The Royal Wolverhampton NHS Trust	NHS

Trust Board Report

Meeting Date:	24th March 2014
Title:	Board Assurance Framework / Trust Risk Register
Executive Summary:	This paper reflects the spread across Board Assurance Framework and Trust Risk Register. The BAF format has now changed to encompass a more streamlined approach to measure the risk impact. It now reports on the impact of each mitigating action/control identified to manage the risk (via the assurance columns). This allows for closer monitoring of the impact of risk reduction measures in place. Where negative assurance/results exists relevant actions (with deadline) can be identified or additional controls may need to be considered to manage the risk. The following risks have been re aligned to the new format and validated by risk leads: • 1734, 2508, 2927 and 2965 All other risks require review/validation by risk leads to confirm the mitigation actions/controls identified and to update results from these within the assurance columns. <u>BAF Key Issues</u> 1 Red Risk - 2965 Failure to reduce Never Events. Still red due to the recent NE within Ophthalmology. Risk 2962 Health Visiting Services has seen some progress. Now downgraded to Yellow. IT issues have been identified and are being managed with Children Services (identified on Children Services risk register). <u>Trust Risk Register Key Issues</u> 3 red risks exist: • 514 - Failure to deliver recurrent efficiency gains and CIPs. • 943 - Non-adherence to chemotherapy policy and procedures resulting in poor patient and staff experience/confidence. • 3685 - Staffing levels and quality of nursing care on A6. This is a new risk. Notably, Staffing and Nursing issues have been highlighted on wards A5, A6, A7 (risks 2828, 3685, 3431) since the last report (Feb 14).
Action Requested:	To inform the Board of updates to the Board Assurance Framework (AF) and Trust Risk Register.
Report of:	Chief Nursing Officer

Author: **Contact Details:**	Governance IM&T Lead Tel: 01902 695114 Email:
Resource Implications:	None identified
Public or Private: **(with reasons if private)**	Public Session
References: **(eg from/to other committees)**	
Appendices/ **References/** **Background Reading**	
NHS Constitution: **(How it impacts on any decision-making)**	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

Background Details

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. It also provides a structure for the evidence to support the Statement on Internal Control" (Integrated Governance Handbook 2006: A handbook for executives and non-executives in healthcare organisations. Department of Health p15.).

Board Assurance Framework – Updates (Appendix A)

Following updates the split of the Assurance Framework is:

Risks currently being managed (on-going)	12
Risks managed to target level	0

There are currently 12 risks contained within the Assurance Framework which are distributed across the Trust categorisation matrix as below:

Likelihood \ Consequence	1 Low	2	3	4	5 High
A – Almost Certain			1		
B – Likely			3		
C – Possible		1	3	2	1
D – Unlikely			1		
E – Rare					

Utilising the Trust's categorisation matrix (risk plot above) as a way of pragmatically prioritising the Trust's risks, the following are considered to be of high risk to the Trust:

	ID	Risk Title	Lead
RED	2965	Failure to reduce Never Events.	CN

Trust Risk Register – Updates (Appendix B)

Following updates the split of the Trust Risk Register is:

Risks currently being managed (ongoing)	34
Risks managed to target level	1

There are currently 35 risks contained within the Trust Register which are distributed across the Trust's categorisation matrix as below:

Likelihood	1 Low	2	3	4	5 High
			Consequence		
A – Almost Certain			**2**	**1**	
B – Likely		**1**	**10**	**2**	
C – Possible			**6**	**11**	
D – Unlikely		**1**		**1**	
E – Rare					

Utilising the Trust's categorisation matrix (risk plot above) as a way of pragmatically prioritising the Trust's risks, the following are considered to be of high risk to the Trust:

	ID	Risk Title	Lead
RED	514	Failure to deliver recurrent efficiency gains and CIPs.	FD
	3685	Staffing levels and quality of nursing care on A6.	COO
	943	Non-adherence to chemotherapy policy and procedures resulting in poor patient and staff experience/confidence.	MD

The following illustrates how risks on the BAF and TRR are mapped against the strategic objectives:

Strategic Objective	BAF				TRR			
	R	A	Y	G	R	A	Y	G
1) To provide our patients & staff with a safe environment.	1	3	1		2	17		1
2) To be the employer of choice.						2		
3) To achieve a balance between demand & capacity of services		1				4		
4) To progressively improve the image and perception of the Trust			1					
5) To be in the national NHS top quartile of benchmarks								
6) Deliver services within financial allocations		3			1	4	1	
7) To be a high quality educator						1		
8) To agree appropriate population catchment areas for RWHT service								
9) To develop our position as a tertiary centre								
10) To achieve Foundation Trust status		1	1			1		
Clinical Negligence Scheme for Trusts						1		

Recommendation(s)

- Trust Board considers the report and any changes with the Board Assurance Framework and Trust Risk Register.

Appendix A: Tracking changes within Board Assurance Framework (Mar 2014)

Lead Director	Risk	Risk Title	Update	Reasoning / Progress Against Actions
Chief Nursing Officer	2965 C5	Failure to reduce Never Events	Positive Assurances and Gaps in Assurance updated.	Never Event - Ophthalmology Theatres Feb 14. A marginal improvement on the 2012 survey results, with an average change of +0.3%.
Director of Planning and Contracting	1734 D3	Introduction of other health providers in the market as a result of Any Qualified Provider leads to a greater shift of activity.	Positive Assurances and Action Plan updated. Downgraded from C3 to D3.	Trust Board reports detailing new business opportunities and delivered successful tenders. Quarterly reports to the F&P Committee and TMC detailing tender opportunities and progress with individual tenders. Reviewing and strengthening the internal resource to support the delivery of tenders and service expressions of interest
	2508 C3	Commissioning responsibility changes - affects contracted income	Positive Controls and Positive Assurances updated. Downgraded from A3 to C3.	Participated in the Better Care Fund Working group to ensure appropriate input and influence TMC and F&P reports outlining outcomes of contract discussions
	2927 B3	Failure to deliver against QIPP scheme resulting in lack of investment.	Positive Assurances, Gaps in Assurance updated.	QIPP tracker monitored via Contracting and Commissioning Group. Contracting and Commissioning Group reports highlighting QIPP business case. RWT suggested QIPP Schemes not adopted by CCG.
Chief Operating Officer	2962 D3	Health Visiting Services	Downgraded from C3 to D3.	IT issues have now been identified within this risk which has led the creation of 2 new risks on Children Services risk register (3689/ 3384).

Appendix B: Tracking changes within Trust Risk Register (Mar 2014)

Lead Director	Risk	Risk Title	Update	Reasoning / Progress Against Actions
Chief Nursing Officer	535 C4	Failure to achieve reductions in HAIs impacting on Trust's reputation and compliance to regulatory standards.	Positive Controls updated.	Fidaxomicin business case amended following TMC. Fidaxomicin business case presented to Contacts and Commissioning Committee in February 2014.
	2482 D4	Failure to learn from national / local organisations experience e.g. Francis report.	Positive Controls and Action Plan updated.	Implement findings from Clwyd / Hart report. Measures for evaluating progress with Francis identified (Mar 14). Improvements in FFT and also in patients voice regarding time to take answering buzzers.
	2680 A3	Interpreting & Translation Service	Gaps in Assurance and Action Plan updated.	Overspend continue. Seek agreement from Directors to transfer budget to divisions who control its use.
	3589 B3	Failure of community equipment supply contractor to meet infection	Gaps in Assurance and Action Plan updated. Target grade now C2 Yellow.	ILS are unable to supply clean equipment and stocks are low. Staff sickness in cleaning bays.

		prevention/decontamination standards.		ILS have not had a deep clean. Seek confirmation from CCG to agree to management control of ILS from RWT. Scope contract to ensure robust and fit for purpose. Infection Prevention contributing to the group Agree 14/15 working arrangements with CCG to enable RWT to exercise management control of ILS.
	3644 B3	CQC risk	Positive Controls, Gaps in Assurance and Action Plan updated. Target grade updated to C3 Amber.	Business Case for refurbishment of Women's Unit Phase 3 approved at TB Feb 14. Assurance received confirming actions evidenced as complete. CQC Action plan presented to QSAG March 13. Continue to see positive assurance of quality indicators and patient experience of changes made.
Director of Planning and Contracting	2929 C3	Failure to deliver CQUINS schemes	Positive Assurances and Action Plan updated.	Reports to Contract and Commissioning Group and F&PC providing assurance. Detailed discussions with CCG re 2014/15 CQUINS proposals shared with clinicians for comments.
Chief Operating Officer	2828 C3	Quality of nursing care on A5 (from 05/03/14)	Title changed from 'Quality of nursing care on A5 and A6' to 'Quality of nursing care on A5 (from 05/03/14)'. Risk downgraded to C3 Amber from B4 Red.	
	3431 B3	A7 staffing	*****New risk*****	Poor skill mix due to change in establishment to A7, CoE 28 beds Dec 12, current position for band 5=vacancy 3.4wte, further 4wte working notice and 1wte on ML, sickness 6.9%
	3685 B4	Staffing levels and quality of nursing care on A6.	*****New risk*****	Staffing levels and quality of nursing care on A6. Difficulty recruiting staff within existing blueprint. Staffing levels are below those recommended by HURST tool, high dependency of patients. High level of incident forms submitted regarding inability to give core care due to staff shortages. Negative historical reputation of A6 makes bank staff reluctant to work on this ward, putting pressure on ward staff to cover. Bank staff - Nurse bank unable to fulfil majority of outstanding shifts.
	2893 C4	Loss of GP Workload	*****Risk closed*****	The Divisional Management Team agreed at the Divisional Governance meeting that this risk should now be closed.
	3256 D3	Premises at West Park	*****Risk closed*****	Decision was made by the Divisional Management Team at the February 2014 Divisional Governance meeting to close this risk.
Director of Human Resources	2626 C4	Implications of Liberating the NHS White Paper on Educational Levies	Positive Assurances updated.	Liaise with LETB/LETCs.

The Royal Wolverhampton NHS Trust Board Assurance Framework (incorporating strategic risks)

Business plan objective KEY: 1. To provide our patients and staff with a safe environment / 2. To be the employer of choice / 3. To achieve a balance between demand and capacity of services / 4. To progressively improve the image and perception of the Trust. / 5. To be in the national NHS top quartile of benchmarks / 6. Deliver services within financial allocations / 7. To be a high quality educator / 8. To agree appropriate population catchment areas for RWT service / 9. To develop our position as a tertiary centre / 10. To consolidate our position as a leading Healthcare provider in a commercial environment.

Risk Owner	Number	Risk ref	Potential risk Description	Business plan objective	Initial risk score (see note 1)			Mitigating Actions in place	Positive Assurance	Negative Evidence	Current residual risk score (see note 2)			Change from initial risk to current residual risk	Further Mitigating Actions	Completion date for actions	Target grade following Mitigation (see note 3)		
			Should be high-level potential risks that are unlikely to be fully resolved and require on-going control.		Likelihood	Impact	RAG status	Systems and processes that are in place and operating to mitigate the risk.	Internal/External evidence that this risk is being effectively managed (e.g. Board/subcommittee reporting, Target/indicator performance, internal/local/national audit external audits, Inspection/visit/reviews, external benchmarks)	Internal/External evidence that this risk is not being effectively managed (e.g. internal/external audit reports/visits, adverse patient outcomes reported, patient experience feedback, poor performance indicator results)	Likelihood	Impact	RAG status		Additional actions required to mitigate risk further (target grade date)	For each further mitigating action a completion date must be provided.	Likelihood	Impact	RAG status
CNO	1	2965	Failure to reduce Never Events. Date of origin: 18/05/12 Date of escalation = 18/05/12	1	C	5	R	Monthly WHO checklist audits in theatres and non theatre areas monitored at PSIG.	**March 14 report on Feb 14 audit - Division 1** 100% compliance with 5 steps to safer surgery in Theatre areas. Division 1 achieved 100% compliance for use of the WHO Surgical Safety Checklist for agreed procedures. Division 1 achieved 100% compliance with the full completion of the WHO Surgical Safety Checklist for agreed procedures. **Division 2** achieved 100% compliant with completion of safety checklist. Division 2 achieved 99.5% compliance with the accurate completion of safety checklist.	Individual sections not all completed within A&E.	C	5	R		Accountability meetings to be arranged with individual staff and CD/Matron.	30/04/2014	E	2	G
								All AFPP training delivered in Maternity (Dec 13)	Report om Maternity AFPP training Jan 14 - final report received, action plan developed, to be discussed via Divisional Governance March 2014.										
								External audit of Safety checklist policy and practice.	A marginal improvement on the 2012 survey results, with an average change of +0.3%.										
								Local risk registers for high risk Never Events		Ophthalmology NE occurred in Feb 14.									
CEO	2	3353	Safeguarding' the Trust for the future - Several significant issues impact at the same time resulting in lack of focus on the "core business" and decisions not consistent with long term strategy. Date of origin: 09/04/13 Date of escalation = 09/04/13	4, 10	C	2	Y	Local intelligence about service delivery across our wider catchment	Involvement in key groups reviewing service provision		C	2	Y				D	3	Y
								Weekly Director review (Jan 14)	Relationships i/c Commissioners and key stakeholders										
								Opportunity assessment process based around strategic goals	Achievements of contractual obligations										
								Review of organisational impact - short, medium and long term											
								Effective and timely consultation											
								Robust board governance											

The Royal Wolverhampton NHS Trust Board Assurance Framework (incorporating strategic risks)

Business plan objective KEY: 1. To provide our patients and staff with a safe environment / 2. To be the employer of choice / 3. To achieve a balance between demand and capacity of services / 4. To progressively improve the image and perception of the Trust. / 5. To be in the national NHS top quartile of benchmarks / 6. Deliver services within financial allocations / 7. To be a high quality educator / 8. To agree appropriate population catchment areas for RWT service / 9. To develop our position as a tertiary centre / 10. To consolidate our position as a leading Healthcare provider in a commercial environment.

Risk Owner	Number	Risk ref	Potential risk Description	Business plan objective	Initial risk score (see note 1)			Mitigating Actions in place	Positive Assurance	Negative Evidence	Current residual risk score (see note 2)			Change from initial risk to current residual risk	Further Mitigating Actions	Completion date for actions	Target grade following Mitigation (see note 3)		
			Should be high-level potential risks that are unlikely to be fully resolved and require on-going control.		Likelihood	Impact	RAG status	Systems and processes that are in place and operating to mitigate the risk.	Internal/External evidence that this risk is being effectively managed (e.g. Board/subcommittee reporting, Target/indicator performance, internal/local/national audit external audits, Inspection/visit/reviews, external benchmarks)	Internal/External evidence that this risk is not being effectively managed (e.g. internal/external audit reports/visits, adverse patient outcomes reported, patient experience feedback, poor performance indicator results)	Likelihood	Impact	RAG status		Additional actions required to mitigate risk further (target grade date)	For each further mitigating action a completion date must be provided.	Likelihood	Impact	RAG status
CEO	3	3645	The short term impact on the Trust of service sustainability at Mid Staffordshire NHSFT. Date of Origin: 14/01/14 Date of Escalation: 14/01/14	1, 3	B	3	A	Attendance at Sustainability Board and other partnership groups (Jan 14)			B	3	A				C	3	A
								Monitoring of changes in activity flows (Jan 14)											
								Interim plans for utilisation of capacity (Jan 14)											
								Internal evaluation of the impact on services of service change (Jan 14)											
								Weekly Director review (Jan 14)											
								The short term impact on the Trust of service sustainability at Mid Staffordshire NHSFT (Jan 14)											
								Memorandum of Understanding in place between the Trusts (Jan 14)											
CEO	4	3352	Potential for rapid growth of the Trust due to changes in the wider health and social care economy. Date of origin: 09/04/13 Date of escalation = 09/04/13	3, 10	B	3	A	Nurture existing and new relationships	Involvements in key groups reviewing serviceprovision		B	3	A				C	2	Y
								Build flexibility into operating systems	Achievements of contractual obligations										
								Organisational intelligence - primary and secondary care providers											
								Understand timescales to implement step change increases in capacity											
								Review workforce plans											

The Royal Wolverhampton NHS Trust Board Assurance Framework (incorporating strategic risks)

Business plan objective KEY: 1. To provide our patients and staff with a safe environment / 2. To be the employer of choice / 3. To achieve a balance between demand and capacity of services / 4. To progressively improve the image and perception of the Trust. / 5. To be in the national NHS top quartile of benchmarks / 6. Deliver services within financial allocations / 7. To be a high quality educator / 8. To agree appropriate population catchment areas for RWT service / 9. To develop our position as a tertiary centre / 10. To consolidate our position as a leading Healthcare provider in a commercial environment.

Risk Owner	Number	Risk ref	Potential risk Description	Business plan objective	Initial risk score (see note 1)			Mitigating Actions in place	Positive Assurance	Negative Evidence	Current residual risk score (see note 2)			Change from initial risk to current residual risk	Further Mitigating Actions	Completion date for actions	Target grade following Mitigation (see note 3)		
			Should be high-level potential risks that are unlikely to be fully resolved and require on-going control.		Likelihood	Impact	RAG status	Systems and processes that are in place and operating to mitigate the risk.	Internal/External evidence that this risk is being effectively managed (e.g. Board/subcommittee reporting, Target/indicator performance, internal/local/national audit external audits, Inspection/visit/reviews, external benchmarks)	Internal/External evidence that this risk is not being effectively managed (e.g. internal/external audit reports/visits, adverse patient outcomes reported, patient experience feedback, poor performance indicator results)	Likelihood	Impact	RAG status		Additional actions required to mitigate risk further (target grade date)	For each further mitigating action a completion date must be provided.	Likelihood	Impact	RAG status
CEO	5	1501	The Trust does not meet the DH / Monitor requirements to become a foundation trust. Date of origin: 05/11/07 Date of escalation = 05/11/07	10	D	4	A	External review of Quality Governance has been completed (inc follow up review) Aug 13.	Achieved milestones to date on sustainability timeline	Monitor letter deferring Trust - Oct 12	C	4	A		Action Learning From TDA FT Network	Ongoing	D	3	Y
								Process for review and comments on documentation via Trust Board - ongoing	CQC inspection completed, action plan in progress (Jan 14)						Regularreview of Monitor Board minutes and reports - ongoing	Ongoing			
								Programme for Communication with staff, patients and public - ongoing											
								TDA performance monitoring and selfcertification process - monthly											
								Board Action Plan to address issues related to deferral - ongoing											
								Trust is engaging in the work of the TSA in relation to Mid Staffordshire HospitalsNHS Foundation Trust.											
								Periodic updates i/c Monitor Assessment Team											
								Review of Monitor's Risk Assurance Framework against Trust performance report											
CEO	6	3330	The long term impact on the Trust of the changes occurring at Mid Staffordshire NHSFT and within the Staffordshire health economy Date of origin: 14/02/13 Date of escalation = 14/02/13	1, 3	C	4	A	Trust presentation to Wolverhampton City CCG	Trust's clinical model has been approved by the National Clinical Group		C	4	A				E	4	A
								CEO attends Sustainability Board (Nov 13)											
								Memorandum of understanding developed with MSFT (Nov 13)											
								Involvement in the work of the TSA (Jan 14)	Trust is named as a key provider in the TSA Final Recommendations (Jan 14)										
								Contributing to TDA lead work - Sep 13											
								Internal evaluation of the impact on services both without and with formal service reconfiguration - ongoing as proposals develop.											
								CEO meetings i/c local MPs											

The Royal Wolverhampton NHS Trust Board Assurance Framework (incorporating strategic risks)

Business plan objective KEY: 1. To provide our patients and staff with a safe environment / 2. To be the employer of choice / 3. To achieve a balance between demand and capacity of services / 4. To progressively improve the image and perception of the Trust. / 5. To be in the national NHS top quartile of benchmarks / 6. Deliver services within financial allocations / 7. To be a high quality educator / 8. To agree appropriate population catchment areas for RWT service / 9. To develop our position as a tertiary centre / 10. To consolidate our position as a leading Healthcare provider in a commercial environment.

Risk Owner	Number	Risk ref	Potential risk Description	Business plan objective	Initial risk score (see note 1)			Mitigating Actions in place	Positive Assurance	Negative Evidence	Current residual risk score (see note 2)			Change from initial risk to current residual risk	Further Mitigating Actions	Completion date for actions	Target grade following Mitigation (see note 3)		
			Should be high-level potential risks that are unlikely to be fully resolved and require on-going control.		Likelihood	Impact	RAG status	Systems and processes that are in place and operating to mitigate the risk.	Internal/External evidence that this risk is being effectively managed (e.g. Board/subcommittee reporting, Target/indicator performance, internal/local/national audit external audits, Inspection/visit/reviews, external benchmarks)	Internal/External evidence that this risk is not being effectively managed (e.g. internal/external audit reports/visits, adverse patient outcomes reported, patient experience feedback, poor performance indicator results)	Likelihood	Impact	RAG status		Additional actions required to mitigate risk further (target grade date)	For each further mitigating action a completion date must be provided.	Likelihood	Impact	RAG status
COO	7	2962	Risk of Health Visiting business/system/service failure due to multiple systemic failings. Date of origin: 17/05/12 Date of escalation = 24/05/12	1	B	4	R	More student Health Visitors taken on.	CQC unnannounced inspection - all standards assessed were met	Not fully compliant with delivery of the service spec/HCP	D	3	Y				D	2	G
								Professional Lead in post	Compliance against HCP/ Service spec indicators monitored and reported monthly.	Some delays in moving to children centres due communinication issues and service reconfiguration									
								Ongoing recruitment and monitoring staff turnover.	Ongoing relocation of services into children centres										
								Reconfiguration of Health Visitor meetings to bimonthly (internal Chair) and external Performance Review meetings via LAT (external Chair).	Increase in student numbers										
								Issue escalated to NHS England	Support workers to be funding as a cost pressure to Division										
								The Chief Operating Officer and the Director of Nursing review the service development programme - leads convene every month to drive service improvements.	Approval for the Family Nurse Partnership posts agreed December 2013.										
								Directorate and Division will be monitoring HR indicators, complaints and any concerns raised through Safeguarding Team.											
CFO	8	3354	Estates quality and flexibility compromise the ability to respond to fluctuation in demand and the implementation of streamlined clinical pathways. Date of origin: 09/04/13 Date of escalation = 09/04/13	1, 3	C	3	A	Prioritise programme for capital investment and completion of backlog maintenance			C	3	A				D	3	Y
								Planning application approved for site redevelopment											
								Interim refurbishment programme											
								Creation of a new emergency department											

The Royal Wolverhampton NHS Trust Board Assurance Framework (incorporating strategic risks)

Business plan objective KEY: 1. To provide our patients and staff with a safe environment / 2. To be the employer of choice / 3. To achieve a balance between demand and capacity of services / 4. To progressively improve the image and perception of the Trust. / 5. To be in the national NHS top quartile of benchmarks / 6. Deliver services within financial allocations / 7. To be a high quality educator / 8. To agree appropriate population catchment areas for RWT service / 9. To develop our position as a tertiary centre / 10. To consolidate our position as a leading Healthcare provider in a commercial environment.

Risk Owner	Number	Risk ref	Potential risk Description	Business plan objective	Initial risk score (see note 1)			Mitigating Actions in place	Positive Assurance	Negative Evidence	Current residual risk score (see note 2)			Change from initial risk to current residual risk	Further Mitigating Actions	Completion date for actions	Target grade following Mitigation (see note 3)		
			Should be high-level potential risks that are unlikely to be fully resolved and require on-going control.		Likelihood	Impact	RAG status	Systems and processes that are in place and operating to mitigate the risk.	Internal/External evidence that this risk is being effectively managed (e.g. Board/subcommittee reporting, Target/indicator performance, internal/local/national audit external audits, Inspection/visit/reviews, external benchmarks)	Internal/External evidence that this risk is not being effectively managed (e.g. internal/external audit reports/visits, adverse patient outcomes reported, patient experience feedback, poor performance indicator results)	Likelihood	Impact	RAG status		Additional actions required to mitigate risk further (target grade date)	For each further mitigating action a completion date must be provided.	Likelihood	Impact	RAG status
CFO	9	2928	Impact of economic environment. Potential reduction of income and activity due to efficiency requirements placed on commissioners and / or private sector withdraw from the market. Date of origin: 13/04/12 Date of escalation = 13/04/12	6	C	3	A	In 2012/13 re-investment of funds into Trust were secured following negotiations (Mar 13)	Financial position of the Trust monitored monthly by Finance & Performance Committee and Board Reports.		C	3	A	→	To identify market opportunities - ongoing		C	1	G
								For 13/14 have secured favourable contracts	Monitoring referral trends for changes						To respond to bids put forward by Commissioners - ongoing				
								Contingency plans in place	Procurement tenders reviewed to ensure sufficient competition						Additional collaboration with other providers to reduce costs - ongoing				
															Maintain good working relationships and communications with commissioners - ongoing				
Dir P&C	10	1734	Introduction of other health providers in the market as a result of Any Qualified Provider leads to a greater shift of activity. Date of origin: 11/06/08 Date of escalation = 11/06/08	10	C	3	A	Internal systems in place to manage procurement processes in case of increased requirement to tender (Oct 13)	Trust Board reports detailing new business opportunities and delivered successful tenders		D	3	Y	↓	Review further AQP proposals - ongoing.	Ongoing	D	2	G
								Process established to monitor Supply2health Website for future opportunities (Oct 13)	Quarterly reports to the F&P Committee and TMC detailing tender opportunities and progress with individual tenders						Reviewing and strengthening the internal resource to support the delivery of tenders and service expressions of interest	Apr-14			
								Submitted AQP proposals for Foot Health and Audiology	No reduction in activity occurred as a result of AQP in 2013/14						Use refinements to NHS Choices & Choose & Book to 'sell' services - ongoing	Sep-14			
															Maximise opportunities to sell services via new Web Site - ongoing.	Sep-14			
															Bi-monthly communication with GP community via a newsletter	Apr-14			

The Royal Wolverhampton NHS Trust Board Assurance Framework (incorporating strategic risks)

Business plan objective KEY: 1. To provide our patients and staff with a safe environment / 2. To be the employer of choice / 3. To achieve a balance between demand and capacity of services / 4. To progressively improve the image and perception of the Trust. / 5. To be in the national NHS top quartile of benchmarks / 6. Deliver services within financial allocations / 7. To be a high quality educator / 8. To agree appropriate population catchment areas for RWT service / 9. To develop our position as a tertiary centre / 10. To consolidate our position as a leading Healthcare provider in a commercial environment.

Risk Owner	Number	Risk ref	Potential risk Description	Business plan objective	Initial risk score (see note 1)			Mitigating Actions in place	Positive Assurance	Negative Evidence	Current residual risk score (see note 2)			Change from initial risk to current residual risk	Further Mitigating Actions	Completion date for actions	Target grade following Mitigation (see note 3)		
			Should be high-level potential risks that are unlikely to be fully resolved and require on-going control.		Likelihood	Impact	RAG status	Systems and processes that are in place and operating to mitigate the risk.	Internal/External evidence that this risk is being effectively managed (e.g. Board/subcommittee reporting, Target/indicator performance, internal/local/national audit external audits, Inspection/visit/reviews, external benchmarks)	Internal/External evidence that this risk is not being effectively managed (e.g. internal/external audit reports/visits, adverse patient outcomes reported, patient experience feedback, poor performance indicator results)	Likelihood	Impact	RAG status		Additional actions required to mitigate risk further (target grade date)	For each further mitigating action a completion date must be provided.	Likelihood	Impact	RAG status
Dir P&C	11	2508	Commissioning responsibility changes - affects contracted income Date of origin: 03/08/10 Date of escalation = 03/08/10	6	B	3	A	Targeted CCGs as they develop; and developed links with Clusters (Dec 12)	Positive contract negotiations for 2013/14		C	3	A		Raising 2014/15 contract issues risks to Executive level for awareness.	Mar-14	C	3	A
								Reviewed "Everyone Counts: Planning for Patients 2014/15" and PbR guidance for 2014/15 (Jan 14)	Agreement of risk share to support maintenance of overall financial quantum (Apr 13)						Engagement with development of Better Care Fund to manage impact of transition and potential risk.	Jun-14			
								Implementation of Commissioning Communication Strategy across organisation (Jul 13)	TMC and F&P reports outlining outcomes of contract discussions						Negotiation with Commissioners at weekly LDP meetings for 2014/15, focus on CCGs.	Mar-14			
								Internal RWT Contract Review/LDP Meetings. (Senior Managers/Directors agreed negotations strategy (ongoing)	Contracts signed with all commissioners in line with national timescales (Jun 13).						Development of relationships with Non-Wolverhampton collaborative commissioners	Jun-14			
								Participated in the Better Care Fund Working group to ensure appropriate input and influence	Report to F&P Committee outlinng the process and potential risks (Feb 14)										
Dir P&C	12	2927	Failure to deliver against QIPP scheme resulting in lack of investment. Date of origin: 13/04/12 Date of escalation = 13/04/12	6	B	3	A	Commissioners requested to provide detailed work plan to support QIPP programme prior to removal of cost from contracts (Mar 14)	Quarterly Contracting Reports to Trust Board and F&P	RWT suggested QIPP Schemes not adopted by CCG	B	3	A		Flagging internal developments to commissioners for inclusion on QIPP list.	Mar-14	B	3	A
								Engaged with Commissioners in early discussions around QIPP Programme for 14/15 (Jan 14)	QIPP tracker monitored via Contracting and Commissioning Group						Monitor MPB tracker via Contracting Team - ongoing	Ongoing			
								Management of QIPP programme through established Modernisation Board (Mar 13)	Contracting and Commissioning Group reports highlighting QIPP business cases										
								Agreed a QIPP work programme for 2014'/15 with commissioners, documented within contract through the Service Development Improvement Plan (Oct 13)											

The Royal Wolverhampton NHS Trust

Trust Risk Register

March-2014

A1	A2	A3	A4	A5
B1	B2	B3	B4	B5
C1	C2	C3	C4	C5
D1	D2	D3	D4	D5
E1	E2	E3	E4	E5

Director	Cross Ref	What is the Risk?	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										

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcom 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

Director	Cross Ref	What is the Risk?	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: Clinical Negligence Scheme for Trusts

Director	Cross Ref	What is the Risk?	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	O4 494	Recent audits of midwifery staffing have recognised a deficit in achieving the local Birthrate Plus ratio of 1:30. This deficit is in addition to the ongoing vacancies within the service and the challenges of recruiting the appropriate levels of staff could have a potential impact upon the quality and safety of care given particularly in periods of high activity. Date of origin: 10/01/05 Date of escalation = 06/03/13	C4 AMBER	Business Case to Trust Management Committee - October 2013. Escalation policy developed and ratified at Directorate in order to support and guide staff during times of increased activity, reduced staffing and potential closure of the unit. Contingency plans invoked at times of increased activity Senior midwifery manager on-call 24hr 7 days a week Weekly midwifery establishments are reviewed by the Head of Midwifery All staffing incidents notified to Head of Midwifery. Ongoing monitoring via incident reporting system for staffing related incidents Bank usage where indicated which is authorised by the matron. Support from HR to explore alternative recruitment methods All staffing breaches and adverse outcomes are reported via senior nurse performance meeting monthly by Head of Midwifery.	Funding for birthrate plus business case has been agreed to be provided substantively in 2014/15 funding. Staff have been appointed to the vacancies Bank hours and requirements are monitored weekly satisfying the senior Directorate team in relation to the management of risk. Will be signed off weekly by Head of Midwifery or Directorate Manager. The Wolverhampton Strategic Oversight Group for Obstetrics and Gynaecology continues to meet and receive reports on progress following the Health Care Commission enquiry. Recruitment is ongoing	Adverse outcomes associated with sub-optimal staffing, are identified through incident reporting. Difficulties recruiting staff with sufficient levels of experience to support required skill mix Recruitment is ongoing however we are unable to recruiit sufficient numbers to meet both vacancies and Birthrate Plus requirements	Recruit and appoint to vacancies with ward areas Explore alternative recruitment methods with HR Midwifery features in the trust wide recruitment plan which is currently in progress.	Apr-14 Apr-14 Jun-14	C1 GREEN	Mar-14	Yes

Director	Cross Ref	What is the Risk?	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?
				Birt rate plus ratio is monitored on a monthly basis via the maternity dashboard which is reported through the risk/governance committee and Intrapartum committee. The dashbaord is also reported through trust board. Birth rate plus ratio is recalculated on an annual basis in line with end of year activity with complexity taken into account. Staffing is a monthly agenda item on the operational meetings chaired by the head of midwifery						

Director	Cross Ref	What is the Risk?	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 provide our patients & staff with a safe environment.**										
Chief Operating Officer	O4 3299	Safer Childbirth and NHSLA requirement for 60hr dedicated labour ward consultant presence for less than 4000 deliveries per year. 98hr presence is required for 4000-5000 deliveries. Current staffing provision is 40hrs consultant presence dedicated to labour ward only. Additional 20hrs consultant presence includes emergency gynaecology cover which is outside the safer childbirth/NHSLA requirement. Therefore the maternity unit is currently non compliant with this. Date of origin: 30/01/13 Date of escalation = 30/05/13	C4 AMBER	Emergency gynaecology lists are 2-5pm Monday, Wednesday and Friday to avoid risk of out of hours emergency gynae surgery. No elective gynaecology work planned over weekends	Sept 2013 - The business case has been redone but Consultants want to input into the timetable so it has not yet been resubmitted. However births remain under 4,000 and predicted to stay so at present. This will be monitored through datix incident reporting No incidents reported concerning obstetric staffing where sub-optimal care has resulted. Monitor consultant hours via obstetric dashboard on a monthly basis through Intrapartum committee & risk managemeht/governance committee. The dashboard is also available up to trust board. This will be reviewed by the risk management/governance committee on a quarterly basis - update in December 2013.	The birth rate has exceeded 4000 at the end of the 2013 calendar year thus requiring 98 hour cover. The 60hr dedicated consultant cover is not currently being met.	Application for extra funds Meeting of consultant body to take place 10/2/14 to discuss job planning models that allow us to meet national standards.	Apr-14 Feb-14	D3 YELLOW	Mar-14	Yes

Director	Cross Ref	What is the Risk?	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	3685	Staffing levels and quality of nursing care on A6. Difficulty recruiting staff within existing blueprint. Staffing levels are below those recommended by HURST tool, high dependency of patients. High level of incident forms submitted regarding inability to give core care due to staff shortages. Negative historical reputation of A6 makes bank staff reluctant to work on this ward, putting pressure on ward staff to cover. Bank staff - Nurse bank unable to fulfil majority of outstanding shifts. 01/10/13 - High number of post-operative patients on A6 due financial recovery plan. 11/02/14 - A6 current staffing levels 19.9 wte registered nurses funded however only 13.96 wte registered nurses working clinically at present (4 wte newly qualified). 10.64 wte unregistered nurses funded and 4.8 wte working clinically at present. Poor skill mix and identified competency issues on the ward, seriously compromising the quality and safety of care on the ward. From 07/04/14 - Only 11.88 wte registered nurses working clinically on A6, reducing to 10.88 wte from 21/04/14 and 4.8 wte unregistered nurses working clinically on A6.	B4 RED	February 2014 - Recruited to substantive Band 7 Ward Manager on A6 - Start date 31/03/14. January 2014 - Matron is working clinically in order to address poor practice and raise standards. Reconfiguration of elective/non-elective Orthopaedic beds in September 2013. Practice Development Team support ward as required. Matron undertakes daily rounds Monday-Friday undertaking case note reviews of all patients on A6 to ensure that care received is appropriate and safe. Cardiothoracic Ward are providing support to A6 by transferring a nurse practitioner to provide clinical expertise to ward to support junior staff in achieving competencies with post-operative care. Nurse Education Department providing supervision and support to newly qualified staff. Matron has asked for increased provision from service. Matron working clinically on A6. Matron undertakes daily rounds Monday-Friday undertaking case note reviews of all patients on A6 to ensure that care received is appropriate and safe.	Head Nurse meeting with Chief Nurse regarding staffing levels on ward from April 2014 onwards. Practice Development Nurse specifically for T&O Directorate working across A5 and A6 will commence post 17/03/14. January 2014 - Matron is working clinically in order to address poor practice and raise standards. Head of Nursing and Director of Nursing met with staff on A6 to discuss concerns July 2013. Appraisal rate for nurses on A6 is now 73% (7 staff outstanding - 4 staff have only been in post since January 2014. January 2014 - Matron is working clinically in order to address poor practice and raise standards. February 2014 - Safety thermometer score = 96%. February 2014 - HAPU = 1. February 2014 - Number of patient falls = 2. 2 formal complaints received in Q4 2014.	Poor compliance of less than 60% with basic life support training on A6. Amber incidents of unsafe staffing levels and care still being received weekly. Red incident for elective patient on A6 (unexpected death) - currently under investigation. Bank shifts often not filled, other than by own staff. 1 recent SUI where omissions in care/documentation have been found. February 2014 - Basic life support compliance level 3 = 52%. February 2014 - Sickness rate = 14.5%. Nursing staff not able to undertake training to enhance patient care due to time constraints and continually being pulled to work clinically on the ward due to staff shortages. February 2014 - Late patient observations = 16%. February 2014 - Registered nurse vacancies = 20%. This will increase in March 2014. March 2014 - Safeguarding referral made against A5 and A6.	Head Nurse meeting with COO regarding staffing levels on ward from April 2014 onwards. May-14 Practice Development Nurse specifically for T&O Directorate working across A5 and A6 will commence post 17/03/14. Mar-14 Local and oversees recruitment drive Apr-14 T&O specific competencies to be written by substantive members of senior nursing team. May-14 Head Nurse to undertake spot-checks of patient care on A6.	D2 GREEN	Mar-14	

Director	Cross Ref	What is the Risk?	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?
				Cardiothoracic Ward are providing support to A6 by transferring a nurse practitioner to provide clinical expertise to ward to support junior staff in achieving competencies with post-operative care. Practice Development Nurse to commence in post on 17/04/14.						

Director	Cross Ref	What is the Risk?	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	3431	Poor skill mix due to change in establishment to A7, CoE 28 beds Dec 12, current position for band 5=vacancy 3.4wte, further 4wte working notice and 1wte on ML, sickness 6.9% Risks identified: a)Direct care and documentation-patients not turned attended to hygiene or toileted regularly, patients are not being offered food and fluids or assisted with them in timely fashion-symbiotic audit Oct-documentation 76%, falls 60%, nutrition 30% b)Above trust target late observation recording-25%, c)High number of HAPU-in last 3 months x3 avoidable and 1 unavoidable, d)Poor discharge planning x2 complaints in last month e)New members of staff feel unsupported, recorded in 1:1 with Sister f)Increased stress on established members of staff g)All of the above recorded incidents resulting in high number of datix records in yellow grading-13 thus far Nov, 5 relate to staffing levels below establishment. h)Inability to provide staff to accompany consultant ward round resulting in poor communication and exacerbation all of the above.	B3 AMBER	Member of staff has been recruited to TV team to support CoE A7's Senior Sister has returned from sick leave and is currently being supported back into work on C24 A Band 6 sister has been seconded Agreement for third Band 6 secondment between from 27 January 2014 for 12 weeks, recruited from A8 Skill mix assessed when planning rota to ensure that the required skills are available on each shift Training needs analysis has been performed for all members of staff on the ward and needs prioritised. Band 6 responsibility to book and confirm attendance Where skills deficit on a shift has been identified and additional support needed established member of team has been asked to provide additional support by working additional hours Out of Hours practitioners to work on A7 for three evenings every week Nursing staff pooled across Care of the Elderly to ensure safe staffing levels across all wards Weekly meetings with Divisional Management		Increased numbers of incidents and complaints Difficulties covering vacancies with Bank staff Band 7 on long term sick High number of HAPU's	Advertise and recruit to vacant Band 5 and Band 2 posts	Apr-14	C2 YELLOW	Mar-14	

Director	Cross Ref	What is the Risk?	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?
				Matron clinical on ward A7 7.30-10am mon-fri for daily observation to reinforce standard setting, ward organisation and management of resources to give quality assurance Retention of staff and teambuilding chat back action plan involves every other week staff meeting with directorate team. Lia planned for 10.12.13 facilitated by service improvement Falls champion identified Additional Junior Dr allocated Practice Development Nurse on ward every day working alongside new staff to improve skills Volunteers helping out during meal times Member of staff inducted on A8 to transfer to A7 w/c 3 March 14. In addition another member of staff is due to begin induction on A8 and will transfer to A7 in due course. C22 providing staff support Dementia Outreach Sister seconded from January 14 for four months to develop skills and training in elderly care concentrating on role modelling on Ward A7						

Director	Cross Ref	What is the Risk?	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?
				Dementia Outreach Sister providing person centred care x2 days a week Band 5 transferred from another ward supporting skill mix							
Chief Operating Officer	O4 840	There is a risk to the quality and safety of care delivered to children and young people admitted as inpatients on NNU, Ward A21 and to those attending for assessment on Paediatric Assessment Unit due to inadequate staffing levels from vacancies, maternity leave and sickness absence. Date of origin: 07/04/05 Date of escalation = 11/12/13	C4 AMBER	Any incident reported daily Monitoring of capacity and activity daily or more frequently as required with escalation to Group management and division when Amber or above. Sickness monitoring and management according to policy . Piloting of joint HCA / phlebotomist post in PAU to reduce waiting times for patients at key pressure points A21, COPD and NNU Sisters to meet weekly to review forthcoming week staffing, identify hot-spots and pressure points and identify any cross cover available Staff in the process of being recruited to vacancies Finances available for manpower for staff employed from the Trust Bank. Staffing flexed according to activity Development of and recruitment to rotational posts between A21 and Neonatal Unit	NNU/ED/COPD based staff supporting team when short staffed. Adverts and vacancies with panel for recruitment. Some B5 and B2 now in post. Work rota shows that staffing levels flexed based on seasonal activity Unit working closing with each other and Safe staffing achieved through joint working with NNU Minimum ward closures reported	Staff sickness absences increasing. Closure of PAU to GPs occurred 16/09/2013. High volumes of staff currently on Maternity leave Training and workshops required for staff who use of specialist devices - eg CFM, cooling mattress, Nitric therapy Short staffing incidents reported on regular basis	Staff to attend workshops to train to use specialist devices Recruitment to Band 6, 5 and 2 Vacancies in a timely manner Provision of formal rota band 7 clinical cover during day shifts Monday - Friday from Senior Sister A21 / Education Lead and CNS Explore further rotational posts between NNU / COPD / Community Children's Nursing Services and ED Robust local induction and preceptorship plans for all new starters Develop action plan to "buddy-up" with general medical / HDU / and PICU at BCH in order to provide clinical experience and to develop rotational band 5 posts between RWT and BCH (post winter pressures) Repatriate inpatient cubicle spaces from PAU area to A21 following building work Ongoing incidents received to be reviewed concerning short staffing in wards Risk to be reviewed at Governance meetings on a Monthly basis.	Apr-14 Apr-14 Apr-14 Apr-14 Jun-14 Apr-14 Apr-14 Apr-14 Apr-14	D2 GREEN	Mar-14	Yes

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcon 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

Director	Cross Ref	What is the Risk?	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	O1 2898	Patients having to wait in ambulance off load area to be seen in ED due to a lack of space. The risk is to patient safety, experience, privacy, dignity and comfort. Date of origin: 27/02/12 Date of escalation = 25/02/13	C3 AMBER	OBC for new department approved October 2013. Additional Majors open Nov 13 The area has telephone access and is " for purpose" regarding equipment ie oxygen points, suction, resus equipment Sept 13 - Recruited additional nursing staff as part of Interim new build Sept 13 - CDU open 24/7 Aug 13 - When there are extra patients on the corridor, the ambulance crew stay with the patient until the patient is handed over/bed becomes available Escalation process in place to ensure appropriate action is taken to prevent the delay of safe treatment for patients visiting the A&E dept (policy available on A&E intranet page) Corridor nurses on duty to attend patients on the corridor Dec 13 Reviewing trends and numbers of patients	Improved A&E performance Quarter 2. Ambulance Handover Times maintained over winter period - December 2013.	Patients do sometimes wait in corridor - Nov 2013. Some delays of poor performance - linked to bed flow.	Build new ED SP to recruit 2 WTE Band 5 nurses (to staff Majors 24/7) ND to identify a trained nurse to rotate on ED to support ED's nursing numbers (to staff Majors 24/7)	May-16 Mar-14 Mar-14	D3 YELLOW	Mar-14	Yes

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcon 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

Director	Cross Ref	What is the Risk?	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	O4 2828	Quality of nursing care on A5. Difficulty recruiting staff within existing blueprint. Staffing levels are below those recommended by HURST tool, high dependency of patients. High level of incident forms submitted regarding inability to give core care due to staff shortages. Patients returned to A5 from the trauma list in the evening as list runs till 9.00pm. Negative historical reputation of A5 makes bank staff reluctant to work on this ward, putting pressure on ward staff to cover. Bank staff - Nurse bank unable to fulfil majority of outstanding shifts. 19/02/14 - A6 - Escalated to red risk therefore new risk generated - see risk 3685. 19/02/14 - A5 - Staffing and quality issues improved therefore aim to reduce this risk to green by 04/04/14. From 05/03/14 - Risk 2828 will pertain to A5 only.	C3 AMBER	Recruited to Matron post, commenced October 2013. 11/02/14 - Recruited Band 6 Practice Development Nurse for T&O - Awaiting start date. Reconfiguration of elective/non-elective Orthopaedic beds in September 2013. Nurse Education Department providing supervision and support to newly qualified staff. Matron has asked for increased provision from service. Workforce review tool started. Ongoing recruitment of registered nurses however not yet at full establishment. Demential outreach service actively supporting. More frequent visits by PALS to seek realtime patient feedback and address any issues as they arise. Practice Development Team support as required.	February 2014 - HAPU = 1. 2 formal complaints received in Q4 2014. Leadership walkaround July 2013. Flow Co-ordinator Band 6 in post August 2013 - working well. February 2014 - Number of patient falls = 2. All sickness absence being appropriately managed and is reducing. Appraisal rate for nurses on A5 is now = 84%. Leadership walk round in May 2013 reported positive patient feedback by PALS, EDs and NED's present. February 2014 - Fully recruited into all registered nurse posts. Remaining vacancy = band 2 wte.	Nursing staff not able to undertake training to enhance patient care due to time constraints and continually being pulled to work clinically on the wards due to staff shortages Bank shifts often not filled, other than by own staff. February 2014 - Documentation compliance = 86%. February 2014 - Late patient observations = 10%. February 2014 - Safety thermometer score = 81%. Safeguarding referral made against A5 and A6 - 48 hour report submitted, awaiting decision if full investigation required. Amber incidents of unsafe staffing levels and care still being received weekly. Mixed feedback from patients regarding negative and positive experiences. February 2014 - Basic life support compliance level 3 = 62%. February 2014 - Sickness rate = 6.8%.	T&O specific competencies to be written by substantive members of senior nursing team and newly appointed Practice Development Nurse.	May-14	D2 GREEN	Mar-14	Yes

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Financial Officer	3462	At the moment, the in-patient records are scanned for some wards while others continue to file paper records. Some areas work in a noteless environment whereby no paper records get added to casenotes. This rollout needs to be completed urgently as there is a risk that a patient could end up with part of their IP documentation scanned and part of it filed in the case note. Surgical wards, day case areas and some medical areas are still to be completed.	C4 AMBER	Ensuring regular communications are circulated across the trust in order to provide staff with an up to date progress report of the in-patient scanning programme Some progress with surgical wards as short term agreement to return inpatient paperwork to the notes with planned full rollout by early March	Additional wards are commencing their in-patient scanning process Scanning has commenced on several surgical wards and rollout is due end March	Some directorates are actively opposed to the in-patient scanning process and therefore no progress has been made. The original completion date for this was June 2013. It has still not been resolved.	Continue with ward rollout Agreement reached at TMT on 22nd Nov 2013 to destroy paperwork over one month; however to implement at three months and review Continue training and education staff e.g senior nurse forum Continue regular communications via all user bulletins and attendance at staff meetings Risk rating to be reviewed once rollout complete	D2 GREEN	Feb-14	
Chief Financial Officer	3079	Over 200,000 records stored in this area, there is no maintenance plan for the up keep of this building. Estates have informed that it is not suitable for staff accommodation. Risk is to records and to the staff as unsuitable environment.	C4 AMBER	Risk is currently on estates register - I.D1197 Estates contacted as and when issues arise	Estates are responding to individual issues when situations arise	Two recent incidents have been reported when leaks have occurred resulting in the potential loss of 36 case notes - Incident ID W24286 A further incident of flooding occured during the weekend of the 27th July - Incident ID W42412 Security incident with attempted break-in - Incident ID W44928. Physiotherapy reported an incident with water damaged casenotes	Governance team to link risk to incidents 107615 and 110187 Alternative storage accommodation to be investigated	E2 GREEN	Feb-14	

Director	Cross Ref	What is the Risk?	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	O4 943	Non-adherence to chemotherapy policy and procedures resulting in poor patient and staff experience/confidence. Date of origin: 29/08/13 Date of escalation = 09/09/13	B4 RED	Chemotherapy Prescribing MDT monthly meeting to discuss all off Formulary chemotherapy treatment requests. Chemo register in place for all prescribers Formulary of agreed prescriptions in place RCA conducted for incidents as required, action plans implemented as indicated by findings and lessons shared Pharmacy scrutiny of prescription that are non compliant with formulary Tested out raising concerns with staff - Meeting between staff, COO and Medical Director to raise any concerns was held External review of governance processes in Oncology planned Dec 13 / Jan 14, following allegations of inappropriate / incorrect treatment requirements being prescribed in Aug - Oct 2013 (Nov 13) Appropriate restrictions of practice in place to manage allegations made (Nov 13) Policy CP8 and procedure in place Annual validation of nursing staff competence	External review by HAQU, no concerns raised Audit of NICE guidance - 18 audits on plan for 13/14 National Cancer pt satisfaction survey Quality system in place to ensure version control of all departmental documentation	Self assessment against peer review measures identified some issues - work plan in place to address Concerns raised by staff members through formal and informal routes Audit of practice	Prospective audits of non formulary treatments to be undertaken Audit of attendance at Formulary group Independent external review of chemotherapy prescribing and treatment regarding allegations made Aug-Oct to be undertaken by a medical and clinical oncologist, with overview of process by an external review panel, planned for Feb 14. Introduction of E-Prescribing	Mar-14 Apr-14 Mar-14 Apr-14	E3 YELLOW	Mar-14	Yes

Director	Cross Ref	What is the Risk?	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	O4 1862	Trust wide consent audits reveal failures within the division to follow a 2 stage consent process and correctly complete DOH consent forms. Date of Origin: 08/07/08 Date of escalation = 06/03/13	C4 AMBER	Mr Ian Badger - Divisional Medical Director (Surgery) is the Trust Lead for Consent within the Trust Staff training on consent available. Standardised DOH consent forms in use across the Trust. Consent Audit 2010/11 has been combined with the documentation audit. This would allow directorates that document consent within the notes to be able to evidence 2-stage consent. Trust junior doctor induction changed so that doctors undertake induction and mandatory training prior to starting. Delegated consent lists kept by all relevant directorates Divisional Patient Information Ratification Committee. CDs compile directorates delegated consent lists with each new medical intake	July 2013 Written Consent Audit - Concludes there is a robust system across the Trust for the seeking of consent from patients. Areas of high compliance include the use of the appropriate consent form, discussions on consent taking place, documentation in the form/medical records of the risks and the benefits of the procedure and the signing of the consent form by the clinician seeking consent and also the patient/person with parental responsibility for the child.	Recent near miss incidents - Shoulder Injection incident and Opthalmology Lucentis incident July 2013 Written Consent Audit - Concludes the areas requiring attention are the documentation of the use of approved patient information leaflets, ensuring the two stage consent process is in place and documentation that a copy of the consent form has or has not been accepted by the Consent forms not being correctly completed. Recurring themes highlighted through annual audit. Complete up-to-date delegated consent lists not held within directorates.	Implement updated consent policy when approved Re-design the consent form	May-14 May-14	E3 YELLOW	Mar-14	Yes

Director	Cross Ref	What is the Risk?	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	O4 2604	Trustwide VTE audits continue to demonstrate poor compliance with VTE policy and procedures, leading to an increased risk of VTE and compromised patient care. Date of origin: 14/12/10 Date of escalation = 06/03/13	B3 AMBER	Prompt cards being given to all medical staff as they start ward rounds and to the nursing teams at each hand over. New anti co-agulation sheet in place All RCA's will now go via the VTE committee - this should improve the standard of RCA's and action plans Mandatory training for junior doctors accessible from the KITE site. VitalPac tool includes VTE risk assessment VTE risk assessment in use VTE nurses in place	Update (12 Nov 2012): Divisional Medical Director (Surgery) to discuss with Medical Director to include risk on Trust Risk Register. During April 2013 the % of admisson assessed for VTE was 96.51 this has increased to 97.32 for July 2013. During April 2013 the % of 1st assessments within 4 hours was 74.45 this has increased to 80.63 for July 2013. July 2013 - The re-assessment in 24 hours is at 8%. Multidisciplinary project team have developed an action plan in respopnse to NPSA patient safety alert. June 12 - NHSLA self assessment for the division - scored 'green'.	Trustwide VTE audit showed poor compliance with policy Concerns highlighted in Cardiology and on A9 Actions are still needed to achieve compliance with NPSA alert Poor compliance of risk assessment completed 24 hours after initial risk assessment; evidenced by health record checks	Daily circulation and follow up of non-compliance	D3 YELLOW	Mar-14	Yes

Director	Cross Ref	What is the Risk?	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	O4 3486	Possible inappropriate oncological treatment of patients with colorectal cancer between 2007 and 2009. Challenge in to the conclusions of an audit taken into treatment of patients with colorectal cancer in 2009 has been made by a staff member using the Trusts whistleblowing policy. The risk declared relates to historical treatment requirements and negative outcomes to patients treated. Date of origin: 03/09/13 Date of escalation = 03/09/13	C4 AMBER				External Review planned FEbruary 2014 To have an external review of the previous audit and practice and management of colo-rectal cancer between 2007-2009 by an expert in this field		C3 AMBER	Mar-14	Yes
Medical Director	O6 3494	Lack of interventional radiology rota for Black Country Vascular network. Date of origin: 06/09/13 Date of escalation = 06/09/13	C4 AMBER	Actively discussing the implementation of the emergency interventional rota with the vascular network lead Patients who require out of hours emergency interventional radiology management will be referred to an alternative vascular centre			Discussion with Medical Director and Vascular Clinical Services Lead arranged for November 2013 to discuss When clinically required, arrange for transfer of patients to an alternative centre for management	Nov-13	D2 GREEN	Mar-14	Yes

Director	Cross Ref	What is the Risk?	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	O16 3370	Poor compliance with completion of Trust annual clinical audit plan (2012/13) resulting in gaps in assurance in relation to clinical practice and completion of actions from previous audits. Adverse impact on compliance with CQC standards, NHSLA standards and Quality Account performance. Poor completion/update of the Trust clinical audit database to inform reporting and lack of engagement in the process by Junior doctors, resulting in audits being started but not completed. Date of origin: 24/04/13 Date of escalation = 09/07/13	C3 AMBER	Agreement with Divisions to limit number of local audits on plan to 10 per directorate for 13/14 plan. 13/14 Audit plans signed off by division Refresher training on Clinical Audit database for Governance Officers - Jun 13 Reviewed the current role - Audit Convenor (Jul 13) Attendance at CAC by convenors tmonitored and fedback to Clinical and Divisional Directors. Provided further training to Governance Officers to improve consistency in their approach to clinical audit MD wrote to all consultants, CD's, convenors regarding role (Jul 13) Clinical Audit progress report to Compliance cttee and CAC (2 monthly) All Trust wide audits on the plan are completed centrally Governance officers follow up audit plans with Directorates and Audit Convenors on a monthly basis Divisional sign off of Directorate Clinical Audit Plans Monthly status report on completion of audit plan (Aug 13).	TB report showed much improved compliance (Jan 14) Improved accuracy of reporting re completion to Directorates and Divisions on monthly basis	Poor attendance by audit convenors at the Clinical Audit Committee Limited progress/ accountability for improvement or actions	Bd 6 to review position of NICE audit status Refine database and functionality to improve search and reporting facility	Jan-14 Apr-14	D2 GREEN	Mar-14	Yes

Director	Cross Ref	What is the Risk?	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	The CQC identified 4 areas requiring improvement following the new inspection process carried out in Sept 2013. A range of actions will ameliorate these apart from the staffing improvements required which continues to present a risk on divisional risk registers. Date of origin: 14/01/14 Date of escalation = 14/01/14	B3 AMBER	Multi-disciplinary action plan with executive oversight and identified leads has been ratified through QSAG and will be monitored monthly via this committee (Jan 14) Evidence to support compliance with actions is lodged via HealthAssure (Jan 14) Reviewing and refreshing use of E Roster to ensure most effective model of staffing is in use (Jan 14) Increase staffing levels on night duty with use of bank and overtime in Medicine and T&O as a cost pressure (Jan 14) Workforce business case has been approved by Trust Board to support increase in staffing levels, discussions around funding continue with CCG/TDA (Jan 14) Business Case for refurbishment of Women's Unit Phase 3 approved at TB Feb 14 Assurance received confirming actions evidenced as complete. CQC Action plan presented to QSAG March 13		Additional staffing business case not funded (Mar 14)	Continue to see positive assurance of quality indicators and patient experience of changes made Undertake an internal peer review of areas to ensure compliance with actions in March Participate in repeat visit by CQC in May 2014	 Apr-14 May-14	C3 AMBER	Mar-14	

Director	Cross Ref	What is the Risk?	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	3589	A routine inspection of Independent Living Services, the Trust contracted supplier of community equipment demonstrated poor compliance with local and national guidance on decontamination of equipment. Lack of 7 day provider of community equipment.	B3 AMBER	Monthly meetings to monitor the ILS contract (Nov 13) Monthly visits to ILS to track & support improvement (Nov 13) CCG fund out of hours service through CERL (internal equipment managed by RWT) Infection Prevention Team continue to monitor progress at ILS via monthly visits to the premises (Feb 14) Risk assess the benefits of moving to a new provider with contracts and commissioning Meet with ILS and senior local authority staff to ensure agreed goals and outcomes. Scope contract to ensure robust and fit for purpose. IP to contribute to group.	Audit reports completed and circulated to ILS making clear recommnendations Improvement notice issued (Oct 13) IP report improvements in decontamination process.	ILS are unable to supply clean equipment and stocks are low. Staff sickness in cleaning bays. ILS have not had a deep clean.	Seek confirmation from CCG to agree to management control of ILS from RWT Scope contract to ensure robust and fit for purpose. Infection Prevention contributing to the group Agree 14/15 working arrangements with CCG to enable RWT to exercise management control of ILS. Procurement are exploring alternative tenders Monthly visits by IP to ILS to identify progress and next steps required	 Mar-14 Apr-14	C2 YELLOW	Mar-14	

Director	Cross Ref	What is the Risk?	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	O4 2680	Interpreting & Translation Service - risk of over performance against central budget held by patient experience. Date of origin: 29/03/11 Date of escalation = 16/05/12	A3 AMBER	Implemented risk assessments and centralising of face to face interpreting in top 3 areas of usage (Jan 13) Developed KPIs to monitor weekly usage (monitored monthly) Current process in place to direct face to face/telephone translation services Commenced action plan to implement same model as pilot across Trust Identified high users and engage to review working practices and demonstrates reduction in overspend.	No evidence of patient or staff concerns from 3 pilot areas (Mar 13) Reduction in overspend by 60% from last year end Reduced overspend (Jan 14) Ensured Matrons in OPD and user inpatients understand control resources (May 13) Continue to monitor telephone face to face bookings (May 13) Ensured all 2 way telephones placed in areas are available and are used (May 13)	Overspend continues	Seek agreement from Directors to transfer budget to divisions who control it's use. Financial update re budget, spend figures going to finance committee for review to consider devolvement to divisions Alternative providers to be sourced	Apr-14 Mar-14 Sep-14	C1 GREEN	Mar-14	Yes

Director	Cross Ref	What is the Risk?	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	O16 2482	Failure to learn from national / local organisations experience e.g. Francis report. Date of origin: 17/06/10 Date of escalation = 06/06/12 Date to achieve Residual Risk rating: Apr-14	D4 AMBER	Developed further mapping of assurances and gaps to the Francis report response (Oct 13) Review and strengthening of the Complaints management process in light of the Clwyd/Hart report. Investigation and reporting on complaints. Monitor and reduce levels of harm eg falls, pressure ulcers, medication adverse incidents. Improve care services for Dementia patients. Review of nurse training, education and development to deliver compassionate care. Develop and audit robust local level data to inform reporting. Establish and audit of policy on death certification. Review and audit transfer and discharge policy and practice. Measures for evaluating progress with Francis identified (Mar 14) Organisational development of values recruitment. Improve care services for the older person. Improve care services at the end of life. Develop formal structure and audit of ward rounds	Clwyd/Hart focus group is in formation. Results for F&F test, Complaints/PALs performance, Patient and carer voice. No upheld ombudsman complaints in January 14. Outcome of local investigation and reports on complaints. Safety thermometer found 93.77% of patients received harm free care in Jan 14. Improvements in FFT and also in patients voice regarding time to take answering buzzers A marginal improvement on the 2012 survey results, with an average change of +0.3%. Board agreed Francis statement response for public website (Feb 14).		Implement findings from Clwyd / Hart report	Apr-14	E2 GREEN	Mar-14	Yes

Director	Cross Ref	What is the Risk?	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	O8 535	Failure to achieve reductions in HAIs impacting on Trust's reputation and compliance to regulatory standards. Date of origin: 07/03/05 Date of escalation = 11/05/11	C4 AMBER	PCR for C-Diff testing from March 2011 Introduced 2% chlorhexidine in alcohol for surgical skin preparation and monitor associated reduction in infection rate - Jan 13 Screening Policy in Trust implemented, updated comms Nov 12 Screening Programme in Community in place Nov 12 IV team in place Mar 13 Surgical Site Infection Surveillance Team in place Mar 13 Robust surveillance system in placeJ Mar 13 Monitored the increase in C-Diff post PCR testing and discussed with commissioners Oct 12 PREVENT Bronze standard achieved by Care Homes - Mar 2013 Appointed Data Analyst for IPT - March 2012 MRSA admission screening pilot in care homes commenced and completed October 2011 Revised Outbreak Mangement Plan to include dehydration clinical pathway in place advised from Wolverhampton Care homes for dehydration as a result of norovirus symptoms over Winter 2011/12 - Oct 12	Achieved C difficile objective for 2012/13 April 13 CQC Visit - January 2013 HPA quarterly report of MESS data ongoing. 2011/12 best year to date for the reduction of MSSA bacteraemia, DRHAB's and MRSA acquisition Aug 12 Current C-diff and MRSA bacteraemia YTD performance -Aug12 Anti-microbial Prescribing Strategy in place. Successful Nursing Times award for infection prevention in community Nov 2011. MRSA rates currently on trajectory Oct 12 MRSA admission screening pilot in care homes commenced October 2011 <1% colonised Oct 12 MRSA Screening for Podiatry Nail screening pilot - 0% MRSA detected April 2012 MRSA early discharge screening Pilot October 2011 - 1/260 positive ICNet NG in place to provide ectroinic alerts. MRSA screening retraining rolled out Reduction in HCAIs other than MRSA bacteremia - Jan 13	National guidelines recommends of Fidaxomicin for C difficile (May 13) Rising community cases of C difficile which could impact on trust numbers. There is a lack of evidence against which PCR positive specimens will be EIA positive and therefore reportable under the new testing algorythm	Train GP's/consultants in the use of Fidaxomicin Amend Fidaxomicin business case following TMC presentation The case for use of Fidaxomicin will be taken to the Area Prescribing Committee Antimicrobial Stewardship Strategy in draft form, pending successful business case for additional Antimicrobial Stewardship support. Infection Prevention Communication campaign to raise IP awareness to commence in March 2014 Fidaxomicin business case to be presented at Contracts and Commissioning Committee in Feb 2014.	Dec-14 Feb-14 Mar-14 Mar-14 Mar-14 Feb-14	E4 AMBER	Mar-14	Yes

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcon 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

Director	Cross Ref	What is the Risk?	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?
				CDI Assurance process updated. Monthly reporting to IPCC on trends - Mar 13 Action plan in place for Hygiene Code to be monitored by IPCC quarterly - reported to IPCC Sept 12 Action plan for reduction in HABs and DRHABs reviewed Mar 13 Fidaxomicin business case presented to Contacts and Commissioning Committee in February 2014 Fidaxomicin business case amended following TMC. C difficile ward round in place and sustained Mar 13 MRSA bacteraemia action plan agreed and presetnted to IPCC Sept 12 - Nov 12 Urinary Catheter policy agreed at IPCC Oct 12						

Director	Cross Ref	What is the Risk?	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 be the employer of choice.**									
Chief Operating Officer	O12 1713	Failure to effectively maximise workforce productivity. Date of origin: 03/06/08 Date of escalation = 11/05/11	B3 AMBER	RAG rated tool to monitor compliance against Job Plans has been developed. Reported to Workforce Group in September 2013. Areas to be contained with SPA allocation - agreed Performance targets including pay costs v clinical income. Locum Bank Project Team set up - terms of reference/scope developed. Action plan for implementation. Medical Bank introduced	Interim Job Planning Audit indicated a number of actions now addressed.	April 2013 - Audit Report RSM Tenon identifies areas for improvement. Medical agency costs not reducing - May 2013. Slow progress in terms of Job Plan completion - September 2013	Develop streamlined Job Planning process - a joint communication to be issued by Chief Operating Officer and Medical Director. Monitor Bank fill rates performance - ongoing Review of medical rotas with potential to introduce electronic rostering system. Clinical Directors to be targeted to complete all Job Plans in areas by the end of May 2014 - a joint letter is to be issued by the COO and MD.	Mar-14 Apr-14 May-14	C2 YELLOW	Mar-14	Yes

Director	Cross Ref	What is the Risk?	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?
Director of Human Resources	O14 1742	Failure to learn from staff survey. Date of origin: 11/06/08 Date of escalation = 11/05/11 Date to meet risk after actions: 31/05/14	B3 AMBER	Chatback 2013 completed (end July 2013) Results cascaded to Managers/Directors/Senior Managers in Sept 2013 Key Indicators in staff survey covered by Trust policies (eg appraisal, harassment and bullying, etc). Staff Governors in constitution have voice to influence direction of Trust staff survey 2013 being conducted Sept - Dec 2013. Results due in Feb 2014 Staff feedback has been incorporated into the Trust Board quality & safety dashboard thereby aligning staff engagement with patient safety agenda. Key Staff Survey indicators included in HR KPIs	Chatback 2013 results received end August 2013 show marked improvement on 2012; local action plans being developed. KPI in annual plan. Overall staff engagement measured for the second time (based on response to 3 questions). RWHT scored 3.72/5 being highly engaged staff. This was in the highest (best) 20% when compared with similar Trusts.(March 2012) Turnover below National average and within Trust target. (as at Sept 2012)	Results received from 2012 staff survey - 45% response rate still leaves us in lowest 205 of Acute Trusts. Chatback staff survey results showed a decline in performance for 2012.	Results from 2013 National Survey due in February 2014	Feb-14	D3 YELLOW	Feb-14	Yes

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcon 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

Director	Cross Ref	What is the Risk?	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 achieve a balance between demand & capacity of services**								
Chief Operating Officer	O6 1714	Failure of other agencies to support discharge process. Date of origin: 03/06/08 Date of escalation = 11/05/11	B3 AMBER	Action Plan from RSM Tenon audit. Additional support for South Staffs Social Care approved December 2013. Daily discharge meeting to review and agree actions aimed at improving discharges and relationships with social care. Daily bed state shows current position Annual 'Reimbursement funds' agreement Business Case for Integrated patient flow team through Reablement funding - approved October 2013. Project Manager posts appointed. Evaluation shows improvements in length of stay. Evaluate impact of Best Practice Wards roll-out agreed. Daily review of all medical outliers. CHC assessment training completed - April 2013 Health Economy Winter Plan Surge Meetings throughout Winter.	Reduction in patients waiting for continuing Healthcare Assessments. Delayed discharges reducing from April 2013. - November 2013	Fluctuations in numbers of patient delays, especially Staffordshire	Chief Operating Officer met with Birmingham & Black Country Chief Operating Officer to discuss joint working with Mental Health Services June 2013 May 2013 & November 2013 meeting with Senior Managers of South Staffordshire to discuss joint working. April 2013 Escalation Meetings with Directors of Social Care - Wolverhampton and Staffordshire. Winter plan for TDA submitted September 2013. Health Economy Surge Plan sign off in August 2013 - includes partnership working.	D2 GREEN	Mar-14	Yes

Director	Cross Ref	What is the Risk?	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	O19 2719	There is no real time bed management. Retrospective admissions on PAS can have a significant impact on electronic testing and potentially e-discharge systems which could lead to a potential impact on patient care/safety. Date of origin: 23/05/11 Date of escalation = 24/05/11	A3 AMBER	Review of ward clerk cover completed - furthur work required January 2014 Communication plan to remind staff to ensure timely and appropriate admission onto PAS and other Trust Clinical systems - December 2013 Awareness has been raised. Detailed plan to resolve being formulated - complete March 2013 and ongoing	E-discharge rates are improving - December 2013	Further investigations carried out and this confirmed that some process redesign is necessary to achieve timely discharges on the system Patients still entered retrospectively on PAS, especially after weekends.	May 2013 review of weekend entries onto PAS in conjunction with CQUIN scheme for 2013/14. Review proposals in draft - December 2013. Introduction of Safe Hands Project will assist with real time bed management September 2013. Long term review of real time bed management and link to I.T. Strategy.		B3 AMBER	Mar-14	Yes
Chief Operating Officer	O4 2639	Failure of Community Dermatology Service - Risk the current Service not being able to sustain increased capacity long term - Risk of increased costs of having to have extra clinics - Risk that Community Service will fail to deliver full service again - Reduced Consultants levels because workload was expected to drop. This hasn't happened so now short staffed Date of origin: 08/02/11 Date of escalation = 07/03/13	B3 AMBER	Providing additional clinics to address the number of referrals Monitor referrals to see the long term impact of the suspended service Other services to be reviewed to balance out the services offered to patients Directorate Manager attending waiting list meetings to monitor waiting lists for the Service Monitoring of spending on a monthly basis Addressed shortfalls in staffing resources by using bank, overtime and waiting list initiatives to deliver service	Secretarial staff have agreed to undertake additional hours CCG - provided update paper on their intention to Health Scrutiny meeting in December 2013. No delays for Community patients. Extra clinics have been put in place to manage Community Services including for fasttrack patients	Secretarial staff have expressed concerns and worries regarding the volumes of work coming through the department CCG have given notice to tender for Community Dermatology - August 2013 Risk that current service not being able to sustain increased capacity long term	Monitoring the ability to deliver a service at Outreach Clinic Commissioners to tender for contract	Apr-15 Apr-15	D3 YELLOW	Mar-14	Yes

Director	Cross Ref	What is the Risk?	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	O4 3051	There are insufficient capacity (medical beds) for the volume of medical patients leading to outliers and the unplanned utilisation of additional unfunded beds. There are a number of risks in association to these: Risk of patient harm due to the lack of timely review by the appropriate medical team. Staffing pressures within ward areas with capacity beds that remain in use, as well as increased staff stress and levels of sickness. Also inappropriate nursing skill mix, resulting in inconsistent standards of care. Increased cost pressures due to continued/extended use of capacity beds outside of agreed timescale's. Potential adverse media attention due to the continued/extended use of capacity beds within the Division. Not achieving targets, standards, KPI's. Not achieving activity income Increased cancelled operations leading to poor patient experience. Reputational impact patients and external monitoring. Date of origin: 13/07/12 Date of escalation = 17/03/13	B3 AMBER	Integrated Team Manager in post B7 opened Nov 13 New reporting framework incorporating Operating Framework and Monitor requirements now in place with data presented to Trust Board on a monthly basis Operational protocol agreed at Divisional level from March 13 Additional capacity open and staffed appropriately - November 2013 Monthly scheduled CIP review meetings with Directorates Utilisation of staff from base wds, flexible capacity team and bank staff Revised Arrangement in place to ensure medical team review outliers by contacting the Consultant base ward and or medical secretary - October 2013 Ward A6 has 22 ringfenced 'elective' orthopaedic beds Increase efficiency and release resource through ambulatory care, enhanced recovery and surgical site surveillance Full review of planned waiting list undertaken. Beynon Ward and Gynae are now being used as a planned process	Increase efficiency and release rescource through ambulatory care, enhanced recoverey and surgical site surveillance Reduction of cancelled operations in December 13 Reduction in length of stay at West Park hospital - November 13 Reduction in the number of medical outliers	Increase in number of patients breaching 18 week referral to treatment time. September 2013. Deviation from the winter plan Increased breaches in ED department. 12 hour breaches in Jan, 8 hour breaches in Q4 and 4 hour breaches A&E traget in Q4	Development of quality management system for escalating areas of concern	Apr-14	D4 AMBER	Mar-14	Yes

Director	Cross Ref	What is the Risk?	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?
				Recovery Action Plan completed and revised trajectory submitted to the LAT - August 2013 Second Cardio bed has been ringfenced Review of nursing workforce included within Business Case for additional staffing, which is awaiting agreement Beds remain open on Beynon Ward at weekend. Plans in place for additional winter capacity and funding A&E targets monitored daily and reported to TMT & Trust Board monthly						

Director	Cross Ref	What is the Risk?	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:		**Deliver services within financial allocations**								
Chief Financial Officer	O16 514	Failure to deliver recurrent efficiency gains and CIPs. Date of origin: 07/03/2005 Date of escalation = 11/05/11	A4 RED	Monthly reporting against projects including to Trust Board KPMG appointed with agreed Terms of Reference to identify efficiency opportunities (Nov 13) Change Program Board (Executive Director led) The Trust is still forecasting the year end achievement of planned net surplus even with the risk of underachieved CIP. The Trust has invested in a new system solution from "TriSolve" which will enable scheme implementers to have more direct involvement in the reporting of their schemes and be held to account. Each project has an executive director lead	Trust Board Reports & Minutes include CIPs - monthly ongoing	Finance report to Finance & Performance Committee and Trust Board Report of the Change Programme Board to Finance & Performance Committee and Trust Board	Monitor closely through CIP Programme Board = Ongoing Identify 'new' projects and programmes in advance - ongoing Continue to identify non recurrent CIP for this year and new projects and programmes in advance of the new financial year, including the projects proposed by KPMG.	B3 AMBER	Feb-14	Yes
Chief Financial Officer	O16 1739	Failure to develop Service Line Reporting across the Trust. Date of origin: 11/06/08 Date of escalation = 11/05/11	C4 AMBER	Reports are being issued monthly and clinical engagement has been improved which has enabled the content of the reports to be improved and be more useful. SLR reports to be distributed on a monthly basis. Contribution levels set end of Q2. Finance & Performance Committee received in December 2013.			Ongoing Monthly Information Shared - ongoing. 2013/14 plans have been agreed in April and are monitored - Patient level Costing is being implemented in the Trust which will enable more in depth SLR to be provided - ongoing	D3 YELLOW	Feb-14	Yes

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Financial Officer	O16 2468	That pay, price rises and cost pressures will be higher than assumptions. Date of origin: 09/06/10 Date of escalation = 11/05/11	B2 YELLOW	2013/14 plan includes cost pressures, pay awards and 2013/14 incremental drift impact. 2013/14 financial plan has modelled impact of pay and non pay cost pressures. Long term financial model has assessed financial impact for 5 year period to 2018/19	Trust Board report on finance position (Nov 13)		Monitor budgetary position closely through operational finance group/TMC/ Finance & Performance Committee and Trust Board - ongoing	D2 GREEN	Feb-14	Yes
Chief Financial Officer	O6 2781	Contractual risks due to tariff changes for emergency threshold. Negotiations have taken place with Commissioners to ensure that funds are re-invested with RWT to mitigate risk. Date of origin: 18/08/11 Date of escalation = 18/08/11	B3 AMBER	System in place to alert when issues occur. Reserve set against risk. Discussions with Commissioners for investment			Monitor new contract terms on a monthly basis through contract meetings with CCG - ongoing. Engage with Commissioners on winter pressure issues and plans	C1 GREEN	Feb-14	Yes
Chief Financial Officer	O16 3176	Commissioners raising issue of patient activity over performance and their ability to pay. Date of origin: 16/10/12 Date of escalation = 16/01/12	C3 AMBER	Monitor through monthly contract performance reports and meetings Contractual meeting to analyse and discuss the forecast level of over performance To ensure details of contract performance are understood by RWT managers and Commissioners	Contract meetings - monthly ongoing	Performance query letters from commissioners - monthly ongoing	Escalate to Directors to resolve when appropriate - ongoing	C3 AMBER	Feb-14	Yes

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcon 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

Director	Cross Ref	What is the Risk?	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?
Director of Planning / Contracting	O16 2929	Failure to deliver CQUINS schemes Date of origin: 13/04/12 Date of escalation = 15/06/12	C3 AMBER	Monthly assurance report presented to Operational Managers at Contracting & Commissioning Forum and Operational Finance Group, for review and discussion on how to improve performance Contracting / Commissioning group standing agenda item Assessment made of costs to deliver Monthly assurance reports introduced from Q1	Reports to Contract and Commissioning Group and F&PC providing assurance. * Commissioner has confirmed payment for all CQUINs in line with Trust self-assessment.		Detailed discussions with CCG re 2014/15 CQUINS proposals shared with clinicians for comments. Proposals for 14/15 CQUINS to be shared with RWT leads for comment and assessment of deliverability. Setting up and implementing audits - ongoing	Mar-13	D3 YELLOW	Mar-14	Yes
Trust Objective:	**To be a high quality educator**										
Director of Human Resources	O16 2626	Implications of Government White Paper "Liberating the NHS" on the provision of educational funding levies and that NHS organisations will become responsible for the funding of education and training for their own staff. Date of Origin: 19/01/11 Date of escalation = 06/06/12	C4 AMBER	Working Group set up to examine medical (PG/UG) education funding model (Sept Close monitoring of funding levies LETBs/LETCs now authorised Sign off by Directors (HRSD, MD, Chief Nurse) for cost collection return Actual cost collection exercise complete for 2013/14 (6 months). Challenge of data if sub specialty outlier Representation on any appropriate workstreams Liaison with LETB and LETCs HR Director now appointed to LETC (Sept 2012)	Review at HR Sub Group + E&T Committee NMET allocation for RWT received Liaise with LETB/LETCs Full engagement with clinical leads involved in costings	Unable to make further plans due to review of MPET is completed SIFT underfunded for 2013 as transition to full fundling not expected until years 3 & 4 workforce planning input to LETC needs strengthening Initial indications are that RWT is outlier (income doesn't meet costs) for exercise. This may adverseley affect income Lack of direction from DOH (ongoing)	Ensure 2nd (6 months) exercise is based on agreed costing templates which have been moderated as required following first exercise	Apr-14	C3 AMBER	Mar-14	Yes

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcon 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

Director	Cross Ref	What is the Risk?	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 achieve Foundation Trust status**

Director	Cross Ref	What is the Risk?	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	O16 2922	Maintenance of a minimum accreditation of level 2 or higher for the IGToolkit v11 - 2013/14 in line with national guidance. Date of origin: 11/04/12 Date of escalation = 11/04/12	C3 AMBER	IG Lead recruited 2. Internal audit recommendation made Sept 12 & Jan 13- Streamline evidence by uploading to one section where key documents are asked for to avoid duplication of evidence in the IGToolkit. completed 20/02/2013 Evidence updated - drafts removed. as per internal audit (Feb 2013) TMT approval of IGTookit final submision scores for 2012/13 (22/03/2013) Progress monitoring- monthly basis (completed up to 22/03/2013) Monthly IGSG Monitoring of actions against toolkit for v11 ICO external audit of Data Protection and Security compliance- Yellow(resonable assurance) rating given IG lead has monthly meetings with requirement leads to maintain progress against action plans. Leads have completed action plans to maintain level 2 and achieve level 3 compliance for v10 IGToolkit. Requirement leads exception reporting monthly to IGSG on any issues relating to maintaining level 2 or achieveing level 3	New IG Lead in post 16/9/2013 - regular review of evidence included in toolkit. 3. Internal audit recommendation Made Sept 12 & Jan 13- "The documentation contained in shared folders and accessed via a link referred to prior years e.g. V8 2010/11, therefore, their relevance in respect of IGToolkit V10 needs to be assured. - completed Gap anlaysis done in July 2012 results fed back to requirement leads and action plans have been put in place to address any gaps in assurance identified IGToolkit return made at 31st October 2012 - all requirements were at level 2 or at level 3 Draft internal audit report released 31/08/2012 advises there is a robust structure in place to support and drive the information governance agenda and provide the Trust with assurance that effective information governance processes are in place within the Trust.	Requirement leads are not uploading to IG Toolkit in timely manner with evidence Out of date evidence remaining on toolkit - requires updating. This gives potentially a false compliance figure.	Progress monitoring Audit review	Feb-14 Feb-14	D2 GREEN	Mar-14	Yes

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcon 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

Director	Cross Ref	What is the Risk?	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?
				Internal re-audit of 10 standards took plance Dec 2012- report provided Jan 2013 31st October performance update submission has been reviewed by Caldicott Guardian before submission 31/10/2012- all req level 2 or above							

Risk Managed to Target Level

Trust Objective: To provide our patients & staff with a safe environment.

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Financial Officer	O6 2570	Inadequate estates as part of the Transfer of Community Services - WCPCT provider Services with effect from 1 April 2011. Legal consequences of a potential estates transfer i.e. property arrangements in line with White Paper with PCT being abolished by April 2013 Date of origin: 21/10/10 Date of escalation = 11/05/11	D2 GREEN	Engagement of Solicitor support External Support is being employed to review the condition of the Estates where Services from WCPCT are undertaken. RWT and PCT have agreed transfer properties (Jan 13) Negotiations continuing re potential properties to transfer. Date for transfer now delayed due to DH. Monthly Project Board meetings with extensive RWHT representation.	Outcome of Due Diligence exercise		Outstanding issues re land at Pond Lane to be resolved	Mar-14	D2 GREEN	Feb-14	Yes

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcon 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;