The Royal Wolverhampton NHS Trust

Board Assurance Framework
6 November 2019

Agenda Item No: 11.

Safe & Effective | Kind & Caring | Exceeding Expectation

The Royal Wolverhampton NHS Trust

Trust Board & Board Committees Report

Report Date:	06 November 2019
Title:	Board Assurance Framework
Executive Summary:	To inform the Trust Board and Trust Board Committees of updates to the Board Assurance Framework (BAF).
Action Requested:	**Receive and note**
For the attention of the Board	**1. Summary** **5 red risks**: **SR1** - Workforce - Recruitment and Retention of staff across the Trust and in particular the future pipeline of nursing and medical staff **SR8** - That there is a failure to deliver recurrent CIP's. **SR9** - That the underlying deficit that the Trust has (in 2018/19) is not eliminated in medium term to bring the Trust back to financial surplus. **SR12 –** Mortality rates – reputational risk. **SR13 –**Cancer performance metrics place RWT in the bottom quartile nationally. **2. Updates** Updates since the previous version of the BAF have been subject to Director and Company Secretary leave periods. Updates SR1 was updated on 14/10/2019, SR8 was updated on 22/10/2019, SR9 was updated on 08/10/2019, SR12 was updated on 23/10/2019. SR13 was updated on 22/10/2019 **3. Reviews:** The respective updates, BAF Risks and red risks are reviewed in depth at the following Board Committees. The Board Committees are provided with the whole BAF in case they need to refer to areas of potential overlap or duplication with other BAF Risks. • SR1 was reviewed by Workforce & Organisational development Committee (WODC) on 25/10/2019. • SR8 was reviewed by Finance & Performance Committee (F&P) on 23/10/2019. • SR9 was reviewed by Finance & Performance Committee (F&P) on 18/10/2019. • SR12 was reviewed by Quality Assurance Governance Committee (QGAC) on 23/10/2019. • SR13 was reviewed by Quality Assurance Governance Committee (QGAC) on 23/10/2019. The Trust Board takes an overview of the whole of the BAF, advised by the Committee Chairs of any specific issues for the attention of the Board. The Board considers whether there are any new or emerging risks from the summary from the Trust Risk Register. **4. Potential BAF Risks discussed.** None in this period. **5. Potential BAF Risks – TRR Red Risks.** • Included in the Report provided. Risk 5243 is pending inclusion in SR1 and SR13.
Assure	• The risks identified in the BAF are regularly reviewed and revised.
Advise	• Revisions to the BAF are undertaken in a systematic and well-Governed way.
Alert	• None at present.

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Links to Trust Strategic Objectives	1. Create a culture of compassion, safety and quality 2. Proactively seek opportunities to develop our services 3. To have an effective and well integrated local health and care system that operates efficiently 4. Attract, retain and develop our staff, and improve employee engagement 5. Maintain financial health – Appropriate investment to patient services 6. Be in the top 25% of all key performance indicators
Resource Implications:	No additional resource implications from this report.
CQC Domains	**Safe:** patients, staff and the public are protected from abuse and avoidable harm. **Effective:** care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence. **Caring:** staff involve and treat everyone with compassion, kindness, dignity and respect. **Responsive:** services are organized so that they meet people's needs. **Well-led:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.
Public or Private:	Public
Other formal bodies involved:	Quality Governance Assurance Committee (QGAC) of the Board, Finance and Performance Committee of the Board (F&P), Audit Committee. Workforce & Organisational Development Committee of the Board (WODC)
References	None
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

Trust Strategic Objectives

Our Values		
Safe and Effective We will work collaboratively to prioritise the safety of all within our care environment	**Kind and Caring** We will act in the best interest of others at all times	**Exceeding Expectation** We will grow a reputation for excellence as our norm

Trust Strategic Objectives 2019-2021					
1. To have an effective and well integrated health and care system that operates efficiently	2. Proactively seek opportunities to develop our services	3. Create a culture of compassion, safety and quality	4. Attract, retain and develop our staff and improve employee engagement	5. Maintain financial health - appropriate investment to patient services	6. Be in the top 25% for key performance measures

Summary of Board Assurance Framework entries as of 06/11/2019

			RISK SCORES: LIKELIHOOD x CONSEQUENCE = TOTAL														Strategic Objectives					
REF	STRATEGIC RISK	ASSURANCE	INITIAL	December 18	January 19	February 19	March 19	April 19	May 19	June 19	July 2019	August 2019	September 2019	October 2019	November 2019	Last to current	SINCE LAST UPDATE	Current Nov 18	Target	1	2	3	4	5	6
SR1	Workforce - Recruitment and Retention of staff across the Trust and in particular the future pipeline of nursing and medical staff.	Director of Workforce	15	20	20	20	20	20	20	20	20	20	20	20	20	→	→	20	12				✓		
SR8	That there is a failure to deliver recurrent CIP's	Chief Operating Officer	20	20	20	20	20	20	20	20	20	20	20	20	20	→	→	20	16					✓	
SR9	That the underlying deficit that the Trust has (in 2018/19) is not eliminated in medium term to bring the Trust back to financial surplus.	Chief Financial Officer	15	20	20	20	20	20	20	20	20	20	20	20	20	→	→	20	20					✓	
SR12	The high and rising SHMI could reduce the confidence of the public, patients, external agencies, regulators and commissioners in the quality of care the Trust provides.	Medical Director	12	16	16	16	16	16	16	16	16	16	16	16	16	→	→	16	9						✓
SR13	That the Trust cancer performance metrics place RWT in the bottom quartile nationally.	Chief Operating Officer	20							20	20	20	20	20	20	→	→	20	16						✓

Trust Board Assurance Framework

The Royal Wolverhampton NHS Trust

The Board Assurance Framework "provides organisations with a simple but comprehensive method for the effective and focused management of the principal risks that arise in meeting their objectives". This Assurance Framework assesses the most important risks that the Trust faces to date (prospective and actual) and that have the highest potential for external impact. Such risks differ in magnitude and complexity to operational risks and often require comprehensive risk mitigation plans which spans over a longer timescale than most operational risks.

The Trust defines strategic risk as a strategic control issue that could:

- Close down a service/services
- Seriously prejudice or threaten achievement of a principal objective
- Threaten the safety of service users.
- Threaten the reputation of the Trust/NHS.
- Lead to significant financial imbalance and/or the need to seek additional funding to enable resolve and/or result in significant diversion of resources from another aspect of the business.

Strategic (principle) risks will be reviewed as part of the annual business planning process and can also be identified in-year. They are managed as part of a complex process as opposed to discrete events. The Trust Board needs to be satisfied that strategic risks are being properly identified and managed robustly.

Risk score = consequence (i.e. impact) x likelihood - The matrix below is used to calculate a risk score, which will determine the category the risk falls within, that score informing follow up action, its urgency, and the required performance management to ensure the risk is managed effectively. For a fuller description/explanation of categories refer OP10 Policy.

	Consequence				
	Detailed descriptions of consequences relevant to different aspects of the Trust functions are in OP10 p21				
Likelihood	1 - Insignificant	2 - Minor	3 - Moderate	4 - Major	5 - Catastrophic
5 - Almost Certain	5	10	15	20	25
4 - Likely	4	8	12	16	20
3 - Possible	3	6	9	12	15
2 - Unlikely	2	4	6	8	10
1 - Rare	1	2	3	4	5
Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Broad description of frequency	Not expected to occur (yearly/years)	Not expected to occur, however could given right circumstances (annually).	May occur occasionally (monthly)	Will probably occur, however not a persistent risk (weekly)	Likely to occur on many occasions; a persistent risk (daily)

The extent to which the origins of the risk currently impact on the strategic risk.	
	The origin of the strategic (principle) risk is significantly impacting on the risk.
	The origin of the strategic (principle) risk is still impacting on the risk to a limited extent.
	The origin of the strategic (principle) risk is no longer impacting on the risk

The extent to which the controls in place are satisfactory in impacting mitigation of the strategic risk.	
	Effective control partially in place and thus only impacting in a limited way on the mitigation of the strategic risk.
	Effective control in place but only partially impacting on the mitigation of the strategic risk
	Effective control in place and positively impacting on the mitigation of the strategic risk.

Movement - The direction from last reported quarter	
↓	Indicates improvement from last reported quarter
→	Indicates same level from last reported quarter
↑	Indicates slippage or further required work from last reported quarter
★	New item added since last quarter

References by section (also used to cross reference with entries in other sections where relevant)	
IC	Impacts and Origins of the risk
CM	Controls and Mitigations in place
PA	Sources of Positive Assurance in place
GC	Identified Gaps in Control/Negative Assurances

Ref	SR1	Strategic Objective: To attract, retain and develop all employees and improve employee engagement year on year.

Statement of Risk, scores

Date identified	STRATEGIC RISKS	EXECUTIVE DIRECTOR	BOARD COMMITTEE
May 2015	Workforce - Attraction, Recruitment and Retention of staff across the Trust and in particular the future pipeline of nursing and medical staff.	Director of Workforce	Workforce & OD/ Finance & Performance

Initial Score	Last Month(M) level	Current level	Target level	Movement M to M
3 x 5 = 15	4 x 5 = 20	4 x 5 = 20	3 x 4 = 12	

Risk Register Risks

OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC OBJECTIVE

RISK No.	RISK TITLE
1713	Consultant Job Plans
GRADE	**OPERATIONAL RISK DESCRIPTION**
4 x 3 = 12	Failure to effectively maximise workforce productivity; failure to routinely review consultant job plans.

OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC OBJECTIVE

RISK No.	RISK TITLE
2080	Recruitment and retention of Nursing staff - Division 2
GRADE	**OPERATIONAL RISK DESCRIPTION**
4 x 5 = 20	If the Trust is unable to recruit and retain sufficient nursing staff across the Division then there will be reduced quality of care for patients, including increased risk of falls or harm. Regraded from 20 RED to 16 RED on 2nd Oct 2018. Following discussion at Div Gov, agreement to reduce risk score to 4 x ~~4 =16~~ 5 = 20. COO and Tim Powell.

OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC OBJECTIVE

RISK No.	RISK TITLE
4161	Qualified Nurse staffing levels - Division 1
GRADE	**OPERATIONAL RISK DESCRIPTION**
4 x 3 = 12	If there are reduced qualified nursing staffing levels across the Division then there is a risk to patient safety and quality of care.

OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC OBJECTIVE

RISK No.	RISK TITLE
4529	Vacancies in consultant or non-consultant medical staff across Division 1.
GRADE	**OPERATIONAL RISK DESCRIPTION**
4 x 3 = 12	Consultant or non-consultant medical staff across the Division, this will compromise the provision of a safe, effective elective service and to the safe staffing of on-call rotas.
RISK No.	**RISK TITLE**
4599	Emergency Services Governance Arrangements
GRADE	**OPERATIONAL RISK DESCRIPTION**
3 x 4 = 12	If there are staffing issues within the Emergency Dept, especially substantive shortages within the Medical team, along with increased numbers of patients attending, leading to significant pressure on the staff within ED. This will lead to an inability to engage fully with Governance processes. This will result in potential compromised patient care, inability to provide assurance in relation to the Governance agenda and financial penalties as a result of missed targets re RCA's and DoC. Date of origin: Aug 16 Date of escalation: Mar 17 Risk Lead: Emergency Department Group Manager
RISK No.	**RISK TITLE**
4170	Lack of capacity - OPD, Snowdrop Suite and Durnall Unit
GRADE	**OPERATIONAL RISK DESCRIPTION**
4 x 3 = 12	If there is a lack of physical and staffing capacity in the Durnall unit, then this will impact on the ability to effectively triage and treat sick patients. This will result in neutropenic sepsis patients not receiving treatment within the 'golden hour', patients receiving line care and other interventions having significant delays and long waiting times, including pts with life limiting conditions. Clinics over running significantly leading to poor patient experience. Date of origin: May 2015 Date of escalation: April 2019 Risk lead: Group Manager for Oncology and Haematology
RISK No.	**RISK TITLE**
5069	Dermatology Fast Track Capacity
GRADE	**OPERATIONAL RISK DESCRIPTION**
3 x 4 = 12	If there is insufficient workforce capacity in Dermatology to meet Fast Track demand then patients will not be seen within two week timeframe as per policy resulting in Cancer target breaches and delay in diagnosis and treatment. Date of Risk: 19/07/2018 Accepted onto Divisional RR: 16/11/2018 Accepted onto Trust RR: 15/02/2019

RISK No.	RISK TITLE
5243	Breast Cancer Service Recruitment Risk (General Surgery and Radiology)
GRADE	**OPERATIONAL RISK DESCRIPTION**
4 x 3 = 12	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: TBC Initial score; 4x5=20 Last review; 23/09/2019

Impacts, Origins

REF	IMPACTS / CONSEQUENCES OF THE RISK?	ORIGINS OF THE RISK?
IC 1	Potential over reliance on agency/locum resource may lead to quality issues and to the temporary medical workforce costs become unaffordable.	Reduction in the number of Doctors in Training coming through the deanery, gaps for some specialities, increasing reliance on temporary workforce and locums, the market is highly competitive.
REF	**IMPACTS / CONSEQUENCES OF THE RISK?**	**ORIGINS OF THE RISK?**
IC 2	Inability to deliver the future workforce plan with potential that the Trust is unable to provide the level of service it is commissioned for and putting quality of patient experience and outcomes at risk.	Lower interest medical training as a career, number of nurses leaving profession, increasing levels of voluntary turnover for Band 5 nurses, increasing number of doctors in training leaving the profession before FY2.
REF	**IMPACTS / CONSEQUENCES OF THE RISK?**	**ORIGINS OF THE RISK?**
IC 3	Inability to attract and retain suitability qualified staff with the potential for costs of attracting and retaining staff becoming unaffordable.	National shortage of trained nurses and medics in the UK, uncertainty re Brexit and cost of attracting and retaining EU and non-EU staff significant, lengthy lead times (6 months - a year for non-EU staff).
REF	**IMPACTS / CONSEQUENCES OF THE RISK?**	**ORIGINS OF THE RISK?**
IC 4	Potential for employee engagement indicators to decline (e.g. satisfaction, motivation) and for negative indicators (sickness, incidents greater than peer group upper quartile) to rise may lead to quality and cost issues, reduced staffing, negative impact~~ing~~ on patient care and morale of remaining staff and their satisfaction.	Shortage of workforce supply and competition from other NHS Providers and agencies with stronger benefits or workforce initiatives.
REF	**IMPACTS / CONSEQUENCES OF THE RISK?**	**ORIGINS OF THE RISK?**
IC 5	Potential for increased competition with other NHS organisations and salary escalation along with the wider issue of NHS competitive pay compared with the private sector	Gaps in key staff groups e.g. Consultant or non-consultant medical staff across the Division could compromise safe, effective elective service and safe staffing of on-call rotas.
REF	IMPACTS / CONSEQUENCES OF THE RISK?	ORIGINS OF THE RISK?
IC 6	Adverse impact on attracting key staff due to competition from other Trusts. Adverse impact on individuals financial positions. Adverse impact on retention of key staff once lifetime limit reached.	Changes to taxation rules and lifetime pension allowances for high earners.

Controls, Mitigations

Ref	***What are the controls in place to mitigate these risks?*** ***Level 1 = Operational, Level 2 = internal oversight, Level 3 = Independent Assurance**	*Level of assurance (L1, L2, L3)	**Where and how often reported/monitored?**
CM1	Recruitment and recruitment initiatives (including Overseas) for Doctors to complement local and national recruitment.	L2	Workforce & OD Committee (WODC), Resourcing Operational Group (ROG), TMC, TB
CM2	Recruitment and recruitment initiatives (including Overseas) for Nurses to complement local and national recruitment.	L1, L2	WODC, ROG, TMC, TB
CM3	Staffing establishment reviewed regularly through the annual workforce plan to provide a clear route/organisational plan for bringing in future workforce pipelines.	L1, L2, L3	WODC, NHSI

CM4	Progress report on Trust-wide workforce review to include the development of new roles.	L2	WODC
CM5	Strategic approach to People Management and employee engagement and measure outcomes of people and OD strategy.	L2	WODC

Positive Assurances

What are the positive assurances (actual) received?

Control Ref	Date Assurance provided	*What is the source for assurance?*
PA1	Initial 01/01/2017 June 17 1, 2 - Trust Board 07/10/2019 WODC 25/10/2019 TMC 25/10/2019 3 – 13/12/2018	1. Workforce & OD Committee - Resourcing Workforce Updates. 2. Executive HR Report to TMC and Trust Board. 3. Medical Workforce Group established to review Medical Recruitment and Retention Actions.

What assurance is provided?	**COMMENT**
Continued monitoring and reporting of recruitment and retention rates through Director of Workforce Reports to TMC, TB including recruitment and retention of clinical fellows. Impact of completed Marketing Approach (April 2019) demonstrated in reducing vacancy figures reported.	

Control Ref	Date Assurance provided	*What is the source for assurance?*
PA2	Initial 01/05/2017 June 17 1, 3, 4 - Trust Board 07/10/2019 WODC 25/10/2019 TMC 25/10/2019 2 – A&RSG 16/07/2019	1. Workforce & OD Committee 2. Attract & Retain Steering Group. 3. Safer Staffing Updates in Chief Nurse Update report to TMC and Trust Board. 4. Executive Workforce report to TMC and Trust Board.

What assurance is provided?	**COMMENT**
Update reports on progress of progress and future cohorts. Employee engagement indicators stability and reports of work of Attract and Retain Steering Group. Impact of completed Marketing Approach (April 2019) demonstrated in reducing vacancy figures reported.	

Control Ref	Date Assurance provided	*What is the source for assurance?*
PA3	Initial 01/05/2017 June 17 Trust Board 07/10/2019 WODC 25/10/2019 TMC 25/10/2019	1. Workforce & OD Committee - Resourcing Workforce Updates. 2. Executive Workforce Report to TMC and Trust Board. 3. Finance & Performance Committee 4. Update reports to Executive Directors through Director of Workforce. 5. Trust CIP Workforce Programme Updates on a monthly basis to include E-roster and Agency/Bank/Locum analysis.

What assurance is provided?	**COMMENT**
Annual workforce plan including Nurse Recruitment, Medical Recruitment, medical staffing establishment and vacancy levels, NHSI return of Workforce Plan. Clinical Fellowship Programme established to assist with recruitment of posts at 'middle grade junior doctor level' and to provide a new career path for medical roles. Trust CIP Workforce Programme has a work stream to control the use of agency, locum and bank staff – and Trust wide resource review is planned. E-rostering established to ensure staffing levels on wards are optimised. Allocate Job Planning Module to provide a control and baseline for medical staffing purchased November 2018 with implementation from April 2019. Impact of completed Marketing Approach (April 2019) demonstrated in reducing vacancy figures reported.	

Control Ref	Date Assurance provided	*What is the source for assurance?*
PA5	Initial 01/09/2016 June 17 25/10/2019 WODC	People and Organisation Development Strategy 2016-2020

People and Organisation Development Strategy 2016-2020 KPI extended and enhanced for 19/20 agreed and reported.

Control Ref	Date Assurance provided	*What is the source for assurance?*
PA6	25/10/2019 WODC	Staff Survey Implementation Group Action Plan

What assurance is provided?	**COMMENT**
Updates on progress reported to WODC and TB in turn.	

Gaps in Controls/Negative Assurances/Action Plans

What are the negative assurances received?							Updates made
Gap Control Ref	**Date Assurance provided**	**NEGATIVE ASSURANCE (include reasoning as appropriate)**	**Action in place to address**	**ACTION PLAN**	**ACTION LEAD**	**Expected resulting Control, Mitigation or Positive Assurance?**	**AGREED DEADLINE**
GC1	01/12/2017	Length of time from interview to start date over 6 months. (Medical)	Deadline extended to align with implementation of TRAC.	Reporting underway Divisions July, WODC August	Head of Resourcing	TRAC Report to WODC	25/10/2019 WODC
GC3	01/10/2017	A lack of consistency and standardisation of some roles within the Trust	Implement agreed action plan. PID agreed	PID approved by FRB 2018	Deputy Director of Workforce	Single (or very small number) JD by role used in recruitment	Review 01/11/2019
GC4	01/09/2017	There is a lack of a consistent organisational employment model to support greater flexibility, recruitment & attraction required.	*Establish and promote and improved flexible enhanced employment model **and overarching approach to recruitment and retention.	*Currently on hold as Trust now part of national programme runs to March 2020 **continues.	Deputy Director of Workforce	Recruitment & retention rates, increase in flexible working requests.	25/10/2019 WODC
GC5	01/12/2018	Failure to effectively maximise workforce productivity; failure to routinely review consultant job plans.	Job planning module procured and implement electronic system	Business Case approved by Board.	Dep Medical Director Head of Resourcing	Organisational reporting of Job Planning implementation from 01/04/2019	01/11/2019
GC6	01/12/2018	A lack of longer term plans to establish a central resourcing for temporary staffing that improves internal bank and external agency placement requests as a Black Country collaborative bank.	Black Country and wider proving difficult –Tier 1 focus with Walsall only*. Tier 2 all Black Country initial conversations** Medical bank being improved across RWT only.	Letter from NHSI **Formal proposal to B/C Trusts in process following scoping by NHS Professionals.	Director of Workforce	Reporting on delivery of collaborative bank to WODC with Walsall as phase 1.	01/12/2019
GC7	01/06/2017	There is a perceived lack of control over agency and locum use require further controls in place in order to have a planned and financially sustainable approach to temporary staffing.	New set developed. Pilot in Division 3 now commenced to be reviewed in June 2019. Pilot to be reviewed at FRB in November.	Paper to WODC	Deputy Director of HR	Workforce Report to TMC (FRB and F&P).	01/12/2019
GC9	01/06/2018	There is perceived to be a gap in engagement and Culture and Organisation Development require further action planning in order to ensure improved employee engagement, involvement and satisfaction.	Develop a business case to fund an electronic tool to improve staff engagement and communication. Behind schedule – revised date. Pulse under development. Exploring zero cost App options.	Exploring further zero cost options using Allocate pilot.	Deputy Director of HR Head of Communications	Staff Survey*, Staff feedback App Survey reported in Workforce Report to TMC and WODC. *2018 Survey Results received are broadly positive.	01/12/2019 App timeline delayed due to Capital Funding

Gap Control Ref	Date Assurance provided	NEGATIVE ASSURANCE (include reasoning as appropriate)	Action in place to address	ACTION PLAN	ACTION LEAD	Expected resulting Control, Mitigation or Positive Assurance?	AGREED DEADLINE
GC10	07/03/2-019	Gaps in key Medical Specialities	Making use of Doctors.net as means of communicating with and attracting new Medical Staff*.	Recruitment Action Plan	Head of Resourcing	Reporting on recruitment rates to posts in key gap areas to TMC & WODC. Reduced vacancies in key areas. Reduced temp staff use.	01/11/2019
GC11	07/03/2019	Gaps in Nursing recruitment.	Clinical Nursing Fellows recruitment including expanded Business Case for Overseas recruitment.	Recruitment Action Plan	Associate Chief Nurse	Reporting on recruitment rates to posts in key gap areas to TMC & WODC. Reduced vacancies in key areas. Reduced temp staff use.	01/01/2020
GC12	13/06/2019	There is perceived to be a gap in engagement and Culture and Organisation Development require further action planning in order to ensure improved employee engagement, involvement and satisfaction.	Monthly staff survey oversight group with Division representation to ensure delivery of short and medium term actions plans from Staff Survey.	Staff Survey Action Plan	Director of Workforce	Completion of action plan, improved position at next Staff Survey	01/03/2020
GC13	13/06/2019	Failure to effectively maximise workforce productivity; failure to routinely review consultant job plans.	Building on existing roll-out of e-rostering, Business Case for extending scale and speed of further roll-out.	Business Case Match funding sought from NHSI.	Deputy Director Workforce and Head of Resourcing	Business Case now with NHSI for full funding.	01/12/2019

Ref	SR8	Strategic Objective: Maintain financial health - appropriate investment enhancement to patient services

Statement of Risk, scores

Date identified	STRATEGIC RISKS	EXECUTIVE DIRECTOR	BOARD COMMITTEE
June 2015	That there is a failure to deliver required CIP's (Revised 2019/2020)	Chief Operating Officer	Finance and Performance

Initial Score	Last Q level	Current level	Target level	Movement Q to Q
4 x 5 = 20	4 x 5 = 20	4 x 5 = 20	4 x 4 = 16	

Risk Register Risks

OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC OBJECTIVE

RISK No.	RISK TITLE
4113	Divisions failure to achieve CIP for 2019/2020
GRADE	**OPERATIONAL RISK DESCRIPTION**
4 x 5 = 20	Failure to achieve corporate and operational CIP target for 19/20.

Impacts, Origins

REF	IMPACTS/CONSEQUENCES OF RISK?	ORIGINS OF THE RISK?
IC 1	Inability to meet regulatory financial targets	National requirement to achieve financial target(s)
IC 2	Inability to invest in services capital and/or revenue due to a lack of funds	Continuing CIP targets with reduced ability to make efficiencies.
IC 3	Inability to meet financial targets impacts adversely on reputation of organisation	Workforce challenges (recruitment) resulting in failure to achieve savings. Failure to achieve previous year recurrent and non-recurring CIP.
IC 4	Inability to meet financial targets results in Trust being placed in financial special measures	Failure to deliver on some identified schemes of slippage i.e. outpatients, model hospital. Failure to identify recurring CIP schemes. Additional CIP required as a result of signing up to the Provider Service Fund (PSF). Trust required to undertake additional elective activity which will affect CIP delivery. Previous over performance was taken as income CIP-now significantly reduced. Inclusion of vacancy factor in budget setting.

Controls, Mitigations

Ref	***What are the controls in place to mitigate these risks?*** ***Level 1 = Operational, Level 2 = internal oversight, Level 3 = Independent Assurance**	*Level of assurance	**Where and how often reported/monitored?**
CM1	Monitoring of CIP target bi-weekly at Financial Recovery Group (FRG) chaired by COO (revised as a result of Governance changes). Revised remit and ToR commenced Jan 19.	L2	Reported to F&P and Trust Board (monthly)
CM3	Carter efficiency team identified savings via hospital model. Includes GIRFT (getting it right first time). Establishment of clinical excellence programme to focus on GIRFT reports. Apr 19 - This team now revised between Clinical Quality Improvement and Service Efficiency and Delivery Teams. Healthcare Analytix Role Based Reporting (HARBR) packs used by the Divisional Teams to identify further CIP opportunities.	L1, L2	FRG, TB (monthly) & TMC
CM4	Appointment of Deloittes to assist with CIP delivery Action Plan i.e. outpatients (until October 2019).	L2	F&P (monthly)

CM5	MD & COO reviewed all medical (doctor) establishments with Directorates and HR to understand vacancies, locum plans. Feeds into workforce plan. Additional review of all medical establishment. Completed - further work identified by directorates for completion by Sept 19. Directorate work has been completed (Oct 19) – further analysis on actions currently underway. Report not expected until November 19. MD, Deputy MD and COO	L1	FRG (6 monthly). To be changed to Quarterly from June 19
CM6	Review of bank and agency spend to be undertaken This work has all been completed. Revised agency requirements for non-clinical and HCA staffing with effect from Sept 19. Must only be linked to projects. Trust is reporting as required (Oct 19)	L1, L2	Workforce Group, FRG, F&P, TMC. Weekly agency report to NHSM
CM7	External review (DM & AC) of all major budget lines for Divisions and Corporate spend with the objective of identifying additional CIP. Initial work completed July 19 and identification of any CIP by end of Aug 19. Discussed at Finance Recovery Group (FRG) in August, agreed that some schemes require corporate agreement. Divisional Schemes to be converted to PIDs in September. A small number of schemes to be transferred to PID, one corporate issue on job planning still require resolution. (Oct 19)	L1, L2	FRG, F&P, TMC

Positive Assurances

What are the positive assurances (actual) received?

Control Ref	Date Assurance provided	*What is the source for assurance?*
PA1	September 19 FRG update from FRG paper	FRG reporting

What assurance is provided?	**COMMENT**
Plan focus on key work streams - Theatres, Outpatients, Workforce, Pharmacy, Pathology and back office (procurement).	CIP target is phased into the latter part of the year. Theatre presentation at FRG in Sept 19 provided additional assurance on progress. Outpatient programme work commenced – amber status for delivery. MD led review of Clinical establishments commenced 7/1/19. Commenced June 19, reported to FRG in July. Updated paper to be presented in September 19 (see above in mitigations). Meeting in Sept 19 to progress chase actions and next steps. Revised Theatre target for 19/20. CIP schemes following independent review of budgets to be developed August/September. This should impact on the value of CIP forecast to be achieved. Budget review meetings completed for all areas, except Division 1. This will be completed by the beginning of November 19.

Control Ref	Date Assurance provided	*What is the source for assurance?*
PA2	September 19 update from FRG paper	FRG reporting

What assurance is provided?	**COMMENT**
CIP schemes continue to be identified (mainly non-recurrent). PIDs agreed by Directors and QSIG.	Non-recurrent CIP higher than forecast. Schemes for 2019/2020 combination of continued existing schemes (from 18/19) and new schemes from April 2019. Small number of additional schemes identified in ~~August 19~~ September 19, Linked in with review of budgets.

Control Ref	Date Assurance provided	*What is the source for assurance?*
PA3	23/10/2019 F&P	CIP Report

What assurance is provided?	**COMMENT**
Development/split of Service Efficiency and Clinical Quality schemes.	Clinical Excellence group has been reviewed and will be placed by Clinical Quality and Service Delivery groups. The work from the Clinical Excellence group have not been lost. All the schemes included in the GIRFT visits have been reviewed, with the transactional GIRFT Schemes transferred to the CIP Team in April 2019 as part of the transition from CQI to CIP. CQI team developing their key areas of focus. Any CIP will be identified and reported separately in order to avoid duplication. This work is completed and CIP schemes have been incorporated into the FRG work-plan.

Control Ref	Date Assurance provided	*What is the source for assurance?*
PA4	July 2019	Product lines standardised by Procurement.

What assurance is provided?	**COMMENT**
Catalogue lines reduced and further review on-going	Merger of UHNM and RWT procurement teams completed in July 19. Review of procurement opportunities being undertaken following merger. Update November 19.

Control Ref	Date Assurance provided	*What is the source for assurance?*
PA5	23/10/2018 F&P	FRG reporting to F&P

What assurance is provided?	**COMMENT**
Deloitte onsite (June 16). FRP developed – actions commenced formal sign off. Regular FRG report to F&P.	NHSI agreed to extend to March 2019. Outpatient support will remain until Sep 19. Head of Service Delivery & Efficiency commenced in post in April 19. Recruitment to this team has been successful and all staff members will be in place by June 19. During the transition period support to the team remains in place from the existing clinical quality team. Handover from the Deloitte team (on outpatients) has commenced to the Service Efficiency Team. Delivery of Outpatient CIP is not expected to be affected. There has been a change to the head of Service Efficiency and Delivery in Oct 19 (Internal promotion)

Control Ref	Date Assurance provided	*What is the source for assurance?*
PA6	Sept 2019	Progress update to FRB

What assurance is provided?	**COMMENT**
Meetings identifying plans for recruitment use of clinical fellows and also where gaps in directorate planning have been completed.	Resource meetings completed April 17 - completed report September 17. Deloitte report on impact of clinical fellows received. Action plans for Obstetrics and Gynaecology, Anaesthetics and T&O – see C1 comment above (MD led). On going review of all clinical workforce establishments. Paper presented to FRG July 19, identifying in going work by Directorate. No calculation of CIP, however significant improvement in budget awareness and alignment. Final paper to be presented to FRG in September. Report has been delayed. Divisional work completed in Oct 19, with final report for sign off expected in November 19. No significant savings expected. Clarity on budget lines will be achieved.

Control Ref	Date Assurance provided	*What is the source for assurance?*
PA7	23/08/2019 WODC	Workforce & FRG

What assurance is provided?	**COMMENT**
Review of non-medical agency (32 posts). Forecast only 7 posts to remain at the end of February. Apr 19 – additional review of non medical posts to be undertaken, small increase in Mar 19. Weekly review of all non-medical agency posts via COO.	Weekly review of non-medical undertaken by COO. Agency forecast to be within capped limit. Review of agency undertaken weekly. Additional review completed in July 19. Recruitment even in radiology expected to have an impact in Sept/Oct 19. Reduction in radiology agency starting. Explanations provided for all other use. Increase in IT agency use due to complex IT projects in pathology. New (central) agency rules implemented in Sept 19, means that non medical and HCA agency should only be procured for specialist projects. Exception reporting now required. All areas reporting are linked to projects (IT and payroll)

Gaps in Controls/Negative Assurances/Action Plans

What are the negative assurances received?							Updates made
Control Ref	**Date Assurance provided**	**NEGATIVE ASSURANCE (include reasoning as appropriate)**	**Action in place to address**	**ACTION PLAN**	**ACTION LEAD**	**Expected resulting Control, Mitigation or Positive Assurance?**	**AGREED DEADLINE**
GC1	Trust Board (TB) 07/10/19	There remains a CIP target with no plans for achievement	All areas reviewing plans.	FRG Plan bi-weekly, Summary to TB	Head of Service Efficiency and Delivery	FRG Monthly Reporting Pack	Unlikely to bridge gap in 19/20 – however monthly deadlines for updating achievements.
GC4	TB 04/08/19. F&P 23/10/2019	Agency spend at variance from control total.	Focus on reduction in agency spend, medical i.e. clinical fellowship, recruitment. Non-medical appointment to post. Reductions in agency online.	Workforce Task Group reporting to FRG and F&P. Medical Variance reducing.	Chief Operating Officer/ Medical Director	FRG Report to TB. Will also be included in F&P reports. Reduced medical variance.	Achieved for non-medical. Medical report expected Nov 19
GC5	TB 07/10/19	Pay spend increasing Quarter 1, 2, 3 & 4.	Independent Review of pay-lines with Directorates/Divisions in July 19. Action to be undertaken as required to reduce/cease spend.	Operational Finance Group reporting to F&P	Chief Operating Officer/Chief Financial Officer	F&P Report to TB	Analysis of pay spend has been presented to F&P. Monitoring to be provided monthly.

GC6	March 2019	The continued gap between required and identified CIP and failure to achieve control total has resulted in NHSWM increasing the Trust risk rating from a level from 2 to 3. This will result in increased scrutiny on CIP Plans.	Continued focus on development of CIP Plan for 2019/2020.	Continued identification of CIP Plans across operational and corporate service lines.	Chief Operating Officer/Chief Financial Officer	FRG, TMC, F&P, TB	Deadline achieved, further work required on CIP linked with 5 year plan – deadline Nov 19

Ref	SR9	Strategic Objective: Maintain financial health - appropriate investment enhancement to patient services

Statement of Risk, scores

Date identified	STRATEGIC RISKS	EXECUTIVE DIRECTOR	BOARD COMMITTEE
June 2015	That the underlying deficit that the Trust has is not eliminated in medium term to bring the Trust back to financial surplus.	Chief Finance Officer	Finance and Performance

Initial Score	Last Month(M) level	Current level	Target level	Movement M to M
5 x 3 = 15	5 x 4 = 20	5 x 4 = 20	5 x 4 = 20	

Risk Register Risks

OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC OBJECTIVE

RISK No.	RISK TITLE
4113	Failure to achieve CIP target
GRADE	**OPERATIONAL RISK DESCRIPTION**
4 x 5 = 20 red	If the Trust is unable to achieve the identified CIP target for 2019/2020 then there are implications for the financial position of the Trust

Impacts, Origins

REF	IMPACTS / CONSEQUENCES OF THE RISK?	ORIGINS OF THE RISK?
IC 1	That the Trust will be placed into recovery and turnaround by NHSI	Lack of fully detailed Recurrent Cost/Efficiency Improvement Programme in 2016/17, 17/18, 18/19 and 19/20
REF	**IMPACTS / CONSEQUENCES OF THE RISK?**	**ORIGINS OF THE RISK?**
IC 2	The Trust could have to apply for a working capital loan to the NHSI/e for working capital/financing, that the Trust is judged as not sustainable	
REF	**IMPACTS / CONSEQUENCES OF THE RISK?**	**ORIGINS OF THE RISK?**
IC 3	Reputational risk to organisation	

Controls, Mitigations

Ref	***What are the controls in place to mitigate these risks?*** ***Level 1 = Operational, Level 2 = internal oversight, Level 3 = Independent Assurance**	*Level of assurance (L1, L2, L3)	**Where and how often reported/monitored?**
CM1	Further detailed Efficiency/Productivity plans from Divisions/Departments.	L1	Reported to F&P, TB
CM2	Detailed plans to deliver to contracted levels of activity	L1	Reported to F&P
CM3	On-going identification and delivery of Carter initiatives on staffing, estates, procurement and pharmacy/medicines.	L1	Reported to FRB
CM4	Action on Agency Costs as per NHSI Guidance on capping arrangements.	L1	Reported to F&P
CM5	Receipt of Deloitte report on Trust CIP and Transformation Programme. Management capacity. Clear list of actions identified.	L2	Reported to F&P
CM6	Update of Long Term Financial Model for discussion at Finance and Performance and then Trust Board on medium term financial plans. This will include a high level assessment of the STPs as they could impact on the organisation. Regulator now requested detailed plan by September 2019.	L2	Reported to F&P
CM7	The year of the MSFT funding deal is realised and paid until 2020/2021	L2	Reported to F&P
CM8	There is close cash monitoring and forecasting to ensure that the Trust has sufficient cash to operate	L2	Reported to F&P
CM9	NHSI CIP Deep Dive review reporting little that the Trust is not already doing with minor additions to the CIP.	L3	Reported to F&P
CM10	FRB now assessing short term action to be taken to deliver financial plan for 2019/2020 and agree an efficiency programme for 2020/2021.	L1	Reported to F&P
CM11	NHSI finance representatives have and are to attend future F&P meetings to observe financial discussions. The Trust with NHSI representatives, conducted a 'deep-dive' review of the Cost Improvement Programme on 8.8.19	L3	Reported to F&P

Positive Assurances

What are the positive assurances (actual) received?

Control Ref	Date Assurance provided	*What is the source for assurance?*
PA1	01/04/2018 16/10/2019 FRB	Finance and Performance FRB report

What assurance is provided?	**COMMENT**
Further efficiency from deep dive reviews identified. FRB is focussing on the CIP gap and identifying recurrent CIP where possible. FRB are identifying financial savings from the GiRFT programme.	

Control Ref	Date Assurance provided	*What is the source for assurance?*
PA3	01/04/2018 16/10/2019 FRB	FRB report to Finance and Performance Committee and the Board

What assurance is provided?	**COMMENT**
Further opportunities have been identified. Ongoing review of agency spend and temporary staffing costs including WLIs. Work with External Consultancy now identified further efficiencies in Outpatients and this is being rolled out. The non-recurrent vacancy control factor now taken as recurrent has been re-evaluated and increased and used to offset this challenge in the first instance. NHSI have approved consultancy extension with caveats.	

Control Ref	Date Assurance provided	*What is the source for assurance?*
PA5	Q2 2018	Audit Committee and Finance and Performance Committee

What assurance is provided?	**COMMENT**
Internal Audit Plan for 2018/19 and 2019/2020 incorporates a review of this financial risk and the Cost Improvement programme.	

Control Ref	Date Assurance provided	*What is the source for assurance?*
PA6	01/09/2018 23/10/2019 F&P	Update to Finance and Performance Committee and then the Board.

What assurance is provided?	**COMMENT**
LTFM to be updated for in year performance/contract mitigations/Forecast year End updated underlying financial position.	

Control Ref	Date Assurance provided	*What is the source for assurance?*
PA7	01/06/2018 23/10/2019 F&P	Update to Finance and Performance Committee and then the Board.

What assurance is provided?	**COMMENT**
2018/19 MSFT financial payment Received. 2019/2020 expected.	

Control Ref	Date Assurance provided	*What is the source for assurance?*
PA8	01/05/2018 23/10/2019 F&P 12/09/2019 Audit Com	Audit Committee and Finance and Performance Committee

Controls in place and management action agreed. 12 month rolling cash forecast implemented. Clear Prompt Payment Statistics reported to Board. Self-review against GT report on Barking, Havering & Redbridge Universities Hospitals.	

Control Ref	Date Assurance provided	*What is the source for assurance?*
PA9	01/07/2018 16/10/2019 FRB	Executive discussion on re-focussing Financial Recovery Board (FRB) on Cost Improvement Programme (CIP) gap and underlying Financial Position. New planning guidance for 2019/20 ask for medium term plans to get the Trust back to underlying break even position.

What assurance is provided?	**COMMENT**
Finance & Performance Committee FRB Report	

Control Ref	Date Assurance provided	*What is the source for assurance?*
PA10	19/09/2018 23/10/2019 F&P	Review of programme by NHSI

What assurance is provided?	**COMMENT**
A further review ('deep dive') of the RWT CIP was carried out by NHSI on 17.09.2018. Whilst NHSI were 'unhappy' with the performance level, the only additional potential actions they identified were to: 1. institute a vacancy freeze with 2 levels of vacancy review panels in place and 2. Land sales. Trust has now sold the WEI – contract completion Feb 2019.	

Control Ref	Date Assurance provided	*What is the source for assurance?*
PA11	10/12/2018 20/05/2019 BDS	Risk gain/share agreement with main Commissioner.

What assurance is provided?	**COMMENT**
The Trust has secured a risk/gain share agreement with Staffordshire CCGs and Wolverhampton CCG. W'ton CCG approved the risk share 15/11/18. New contracts structures in process of being agreed – in place with Wolverhampton CCG and Specialist Commissioners. Contract in place and signed with Staffordshire CCGs for 2019/2020.	

Gaps in Controls/Negative Assurances/Action Plans

What are the negative assurances received?							Updates made
Control Ref	**Date Assurance provided**	**NEGATIVE ASSURANCE (include reasoning as appropriate)**	**Action in place to address**	**ACTION PLAN**	**ACTION LEAD**	**Expected resulting Control, Mitigation or Positive Assurance?**	**AGREED DEADLINE**
GC1	10/12/2018	There is a continued increase in overall pay spend including bank staff when substantive recruitment has increased. (Gap in controls)	Work is underway to understand: the lag between recruitment and impact on temporary staffing costs; 'hotspot' areas of spend; junior medical staffing situation.	Review of agency spend against impact of recruitment underway led by COO. Increased controls on bank being implemented and detailed junior Dr manpower discussions underway.	COO	IQPR, Finance and Workforce Reports to TB	01/12/2019
GC3	01/05/2018	The increasing reliance on Non-recurrent CIPs means that the underlying position is deteriorating.	Further work on the underlying financial position identifies that the underlying position is deteriorating due to increasing levels of Non-Recurrent CIP. This will be shared in detail with F&P	Cost Improvement Plan updates and budget setting now approved for 19/20	CFO	Finance Reports to TB FRG reports to F&P and TB	Monthly reports to TB. 06/11/2019
GC5	04/04/2019	Enforcement action taken by NHS Improvement and Trust placed in category 3 of the Single Oversight Framework due to level of CIP/unidentified CIP.	Continued work on CIP. Medium term financial plan covering the period 2019/20 to 23/24 required to be produced by 30 September 2019. Regime may have been superseded – tbc.	Resources secured to help with producing financial model. Discussion at Executive Directors 19/6/19, F&P 24/7/19 & BDS 19/8/19	COO/ CFO	F&P	06/11/2019
GC6	30/07/2019	Medium term financial forecast does not bring Trust back into financial balance by 2024/25. Notice received (07/10/19) from NHSI/E Office of 4 year Financial Control Totals.	Developing forecast discussions at Executive and Trust Board re ideas for closing the gap including meeting with W'hampton CCG & other STP Providers.	BDS 16/09/2019 presentation by Deloitte. Further work required to clarify options. STP considering financial plans and options provided in STP context.	CFO	F&P	TB 03/11/2019

Ref	SR12	Strategic Objective: Be in the top 25% for key performance measures.

Statement of Risk, scores

Date identified	STRATEGIC RISKS	EXECUTIVE DIRECTOR	BOARD COMMITTEE
03/04/17	The elevated SHMI could reduce the confidence of the public, patients, external agencies, regulators and commissioners in the quality of care the Trust provides.	Medical Director	QGAC

Initial Score	Last Month(M) level	Current level	Target level	Movement M to M
4 x 3 = 12	4 x 4 = 16	4 x 4 = 16	3 x 3 = 9	

Risk Register Risks

OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC OBJECTIVE	
	None currently identified

Impacts, Origins

REF	IMPACTS / CONSEQUENCES OF THE RISK?	ORIGINS OF THE RISK?
IC 1	Adverse publicity	Adverse SHMI
REF	**IMPACTS / CONSEQUENCES OF THE RISK?**	**ORIGINS OF THE RISK?**
IC 2	Greater scrutiny from external bodies (regulators, commissioners et al)	Adverse SHMI
REF	**IMPACTS / CONSEQUENCES OF THE RISK?**	**ORIGINS OF THE RISK?**
IC 3	Loss of public confidence	Adverse publicity
REF	**IMPACTS / CONSEQUENCES OF THE RISK?**	**ORIGINS OF THE RISK?**
IC 4	Reduction/adverse impact on activity/performance and income	Loss of reputation

Controls, Mitigations

Ref	***What are the controls in place to mitigate these risks?*** ***Level 1 = Operational, Level 2 = internal oversight, Level 3 = Independent Assurance**	*Level of assurance (L1, L2, L3)	**Where and how often reported/ monitored?**
CM1	All relevant* Mortality data is reviewed and findings investigated and discussed at Mortality Review Group (MRG – RWT Group) (monthly updates) and a report is presented at COG, QGAC and TB on a monthly basis. *SHMI, Alerts against diagnosis, Reviews - Directorate Findings, Outcomes and themes from reviews, Coding compliance - programme of work progress.	L2	Trust Board
CM2	Mortality data relating to health economy themes is reviewed e.g. End of Life Care (Place of death) and discussed at Mortality Improvement Group (MIG – Cross-City multi-agency) (bi-monthly) and Quality Improvement Programme Board (QIPB) chaired by CEO monthly, along with data and information across services and providers.	L3	Trust Board
CM4	The Trust requires all directorates to follow the process set out by the Learning from Deaths Policy (OP87*). Deaths in pre-defined specified groups* undergo an SJR1 with 10% random sample of other deaths. These reviews are undertaken by independent internal Mortality Reviewers. A cohort of cases is referred for a second stage, multidisciplinary review. The findings are reviewed with the Directorate and at MRG and QGAC, TMC and TB through IQPR. The Trust will extend the scrutiny of deaths by reviewing those that occur 30 days after discharge with involvement of primary care teams.	L1	QGAC
CM5	For all diagnosis groups showing a higher than expected SHMI (at internal alert level, which is a lower threshold than external alerts) a coding and data quality review are undertaken.	L1	QGAC
CM6	A Trust wide action plan is in place to investigate potential causes of the elevated Standard Mortality Rates (SMR's) (SHMI and HSMR) and to provide evidence and assurance of the quality of clinical care.	L2	QGAC
CM11	The early introduction of the Medical Examiner Role has been implemented and MEs have been appointed. The ME roles and review process have been developed. This new process will improve the timeliness of review and investigation of deaths and therefore access to learning. OP87 has been reviewed in line with these new roles.	L1	Trust Board

CM12	The Trust has commissioned an independent Medical expert to provide oversight and advice regarding Mortality Statistics, Clinical Pathways of Care and the Learning from Deaths Agenda, reported to the Medical Director with independent access to CCG and Trust Board. An update was presented to the Board 4 March 2019 with a further update planned for the Board 2 December 2019. In addition, PwC presented to the Trust Board at a development session on 15 July 2019.	L3	Trust Board
CM13	The Trust has now approved a local service coding procedure that allows for the inclusion of all identified co-morbidities in the recorded and submitted data. Overview at MRG of Coding Audits that include recording and coding of co-morbidities. MRG includes CCG representation and Public Health (LA) representation and report to CCG Clinical Quality Review Meeting (CQRM).	L1, L2	Quarterly, QGAC, Trust Board

Positive Assurances

What are the positive assurances (actual) received?

Control Ref	Date Assurance provided	*What is the source for assurance?*
PA6	July 2018 07/10/2019 TB	Learning from Deaths Action Plan

What assurance is provided?	**COMMENT**
	Held by Medical Director

Control Ref	Date Assurance provided	*What is the source for assurance?*
PA5	April 17-March 18 15/07/2019	Audits of Clinical Coding, PwC targeted audits of specific coding (individual & cohort)

What assurance is provided?	**COMMENT**
Audits of coding and clinical documentation 2017/18 financial year 15 different audits, covering up to 121 spells with primary diagnosis revised in 11% (13 of 121) cases. Each coders work is audited at least annually covering a minimum of 40 spells internally, reported to MRG. PwC targeted audits of specific coding of individuals and cohorts based on relative risk of death with primary diagnosis and co-morbidity index continues reported monthly to MRG & Quality Programme Improvement Board for Mortality.	Held by Medical Director, via Mortality Action group

Control Ref	Date Assurance provided	*What is the source for assurance?*
PA1	July 2018 07/10/19 TB	Mortality/Learning from Deaths Trust Board Reports

What assurance is provided?	**COMMENT**
	Held by Medical Director

Control Ref	Date Assurance provided	*What is the source for assurance?*
PA11	March 2019 04/03/19 TB	Review of Mortality Statistics and Learning from Deaths by external independent Medical expert (Mr Stan Silverman).

What assurance is provided?	**COMMENT**
Copy of Interim report provided March 2019.	Held by Medical Director

Control Ref	Date Assurance provided	*What is the source for assurance?*
PA12	April 2019 24/07/19 QGAC	Trust development of Continuous Quality Improvement (CQI) programme following in part from review of Mortality Statistics and Learning from Deaths by external independent Medical expert (Mr Stan Silverman).

What assurance is provided?	**COMMENT**
Reports to QSIG, QGAC, TMC and TB. Clinical Lead(s) for CQI Programme appointed and in post. (April 2019)	Held by Director of Strategic Planning and Performance

Gaps in Controls/Negative Assurances/Action Plans

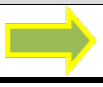
What are the negative assurances received?							Updates made
Control Ref	**Date Gap in Assurance provided**	**NEGATIVE ASSURANCE (include reasoning as appropriate)**	**Action in place to address**	**ACTION PLAN**	**ACTION LEAD**	**Expected resulting Control, Mitigation or Positive Assurance?**	**AGREED DEADLINE**
GC1	02/08/2018	Lack of evidence of learning from mortality reviews in clinical areas.	Robust governance processes to evidence learning from mortality reviews embedded in all clinical areas. Internal Audit recommendations – actions agreed.	Mortality Action Plan	Medical Director	Report to MRG then to QGAC and IQPR SJR Learning Monthly from November 2018	01/12/2019

GC4	09/08/2018	Lack of co-ordinated and consistent approach to end of life care	Develop a Bereavement centre with collated Medical Examiners -Registrar of deaths/ Administration/ Family services to improve quality of service for families and support timeliness of investigations and learning from deaths. Bereavement Nurse in-post. Registrar for Deaths additional location agreed.	Mortality Action Plan	Medical Director	All now in place and operational reports of the revised pathway and centre in place and operational. Reports (e.g. Audits) of pathway compliance. Patient/carer satisfaction survey data. System and early data available.	01/11/2019
GC5	01/06/2018	Lack of consistent approach to end of life care with patients dying in hospital where their preferred place of death may be elsewhere.	The Health Economy Mortality Improvement Group is developing an end of life clinical group to review provision and provide assurance that patients are supported in achieving their preferred place of death wherever possible. Enhanced palliative care team with 4 consultants recently appointed alongside Nursing Team enhancement.	Mortality Action Plan	Medical Director	Audits against End of Life Care and achievement of preferred place of death. End of Life Project Group for Wolverhampton in place for health and social care economy.	01/02/2020
GC6	01/04/2018	Lack of assurance regarding accuracy and completeness of coding	Review of clinical coding with clinicians to ensure quality and accuracy of coding. Joint clinician/coder work underway to agree primary and secondary diagnoses. (Previous GC17 incorporated)	Mortality Action Plan	Medical Director	Audit of concordance and compliance between clinicians and coders. CQI project commenced to achieve concordance.	01/11/2019
GC14	15/01/2019	Lack of assurance regarding clinical pathways in diagnostic groups with elevated mortality	Audit of patient management in identified areas to provide assurance of clinical pathway compliance, patient quality and safety. (Previous GC18 included)	Mortality Action Plan	Medical Director	Audit of compliance with Clinical Pathways. Audits complete. Service areas working with CQI Team to enhance future compliance.	02/01/2020
GC15	08/04/2019	Lack of prospective audit of clinical care pathways related to elevated Standardised Mortality rates (SMR's) with SMART Action Plans (as per External Report).	Undertaking planned relevant audits.	Mortality Action Plan	Medical Director	Audits in progress. Sepsis & Pneumonia Audits in Emergency Department completed April 2019. BTS Pneumonia Audit completed & data submitted March 2019. AKI completed.	AKI completed – Renal Governance Meeting September 2019. Next check point on others 01/11/2019
GC16	19/06/2019	Areas of gap in assurance identified by Mr Silverman in his interim report of March 2019.	Each gap now addressed individually in Action Plan with RAG rated Mortality Action Plan.	Quality Improvement Programme (Board)	David Loughton	All areas of gaps to be addressed. Planned update to TB 2 December 2019	02/12/2019

Ref	SR13	Strategic Objective: Be in the top quartile for performance measures.

Statement of Risk, scores

Date identified	STRATEGIC RISKS	EXECUTIVE DIRECTOR	BOARD COMMITTEE
Mar 19	That the Trust cancer performance metrics place RWT in the bottom quartile nationally.	Chief Operating Officer	Quality Governance Assurance Committee

Initial Score	Last Q level	Current level	Target level	Movement Q to Q
4 x 5 = 20	4 x 5 = 20	4 x 5 = 20	4 x 4 = 16	

Risk Register Risks

OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC OBJECTIVE

RISK No.	RISK TITLE
4170	Lack of capacity - OPD, Snowdrop Suite and Durnall Unit
GRADE	**OPERATIONAL RISK DESCRIPTION**
4x3=12	If there is a lack of physical and staffing capacity in the Durnall unit, then this will impact on the ability to effectively triage and treat sick patients. This will result in neutropenic sepsis patients not receiving treatment within the 'golden hour', patients receiving line care and other interventions having significant delays and long waiting times, including pts with life limiting conditions. Clinics over running significantly leading to poor patient experience. Date of origin: May 2015. Date of escalation: April 2019. Risk lead: Group Manager for Oncology and Haematology
RISK No.	**RISK TITLE**
4696	UNREPORTED IMAGING STUDIES
GRADE	**OPERATIONAL RISK DESCRIPTION**
4x3=12	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
RISK No.	**RISK TITLE**
5069	Dermatology Fast Track Capacity
GRADE	**OPERATIONAL RISK DESCRIPTION**
3x4=12	If there is insufficient workforce capacity in Dermatology to meet Fast Track demand then patients will not be seen within two week timeframe as per policy resulting in Cancer target breaches and delay in diagnosis and treatment. Date of Risk: 19/07/2018. Accepted onto Divisional RR: 16/11/2018 Accepted onto Trust RR: 15/02/2019 Lead: Clinical Director - Dermatology and Divisional Medical Director, Division 3.
RISK No.	**RISK TITLE**
5246	Lack of Consultant cover within Cancer Services
GRADE	**OPERATIONAL RISK DESCRIPTION**
3x4=12	If there is insufficient Consultant cover for H&N, colorectal, sarcoma and upper GI cancer sites (currently only 1 Cons for each of these sites due to inability to successfully recruit), then this will impact on the ability of the service to provide appropriate and timely care to patients at times of additional vacancies, staff sickness and annual leave. This will lead to a risk of compromised patient care, inability to treat specific cancer site patients at RWT, delays in treatment, inability to achieve cancer targets and increased workload/stress for existing Cons staff. Date of Risk: 20/06/2019. Accepted onto Divisional RR: 20/06/2019 Accepted onto Trust RR: 25/09/2019 Lead: Deputy COO, Division.
RISK No.	**RISK TITLE**
5243	Breast Cancer Service Recruitment Risk (General Surgery and Radiology)
GRADE	**OPERATIONAL RISK DESCRIPTION**
4 x 3 = 12	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: TBC Initial score; 4x5=20 Last review; 23/09/2019

Impacts, Origins

REF	IMPACTS/CONSEQUENCES OF RISK?	ORIGINS OF THE RISK?
IC 1	Inability to meet regulatory performance metrics	National requirement to achieve cancer performance metrics, including 2 week wait, 31 day symptomatic and 62 day treatment
REF	**IMPACTS/CONSEQUENCES OF RISK?**	**ORIGINS OF THE RISK?**
IC 2	Inability to achieve standards could cause harm to patients	Increased referrals, capacity not available to treat patients in the appropriate timeframes.
REF	**IMPACTS/CONSEQUENCES OF RISK?**	**ORIGINS OF THE RISK?**
IC 3	Inability to meet performance targets impacts adversely on reputation of organisation	Workforce (recruitment) and equipment challenges leading to delays in treatment for some patients.
REF	**IMPACTS/CONSEQUENCES OF RISK?**	**ORIGINS OF THE RISK?**
IC 4	Inability to meet performance targets may result in Trust being placed in performance special measures	CQC expectation with regard to the treatment of patients within the standards.

Controls, Mitigations

Ref	***What are the controls in place to mitigate these risks?*** ***Level 1 = Operational, Level 2 = internal oversight, Level 3 = Independent Assurance**	*Level of assurance	**Where and how often reported/monitored?**
CM1	Monitoring of performance metrics on a weekly basis at the operational performance group	L 1, L2	Reported to F&P, QGAC, TMC and Trust Board (monthly)
CM2	~~Twice~~ Monthly performance calls that include NHSM, CCG and the cancer alliance to discuss performance. Monthly face to face meeting that includes CCG and NHSM.	L3	Reported to TMC, Trust Board and Clinical Quality Review Meeting
CM3	Support from cancer intensive support team to review training, pathways and produce demand and capacity plans. Cancer IST support ended in July 19. Support still available if required. IST will revisit the Trust in Dec 19 to ensure action plan are fully implemented and embedded.	L1, L2 & L3	Monthly cancer meeting, F&P, Trust Board, CCG and NHSI/E Performance review meetings
CM5	Weekly PTL meetings to monitor progress of patients on the cancer pathways	L1, L3	Not reported, but attended by CCG. Reviewed by IST and Cancer Alliance
CM6	Establishment of monthly harm review process in conjunction with CCG.	L2, L3	Clinical Quality Review Meeting, Quality Standard (QSIG) on a monthly basis
CM7	External meetings with NHSI/E and national support teams to review systems and processes for cancer performance. Meeting with NHSM to be scheduled for Oct 19.	L3	Trust Board
CM8	Internal Trust Cancer Board with all Tumour Site leads	L1	Reports to TMC
CM9	Recruitment. Gaps in breast radiology / radiographer. Use of overseas clinical fellows. Gaps in Oncology consultants, exploring links with other Trusts (UHNM). Continued use of agency doctors in oncology and radiographers to ensure workforce shortages are minimised.	L1, L2	Medical workforce group already sighted on the workforce issues.
CM10	Equipment. Use of the private sector for routine radiology scans and reporting and also additional endoscopy. Outsourcing. Use of private sector for some pathology reporting (Dermatology) to ensure turnaround times are maintained.	L1	Reported to Monthly Operational Cancer Performance review meeting.
CM11	July 19 - Black Country STP (and CCG) support to divert breast referrals at source from GPs to alternative local hospitals to assist with waiting times at RWT. Initial phase to divert from GP's, agreement from **Sep 19** to divert at RWT (for GP's within a 3 mile radius of Walsall or Dudley Hospitals)	L1, L3	Will be reported to CCG on weekly/monthly calls, F&P and also the CQRM
CM12	July 19 – Establishment of Black Country and West Birmingham STP cancer group to review delivery of STP Priorities. Chaired by D Wake (CEO of DGHFT). Initial meeting in Aug 19 then monthly.	L3	Will report to STP oversight group (frequency TBC)

Positive Assurances

What are the positive assurances (actual) received?			
Control Ref	Date Assurance provided	*What is the source for assurance?*	
PA1	23/10/2019	F&P, QGAC	
What assurance is provided?			**COMMENT**
Updates on cancer recovery plan for internal and external review			Regular update on the cancer recovery plan provided by the COO. Information provided to internal meetings, F&P, QGAC, TMC and Trust Board. Also shared with CQRM
Control Ref	Date Assurance provided	*What is the source for assurance?*	
PA2	Aug 19	Harm review reports to QSIG meeting.	
What assurance is provided?			**COMMENT**
Monthly review of all patients treated over 104 days in conjunction with the CCG. This is to assess if patients who waiting longer than standard incur harm whilst waiting for their treatment.			No patients identified with harm to date. Harm reviews for August and September outstanding due to change in cancer lead clinician.
Control Ref	Date Assurance provided	*What is the source for assurance?*	
PA3	Sept 19	F&P	
What assurance is provided?			**COMMENT**
Presentation on the findings of the intensive support team			Presentation on the work of the IST demand and capacity plan to F&P. Also present to cancer recovery group and external to NHSI/E. Final IST report shared with NEDs in September 19.
Control Ref	Date Assurance provided	*What is the source for assurance?*	
PA4	Dec 18	External Visit from the National COO	
What assurance is provided?			**COMMENT**
Review of Trust systems and processes with the national team found no significant shortfall in Trust actions. Challenge of diagnostic capacity identified			Actions from the letter from the K McLean visit all undertaken.
Control Ref	Date Assurance provided	*What is the source for assurance?*	
PA5	July 2019	Sign off report from Cancer Intensive Support team	
What assurance is provided?			**COMMENT**
Closure report from the Cancer Intensive Support team on their work with the Trust in the last 12 months. All actions completed.			Report shared with F&P for information. Cancer IST to revisit the Trust in Dec/Jan 20 to ensure that all actions remain embedded in the organisation.
Control Ref	Date Assurance provided	*What is the source for assurance?*	
PA6	Oct 19	2 week waiting times for all specialties, other than Breast.	
What assurance is provided?			**COMMENT**
All specialities, other than 2 week breast are booking within the 2 week standard.			Performance metrics monitored weekly. Oct 19, all specialties, other than breast, continue to be compliant for 2 WW

Gaps in Controls/Negative Assurances/Action Plans

What are the negative assurances received?							Updates made
Control Ref	**Date Assurance provided**	**NEGATIVE ASSURANCE (include reasoning as appropriate)**	**Action in place to address**	**ACTION PLAN**	**ACTION LEAD**	**Expected resulting Control, Mitigation or Positive Assurance?**	**AGREED DEADLINE**
GC1	Sept 19	The cancer recovery plan as yet has not resulted in an improvement in cancer standards.	All areas review plans on a monthly basis. This is subject to external scrutiny (CCG).	Action plan to TMC and F&P	Chief Operating Officer	F&P monthly papers	Completed
GC2	Oct 19	Lack of capacity in specialties to see patients in 2 weeks for Breast referrals	Blitz weeks planned for May and June to reduce the numbers of patients waiting outside of 2 weeks. Additional Blitz clinic in Sept, Oct and Nov to assist with backlog In conjunction with 2 other Trust in STP, referrals to be diverted at source (GP) to other Trusts to assist with waiting times. Scheme further extended to include diverts received at RWT from Sept 19. Oct 19, waiting times reduced to 24 days. Cessation of referrals from RWT to Walsall. Trajectory for equalisation of waiting times across STP is Nov 19.	Cancer recovery plan	Group Manager - Surgery and Radiology	Impact – reduction in waiting times for 2 week wait appointment. Cancer Recovery Group and F&P	Nov 19

GC3	Oct 19	Lack of diagnostic capacity in /MRI and Fine Needle Aspiration (FNA)	Outsourcing of routine work and reporting to assist with demand. Business case for additional capacity in development. Appointment of two clinical fellows to help reduce the waiting times for FNA. Clinical Fellows in place and training commenced for FNA. Trust to commission external body to assist in writing strategic outline case for additional diagnostic support. Work commenced. Options appraisal being written.	Business case in developm ent	Group Manager - Radiology	Reduction in waiting time for FNA. MRI times are currently compliant (Oct 19)	Oct 19
GC4	Sept 19	Lack of capacity in endoscopy	Referrals continue to increase. Additional clinical staff to be appointed to enable additional sessions to be utilised. Outsourcing to Private Sector to assist with meeting demand.	Cancer Recovery Plan	Group Manager - Medicine	Cancer Recovery Meeting	Oct 19
GC5	Sept 19	Increasing turnaround times in pathology as a result of increased referrals	Outsourcing to Private sector for reporting. Consultants commenced in post. Turnaround times improving across the STP. Detail in the cancer recovery plan.	Cancer Recovery Plan	Head Biomedical Scientist	Cancer recovery Meeting	Oct 19
GC6	Oct 19	Workforce shortages in Radiology	Overseas recruitment. Additional post been appointed to from overseas. Appointment to 1 breast radiographer post, commence Dec 19.	Cancer Recovery Plan	CD in radiology	Reduction in agency spend. Cancer Recovery meeting. Trust Management Committee	Oct 19 – 4 other appointme nts made.
GC7	Oct 19	Workforce shortages for breast screening	Support and help sought from neighbouring Trusts.	Cancer Recovery Plan	Deputy COO – Div 3 and Chief Operating Officer	No support made available to date	Review meeting in Oct 19. Trust to review abilitity to deliver the screening contract
GC8	Sep 19	Workforce shortages in Oncology leading to increased waiting times	Use of locums in short term. Long term plan to explore appointment of a Professor of Oncology.	Cancer Recovery Plan	CD/DMD covering oncology and MD	Cancer Recovery Meeting, Trust Management Committee	Appoint-ment of Professorial post likely to be late 20/21
GC9 (links to GC3)	Sep 19	Lack of capital funding to support investment in additional equipment required for cancer services	National Lobbying. Business case for additional MRI/CT/Aseptics and Radiopharmacy in development.	Paper to be presented Trust Board	Deputy COO – Div 3 and Chief Operating Officer. Strategic Advisor to the Trust Board.	Trust Board	Business case going through Trust discussion, will be presented to TB in Nov 19

Review of 'Red' Trust Risk Register Risks in relation to Board Assurance Framework (BAF) as of 31/10/2019.

Red risk on TRR	BAF risk associated	Initial score	Current score	Target	Title	Area	Reviewed at	Decision
Known Red Risks as of 26/06/2019								
4113	SR8, SR9	20	20	9	Divisions inability to achieve CIP *If the Divisions are unable to achieve the identified CIP target for 2018/2019 then there are implications for the financial position of the Trust.* Opened; 07/04/15 Risk lead; COO	All	F&P, QGAC 2019 Last review 09/10/19	Remain on BAF
4661		16	16	-	Lack of robust system for review and communication of test results *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	Corporate	F&P, QGAC 2019 Last review 07/10/19	Remain treated as Red Risk on TRR.
5182		16	16	4	Lack of Network support for Vascular Services at RWT. *If RWT does not meet NHSE requirements of having Cardiac Thoracic and Aortic Services co-located with Vascular services on RWT site, then the Aortic service specification will not be met and RWT may not be authorised for Aortic services, this will adversely impacting patient service provision at RWT.* Opened on 11/03/19	Division 1	F&P, QGAC 2019 Last review 18/10/19	Remain treated as Red Risk on TRR.
2080	SR1	12	20	12	Risk to quality of patient care: reduced manpower *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 falls from harm.(Linked to local risks 2780 CHU, 4164 Renal, 4272 Therapy Svs, 4321 DN's, 3431 CofE)* Opened; 02/01/09 Date of escalation = 12/01/16 Risk Lead: Div 2 Deputy COO	Division 2	WODC Last review 07/10/19	Remain on BAF
Red Risks as of 22/10/2019								
5243		20	20	2	Breast Service (General Surgery & Radiology)	Held on Divisional Risk Register As relates in part to recruitment then once confirmed will be included as associated risk in SR1 and SR13. Awaiting agreement between Div 1 and Div 3 to finalise.		
De-escalated and closed Red Risks								

Keith Wilshere, Company Secretary, 06/11/2019

Categorisation Matrix {Reviewed June 2018)

This mat rix is designed to assist you when you are grading incidents, complaints and risks for severity. By determin ing the hazard or consequence, and then the likelihood of recurrence, you are able to assign a grade - for example, SxS, 3x3, 1x1, etc. Then, by using the colour-co ded table, you can determine the severity - yellow, green, red or amber. Grading should be completed by the person reporti ng as soon as p055ible after the incident occurs - the department / area manager will then review the initia l grading and amend if necessa y

Step 1: What is the hazard / / harm / consequence?

			Need to considerwh ether the incident falls within the categor iesof Seriousln c ident Requiring Investigation(SIRI), refe r OP 10protocol2		
			3	4	
DESCRIPTOR	Insign ificant	Minor	Moderate	Major	Catastrophic
Injury/ill health •• Conside r harm caused to patient. Seeop po'lite.	No injury	Short term injury probablytakesle§S than one month to resol ve. RIDDDR re portable m ino r injury/ill health	Semi -permanen t in jury, e.g., may takeuptooneyear tore- olve. RIDDDRrepo rtab le moderate injury/ill health	F'ermanent injury, e.g ., lossof body part,mi<;diagnosis, permanent di5ilbility. RIDDDR reportable major inj ury / ill health	Death
Objectiveo;lprojects	Insignificant cost increase/ o;cheduleslippage. Barelynotic e.1ble reductionino;cope or quality.	<1% over budge t . o;chedu l e slip page. Minor reduction in SCope o r quality.	1 - 5 % o ver budget / o;chedule slippage Reductionin,_c:ope or quality requiring client approval	6 - 25% over budget/,;chedule slip page . Doesn't meet primary objectives	> 25% over budget Doeo;n'tmeet primary objectives.
Patient and public experience	Unsat isf acto ry experience not direct ly re lated to patient care	Unsatisfactory experience - readilyr esolvable. Incorrect patient identification - no adverse outcome	Mismanagement of patient care - short-termconsequenceo;. Incorrect patient identification - short- t erm consequences. Consent i5Su es - read ilyre-.olvable	Mismanagementof Totally patient care - long - unsatisfactory term consequence-; patientoutrnmeor Incorrect pat ient identificat ion. - long-term consequences experience . Consenti5Suej- Incorrect patie nt incorrect treatment leading identification with long-term leading to death or sequelae permanent damage. Consenti5Sues	
Complaint/claim potential	Locally resolved complaint(both formal and informal] Potent ial f or settlement/litiga t ion <£500	Subst antiated complaint peripheral tollin ical Minorstaffattitude problems Potential for lit igation/ settlem ent < [S K	Below excess claim Substantiated complaint involving lack of appropriate care / seriouss tatf attitude problems Potential for litigation/settlement <£SOK	Claim above excess Multiple claims or level.Mult iple single majorclaim substantiated complaints Potential for Externalinquiry litigatio n/settlem ent Poten t ial for litigatio n/settlement >£SOOK <£SOOK	
Servicel busine5'.i interrupt ion Staff ing and competence	Loss/interruption> 1 hour. Short -term l ow staffing level temporarily reduces servicequa lity(< 1 day).	lo5sl interrup t ion > 4hou rs Ongo ing low staffing level reduceo;service quality	Loss/ interruption >1 day. Unsafe staffing level or compe tence(< 1 day).	lo.is / Interruption > 1 week F'ermanentl055of service/facility Ongoing orc riti cal or competen ce(< 1 unsafe staffing level week). or competence.	
Busines'irisk (EXECUTIVE USE ONLY)			Moderate business failurer eo;u t ting in reorganisat ion across a service/ division.M oder ate lossofincome.lo5s of a sing le service All staff within a major service affected.	Majorbusines'i Large ,;calebusines'i tai lu re affecting a failure affecting major service. Major care of all patients loss of income.Loss and employment of major service.All of all staff.Trust staffwithinamajor auditors notable service affected to provide Board Assurance.All .;ervicesatrisk.All staff at risk.	
	Small loss (<£500)	Moderate loss (>£500)	Loss> □.00 5% of budget (> £1□.000)	L05'i> □.05% of budget (>£100,□OO)	L05'i;>1%ofbudget (£2,000,000).
Inspect ion /aud it / NICE guidance/NSF.	Minor recommeodations Minor noncompliance with staodards	Recommendations given. Noncompliance with minor standards DR compliance but noauditt railto demonstrate that object ives are being met (NSFINICEe tc.)	Challenging recommendat ions Noncompliance with regulation staodards 0Rlesr; t ha n 50% of objectives wit hin standard are met	Enforcement action Prosecut ion.Zero Critical report. rat ing.Severely Multiple challenging critical report. recommendations. Noncompliance with Major noncompliance NHS standards due with core standards. to no objectives/ targe ts being met (NSF/NICE etc .)	
Adverse pub licit y/ staff morale	Rumou r s	Local media - short - term inter eo;t . Minor effect on staff morale	Local media - long term inter eo;t. Significant effect on staff morale.	Nationalmedia>3 days.Enquiriei;from M . Nat ional media> 3days . Ministerial Secretary of State involvement	
FireSafety General security of Trust property or *N.8. All in cidents ofph icala§';ault must be entered ontoDatixwithin 48hrs•	Minor nonrnmpliancewith fire safety codes of practice that will not compromiSe st aff and patient fefy Security incident with noadverse	Firecocle noncompliance that as a consequence could compromise staff taking effective action in the event of fire Security incident managed locally. Theftorl055of Trust property value<fHNJ. Controlled drug (CD)di5Crepancy (acrnuntedfor)	Significant fire risk or Fire code noncompliance that will compromi,;e staff taking effective action in t he eventof fire Security incident leading to compromised patient or staff safety.Theft orlOS'iolTrust property<£1000 CDdi5Crepancynot accounted for.	Significant fire risk or serious breach of statuto ry fire will compromise legi slation that could compromise life Safetyor render the Trust liable to Theftorlossof Trust prosecution property£20,000 Serious compromise of patien t or staff safety.Theft or loss of Trust property <£20,000.	Significant fire risk that in theevent of life safety Infant abduction plus
Envi ronmen t al impact	Minor noncompliance wi th standards Mi nimal incre<1se in en viro nm enta l impact	Noncompliance with minor Standard s. Small increase in env ironmental impact	Noncompliance with core standa rds. Sig n ifi cant increase in environm enta l impact.	Enforcement action. Major noncompliance with core standards. Unacceptable impact	Prosecution Severely critical report.Severe impact on envir onment .
Staff experi ence *N.8 . All incidents ofphysicala§';ault must be entered ontoDatixwithin 48hours•	Theft/ordamage ofpersonalproperty <£50.	Minorverbalabuo;e Theft l or damage ofpersonalproperty < £15□.	Seriousverb al abu se Iminorphysical assault.Theft/or damage of personal property£150plus	Seriousphysical assault / majo r injury.	Serious physical assault leading to death
Informat ion Governance/LT.	Minor breach of confidentia l ity - no advero;eoutcome. Unplanned loss of IT faciliti es<h alf day. Health records l documentation incident - no adverse outcome Equiva lent to IG calculator ,,core" □	Minor breach of confide nt iality - readily resolvable. Unplanned loss of IT facili t ieo;< 1day. Healt h records / documentation incident - readily resolvab le. Equi valent to IG calculatoro;c:ore"l	Moderate breach ofconfidentiality - complaint initiated / adverselocal publ icity. Health records / documentation incident - patient careaffected w ith short- t erm consequence. EquivalenttolG calculator 5Core" 2 and above	serious breach of Seriousbreach - confidentiali ty - largenumbersl morethanone national publicity person /sust ained /risk of claims local publicit y/ payment. serious complaint Unplanned loss of IT UnplannedlOS'lofIT facili ti eo; ;,.1daybut laciliti eo;;, 1 week . leo;sthanoneweek Health reco rds / documentation incident - serious consequence. Health records/ documentation incident - patient care affected wi t h mode rate consequence EquivalenttolG calculat or score" 2 andabove EquivalenttolG calculator;o;core:2 and above	
Number of people affected	□ to S				More than S□

U se the information from the incident form/ risk assessment/ complaint to decide which descriptor box from the first column is applicable. Then read across to establish how severe the consequences or hazards are. You may find that the incident / risk assessment/ complaint has consequences which fi t into more than one descriptor box - if this is the case, you should choose whichev er gives the higher score between 1 and 5.

**Please consider level of harm below where injury or ill health applies

No harm: Impact prevented - patient safety incident t hat had the potentia l to cause harm but was prevented; or incident occur re d bu t no harm was caused.

Lo w harm: patient 5c1fety incident that required extra observat i on or minor treatment and caused minimal harm, to one or more per'lions.

Moderate harm: patient safety incident that re5ulte d in a moderate increase in treatm ent and wh ich caused significant but not permanent harm, to one or more persons .

Moderate increase in treatment : An unplanned return to surgery, an unplanned readmission, a pro longed episode of care, ext ra time in hospital or as an outpatient, cance lli ng of treatment, or transfer to another treatment area (such as intensive care)

Severe harm: A patient safety incident that appears to have resulted in permanent harm to one or more persons.

Permanent harm: Permanent lessening of bodi ly functions; including senso ry, motor, physiological or intellectual (Directly related to the incident and not related to the natural courlie of a patient's illn ess or underlying condition)

Death: Any patient safety incident that directly resulted in the death of one or more persons recei ving NHS-funded

Prolo nged psychological harm: psychological harm which th e service user has experienced or is likel y to exper i ence, for a continuous period of at least 28 days. Please note incidents of prolonged psychological harm must be entered as either moderate or severe harm on Datix dependent on the circumst ance s in each case.

NB : For patient safety incidents w hell! moderate, severe harm, death or prolonged psychological harm is caused please refer to OP60 Being Open Policy to apply The Duty of Candour.

Step 2: What is the likelihood of occurrence?

Use the table below to ascertain how likely or how often the hazard is to occur.

LEVEL	D ESCRIPTOR	D ESCRIPTION
	Almost certain	likely to occur on many occasions; a persistent risk (daily)
	Likely	Will probably occur, however not a persistent risk (weekly) .
	Possible	May occur occasionally (month ly).
	Unlikely	Not expected to occur, however could given the right circumstances (annually).
	Rare	Not expected to occur (yearly/ years).

Step 3: Assign a grade

Multiplying the conseque nce (1 to 5) wi th the likelihood of occurrence (1 to 5) will give you the grade, e.g. Consequence : Minor (2) x Likelihood : almost certain (5) = 10 Amb er.

Step 4: Assign severity

Use the colour -coded table below to plot the severity,e.g., SxS = Red, 3x3 = Amber, 1x1 = Green.

Likelih ood	Consequence				
	1 - Insi gnif icant	2 - Mino r	3 - Moderate	4 - Major	5 - Catastrophic
5- Almost Certain		10	15	20	25
4 - Likely			12	16	20
3 - Possible			9	12	15
2 - Unl ikely			6	8	10
1- Rare			3	4	5

• All risks graded .::12 mus t be escalated to the appropriate line management fo r further action/ escalation to TRR.

Step 5: What action need s to be taken now?

The table below gives a brief guide to what level of action is required once you have identified the severity of the incident/ risk. For a detailed explanation of staff responsibili ties for risk management, please refer to Trust policies: OP 10, Risk Management Re port ing. Comp laints Policy OP 08. The reporter must esta blish wheth er the i ncident is a seri ous incident requiring investigation (SIRI) as listed in protocol 2 of OP1□ policy. E.g never events, unexpected/ avoidable deaths, serious harm, abuse.

	Per§on(5) re5ponsible for investigation and level of management.	Localprocesse5forreview and accountability.	Notifyrec;ponsibleper§on within
GREEN	line/department manager/ localstaff	Quarterlyreviewofallgreen incidents,risksetc.,bylocal Governance forum.Sharing ofi sonslearnedamongst relevant staff . Actions taken andlesson5mustbeupdated on Datix.	5workingdays (If5IRI2hours,max1 working day)
	Line/department manager/ · local staff	Quarterly review of all yel low incidents, r isksetc., by l ocal Governance forum.Sharing of lessons learned amongst relevant staff.Actions taken andlessonsmustbeupdated on Datix	Sworkingdays (If5IRI2hours,max1 working day)
	Depart ment manager/head of service or appointed investigator.	Review inciden ts at local Governance forum, agreeactionplan,and sharing of lessons learned Amber incidents require investigation/enquiry and anactionplanwherenot immediately resolvabl e Amber risks ,;coring .::12 must be e,;ca lated to the approp riate line management foraction.*SUI	lworkingdays. (If5IRI2hours,max1 working day)
• For o;eriou sevents w hich are like ly to attract meclia attention,allthoseaHectecl must be informed of the incident before the med ia ar e (refer to OP 10 Pr ot ocol 2, SeriousIncident Pr oceclur)	Department manager / head of service or appointed investigator.	Review incide nts at local Governanceforum,agree action plan, and sharing of le550nslearnecl.Reclincidents require investigation/ enquiryandanactionplan wherenot immediately resolvable. All reel risks scoring 2 12 and must be escalated to the appropriate line management *SUI - Local Dept/Service managers are responsible for ensuring the follo w up and closure of RCA actions and for assurance on improvement	2 hours, max 1 wor kin g day

Remember:

All incide nt en tri es must be entered onto Datix wit hin 5 working days.
All inc ide n t entries must be updated onto Datix and closed, within 45working days.
Update of investigation findings, lessons, actions and documents must be made on Datix.
Please refer to SIRI guidance in protocol 2 of OP10 Risk Management Reportin g Policy for serious and externally reported incidents.
All SIRI to be reported to the service/ line manager wi thin 2 hourli or at latest w ithin 1 working day.
All action plans must include the names of those responsib le for any actions, timescales for imple mentat io n and revie w and evidence of achievement .
All action plans should be monitor ed by local Governance forums, wit h further monitoring asindicated above
All formal complaints must be answered within 30 working days.
For help, advice or gu idance, please contact: The Central Governance Team ext . 5114.