The Royal Wolverhampton NHS Trust	

Trust Board Report

Meeting Date:	28th July 2014
Title:	Board Assurance Framework / Trust Risk Register
Executive Summary:	<u>BAF Key Issues</u> 2 Red Risks - Failure to reduce Never Events (2965) and The short term impact on the Trust of service sustainability at Mid Staffordshire NHSFT (3645). <u>Trust Risk Register Issues</u> 2 red risks exist: • 514 - Failure to deliver recurrent efficiency gains and CIPs. • 3685 - Staffing levels and quality of nursing care on A6. Staffing and Nursing issues have been highlighted on wards A5, A6, A7 (risks 2828, 3685, 3431). Risk - Poor compliance with the Trusts Clinical Audit Plan is now closed (3370). Risk - Failure to integrate Service Line Reporting across the Trust is now closed (1739). Risk - IG Toolkit Level 2 Maintenance has now been removed from the Trust risk register, but will be continued to be managed at an operational level (2922). Risk - Pay, price rises and cost pressures are higher than assumptions has now been removed from the Trust risk register, but will be continued to be managed at an operational level (2468). Risk - Risk that patient records are harmed in Wrekin house due to water ingress previously experienced has now been removed from the Trust risk register, but will be continued to be managed at an operational level (3076). Risk - Risk that part scanned and part manual records could lead to an adverse event has now been removed from the Trust risk register, but will be continued to be managed at an operational level (3462).
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

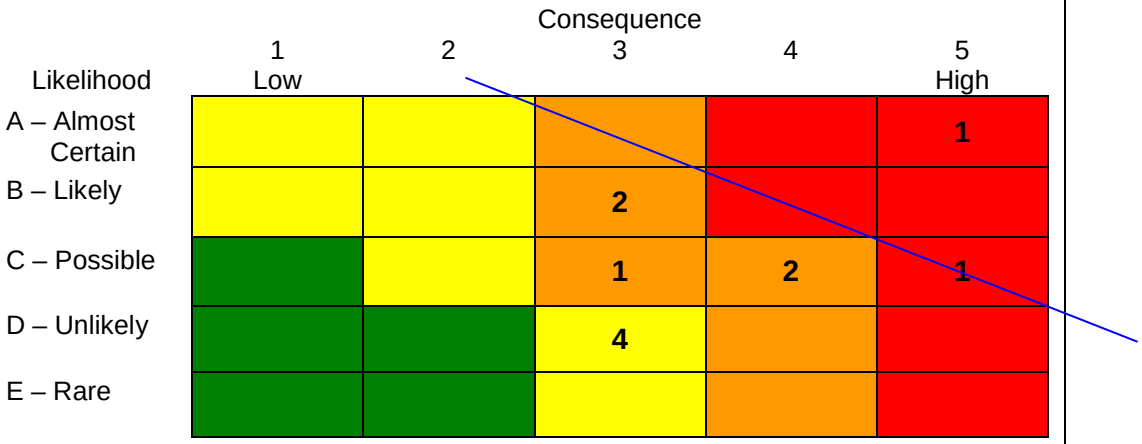
The Board Assurance Framework "provides organisations with a simple but comprehensive method for the effective and focused management of the principal risks that arise in meeting their objectives. It also provides a structure for the evidence to support the Statement on Internal Control" (Integrated 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)	8
Risks managed to target level	3

There are currently 11 risks contained within the Assurance Framework which are distributed across the Trust categorisation matrix as below:



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:

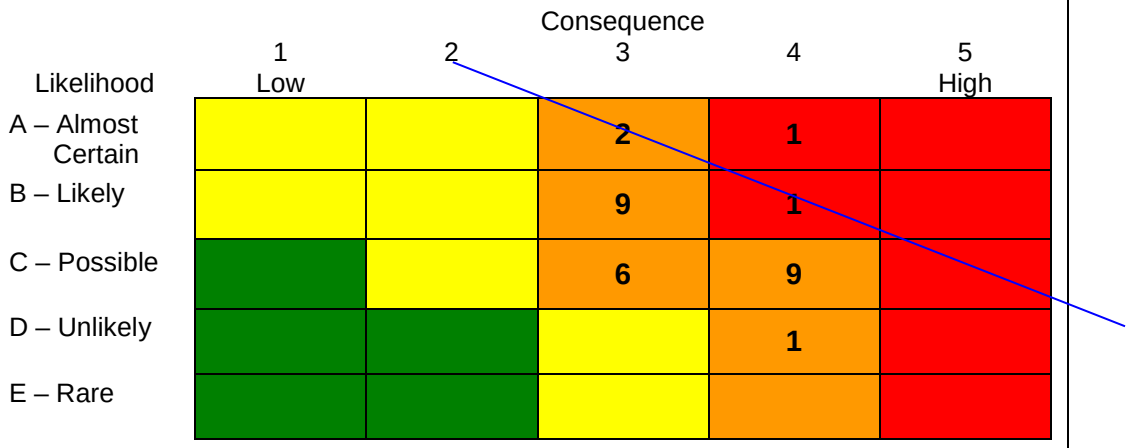
	ID	Risk Title	Lead
RED	3645	The short term impact on the Trust of service sustainability at Mid Staffordshire NHSFT	CEO
	2965	Failure to reduce Never Events.	CN

Trust Risk Register – Updates (Appendix B)

Following updates the split of the Trust Risk Register is:

Risks currently being managed (on-going)	30
Risks managed to target level	0

There are currently 30 risks contained within the Trust Register which are distributed across the Trust's categorisation matrix as below:



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

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.	2	1	2		1	17		
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		2			1	2		
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					
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 (July 2014)

Lead Director	Risk	Risk Title	Update	Reasoning / Progress Against Actions
Director of Planning and Contracting	1734 C3	Impact of competition to a significant shift of activity.	Mitigating Actions in place and Positive Assurance updated.	Recruitment of Business Development Manager Weekly updates on active opportunities presented to Directors.
Chief Financial Officer	3354 D3	Estates quality and flexibility compromise the ability to respond to fluctuation in demand and the implementation of streamlined clinical pathways.	Current Residual Risk Rating now D3 Yellow. Mitigating Actions in place, Positive Assurance and Further Mitigating Actions updated.	Acquisition of Cannock and move of elective capacity to Cannock. Additional modular medical ward being secured. Council have approved. Being worked through and presented to Trust Management Committee. Emergency Centre approved and now in build phase. On-going reports to Trust Board through Medical Director in progress. Acquisition business case and underlying plans for Cannock and New Cross presented to Board on a number of occasions and approved. Capital Programme for 14/15 to reflect refurbishment programme. Work closely with TDA to ensure successful approval of the Acquisition Business Case.
	2928 C3	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.	Target grade now C1 Green. Mitigating Actions in place, Positive Assurances, Negative Evidence and Further Mitigating Actions updated.	Successful discussions with Commissioners in agreeing 2014/15 contracts. Setting a Business Plan for 2014/15 to deliver surpluses for re-investment. Contingency reserves and plans in place against the risks to mitigate financial risks. Ensure successful bids by targeting bids that strategically align with the Trust's future vision and ensure that bids are resourced and produced of a high quality. On-going monthly discussions on referral patterns, activity performance and negotiations around over performance. Trust has successfully bid for projects to date. Trust has now received over-performance notice from Wolverhampton CCG. Cost Improvements Plans (CIPs) are behind original trajectories. On-going discussions/relationships with Commissioners - On-going Additional collaboration with other providers to reduce costs - on-going. Escalation and performance management of CIP schemes.

Chief Executive	3645 A5	The short term impact on the Trust of service sustainability at Mid Staffordshire NHSFT.	Current risk rating is now A5.	

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

Lead Director	Risk	Risk Title	Update	Reasoning / Progress Against Actions
Chief Operating Officer	494 C4	Midwifery Staffing	Positive Assurances and Gaps in Assurance updated.	Offered positions to 15 newly qualified students which will fill at the current vacancies and some of the birth rate plus numbers. Overseas recruitment has not been successful for Maternity.
	2828 C£	Quality of nursing care on Ward A5 (from 05/03/14)	Risk description altered. Positive Assurances and Action Plan updated.	Vacancies are reducing and will be further supporting overseas recruitment which will be phased between July – October 2014 Reviews of environment to establish further support trauma patients with dementia. Overseas recruitment phased between July – October 2014
	2898 C3	Patients having to wait in ambulance off load area to be seen in ED due to a lack of space.	Positive Assurances updated.	Ambulance handover times maintained over winter period – December – July 2014
	3051 B3	There are insufficient capacity (medical beds) for the volume of medical patients leading to outliers and the unplanned utilisation of additional unfunded beds.	Positive Controls, Positive Assurance, Gaps in Assurance and Action Plan updated.	Revised Nursing establishment agreed. Reduction of cancelled operations throughout winter/spring 14. Overseas recruitment. Vacancies on ward Plan to introduce additional 7 day services for Autumn/Winter Oct 2014 Introduction of morning board rounds across wards Sept 2014 Additional overseas recruitment Sept 2014.
	3685 B4	Staffing levels and quality of nursing care on Ward A6.	Risk description altered. Positive Controls and Action Plan updated.	Reductions in falls, pressure ulcers High level of sickness rates Review of environment to identify support for trauma patients with dementia. Proposal enhanced rates for bank staff covers A5 and A6 to Division and WAG.
	2719 A3	Timeliness of PAS Admission	Positive Controls and Positive Assurances updated.	Review of ward clerk cover required. CCG plan to re-tender service 2014/15.
	1713 B3	Failure to effectively maximise workforce productivity; failure to routinely review consultant job plans.	Gaps in Assurance updated.	Medical agency costs not reducing June 2014 Slow progress in terms of Job Plan May 2014.
	3431	A7 staffing	Positive Controls and Positive Assurances	Additional Nursing Support provided from other wards.

	B3		updated.	Recruitment to posts on going.
	3299 C4	Obstetric staffing for Labour Ward	Positive Controls and Positive Assurances updated.	Business Case for additional resource approved in Division. This will be reviewed by the risk management/governance committee on a quarterly basis – update in June 2014
	1714 B3	Failure of other agencies to support discharge process.	Positive Assurance and Action Plan updated.	Health Economy Winter Plan Surge Meeting throughout winter. (2014/15) Fluctuations in numbers of patient delays, and especially Staffordshire And Walsall. Discussions with Social Care partners for 7 day services to commence winter 2014/15.
Chief Nursing Officer	535 C4	If the Trust fails to achieve reductions in healthcare associated infection then the Trust's reputation and the impact will be that compliance to regulatory standards and objectives will not be achieved.	Positive Controls, Positive Assurances, Gaps in Assurance and Action Plan updated.	PCR data for Clostridium difficile monitored monthly through IPCG. MRSA Screening Policy in Trust audited annually. Care home patients in community screened for MRSA in response to concerns indicated by CCG/Public Health/IP teams. IV Team assist investigation on all device related infection. Surgical site infection surveillance monitored continuously. Toxin positive Clostridium difficile numbers reported to commissioners monthly. Training plan to care homes in place with numbers collated quarterly. Care home participate in infection prevention and control audit and education. Action plan in place for Hygiene Code to be monitored by IPCC quarterly. Device related bacteraemia reported to IPCG monthly. Fidaxomicin in use to treat recurrence of CDI. No avoidable MRSA bacteramia case year to date. Catheter associated urinary tract infection surveillance not currently in place. Urinary catheter process for removal in the community not consistently in place. MRSA screening data not automatically fed due to lack of HL7 feed. Rising community cases of C difficile. The process for faecal transplantation for re-current cases of C.Diff infections is being devised by DIV 2 through the business case route. Identify high risk areas/procedures for

				DRHAB and develop actions to reduce. Identify high risk areas for MRSA and develop action plan to reduce.
	3589 C3	Failure of community equipment supply contractor to meet infection prevention/decontamination standards.	Positive Controls, Positive Assurance, Gaps in Assurance and Action Plan updated.	Monthly meetings to monitor the ILS contract. Specification redesigned with requirement for infection prevention audit, training and policy. Goals and Outcomes of poor performance period agreed. No education delivered during Q1 of 14/15 due to contract not being signed. Current audit programme not funded as part of contract yet. Last audit reports completed in Q4 14/15 and circulated to ILS making clear recommendations. IP improvements in decontamination process noted in 13/14. Develop detailed action plan following communication of intent to take out contract for IP July 14
	3655 B3	Compromised functionality of Datix (v10.1) due to inability to upgrade to v12.2 (server issues)	Positive Assurance and Action Plan updated.	Test commenced - no faults W/E 11/07/14 Complete testing of v 12.3 Agree date for upgrade with Datix in live environment. Implement upgrade. Roll out to all staff.
	3711 C3	Failure to fully implement CPE toolkit	Positive Controls, Positive Assurances, and Gaps in Assurances updated	Action plan developed and monitored. Surveillance of all cases reported monthly to IPCG. Nil cases for June 14. No serious infections to date. Most recent contact screening negative. Automated surveillance does not detect cases. Lack of confirmation from Public Health England on a system to communicate between hospitals regionally Unknown number of high risk patients entering the Trust. Some contacts (patients) refuse screening.
	2680 A3	Interpreting and translation budget is over spent due to over performance in face to face interpreting.	Risk description altered. Positive Controls, Positive Assurances, Gaps in Assurance and Action Plan. Target grade now D2 Green.	Risk assessments in place to be used when booking face to face interpreting. KPIs in place to monitor monthly usage by department Reduced rate negotiated with interpreting provider who will manage the move to 20% less face to face interpreting usage in 10 months

				Telephones and posters advertising use of Language Line in place. Policy has been updated to reflect the need to use risk assessments for face to face interpreting. 20% reduction in overspend over 18 months. No adverse incidents or complaints in interpreting reported. Monthly expenditure overspend No evidence to support use of risk assessments by directorates when booking face to face interpreters
	3644 B3	The CQC will undertake an inspection and if no improvement following implementation of the CQC Action Plan, this would impact on the Trusts' registration status.	Risk description altered. Positive Controls, Positive Assurances, Gaps in Assurance and Action Plan. Target grade now D2 Green.	DCNO/HoNs/Governance have undertaken a review of areas inspected by the CQC A system of internal review is in development to run mini CQC audits A business case has been developed to support increases in ward nursing establishments A recruitment plan is in place Monthly performance is monitored through the nursing midwifery KPIs for signs of deterioration Capital funded environmental refurbishment in areas highlighted by the CQC requiring improvement. Results from the review are positive and have been shared as part of the monthly report monitored at QSAG. Several actions have now been closed as achieved in the action plan. Positive satisfaction following bereavement support questionnaire Governance department leading the development of mini CQC audits due for July 2014 Business case was approved by the Board and the CCG to fund additional nursing staff, plan of priority areas for investment now in place. Decrease in vacancies. Overseas recruitment successful in bringing 3 cohorts of nurses into the Trust. All student nurses due to graduate in Sept 14 have been approached to be interviewed for jobs at RWT. Recruitment Manager working with HoN/M to determine areas for recruitment and monitored via Workforce Action Group. Nursing and Midwifery KPIs moved to Health Assure reporting and emailed out to ward sisters/matrons and HoNs monthly. Capital programme agreed refurbishment in Mortuary and Outpatients. Sickness absence needs to be driven down

				to Trust average in all ward areas. Electronic Rostering demonstrates more work needs to be done on using e roster to fully to maximise staff resource. Use the CQC Intelligent Monitoring Report (IMR) to determine areas of weakness. Undertake the NTDA Patient Experience Framework at Board and then divisional level to determine what else Trust can do to improve patient experience. Monitor monthly staffing submitted on Unify to NHSE to check Trust achieves 95% fill rate for staffing planned versus actual.
Medical Director	2922 C3	IG Toolkit Level 2 Maintenance	Risk removed from Trust Risk Register (C3 Amber). Positive Controls, Positive Assurances, Gaps in Assurances and Action Plan updated.	IG Action Group meets bi-monthly to progress actions on IG action plan to ensure toolkit requirements are completed. IG Steering Group monitors progress against IG Action Plan and receives exception report for any areas of concern from IGAG bi-monthly. Current IG Lead vacancy being covered by Compliance Manager. v11 (Mar 14 submission) 87% - satisfactory July 14 baseline score is unsatisfactory. July baseline is less than planned due to loss of IG lead in May 14. Recruit IG Lead (starts Sept 14)
	2604 B3	Trust wide VTE audits continue to demonstrate improved compliance but reassessments do not reach compliance with VTE policy and procedures, leading to an increased risk of VTE and compromised patient care.	Risk description altered. Positive controls, Positive assurances, Gaps in assurance and Action Plan updated.	On admission all patients receive an initial risk assessment within 4 hours. Within 24 hours of admission all initial VTE risk assessments are reviewed. 95% of all medical and nursing staff are expected to attend VTE mandatory training. Level 2 RCA's are completed for all patients where there has been a breach in policy. VTE admission risk assessment compliance is currently at 75%. Training compliance for June 2014 is 99.2%. Compliance for reassessment within 24 hours is currently at 18% (June 14)
	3370 C3	Poor compliance with the Trusts Clinical Audit Plan	***Risk Closed***	
	943 C4	Non-adherence to chemotherapy policy and procedures resulting in poor patient and staff experience / confidence.	Risk Level now C4 Amber. Positive controls, Positive Assurances and Action Plan updated.	Chemotherapy Prescribing MDT monthly meeting to discuss all off Formulary chemotherapy treatment requests. Pharmacy to report non-compliance of formulary at MDT. RCA conducted for incidents as required, action plans implemented as indicated by findings and lessons shared.

				Audit of Policy CP8 through peer review. Audit of NICE guidance - 18 audits on plan for 13/14. Local / Executive Walkabout take place. National Cancer patient satisfaction survey 2013 Annual validation of nursing staff competence.
	3494 C4	Lack of interventional radiology rota for Black Country Vascular network.	Gap in Assurance updated	No adverse incidents reported.
	1862 C4	Trust wide consent audits reveal failures within the Trust to follow a 2 stage consent process.	Risk description altered. Positive controls, Gaps in Assurance and Action plan updated.	Monthly prospective clinical audit on consent process. Review of incidents / complaints / claims involving consent (quarterly). Recent near miss incident - Ophthalmology Lucentis incident. Non-compliance at two stage consent process (Audit July 2013). Re-design the consent form. Implement updated consent policy when approved. Design new audit tool. Review consent training programme.
Chief Financial Officer	514 A4	Failure to deliver recurrent efficiency gains and CIPs.	Positive controls, Gaps in Assurance and Action Plan updated.	The Trust has split the CIP target into Transactional and Transformational schemes. The transactional schemes are monitored via the PMO and reported through the monthly Operational Finance Group meeting, (chaired by the CFO) through to Trust Board. The Transformation Programme schemes are grouped into four like-minded programmes of work. Each of the transformation programmes has a dedicated Programme Manager lead, Executive Director Sponsor and Clinical lead monitoring progress. Formal monthly meetings are held at the Transformation Programme Group to monitor and validate savings and review progress (Executive Director lead). Detailed finance report is presented and reviewed at Finance and Performance Committee through to Board. Additional PMO staff appointed to facilitate and manage the transformation programmes. Currently forecasting a shortfall in the CIP programme for 2014/15. Escalate performance with Divisions / Directorates and institute recovery plans.

	1739 C4	Failure to integrate Service Line Reporting across the Trust.	***Risk closed***	No longer considered to be a risk, as service line reporting is now fully implemented.
	2468 D2	Pay, price rises and cost pressures are higher than assumptions.	Risk description altered. Current grade now D2 Green. Removed from Trust risk register. Positive controls,	14/15 plan includes sufficient reserves to cover risk based on current assessments Long term financial model includes assessment of pressures and is funded within the model. No pressures relating to the risk are being raised by Divisions. Continue to monitor the position.
	2781 B3	Significant loss of income causing the Trust to take action to address the situation. This could occur due to emergency threshold and emergency readmissions.	Risk description altered. Positive controls, Positive Assurances and Action Plan updated.	Monthly monitoring of actual performance against planned levels. Reserve set to offset potential risk exposure. Negotiation with commissioners to ensure money re-invested back within the Trust. Successful negotiations delivered and reported to Finance and Performance Committee. Board to Board engagement and whole economy plan to reduce demand on urgent care
	3076 C3	Risk that patient records are harmed in Wrekin house due to water ingress previously experienced.	Risk description altered. Current grade now C3 Amber. Risk now removed from Trust Risk Register. Positive Controls, Positive Assurances and Action Plan updated.	Estates have taken action and have used nets to remove pigeons, repaired the skylight and drain flow. No further leakages have been experienced. Alternative storage accommodation is being investigated. Regular visual checks by health records staff.
	3176 B3	Commissioners raising issue of patient activity over performance and their ability to pay.	Current grade now B3 Amber. Target grade now B2 Yellow. Positive controls, Positive Assurances and Action Plan updated.	Negotiate through monthly contract performance reports and meetings with commissioners. Ensure managers are aware of the issues and take appropriate actions at operational finance group and contracts commissioning group. Negotiations are currently on-going. Escalate to Directors if unable to conclude successfully.
	3462 C3	Risk that part scanned and part manual records could lead to an adverse event.	Risk description altered. Current grade now C3 Amber. Risk now removed from Trust Risk Register. Positive Controls, Positive Assurances and Action Plan updated.	The scanning programme has advanced and now includes all impatient wards except for Paediatrics, Gynaecology and Ward A4. The portal has been improved so that clinicians will use it more. No incidents reported where care has been compromised. Further roll out of programme to Gynaecology and Ward A4.

The Royal Wolverhampton NHS Trust

Board Assurance Framework (incorporating strategic risks) - July 2014

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)			Date last Reviewed
			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.	Div 1: Compliance with the 5 steps to safer surgery is 98%. Compliance with the use of the WHO Surgical checklist is 100%. Compliance with full completion of the WHO surgical safety checklist agreed for procedures is 80%. Div 2: Compliance with the use of the WHO Safety checklist is 99.36%. Compliance with full completion of the WHO safety checklist agreed for procedures is 99%.	Div 1: Cardiac Theatres 98% on sign out. WEI Theatres 98% on sign out. Breast Imaging and Obstetrics did not achieve 100%. Div 2: 1 form not completed in Respiratory. Accurate completion remains an issue for the Emergency Services Department.	C	5	R	⇨	Accountability meetings to be arranged with individual staff and CD/Matron. Respiratory CD taking action. Emergency Services CD holding individuals to account.	30/04/2014	E	2	G	Jun-14
								Audit of Safety checklist policy and practice (internal audit).	A marginal improvement on the 2013 audit results, with an average change of +0.3%.											
								Local risk registers for high risk Never Events		The adequacy of mitigating / controls not reviewed / reported.					Undertake a review of all NE risks and mitigating actions across all areas	31/07/2014				
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 to identify potential issues.	Involvement in key groups reviewing service provision		D	3	Y	⇨	Securing additional support for specific projects.		D	3	Y	Jun-14
								Weekly Director review (Jan 14) of critical priorities.	Relationships i/c Commissioners and key stakeholders											
								Opportunity assessment process based around strategic goals of potential developments and organisation focus.	Achievements of contractual obligations											
								Review of organisational impact - short, medium and long term of any proposed planned and unplanned changes.												
								Effective and timely consultation with stakeholders on any change.												
								Robust board governance												

NOTES:

1. This is the grade of the initial risk identified (before mitigating actions)
2. This is the current risk score having regard to the positive assurance, negative evidence given for that month as well as any other current impacts known from other sources eg TDA focus, CQC visit imminent etc.
3. This is the level/grade that the risk is expected to be managed down to.

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			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	4	R	Weekly review of MSFT position at either LTB or SSB as part of contingency planning.	Contingent plans to provide interim support for ambulance diverts	Continued fragility of MSFT services	A	5	R	⇧	Developing clinical protocols between UHNS/RWT/MSFT/TSA/WMAS	30/06/2014	B	4	R	Jul-14
								Commissioner led review of contingent actions.	Contingent plans to provide interim support for some elements of radiology and Care of the Elderly.						Communications to MSFT staff re service model post dissolution					
								Trust to Trust (and other providers/commissioner) discussions as part of escalation process							Working with Commissioners on demand management.					
								Service level review of impact for RWT												
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	Jun-14
								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												
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	TDA performance monitoring and selfcertification process - monthly	Trust remains at Level 2 escalation.		C	4	A	⇧			D	3	Y	Jun-14
								Trust is engaging in the work of the TSA in relation to Mid Staffordshire HospitalsNHS Foundation Trust.	See risk 3645/3330											
								Periodic updates i/c Monitor Assessment Team	Monitor letter deferring Trust - Oct 12											

NOTES:

1. This is the grade of the initial risk identified (before mitigating actions)
2. This is the current risk score having regard to the positive assurance, negative evidence given for that month as well as any other current impacts known from other sources eg TDA focus, CQC visit imminent etc.
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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)			Date last Reviewed
			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	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	Memorandum of understanding developed with MSFT (Nov 13)	Joint working with UHNS on separation of services.		C	4	A	⇨			E	4	A	Jun-14
								Involvement in the work of the TSA (Jan 14)	Trust is named as a key provider in the TSA Final Recommendations (Jan 14)											
								Internal evaluation of the impact on services both without and with formal service reconfiguration - ongoing as proposals develop.	Internal service plan will complement TSA separation plan disaggregation.											
								Transaction business case being developed.												
								Process in place for consultation.												
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 unnanounced inspection - all standards assessed were met	Not fully compliant with delivery of the service spec/HCP	D	3	Y	⇩			D	2	G	Jun-14
								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	Behind on trajectory for recruitment. RAG rates with AT.										
								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 funded 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 monitor HR indicators, complaints and any concerns raised through Safeguarding Team.												

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The Royal Wolverhampton NHS Trust

Board Assurance Framework (incorporating strategic risks) - July 2014

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)			Date last Reviewed
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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	Quarterly estates report on delivery of capital programme.	None	D	3	Y				D	3	Y	Jul-14
								Planning application approved for site redevelopment	Council have approved											
								Interim refurbishment programme	Being worked through and presented to Trust Management Committee.						Capital Programme for 14/15 to reflect refurbishment programme					
								Creation of a new emergency department	Emergency Centre approved and now in build phase. On-going reports to Trust Board through Medical Director in progress.											
								Acquisition of Cannock and move of elective capacity to Cannock. Additional modular medical ward being secured.	Acquisition business case and underlying plans for Cannock and New Cross presented to Board on a number of occasions and approved.						Work closely with TDA to ensure successful approval of the Acquisition Business Case.					
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	Successful discussions with Commissioners in agreeing 2014/15 contracts	On-going monthly discussions on referral patterns, activity performance and negotiations around over performance.	Trust has now received over-performance notice from Wolverhampton CCG	C	3	A		Ongoing discussions/relationships with Commissioners - Ongoing		C	1	G	Jul-14
								Setting a Business Plan for 2014/15 to deliver surpluses for re-investment	Financial position of the Trust monitored monthly by Finance & Performance Committee and Board Reports.	Cost Improvements Plans (CIPs) are behind original trajectories					Additional collaboration with other providers to reduce costs - ongoing. Escalation and performance management of CIP schemes.					
								Contingency reserves and plans in place against the risks to mitigate financial risks												
								Ensure successful bids by targeting bids that strategically align with the Trust's future vision and ensure that bids are resourced and produced of a high quality	Trust has successfully bid for projects to date.						To identify market opportunities/bids - ongoing					

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The Royal Wolverhampton NHS Trust

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Dir P&C	10	1734	Impact of competition to a significant 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	Trust Board reports detailing new business opportunities and delivered successful tenders		D	3	Y		Reviewing and strengthening the internal resource to support the delivery of tenders and service expressions of interest	Jul-14	D	2	G	Jul-14
								Process established to monitor Supply2health and similar websites for future opportunities	Quarterly reports to the F&P Committee and TMC detailing tender opportunities and progress with individual tenders						Use refinements to NHS Choices & Choose & Book to 'sell' services - ongoing	Sep-14				
								Recruitment of Business Development Manager	Weekly updates on active opportunities presented to Directors.						Maximise opportunities to sell services via new Web Site - ongoing.	Sep-14				
															Bi-monthly communication with GP community via a newsletter	Jul-14				
															Recruitment of Business Development Manager	Jul-14				
Dir P&C	11	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	Quarterly Contracting Reports to Trust Board and F&P	RWT suggested QIPP Schemes not adopted by CCG	B	3	A		Monitor MPB tracker via Contracting Team - ongoing	Ongoing	B	3	A	Jul-14
								Engaged with Commissioners in early discussions around QIPP Programme for 14/15	QIPP tracker monitored via Contracting and Commissioning Group											
								Management of QIPP programme through established Modernisation Board	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	Regular RWT involvement in Better Care Fund governance process.											
								Monitoring of actions to support QIPP schemes managed through contracting and monitored via Contracting & Commissioning Group												

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The Royal Wolverhampton NHS Trust

Trust Risk Register

July-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**								

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?
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 Midwifery establishments are reviewed weekly 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 is authorised by the matron. All staffing breaches and adverse outcomes are reported via senior nurse performance meeting monthly by Head of Midwifery. Trust is exploring overseas recruitment of Midwives. Increase in students due to qualify in September 2014.	Staff are appointed who fulfill the interview requirements. 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. Offered positions to 15 newly qualified students which will fill all the current vacancies and some of the birth rate plus numbers.-July 2014 Recruitment is ongoing A business case was approved for 2012/13 activity which is funded recurrently for 14/15.	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 Overseas recruitment has not been successful for Maternity. Although a business case was approved for 2012/13 activity which will be funded recurrently for 14/15 there is now a further deficit based on 13/14 activity which will need to go through the business planning process.	Recruit and appoint to vacancies across the maternity service.	Sep-14	C1 GREEN	Jul-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; 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?
				Birth 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 dashboard 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						
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 Business Case for additional resource approved i Division - July 2014.	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 June 2014.	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.	Business case to be approved at Business Forum	Jul-14	D3 YELLOW	Jul-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. Poor skill mix and identified competency issues on the ward, compromising the quality and safety of care on the ward. reducing to 10.88 wte from 21/04/14 and 4.8 wte unregistered nurses working clinically on A6. Date of origin:05/03/14 Date of escalation: 06/03/14	B4 RED	February 2014 - Recruited to substantive Band 7 Ward Manager on A6 Matron reviewing staffing across A5 and A6. Staff being pulled from A5 to cover A6 as appropiate. Following the increase in staffing establishment due to Trust wide workforce review both wards have vacancy at Band 2 - recruitment in progress Following the overseas recrutment campaign both wards will have only 0.5 wte Band 5 vacancy - once all those recruited are in place - will be on the wards end of August 2014 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.	May 2014 - Documentation compliance = 100% Head Nurse meeting with Chief Nurse regarding staffing levels on ward from April 2014 onwards. Appraisal rate for nurses on A6 is now 78% aim to be 100% by July 2014 Reductions in falls, pressure ulcers. 3 registered nurses recruited and 2 members of staff expected to be on ward beginning of August 2014. Agreement given to increase nursing establishment on ward - RGNs current establishment 19.95 to increase to 22.9 and HCAs current establishment 9.85 to increase to 12.3. Recruitment commenced. New substantive Ward Manager commenced in post 31 March 2014.	July 2014 - Staffing remains a challenge for A6 Poor compliance with basic life support training on A6 - Amber incidents of unsafe staffing levels and care still being received weekly. Two STEIS reportable incidents (Jan 2014: 2014/1381 and March 2014 STEIS 2014/10853 unexpected death following knee replacement an A6 Bank shifts often not filled, other than by own staff. High level of sickness rates 1 recent SUI where omissions in care/documentation have been found. 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. May 2014 - Late patient observations = 12%. March 2014 - Safeguarding referral made against A5 and A6. 2 formal complaints received in Q4 2013/14 and 2 in Q1 2014.	Band 6 on A6 has resigned - post to be advertised. Review of environment to identify support for trauma patients with dementia Proposal enhanced rates for bank staff covers A5 and A6 to Divsion and WAG	Jul-14 Aug-14 Jul-14	D2 GREEN	Jul-14	

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?
				Complaints handling training and quality of care training with Ward Manager/Head of Nursing Ongoing workforce review base establishment to new						

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
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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	Issue 1: Poor skill mix due to change in establishment to A7, CoE 28 beds, current position for band 5=vacancy 3.4wte, further 4wte working notice and 1wte on ML, sickness 6.9% Issue 2: Consultant cover required at WPH due to retirement until vacancy filled; Cannock and Stafford due to vacancy factors requiring stability of service until 1.11.14. Consultant cover including AL cover for each other agreed to be shared between the 3 consultants on ward A7, reducing the consistent senior medical input for ward A7 patients. Risks identified: a) Direct care and documentation-patients not turned, hygiene or toileted regularly, patients are not being offered food and fluids or assisted with them in timely fashion. Synbiotix audit May - documentation 100%, falls 96%, nutrition 100% b) Above Trust target rate - observation recording - 7% c) High number of HAPU - No HAPU's in May 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) No incidents reported h) Inability to provide staff to accompany Cons ward round resulting in poor communication and exacerbation all of the	B3 AMBER	Member of staff has been recruited to TV team to support CoE Agreement for third Bd 6 secondment between from 27 Jan 14 for 12 weeks, recruited from A8 Skill mix assessed when planning rota to ensure required skills are available on each shift Training needs analysis performed for all members of staff on ward and needs prioritised. Bd 6 responsible to book and confirm attendance Where skills deficit on a shift identified and additional support need established member of team asked to provide additional support by working additional hours Additional nursing support provided from other wards CNS for MS (previously worked as charge nurse at WPH) to work 1 day a week to assist in assurance of the standard of quality and safety of care Dementia outreach nurse to work on ward 2 days per week as supernumerary nurse to provide bed side training on caring for patients with Dementia. She will leave the ward as required to respond to outreach requests	Recruitment to posts on going	Increased numbers of staff-related incidents Difficulties covering vacancies with Bank staff Band 7 on long term sick	Chase Nurse Bank to ensure that nurses availble to be booked have received training for BLS and Manual Handling Chase PALS to ensure that volunteers who complete training on the 18th July 2014 are allocated to support A7 in mealtimes and other duties as required Liaise with Staff Nurse Kaur to see if she would like to return to the ward. Uplift from acuity business case agreed - need to recruit staff Paper to Division and Workforce Assurance Grp for incentivised payments for hard to fill wards	Jul-14 Jul-14 Jul-14 Sep-14 Jul-14	C2 YELLOW	Jul-14	

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;

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		above. i) Curently there are 2 Bd 6's off sick potentially long term. The third Bd 6 is very junior. This leaves a junior Bd 7, 3 senior Bd 5's but one has been suspended from medication administration as a result of concerns in practice being raised from a nursing home where the nurse works part time. Also a complaint has been received by a relative regarding the communication style of staff and care given to patients with dementia. This has also been substantiated by a member of staff who raised concerns following observations in practice a week before the complaint was received. Date of origin: 24/06/13 Date of escalation: 18/02/14		Practice Development team have agreed to reinstate their presence on ward and offer bed side training and education Bd 6 secondment opportunity developed to back-fill Bd 6 staff who is potentially on long term sick. This will improve skill mix of the dept Out of Hours practitioners to work on A7 for three evenings a week Nursing staff pooled across Care of the Elderly to ensure safe staffing levels across all wards Weekly meetings with Divisional Management Matron clinical on ward A7 7.30-10am mon-fri for daily observation, reinforces 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					

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?
				Volunteers helping out during meal times Uplift following workplace review Newly appointed Bd 7 to be put on A7. W/c 2 June induction. W/c 9 June start properly. Dementia Outreach Sister seconded from Jan 14 for four months to develop skills and training in elderly care concentrating on role modelling on Ward A7 Vacancy Recruitment process in place: Bd 5 - 8.02 wte vacancies - with 6 wte offered but no start date. Band 2 - 2.94 wte vacancies. New senior sister commenced in post 9 June 2014						

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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 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. Work rota shows that staffing levels flexed based on seasonal activity Significant number of staff have returned to work from maternity leave. Business case - Paedriatric Workforce Review has highlighted additional staff required. Training and workshops conducted for staff who use of specialist devices Most posts have been recruited to and staff expected to be in post by SEPT 2014	Staff sickness absences reported Short staffing incidents reported on regular basis	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 Review local induction and preceptorship plans for all new starters Ongoing incidents received to be reviewed concerning short staffing in wards	Aug-14 Aug-14 Aug-14 Aug-14	D2 GREEN	Jul-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; 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?
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. 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. Date of origin: 07/10/11 Date of escalation: 14/02/13	C3 AMBER	Recruited to Matron post, commenced October 2013. Following the increase in staffing establishment due to Trust wide workforce review both wards have vacancy at Band 2 - recruitment in progress Following the overseas recruitment campaign both wards will have only 0.5 wte Band 5 vacancy - once all of those receruited are in place - will be on the wards end of August 2014 Recruited Band 6 Practice Development Nurse for T&O Reconfiguration of elective/non-elective Orthopaedic beds in September 2013. Matron reviewing staffing across both A5 and A6. Staff being pulled from A5 to cover A6 as appropriate. Ongoing workforce review base establishment to new Ongoing recruitment of registered nurses 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.	May 2014 - HAPU = 2 Q4 2014 - 2 formal complaints relating to the quality of care May 2014 - Documentation compliance = 100% Vacancies are reducing and will be further supported by overseas recuritment which will be phased between July-October 2014 Flow Co-ordinator Band 6 in post August 2013 - working well. May 2014 - Number of patient falls = 0 All sickness absence being appropriately managed and is reducing. Appraisal rate for nurses on A5 in May 2014 = 89% aim to be 100% by July 2014 Vacancies are reducing and will be further supported overseas recruitment which will be phased between July-October 2014 May 2014 - Sickness rate = 4.3% Leadership walk round in May 2013 reported positive patient feedback by PALS, EDs and NED's present.	Bank shifts often not filled, other than by own staff. May 2014 - Late patient observations = 2% May 2014 - Safety thermometer score = 88% Safeguarding referral made against A5 and A6 - 48 hour report submitted, awaiting decision if full investigation required. Red incident reported 30/06/2014 - Unexpected Death (x-ray not ordered) - Datix: 123198 STEIS:2014/21489 Amber incidents of unsafe staffing levels and care still being received weekly. Mixed feedback from patients regarding negative and positive experiences. May 2014 - Basic life support compliance level 3 = 40% and Level 2 BLS = 60%. All staff have dates booked.	Review of environment to establish further support trauma patients with dementia Overseas recuitment phased between July - October 2014 Matron reviewing staffing across both A5 and A6. Staff being pulled from A5 to cover A6 as appropriate. Proposal enhanced rates for bank nurses covering A5 and A6 to Division an WAG	Aug-14 Oct-14 Jul-14 Jul-14	D2 GREEN	Jul-14	Yes

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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	Additional Majors open The area has telephone access and is " for purpose" regarding equipment ie oxygen points, suction, resus equipment CDU in place 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 to attend patients on the corridor when required Reviewing trends and numbers of patients	Ambulance handover times maintained over winter period - December-July 2014. Reduction in patients managed in the ambulance off load space.	Patients do sometimes wait in corridor Delays in patient transfer - linked to bed availability / bedflow / waiting to be transferred	To start rotation when AMU is fully established to support ED Build new ED	Jul-14 Dec-15	D3 YELLOW	Jul-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; Outcom 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

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Chief Operating Officer	2905	Originally raised as Risk No 2078 (now closed). Lack of e-prescribing for chemotherapy: 1. E prescribing for chemotherapy and wider inpatient and out patient prescribing not in place, risk of prescribing errors leading to dispensing and admin errors. 2. Chemotherapy pre printed prescriptions have not been reviewed and updated due to the impending introduction of electronic prescribing. Risk of incorrect delivery of treatment due to amendments being made by hand. 3. Chemotherapy wastage due to changes in dose not being received by pharmacy. This would be eleviated with the e prescribing system. 4 Risk of not be able to code and claim funding for activity undertaken 5. SACT criteria required to be uploaded will result in poor information due to the amount of data and the time to upload manually Date of origin: 12/03/12 Date of escalation: 16/04/14	C4 AMBER	Review of printed prescriptions commenced Paper based systems in use Increased toxicity clinics to ensure Pharmacy alerted immmediately to any change in treatment Consultants cannot prescribe non-formulary without approval via Governance process Pharmacy double check all prescriptions May 14 - Escalation meeting held with IT, Execs, Pharmacy and Directorate to discuss options for implementation of e-prescribing system. Option appraisal due September 2014.	Monitoring of incidents	Pharmacy error log - pharmacist interventions prevent many misprescribing incidents but are logged as near misses.	Update from chemo prescribing meetings	Aug-14	D2 GREEN	Jul-14	

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Medical Director	O4 943	Chemotherapy Administration 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	C4 AMBER	1) Chemotherapy Prescribing MDT monthly meeting to discuss all off Formulary chemotherapy treatment requests. Pharmacy to report non-compliance of formulary at MDT 2) RCA conducted for incidents as required, action plans implemented as indicated by findings and lessons shared 3) External review of governance processes in Oncology commissioned and underway following allegations of inappropriate / incorrect treatment requirements being prescribed in Aug - Oct 2013 (Nov 13). Due for completion and feedback in April 2014. Appropriate restrictions of practice in place to manage allegations made (Nov 13) 4) Audit of Policy CP8 through peer review. 6) Local / Executive Walkabout take place 5) Audit of NICE guidance - 18 audits on plan for 13/14	4) External review by HAQU, no concerns raised (Nov 13) 3) National Cancer patient satisfaction survey 2013	4) Self assessment against peer review measures identified some issues - work plan in place to address (2013) 3) Concerns raised by staff members through formal and informal routes (2013)	4) Awaiting external report 4) Annual validation of nursing staff competence 1) Prospective audits of non formulary treatments to be undertaken 1) Introduction of E-Prescribing	Aug-14 Jul-15 Sep-14 Apr-15	E3 YELLOW	Jul-14	Yes

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Medical Director	O4 1862	Trust wide consent audits reveal failures within the Trust to follow a 2 stage consent process. Date of Origin: 08/07/08 Date of escalation = 06/03/13	C4 AMBER	1) Staff training on consent available. 4) Monthly prospective clinical audit on consent process. 2) Annual Consent Audit undertaken. 5) Review of incidents / complaints / claims involving consent (quarterly) 3) Delegated consent lists kept by all relevant directorates		5) Recent near miss incident - Ophthalmology Lucentis incident 2) Non-compliance at two stage consent process (Audit July 2013)	2) Design new audit tool 1) Review consent training programme 2) Implement updated consent policy when approved 2) Re-design the consent form	Dec-14 Dec-14 Nov-14 Nov-14	E3 YELLOW	Jul-14	Yes
Medical Director	O4 2604	Trust wide VTE audits continue to demonstrate improved compliance but reassessments do not reach 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	1) On admission all patients receive an initial risk assessment within 4 hours 2) Within 24 hours of admission all initial VTE risk assessments are reviewed 3) 95% of all medical and nursing staff are expected to attend VTE mandatory training 4) Level 2 RCA's are completed for all patients where there has been a breach in policy.	1) VTE admission risk assessment compliance is currently at 75% (June 14) 3) Training compliance for June 2014 is 99.2%	2) Compliance for reassessment within 24 hours is currently at 18% (June 14)	2) Weekly RAG report circulated to all clinical areas		D3 YELLOW	Jul-14	Yes

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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	A formal investigation into the allegations has been initiated with a referred histopathologist as core investigator. A review of rectal cancer patients treated in 2007 & 08 will be conducted by external reviewers in April 2014	Await outcome of investigation	Await outcome of investigation	External Review planned April 2014 To have an external review of the previous audit and practice and management of colo-rectal cancer between 2007-2009 by an external expert in this field (clinical & medical oncologists)	C3 AMBER	Jun-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	1) Patients who require out of hours emergency interventional radiology management will be referred to an alternative vascular centre	1) No adverse incidents raised (July 14)		1) When clinically required, arrange for transfer of patients to an alternative centre for management - ongoing	D2 GREEN	Jun-14	Yes

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Chief Nursing Officer	3655	Risk of compromised functionality of Datix (v10.1) due to inability to upgrade to v12.2 (server issues) risk includes: data/auto processing being compromised Data quality issues in relation to information extracted from Datix and incidents that are not be finally approved may not be adequately reviewed. Potential impact on SUI's not being reported to STEIS within the expected timeframe and the Trust would be penalised via fines. The latest reports from updated versions of Datix and functionality would not be available to the Trust, hence the progression of Health informatics and adhering to the Governance agenda could be halted. Adverse impact on additional users due to Cannock. Date of origin: 27/01/14 Date of escalation: 04/04/14	B3 AMBER	6) Implemented process for removal of duplications 1) Implemented daily data quality checks of all incidents reported inc: reviewing datix for potential SUIs/PUs/Falls 4) All red incidents are screened, reviewed and validated by Directorates/Wards. GOs check all incidents assigned to directorates/wards and raise queries 5) All medication incidents screened and validated 2) Report sent to TVN Nurses daily for previous days incidents (G3/G4) 3) Grade 2 PUs - weekly report to Matrons/TVN for all incidents reported in previous week (Mondays) 7) Test environment to be set up and tested on 7th July 2014	7) Test commenced - no faults W/E 11/07/14 2+4) No breaches of PU reporting (SUIs) - July 14 3) Reports received by Matrons/TVNs for G2 PUs on wkly basis 6) Duplications removed as notified/identified 7) IT completed new server to facilitate DATIX 1) No breaches of SUI reporting 7) IT now corresponding directly with DATIX & BT to establish a test environment prior to full rollout of the upgrade 7) Data sharing agreement completed and sent to DATIX. Awaiting response	Email prompts to users not function correctly No email following auto password reset Duplication queries remain high from directorates/wards	7) Complete testing of v 12.3 7) Agree date for upgrade with Datix in live environment 7) Implement upgrade 7) Roll out to all staff 1 to 6) Monitor all queries raised in relation to Datix	Aug-14 Sep-14 Sep-14 Sep-14	E1 GREEN	Jun-14	

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Chief Nursing Officer	3711	If the Trust fails to fully implement CPE toolkit then there is a risk of spread or outbreak of one of these organisms resulting in a subsequent serious infection, operational interruption or negative publicity. Date of origin: 14/04/14 Date of escalation: 14/04/14	C3 AMBER	Action plan developed and monitored - July 14 Surveillance of all cases reported monthly to IPCG - July 14	Nil cases for June 14 - July 14 No serious infections to date - July 14 Most recent contact screening negative - July 14	Automated surveillance does not detect cases - July 14 Lack of confirmation from Public Health England on a system to communicate between hospitals regionally - July 14 Unknown number of high risk patients entering the Trust - July 14 Some contacts (patients) refuse screening - July 14	DIPC leading on action plan - Attached existing action plan Antibiotic Resistant Organism policy (IP03) to be revised as soon as consensus is reached on local / regional actions	Aug-14 Aug-14	C2 YELLOW	Jul-14	

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Chief Nursing Officer	3644	The CQC will undertake an inspection and if no improvement following implementation of the CQC Action Plan, this would impact on the Trusts' registration status. Date of origin: 14/01/14 Date of escalation = 14/01/14	B3 AMBER	1) DCNO/HoNs/Governance have undertaken a review of areas inspected by the CQC 3) A business case has been developed to support increases in ward nursing establishments 2) A system of internal review is in development to run mini CQC audits 4) A recruitment plan is in place 5) Monthly performance is monitored through the nursing midwifery KPIs for signs of deterioration 6) Capital funded environmental refurbishment in areas highlighted by the CQC requiring improvement	1) Results from the review are positive and have been shared as part of the monthly report monitored at QSAG. Several actions have now been closed as achieved in the action plan. Positive satisfaction following bereavement support questionnaire 2) Governance department leading the development of mini CQC audits due for July 2014 3) Business case was approved by the Board and the CCG to fund additional nursing staff, plan of priority areas for investment now in place. Decrease in vacancies. 4) Overseas recruitment successful in bringing 3 cohorts of nurses into the Trust. All student nurses due to graduate in Sept 14 have been approached to be interviewed for jobs at RWT. Recruitment Manager working with HoN/M to determine areas for recruitment and monitored via Workforce Action Group. 5) Nursing and Midwifery KPIs moved to Health Assure reporting and emailed out to ward sisters/matrons and HoNs monthly. 6) Capital programme agreed refurbishment in Mortuary and Outpatients	3) Electronic Rostering demonstrates more work needs to be done on using e roster to fully to maximise staff resource 3) Sickness absence needs to be driven down to Trust average in all ward areas.	2) Undertake the NTDA Patient Experience Framework at Board and then divisional level to determine what else Trust can do to improve patient experience 4) Monitor monthly staffing submitted on Unify to NHSE to check Trust achieves 95% fill rate for staffing planned versus actual 1) Use the CQC Intelligent Monitoring Report (IMR) to determine areas of weakness	D2 GREEN	Jul-14	

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Chief Nursing Officer	3589	If Independent Living Services does not provide a consistent approach to infection prevention and decontamination then there is potential for community patients to develop healthcare associated infection which will impact on Trust performance and patient safety. Date of origin: 20/11/13 Date of escalation: 24/01/14	C3 AMBER	Monthly meetings to monitor the ILS contract July 14 Specification redesigned with requirement for infection prevention audit, training and policy July 14 Goals and Outcomes of poor performance period agreed July 14	Last audit reports completed in Q4 14/15 and circulated to ILS making clear recommendations July 14 IP improvements in decontamination process noted in 13/14 July 14.	Contract not signed for Infection Prevention support July 14 Goals and outcomes not monitored due to lack of access currently July 14 No regular visits July 14 No education delivered during Q1 of 14/15 due to contract not being signed - July 14 Current audit programme not funded as part of contract yet - July14	Review contract with ILS and monitor monthly Agree 14/15 working arrangements with CCG to enable RWT to exercise management control of ILS. Develop detailed action plan following communication of intent to take out contract for IP July 14	Aug-14 Aug-14 Aug-14	D2 GREEN	Jul-14	
Chief Nursing Officer	O4 2680	Interpreting and translation budget is over spent due to over performance in face to face interpreting. Date of origin: 29/03/11 Date of escalation = 16/05/12	A3 AMBER	1) Risk assessments in place to be used when booking face to face interpreting. 2) KPIs in place to monitor monthly usage by department 3) Reduced rate negotiated with interpreting provider who will manage the move to 20% less face to face interpreting usage in 10 months 4) Telephones and posters advertising use of Language Line in place	1) Policy has been updated to reflect the need to use risk assessments for face to face interpreting 2) 20% reduction in overspend over 18 months 3) No adverse incidents or complaints in interpreting reported	1) Monthly expenditure overspend 2) No evidence to support use of risk assessments by directorates when booking face to face interpreters	1) Monitor a sample of risk assessments used in high usage directorates 2) Review how the process is managed for face to face interpreting in high usage directorates and monitor expenditure monthly with directroate		C1 GREEN	Jul-14	Yes

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Chief Nursing Officer	O8 535	If the Trust fails to achieve reductions in healthcare associated infection then the Trust's reputation and the impact will be that compliance to regulatory standards and objectives will not be achieved. Date of origin: 07/03/05 Date of escalation = 11/05/11	D4 AMBER	PCR data for Clostridium difficile monitored monthly through IPCG July 14 Monthly conversation of avoidability of Clostridum difficle numbers with CCG agreed July 14 MRSA Screening Policy in Trust audited annually July 14 Care home patients in community screened for MRSA in response to concerns indicated by CCG/Public Health/IP teams July 14 IV Team assist investigation on all device realted infection July 14 Surgical site infection surveillance monitored continuously July 14 Toxin positive Clostridium difficle numbers reported to commissioners monthly July 14 Training plan to care homes in place with numbers collated quarerly July 14 Care home participate in infection prevention and control audit and education. July 14 CDI Assurance process updated. Monthly reporting to IPCC on trends July 14 Action plan in place for Hygiene Code to be monitored by IPCC quarterly - July 14	C diff below trajectory for year to date - July 2014 PHE quarterly assurance shows the Trust performing to CDI objective July 2014 Fidaxomicin used on first case of recurrance - July 14 Care home prevalence for MRSA below 2% for end Q4 13/14 - July 2014 No avoidable MRSA bacteramia case year to date. July 14 Care home prevalence of MRSA below 2% at April 14 (July14) Anti-microbial Prescribing Strategy in place (July 14) ICNet NG in place to provide electroinic alerts.July 14 Reduction in HCAIs other than MRSA bacteraemia. (July 14)	Catheter associated urinary tract infection surveillance not currently in place July 14 Urinary catheter process for removal in the community not consistently in place July 14 MRSA screening data not automatically fed due to lack of HL7 feed July 14 Rising community cases of C difficile July 14	Identify high risk areas/procedures for DRHAB and develop actions to reduce. Identify high risk areas for MRSA and develop action plan to reduce The process for faceal transplantation for re-current cases of C.Diff infectionsis being devised by DIV 2 through the business case route Antimicrobial Stewardship Strategy in draft form, pending successful business case for additional Antimicrobial Stewardship support.	Aug-14 Aug-14 Aug-14 Aug-14	E4 AMBER	Jul-14	Yes

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				Device reated bacteramia reported to IPCG monthly July 14 Fidaxomicin in use to treat recurrence of CDI. July 14 Urinary catheter policy audited six monthly							
Trust Objective:		**To be the employer of choice.**									
Chief Operating Officer	O12 1713	Failure to effectively maximise workforce productivity; failure to routinely review consultant job plans. Date of origin: 03/06/08 Date of escalation = 11/05/11	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. Trust to use pilot job planning module - associated with revalidation process (June-Sept 2014.) 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 - June 2014.. Slow progress in terms of Job Plan completion - May 2014	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.	Apr-14 Sep-14	C2 YELLOW	Jul-14	Yes

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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 results published 2014. Results from 2013 National Staff Survey have been cascaded to Divisions for action planning 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 2013 staff survey - 35% response rate still leaves us in lowest 205 of Acute Trusts.		D3 YELLOW	Jul-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; Outcom 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

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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	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. 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. (14/15)	Integrated Health and Social Care Team commenced January 2014. Reduction in patients waiting for continuing Healthcare Assessments. Delayed discharges reducing from April 2013 - March 2014.	Fluctuations in numbers of patient delays, especially Staffordshire and Walsall	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. Discussions with social care partners for 7 day services to commence in winter 2014/15 Winter plan for TDA submitted September 2013. Early planning for winter 2014/15 commenced.	D2 GREEN	Jul-14	Yes

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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 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 - May 2014	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.	Introduction of Safe Hands Project will assist with real time bed management. Long term review of real time bed management and link to I.T. Strategy.		B3 AMBER	Jul-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	C3 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 plan to re-tender service 2014/15 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 whole service	Apr-15	D3 YELLOW	Jul-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 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 A10 opened May 2014 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 Second Cardio bed has been ringfenced Beds remain open on Beynon Ward at weekend.	Increase efficiency and release resource through ambulatory care, enhanced recovery and surgical site surveillance Reduction of cancelled operations throughout winter/spring 2014 Reduction in length of stay at West Park hospital - November 13 Overseas recruitment Reduction in the number of medical outliers	Increase in number of patients breaching 18 week referral to treatment time. May 2014. Deviation from the winter plan Vacancies on ward 12 hour breaches in Jan, 8 hour breaches in Q4.	Plan to introduce 7 day services for autumn/winter Introduction of morning board rounds across wards Additional overseas recruitment Proposal enhanced rates for bank nurse cover A5, A6, A7 & A8 to WAG Explore/review staffing plan for Cardiac Cath Lab to consolidate temp staffing wte into base estalishment Reduce Gynae outliers due to capital works	Oct-14 Sep-14 Sep-14 Aug-14 Sep-14 Sep-14	D4 AMBER	Jul-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?
				Revised nursing astablishment agreed Plans in place for additional winter capacity and funding A&E targets monitored daily and reported to TMT & Trust Board monthly						

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:		**Deliver services within financial allocations**								
Chief Financial Officer	O16 514	Failure to deliver recurrent efficiency gains and CIPs. Date of origin: 01/04/2014 Date of escalation = 01/05/14	A4 RED	1) The Trust has split the CIP target into Transactional and Transformational schemes. The transactional schemes are monitored via the PMO and reported through the monthly Operational Finance Group meeting, (chaired by the CFO) through to Trust Board. 2) The Transformation Programme schemes are grouped into four like-minded programmes of work. 3) Each of the transformation programmes has a dedicated Programme Manager lead, Executive Director Sponsor and Clinical lead monitoring progress. 4) Formal monthly meetings are held at the Transformation Programme Group to monitor and validate savings and review progress (Executive Director lead). 5) Detailed finance report is presented and reviewed at Finance and Performance Committee through to Board. 6) Additional PMO staff appointed to facilitate and manage the transformation programmes.		1) Currently forecasting a shortfall in the CIP programme for 2014/15.	1) Continually working to identify 'new' projects and programmes - ongoing. 1) Escalate performance with Divisions / Directorates and institute recovery plans 1) Continue to identify non recurrent CIP for this year and new projects and programmes in advance of the new financial year.	B3 AMBER	Jul-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; 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?
Chief Financial Officer	O6 2781	Significant loss of income causing the Trust to take action to address the situation. This could occur due to emergency threshold and emergency readmissions. Date of origin: 01/04/14 Date of escalation = 01/05/14	B3 AMBER	1) Monthly monitoring of actual performance against planned levels. Reserve set to offset potential risk exposure. 2) Negotiation with commissioners to ensure money re-invested back within the Trust.	2) Successful negotiations delivered and reported to Finance and Performance Committee		1) Board to Board engagement and whole economy plan to reduce demand on urgent care.	C1 GREEN	Jul-14	Yes
Chief Financial Officer	O16 3176	Commissioners raising issue of patient activity over performance and their ability to pay. Date of origin: 01/04/14 Date of escalation = 01/05/14	C3 AMBER	1) Negotiate through monthly contract performance reports and meetings with commissioners. 2) Ensure managers are aware of the issues and take appropriate actions at operational finance group and contracts commissioning group.	1) Negotiations are currently on-going		1) Escalate to Directors if unable to conclude successfully	B2 YELLOW	Jul-14	Yes
Trust Objective:	**To be a high quality educator**									
Medical Director	O16 2626	Reduction in national and regional education funding. 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. Direct implications are that the Trust will have to fund educational requirements Date of Origin: 19/01/11 Date of escalation = 06/06/12	C4 AMBER	Representation on LETC to influence the decision making process Internal working group to examine costings 2nd costings exercise being undertaken	Attendance of RWT rep is high Minutes of HR Workforce Assurance Group Working Group has completed cost collection exercise Results of Cost collection exercise monitored by Academy Steering Group	2013/2014 SIFT was lower than expected		C3 AMBER	Jul-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; Outcom 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;