The Royal Wolverhampton NHS Trust

Chief Nurse's Governance Report
3 March 2020

Agenda Item No: 7.2

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	3rd March 2020
Title:	Chief Nursing Officer Governance report
Action Requested:	**Receive for assurance and note**
For the attention of the Board	
Assure	• Trust Risk Register (TRR) updates are requested monthly, with review/challenge on risk progress at Divisional and Trust level groups. • The number of risks scoring 12 or above that are awaiting approval to TRR has reduced.
Advise	• 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. Oversight of local procedures and guidelines is reported to Trust Policy Group.
Alert	• The Data Protection and Security Toolkit (DPST) require the Trust to achieve 95% compliance for Information Governance (IG) training within the 19/20 financial year; current compliance is 88%. • National Opt out work plan has commenced but requires swift action and responses from key areas (below) to meet the deadline of 31st March 20. • Delays with identifying leads for root cause analysis (RCA) investigators have led to breeches in RCA completion timescale. A draft proposal for dedicated central investigators has been prepared and a meeting set for review prior to formal approval processes.
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Links to Trust Strategic Objectives	1. Create a culture of compassion, safety and quality 2. Proactively seek opportunities to develop our services 3. To have an effective and well integrated local health and care system that operates efficiently 4. Attract, retain and develop our staff, and improve employee engagement 5. Maintain financial health – Appropriate investment in patient services 6. Be in the top 25% of all key performance indicators
Resource Implications:	Opt out resource to be raised as cost pressure
Report Data Caveats	This is a standard report using the previous month's data and updates within a live Datix system. It may therefore be subject to cleansing and revision.
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**
Equality and Diversity Impact	No adverse impact on personal protected characteristics.
Risks: BAF/ TRR	Risks relate to capacity and resources to comply with Statutory and Regulatory requirements. See TRR risk detail below plus -: Governance Department risk register: 3285 Non Compliance with Freedom of Information timescale – grade 9 amber 4769 Capacity Information Governance (IG) – grade 9 amber 4663 Capacity Health and Safety – grade 9 amber
Public or Private:	Public

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

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 update – February 20
2. Serious Untoward incident (SUI) Performance
3. Information Governance work plan – Progress on IG work plan and DPST compliance due 31st March 20.
4. Governance structure review
5. Governance of local Procedural Documents (ie Clinical Procedures, Guidelines, Protocols etc)

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

Item/paragraph 1.0

1. Trust Risk Register update – February 20

0 new risks.

3 risks removed:

4523 - Failing Heater Cooler Units (Chief Operating Officer - COO)

4170 - Lack of capacity – Out Patient Department, Snowdrop Suite and Durnall Unit (COO)

5253 - Dell Tablets damage and unsupported warranty on the Electronic Prescribing and Medicines Administration (ePMA) wards (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 (Medical Director - MD)

4113 - Divisions inability to achieve Cost Improvement Plan (CIP) (COO)

5182 - Lack of Network support for Vascular Services at the Royal Wolverhampton Trust (MD)

5246 - Lack of Consultant cover within Cancer Services (COO)

There are currently 32 risks contained within the Trust Register which are distributed across the Trust's (5x5) categorisation matrix as below:

	Consequence				
Likelihood	1 Low	2	3	4	5 High
5 – Almost Certain				**1 risk**	
4 – Likely			**13 risks**	**3 risks**	**1 risks**
3 – Possible			**3 risks**	**11 risks**	
2 – Unlikely					
1 – Rare					

Attention is required to the following risks:

4113 COO – Actions 1st, 2nd 3rd to be considered as controls for ongoing monitoring, 7th action to update.
1713 COO – Action and assurance update
4375 COO – Add actions in progress and a timescale for completion
4411 COO – Add action timescales
5045 MD – Action update
5182 MD – Action update
5246 COO – 2nd 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
Jan 20	26(6)	10	8	10	3	0
Analysis					20489 - Division 3 - Diagnostic (difficulty with dates with the division) 20607 - Division 1 - Sub Optimal care (difficulty appointing a lead) 21323 - Division 3 - Diagnostic (awaiting input from other area)	

3. Information Governance (IG) work plan

Data Security and Protection Toolkit (DSPT) toolkit update

- Working towards compliance for March 2020. 100 mandatory assertions have been achieved 16 are still outstanding. National opt out compliance is still outstanding and a plan is being implemented.
- Still some work to be done with the General Practitioner practices to ensure the 9 DSPT toolkits are at a standard which is complaint for March 2020. This has been challenge due to staff changes within the Primacy care team, and some of this work had not been picked up

internally.

- Training compliance is behind target with current compliance at 88% and a target of 95% to be achieved by 31st March 20. There is a significant challenge to train approximately 800 staff in order to meet the target over the next 6 week. Follow up reports to managers and communication are in place and the plan is to ramp up the focus via an all user email from the Medical Director, report reminders to managers, re advertise face to face courses for those who may not easily access e training, targeted sessions for staff who are overdue. The IG Steering Group will monitor the progress of training compliance.
- The DSPT toolkit 20/21 is currently being appraised for changes to the current assessment regime; these changes will apply from April 2020.

National opt out Update:

- Resource to assist in implementation was established in late January. A project action plan has been drafted along with a draft policy. Teams that are currently being supported to appraise the application of opt out to their processing.
- Teams being appraised against opt out include Research, Information team, Cancer services, Patient Advice and Liaison Service (PALs) for national surveys and Clinical audit (including local audits undertaken within Directorates). Digital innovation service is also in scope if time allows pre April and/or continuing into 2020/21.
- Areas management are asked to encourage the completion of this work for the Trust by timescales.

IG spot audits

- All areas elected for an audit (2019/20) have been audited and recommendations issued with feedback with exception of a few General Practitioner practices which will be completed by the end of February 2020.
- Recommendations will be linked to incidents and trends data for end of year reporting.
- Themes indicate that knowledge of policies and processes is a consistent issue across all services.

Information asset assurance

- The Trust is finalising its selection for an information asset tool, which will assist the Trust is documenting information assets, mapping information flows and risks linked to those assets. The system will look to be implemented from April 2020 with a view to establishing an asset owner structure across the Trust.

4. 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. Communication and consultation with key stakeholders will follow.

5. Governance of Local Procedural Documents

As at January 2020 72% of local procedures and guidelines are reviewed (67% in December), 4% have been archived and 24% require review (30% in Dec). Good progress is maintained and engagement from Directorates and Divisions.

A status for CP50 (Results Reporting) standing operating procedures (SOPs) is awaited for Division 1. Directorates will be required to schedule routine audits of CP50 SOPs within local audit plans for 2020/21.

Reference Pack CNO Governance Report TB 3/3/20

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

Lead Director	Risk	Risk Title	Field updated	Update made
Chief Operating Officer	5308	Risk of RTT breaches for Paediatric/Adult Patients		
			Positive Assurance – **New**	T&O Directorate - Locum in place
	5316	Risk of RTT breaches for Paediatric/Adult Patients		
			Positive Assurance – **New**	New consultant undertaking squint surgery in Jan 20 alongside SHS consultants
	5173	IT infrastructure in Audiology clinics		
			Gap in Assurance - **New**	Interrupted, incomplete, rescheduled appointments and failure to save documents and audiograms (144 incidents reported via Datix 1/12/18 to 12/2/2020)
	4523	Failing Heater Cooler Units		
			Risk now managed on local risk register	Risk grading now GREEN from AMBER.
	4903	Risk of non-compliance with Thoracic Service Specification		
			Action Plan - **New**	Group Manager has emailed SATH to see if there is any appetite for lung cancer surgery
	4706	Infrastructure/environment in Nucleus Theatres		
			Action Plan - **New**	Scope the provision of flushable wipes for the wards
			Action Plan - **New**	Theatre 4 & 7 light replacement to take place on the 4th and 5th March 2020
	5243	Breast Service (General Surgery & Radiology)		
			Positive Assurance – **New**	Latest West Midlands report shows improvement from 13th to 9th out of 13 Trusts

			Positive Assurance – **New**	Improvement in 2 week wait Aug 19 - 3%, Dec 19 - 87.8%
			Positive Assurance – **New**	Achieving 28 day faster diagnosis 92%
			Positive Assurance – **New**	Improvement in 62 day Aug 19 - 18.20%, Dec 19 - 75%
			Positive Assurance – **New**	Improvement in Breast symptomatic Aug 19 - 2.3%, Dec 19 - 80.30%
			Action Plan - **New**	Superintendent Radiographer appointed, awaiting start date
	4472	Delays in triage in ED		
			Positive Control – **New**	AEC opened to filter ambulatory patients
			Positive Control – **New**	Band 7 - 2nd cohort interviewed, 3 appointed and in place
			Positive Control – **New**	GIRFT Visit completed September 2018. Report received, Group Manager reviewing report (Winter pressures July completion date) monitoring actions through Governance meetings on a monthly basis
			Gap in Assurance - **New**	Inability to achieve 2 hr target in month, significant delays experienced - Q1 19/20 = 24%, Q2 19/20 = 21%, Q3 19/20 = 16%
			Gap in Assurance - **New**	Significant number of attendances through ED experienced (Q1 19/20 to Q3 19/20 = average of 381 patients a day
			Gap in Assurance - **New**	Inconsistent average attainment of the 15 minute target ((Q2 18/19 - 62.2%. Q3 18/19 - 60.7%. Q4 18/19 - 56.8%. Q1 19/20 - 58.6%. Q2 19/20 - 67.4% AND Q3 19/20 - 60.5%)
			Action Plan - **New**	Comprehensive review of patient through UECC underway
	4170	Lack of capacity - OPD,		

		Snowdrop Suite and Durnall Unit	**Risk now managed on local risk register**	
	4696	Unreported Imaging Studies		
			Positive Assurance – **New**	Backlog against a backdrop of increased referrals has reduced from 7332 May 2017 to less than 5836 in January 2020
			Gap in Assurance - **New**	Approximately 5836 non-urgent imaging studies unreported January 2020 (inclusive of 629 CT scans and 2491 MRI scans). Over 20 days there are 2962 in total (inclusive of 310 CT scans and 1450 MRI scans)
	4411	NX08/NX09 McHale Building - Fire Safety		
			Positive Assurance – **New**	0 incidents relating to Reportable Fire's within Jan 20
			Positive Assurance – **New**	0 Unwanted Fire Signals within Jan 20
	4382	NX55 Main Theatres, Wards A12, A14, Admin, Plant Rooms) - Fire Safety		
			Positive Assurance – **New**	0 incidents relating to Reportable Fire's within Jan 2020
			Positive Assurance – **New**	0 Unwanted Fire Signals within Jan 2020
	4375	NX87 Heart Centre - Fire Safety		
			Positive Assurance – **New**	0 unwanted fire signals during Jan 2020
			Positive Assurance – **New**	0 incidents relating to Reportable Fire's within Jan 2020
	5246	Lack of Consultant cover within Cancer Services		
			Gap in Assurance - **New**	2 locums secured to cover vacancies, not Gynae
	5284	EPMA - system and operational use (overarching risk)		
			Gap in Assurance - **New**	The Datix assessment shows 13 incidents directly relating to EPMA for Jan 20 System user errors are the greatest source of incidents (4

				reports). There is 0 report of moderate patient harm.
			Gap in Assurance - **New**	System down time is still occurring, 19 occurrences from 1/1/20 to 31/1/20 5308
	5197	Unacceptable waiting times for Cardiology follow-up appointments		
			Positive Assurance – **New**	Appointed new Interventional Cardiologist due to start 5 March 2020 and will be doing some clinics
			Positive Assurance – **New**	There are monthly meetings with Arrhythmia Nurses/Cardiology ANP to undertake additional clinics to support
			Positive Assurance – **New**	Locum Consultant appointed due to backlog of patients. They have been asked to do 5 clinics a week which should help the situation
	2080	Risk to quality of patient care: reduced manpower		
			Positive Assurance – **New**	67.76 wte trained nursing vacancies remain
			Positive Assurance – **New**	Newly qualified and overseas nurses arriving on wards - approx 20 in OSCI bootcamp
			Positive Assurance – **New**	All closed bays are now open
			Positive Assurance – **New**	32.35 HCA vacancies
			Positive Assurance – **New**	Division 2 real time electronic system in place to monitor vacancies - working to get complete figures
Medical Director	5182	Lack of Network support for Vascular Services at RWT.		
			Action Plan - **New**	Currently engaged in the setting up of a W Midlands acute aortic surgery rota. It is anticipated that 3 of the cardiac surgical team will participate in this, in order to concentrate the clinical experience in the aim of optimizing results.
Chief Financial	5253	Dell Tablets on ePMA wards		

Officer		damage and unsupported warranty	**Risk now managed on local risk register**	All actions completed.

The Royal Wolverhampton NHS Trust

Trust Risk Register

February-2020

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

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Risk Lead	ID	Principal Risk		Controls	Positive Assurances	Gaps in Assurance/Control	Action Plan that addresses Gaps in Control		Residual Risk Level		
Risks Currently Being Managed											
Trust Objective:		**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 cytology screening reporting for patients within the geographical area covered by the Tender (Midlands) and delays in patient management due to the late reporting. Accepted onto the Divisional RR = 13/12/2019 Accepted onto the TRR = 01/01/2020	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	Feb-20	

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

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Trust Objective:		**Proactively seek opportunities to develop our services**									
Chief Operating Officer	5173	If the information technology infrastructure is inadequate within the Audiology Clinics then patient appointments will frequently be interrupted due to lack of necessary IT to support delivery of service, resulting in a poor patient experience as occasionally this necessitates patients being recalled to future appointments. Date of origin: 20 February 2019 Date of escalation: 28 March 2019 Risk Lead: Head of Audiology	4 x 3 = 12 AMBER	1) Manual rebooting of computers (Mar 2019) 2) Audit of all computers all all sites for specification checks (Mar 2019)		1) Interrupted, incomplete, rescheduled appointments and failure to save documents and audiograms (144 incidents reported via Datix 1/12/18 to 12/2/2020) (Feb 20) 1) Multiple complaints from staff re: slow and hanging computers, often necessitating forced shut down of computers (Feb 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 (Feb 20) 1) Upgrade of Auricals to Windows Version 10 is not achievable (Feb 20)	1-2) Procure equipment 1-2) Liaise with IT to install equipment 1-2) Business case to be finally approved	May-20 Mar-20 Mar-20	1 x 1 = 1 GREEN	Feb-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?
Trust Objective:		**To have an effective & well integrated health and care system th**									
Chief Operating Officer	2719	Lack of real time bed management and retrospective admissions on PAS can have a significant impact on electronic testing and potentially e-discharge systems leading to a potential impact on patient care/safety. Date of origin: 23/05/11 Date of escalation = 24/05/11 Risk Lead: COO	3 x 3 = 9 AMBER	1) Monitoring of PAS update / use (monthly) (Nov 14) 3) Implementation of safehands bed management (Apr 15) 4) Additional support from Teletracking to optimise use of real time system. 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	Feb-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.	1-6 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) (Jan 2020) 1-6 Hot gallbladders undertaken on the CEPOD list by both UGI and non UGI Surgeons (Jan 20) 1-6 Hot gallbladder list undertaken every Tuesday by Locum Upper GI Consultant (January 2020)	1 Patients continue to present with complications of gallstones (Jan 20) 1 Local audit showing recurrent admissions (June 18) 1-6Highlighted as a 'service at risk' to Division and as part of Medical Workforce Report 1-6 Unable to appoint to the 4th UGI Consultant substantive post (Jan 20)	1-6 Re-locate UHNM staging lap list on Friday morning to give weekly 3rd session (Critical Care Services Directorate - no available theatre to relocate session) 1-6 Recruit 4th substantive UGI surgeon to enable full utilisation of allocated capacity. Currently being undertaken as additional to job plan 1-6 Purchase bile duct exploration kit	Jul-20 Mar-20 Mar-20	2 x 2 = 4 YELLOW	Feb-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	5083	IF staff do not understand their roles/ role boundaries and receive training and maintain competency needed to accurately identify dysphagia needs and manage these appropriately, THEN patients' needs may not be assessed (or inadequately assessed) RESULTING IN aspiration of oral intake and the potential negative effect on the patient's health. This can lead to increased antibiotic usage, increased length of hospital stay, increased likelihood of readmission and - in the most severe cases - the patient's death. Additional potential outcomes could be increased exposure to medical negligence actions for both staff and the Trust. Date of origin: August 2018 Accepted onto Divisional Risk Register: August 2018 Accepted onto Trust Risk Register: 08/10/18 Risk Lead: Head of Therapy Services	4 x 3 = 12 AMBER	(3) Care Pathway and initial guidance published on intranet (SALT pages) for wards to manage initial presentation of patients with swallowing problems (Aug 2018) (2) Use of swallow screening tool is now for trained/ competent Stroke nurses only (Aug 2018) (1) IDDSI (International Dysphagia Diet Standardisation Initiative) fully implemented across Trust (May 19) (4) Under Care Pathway, wards manage initial presentation and then refer to SALT who see patients within 2 working days (Nov 2018). (5) Implementation in progress with NHS/PSA/RE/2018/004 (May 19)	(5) Mainly compliant with Patient Safety Alert (NHS/PSA/RE/2018/004) - few remaining local actions being monitored via Nutrition & Hydration Steering Group (Jan 20) 19)	(1) 20 x related datix incidents in 2017; 15 x related datix incidents to Nov 2018 [datix reports Nov18-Apr19 under review] (Oct 19) (2) Staff who are untrained/ no competency cannot use swallow screening tool (all areas outside Stroke) [(Oct 19) (4) SALT only available on working days, so at Bank Holiday times there could gaps of up to 4 additional days (on top of 2 day response target) before SALT assess the patient (Oct 19)	(4) Investigate the possibility of extending the SALT service beyond working days only - await outcome of TMC review of business case	Jan-20	2 x 2 = 4 YELLOW	Feb-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?
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 Divsions (06/19) 5. If there is a risk that impacts on a team's ability to deliver their CIP schemes then the member of Service effiency 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	Nov-19 Nov-19 Nov-19 Mar-20 Mar-20 Mar-20 Nov-19	3 x 3 = 9 AMBER	Feb-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?
				10. Outpatient efficiencies continue to be identified via OPEG (Outpatient) Dec 18. Decision to proceed with Zesty (Nov 19) 11. Trust supporting GIRFT Visits (Nov 19) 12) Use of external support to challenge budget management and CIP opportunities (Jul 19) 11) Use of model hospital to identify opportunities for CIP (Apr 19)						
Chief Operating Officer	4903	If the Directorate are unable to meet the new NHSE service specification for thoracic work then thoracic work will no longer be commissioned at this Trust from April 2019. This will result in a loss of income circa £2,000,000 of income for the Trust per year. Date of origin: 16th Nov 2017 Date of escalation: 18th Dec 2017 Risk Lead: Cardiac Group Manager	3 x 4 = 12 AMBER	1. Medical Director held discussions with Walsall Manor Hospital to increase referral cases to RWT (Jan 18) 2. Recruitment strategy in place (April 2018) 3. Group Manager and Thoracic Consultant have met with Worcester colleagues and pathways agreed (Sept 18)	2. Thoracic ANP has been recruited and in post (Jan 20) 2. Consultant Thoracic Surgeon recruited and in post (Jan 20) 1-3 Continue to approach other Trusts for referrals (Jan 20) 2. Locum Thoracic Surgeon recruited and started 4 November 2019 (Jan 20) 2. Thoracic Surgeons have undertaken proctored Robotic training sessions in the hope of attracting new work to RWT (Jan 20)	1. Referrals have not increased, this has been escalated to DCOO and COO (Jan 20) 1. Despite agreed referral pathway with Walsall they are unwilling to move forward at present (Jan 20)	1. Plan further approaches to Walsall Hospital - Chased again 1. Group Manager has emailed SATH to see if there is any appetite for lung cancer surgery	Feb-20 Feb-20	1 x 5 = 5 YELLOW	Feb-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?
Trust Objective:		**Attract, retain & develop our staff & improve employee engagemen**									
Chief Operating Officer	1713	Failure to effectively maximise workforce productivity; failure to routinely review consultant job plans. Date of origin: 03/06/08 Date of escalation = 11/05/11 Risk Lead: COO/Deputy Medical Director	4 x 3 = 12 AMBER	2) Areas to be contained with SPA allocation have been agreed 4) Usage reports for medical bank 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	Jan-20 Dec-19 Jan-20	3 x 2 = 6 YELLOW	Feb-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 (02/20) 1) Proactive recruitment approach continuing (02/20) 1) 67.76 wte trained nursing vacancies remain (02/20) 1) Nursing clinical fellows recuited to and in post - working well (02/20) 1-10) Matrons meeting every Friday to ensure hospital is staffed over the weekend (02/20) 3) Snr Srs and Charge nurses meeting daily to ensure wards are safe (02/20) 3) Newly qualified and overseas nurses arriving on wards - approx 20 in OSCI bootcamp (02/20) 3) All closed bays are now open (02/20) 1) Local recruitment for Bd5's ongoing - successful (02/20) 3) Additional support to base wards to allow completion of D2A's to improve flow (02/20) 1) 32.35 HCA vacancies (02/20) 3) Significant improvements seen in vacancy figures on wards of most concern C16, C19 and C25 (02/20) 1) Some wards have been 'green' for safe staffing levels in month (02/20)	8) Insufficient RN's available on Bank (02/20) 1) Nationallly we are an outlier re safe staffing levels (02/20) 1) New staff are newly qualified and overseas which can lead to mentorship and training pressures (02/20) 1) Most wards are 'Amber' re safe staffing levels on daily basis (02/20) 3) Issue remains in relation to ability to provide accurate staffing figures - electronic solution progressing (02/20) 3) Breaches in minimum safe staffing levels (02/20) 3) Continuing to see an increase in HCA vacancy numbers - raised at QSIG and TMC (02/20)	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	Mar-20 Mar-20 Mar-20 Apr-20	4 x 3 = 12 AMBER	Feb-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?
					1-10) PEF's and Mentors in place to improve retention of new starters (02/20) 3) Division 2 real time electronic system in place to monitor vacancies - working to get complete figures (02/20) 1-8) All acting Bd 7's have been made substantive (02/20)					

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

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	3069	If a Never Event occurs within Division 1 this may result in an adverse outcome, there is potential for severe harm and/or patient death and also reputational impact including increased external monitoring Date of origin: 19/07/12 Date of escalation = 17/11/15 Risk Level: Div 1 Deputy COO	3 x 4 = 12 AMBER	5. Monitoring and circulation of incident notification reports to all senior staff for review 6. Trustwide learning via a "Lessons Learned" sheet in the monthly IGR, Risky Business Newsletter and the CLIP Group. 8. Regular scrutiny of Directorate risk registers and minutes of Directorate governance meetings at the Quality Meetings 2. Review completed of all documentation and Theatre protocols/procedures amalgamating where possible 1. Perioperative care plans are in place across the Trust 9. Agreed communication strategy with Division 2 to share/raise awareness of never events and lessons learnt 3. Monitoring of Policy OP100 and monthly audit of WHO Checklist for agreed procedures. Directorates providing assurance of the shortfalls in performance at Directorate Governance Meetings and Quality Meetings. 4. New NE Guidance (published Jan 2018) being used for NE classification	10. Human Factors continues to be recgonised as a trend (Jan 20) 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) 11. Staff across the Division are supported to undertake PCM training (Jan 20) 12. Audit of LocSSIPs have previously been presented to Division before presentation at QSIG (Jan 20) 1-8. Meeting between CCG and Trust (April 18) to provide assurance and context regarding reported NEs was largely positive. Actions being taken by the Trust were recognised to be proportionate and timely in response. (June 18) 13. Over 5 AfPP training days - approx. 240 staff members have been trained (Sept 19) 1-13 There has been no new never events reported for 6 x consecutive months within Division 1 (Jan 2020)	4. There have been 3 x Never Event incidents 2 x Wrong Site Surgery and 1 x Retained foreign object) reported and investigated during 2015 4. 5 x NE in 16/17 reported to CCG - 1. Maternity NE (retained tampon) reported (Datix ID: 158830), 2. Radiology NE (wrong ankle injected) reported (Datix 165455), 3. Opthalmology (wrong eye injected) reported (Datix 166680) 4. Theatres (retained foreign object) reported (Datix ID: 169339) 5. Theatres/T&O Cannock (wrong prosthesis) reported (Datix ID: 174038) occured Mar 2017 4. 5 x NE incidents reporting in 17/18 reported to CCG from April 2017 (175581,179911,181941,185875 186479) (Dec 17) 4. 4 x NE in 18/19 reported to CCG - 2 x Wrong Site Surgery incidents (Neonates Datix 194205 and H&N Datix 194977 - both in April 2018). There has been and 2 Retained Foreign Object incidents (Theatres 197654 and Obstetrics 197996 - both in June 2018) (Jan 20) 4. 1 x NE in 19/20 reported to CCG (June 2019) - 1 x Wrong Site Surgery - Wrong Side Fascia Iliaca Block (T&O/Theatres Datix 218936) (Jan 20)	1-11. Staff continue to undertake PCM training 1-13 Ongoing implementation of remaining x 2 actions (10,000ft and Human Factors training) as identified on the action plan following the NE Leicester Conference	Mar-20 Mar-20	2 x 4 = 8 AMBER	Feb-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?
				7. Policy for the management of retained swabs in place 10. New qualitative and observational WHO checklist being used in Theatres (Oct 17) 11. Sign up to Safety campaign was supported - T&O and Maternity participation (Oct 17) 12. LocSSIPs developed by Directorates auditing underway and presented to Division and QSIG (Jan 2018) 13. AFFP Peer Review and Training undertaken	3. Monthly monitoring data of compliance with WHO checklist and Procedural Safety Checklist - 100% for full completion (documentation) in Dec 2019 (Jan 20) 3. Monthly monitoring and compliance with WHO checklist use - There has been 100% compliance achieved during Dec 19 (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	3256	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: - 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. - Potential complaints and litigation and a risk of loss of contract(s) from misdiagnosis and incorrect treatment. - 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. Date of origin: 04/10/12 Approved onto TRR: 11/11/2019 Division approved: 04/10/19	3 x 4 = 12 AMBER	2) Signs are in place in clinical area and corridor requesting silence at all times (May 2017) 3) Incident trends being monitored along with any complaints on a monthly basis (May 2017) 1) Introduction of insert earphones and Sound Level meters to monitor sound levels (May 2017) 4) Noise logs are undertaken during testing - compiled and produced each month (as per UKAS requirements) (Feb 2016) 5) Sound level meters calibrated (August 2019) 6) 1/3 Octave room measurements undertaken at West Park, to aid in determination of least noisy rooms for testing patients hearing (August 2019)	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 (Feb 20) 1-4) Accreditation feedback session Oct16 was very positive and praised team (Feb 20) 6) Testing confined to the least noisy rooms (Feb 20)	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 (Feb 20) 1) Inserts do not provide adequate attenation to overcome the issue of the environment (Feb 20) 4) Ambient noise levels are too high to be able to perform diagnostic testing accurately (Feb 20) 5) Linearity and accurate measurements are achieved at low sound levels (Feb 20)	1-6) Plans for relocation of service to be confirmed 1-6) To put in place a combined business case for West Park - 3 booths	Dec-20 Mar-20	1 x 1 = 1 GREEN	Feb-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 avaiaible and reported for July 19 (Nov 19) 1) Verbal feedback from CQCQ is largerly positive, all points raised responded to and in action plan (Oct 19) 1) Refreshed Trust Intranet site to go live on 27/1/20. (Jan 20)	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 final CQC action plan.	Feb-20 Mar-20 Feb-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?
				1) Monitoring via Quality review visit and re-visit programme to assess CQC compliance (Nov 19) 1) NEWS2 implemented Trust-wide (Nov 19) 1) Information provided in PIR according to timescales (Nov 19) 1) Series of Board development sessions sharing learning from other insepections and risks completed (Nov 19) 1) comunication of Trust Stragey including visions and vaultes commenced (Nov 19) 1) Evidence on PIR triangulated with KLOEs (ONov 19)					

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	4375	(NX87) Heart Centre - Fire Safety: As a consequence of shortfalls in structural fire protection (including emergency lighting) and the recent failure of external ACM cladding, fire could spread both externally and internally throughout the building , compromising life safety. Date of origin: July 2017 Date of escalation: Sep 17 Risk Lead: Estates and Facilities Divisional Manager	3 x 4 = 12 AMBER	Implementation of a 4 Stage Risk Mitigation Plan; details include 1) Restricted parking of vehicles to 6m 2) Management of waste in the external compound 3) Increased security and surveillance 4) Augmented Fire Service reponse 5) Increased Trust Fire Response 6) Additional Fire Wardens trained 7) Additional fire exercises and drills 8) Review of fire risk assessments (15 completed, local risks managed by Directorates) 9) Building & Maintenance risks managed by Estates via Planet FM 10) Statutory fire alarm testing (weekly), Fire Damper Testing (Annual)	10) 0 incidents relating to Reportable Fire's within Dec 2019 3) Additional Security Fire Patrols undertaken and recorded 9) Priority Planned Preventative Maintenance undertaken 2) Waste compound has been relocated 7) Third Floor Fire Evacuation Exercise on 31.05.18 9) Automatic Fire Detection (AFD) in identified areas has been upgraded with Tri-State Detectors. Areas identified from UwFS 10) Break-glass over-ride facility for 3rd floor installed to enable lifts to be used in the event of an evacuation. 1-10) Construction work underway in removing ACM cladding. Approx 70% has been removed from outer building. Inner courtyards had been resolved. 4) WMFSvisited site, agreed security patrols and WMFS attendance to continue 10) 0 unwanted fire signals during Dec 2019	9) Outstanding fire stopping required following compartmentation survey		2 x 2 = 4 YELLOW	Feb-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	1. Statutory fire alarm testing (weekly), fire damper testing (annual) 2. Departmental Fire Risk Assessments undertaken. Main Theatres frequency increased to 6 monthly due to risk 3. Statutory Planned Preventative 4. Bespoke Fire Warden Training 5. Additional Fire Exercises and Drills 7.Revised Management of External Waste in the Compound 6. Departmental Fire Warden Daily Checks undertaken	1. 0 incidents relating to Reportable Fire's within Dec 2019 3. Fire strategy has been approved and money set aside. 1. 0 Unwanted Fire Signals within Dec 2019 1. Fire Alarm is being upgraded to L1. Being montiored via Fire Safety Group	2. Compartmentation Survey to be completed 3. Operational issues have meant the fire strategy work will take longer to complete with some work on hold 1. Fire alarm & ancilliary systems do not comply with current regulations	1. monitor and work towards completion of fire stategy for block	Mar-20	2 x 2 = 4 YELLOW	Feb-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	1. Statutory fire alarm testing (weekly) 2. Departmental Fire Risk Assessments undertaken 3. Statutory Planned Preventative 4. Waste Management 6. Fire Evacuation Drill taken place on 12th November 2019. Fire drill is on a rolling programme 5.Departmental Fire Warden Daily Checks undertaken 7. Tugway Safety & Environmental Group commenced May 2018 4. Implementation of robust waste management controls to reduce the risk of a fire occurring. 7.Basement area (Tugway) now being monitored following the Installation of CCTV.	1. 0 Unwanted Fire Signals - Dec 2019 1. 0 incidents relating to Reportable Fire's - Dec 2019 2. Combustible items located in the Tugway have been removed. The area is being monitored by Estates Department via the Tugway Group 7. Structural fire safety repairs carried out to minimise risk fire spread from the Basement (Tugway) into the building above. 7. Implementation of robust management controls 4. Environmental Audit Group carry out 3 monthly audits of Tugway		2. Departmental Business Continuity Plans need to be updated 6. Develop interim protocols for switchboard and security	2 x 2 = 4 YELLOW	Feb-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 (02/20) 4-5) Reallocation of staff working well to help reduce wait times during pressured times (02/20) 15) Urgent treatment doctor is making an improvement to patients recieving appropiate emergency treatment (02/20) 1,2,7) Plan for Bd 7 to cover Zone A&B during day to be trialled - used intermittantly, but successful when used (02/20) 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 (02/20) 7) Medical and nursing vacancies and sickness/annual leave resulting in gaps in rota. Link to risk 4496 and 2374 (02/20) 9) UCC minimum impact on pt numbers and delays in assessments (02/20) 7) Continued use of long term locums, overall 5 substantive Cons vacancies (02/20) 1) Inability to achieve 2 hr target in month, significant delays experienced - Q1 19/20 = 24%, Q2 19/20 = 21%, Q3 19/20 = 16% (02/20) 1) Significant number of attendences through ED experienced (Q1 19/20 to Q3 19/20 = average of 381 patients a day (02/20) 1,2) Significant increase in number of 8hr waits for beds in month due to low discharges in Trust (02/20) 1-22) 12hr wait experience in month (01/20)	7)Continue with recruitment of medical staff 1-22) Comprehensive review of patient through UECC underway	Mar-20 Jun-20	1 x 4 = 4 YELLOW	Feb-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?
				11) Human factors review completed and resulted in department restructure. All staff provided with human factors training and rapid improvement events [6/3/19] 12) Medical and nurse staffing managed via the risk regsiter (risk 2374 & 4496) [5/3/19] 13) Nurse led RAT and SOP ratified and in place (5/3/19) 14) Where possible, newly qualified starters have their last student placement transferred to RWT ED [5/3/19] 15) System in place to ensure that Cat 2 patients are shown red at 15 minutes. Urgent treatment Doctor role developed to see cat 2 patients [5/3/19] 16) Use of internal bank rather than locum agencies where possible [5/3/19] 17) Extra Triage room and escalation process in place [5/3/19] 18) Escalation tool developed and identifies pressure points with agreed action [5/3/19] 19) Appointed Specialty Doctor in November 18 (5/3/19) 20) GIRFT Visit to be reviewed by end of July (7/19)		1-22) Inconsistent average attainment of the 15 minute target ((Q2 18/19 - 62.2%. Q3 18/19 - 60.7%. Q4 18/19 - 56.8%. Q1 19/20 - 58.6%. Q2 19/20 - 67.4% AND Q3 19/20 - 60.5%)			

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
				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) 22) AEC opened to filter ambulatory patients 23) Band 7 - 2nd cohort interviewed, 3 appointed and in place (02/20) 24) GIRFT Visit completed September 2018. Report received, Group Manager reviewing report (Winter pressures July completion date) monitoring actions through Governance meetings on a monthly basis						

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	4528	If Clinical Web Portal does not contain full copies of patient's notes/health records (if seen before 2013) as well as all Paediatric admissions/Badgernet information then clincians will only have access to an incomplete health record for inpatient and outpatient encounters. Lack of a comprehensive record may impact on the accuracy and/or timeliness of clinical decision making. NHSI link NE's to lack of complete clinical records in OPD clinics. Date of origin: 29/04/16 Date of escalation = 17/05/16 Risk Lead: Div 1 Deputy COO	4 x 3 = 12 AMBER	1. Ability to request paper notes (May 16) 2. Process for both access to patient records aswell as the process for when there is a need to have a complete patient scanned has been circulated by Patient Access (Dec 16) 3. Badgernet System in place in Maternity (Feb 19)	1. No continuous Datix incidents (Jan 20) 3. The Badgenet 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	Feb-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 clinicans are telephoned about these. Other less urgent abnormal results are highlighted as such in TD Web when they are reviewed (June 2017) 6) As at 31st Dec 18 21% of Pathology and Radiology results were filed 6) TD Web requesting facility is disabled, allowing only for the review of historic results. This will continue with monitoring of usage until further notice (May 19). 6) From 3rd September 19 histology results will be available via ICE. Moving closer towards the soe use of ICE for results reporting (June 19)	1-4) Audit of local safety net procedures demonstrated significant gaps (Nov 16) 2) Size of Radiology reports is significant resulting in inbox limits being frequently exceeded (Nov 16) 5) Incidents continue to be reported where the reviewing if abnormal results has been delayed with significant consequences to patient outcome (May 17) 3) No further action can be taken by Pathology until ICE is implemented (June 2017) 6) As at 31st Dec 18 79% of Pathology and Radiology results were unfiled. (Feb 19) 6) As at 31st Jan 19, 20% of Pathology and Radiology results were filed which has slightly reduced from Dec 18 report; and 80% of Pathology and Radiology results were unfiled.(Mar 19) 3,6) Currently unable to" freeze" TD Web which means it is still available for reviewing results in conjunction with ICE (June 19) 6) ICE filing compliance remains low across all reporting (circa 20%) (June 19) 6) 76% of results on ICE are unfiled, 23% of results are filed (Sept 19)	1-4) Local 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 =	Feb-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?
					6) Small increase in filed results from 20% to 23% (74% unfiled) however a plan is progressing with the migration of Cytology services to ICE on the 17th of September, followed by all new Histopathology results via ICE from 23/9/19 and Blood Sciences (Biochemistry, Haematology and Transfusion) and Microbiology results only being available via ICE aimed for February 2020. At the point of migration of reports to ICE, TD web will only be available to view historical reports (preceding the date of data transfer.) (Sept 19) 6) From 23/9/19 Histology results available on ICE only. Only historic Histology results are viewable via TD Web. (Oct 19) (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)					

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) (Feb 2020) 4) Review meetings are happening fortnightly (Feb 2020) 1), 5) & 6) Backlog against a backdrop of increased referrals has reduced from 7332 May 2017 to less than 5836 in January 2020 (Feb 2020) 3) Office space sourced (Feb 2020) 1) The backlog is actively monitored by Group Manager (Feb 2020)	1) Approximately 5836 non-urgent imaging studies unreported January 2020 (inclusive of 629 CT scans and 2491 MRI scans). Over 20 days there are 2962 in total (inclusive of 310 CT scans and 1450 MRI scans) (Feb 2020) 1) Poor patient experience if patients and doctors are unsure when their scans are reported (Feb 2020) 3), 4), 5) & 6) Demand for reporting imaging studies is higher than expanded reporting capacity (Feb 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	Feb-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	If longstanding maintenance continues to be a challenge around infrastructure/environment in Nucleus Theatres, which includes: 1. Sewage - usually in the form of water leaking through ceilings 2. Electrical infrastructure - emergency power back-up in theatres 3. Fire safety - storage of equipment and consumables compromising emergency evac routes - This has been addressed with the creation of storage in the basement. (July 2019) 4. Operating lights - (Theatre 7 require light replacement - July 2019 awaiting delivery Jan 2020) 5. Air-flow/ventilation - (addressed) 6. Storage - not enough dedicated storage space in theatres for equipment and consumables (addressed) 7. Insect infestation - flies and bugs being seen in theatres - (addressed No incidents reported 01/01/19 to 08/01/20) 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. Date of origin: Feb 17 Date of escalation to Divisional Management: Sep 17 Risk Lead: Critical Care Group Manager	4 x 3 = 12 AMBER	1. Existing programme of theatre works in place (3 phase refurbishment is underway - expected completion is August 2020). Stage 1 completed, started Stage 2 - Phase 1 (Dec 2019) 2. All leakage/flooding/insect infestations incidents reported to management are immediately escalated to Hotel Services 3. Theatre 5 was closed for refurb between April 17 - Oct 18 - This is now open and is fully utilised.	1 - 7 No procedure cancellations due to any of the listed issues for 12 months (Jan 20) 2 - 1 x reported incident of power outage or back-up power failure in Theatre 7 during August 19 - no further reports (Jan 20) 7 - No reported incidents of insect infestation for last 12 months (Jan 20) 1. Work completed for fire compartmentalisation in clinical areas (Feb 20) 1. Storage reconfiguration has been completed (Jan 20) 1. Replacement of mainboards for Theatres 3,4,5 and non-clinical areas underway (Jan 20)	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) 2) 1x incident reported in Jan 2020 re: water/ waste leaking through the ceiling along the dirty corridor outside theatre 5 - Datix 231074 (Jan 20)	1-3. Reconfiguration of Theatre reception continues. Stage 2 underway. 1-3. Scope the provision of flushable wipes for the wards 1-3. Theatre 4 & 7 light replacement to take place on the 4th and 5th March 2020	Mar-20 Apr-20 Mar-20	2 x 1 = 2 GREEN	Feb-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	If sub-optimal staffing (reduction in 39%) continues within the Ultrasound Scan Department, then it will impact on required compliance with national screening standards - this includes submitting the required data and proving quality of work is assessed continually for obstetric patients. Neonatal hip and cranial scans also need to comply with national standards and this may be affected. Training will also be impeded affecting the future of service provision. There may be a rise in litigation cases and disability, amongst other issues. Date of origin: 17/05/18 Date of escalation: 05/09/19 Risk Lead: Head of Midwifery	3 x 4 = 12 AMBER	1) Dating and Fetal Anomaly scans are given priority over Gynaecology scans to ensure women have their scans performed in accordance with the national programme standards. 9/4/19 2) Community Midwives have the facility to telephone the Maternity Unit and organise an urgent priority scan if a woman is thought to have booked late (9/4/19) 3) Midwife Sonographers in fetal medicine (FMU) are being asked to assist with scanning both obstetric and gynae scans in the main scan department when staffing in FMU allows (9/4/19) 4) Staff in Maternity Scan Dept.are continually reviewing their staffing levels to escalate their concerns appropriately (9/4/19) 5) Agreement for sonographers to volunteer to run weekend clinics and extended days to increase available scanning slots. (09/04/2019) 6) Current adhoc support from midwife sonographers enables the sonographers to undertake hip, cranial and emergency gynae scans which have been prioritised. (9/04/2019)	1-4) There are no reported incidents whereby a woman has missed the opportunity to have her dating or anomaly scan as a direct result of sub standard staffing within main scan (11/2/20) 1-3) The Antenatal Screening Coordinator (Midwives) has not received any notifications from any community midwives to inform of missed antenatal screening (11/2/20) 1-15) Prioritisation of urgent patients, e.g., ectopics from ward and EPAU (11/2/2020) 1-15) Patients may be admitted to ward if unable to perform scan and confirm diagnosis (11/2/2020) 1-15) Currently, due to the prioritisation of work, sonographers are attempting to perform scans within standards stipulated for babies and mothers.(11/2/2020) 11) Staff have worked additional hours on the enhanced rate (11/2/20) 1-15) Still working weekend sessions to keep hip scans within 6 weeks (11.2.20) 1-15) Currently, all obstetric patients are being offered screening and anomaly scans within the screening standard and no incidents have been reported (11/2/20)	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 (11/2/20) 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.(11/2/2020) 11) There remains a vacancy for a dedicated sonographer Manager. (11/2/20) 1-3) Whilst patients aren't missing screening there have been incidences where women have not been offered the combined screening (Downs, syndrome, Edwards and Pataus syndromes) at 11+2 - 14+1 weeks gestation which is the optimal screening test. Patients have gone on to have the QUAD test which is a less accurate screening test and is for Downs syndrome screening only (11/2/20).	1) Increase staffing of sonographers in main scan 1) Re-advertise for permanent sonographers 1) Ultrasound Superintendent Manager to be advertised and recruited. 1) Further training of midwife to undertake full sonography role	Jun-20 Jun-20 Apr-20 Jun-20	1 x 3 = 3 GREEN	Feb-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?
				7) Selected low risk gynae patients have been referred to Radiology (09/04/2019) 8) Doctors training cancelled as a temporary measure in Women and Children's to maximise the patients being scanned in a list. (9/04/2019) 9) x2 sonographers have been employed via the Bank - booked if they are available (09/04/2019) 10) x2 members of staff have increased their hours on a permanent basis (09/04/2019) 11) Enhanced Bank Rates £45/hr are being offered for any part time current staff (09/4/2019) 12) Plans to train a nurse from EGAU to do scanning (9/4/2019) 13) Training two midwives to scan 3rd trimester scans (9/4/19) 14) Health & Safety assessment from Occupational Health undertaken (9/4/19) 15) Agency sonographer started on the 07.01.19 - 0.4 WTE (9/4/19) 16) Recruitment drive for both agency sonographers and permanant staff continues. 1WTE appointed (started April 19) and 1 WTE due to start October 2019. 20/8/19	13) One midwife has completed her training and one midwife is due to complete her training (11/2/20) 12) Nurse started University in February 2019 (11/2/20) 15) Weekends are being utilised to adhere to Gynae and Hip scan standards (11/2/20)				

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?
Medical Director	5045	Sepsis and severe infection are perhaps the most common reasons for admission to hospital and cause of inpatient deterioration. If patients do not receive high quality and timely sepsis care through detection, recognition and management of the deteriorating patient then patient harm or death could result. Date of origin: Jun 18 Date of escalation: Jun 18 Risk Lead: Medical Director	4 x 3 = 12 AMBER	4) Training staff in the recognition and management of sepsis - ongoing monitoring. 2) Early warning systems for paediatric, maternal and adult patients assist in the detection of deteriorating patients - many of whom will have sepsis. 3) Sepsis screening tools exist for paediatric, maternal and adult patients who deteriorate and may have sepsis. Optimal utilisation of these tools help reduce the mortality and morbidity from sepsis. 1) A trust antimicrobial guideline has been developed to advise appropriate antibiotics for given indications. This is available as an app and on the intranet and is subject to audit. 5) Two sepsis nurses have been recruited (1 band 7 and 1 Band 6) (Feb 19) 6) Vital PACS upgrade with sepsis module have been implemented on 28th March. Captured data will measure compliance and improvement in identification and timely management of sepsis. 7) Weekly sepsis report is being forwarded to all directorates and the performance will be discussed at QSIG meeting and at the Governance meeting.	4) Mandatory training compliance in IP and Sepsis is monitored at directorate governance 2) Early Warning Score audit compliance. Auditing medical records to ensure the processes of detection, recognition and management of deteriorating patients is robust with feedback of performance to directorates and the development of action plans to achieve compliance 3) Compliance with sepsis screening and sepsis 6 delivery. Auditing the use of the sepsis screening tool and delivery of the sepsis 6 with feedback of performance to directorates and the development of action plans to achieve compliance 1) Antimicrobial prescribing compliance. To ensure that antimicrobial prescribing is compliant with trust guidance and that antimicrobials are reviewed to reduce antimicrobial resistance 4) LBR training funding for 19/20 is risk prioritised and includes Intermediate Life Support, Neonatal Life Support, Advanced Paediatric Life Support, ALERT training, ALS, Non Medical Prescribing etc. (May 19)	4) Mandatory training performance report. 2) Non-Compliance with EWS audit. 1) Non-compliance with Antimicrobial audit. 5) Currently we have three sepsis nurses (last appointment Nov 2019). One of them is currently on maternity leave.	Conducting regular sepsis compliance audits in ED, Inpatients, Haemat-oncology, Paediatrics and Obstetrics. The results of these are fed back to the DPG monthly. Regular QIP projects to improve the delivery of sepsis screening, awareness and antibiotic delivery within an hour in patients with sepsis or suspected sepsis. This will also help identify any barriers that influence the uptake of the sepsis screening. Generating weekly sepsis report from sepsis module and sharing it with the directorates. (Sep 19)	x =	Feb-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?
Medical Director	5182	If RWT does not meet NHSE requirements of having Cardiac Thoracic and Aortic Services co-located with Vascular services on RWT site, then the Aortic service specification will not be met and RWT may not be authorised for Aortic services, this will adversely result on impacting patient service provision at RWT. Date of origin: 11/03/19 Date of escalation: 25/03/19	4 x 4 = 16 RED	1. Vascular support in place for TAVI (Mar 19) 2. Monthly aortic MDT occuring at RWT (Mar 19) 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) 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) 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)		1-2 Frozen Elephant Trunk (FET) Device is not yet approved (Jan 20) 1, 2, 5. From May-Dec19 there have been 3 x TAVI lists cancelled due to lack of vascular cover (Jan 20)	1-2. To seek further evidence to enable approval of FET device. 3, 4. A further regional meeting to confirm the workings of the rota etc is planned in November 2019.	Dec-19 Nov-19	2 x 2 = 4 YELLOW	Feb-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	2. Consultants and ANP's being offered WLI rates/overtime to do additional clinics in areas where there are a particularly large number of patients overdue their review appointment 3. As we use partial booking the review appointments are actively managed and not booked up too far in advance so if a patient contacts the Directorate with any concerns we are able to give them an appointment within a reasonable timescale and will speak to the consultant about overbooking if a patient needs to be seen urgently. 4. Patients on FU OWL are validated by the FU OWL coordinator to ensure that they are appropriately booked so that slots aren't wasted 5. Assistant Directorate Manager regularly reviews slot utilisation report to ensure that all review slots are used 1. Recuitment Stategy in place 6. Added an additional bex to the RTT form so that Consultants can indicate if a patient needs to be seen by a specified date. 7. Registrars have been asked to review patients who are red on follow-up OWL starting with the Consultants who have the most to pull out clinically urgent.	2. Extra clinics continue to run when consultants/ANPs agree to do so (Jan 20) 3. Partial booking process remains in place (Jan 20) 4 & 5. Deloittes KPI report showed high level of slot utilisation for review clinics (Jan 20) 1. Appointed new EP Consultant Cardiologist started 20 January 2020 (Jan 20) 1. Appointed new Interventional Cardiologist due to start 5 March 2020 and will be doing some clinics (Jan 2. There are monthly meetings with Arrhythmia Nurses/Cardiology ANP to undertake additional clinics to support (Jan 20) 1. Locum Consultant appointed due to backlog of patients. They have been asked to do 5 clinics a week which should help the situation (Jan 20)	2, 4, 5. Numbers of review patients on FU OWL and overdue continuing to rise despite additional clinics and other controls (Dec 2019) 1-6. Red FU OWL = total waits 2872 (14.01.2020) the patient is overdue their appointment (Jan 20) 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) 1-6 Green FU OWL = total waits 2403 (14.01.2020) the patient is due their appointment in more than 6 weeks (Jan 20)	1. Extra consultant posts being recruited into to increase OP capacity across whole of cardiology 2-7. Review capacity and demand. 1-7. A further business case will be required which is in line with years 2-3 of the 10 year plan. 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. 6,7. Identify patients that do not require a Consultant review for a pacemaker check to ease waiting list times 3,5,6,7. Pooling internal referrals for EP 1. Band 7 Arrythmia Nuse advertised.	Feb-20 Feb-20 Jan-20 Jan-20 Jan-20 Jan-20 Jan-20	4 x 2 = 8 AMBER	Feb-20	

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Chief Operating Officer	5243	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 & wellbeing. Created: 14/06/19 Accepted onto Divisional Risk Registers (1 and 3): 23/09/19 Accepted onto Trust Risk Register: 04/11/19	3 x 3 = 9 AMBER	1. Twice weekly reports from Fast Track team re outstanding referrals v available capacity (June 19) 3. Communication put on ERS for GPs to advise patients that wait is longer than 14 days (June 19) 4. Regular backfill of cancelled sessions (due to annual leave, study leave, on-call and post on-call time off) where possible (June 19) 5. Saturday clinics when possible (Sept 19) 7. Weekly PTL meeting (June 19) 6. Agenda item at weekly performance meeting (June 19) 8. Monthly Cancer Recovery Meeting and associated action plan shared with external stakeholders 9. Additional Radiologist capacity in place with locums (November 2019) 10. Advanced Practitioner Radiographer recruited to start in post from December 2019 (September 2019) 2. Script provided to Fast Track for managment of patient expectations (June 2019)	5. Saturday clinics are having a positive impact (January 20) 1-10 As at the 09/01/20 the Trust has capacity to see patients within 9 days (January 2020) 1-10. Latest West Midlands report shows improvement from 13th to 9th out of 13 Trusts (January 2020) 1-10. Improvement in 2 week wait Aug 19 - 3%, Dec 19 - 87.8% (January 2020) 1-10. Achieving 28 day faster diagnosis 92% (January 2020) 1-10. Improvement in 62 day Aug 19 - 18.20%, Dec 19 - 75% (January 2020) 1-10. Improvement in Breast symptomatic Aug 19 - 2.3%, Dec 19 - 80.30% (January 2020)	1. Continued pressure on workload due to increased referrals - Jan 407 (January 2020) 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) 7. Reporting mechanism only (June 19) 9. Additional Radiology capacity is locum / non-substantive so potentially fragile (Sept 19)	1-8. Clinical Fellow from India has commenced, will require training in general & breast (January 2020) 9. Recruit Consultant Radiologist - out to advert (January 2020) 1-10 Implementation of new referral form and pain pathway across the West Midlands with an anticipated referral reduction of 15% (January 2020) 1-8 Business Case for Consultant Nurse (Breast) to be presented to Division (January 2020) 1-10 Introduction of stratified follow up of Breast patients with associated workforce (January 2020) 9-10. Superintendent Radiographer appointed, awaiting start date (January 2020)	Mar-20 Feb-20 Apr-20 Jan-20 Jun-20 Feb-20	2 x 1 = 2 GREEN	Feb-20	

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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	1) Palliative Consultant Radiologist reviewing Palliative care patients (07/19) 2) Prioritisation of existing patients (07/19) 3) On- going monitoring of service performance against national cancer targets (07/19) 4) Clinical Director trained in managing thyroid cancer patients (07/19) 5) 104 day harm reviews to identify harm (09/19) 6) Senior Clinical Fellow programme is providing support to the existing service	6) Senior Clinical Fellows are being supported through the CESR programme (01/20) 2&3) Discussions are ongoing with other healthcare providers (01/20) 5) No harm identified from 104 day reviews (01/20) 6) Senior Clinical Fellows continue to provide significant support to service (01/20) 4) Dr who manages thyroid cancer patients will return from sabattical in Feb 20 (01/20) 4) 2 locums secured to cover vacancies, not Gynae 01/20)	1 & 4) Consultant consistently raising concerns regarding lack of cover during periods of leave (01/20) 3) The service is severely compromised in its ability to provide adequate clinic appointments at the end of the 62 day target pathway (01/20) 1-6) Currently no appropriate locum cover available (01/20) 1, 2, 4) Increase in number of medical staffing incidents on Datix (01/20)	1-4) Formalise competencies in the current Clinical Fellowship programme to identify medical staff of suitable calibre 1-6) Identify locum Cons cover 1-4) Work with Dudley to standardise the discharging process and subsequent radiotherapy referrals 1-6) Discussions ongoing with SATH specifically including brachytherapy 1-6) Discussions with SATH and UHNM with regards to brain and gynae service provision 6) Senior Clinical Fellow job plan to be reviewed to provide support to existing gynae Cons	Feb-20 Dec-19 Feb-20 Jan-20 Jan-20 Jan-20	2 x 4 = 8 AMBER	Feb-20	

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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. Accepted onto TRR: 16/09/2019	4 x 3 = 12 AMBER	2. 1 x CFM machine available and 1 x loan machine is currently in place (Dec19) 4. Local printer set up to one CFM for printing of CFM trace (Dec19) 3. Fast track charger available for failure during recording (Dec19) 1. Current situation awareness for all consultants and senior nursing team (Dec 19) 5. The directorate is undertaking a trial of 2 x different machines in order to identify the preferred product (Dec 19)	5. The directorate has 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)	1-5) Replace existing equipment 1-5) Business Case to be presented to support replacement of equipment 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	Apr-20 Mar-20 Feb-20	1 x 1 = 1 GREEN	Feb-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	5284	If the issues relating to EPMA are not resolved then healthcare professionals involved in the prescribing and administration of medicines may not be able to prescribe or administer medicines in a safe or timely manner. As a consequence this may result in patient harm due to incorrect prescribing or administration of medicines, or missed or delayed doses. The issues relating to EPMA that contribute towards this risk can be categorised into: Lack of functionality or errors associated with the software. Lack of or errors associated with interfaces with other Trust systems (electronic and paper). Staff using the system incorrectly or suboptimally. Lack of and poor suitability of hardware for EPMA. 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 buisness continuity.	4 x 3 = 12 AMBER	1. There is an EPMA Steering Group chaired by the Medical Director which provides Executive level oversight and strategic direction for EPMA. (Aug 19) 2. Establishment of the EPMA Operational Group to address the issues with EPMA. This group reports into the Steering Group and links with the Trust Medicines Managment Group. (Aug 19) 3. A meeting was held with the system suppliers Emis to secure ongoing engagement to resolve system issues 10.7.19. List of priority system issues was presented to Emis. (Aug 19) 4. A list of priority system issues has been produced by the EMPA Steering Group. (Aug 19) 5. An assessment of all Datix relating to EPMA since go-live has been produced and will be shared with the Steering Group and Operational Group in August. This will continue to be monitored and reported on. (Aug 19) 6. A business case for additional resource to support EPMA has been approved and the posts are being recruited to (Datix 5204), this includes additional posts to support training.. (Aug 19)	1. The EPMA Steering Group meets monthly and minutes are available. (Feb 2020) 2. The first meeting for the EPMA Operational Group is scheduled for September. A Chair has been appointed. (Feb 2020) 4. Emis has responded in writing to the priority list and will be undertaking a site visit in September. (Feb 2020) 5. Datix reports relating to EPMA are monitored monthly. (Feb 2020) 6. The business case is approved and posts being recruited to. (Feb 2020) 9. Emis are actively managing the intermittent issue where the system freezes and this is preventing it from occurring. (Feb 2020)	5,6. User error is a cause of incidents reported via Datix, this could be improved with better training for EPMA. (Feb 2020) 7. Hardware is being reported as broken and monies need to be identified to replace. (Feb 2020) 5. The Datix assessment shows 13 incidents directly relating to EPMA for Jan 20 System user errors are the greatest source of incidents (4 reports). There is 0 report of moderate patient harm. (Feb 2020) 4,9. System down time is still occuring, 19 occurances from 1/1/20 to 31/1/20 (Feb 2020) 4,9. No issues on the priority list have been resolved. (Feb 2020) 1,2. The Medical Director is receiving complaints from Consultants regarding EPMA. (Feb 2020) 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. (Feb 2020)	Business case for IT hardware support Review and improve user training Replace broken hardware Upgrade software Develop SOP's to support user guide Address PAS issues impacting on ePMA Write a business case for additional BC machines Review BC SOP's and agree actions to be taken when EPMA is unavailable	Feb-20 Feb-20 Feb-20 Apr-20 Feb-20 Mar-20 Feb-20 Feb-20	1 x 3 = 3 GREEN	Feb-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?
				7. IT are undertaking a trial of alternative hardware solutions and requesting that wards report all hardware issues to IT. (Aug 19) 8. The Medicines Managment Group and Steering Group approved an SOP which means that EPMA will not be used for day case surgery and will not be used on admission for elective surgery. This will be reviewed if Emis can make system changes to improve the use of EPMA in patients following the surgical pathway. (Aug 19) 9. There is an issues (hazards log) which records all EPMA issues and actions. This is maintained by the EPMA Team and managed by the EPMA Operational Group. (Aug 19) 10. The EPMA Steering Group has agreed not to extend the current EPMA system to new areas until current issues are resolved. This means it will not be extended to paediatrics, neonates and maternity at the current time. (Aug 19)						

Director	Cross Ref	What is the Risk?	Current Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	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 iniatives (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 iniatives are still being undertaken (Jan 20) 2. T&O Directorate - Locum in place (Jan 20)	4. Letters received week commencing 30th Sept 2019 - no individuals have taken up the offer (Jan 20) 3. Some specialties could improve session utilisation (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 Feb-20 Mar-20	2 x 2 = 4 YELLOW	Feb-20	
Chief Operating Officer	5315	DGFT/RWT 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	Feb-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	5316	The Ophthalmology department has a backlog of paediatric and adult patients awaiting squint surgery. This has occurred due to a combination of: (a) the Trust's decision to move paediatric surgery from Beynon Centre theatres to Nucleus theatres in 2017. (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) (c) a lack of paediatric bed capacity on the Paediatric Ward on the allocated day of Ophthalmology surgery in Nucleus theatre. 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. Accepted onto Divisional RR = 11/12/2019 Accepted onto the TRR = 02/01/2020	4 x 3 = 12 AMBER	5. Insource services from SHS to carry out paediatric and adult squint surgery in order to reduce waiting lists. 4. Recruitment of Occular Motility Consultant 3. Nucleus theatre team offer Opthalmology team theatre session cancellations. 2. Weekly activity review meeting with Patient Access team to discuss waiting lists and strategy 1. Practice Manager monitors weekly PTL data to ensure patient waiting times do not breach 6. Seek Trust approval to continue utilising services of SHS private organisation to carry out paediatric and adult squint surgery at New Cross Hospital 7. Prioritise longer waiters to ensure no clinical implications for patients and decrease the risk of breaching and financial implications to the Trust 8. Accept available nucleus theatre slots when paediatric beds/nursing staff are available. 9. Recruitment of Paediatric Consultant Opthalmologist 10. Theatre allocation of 8 beds and regular paediatric theatre session	1-10. No complaints or concerns raised (17.01.20) 1. Closely monitoring waiting list to avoid 52wk breaches (17.01.20) 9. Appointment Paediatric Consultant Opthalmologist, due to start January 2020 (17.01.20) 10. Allocated regular paediatric Monday theatre slot with 8 beds (17.01.20) 5. New consultant undertaking squint surgery in Jan 20 alongside SHS consultants (17.01.20)	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 (17.01.20) 2. Waiting times may still rise if no theatre sessions available and if consultants availability is limited to operate. In addition patients may be unable to attend for surgery at short notice (17.01.20) 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 (17.01.20) 4. Ocular Motility Postholder unable to commence in post until February 2020 (17.01.20) 5. SHS may be unable to support all dates (17.01.20) 5. RWT may not be able to provide theatre teams/anaesthetists when required on an overtime basis (17.01.20) 5. SHS may be unable to provide theatre teams/anaesthetists when needed (17.01.20)	1-10 Consider Associate Specialty Doctor reviewing new patients in order to determine a plan for care 1-10 Validate waiting lists to ensure patients treated before 52 weeks breach date	Jan-20 Mar-20	3 x 2 = 6 YELLOW	Feb-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?
						5. Patients may be unable to attend for surgery on appointed dates (17.01.20) 5. Limited paediatric bed availability that could be further reduced during winter months (17.01.20) 5. Waiting list increases due to new patients being added, currently 172 patient on the OPWL waiting for a new appointment, 46 have waitied over 30 weeks for a new appointment with no clinics available to offer an appointment. Longest wait for a new appointment 41 weeks (Dec19) to be updated 5. There are currently 93 patients waiting for squint surgery, longest wait at 49 weeks (Dec 19) to be updated 5. There are currently 32 patients that will breach 52 weeks between 30/12/2019-30/03/2020 if not operated on (Dec 19) to be updated				