering Group (Jan 20 19)</p>	<p>(1) 20 x related datix incidents in 2017; 15 x related datix incidents to Nov 2018 [datix reports Nov18-Apr19 under review] (Oct 19)</p> <p>(2) Staff who are untrained/ no competency cannot use swallow screening tool (all areas outside Stroke) [(Oct 19)</p> <p>(4) SALT only available on working days, so at Bank Holiday times there could gaps of up to 4 additional days (on top of 2 day response target) before SALT assess the patient (Oct 19)</p>	<p>(4) Investigate the possibility of extending the SALT service beyond working days only - await outcome of TMC review of business case</p>	Jan-20 2 x 2 = 4 YELLOW	Jan-20	

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

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	4113	If the Divisions are unable to achieve the identified CIP target for 2019/2020 then there are implications for the financial position of the Trust  Linked to BAF risk SR8.  Date of origin: 11/01/19  Date of escalation = Dec 18  Risk Lead: All Deputy COO's	4 x 5 = 20 RED	3. Vacancy control panel in place (Oct 2015) and higher restrictions applied (Jan 17)  2. Financial Forecasting meetings include Confirm & Challenge CIP so that there is a consistent approach to Directorate financial position/challenge (Nov 19)  1. Internal PMO resources to support delivery of the Trusts efficiency programme (Apr 19)  4. Monitored by the Financial Recovery Board (FRB) (Oct 2017)  5. Member of Clinical Quality Improvement team (CQI) aligned to Divisional Programmes to provide structure and targeted support to operational teams in their delivery of CIP where required (Apr 19)  6. Operating Theatre Efficiency Group (OTEG) set-up and running for over 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 COO (Apr 2019)  9. PIDs are forthcoming to the Finance team (Dec 2018)	2, 3 & 4. Structure in place to discuss and identify opportunities to create efficiencies and business growth (06/19)  3. VCP meetings held weekly and posts go through this process for all Divisions (06/19)  5. If there is a risk that impacts on a team's ability to deliver their CIP schemes then the member of Service efficiency would be available to support as and when required at the Quality Meetings. (06/19)  1-11) CIP partner now in post (11/19)  11. All GIRFT's are monitored by the CQI team (Nov 19)  1-11) All PID's risk assessed by CNO (Apr 19)  1-11) Identified CIP of £14.8 million (month 7) across all divisions and corporate (Nov 19)	2 & 3. Unidentified CIP still remains across the divisions (11/19)  1-12 Low value of recurring CIP (Nov 19)	1-12) 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  1-10) Progress to be made with LOS - drive across all areas. Links with discharge PTL and CQI team  12) Project team for Zesty project to be established  1-12) Development of STP schemes  1-12) Development of schemes for 20/21  1-12) Review ideas from other Trusts meeting with NHSI	3 x 3 = 9 AMBER	Nov-19  Nov-19  Nov-19  Mar-20  Mar-20  Mar-20  Nov-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?
				<p>10. Outpatient efficiencies continue to be identified via OPEG (Outpatient) Dec 18. Decision to proceed with Zesty (Nov 19)</p> <p>11. Trust supporting GIRFT Visits (Nov 19)</p> <p>12) Use of external support to challenge budget management and CIP opportunities (Jul 19)</p> <p>11) Use of model hospital to identify opportunities for CIP (Apr 19)</p>						
Chief Operating Officer	4903	<p>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.</p> <p>Date of origin: 16th Nov 2017</p> <p>Date of escalation: 18th Dec 2017</p> <p>Risk Lead: Cardiac Group Manager</p>	3 x 4 = 12 AMBER	<p>1. Medical Director held discussions with Walsall Manor Hospital to increase referral cases to RWT (Jan 18)</p> <p>2. Recruitment strategy in place (April 2018)</p> <p>3. Group Manager and Thoracic Consultant have met with Worcester colleagues and pathways agreed (Sept 18)</p>	<p>2. Thoracic ANP has been recruited and in post (Jan 20)</p> <p>2. Consultant Thoracic Surgeon recruited and in post (Jan 20)</p> <p>1-3 Continue to approach other Trusts for referrals (Jan 20)</p> <p>2. Locum Thoracic Surgeon recruited and started 4 November 2019 (Jan 20)</p> <p>2. Thoracic Surgeons have undertaken proctored Robotic training sessions in the hope of attracting new work to RWT (Jan 20)</p>	<p>1. Referrals have not increased, this has been escalated to DCOO and COO (Jan 20)</p> <p>1. Despite agreed referral pathway with Walsall they are unwilling to move forward at present (Jan 20)</p>	<p>1. Plan further approaches to Walsall Hospital</p>	Feb-20	1 x 5 = 5 YELLOW	Jan-20

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?
<b>Trust Objective: Attract, retain &amp; develop our staff &amp; improve employee engagement</b>										
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 produced monthly (Nov 19)  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 of Allocate completed Sep 19. Job planning meetings with Divisions scheduled Dec 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 Nov 19.  1) Increase in number of 'signed off' job plans October 2017 + April 2018 + Sep 18	1) Sign off of all job plans not complete (Nov 2019)  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	3 x 2 = 6 YELLOW	Jan-20  Dec-19  Jan-20	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 (01/20)  1) Proactive recruitment approach continuing (01/20)  1) 72.94 wte trained nursing vacancies remain (01/20)  1) Continued recruitment to nursing clinical fellows (01/20)  1-10) Matrons meeting every Friday to ensure hospital is staffed over the weekend (01/20)  3) Snr Srs and Charge nurses meeting daily to ensure wards are safe (01/20)  3) Newly qualified and overseas nurses arriving on wards (01/20)  3) 1 bay remains closed on C24 and C16 - having a beneficial impact (01/20)  1) Local recruitment for Bd5's ongoing (01/20)  3) Ongoing weekly meetings to address vacancies as part of the Renal action plan - Twitter/Facebook campaign (01/20)  3) Additional support to base wards to allow completion of D2A's to improve flow (01/20)  1) 27.62 HCA vacancies (01/20)  3) Continued improvements in vacancy figures on wards of most concern C16, C19 and C25 (01/20)	8) Insufficient RN's available on Bank (01/20)  1) Nationally we are an outlier re safe staffing levels (01/20)  1) New staff are newly qualified and overseas which can lead to mentorship and training pressures (01/20)  1) Most wards are 'Amber' re safe staffing levels on daily basis (01/20)  3) Issue remains in relation to ability to provide accurate staffing figures - electronic solution progressing (01/20)  3) Breaches in minimum safe staffing levels (01/20)  3) Significant nursing shortages remain on C16, C19 and C25, working with 35% - 40% vacancies at Bd 5 level.(01/20)  3) Continuing to see an increase in HCA vacancy numbers - raised at QSIG and TMC (01/20)	1) Continue with proactive recruitment approach  1) UK recruitment for Clinical Nurse Fellow posts - ongoing recruitment  3) Continued local  1-10) Investigate use of Pharmacists in drug admin to free up trained nurses. Director of Pharmacy reviewing Pharmacy priorities	Feb-20  Feb-20  Feb-20  Apr-20	4 x 3 = 12 AMBER	Jan-20	Yes

Director	Cross What is the Risk? Ref	Current How are we managing Level of the risk? Risk	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
			<p>1) Some wards have been 'green' for safe staffing levels in month (01/20)</p> <p>3) Close beds re-opened on C24 (01/20)</p> <p>1-10) PEF's and Mentors in place to improve retention of new starters (01/20)</p> <p>3) Division 2 real time electronic system in place to monitor vacancies (01/20)</p>					

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?	
Chief Operating Officer	4529	<p>If there continues to be vacancies in consultant and training grade medical posts across Division 1 alongside an increase in elective activity (in some directorates) then this will result in the need to engage agency and locum staff in order to deliver a safe and effective elective service and to safely staff on-call rotas. Agency and locum staff are often engaged at premium rates which places an enhanced pressure on the divisional staffing budget; it is also recognised that locum/agency staff may not be familiar with the Trust procedures and that this unfamiliarity may have a detrimental impact on the quality and continuity of patient care.</p> <p>Please note: Risk 4239 (Obs &amp; Gynae) staffing risk has been linked to this overarching Divisional medical staffing risk.</p> <p>Date of origin: 23/04/16</p> <p>Date of escalation = 17/05/16</p> <p>Risk Level: Div 1 Deputy COO</p>	4 x 3 = 12 AMBER	<p>2. Baseline resourcing meetings continue to be held to review vacancies and expenditure, identify recruitment opportunities within Directorates explore alternative solutions including future workforce planning and forecasting (Sept 17)</p> <p>1. Recruitment Strategy in place for Consultant and Middle Grade vacant posts - this is ongoing (Dec 17)</p> <p>4. Utilisation of the Fellowship Programme (Sept 18)</p> <p>5. Agency spend reviewed monthly at Directorate/Divisional meetings via the dashboard (Dec 18)</p> <p>6. National NHSI Led programme continues (Dec 19)</p> <p>3. Trust continues to be part of West Mid's Project to reduce Locum Agency use and pay (Dec 2017)</p>	<p>1-6) Vacancy Rate Medical Staff 5.87%, (Dec 19)</p> <p>5) There continues to be no agency used in nursing (Jan 20)</p> <p>2) Baseline meetings are still continuing on-going on a regular basis ((Jan 20)</p> <p>3) Recruitment continues to develop relationships with agencies to reduce rates (Jan 20)</p> <p>1) Recruitment is ongoing (Jan 20)</p> <p>1-6) Ongoing T&amp;O medical vacancies sent 20 CVs as were struggling to recruit, 4 T&amp;O Jnr Med appointments recruited (Aug 19)</p> <p>1-6) Agency Spend in August dipped under 100k for the first time in over 18 months (Sept 19)</p> <p>1) Recruitment has been successful to most established medic positions, for those where recruitment is on hold pending sign off of business cases Divisional HR Manager is linking in with the medical resourcing lead to discuss recruitment strategies (Jan 20)</p> <p>4) 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 ((Jan 20)</p>	<p>1-6) Number of vacancies remain across Division 1 ((Jan 20)</p> <p>1-6) Rising agency spend but continues at a lower rate than previously (Dec 19)</p>	<p>3. Fellowship Programme ongoing</p> <p>1. Continuing campaign with regular adverts</p> <p>1. Continuing to develop roles to support medical rota (ANPs and ACCPs)</p> <p>1. Continue to implement recruitment strategy</p> <p>2. HR working with Anaesthetics and Ophthalmology to optimise rota configuration</p> <p>4. Divisional HR Manager to share an update on Locum list at DMT later this month</p>	<p>Jun-20</p> <p>Jun-20</p> <p>Jun-20</p> <p>Jun-20</p> <p>Apr-20</p> <p>Jan-20</p>	<p>2 x 2 = 4 YELLOW</p>	<p>Jan-20</p>	<p>Yes</p>

Director	Cross Ref	What is the Risk?	Current How are we managing Level of the risk? Risk	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
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5) RWT only lead employer for palliative (Jan 20)

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

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	3069	<p>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</p> <p>Date of origin: 19/07/12</p> <p>Date of escalation = 17/11/15</p> <p>Risk Level: Div 1 Deputy COO</p>	3 x 4 = 12 AMBER	<p>5. Monitoring and circulation of incident notification reports to all senior staff for review</p> <p>6. Trustwide learning via a "Lessons Learned" sheet in the monthly IGR, Risky Business Newsletter and the CLIP Group.</p> <p>8. Regular scrutiny of Directorate risk registers and minutes of Directorate governance meetings at the Quality Meetings</p> <p>2. Review completed of all documentation and Theatre protocols/procedures amalgamating where possible</p> <p>1. Perioperative care plans are in place across the Trust</p> <p>9. Agreed communication strategy with Division 2 to share/raise awareness of never events and lessons learnt</p> <p>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.</p> <p>4. New NE Guidance (published Jan 2018) being used for NE classification</p>	<p>10. Human Factors continues to be recognised as a trend (Jan 20)</p> <p>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 (Jan 2020)</p> <p>11. Staff across the Division are supported to undertake PCM training (Jan 20)</p> <p>12. Audit of LocSSIPs have previously been presented to Division before presentation at QSIG (Jan 20)</p> <p>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)</p> <p>13. Over 5 AfPP training days - approx. 240 staff members have been trained (Sept 19)</p> <p>1-13 There has been no new never events reported for 6 x consecutive months within Division 1 (Jan 2020)</p>	<p>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</p> <p>4. 5 x NE in 16/17 reported to CCG - 1. Maternity NE (retained tampon) reported (Datix ID: 158830), 2. Radiology NE (wrong ankle injected) reported (Datix 165455), 3. Ophthalmology (wrong eye injected) reported (Datix 166680) 4. Theatres (retained foreign object) reported (Datix ID: 169339) 5. Theatres/T&amp;O Cannock (wrong prosthesis) reported (Datix ID: 174038) occurred Mar 2017</p> <p>4. 5 x NE incidents reporting in 17/18 reported to CCG from April 2017 (175581,179911,181941,185875 186479) (Dec 17)</p> <p>4. 4 x NE in 18/19 reported to CCG - 2 x Wrong Site Surgery incidents (Neonates Datix 194205 and H&amp;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) (Jan 20)</p> <p>4. 1 x NE in 19/20 reported to CCG (June 2019) - 1 x Wrong Site Surgery - Wrong Side Fascia Iliaca Block (T&amp;O/Theatres Datix 218936) (Jan 20)</p>	<p>1-11. Staff continue to undertake PCM training</p> <p>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</p>	2 x 4 = 8 AMBER	Jan-20	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. Policy for the management of retained swabs in place	3. Monthly monitoring data of compliance with WHO checklist and Procedural Safety Checklist - 100% for full completion (documentation) in Dec 2019 (Jan 20)					
				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)	3. Monthly monitoring and compliance with WHO checklist use - There has been 100% compliance achieved during Dec 19 (Jan 20)					
				12. LocSSIPs developed by Directorates auditing underway and presented to Division and QSIG (Jan 2018)						
				13. AAFP Peer Review and Training undertaken						

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	3256	<p>If the premises at West Park Hospital are assessed by UKAS as unsuitable for clinical service delivery (lack of adequate soundproofing and an inability to maintain ambient temperatures in clinical rooms), then this leads to:</p> <ul style="list-style-type: none"> <li>- Compromised patient care in that we cannot perform diagnostic testing at very quiet levels, resulting in inaccurate testing, misdiagnosis and incorrect treatment in a variety of hearing conditions.</li> <li>- Potential complaints and litigation and a risk of loss of contract(s) from misdiagnosis and incorrect treatment.</li> <li>- Loss of UKAS accreditation (UKAS Visit 30th -31st July 2019 West Park removed from scope of practice in part to the ongoing concerns re sound treatment) due to major non-compliance with core standards under the inspection/audit/NICE Guidelines/NSF criteria.</li> </ul> <p>Date of origin: 04/10/12 Approved onto TRR: 11/11/2019 Division approved: 04/10/19</p>	3 x 4 = 12 AMBER	<p>2) Signs are in place in clinical area and corridor requesting silence at all times (May 2017)</p> <p>3) Incident trends being monitored along with any complaints on a monthly basis (May 2017)</p> <p>1) Introduction of insert earphones and Sound Level meters to monitor sound levels (May 2017)</p> <p>4) Noise logs are undertaken during testing - compiled and produced each month (as per UKAS requirements) (Feb 2016)</p> <p>5) Sound level meters calibrated (August 2019)</p> <p>6) 1/3 Octave room measurements undertaken at West Park, to aid in determination of least noisy rooms for testing patients hearing (August 2019)</p>	<p>3) Analysis shows that there are very low levels of reported incidents re: noise disturbance and there have been very few formal complaints over the past 12 months (Jan 20)</p> <p>1-4) Accreditation feedback session Oct16 was very positive and praised team (Jan 20)</p> <p>6) Testing confined to the least noisy rooms (Jan 20)</p>	<p>2) Service unable to guarantee that patients will get an accurate hearing test as noise levels cannot be controlled fully. Informal complaints/comments have been made and recorded (Jan 20)</p> <p>1) Inserts do not provide adequate attention to overcome the issue of the environment (Jan 20)</p> <p>4) Ambient noise levels are too high to be able to perform diagnostic testing accurately (Jan 20)</p> <p>5) Linearity and accurate measurements are achieved at low sound levels (Jan 20)</p>	<p>1-6) Plans for relocation of service to be confirmed</p> <p>1-6) To put in place a combined business case for West Park - 3 booths</p>	Dec-20  Mar-20	1 x 1 = 1 GREEN	Jan-20	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 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 (Nov 19)  1) Monitor monthly performance through the nursing midwifery KPIs reported to QSIG (Nov 19)  1) Environmental Standards are monitored via the environmental group monthly (Nov 19)  1) Daily staffing (safe staffing, Skill mix) is monitored via the Divisional ops meetings (Nov 19)  1) Fundamental standards are reviewed & monitored by the designated specialist groups and bi annually by the sponsor which then reports to COG (Nov 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 (Nov 19)  1) Mortality QI plan is monitored via Programme Board monthly and learning outcomes via MRG (Nov 19)  1) EOL strategy with TOR has been developed and milestones monitored via the EOL group monthly (Nov 19)  1) Monitoring of the Nursing System Framework monthly via TMC (Nov 19)	1) Nursing and Midwifery KPIs are on Health Assure reporting and emailed out to ward sisters/matrons and HoNs monthly. (Nov 19)  1) QRV process is now embedded and refined, plan formulated for ongoing inspections 2019/20 (Nov 19)  1) Lord Carter metrics monitored monthly via Divisional Performance meetings (Nov 19)  1) Divisions monitor performance via monthly Governance meetings (Nov 19)  1) Improved staff survey results (Nov 19)  1) There is a system of nursing audits taking place monthly (Nov 19)  1) There are no Registered Midwife Vacancies (Nov19)  1) SHIMI coming down in lines with national expectation. 1.15 in September 2019 (Nov 19)  1) Nursing Audit data available and reported for July 19 (Nov 19)  1) Verbal feedback from CQCQ is largely positive, all points raised responded to and in action plan (Oct 19)	1) Vacancy rates remain high in Medinine (Nov 19)  1) Safer staffing fill rates remain transient particularly for nights (Nov 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 (Nov19)  1) Registerd Nurse vacancies are 182.03 WTE and HCA 55.35 in October 2019 (Nov 19)  1) CQC final report unpublished (Nov 19)	Develop Mental Health Act training plan and business case  A Mental Health Act Use Policy is in development - being reviewed by independent agency  Draft CQC action plan developed. Update CQC action plan on receipt of the draft CQC action plan.	Feb-20  Jan-20  Jan-20	2 x 2 = 4 YELLOW	Jan-20	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?
					<ul style="list-style-type: none"> <li>1) Monitoring via Quality review visit and re-visit programme to assess CQC compliance (Nov 19)</li> <li>1) NEWS2 implemented Trust-wide (Nov 19)</li> <li>1) Information provided in PIR according to timescales (Nov 19)</li> <li>1) Series of Board development sessions sharing learning from other inspections and risks completed (Nov 19)</li> <li>1) communication of Trust Strategy including visions and values commenced (Nov 19)</li> <li>1) Evidence on PIR triangulated with KLOEs (ONov 19)</li> </ul>					

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)  10) Improvements made to increase space and improve signage (12/19)  1-8) Trust AOS Low risk sepsis service to consider community reviews, daily follow ups and weekend follow ups (12/19)	6) Approx 40% of nurses now trained to take blood cultures (12/19)  1-9) Service Improvement Team undertaking demand v activity v capacity - await outcome (12/19)  7) Positive feedback from patients about the weekly community clinics (12/19)  1-7) Ongoing progress with action plan following process mapping of patient journey (12/19)  1) PEF advert closed - await outcome of interviews (12/19)  1-9) Positive QRV report for Durnall (12/19)  7) Business Case finalised by Group Manager for increased nursing allowing for Community clinics and increased staffing in Durnell (12/19)  1) AOS nurse has undertaken RCA to review 'golden hour' patients. For any patients who do not get antibiotics within the hour (12/19)  9) Utilising Discharge Lounge for appropriate patients (12/19)  1-8) 95% staff to attend sepsis study day and online training - study day 11.06.2019 well attended remainder of staff to be captured (12/19)  1-8) Recruitment successful 2 x AOS Posts (12/19)	7) Overspend for Directorate (12/19)  7) Capacity review means some patients may have to attend hospital every other week (12/19)  6) Approx 60% of nurses still to be trained to take blood cultures. Training postponed (12/19)  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 (12/19)  8) SEPSIS 6 Rolled out in dept reduction in door to needle time compliance and compatability with vitalpac (12/19)  6) Gaps in numbers of nurses trained to take blood cultures (12/19)  10) Decrease in patients treated within "Golden Hour" (12/19)  9) Patients stranded on Durnall Unit after 7pm in month (12/19)  3,4) Staff transfer has been required in this month (12/19)  6) Nurse training on hold (12/19)  1-8) 2 x newly appointed AOS posts will not commence in post until March 2020 (12/19)	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  6) Ongoing training for nurses to take blood cultures- 13/06 on hold until workforce more stable  1) Meeting with estates to access alternative areas to accommodate Durnall day case area. Various options discussed Group Manager to escalate to divisional management  1-9) CQI project underway to review all patient activity  7) 2 Band 8a and a Band 7 to be interviewed  1-8) Directorate to look at transferring services e.g line care in the Community  1-8) Interviews scheduled in December for AOS Lead	3 x 3 = 9 AMBER	Jan-20  Jan-20  Mar-21  Apr-20  Jan-20  Feb-20  Dec-19	Jan-19	

Director	Cross What is the Risk? Ref	Current How are we managing Level of the risk? Risk	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
			<p>3) 70% of staff have attended a chemotherapy course (20/29) (Dec 19)</p> <p>3) Projected percentage of nursing staff 2020 indicates from Jan 2020 @ 45% increasing quarterly to Oct 2020 @ 77% (Dec 19)</p>	<p>3) After the leavers in January 2020, the number of staff attending chemotherapy course will drop to 11/29 = 38% (Dec 19)</p> <p>3) Vacancies 23.51 WTE B5, of wich 9.00 have been recruited and awaiting start date on ward (Dec 19)</p>				

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	4375	<p>(NX87) Heart Centre - Fire Safety:</p> <p>As a consequence of shortfalls in structural fire protection (including emergency lighting) and the recent failure of external ACM cladding, fire could spread both externally and internally throughout the building , compromising life safety.</p> <p>Date of origin: July 2017</p> <p>Date of escalation: Sep 17</p> <p>Risk Lead: Estates and Facilities Divisional Manager</p>	3 x 4 = 12 AMBER	<p>Implementation of a 4 Stage Risk Mitigation Plan; details include</p> <ol style="list-style-type: none"> <li>1) Restricted parking of vehicles to 6m</li> <li>2) Management of waste in the external compound</li> <li>3) Increased security and surveillance</li> <li>4) Augmented Fire Service reponse</li> <li>5) Increased Trust Fire Response</li> <li>6) Additional Fire Wardens trained</li> <li>7) Additional fire exercises and drills</li> <li>8) Review of fire risk assessments (15 completed, local risks managed by Directorates)</li> <li>9) Building &amp; Maintenance risks managed by Estates via Planet FM</li> <li>10) Statutory fire alarm testing (weekly), Fire Damper Testing (Annual)</li> </ol>	<p>10) 0 incidents relating to Reportable Fire's within Dec 2019</p> <p>3) Additional Security Fire Patrols undertaken and recorded</p> <p>9) Priority Planned Preventative Maintenance undertaken</p> <p>2) Waste compound has been relocated</p> <p>7) Third Floor Fire Evacuation Exercise on 31.05.18</p> <p>9) Automatic Fire Detection (AFD) in identified areas has been upgraded with Tri-State Detectors. Areas identified from UwFS</p> <p>10) Break-glass over-ride facility for 3rd floor installed to enable lifts to be used in the event of an evacuation.</p> <p>1-10) Construction work underway in removing ACM cladding. Approx 70% has been removed from outer building. Inner courtyards had been resolved.</p> <p>4) WMFSvisited site, agreed security patrols and WMFS attendance to continue</p> <p>10) 0 unwanted fire signals during Dec 2019</p>	<p>9) Outstanding fire stopping required following compartmentation survey</p>		2 x 2 = 4 YELLOW	Jan-20	

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	<ol style="list-style-type: none"> <li>1. Statutory fire alarm testing (weekly), fire damper testing (annual)</li> <li>2. Departmental Fire Risk Assessments undertaken. Main Theatres frequency increased to 6 monthly due to risk</li> <li>3. Statutory Planned Preventative</li> <li>4. Bespoke Fire Warden Training</li> <li>5. Additional Fire Exercises and Drills</li> <li>7. Revised Management of External Waste in the Compound</li> <li>6. Departmental Fire Warden Daily Checks undertaken</li> </ol>	<ol style="list-style-type: none"> <li>1. 0 incidents relating to Reportable Fire's within Dec 2019</li> <li>3. Fire strategy has been approved and money set aside.</li> <li>1. 0 Unwanted Fire Signals within Dec 2019</li> <li>1. Fire Alarm is being upgraded to L1. Being monitored via Fire Safety Group</li> </ol>	<ol style="list-style-type: none"> <li>2. Compartmentation Survey to be completed</li> <li>3. Operational issues have meant the fire strategy work will take longer to complete with some work on hold</li> <li>1. Fire alarm &amp; ancillary systems do not comply with current regulations</li> </ol>	1. monitor and work towards completion of fire strategy for block	Mar-20 2 x 2 = 4 YELLOW	Jan-20	

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	<ol style="list-style-type: none"> <li>1. Statutory fire alarm testing (weekly)</li> <li>2. Departmental Fire Risk Assessments undertaken</li> <li>3. Statutory Planned Preventative</li> <li>4. Waste Management</li> <li>6. Fire Evacuation Drill taken place on 12th November 2019. Fire drill is on a rolling programme</li> <li>5. Departmental Fire Warden Daily Checks undertaken</li> <li>7. Tugway Safety &amp; Environmental Group commenced May 2018</li> <li>4. Implementation of robust waste management controls to reduce the risk of a fire occurring.</li> <li>7. Basement area (Tugway) now being monitored following the Installation of CCTV.</li> </ol>	<ol style="list-style-type: none"> <li>1. 0 Unwanted Fire Signals - Dec 2019</li> <li>1. 0 incidents relating to Reportable Fire's - Dec 2019</li> <li>2. Combustible items located in the Tugway have been removed. The area is being monitored by Estates Department via the Tugway Group</li> <li>7. Structural fire safety repairs carried out to minimise risk fire spread from the Basement (Tugway) into the building above.</li> <li>7. Implementation of robust management controls</li> <li>4. Environmental Audit Group carry out 3 monthly audits of Tugway</li> </ol>		<ol style="list-style-type: none"> <li>2. Departmental Business Continuity Plans need to be updated</li> <li>6. Develop interim protocols for switchboard and security</li> </ol>	2 x 2 = 4 YELLOW	Jan-20	

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 (01/20)  4-5) Reallocation of staff working well to help reduce wait times during pressured times (11/19)  15) Urgent treatment doctor is making an improvement to patients recieving appropriate emergency treatment (01/20)  1,2,7) Interviews underway for Bd 7 - 2nd cohort interviewed, 3 appointed (11/19)  1,2,7) Plan for Bd 7 to cover Zone A&B during day to be trialled - used intermittantly, but successful when used (01/20)  1) Approval recieved for additional Middle grade posts (11/19)	1, 2) Inability to achieve 15 minute triage consistently breaches mainly in minors, at 1.5hrs at points in month (01/20)  4,5) Staff not always available to be reallocated (01/20)  7) Medical and nursing vacancies and sickness/annual leave resulting in gaps in rota. Link to risk 4496 and 2374 (01/20)  9) UCC minimum impact on pt numbers and delays in assessments (01/20)  7) Continued use of long term locums, overall 5 substantive Cons vacancies(01/20)  1) Inability to achieve 2 hr target in month, significant delays experienced (01/20)  1) Significant number of attendences through ED experienced (01/20)  1,2) Significant increase in number of 8hr waits for first assessments in month due to no beds in Trust (01/20)  ) 12hr wait experience in month (01/20)	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  1-21) LEAN Project (28/06/19 & 19/07/19) to look at processes and flow in Zone B. 2nd lean meeting to be held	Feb-20  Dec-19  Feb-20	1 x 4 = 4 YELLOW	Jan-20	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?
				11) Human factors review completed and resulted in department restructure. All staff provided with human factors training and rapid improvement events [6/3/19]						
				12) Medical and nurse staffing managed via the risk register (risk 2374 & 4496) [5/3/19]						
				13) Nurse led RAT and SOP ratified and in place (5/3/19)						
				14) Where possible, newly qualified starters have their last student placement transferred to RWT ED [5/3/19]						
				15) System in place to ensure that Cat 2 patients are shown red at 15 minutes. Urgent treatment Doctor role developed to see cat 2 patients [5/3/19]						
				16) Use of internal bank rather than locum agencies where possible [5/3/19]						
				17) Extra Triage room and escalation process in place [5/3/19]						
				18) Escalation tool developed and identifies pressure points with agreed action [5/3/19]						
				19) Appointed Specialty Doctor in November 18 (5/3/19)						
				20) GIRFT Visit to be reviewed by end of July (7/19)						

Director	Cross What is the Risk? Ref	Current How are we managing Level of the risk? 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)						

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Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	4528	If Clinical Web Portal does not contain full copies of patient's notes/health records (if seen before 2013) as well as all Paediatric admissions/Badgernet information then clinicians will only have access to an incomplete health record for inpatient and outpatient encounters. Lack of a comprehensive record may impact on the accuracy and/or timeliness of clinical decision making. NHSI link NE's to lack of complete clinical records in OPD clinics.  Date of origin: 29/04/16  Date of escalation = 17/05/16  Risk Lead: Div 1 Deputy COO	4 x 3 = 12 AMBER	1. Ability to request paper notes (May 16)  2. Process for both access to patient records as well as the process for when there is a need to have a complete patient scanned has been circulated by Patient Access (Dec 16)  3. Badgernet System in place in Maternity (Feb 19)	1. No continuous Datix incidents (Jan 20)  3. The Badgernet System remains embedded within the Maternity department (Jan 20)  2. Procedures continue to be in place to access paper records/request scanning of records onto portal (Jan 20)	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 (Jan 20)  1. Records are not always available for elective clinics, even if they are available this creates a time lag within the clinic (Jan 20)  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 (Jan 20)  3. Restricted access to the Badgernet System - no immediate access to Maternity notes (Jan 20)  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	May-20 2 x 2 = 4 YELLOW	Jan-20	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 clinicians 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 CP50 SOPs for results reporting are completed for Div 2 &3. Div 1 to provide status of completed SOPs.  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  (1-4) Aim is to achieve full compliance with mandatory reviewing and filing of results with audit of compliance by Directorate and Consultant.	Jan-20  Feb-20  Feb-20  Feb-20	x =	Jan-20	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?
					<p>6) Small increase in filed results from 20% to 23% (74% unfilled) 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)</p> <p>6) From 23/9/19 Histology results available on ICE only. Only historic Histology results are viewable via TD Web. (Oct 19)</p> <p>(1-4) A current position on completed CP50 (Results Reporting) local SOPs is received for Divisions 3 and 2 and in progress within Division 1. (Jan 2020)</p>					

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?	
Chief Operating Officer	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 (5 in place) (Jan 2020)  4) Review meetings are happening fortnightly (Jan 2020)  1), 5) & 6) Backlog against a backdrop of increased referrals has reduced from 7332 May 2017 to less than 6275 in December 2019 (Jan 2020)  3) Office space sourced (Jan 2020)  1) The backlog is actively monitored by Group Manager (Jan 2020)	1) Approximately 6275 non-urgent imaging studies unreported December 2019 (inclusive of 713 CT scans and 2708 MRI scans). Over 20 days there are 3257 in total (inclusive of 458 CT scans and 1599 MRI)  1) Poor patient experience if patients and doctors are unsure when their scans are reported (Jan 2020)  3), 4), 5) & 6) Demand for reporting imaging studies is higher than expanded reporting capacity (Jan 2020)	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	Mar-20  Mar-20	2 x 4 = 8 AMBER	Jan-20	Yes

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?	
Chief Operating Officer	4706	<p>If longstanding maintenance continues to be a challenge around infrastructure/environment in Nucleus Theatres, which includes:</p> <ol style="list-style-type: none"> <li>1. Sewage - usually in the form of water leaking through ceilings</li> <li>2. Electrical infrastructure - emergency power back-up in theatres</li> <li>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)</li> <li>4. Operating lights - (Theatre 7 require light replacement - July 2019 awaiting delivery Jan 2020)</li> <li>5. Air-flow/ventilation - (addressed)</li> <li>6. Storage - not enough dedicated storage space in theatres for equipment and consumables (addressed)</li> <li>7. Insect infestation - flies and bugs being seen in theatres - (addressed No incidents reported 01/01/19 to 08/01/20)</li> </ol> <p>Then, this could result in patient (and staff) safety being compromised, non-compliance with external regulations and/or internal standard/ audits and also adverse media publicity and increasing number of raising concerns via local policy.</p> <p>Date of origin: Feb 17 Date of escalation to Divisional Management: Sep 17 Risk Lead: Critical Care Group Manager</p>	4 x 3 = 12 AMBER	<ol style="list-style-type: none"> <li>1. Existing programme of theatre works in place (3 phase refurbishment is underway - expected completion is August 2020). Stage 1 completed, started Stage 2 - Phase 1 (Dec 2019)</li> <li>2. All leakage/flooding/insect infestations incidents reported to management are immediately escalated to Hotel Services</li> <li>3. Theatre 5 was closed for refurb between April 17 - Oct 18 - This is now open and is fully utilised.</li> </ol>	<p>1 - 7 No procedure cancellations due to any of the above issues for 12 months (Jan 20)</p> <p>1 - 2 x reported incident of Sewage ingress/water leaks since May 2019 - Sewage leak reported January 2020(Jan 2020)</p> <p>2 - 1 x reported incident of power outage or back-up power failure in Theatre 7 during August 19 - no further reports (Jan 20)</p> <p>7 - No reported incidents of insect infestation for last 12 months (Jan 20)</p> <p>1. Work completed for fire compartmentalisation in clinical areas (Jan 20)</p> <p>1. Storage reconfiguration has been completed (Jan 20)</p> <p>1. Replacement of mainboards for Theatres 3,4,5 and non-clinical areas (Jan 20)</p>	<p>3) 3 x recent incidents of fire alarms sounding in theatres - of unknown cause between 01/01/19 and 15/08/19 - no further incidents reported (Jan 20)</p> <p>2) 1x Sewage leak behind Theatre 5, from the ward toilets in January (Jan 20)</p>	<p>1 - 4. Reconfiguration of Theatre reception continues. Stage 2 underway.</p>	Mar-20	2 x 1 = 2 GREEN	Jan-20	

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	5031	<p>If sub-optimal staffing (reduction in 39%) continues within the Ultrasound Scan Department, then it will impact on required compliance with national screening standards - this includes submitting the required data and proving quality of work is assessed continually for obstetric patients. Neonatal hip and cranial scans also need to comply with national standards and this may be affected. Training will also be impeded affecting the future of service provision. There may be a rise in litigation cases and disability, amongst other issues.</p> <p>Date of origin: 17/05/18 Date of escalation: 05/09/19 Risk Lead: Head of Midwifery</p>	3 x 4 = 12 AMBER	<p>1) Dating and Fetal Anomaly scans are given priority over Gynaecology scans to ensure women have their scans performed in accordance with the national programme standards. 9/4/19</p> <p>2) Community Midwives have the facility to telephone the Maternity Unit and organise an urgent priority scan if a woman is thought to have booked late (9/4/19)</p> <p>3) Midwife Sonographers in fetal medicine (FMU) are being asked to assist with scanning both obstetric and gynae scans in the main scan department when staffing in FMU allows (9/4/19)</p> <p>4) Staff in Maternity Scan Dept. are continually reviewing their staffing levels to escalate their concerns appropriately (9/4/19)</p> <p>5) Agreement for sonographers to volunteer to run weekend clinics and extended days to increase available scanning slots. (09/04/2019)</p> <p>6) Current adhoc support from midwife sonographers enables the sonographers to undertake hip, cranial and emergency gynae scans which have been prioritised. (9/04/2019)</p>	<p>1-4) There are no reported incidents whereby a woman has missed the opportunity to have her dating or anomaly scan as a direct result of sub standard staffing within main scan (8/11/19)</p> <p>1-3) The Antenatal Screening Coordinator (Midwives) has not received any notifications from any community midwives to inform of missed antenatal screening (8/11/19)</p> <p>1-15) Prioritisation of urgent patients, e.g., ectopics from ward and EPAU (8/11/2019)</p> <p>1-15) Patients may be admitted to ward if unable to perform scan and confirm diagnosis (8/11/2019)</p> <p>1-15) Currently, due to the prioritisation of work, sonographers are attempting to perform scans within standards stipulated for babies and mothers.(8/11/2019)</p> <p>11) Staff have worked additional hours on the enhanced rate (8/11/19)</p> <p>1-15) Still working weekend sessions to keep hip scans within 6 weeks (8.11.19)</p> <p>1-15) Currently, all obstetric patients are being offered screening and anomaly scans within the screening standard and no incidents have been reported (8/11/19)</p>	<p>1-4) Datix incident reports have been received concerning staff shortages resulting in no scan service in the EPAU - none received since 07.01.19 (8/11/19)</p> <p>15) Whilst weekend clinics are ensuring hip scans are not breached, there are still a number of gynae women who are not scanned within the national standard for emergency gynae fast track.(8/11/2019)</p> <p>11) There remains a vacancy for a dedicated sonographer Manager. (8/11/19)</p> <p>1-3) Whilst patients aren't missing screening there have been incidences where women have not been offered the combined screening (Downs, syndrome, Edwards and Patau syndromes) at 11+2 - 14+1 weeks gestation which is the optimal screening test. Patients have gone on to have the QUAD test which is a less accurate screening test and is for Downs syndrome screening only (8/11/19).</p>	<p>1) Increase staffing of sonographers in main scan Dec-19</p> <p>2) Resolve HR issues Dec-19</p> <p>1) Re-advertise for permanent sonographers Dec-19</p> <p>1) Ultrasound Superintendent Manager to be advertised and recruited. Apr-20</p> <p>1) Further training of midwife to undertake full sonography role Jun-20</p>	1 x 3 = 3 GREEN	Jan-20	



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

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Medical Director	5045	<p>Sepsis and severe infection are perhaps the most common reasons for admission to hospital and cause of inpatient deterioration.</p> <p>If patients do not receive high quality and timely sepsis care through detection, recognition and management of the deteriorating patient then patient harm or death could result.</p> <p>Date of origin: Jun 18</p> <p>Date of escalation: Jun 18</p> <p>Risk Lead: Medical Director</p>	4 x 3 = 12 AMBER	<p>4) Training staff in the recognition and management of sepsis - ongoing monitoring.</p> <p>2) Early warning systems for paediatric, maternal and adult patients assist in the detection of deteriorating patients - many of whom will have sepsis.</p> <p>3) Sepsis screening tools exist for paediatric, maternal and adult patients who deteriorate and may have sepsis. Optimal utilisation of these tools help reduce the mortality and morbidity from sepsis.</p> <p>1) A trust antimicrobial guideline has been developed to advise appropriate antibiotics for given indications. This is available as an app and on the intranet and is subject to audit.</p> <p>5) Two sepsis nurses have been recruited (1 band 7 and 1 Band 6) (Feb 19)</p> <p>6) Vital PACS upgrade with sepsis module have been implemented on 28th March. Captured data will measure compliance and improvement in identification and timely management of sepsis.</p> <p>7) Weekly sepsis report is being forwarded to all directorates and the performance will be discussed at QSIG meeting and at the Governance meeting.</p>	<p>4) Mandatory training compliance in IP and Sepsis is monitored at directorate governance</p> <p>2) Early Warning Score audit compliance. Auditing medical records to ensure the processes of detection, recognition and management of deteriorating patients is robust with feedback of performance to directorates and the development of action plans to achieve compliance</p> <p>3) Compliance with sepsis screening and sepsis 6 delivery. Auditing the use of the sepsis screening tool and delivery of the sepsis 6 with feedback of performance to directorates and the development of action plans to achieve compliance</p> <p>1) Antimicrobial prescribing compliance. To ensure that antimicrobial prescribing is compliant with trust guidance and that antimicrobials are reviewed to reduce antimicrobial resistance</p> <p>4) LBR training funding for 19/20 is risk prioritised and includes Intermediate Life Support, Neonatal Life Support, Advanced Paediatric Life Support, ALERT training, ALS, Non Medical Prescribing etc. (May 19)</p>	<p>4) Mandatory training performance report.</p> <p>2) Non-Compliance with EWS audit.</p> <p>1) Non-compliance with Antimicrobial audit.</p> <p>5) Currently we have three sepsis nurses ( last appointment Nov 2019). One of them is currently on maternity leave.</p>	<p>Conducting regular sepsis compliance audits in ED, Inpatients, Haemat-oncology, Paediatrics and Obstetrics. The results of these are fed back to the DPG monthly.</p> <p>Regular QIP projects to improve the delivery of sepsis screening, awareness and antibiotic delivery within an hour in patients with sepsis or suspected sepsis. This will also help identify any barriers that influence the uptake of the sepsis screening.</p> <p>Generating weekly sepsis report from sepsis module and sharing it with the directorates. (Sep 19)</p>	x =	Jan-20	

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Medical Director	5182	<p>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.</p> <p>Date of origin: 11/03/19</p> <p>Date of escalation: 25/03/19</p>	4 x 4 = 16 RED	<p>1. Vascular support in place for TAVI (Mar 19)</p> <p>2. Monthly aortic MDT occurring at RWT (Mar 19)</p> <p>3. A regional meeting took place in September 2019 to discuss the regional aortic dissection rota and RWT will be a part of this rota (Oct 19)</p> <p>4. 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 (Oct 19)</p> <p>5. Email sent from Professor Cotton on 8.12.19 to Dr Odum raising concerns over the current status of the TAVI service, with particular reference to "acute on chronic" problems gaining appropriate vascular cover (Dec 19)</p>		<p>1-2 Frozen Elephant Trunk (FET) Device is not yet approved (Nov 19)</p> <p>1, 2, 5. From May-Oct 19 there have been 3 x TAVI lists cancelled due to lack of vascular cover (Nov 19)</p>	<p>1-2. To seek further evidence to enable approval of FET device.</p> <p>3, 4. A further regional meeting to confirm the workings of the rota etc is planned in November 2019.</p>	<p>Dec-19 2 x 2 = 4 YELLOW</p> <p>Nov-19</p>	Jan-20	

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 review patients by the date the doctor has requested. If there continues to be inadequate capacity then this may result in patient harm due to delays in further diagnosis and treatment if required.	4 x 3 = 12 AMBER	<p>2. Consultants and ANP's being offered WLI rates/overtime to do additional clinics in areas where there are a particularly large number of patients overdue their review appointment</p> <p>3. As we use partial booking the review appointments are actively managed and not booked up too far in advance so if a patient contacts the Directorate with any concerns we are able to give them an appointment within a reasonable timescale and will speak to the consultant about overbooking if a patient needs to be seen urgently.</p> <p>4. Patients on FU OWL are validated by the FU OWL coordinator to ensure that they are appropriately booked so that slots aren't wasted</p> <p>5. Assistant Directorate Manager regularly reviews slot utilisation report to ensure that all review slots are used</p> <p>1. Recruitment Strategy in place</p> <p>6. We are adding an additional box to the RTT form so that Consultants can indicate if a patient needs to be seen by a specified date.</p> <p>7. We are asking the Registrars to review patients who are red on follow-up OWL starting with the Consultants who have the most to pull out clinically urgent.</p>	<p>2. Extra clinics continue to run when consultants/ANPs agree to do so (Jan 20)</p> <p>3. Partial booking process remains in place (Jan 20)</p> <p>4 &amp; 5. Deloitte's KPI report showed high level of slot utilisation for review clinics (Jan 20)</p> <p>1. Appointed a new EP Consultant due to start 20 January 2020 (Jan 20)</p>	<p>2, 4, 5. Numbers of review patients on FU OWL and overdue continuing to rise despite additional clinics and other controls (Dec 2019)</p> <p>1-7. Red FU OWL = total waits 2872 (14.01.2020) the patient is overdue their appointment (Jan 20)</p> <p>1-6 Amber FU OWL = total waits 687 (14.01.2020) the patient will be due their appointment within the next 6 weeks (Jan 20)</p> <p>1-5 Green FU OWL = total waits 2403 (14.01.2020) the patient is due their appointment in more than 6 weeks (Jan 20)</p>	<p>1. Extra consultant posts being recruited into to increase OP capacity across whole of cardiology</p> <p>2-7. Review capacity and demand.</p> <p>1-7. A further business case will be required which is in line with years 2-3 of the 10 year plan.</p> <p>6,7. Arrange a review of the long waiters/urgency in the first instance by one of the middlegrades using notes on portal and arrange for any clinically significant patients to be seen.</p> <p>6,7. Identify patients that do not require a Consultant review for a pacemaker check to ease waiting list times</p> <p>2. Monthly meeting with Arrhythmia Nurses/Cardiology ANP to undertake additional clinics to support.</p> <p>3,5,6,7. Pooling internal referrals for EP</p> <p>1. Locum Consultant appointed due to backlog of patients. They have been asked to do 5 clinics a week which should help the situation.</p> <p>1. Band 7 Arrhythmia Nurse advertised.</p>	<p>Feb-20</p> <p>Feb-20</p> <p>Nov-19</p> <p>Nov-19</p> <p>Sep-19</p> <p>Dec-19</p> <p>Dec-19</p> <p>Dec-19</p>	<p>4 x 2 = 8 AMBER</p>	<p>Jan-20</p>	

Director	Cross Ref	What is the Risk?	Current How are we managing 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?
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Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?	
Chief Operating Officer	5243	<p>If there continues to be fragility of the Trust's ability to deliver the Breast Service to within national standards, then this may lead to delayed diagnosis and treatment of cancer and failure to meet national cancer targets, resulting in patient harm and an adverse impact on substantive staffs health &amp; wellbeing.</p> <p>Created: 14/06/19 Accepted onto Divisional Risk Registers (1 and 3): 23/09/19 Accepted onto Trust Risk Register: 04/11/19</p>	3 x 4 = 12 AMBER	<p>1. Twice weekly reports from Fast Track team re outstanding referrals v available capacity (June 19)</p> <p>3. Communication put on ERS for GPs to advise patients that wait is longer than 14 days (June 19)</p> <p>4. Regular backfill of cancelled sessions (due to annual leave, study leave, on-call and post on-call time off) where possible (June 19)</p> <p>5. Saturday clinics when possible (Sept 19)</p> <p>7. Weekly PTL meeting (June 19)</p> <p>6. Agenda item at weekly performance meeting (June 19)</p> <p>8. Monthly Cancer Recovery Meeting and associated action plan shared with external stakeholders</p> <p>9. Additional Radiologist capacity in place with locums (November 19)</p> <p>10. Advanced Practitioner Radiographer in post (Dec 19)</p>	<p>11. Divert to Dudley and Walsall remains in place; closer working with Walsall (January 2020)</p> <p>5-6. Saturday clinics are having a positive impact (October 19)</p> <p>11. With agreement of the STP on 10/10/2019 we will turn off the diversion to Walsall from GP surgeries who are greater than 1 mile but less than 3 miles so only referrals from GPs within 1 mile additional travelling distance will be diverted. The status quo remains for Dudley (Oct 19)</p> <p>1-12. As at the 09/01/20 the Trust has capacity to see patients within 14 days (January 2020)</p>	<p>1. Continued pressure on workload due to increased referrals (January 2020)</p> <p>3. Inability to be assured that GPs are sharing this information with patients and or providing reassurance/referral elsewhere (patient choice) (June 19)</p> <p>4. Not always possible due to other elective commitments e.g. operating and due to the 'spread' of capacity throughout the week. Continued provision is unsustainable for the existing workforce (June 19)</p> <p>7. Reporting mechanism only (June 19)</p> <p>1-12. Breaching the initial 2/52 target by such an extent that achieving the subsequent targets for treatment is challenging (January 2020)</p> <p>9. Additional Radiology capacity is locum / non-substantive so potentially fragile (Sept 19)</p> <p>11. Not known how long the GP referral divert can be sustained (Sept 19)</p> <p>1-12. No control over external factors potentially influencing national referral increase (Sept 19)</p>	<p>1-8. Explore options to secure Clinical Fellows from India</p> <p>9. Recruit Consultant Radiologist - one candidate in negotiation (November 2019)</p> <p>4. Review pathway for patient's with pain. Joint working with EAG / CCG re criteria and initial GP management</p> <p>Implementation of new referral form and pain pathway across the West Midlands with an anticipated referral reduction of 15% (January 2020)</p> <p>Business Case for Consultant Nurse (Breast) to be presented to Division (January 2020)</p> <p>Introduction of stratified follow up of Breast patients with associated workforce (January 2020)</p>	2 x 1 = 2 GREEN	Jan-20 Jan-20 Jan-20	Jan-20	

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				<p>11. Following the implementation of the divert agreement with Dudley and Walsall, backlog numbers and day booking to are being monitored across all 3 Trusts; If any of the Trusts see an increase in either backlog or day booking to, the divert will be reviewed accordingly to maintain equitable waiting times across the STP (Nov 19)</p> <p>12. 1-8. Breast symptomatic patients to be subject to 1 DNA and no further appointment sent. Cancer suspicious patients to be subject to 2 DNA's. Fast track are ringing the patients to negotiate the appointment and to remind them to attend. (Sept 19)</p> <p>13. STP/ NHSI agreement that waiting times across the Black Country should be equitable (Nov 19)</p>						

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	5246	If there is insufficient Consultant cover for H&N, colorectal, sarcoma, gynaecology 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 and Russell's Hall, delays in treatment, inability to achieve cancer targets and increased workload/stress for existing Cons staff.	4 x 4 = 16 RED	<p>1) Palliative Consultant Radiologist reviewing Palliative care patients (07/19)</p> <p>2) Prioritisation of existing patients (07/19)</p> <p>3) On- going monitoring of service performance against national cancer targets (07/19)</p> <p>4) Clinical Director trained in managing thyroid cancer patients (07/19)</p> <p>5) 104 day harm reviews to identify harm (09/19)</p> <p>6) Senior Clinical Fellow programme is providing support to the existing service</p>	<p>6) Senior Clinical Fellows are being supported through the CESR programme (12/19)</p> <p>2&amp;3) Discussions are ongoing with other healthcare providers (12/19)</p> <p>5) No harm identified from 104 day reviews (12/19)</p> <p>6) Senior Clinical Fellows continue to provide significant support to service (12/19)</p> <p>4) Dr who manages thyroid cancer patients will return from sabattical in Feb 20 (12/19)</p>	<p>1 &amp; 4) Consultant consistently raising concerns regarding lack of cover during periods of leave (12/19)</p> <p>3) The service is severely compromised in its ability to provide adequate clinic appointments at the end of the 62 day target pathway (12/19)</p> <p>1-6) Currently no appropriate locum cover available (12/19)</p> <p>1, 2, 4) Increase in number of medical staffing incidents on Datix (12/19)</p>	<p>1-4) Formalise competencies in the current Clinical Fellowship programme to identify medical staff of suitable calibre</p> <p>1-6) Identify locum Cons cover</p> <p>1-4) Work with Dudley to standardise the discharging process and subsequent radiotherapy referrals</p> <p>1-6) Discussions ongoing with SATH specifically including brachytherapy</p> <p>1-6) Discussions with SATH and UHNM with regards to brain and gynae service provision</p> <p>6) Senior Clinical Fellow job plan to be reviewed to provide support to existing gynae Cons</p>	<p>Feb-20</p> <p>2 x 4 = 8 AMBER</p> <p>Dec-19</p> <p>Dec-19</p> <p>Feb-20</p> <p>Jan-20</p> <p>Jan-20</p> <p>Jan-20</p>		



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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.	4 x 3 = 12 AMBER	<p>2. 1 x CFM machine available and 1 x loan machine is currently in place (Dec19)</p> <p>4. Local printer set up to one CFM for printing of CFM trace (Dec19)</p> <p>3. Fast track charger available for failure during recording (Dec19)</p> <p>1. Current situation awareness for all Consultants and Senior nursing team (Dec 19)</p> <p>5. Directorate undertaking a trial of 2 x different machines in order to identify the preferred product (Dec 19)</p>	5. Directorate have trialled the inspiration CFM. The other provider has not been evaluated (Jan 20)	1-3) There is no assurance with the current set-up (Jan 20)	<p>1-5) Replace existing equipment</p> <p>1-5) Business Case to be presented to support replacement of equipment</p> <p>1-5) Trial to be undertaken of 2 x different machines by both companies which will then inform the Business Case as to preferred product</p>	Apr-20  Mar-20  Feb-20	1 x 1 = 1 GREEN	Jan-20
Accepted onto TRR: 16/09/2019										

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 Financial Officer	5253	Dell Latitude tablet computers were purchased for use on ePMA wards to enable drug rounds. Significant numbers have been damaged around the charging ports and are either difficult to charge and/or rendering the device unchangeable. The supplier has identified excessive use in a ward environment and the fact that they are not used on a one user to one device basis as the root cause. The supplier has therefore stated that these device failures are not supported under the 3 year warranty because the damage is due to user misuse. The devices are vital to administering drugs at the patient's bedside. If insufficient devices are available the wards will have to use computers on wheels or desktops for administration. This would be acceptable for business continuity in the short term whilst Wi-Fi issues are resolved however for unspecified and ongoing durations it introduces significant risks. The risks are that patients may receive the wrong drugs or doses.	4 x 3 = 12 AMBER	<p>1) Continue to attempt to send devices to Dell for repair (June 19)</p> <p>2) Extra kit re-purposed for deployment as EPMA tablets (36 additional devices) (June 19)</p> <p>3) Magnetic adapters used on new devices to relieve pressure on charging ports and help durability of devices.(June 19)</p> <p>4) Redeployment of kit (June 19)</p> <p>5) Trial is running using alternative Getac tablet devices in 3 clinical areas for 8 weeks until Oct 19, currently going well</p> <p>6) IT to raise business case for requirement of further devices in all clinical areas</p> <p>7) 100k of IT funding re-directed towards this pressure</p> <p>8) 72 GTAC new and robust mobile tablet devices have been ordered as outcome from a successful pilot which was mainly targeted at ePMA usage</p>	<p>2) Extra kit re-purposed for deployment as EPMA tablets (36 additional devices) (June 19)</p> <p>3) Magnetic adapters used on new devices to relieve pressure on charging ports and help durability of devices.(June 19)</p> <p>7) Pilot outcomes proved positively the likes of battery time, usability of devices, robustness of hardware and Wi-Fi connectivity.</p>	<p>1) Not all devices will be fixed under warranty</p> <p>2) Durability of devices still questionable and even replacements exhibit same weaknesses as those devices which are being replaced. Eventually we will run out of replacement devices</p> <p>3) May provide some additional durability to new devices being redeployed but will not provide any durability to devices already weakened by use.</p> <p>4) Has reduced overall number of devices on each ward.</p> <p>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)</p>	<p>2) Identify funding to procure replacement devices. Sufficient devices are required to mitigate issues based on current reduction in numbers.</p> <p>2) Procure additional devices and build for deployment.</p> <p>4) Monitor number of replacement devices available and report count to Head of Technical Services, Dell have been able to repair and return some devices (Sep 19)</p> <p>5) Once trial ended to gain agreement from clinical areas and IT to go ahead with new Getec devices</p> <p>5) IT to work on a roll out plan</p> <p>6) IT to raise business case for further devices</p> <p>7) The devices arrive onsite end of this month and build/ deployment will commence through-out December to target those wards</p>	<p>Oct-19 4 x 1 = 4 YELLOW</p> <p>Oct-19</p> <p>Oct-19</p> <p>Oct-19</p> <p>Nov-19</p> <p>Nov-19</p> <p>Dec-19</p>	<p>Jan-20</p>	

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Chief Operating Officer	5284	<p>If the issues relating to EPMA are not resolved then healthcare professionals involved in the prescribing and administration of medicines may not be able to prescribe or administer medicines in a safe or timely manner. As a consequence this may result in patient harm due to incorrect prescribing or administration of medicines, or missed or delayed doses. The issues relating to EPMA that contribute towards this risk can be categorised into:</p> <p>Lack of functionality or errors associated with the software. 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. An inadequate business continuity solution. 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] Updated 19.12.19 on request of the EPMA Steering Group to specifically include risk related to inadequate business continuity.</p>	4 x 3 = 12 AMBER	<p>1. There is an EPMA Steering Group chaired by the Medical Director which provides Executive level oversight and strategic direction for EPMA. (Aug 19)</p> <p>2. Establishment of the EPMA Operational Group to address the issues with EPMA. This group reports into the Steering Group and links with the Trust Medicines Management Group. (Aug 19)</p> <p>3. A meeting was held with the system suppliers Emis to secure ongoing engagement to resolve system issues 10.7.19. List of priority system issues was presented to Emis. (Aug 19)</p> <p>4. A list of priority system issues has been produced by the EMPA Steering Group. (Aug 19)</p> <p>5. An assessment of all Datix relating to EPMA since go-live has been produced and will be shared with the Steering Group and Operational Group in August. This will continue to be monitored and reported on. (Aug 19)</p> <p>6. A business case for additional resource to support EPMA has been approved and the posts are being recruited to (Datix 5204), this includes additional posts to support training.. (Aug 19)</p>	<p>1. The EPMA Steering Group meets monthly and minutes are available. (Oct 19)</p> <p>2. The first meeting for the EPMA Operational Group is scheduled for September. A Chair has been appointed. (Oct 19)</p> <p>4. Emis has responded in writing to the priority list and will be undertaking a site visit in September. (Oct 19)</p> <p>5. Datix reports relating to EPMA are monitored monthly. (Oct 19)</p> <p>6. The business case is approved and posts being recruited to. (Oct 19)</p> <p>9. Emis are actively managing the intermittent issue where the system freezes and this is preventing it from occurring. (Oct 19)</p>	<p>5,6. User error is a cause of incidents reported via Datix, this could be improved with better training for EPMA. (Oct 19)</p> <p>7. Hardware is being reported as broken and monies need to be identified to replace. (Oct 19)</p> <p>5. The Datix assessment shows 231 incidents directly relating to EPMA March 18 - July 19. System user errors are the greatest source of incidents (121 reports). There is 1 report of moderate patient harm, 64 reports of no patient harm and 166 reports do not have harm recorded. (Oct 19)</p> <p>4,9. System down time is still occurring (need to add report of incidence). (Oct 19)</p> <p>4,9. No issues on the priority list have been resolved. (Oct 19)</p> <p>1,2. The Medical Director is receiving complaints from Consultants regarding EPMA. (Oct 19)</p> <p>7. IT report that 90 devices have been returned to IT as not working. Reports that nursing staff not using EPMA hardware and are using desktop PC's. (Oct 19)</p>	<p>Business case for IT hardware support</p> <p>Review and improve user training</p> <p>Replace broken hardware</p> <p>Upgrade software</p> <p>Develop SOP's to support user guide</p> <p>Address PAS issues impacting on ePMA</p> <p>Write a business case for additional BC machines</p> <p>Review BC SOP's and agree actions to be taken when EPMA is unavailable</p>	<p>Feb-20</p> <p>Feb-20</p> <p>Jan-20</p> <p>Apr-20</p> <p>Feb-20</p> <p>Jan-20</p> <p>Feb-20</p> <p>Feb-20</p>	1 x 3 = 3 GREEN	Jan-20	

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		<p>7. IT are undertaking a trial of alternative hardware solutions and requesting that wards report all hardware issues to IT. (Aug 19)</p> <p>8. The Medicines Management Group and Steering Group approved an SOP which means that EPMA will not be used for day case surgery and will not be used on admission for elective surgery. This will be reviewed if Emis can make system changes to improve the use of EPMA in patients following the surgical pathway. (Aug 19)</p> <p>9. There is an issues (hazards log) which records all EPMA issues and actions. This is maintained by the EPMA Team and managed by the EPMA Operational Group. (Aug 19)</p> <p>10. The EPMA Steering Group has agreed not to extend the current EPMA system to new areas until current issues are resolved. This means it will not be extended to paediatrics, neonates and maternity at the current time. (Aug 19)</p>						

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Chief Operating Officer	5308	If waiting list indicative sessions (WLI) reduce as a result of pension changes then waiting list times for outpatients and elective surgery will increase, planned outpatient sessions and theatre sessions will go unutilised resulting in delays to patient care and a reduction in patient income.  Approved by Division 1: 11/10/2019 Accepted onto TRR: 11/11/2019 Accepted onto Division 3: 13/01/2020	3 x 4 = 12 AMBER	2. Areas where this is considered high impact are considering use of locums (Oct 19)  1. Consultants are still being requested to run waiting list initiatives (Oct 19)  3. Theatre utilisation is being monitored and existing sessions are being actively managed (Oct 19)  4. Shared Business Authority are advising all employees who are potentially impacted by the pension changes (Oct 19)  5. SHS Ltd are providing additional Dermatology capacity (Jan 20)	3. OTEG monitors trust wide session utilisation (Jan 20)  1. Waiting List initiatives are still being undertaken (Jan 20)	4. Letters received week commencing 30th Sept 2019 (Jan 20)  3. Some specialties could improve session utilisation (Jan 20)  2. T&O Directorate reviewing funding for locum (Jan 20)  1. Unable to determine where WLI are declined the reason they are being declined (Jan 20)  1-4. In year 18/19 approx.3817 waiting list sessions were completed, in year 19/20 the full year equivalent based on a extrapolated basis is 3236 WLI a decrease of 581 if this continues (Jan 20)	1. Request further information from directorates where WLI are declined.  2. Secure funding for recruitment of Locum to replace WLI  3. Introduction of theatre scheduling meetings  4. Directorates to present impact assessment to divisional management team.  1-4. Develop a corporate action plan that will provide choices and advice to clinicians with regard pension and tax implications  5. Revisit activity modelling assumptions and workforce requirements for future service model	Feb-20  Feb-20  Feb-20  Feb-20  Mar-20	2 x 2 = 4 YELLOW	Jan-20	
Chief Operating Officer	5315	If the only permanent Consultant Microbiologist at DGFT Microbiology is unexpectedly off work then clinical cover will be from a Locum based at DGFT and supported from Microbiologists from RWT who already have vacancy due to the retirement of a Consultant Microbiologist in March 2020. Resulting in delayed support to clinicians which may adversely affect patient management.  Accepted onto TRR: 04/12/2019 Accepted onto Divisional RR: 13/11/2019	4 x 3 = 12 AMBER	1. Currently there are two full time posts for Microbiologists providing a consultant service for the Microbiology Department at DGFT (Nov 19)	1. The recruitment process has begun to fill the vacant consultant Microbiologist post, in the interim a locum is providing some support RWT have agreed to support the on-call consultant service at additional cost. (Jan 20)  1. Additional locum appointed when substantive Consultant absent (Jan 20)  1. Provision to support clinical service at DGFT by Microbiology Consultants based at RWT (DGFT) (Jan 20)  1. On call/ weekend roster planned in advance (Jan 20)	1. Limited contingency in place for loss/absence of the only permanent full-time consultant Microbiologist at DGFT (Jan 20)  1. There is only one full-time post filled and one vacant post at DGFT, with a locum providing some cover (Jan 20)  2. Potential delay in Andrology clinical interpretation (Jan 20)	1. Recruit Microbiology Consultant  1. BCPS microbiology service consolidation	Jan-20  Mar-21	1 x 4 = 4 YELLOW	Jan-20	

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Chief Operating Officer	5316	<p>The Ophthalmology department has a backlog of paediatric and adult patients awaiting squint surgery. This has occurred due to a combination of:</p> <p>(a) the Trust's decision to move paediatric surgery from Beynon Centre theatres to Nucleus theatres in 2017.</p> <p>(b) the subsequent retirement of the Occular-motility Consultant (with no other consultant able to carry out this type of surgery for paediatric or adult patients)</p> <p>(c) a lack of paediatric bed capacity on the Paediatric Ward on the allocated day of Ophthalmology surgery in Nucleus theatre. I</p> <p>If the department is unable to access sufficient beds on a weekly basis for paediatric surgery and remains unable to recruit to the Occular Motility vacancy, then both paediatric/adult waiting list will continue to rise and could result in waiting list breaches and financial penalties for the Trust.</p> <p>Accepted onto Divisional RR = 11/12/2019 Accepted onto the TRR = 02/01/2020</p>	4 x 3 = 12 AMBER	<p>5. Insource services from SHS to carry out paediatric and adult squint surgery in order to reduce waiting lists.</p> <p>4. Recruitment of Occular Motility Consultant</p> <p>3. Nucleus theatre team offer Ophthalmology team theatre session cancellations.</p> <p>2. Weekly activity review meeting with Patient Access team to discuss waiting lists and strategy</p> <p>1. Practice Manager monitors weekly PTL data to ensure patient waiting times do not breach</p> <p>6. Seek Trust approval to continue utilising services of SHS private organisation to carry out paediatric and adult squint surgery at New Cross Hospital</p> <p>7. Prioritise longer waiters to ensure no clinical implications for patients and decrease the risk of breaching and financial implications to the Trust</p> <p>8. Accept available nucleus theatre slots when paediatric beds/nursing staff are available.</p> <p>9. Recruitment of Paediatric Consultant Ophthalmologist</p> <p>10. Theatre allocation of 8 beds and regular paediatric theatre session</p>	<p>1-10. No complaints or concerns raised (Dec 19)</p> <p>1. Closely monitoring waiting list to avoid 52wk breaches (avoided 2) (Dec 19)</p> <p>9. Appointment Paediatric Consultant Ophthalmologist, due to start 2020 (Dec 19)</p> <p>10. Allocated regular paediatric Monday theatre slot with 8 beds (Dec 19)</p>	<p>1. Monitoring of waiting times will identify long waiters and identify increased waiting times, but waiting times still rise if no theatre slot available or consultant unavailable to carry out surgery (Nov 19)</p> <p>2. Waiting times still rise if no theatre sessions available and no consultants to operate. In addition patients may be unable to attend for surgery at short notice (Nov 19)</p> <p>3. Due to short notice, beds on paediatric ward already allocated to other specialties which prevents theatre session from being utilised by Ophthalmology. In addition patient may be unable to attend for surgery at short notice (Nov 19)</p> <p>4. Ocular Motility Postholder unable to commence in post until February 2020 (Nov 19)</p> <p>5. SHS may be unable to support all dates (Nov 19)</p> <p>5. RWT may not be able to provide theatre teams/anaesthetists when required on an overtime basis (Nov 19)</p> <p>5. SHS may be unable to provide theatre teams/anaesthetists when needed (Dec 19)</p> <p>5. Patients may be unable to attend for surgery on appointed dates (Dec 19)</p>	<p>1-10 Consider Associate Specialty Doctor reviewing new patients in order to determine a plan for care</p> <p>1-10 Validate waiting lists to ensure patients treated before 52 weeks breach date</p>	<p>Jan-20</p> <p>Dec-19</p>	3 x 2 = 6 YELLOW	Dec-19	

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					<p>5. Limited paediatric bed availability that could be further reduced during winter months (Dec 19)</p> <p>5. Waiting list increases due to new patients being added, currently 172 patient on the OPWL waiting for a new appointment, 46 have waited over 30 weeks for a new appointment with no clinics available to offer an appointment. Longest wait for a new appointment 41 weeks (Dec19)</p> <p>5. There are currently 93 patients waiting for squint surgery, longest wait at 49 weeks (Dec 19)</p> <p>5. There are currently 32 patients that will breach 52 weeks between 30/12/2019-30/03/2020 if not operated on (Dec 19)</p> <p>9. No confirmed start date for newly appointed Paediatric Consultant Ophthalmologist which is putting additional pressure on the service (Dec 19)</p> <p>5. Soley relying on SHS consultants to run the squint surgery (Dec 19)</p>				