The Royal Wolverhampton NHS Trust

NHS

Trust Board Report

Meeting Date:	29th September 2014
Title:	Board Assurance Framework / Trust Risk Register
Executive Summary:	BAF Key Issues 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). Trust Risk Register Issues 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 2639 - Failure of Community Dermatology Service has been downgraded to an E1 Green and now removed from the Trust Risk Register.
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:

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

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

	ID	Risk Title	Lead
RED	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)	28
Risks managed to target level	0

There are currently 28 risks contained within the Trust Register which are

distributed across the Trust's categorisation matrix as below:

Likelihood	Consequence 1 Low	2	3	4	5 High
A – Almost Certain			2	1	
B – Likely			8	1	
C – Possible			5	9	
D – Unlikely			1	1	
E – Rare					

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

	ID	Risk Title	Lead
RED	514	Failure to deliver recurrent efficiency gains and CIPs.	FD
	3685	Staffing levels and quality of nursing care on A6.	COO

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	1	
2) To be the employer of choice.						1		
3) To achieve a balance between demand & capacity of services		1				3		
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		

Looking back to April 2014

- 1 red risk on the BAF – 2965 Failure to reduce Never Events
- 3 red risk on the TRR - 514 - Failure to deliver recurrent efficiency gains and CIPs, 943 - Non-adherence to chemotherapy policy and procedures resulting in poor patient and staff experience/confidence and 3685 - Staffing levels and quality of nursing care on A6.
- 11 risks on the BAF
- 38 risks on the TRR

Strategic Objective	BAF				TRR			
	R	A	Y	G	R	A	Y	G
1) To provide our patients & staff with a safe environment.	1	3	1		2	20		1
2) To be the employer of choice.						2		
3) To achieve a balance between demand & capacity of services		1				4		
4) To progressively improve the image and perception of the Trust			1					
5) To be in the national NHS top quartile of benchmarks								
6) Deliver services within financial allocations		2			1	4	1	
7) To be a high quality educator						1		
8) To agree appropriate population catchment areas for RWHT service								
9) To develop our position as a tertiary centre								
10) To achieve Foundation Trust status		1	1			1		
Clinical Negligence Scheme for Trusts						1		

Recommendation(s)

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

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

Lead Director	Risk	Risk Title	Update	Reasoning / Progress Against Actions
Director of Planning and Contracting	1734 D3	Impact of competition to a significant shift of activity.	Positive Assurances and Mitigating Actions in place updated.	Reviewing and strengthening the internal resource to support the delivery of tenders and service expressions of interest. Business Development Manager commenced in post 1/8/14.
	2927 B3	Failure to deliver against QIPP scheme resulting in lack of investment.	Positive Assurances updated.	Regular updates to Service Development Improvement Plan agreed with commissioners to be presented to monthly Contracting Commissioning Group.
Chief Nursing Officer	2965 C5	Failure to reduce Never Events	Positive Assurances and Negative Assurances updated	Compliance with the 5 steps to safer surgery is 100% for the 681 theatre operating sessions conducted. 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 90%. Breast Imaging was the only directorate that did not achieve 100% compliance. The Head of Nursing and Divisional Medical Director are currently reviewing the process with the directorate.
Chief Executive	3645 A5	The short term impact on the Trust of service sustainability at Mid Staffordshire NHSFT.	Positive Assurance, Negative Evidence and Further Mitigating Actions updated.	Contingent plans are supporting safer services - review through Local Transition Board bi monthly, Sustaining Services Board – monthly. Negative impact on operational performance at RWT. Ongoing focus on improving patient flow/ work commenced on additional capacity at New Cross linked to service transfers.
	3353 D3	'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.	Positive Assurance updated.	Planned actions to support service fragility at MSFT
	3352 B3	Potential for rapid growth of the Trust due to changes in the wider health and social care economy.	Positive Assurance updated	No unknown developments or service changes.
	3330 C4	The long term impact on the Trust of the changes occurring at Mid Staffordshire NHSFT and within the Staffordshire health economy	Mitigating Actions in place, Positive Assurance, Negative Evidence and Further Mitigating Actions updated.	Involvement in the work of the TSA - ongoing to 1st November 2014. Activities in place to prepare the transaction documents for approval in October. Joint Public consultation with CCG on proposals for services for Wolverhampton patients 18 July - 17 October. Trust is actively participating in plans for transfer of services. The Trust work programme is keeping pace with all other parties.

				Broad communication and engagement plan Some delays in drafting documents due to external parties Some concern expressed regarding travel Additional Board sessions agreed. Review of work programme to ensure key milestones are achieved. Reinforce messages about distance to Cannock and Trust plans for bus services

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

Lead Director	Risk	Risk Title	Update	Reasoning / Progress Against Actions
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.	MRSA Screening Policy in Trust audited annually Sept 14. Support oncology directorate with action plans Communicate faecal transplantation availability Establish referral system for faecal transplant
	3589 C3	Failure of community equipment supply contractor to meet infection prevention/decontamination standards.	Action Plan updated.	Await confirmation from WCC that contract is purchased to provide infection prevention support
	3655 B3	Compromised functionality of Datix (v10.1) due to inability to upgrade to v12.2 (server issues)	Positive Assurance updated.	Test commenced - no faults W/E 15/09/14
	3711 C3	Failure to fully implement CPE toolkit	Positive Controls and Action Plan updated.	ICNet automates surveillance - Sept 14. Publicise action plan and associated information
	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.	Positive Assurance updated.	Proposal paper for Quality review revisit being presented to QSAG in Sept. Pilot report to QSAG Dec 14, full programme of reviews from March 15. Latest CQC Intelligence monitoring report for July 14 identifies the trust as low risk.
Medical Director	2626 C4	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	Positive Controls, Positive Assurances, Gaps in Assurance and Action Plan updated.	RWT costing group formed and worked on costing's for all tariff based education funding to ensure accurate data Positive engagement with LETC and education funding by influencing business plan. RWT tariff costing's data was as accurate as could be and most areas were not outside benchmarking

		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.		Medical Post graduate funding had outliers All Post grad areas were re-challenged to approve outlier figures Re-challenge data annually Re-assess RWT education income when tariff known in 2015, and then determine if end result of costing exercise and tariff = higher or lower income for TWT education funding
Chief Operating Officer	1713 B3	Failure to effectively maximise workforce productivity; failure to routinely review consultant job plans.	Positive Controls, Gaps in Assurance updated	Usage reports for medical bank Job plans continue to be reviewed and sign off by DMD / MD- ongoing Baker Tilly follow up report indicated not all job plans reviewed - Jun 14
	1714 B3	Failure of other agencies to support discharge process.	Positive Controls and Positive Assurances updated	Development of winter Plan for 14/15 identifies expectation on social care response. Weekly monitoring of formal delayed transfers of care by CCG Trust reviewed structure for integrated working between health and social care (Dec 13) Yearly review of re-imbursement of funds Health economy Winter plan for 14/15 has received formal sign off by Area Team - Sep 14
	3256 D3	Premises at West Park do not conform to professional standards for Audiology	Action Plan updated	Option appraisal business case for refurbishment / relocation is being developed and reviewed in the division.
	3299 C4	Obstetric Staffing for Labour Ward	Action Plan updated	Monitor impact of MSFT services and potential for additional staff – ongoing.
	3431	A7 staffing	Positive Assurances updated	New sister commenced in post
	2905 C4	Lack of e-prescribing for chemotherapy	Positive Controls updated	Business case scoping the requirement for e-prescribing system
	2719 A3	Timeliness of PAS Admission	Positive Controls updated	Scoping review of business processes and staffing underway
	2639 E1	Failure of Community Dermatology Service	**Risk downgraded from C3 Amber to E1 Green.**	Now managed on the relevant departmental risk register.
	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 Assurances and Gaps in Assurances updated.	Trust transformation projects focussed on elective and non-elective lengths of stay. Detailed plan for overseas recruitment in place. Winter plan agreed - additional funding available. Reports to Transformation group not yet demonstrated improvement in length of stay Increase bed pressure in Aug 14

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Board Assurance Framework (incorporating strategic risks) - Sept 2014

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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	
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 100% for the 681 theatre operating sessions conducted. - 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 90%.	Div 1: Breast Imaging was the only directorate that did not achieve 100% compliance. The Head of Nursing and Divisional Medical Director are currently reviewing the process with the directorate.	C	5	R		Accountability meetings to be arranged with individual staff and CD/Matron.	30/09/2014	E	2	G	Sep-14
									Div 2: - Compliance with the use of the WHO Safety checklist is 99.9%. - Compliance with full completion of the WHO safety checklist agreed for procedures is 97.8%.	Div 2: - 1 form not completed in ED. - Accurate completion remains an issue for the Emergency Services Department.					Clinical Director to embed compliance requirements with the new team..					
								Audit of Safety checklist policy and practice (internal audit).	A marginal improvement on the 2013 audit results, with an average change of +0.3%.											
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	Sep-14
									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.	Planned actions to support service fragility at MSFT											
								Effective and timely consultation with stakeholders on any change.												
								Robust board governance												

NOTES:

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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	Sep-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	Contingent plans are supporting safer services - review through Local Transition Board bi monthly, Sustaining Services Board - monthly						Working with Commissioners on demand management.					
								Service level review of impact for RWT		Negative impact on operational performance at RWT					Ongoing focus on improving patient flow/ work commenced on additional capacity at New Cross linked to service transfers	31/12/2014				
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	Sep-14
								Build flexibility into operating systems	Achievements of contractual obligations											
								Organisational intelligence - primary and secondary care providers	No unknown developments or service changes											
								Understand timescales to implement step change increases in capacity												
								Review workforce plans												

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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	Sep-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											
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 all parties involved in the transaction (July 2014)	Joint working with UHNS on separation of services.		C	4	A	⇨			E	4	A	Sep-14
								Involvement in the work of the TSA - ongoing to 1st November 2014	Trust is actively participating in plans for transfer of services											
								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.											
								Activities in place to prepare the transaction documents for approval in October	The Trust work programme is keeping pace with all other parties.	Some delays in drafting documents due to external parties					Additional Board sessions agreed. Review of work programme to ensure key milestones are achieved					
								Joint Public consultation with CCG on proposals for services for Wolverhampton patients 18 July - 17 October	Broad communication and engagement plan	Some concern expressed regarding travel					Reinforce messages about distance to Cannock and Trust plans for bus services					

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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 unannounced inspection - all standards assessed were met	Not fully compliant with delivery of the service spec/HCP	D	3	Y				D	2	G	Sep-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.												
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	Sep-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.					

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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	Sep-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					
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		Use refinements to NHS Choices & Choose & Book to 'sell' services - ongoing	Sep-14	D	2	G	Sep-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						Maximise opportunities to sell services via new Web Site - ongoing.	Jan-15				
								Recruitment of Business Development Manager	Weekly updates on active opportunities presented to Directors.						Bi-monthly communication with GP community via a newsletter	Jan-15				
								Reviewing and strengthening the internal resource to support the delivery of tenders and service expressions of interest	Business Development Manager commenced in post 1/8/14.											

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.

The Royal Wolverhampton NHS Trust
Board Assurance Framework (incorporating strategic risks) - Sept 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	
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	Sep-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	Regular updates to Service Development Improvement Plan agreed with commissioners to be presented to monthly Contracting Commissioning Group.											

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.

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											
Trust Objective:		**Clinical Negligence Scheme for Trusts**									
Chief Operating Officer	O4 494	Deficit in achieving the local Birthrate Plus ratio of 1:30, on-going 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	2) Midwifery establishments are reviewed weekly by the Head of Midwifery and all staffing breaches and outcomes are reported via Senior Nurse performance meeting monthly by Head of midwifery. 3) All staffing incidents notified to Head of Midwifery. On-going monitoring via incident reporting system for staffing related incidents. 1) Funding approved for recruitment of midwives (recurrent for 14/15) 4) 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. 5) Birth rate plus ratio is recalculated on an annual basis in line with end of year activity with complexity taken into account.	1) Offered positions to 15 newly qualified students which will fill all the current vacancies and some of the birth rate plus numbers -July 2014	3) Adverse outcomes associated with sub-optimal staffing, are identified through incident reporting. 1) Difficulties recruiting staff with sufficient levels of experience to support required skill mix 1) Overseas recruitment has not been successful for Maternity. 1) 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.	1) Recruit and appoint to vacancies across the maternity service.	Nov-14	C1 GREEN	Sep-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?
Trust Objective:		**To provide our patients & staff with a safe environment.**									
Chief Operating Officer	O16 3256	Premises at West Park (Audiology) are deemed unsuitable for clinical service delivery - there is a lack of adequate soundproofing and an inability to maintain ambient temperatures in clinical rooms. The service specification specifies room requirements: BS EN ISO 8253-1:1998 Acoustics. Audiometric test methods - Part 1: Basic pure tone air and bone conduction threshold audiometry where possible. External assessment on Audiology Service completed in December 2013. Date of origin: 04/10/12 Date of escalation = 06/03/13	D3 YELLOW	1) Introduction of insert earphones and Sound Level meters to monitor sound levels 2) Signs are in place in clinical area and corridor requesting silence at all times. 3) Incident trends being monitored along with any complaints on a monthly basis	1) Accreditation feedback session was very positive and praised team. 3) Analysis shows that there are very low levels of reported incidents re. noise disturbance and there have been very few formal complaints over the past 12 months.	2) Service unable to guarantee that patients will get an accurate hearing test as noise levels cannot be controlled fully. Informal complaints/comments have been made and recorded.	3) Option appraisal business case for refurbishment / relocation is being developed and reviewed in the division	Sep-14	E2 GREEN	Sep-14	Yes
Chief Operating Officer	O4 3299	A 98-hour Labour Ward presence is required for 4,000 - 5,000 deliveries and current staffing provision is 40 hrs consultant presence dedicated to the Labour Ward. This causes a potential delay in patients from Gynaecology Ward with a greater risk deficit on patient quality care out of hours. Date of origin: 30/01/13 Date of escalation = 30/05/13	C4 AMBER	1) The deficit in consultant hours will be monitored through DATIX incident reporting. 3) Business case for additional resource to recruit 4 consultants in July 2014 being considered at Division 2) Monitor the maternity dashboard on a monthly basis re: core hours.	1) No incidents reported concerning obstetric staffing where sub-optimal care has resulted.	2) The birth rate has exceeded 4000 at the end of the 2013 calendar year thus requiring 98 hour cover (July 14) 2) The 98 hr dedicated consultant cover is not currently being met (July 14)	3) Monitor impact of MSFT services and potential for additional staff - ongoing 3) Business Case to represented back to the Divsion once job plans have been reviewed. Following Divisional approval this will then need to be approved bt TMT	Dec-14	D3 YELLOW	Sep-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	3685	Deficit in Nursing Staffing levels, difficulty in recruiting staff and appropriate competency's which us having a potential adverse impact on the quality of nursing care on A6. Staffing skill sets, mutli-disciplinary team working and negative historical reputation. Date of origin:05/03/14 Date of escalation: 06/03/14	B4 RED	2) Recruitment strategy in place 3) TNA reviewed and LBR funding secured for training plan with specialist practice development support 4) Quality measures monitored including matron rounds, quality metrics via Health Assure, SUI/RCA and complaints.. 1) Reviewing staffing establishments to address staffing deficits.	2) Recruitment of qualified nurses to reduce staffing deficit (Aug/Sep 14)	1) July 2014 - Staffing remains a challenge for A6 4) Two STEIS reportable incidents (Jan 2014: 2014/1381 and March 2014 STEIS 2014/10853 unexpected death following knee replacement an A6 1) Bank shifts often not filled and risk presented by staff being unfamiliar 3) 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.	2) Fulfil current recruitment plan to establishment 4) Progress HR processes with individual staff 1) Proposed enhanced rates for bank staff covers A5 and A6 to Division and WAG	Sep-14 Jan-15 Sep-14	D2 GREEN	Sep-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?
Chief Operating Officer	3431	CAUSE Poor skill mix due to change in establishment to A7, CoE 28 beds, ADVERSE EVENTS (i) Difficulty in attracting the right calibre of staff and retention of existing staff (ii) Poor patient experience: direct care and documentation -patients not turned, hygiene or toileted regularly, patients not being offered food and fluids or assisted with them in a timely fashion. (iii) Poor discharge planning (iv) Adverse scores on Nursing and HR KPIs IMPACTS (i) Failure to recognise the deteriorating patient (ii) Hospital Acquired Pressure Ulcers (iii) An increase in falls, resulting in serious harm and increased length of stay (iv) Delayed discharges (v) Increased complaints (vi) Adverse scores on Friends and Family Test (vii) Poor publicity (viii) Extended inpatient lengths of stay (ix) Matron has spoken to learning and development and they agreed to pause student nurse placements on the ward Date of origin: 24/06/13 Date of escalation: 18/02/14	B3 AMBER	1) Staff paid to substantive grade on bank when working on wards A7/8 7) Dementia outreach nurse to work on ward as required by patients with Dementia to provide bed side training on caring for patients with Dementia. She will leave the ward as required to respond to outreach requests 2) Enhanced pay agreed to encourage bank staff to work on the ward 13) Additional Junior Dr allocated 4) Skill mix assessed when planning rota to ensure required skills are available on each shift 5) Training needs analysis performed for all members of staff on ward and needs prioritised. Bd 6 responsible to book and confirm attendance 17) Start allocating males onto A7 and females onto A8 to become a mixed sex ward again and assist in reducing the dependency on ward A7 8) Practice Development team have agreed to reinstate their presence on ward and offer bed side training and education 10) Weekly meetings with Divisional Management 12) Falls champion identified	4) Nursing staff pooled across Care of the Elderly to ensure safe staffing levels across all wards 15) Recruitment to posts ongoing 15) New sister commenced in post - Jun 15 14) Recruitment campaign in place for volunteers to help with feeding. Seven volunteers now in place. 4) Where skills deficit on a shift identified and additional support need established member of team asked to provide additional support by working additional hours 4) Additional nursing support provided from other wards	15) Difficulties covering vacancies with Bank staff 4) Increased numbers of staff related incidents	4) Identify PDN from MAU to work on A7 for a 3 month period 15) Advertise for a permanent band 7 PDN for Care of the Elderly only 4) Uplift from acuity business case agreed - need to recruit staff	Oct-14 Oct-14 Oct-14	C2 YELLOW	Sep-14	

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
				14) Volunteers helping out during meal times 15) Recurrent advert on NHS Jobs. 16) Overseas nurses allocated. New starters in place. 9) Out of hours practitioners to work on A7 for three evenings a week 11) Matron clinical on ward A& 7:30-10am Mon-Fri for daily observation, reinforces standard setting, ward organistion and management of resources to give quality assurance						

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 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. This risk is due to inadequate staffing levels from vacancies, maternity leave, sickness absence and with some current staff leaving the Directorate. Date of origin: 07/04/05 Date of escalation = 11/12/13	C4 AMBER	1) Staff recruited to vacancies - almost fully established 4) Finances available for manpower for staff employed from the Trust Bank. 3) Staffing flexed according to activity and any incident reported daily - Sickness monitoring and management according to policy . 2) Development of and recruitment to rotational posts between A21 and Neonatal Unit	2) NNU/ED/COPD based staff supporting team when short staffed. 2) Rotational of posts taking place between NNU / COPD / Community Children's Nursing Services and ED 1) Local induction and preceptorship plans in place for the new starters 2) Work rota shows that staffing levels flexed based on seasonal activity 3) Significant number of staff have returned to work from maternity leave. 1) Business case - Paedriatric Workforce Review has highlighted additional staff required. 1) Training and workshops conducted for staff who use of specialist devices 1) Most posts have been recruited to and staff expected to be in post by SEPT 2014	4) Trust Bank not always able to provide staff and not always available - skill mix problems now being reported 1) Recruitment near completion - not all staff in post working. 2, 3) Staff sickness/absences and short staffing incidents reported on a regular basis	1,2,3,4) Business Case in progress 1,2,3,4) DATIX Incidents and monthly IGR report to be reviewed and any issues of staff shortages on wards to be discussed at the Governance meeting	Oct-14 Sep-14	D2 GREEN	Sep-14	Yes

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	O4 2828	Quality of care on A5 is adversely impacted by dependency acuity of patients (against HURST tool), staff skill sets, multi-disciplinary team working and negative historical reputation. Date of origin: 07/10/11 Date of escalation: 14/02/13	C3 AMBER	1) Recruitment strategy in place 2) TNA reviewed and LBR funding obtained for training plan with specialist practice development support 3) Review of staffing establishment to address staffing deficits 4) Quality measures monitored including Matron rounds, Quality metrics via Health Assure, SUI/RCA, complaints and PALS 5) Demential outreach service to meet specialist care leads	4) Q4 2014 - 2 formal complaints relating to the quality of care 1) Vacancies are reducing and will be further supported by overseas recruitment which will be phased between July-October 2014	1) Bank shifts often not filled and risk presented of staff not being familiar 4) Full review of dementia needs not completed. 4) Required dementia outreach not in place 4) Red incident reported 30/06/2014 - Unexpected Death (x-ray not ordered) - Datix: 123198 STEIS:2014/21489 4) Mixed FFT feedback from patients regarding negative and positive experiences.	1) Overseas recruitment phased between July - October 2014 4) RCA action plan to be implemented when completed	Oct-14 Sep-14	D2 GREEN	Sep-14	Yes
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	1) Additional Majors in place 2) Patients are transferred when beds are available 3) CDU in place 4) Escalation process in place to ensure appropriate action is takento prevent the delay of safe treatment for patients 5) Corridor nurses to attend patients on the corridor when required 6) Trends and numbers of patients are reviewed 7) Additional staffing authorised 8) Boundary & border change within WMAS	3) Utilisation of CDU has improved 1) to 8) Ambulance handover times maintained over winter period - December-August 2014.	6) Increase in attendences 2) Delays in patient transfer - linked to bed availability / bedflow / waiting to be transferred 1) to 7) Increase in numbers and utilisation of the Ambulance Offload Area 6) Extra pressures from Stafford Hospital impacting on service delivery 6) Increase in number of ambulances	7) To start rotation when AMU is fully established to support ED 7) To HF to allocate a 12.5 hour ambulance nurse 1) to 7) Build new ED 1) to 8) To start using the Rapid Assessment and Triage room 7) To increase the number of Band 2's and 5's (this should help with improved patient safety/experience)	Nov-14 Dec-15 Sep-14 Sep-14	D3 YELLOW	Sep-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	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. Not all 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	2) Paper based systems in use for recording which is reliant on staff to complete accurately 1) Pharmacy double check all prescriptions 3) Consultants cannot prescribe non-formulary drugs without approval via the Governance process. 4) Increased number of toxicity clinics to ensure Pharmacy are alerted immediately to any change in treatment 5) Review of printed prescriptions has commenced. 6) Business case scoping the requirement for e-prescribing system	3) CNS clinic schedule 2) Prescriptions available on the directorate intranet page 4) 5) Information on Somerset database 1) Sept 14 No incidents to date 1) Chemo MDT meeting minutes	4) Haematology prescriptions to be fully completed and added to the intranet . Member of staff on maternity leave 1) Delay in implementation due to the need to continue demonstrations to show that the systems can provide the correct needs for the directorate	1) Review following the demonstration on 23 Sept 14 4) Prescriptions not on the intranet to be hand written by the clinician using a blank prescription template	Oct-14 Oct-14	D2 GREEN	Sep-14	

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Medical Director	O4 943	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. 5)Audit of NICE guidance - 18 audits on plan for 13/14 6) Local / Executive Walkabout take place 7) Codes of clinical practice 8) Policy and procedure for chemotherapy prescribing and administration 9) Chemotherapy register for all staff prescribing Chemotherapy 10) RCA of incidents as required	4) External review by HAQU, no concerns raised (Nov 13) 3) National Cancer patient satisfaction survey 2013 3) Sept 14 No incidents reported to date and will continue to monitor	3) Final Panel hearing due when reports will be released. Date to be confirmed 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) Annual validation of nursing staff competence Introduction of e precribing	Jul-15 Nov-14	E3 YELLOW	Sep-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?
				11) Introduction of Formulary prescriptions as a result of previous incident. 12) CD reviews concerns as they are raised to decide whether full investigation is required.							
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	Sep-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 77% (August 14) 3) Training compliance for June 2014 is 99.2%	2) Compliance for reassessment within 24 hours is currently at 17% (August 14)	2) Weekly RAG report circulated to all clinical areas		D3 YELLOW	Sep-14	Yes

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Medical Director	O4 3486	Possible inappropriate oncological treatment of patients with colorectal cancer between 2007 and 2009. Challenge in to the conclusions of an audit taken into treatment of patients with colorectal cancer in 2009 has been made by a staff member using the Trusts whistleblowing policy. The risk declared relates to historical treatment requirements and negative outcomes to patients treated. Date of origin: 03/09/13 Date of escalation = 03/09/13	C4 AMBER	1) 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 2) External case note review into neoadjuvant treatment of patients with rectal cancer in 2007 and 2008 has been completed by 2 external oncologists. Report and its conclusions is awaited (expect late July 2014)	1) Await outcome of investigation	1) Await outcome of investigation	1) External Review planned April 2014 2) For external report to be reviewed by a panel of reviewers including external and internal representation to decide on 'next steps'	 Aug-14	C3 AMBER	Sep-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	Sep-14	Yes
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	1) Action plan developed and monitored - Sept 14 3) ICNet automates surveillance - Sept 14 2) Surveillance of all cases reported monthly to IPCG - Sept 14	1,2) Nil cases for June 14 -Sept14 1,2) No serious infections to date - Sept 14 1,2) Most recent contact screening negative - Sept 14	1) Lack of confirmation from Public Health England on a system to communicate between hospitals regionally - Sept 14 2) Unknown number of high risk patients entering the Trust -Sept 14 3) Some contacts (patients) refuse screening - Sept 14	1, Publicise action plan and associated information 1,2,3,DIPC leading on action plan - Attached existing action plan 1,Antibiotic Resistant Organism policy (IP03) to be revised as soon as consensus is reached on local / regional actions	Dec-14 Oct-14 Nov-14	C2 YELLOW	Sep-14	

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Nursing Officer	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 15/09/14 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	Sep-14 Sep-14 Oct-14 Oct-14	E1 GREEN	Sep-14	

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Nursing Officer	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) Latest CQC Intelligence monitoring report for July 14 identifies the trust as low risk. 2) Proposal paper for Quality review revisit being presented to QSAG in Sept. Pilot report to QSAG Dec 14, full programme of reviews from March 15. 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	D2 GREEN	Sep-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?
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	1,Monthly meetings to monitor the ILS contract Sept 14 2, Specification redesigned with requirement for infection prevention audit, training and policy Sept 14 3, Goals and Outcomes of poor performance period agreed Sept 14	1, Last audit reports completed in Q4 14/15 and circulated to ILS making clear recommendations July 14 1, IP improvements in decontamination process noted in 13/14 July 14.	1,Contract not signed for Infection Prevention support July 14 1, Goals and outcomes not monitored due to lack of access currently July 14 1,2,3, No regular visits July 14 1,2,3,No education delivered during Q1 of 14/15 due to contract not being signed - July 14 1,Current audit programme not funded as part of contract yet - July14	1, Await confirmation from WCC that contract is purchased to provide infection prevention support	Sep-14	D2 GREEN	Sep-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 , 3. 20% reduction in overspend over 18 months 1,2,3,4. No adverse incidents or complaints in interpreting reported	1,2,3,4. Monthly expenditure overspend 1,2,3,4. No evidence to support use of risk assessments by directorates when booking face to face interpreters	1,2,3,4. Monitor a sample of risk assessments used in high usage directorates 1,2,3,4. Review how the process is managed for face to face interpreting in high usage directorates and monitor expenditure monthly with directroate		C1 GREEN	Sep-14	Yes

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Nursing Officer	O8 535	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	2) PCR data for Clostridium difficile monitored monthly through IPCG Sept 14 14) Able to identify high risk areas for MRSA and develop action plan to reduce issues Sept 14 1) Monthly conversation of avoidability of Clostridum difficile numbers with CCG agreed Sept 14 6) MRSA Screening Policy in Trust audited annually Sept 14 9) Care home patients in community screened for MRSA in response to concerns indicated by CCG/Public Health/IP teams Sept 14 7) IV Team assist investigation on all device realted infection Sept 14 8) Surgical site infection surveillance monitored continuously Sept14 3) Toxin positive Clostridium difficle numbers reported to commissioners monthly Sept 14 10) Training plan to care homes in place with numbers collated quarerly Sept 14 11) Care home participate in infection prevention and control audit and education. Sept 14	1-6C diff below trajectory for year to date - Sept 2014 1-6PHE quarterly assurance shows the Trust performing to CDI objective Sept 2014 1-6Fidaxomicin used on first case of recurrance - Sept 14 6-12 Care home prevalence for MRSA below 2% for end Q4 13/14 - Sept 2014 6-12No avoidable MRSA bacteramia case year to date. Sept 14 6-12 Care home prevalence of MRSA below 2% at April 14 (Sept14) 1-6 Anti-microbial Prescribing Strategy in place Sept 14 1-14 ICNet NG in place to provide electroinic alertsSept 14 13,12 Reduction in HCAIs other than MRSA bacteraemia. (Sept 14)	6-12 National shortage in Mupirocin nasal ointment for MRSA decolonisation resulting in non-compliance with policy IP03. As an interim, Naseptin is being used as a substitute for decolonisation. This product requires a longer duration and the risk is non concordance with the potential for failure to decolonise. Sept 14 13 Catheter associated urinary tract infection surveillance not currently in place sept14 13, Urinary catheter process for removal in the community not consistently in place Sept14 6-12 MRSA screening data not automatically fed due to lack of HL7 feed Sept 14 1-6 Rising community cases of C difficile Sept 14	1-14 Support oncology directorate with action plans 1-6 Communicate faecal transplantation availability 1-6 Establish referral system for faecal transplant 1-14 Antimicrobial Stewardship Strategy in draft form, pending successful business case for additional Antimicrobial Stewardship support.	Jan-15 Jan-15 Jan-15 Nov-14	E4 AMBER	Sep-14	Yes

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				4) CDI Assurance process updated. Monthly reporting to IPCC on trends Sept 14 5) Action plan in place for Hygiene Code to be monitored by IPCG quarterly - Sept 14 12) Device reated bacteramia reported to IPCG monthly Sept 14 13) Urinary catheter policy audited six monthly Sept 14							
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	3) RAG rated tool to monitor compliance against Job Plans has been developed. 1) Job plans continue to be reviewed and sign off by DMD / MD- ongoing 2) Areas to be contained with SPA allocation have been agreed 4) Usage reports for medical bank	1) Job Planning Audit indicated a number of actions now addressed - Jun 14	1) Baker Tilly follow up report indicated not all job plans reviewed - Jun 14 4) Medical agency costs not reducing - July 2014.. 1) Slow progress in terms of Job Plan completion - Aug 2014	1) Trust to use pilot job planning module - associated with revalidation process 1) Develop streamlined Job Planning process - a joint communication to be issued by Chief Operating Officer and Medical Director. 1) Review of medical rotas with potential to introduce electronic rostering system.	Dec-14 Jan-15 Jan-15	C2 YELLOW	Sep-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?
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	1) Daily discharge meeting to review and agree actions aimed at improving discharges and relationships with social care and medical outliers 5) Trust reviewed structure for integrated working between health and social care (Dec 13) 4) Weekly monitoring of formal delayed transfers of care by CCG 3) Development of winter Plan for 14/15 identifies expectation on social care response. 2) Health Economy Winter Plan Surge Meetings throughout Winter. (14/15)	3) Integrated Health and Social Care Team commenced January 2014. 3) Health economy Winter plan for 14/15 has received formal sign off by Area Team - Sep 14 4) Reduction in patients waiting for continuing Healthcare Assessments - Sep 14 4) Yearly review of re-imbursement of funds 1) Delayed discharges reducing from April 2013 - Aug 2014. 1) Additional support for South Staffs Social Care approved December 2013.	1) Fluctuations in numbers of patient delays, especially Staffordshire and Walsall	4) Regular meetings with Senior Managers of South Staffordshire to discuss joint working. 3) Discussions with social care partners for 7 day services to commence in winter 2014/15	D2 GREEN	Sep-14	Yes
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	1) Communication plan to remind staff to ensure timely and appropriate admission onto PAS and other Trust Clinical systems - December 2013 2) Scoping review of business processes and staffing underway	1) Awareness has been raised. Detailed plan to resolve being formulated - complete March 2013 and ongoing 1) E-discharge rates are improving - Aug 2014	2) Further investigations carried out and this confirmed that some process redesign is necessary to achieve timely discharges on the system 1) Patients still entered retrospectively on PAS, especially after weekends.	2) Introduction of Safe Hands Project will assist with real time bed management. 2) Long term review of real time bed management and link to I.T. Strategy.	B3 AMBER	Sep-14	Yes

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	O4 3051	There are insufficient capacity (medical beds) for the volume of medical patients leading to outliers and the unplanned utilisation of additional unfunded beds. There are a number of risks in association to these: Risk of patient harm due to the lack of timely review by the appropriate medical team. Staffing pressures within ward areas with capacity beds that remain in use, as well as increased staff stress and levels of sickness. Also inappropriate nursing skill mix, resulting in inconsistent standards of care. Increased cost pressures due to continued/extended use of capacity beds outside of agreed timescale's. Potential adverse media attention due to the continued/extended use of capacity beds within the Division. Not achieving targets, standards, KPI's. Not achieving activity income Increased cancelled operations leading to poor patient experience. Reputational impact patients and external monitoring. Date of origin: 13/07/12 Date of escalation = 17/03/13	B3 AMBER	1) Additional beds opened in Nov 13 and May 14 11) Trust transformation projects focussed on elective and non-elective lengths of stay 2) Monthly scheduled CIP review meetings with Directorates 3) Utilisation of staff from base wds, flexible capacity team and bank staff 4) Revised Arrangement in place to ensure medical team review outliers by contacting the Consultant base ward and or medical secretary - October 2013 10) A&E targets monitored daily and reported to TMT and Trust Board Monthly 5) Ward A6 has 22 ringfenced 'elective' orthopaedic beds 6) Full review of planned waiting list undertaken. 9) Plans in place for additional winter capacity and funding 7) Proposal enhanced rates for bank nurse cover A5, A6, A7, A8, A12 and A14 agreed. 8) Detailed plan for overseas recruitment in place	9) Winter plan agreed - additional funding available 11) Increase efficiency and release resource through ambulatory care, enhanced recovery and surgical site surveillance e.g. day case rates 1) Reduction of cancelled operations throughout winter/spring 2014 1) Intergrated Team Manager in post 1) Reduction in the number of medical outliers	6) Increase in number of patients breaching 18 week referral to treatment time. July 2014. 7) Vacancies on ward 1) Increase bed pressure in Aug 14 11) Reports to Transformation group not yet demonstrated improvement in length of stay - Aug 14	4) Plan to introduce 7 day services for autumn/winter for medical specialities 4) Introduction of morning board rounds across wards 8) Additional overseas recruitment 1) Review staffing plan for Cardiac Cath Lab to consolidate temp staffing wte into base estalishment	Oct-14 Sep-14 Oct-14 Sep-14	D4 AMBER	Sep-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?
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	Sep-14	Yes

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Financial Officer	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	Sep-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	Sep-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	1) Representation on LETC to influence the decision making process 2) RWT costing group formed and worked on costing's for all tariff based education funding to ensure accurate data	1) Positive engagement with LETC and education funding by influencing business plan 2) RWT tariff costings data was as accurate as could be and most areas were not outside benchmarking	2) Medical Post graduate funding had outliers	2) All Post grad areas were re-challenged to approve outlier figures 2) Re-challenge data annually 2) Re-assess RWT education income when tariff known in 2015, and then determine if end result of costing exercise and tariff = higher or lower income for TWT education funding	C3 AMBER	Sep-14	Yes

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