The Royal Wolverhampton NHS Trust	

Trust Board Report

Meeting Date:	26th January 2015
Title:	Board Assurance Framework / Trust Risk Register
Executive Summary:	<u>BAF Key Issues</u> 1 Red Risk exists - The short term impact on the Trust of service sustainability at Mid Staffordshire NHSFT (3645). This risk has been transferred from the CEO's portfolio to the COO's. Risk 3352 – Potential for rapid growth of the Trust due to changes in the wider health and social care economy adversely impacting service stability. This risk was owned by the CEO, but has been merged into risk 1734 (If competition causes a significant shift in activity this will result in reduced income for the Trust). The owner of 1734 is the Director of Planning and Contracting. Risk 1501 – The Trust does not meet the DH / Monitor requirements to become a foundation trust. This risk has been transferred from the CEO's portfolio to the Chief Financial Officer's. <u>Trust Risk Register Issues</u> 1 red risk exists: • 514 - Failure to deliver recurrent efficiency gains and CIPs. Risks removed from Trust risk register (but still being managed on the respective directorate risk register): Risk 2828 - Quality of care on Ward A5- is being managed on Division 1's risk register as well as T&O's directorate risk register. Risk 494 – Midwifery Staffing - Was C4 and now is C2 Yellow. Now removed from Trust Risk Register. The risk is still being managed on Maternity's Directorate 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

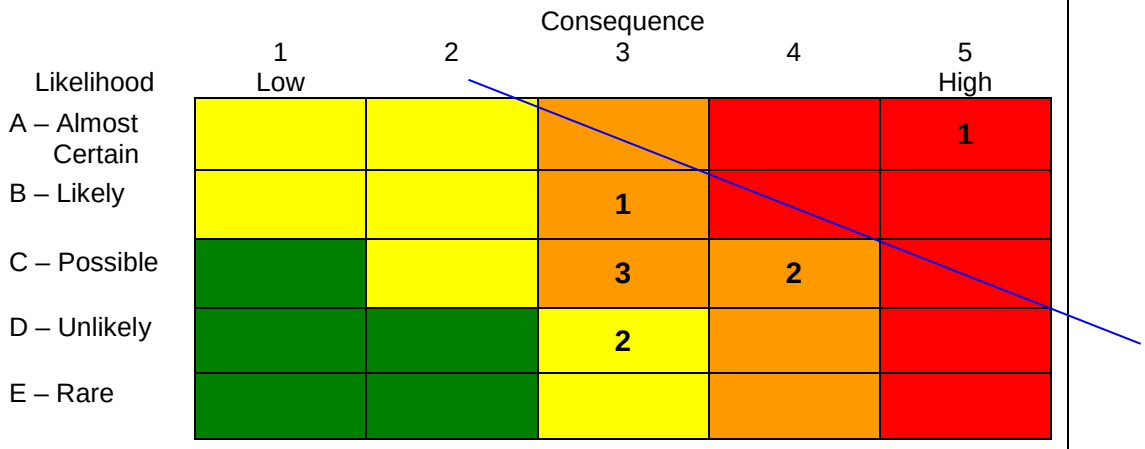
The Board Assurance Framework "provides organisations with a simple but comprehensive method for the effective and focused management of the principal risks that arise in meeting their objectives. It also provides a structure for the evidence to support the Statement on Internal Control" (Integrated Governance Handbook 2006: A handbook for executives and non-executives in healthcare organisations. Department of Health p15.).

Board Assurance Framework (Appendix A)

Following updates the split of the Assurance Framework is:

Risks currently being managed (on-going)	7
Risks managed to target level	2

There are currently 9 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	COO

Tracking the Board Assurance Framework

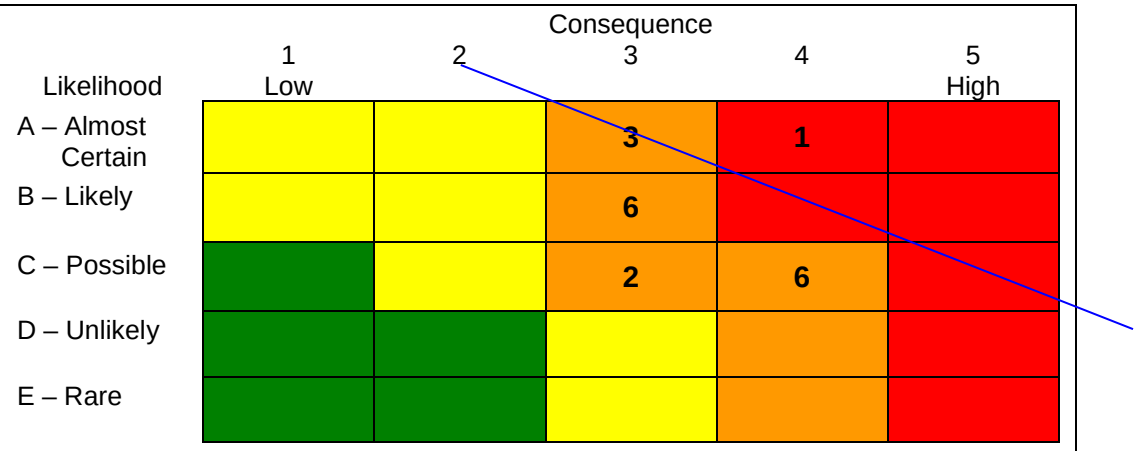
			Current Grade at the end of:			
Risk ID	Risk Title	Risk owner	Q1	Q2	Q3	Q4
2965	If the Trust fails to learn from and reduce Never Events, this will have an adverse impact including patient experience and choice, CQC/TDA/media interest, loss of public confidence etc.	CNO	C5	C5	C3	
3645	The short term impact on the Trust of service sustainability in Staffordshire	COO	A5	A5	A5	
1501	The Trust does not meet the DH / Monitor requirements to become a foundation trust.	CFO	C4	C4	C4	
3330	The long term impact on the Trust of the changes occurring at Mid Staffordshire NHSFT and within the Staffordshire health economy	CEO	C4	C4	C4	
2962	Risk of Health Visiting business/system/service failure due to multiple systemic failings.	COO	D3	D3	D3	
3354	Estates quality and flexibility compromise the ability to respond to fluctuation in demand and the implementation of streamlined clinical pathways.	CFO	D3	D3	C3	
2928	Impact of economic environment.	CFO	C3	C3	C3	
1734	Impact of competition to a significant shift of activity.	DP&C	D3	D3	D3	
2927	Failure to deliver against QIPP scheme resulting in lack of investment.	DP&C	B3	B3	B3	

Trust Risk Register – Updates (Appendix B)

Following updates the split of the Trust Risk Register is:

Risks currently being managed (on-going)	18
Risks managed to target level	0

There are currently 18 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

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

Strategic Objective	BAF				TRR			
	R	A	Y	G	R	A	Y	G
1) To provide our patients & staff with a safe environment.	1	3	1			11		
2) To be the employer of choice.						1		
3) To achieve a balance between demand & capacity of services						3		
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		2			1	2		
7) To be a high quality educator								
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								

Update from Nov 2014 QGAC

At the November 2014 QGAC, it was requested that more detail to be provided with regards to the executive summary provided in the Nov 2014 BAF/ TRR report. Here is a table below with the extra information:

Register	Risk ID	Risk Title	Current Status
BAF	2965	Failure to reduce Never Events	Now C3 Amber from C5 Red. No Never Events since July 2014 and positive WHO checklist scores on a constant basis.
BAF	3353	'Safeguarding' the Trust for the future	Requested for removal from BAF due to no prominent issues being identified. Discussion required whether to close outright or move to a local risk register.
TRR	3711	Failure to fully implement CPE toolkit	The current grading (C3 Amber)has fallen below the threshold required to sit on the TRR (Red, A3, B3 or C4)
TRR	3589	Failure of community equipment supply contractor to meet infection prevention/decontamination standards	The current grading (C3 Amber)has fallen below the threshold required to sit on the TRR (Red, A3, B3 or C4)
TRR	535	Failure of community equipment supply contractor to meet infection prevention/decontamination standards	The current grading (D4 Amber)has fallen below the threshold required to sit on the TRR (Red, A3, B3 or C4)
TRR	3843	Reduction of theatre capacity and subsequent financial impact due to lack of Anaesthetic Registrars	Now a D2 Green. Recruitment of staffing successful.
TRR	2626	Reduction in national and regional educational funding	Now C3 Amber. The present problem is not currently realised or presenting.
TRR	3494	Lack of interventional radiology rota for Black Country Vascular network	Now a D3 Yellow. No incidents reported and a stable arrangement in place to transfer patients to other services.

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 (January 2014)

Lead Director	Risk	Risk Title	Field updated	Update made
Chief Nursing Officer	3655 B3	If the Trust fails to learn from and reduce Never Events, this will have an adverse impact including patient experience and choice, CQC/TDA/media interest, loss of public confidence etc.		
			Positive Assurance – **updated with new scores**	Div 1 (Dec 14): - Compliance with the 5 steps to safer surgery is 100% for 688 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 100%
			Positive Assurance – **updated with new scores**	Div 2 (Dec 14): - Compliance with the use of the WHO Safety checklist is 99.6%. - Compliance with full completion of the WHO safety checklist agreed for procedures is 99.4%.
			Negative Assurance - **updated**	Div 2: -New intake of doctors/locums in ED not completed forms. - Accuracy remains an issue with Emergency Services. Slight fall in compliance this month due to intake of doctors and locum doctors. CD embedding compliance during induction process.
Chief Financial Officer	2929 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.		
			Further Mitigating Actions - **amended**	Discussions/negotiations commenced with CCG, to be part of year end discussions.
	1501 C4	The Trust does not meet the DH / Monitor requirements to become a foundation trust.		
			New risk inherited	Inherited from Chief Executive Officer's BAF
			Mitigating Actions in place - **New**	Monitor financial compliance for FT status.
Chief Executive Officer	3330 C4	Risk of adverse impact on the Trust following service transfer in Nov 14 and changes/uncertainties within the Staffordshire health economy		
			Risk title - **amended**	Previous title was: 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 - **New**	Monitoring of post Day 1 transformation planning/implementation through integration steering group and Executive Directors.
			Mitigating Actions in place - **New**	Monitoring of allocated budget from Stafford and Surrounds CCG.
			Positive Assurance - **New**	Service transfer risks would be monitored through directorate governance meetings, escalated to Operational Mobilisation group and then up to Integration Steering Group.
			Positive Assurance - **New**	TB approved transaction on 1st Nov 14 and subsequent service transfers based on a funding package for 29 months.
			Negative Evidence - **New**	Funding beyond 29 months is not yet established. Staffordshire and CCG (LHE) to identify.
			Further Mitigating Actions - **New**	Stafford LHE to establish working group/s to monitor KPMG recommended

				transformation workstreams.
	3352 B3	Potential for rapid growth of the Trust due to changes in the wider health and social care economy adversely impacting service stability.		
			Risk removed and merged into risk 1734.	The risk owner of 1734 is the Director of Planning and Contracting has asked for this risk to be merged. 1734 now incorporates all previous Mitigating Actions in place and Positive Assurances.
Director of Planning and Contracting	1734 D3	If competition causes a significant shift in activity this will result in reduced income for the Trust.		
			Mitigating Actions in place – **New (inherited from 1734)**	Horizon scanning for potential changes
			Mitigating Actions in place – **New (inherited from 1734)**	Build flexibility into operating systems.
			Mitigating Actions in place – **New (inherited from 1734)**	Review of healthcare tenders. Community and Local Authority platform to pre-empt changes / demand.
			Positive Assurance – **New (inherited from 1734)**	No unexpected/unplanned changes occur
			Positive Assurance – **New (inherited from 1734)**	Achievements of contractual obligations
			Positive Assurance – **New (inherited from 1734)**	No unknown developments or service changes
	2927 B3	Failure to deliver against QIPP scheme resulting in lack of investment.		
			Mitigating Actions in place - **New**	CCG and RWT forum established to share accurate financial positions of the two organisations.

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

Lead Director	Risk	Risk Title	Field updated	Update made
Chief Nursing Officer	3655 B3	Compromised functionality of Datix (v10.1) due to inability to upgrade to v12.3 (server issues)		
			Positive Assurance - **New**	Date of upgrade agreed - Jan 21
			Gaps in Assurance – **updated with new figure**	Duplication incidents remain high from directorates/wards (67 in Dec 14)
Chief Operating Officer	2828 C3	Quality of care on Ward A5		
			Risk Removed from Trust Risk Register	The risk is still being managed on Division 1's risk register as well as T&O's Directorate Risk Register.
	494 C2	Midwifery Staffing		
			Risk downgraded	Was C4 and now is C2 Yellow. Now removed from Trust Risk Register. The risk is still being managed on Maternity's Directorate Risk Register
Chief Financial Officer	2781 B3	Contractual risks due to tariff changes for emergency threshold.		
			Positive Controls - **amended**	Monitor negotiation with commissioners to ensure money re-invested back within the Trust. discussions with CCG in relation to year end position (Jan 15)
Medical Director	943 C4	Non-adherence to chemotherapy prescribing policy and procedures potentially resulting in poor patient experience/outcome		
			Risk title amended	Previous title: Non-adherence to chemotherapy prescribing policy and procedures potentially resulting in poor patient experience/ **confidence.**

The Royal Wolverhampton NHS Trust

Board Assurance Framework (incorporating strategic risks) - Nov 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	Date Identified	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.			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)	RAG status		Additional actions required to mitigate risk further (target grade date)	For each further mitigating action a completion date must be provided.	RAG status	
CNO	1	2965	If the Trust fails to learn from and reduce **Never Events**, this will have an adverse impact including patient experience and choice, CQC/TDA/media interest, loss of public confidence etc. Date of origin: 18/05/12 Date of escalation = 18/05/12	1	C5	Monthly WHO checklist audits in theatres and non theatre areas monitored at PSIG.	Mar-14	Div 1 (Dec 14): - Compliance with the 5 steps to safer surgery is 100% for 688 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 100%		C3				E2	Jan-15
								Div 2 (Dec 14): - Compliance with the use of the WHO Safety checklist is 99.6%. - Compliance with full completion of the WHO safety checklist agreed for procedures is 99.4%.	Div 2: -New intake of doctors/locums in ED not completed forms. - Accuracy remains an issue with Emergency Services. Slight fall in compliance this month due to intake of doctors and locum doctors. CD embedding compliance during induction process.			Clinical Director to embed compliance requirements with the new team.	30/01/2015		
								A marginal improvement on the 2013 audit results, with an average change of +0.3% (internal audit).							
						Monitoring of NE mitigation on Directorate risk registers.	Nov-14	All appropriate areas have a NE risk recorded (Nov 14)							
								All appropriate areas have identified applicable NE to their area (Nov 14)	One area needed to define controls to specific NE's each applicable NE (Nov 14)			Governance officers working with Directorate to identified specific controls to NE's and/or strengthen controls	28/02/2015		
								Large majority of risk actions are closed (Nov 14)	Open actions present in Respiratory, Obs & Gynae, H&N, (A&E and EMA new actions added) (Nov 14)			Directorates to follow up open actions at risk review. Feb 15	28/02/2015		
								Robust controls are identified in most areas. (Nov 14)	Work needed to strengthen controls in Dental, General Surgery and Cardiac. (Nov 14)						
									Other gaps in assurance relate to the occurrence of NE, Staffing A5, A6 and non compliance with policy/procedure/protocol (Nov 14)			Gaps addressed in each risk/incident RCA			
						Monitoring and assurance on completed actions and shared lessons following NE RCA.	Nov-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.

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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	Date Identified	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.			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)	RAG status		Additional actions required to mitigate risk further (target grade date)	For each further mitigating action a completion date must be provided.	RAG status	
COO	2	3645	The **short term impact** on the Trust of service sustainability in **Staffordshire** Date of Origin: 14/01/14 Date of Escalation: 14/01/14	1, 3	B4	Weekly review of position at either LTB or SSB	Jun-14	Contingent plans to provide interim support for ambulance diverts clinical protocols in place between UHNS/RWT/MSFT/TSA/WMAS	Continued fragility of MSFT services impact on RWT operational performance	A5	⇧		01/01/2015	B4	Nov-14
						Commissioner led review of contingent actions.	Jun-14	Clinical services remain stable with no adverse reporting				All transferring staff are moving to RWT policies and procedures	01/10/2014		
						Trust to Trust (and other providers/commissioner) discussions continue as part of service separation	Jun-14	Contingent plans are supporting safer services - review through Local Transition Board bi monthly, Sustaining Services Board - monthly				Working with Commissioners and primary care on demand management.			
CFO	3	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	D4	TDA performance monitoring and selfcertification process - monthly continual review of expected standards	Nov-14	Trust is at Level 4 - Standard Oversight (Oct 14) full complinace with Board/Provider Licence statements.		C4	⇧			D3	Jan-15
						Periodic updates with Monitor Assessment Team	Apr-14	Monitor letter deferring Trust - Oct 12.							
						Monitor financial compliance for FT status	Dec-14								
CEO	4	3330	Risk of **adverse impact** on the Trust **following service transfer** in Nov 14 and **changes/uncertainties within the Staffordshire health economy** Date of origin: 14/02/13 refined to include post day 1 challenges Dec 14 Date of escalation = 14/02/13	1, 3	C4	Monitoring of post Day 1 transformation planning/implementation through integration steering group and Executive Directors.	Jan-15	Service transfer risks would be monitored through directorate governance meetings, escalated to Operational Mobilisation group and then up to Integration Steering Group.		C4	⇨			E4	Jan-15
						Monitoring of allocated budget from Stafford and Surrounds CCG.	Jan-15	TB approved transaction on 1st Nov 14 and subsequent service transfers based on a funding package for 29 months.	Funding beyond 29 months is not yet established. Staffordshire and CCG (LHE) to identify.			Stafford LHE to establish working group/s to monitor KPMG recommended transformation workstreams.			

NOTES:
1. This is the grade of the initial risk identified (before mitigating actions)
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3. This is the level/grade that the risk is expected to be managed down to.

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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	Date Identified	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.			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)	RAG status		Additional actions required to mitigate risk further (target grade date)	For each further mitigating action a completion date must be provided.	RAG status	
COO	5	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	B4	Compliance against HCP/ Service spec indicators monitored and reported monthly.	Nov-14	CQC unnanounced inspection - all standards assessed were met	Not fully compliant with delivery of the service spec/HCP	D3				D2	Nov-14
									Some delays in moving to children centres due communinication issues and service reconfiguration						
						Ongoing recruitment and monitoring staff turnover.	Apr-14	Ongoing relocation of services into children centres	Behind on trajectory for recruitment. RAG rates with AT.		⇩				
								Professional Lead in post							
								More student Health Visitors taken on.							
						Reconfiguration of Health Visitor meetings to bimonthly (internal Chair) and external Performance Review meetings via LAT (external Chair).	Apr-14								
						Directorate and Division will monitor HR indicators, complaints and any concerns raised through Safeguarding Team.	Apr-14								
CFO	6	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	C3	Monitor programme for capital investment.	Nov-14	Board Development Session held 10 November setting out 5 year programme, strategic investment options and potential options to reduce funding gap.	Funding gap remains and will need further action to be identified and brought back to Board for agreement in January 2015.	C3		Identify potential external funding sources to close gap.		D3	Nov-14
						Monitor the establishment of an Interim refurbishment programme.	Nov-14	Proposal discussed at Trust Management Committee.	Refurbishment programme not fully agreed.			5 year Capital Programme to reflect refurbishment programme			
						Creation of a new Urgent and Emergency Care Centre. Ongoing reports to the Board as to progress.	Nov-14	Emergency Centre approved and now in build phase.			⇨				
						Monitor the development of Cannock Chase site as a centre of excellence for elective capacity. Regular reports to Board as to progress.	Nov-14	Original Acquisition Business Case approved by Board. Updated case being prepared for presentation to Finance Committee in December 2014				Work closely with TDA to ensure successful approval of the Acquisition Business Case.			

NOTES:
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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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Risk Owner	Number	Risk ref	Potential risk Description	Business plan objective	Initial risk score (see note 1)	Mitigating Actions in place	Date Identified	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.			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)	RAG status		Additional actions required to mitigate risk further (target grade date)	For each further mitigating action a completion date must be provided.	RAG status	
CFO	7	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	C3	Monitor CCG contract delivery and fines at Finance and Performance Committee monthly.	Nov-14	The Trust is overperforming against contract in most areas with the exceptions of critical care, obstetrics and cardiothoracic. Action is being taken with regard to disinvestment in Cardiac related services.	Trust has now received over-performance notices from Wolverhampton CCG and is incurring fines. Furthermore a letter has been received which details a number of proposed financial deductions.	C3	⇨	Discussions/negotiations commenced with CCG, to be part of year end discussions	Jan-15	C3	Jan-15
						Monitor the Business Plan for 2014/15 to deliver surpluses for re-investment.	Nov-14	Financial position of the Trust monitored monthly by Finance & Performance Committee and Board Reports.	The Trust is currently in deficit and the Cost Improvements Plans (CIPs) are behind original trajectories			Additional collaboration with other providers to reduce costs - ongoing. Escalation and performance management of CIP schemes.			
						Recovery plan proposals constructed to achieve year end planned surplus.	Nov-14	Monthly run rates in place in Divisons to achieve year end target.	Discussions with CCG on year end position have not been completed. Expect to finalise by end of Jan 15						
						Make bids for services that align to the Trust's strategy.	Nov-14	Trust has been shortlisted for 2 new tenders (Cancer and End of Life).				To identify market opportunities/bids - ongoing			
Dir P&C	8	1734	If competition causes a significant shift in activity this will result in reduced income for the Trust. Date of origin: 11/06/08 Date of escalation = 11/06/08	10	C3	Process established to monitor contracts finder and similar websites for future opportunities with a quarterly report to F&P Committee, TMC and TB.	Oct-14	All opportunities considered to be appropriate have been progressed to the expression of interest stage.		D3	⇩	Development of pipeline monitoring of business opportunities	Jun-15	D2	Jan-15
						Quarterly report to F&P Committee, TMC and TB on progress of tenders.	Nov-14	Report identifies all tenders submissions delivered within the required timeframe, appropriate operational and clinical engagement and sign-off and successes.				Development of training package to support operational staff in requirements of tendering process	Mar-15		
						Monitoring of internal procurement system to manage increased tender requirement.	Dec-14								
						Horizon scanning for potential changes	Nov-14	No unexpected/unplanned changes occur							
						Build flexibility into operating systems.	Apr-14	Achievements of contractual obligations							
						Review of healthcare tenders. Community and Local Authority platform to pre-empt changes / demand.	Nov-14	No unknown developments or service changes							

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) - Nov 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	Date Identified	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.			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)	RAG status		Additional actions required to mitigate risk further (target grade date)	For each further mitigating action a completion date must be provided.	RAG status	
Dir P&C	9	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	B3	Agreed a QIPP work programme for 2014/15 with commissioners, documented within contract through the Service Development Improvement Plan and monitored monthly through Contracting Commissioning Group.	Apr-14		RWT suggested QIPP Schemes not adopted by CCG	B3	⇨	Review of risk to QIPP programme in April 15 following contract negotiations for 15/16	Apr-15	B3	Jan-15
												Recording of contractual agreements and logging for inclusion in contract documentation	Mar-15		
						Monitoring of actions to support QIPP schemes managed through contracting and monitored monthly via Contracting & Commissioning Group	Apr-14								
						Maintain awareness of Commissioner finance position and pre-empt financial issues through contract negotiation process and outcomes (quarterly).	Oct-14		Accessibility of accurate finance position difficult to ascertain						
						Monitor MPB tracker via Contracting Team (monthly)	Nov-14								
						CCG and RWT forum established to share accurate financial positions of the two organisations.	Dec-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

Trust Risk Register

January-2015

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:		**To provide our patients & staff with a safe environment.**									
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. 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. 1) Annual review undertaken of Consultant cover and any issues which have arisen (January) 2) Dashboard reviewed monthly at the risk management/governance committee see minutes	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)	1) Monitor impact of MSFT services and potential for additional staff - ongoing 1) 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 2) Business case for additional resource to recruit 4 consultants in July 2014 being considered at Division. Approval in principle for 4 additional consultants. Rota and job plans being designed.	Dec-14	D3 YELLOW	Jan-15	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; Outcome 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 (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 (viiii) Student nurse placements on the ward on pause Date of origin: 24/06/13 Date of escalation: 18/02/14	B3 AMBER	3) Monitoring delivery of Training Needs Analysis for all members of staff on ward. 4) Assist in reducing the dependency on ward A7 by allocating males onto A7 and females onto A8 to become a mixed sex ward (Nov 14) 9) Falls champion identified 8) Substantive Band 6's recruited. Senior staff now fully established 5) Weekly meetings with Divisional Management Team to monitor (and escalate risks) 6) Ward performance indicators monitored to identify issues 2) Assess skill mix when planning rota to ensure required skills are available on each shift 1) Recruit to maintain establishment considering incentives (Nov 14) 7) Matron clinical on ward A7 7:30-10am Mon-Fri for daily observation, reinforces standard setting, ward organistion and management of resources to give quality assurance 10) Volunteers helping out during meal times 12) Out of hours practitioners to work on A7 for three evenings a week	2) Nursing staff pooled across Care of the Elderly to ensure safe staffing levels across all wards 7) Dementia outreach nurse to work on ward to provide bed side training on caring for patients with Dementia. 3) Practice Development team have agreed to reinstate their presence on ward and offer bed side training and education 1) Staff paid to substantive grade on bank when working on wards A7/8 1) Overseas nurses allocated. New starters in place.	3) Investigation of Norovirus has identifed poor IP practice 6) Ward performance indicators remain stable (down from Aug 14) 1) Difficulties covering vacancies with Bank staff 6) Increased numbers of staff related incidents	1) 2nd and 3rd year students returning on spoke placement 1) Advertise for a permanent band 6 PDN for Care of the Elderly only 1&2) Uplift from acuity business case agreed - need to recruit staff 1) Recurrent advert on NHS Jobs.	Mar-15 Dec-14 Jan-15	C2 YELLOW	Jan-15	

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; Outcome 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) Additional nursing support provided from other wards							
Chief Operating Officer	O4 840	The trust does not meet national guidelines for NNU and Paeds staffing levels leading to 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. Date of origin: 07/04/2005 Date of escalation = 11/12/2013	C4 AMBER	1) Recruit to the current vacancies in the service (Nov 14) 3) Sickness monitored and managed according to policy. 4) Recruitment & Retention groups being held in each of the areas. 5) Workforce Reviews completed for each area. 2) Monitor daily establishment and skill mix flex according to activity. Low staffing reported on daily escalation process (Nov 14)	2) Staff from NNU/Children's Ward/COPD to support the team when possible (suboptimal cover provided) 2) Finance available to employ nurses from Trust Bank 1) NNU: 2x Band 5 vacancies advertised in JAN 2015 1) Paeds: Band 6 recruitment taking place in JAN 2015. 1) Paeds: 10 additional Nurses to start between JAN 2015 - end of April 2015, 2x Band 2 awaiting clearance. 1) Robust recruitment in place from internal, external, and overseas sources 1) NNU: 8 additional Nurses to start between 19.01.2015 - end of FEB 2015 1) Trust & Local inductions in place to encourage staff retention	2) Experienced and skilled Paeds/NNU staff not always available from the Trust Nurse Bank. 2) Not always agreed staffing levels. 2) Lack of control re: patient numbers/dependency of babies.	1) Awaiting Business Case from Paediatric Workforce Review from Senior Managers 1) Recruitment phases in progress to recruit additional staff for Paeds and NNU 1) Awaiting financial uplift to recruit to agreed recommendations from Senior Managers.	Apr-15 Apr-15 Apr-15	D2 GREEN	Jan-15	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; Outcome 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	2905	Originally raised as Risk No 2078 (now closed). Lack of e-prescribing for chemotherapy: E prescribing for chemotherapy and wider inpatient and out patient prescribing not in place, risk of prescribing errors leading to dispensing and admin errors. Not all chemotherapy pre printed prescriptions have 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. Chemotherapy wastage due to changes in dose not being received by pharmacy. This would be elevated with the e prescribing system. Risk of not be able to code and claim funding for activity undertaken 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	1) Pharmacy to monitor all prescriptions (Nov 14) 3) Increased number of toxicity clinics to ensure Pharmacy are alerted immediately to any change in treatment 2) Use of pre-printed prescriptions are available on the Intranet 4) Monitoring of information recorded on Somerset Database for SACT	4) High level of completeness shown on SACTS compliance report 1) Oct 14 No incidents to date	2) Haematology Prescriptions are not yet available on the Intranet 2) Due to large amount of Information, data entry is time consuming and not all information is readily available 2) Not all pre-printed prescriptions have been reviewed resulting in amendments being made by hand	Await outcome from TMT	Feb-15	D2 GREEN	Jan-15	

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; Outcome 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	O1 2898	Risk to patient safety, experience, privacy, dignity and comfort due to patients having to wait in ambulance off load area to be seen in ED due to a lack of space Date of origin: 27 Feb 2012 Date of escalation: 25 Feb 2013	A3 AMBER	3) Daily monitoring process in place to ensure appropriate action is taken to prevent the delay of safe treatment for patients (Nov 14) 1) Increase capacity within A&E (Nov 14) 2) Monitor A&E targets (waiting times and ambulance handover times) (Nov 14) 4) Introduction of Rapid Assessment and Triage room (Nov 14)	1) Utilisation of CDU has improved 3) Increased staffing in ED (Ratio of 1 to 5 from 1 to 9) 3) Corridor now staffed 3) Increased consultant cover until 2:00am	2) Increase in fines in ambulance handovers (Nov 14) 2) Delays in patient transfer - linked to bed availability / bedflow / waiting to be transferred 3) High turnover of nursing staff 1) Increase in numbers and utilisation of the Ambulance Offload Area (average 11-12 patients per hour on the corridor, maximum of 21 patients) 3) Attempted suicide SUI Jan 15 1) Increase in number of ambulances - 161 in one day in Dec 14	3) To start rotation when AMU is fully established to support ED 3) Recruit nursing staff (in line with the agreed increased ratio of 1 to 5) 1) & 2) To facilitate development of a SOP for the corridor 1) to loan trolleys from company 1) To move 3 trolleys from CDU to the corridor and replace with beds 1) Review equipment 3) Implement Safe Hands in area 1) and 2) Build new ED 1) To implement a revised escalation policy. 1) To mark out bays for trolleys	Feb-15 Mar-15 Mar-15 Feb-15 Feb-15 Mar-15 Feb-15 Dec-15 Mar-15 Jan-15	D3 YELLOW	Jan-15	Yes
Medical Director	O4 943	Non-adherence to chemotherapy prescribing policy and procedures potentially resulting in poor patient experience/outcome.	C4 AMBER	3) Audit of Policy CP8 through peer review. 4) Audit against NICE guidance - 18 audits on plan for 13/14 1) Monitor adherence to chemotherapy polices (FM-CM20, P19 and C28) at the monthly Chemotherapy Prescribing MDT meeting (Nov 14) 1) Business case completed for e - prescribing 2) Monitoring of incidents (Nov 14)	4) External review by HAQU, no concerns raised (Nov 13) 2) Dec 14 - No incidents reported to date and will continue to monitor 1) Business case to completed and now in Trust process for approval	3) Concerns raised by staff members through formal and informal routes (2013)	4) Annual validation of nursing staff competence 1) Audit of FM-CM20, C29 and P19 to be undertaken 1) Introduction of e precribing	Jul-15 Apr-15 Mar-15	E3 YELLOW	Jan-15	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; Outcome 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?
Medical Director	O4 1862	Trust wide consent audits reveal failures within the Trust to follow a 2 stage consent process which could have a potential adverse impact on patient experience (leading to SUIs, complaints and litigation). Date of Origin: 08/07/08 Date of escalation = 06/03/13	C4 AMBER	1) Monitoring staff training on consent (Nov 14) 3) Monthly prospective clinical audit on delegated consent process and lists kept by all relevant directorates (Nov 14) 2) Annual Consent Policy Audit undertaken. 4) Monitoring incidents / complaints / claims involving consent (quarterly) (Nov 14)		4) Near miss incident - Ophthalmology Lucentis incident (June 14) 2) Non-compliance at two stage consent process (Audit July 2013)	2) Design new audit tool 1) Review consent training programme and compliance 2) Implement updated consent policy when approved 2) Re-design the consent forms (1,2 and 4)	Feb-15 Mar-15 Jan-15 Jan-15	E3 YELLOW	Jan-15	Yes
Medical Director	O4 3486	Risk of possible inappropriate oncological Neoadjuvant treatment of patients with rectal cancer between 2003 and 2009 leading to adverse patient experience (SUI's, complaints, litigation and media attention). Date of origin: 03/09/13 Date of escalation = 03/09/13	C4 AMBER	1) A formal external review into the allegations has been completed (Nov 14)			1) Reference panel established to review outcome of investigation in order to define and Action Plan		C3 AMBER	Jan-15	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; Outcome 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	3655	Risk of compromised functionality of Datix (v10.1) due to inability to upgrade to v12.3 (server issues) Risk impact includes: - data/auto processing malfunction - Lack of e-mail prompts to review/approve incidents. - Potential for missed or late reporting of SUI's penalised via fines. - Inadequate reporting functionality (due to dated datix templates). - Hinder roll out to Cannock due to additional users. Date of origin: 27/01/14 Date of escalation: 04/04/14	B3 AMBER	1) Implemented daily data quality checks of all incidents reported inc: reviewing datix for potential SUIs/PUs/Falls 2) Report sent to TVN Nurses for previous days incidents (G3/G4) 3) Monitor plan to upgrade to version 12.3 (Dec 14)	3) Test environment to be set up and tested 3) Bug fixed with email notification (Dec 14) 3) IT completed new server to facilitate DATIX 3) IT now corresponding directly with DATIX & BT to establish a test environment prior to full rollout of the upgrade 3) Date of upgrade agreed - Jan 21 3) ISP received from Datix (Nov 14)	1) 1 breach in SUI reporting within timescale (Cardiac - Oct 2014) 3) Email prompts to users not function correctly 3) No email following auto password reset 3) Duplication incidents remain high from directorates/wards (67 in Dec 14)	3) Implement upgrade 3) Roll out to all staff 1&3) Monitor all queries raised in relation to Datix	Jan-15 Jan-15	E1 GREEN	Jan-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; Outcome 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	3644	Failure to make an improvement in compliance gaps will impact the Trust's registration status with CQC. Date of origin: 14/01/14 Date of escalation = 14/01/14	C3 AMBER	1) Monitor IMR quarterly (Nov 2014) 5) Monitoring of staffing establishment (Nov 14) 6) Monitor CQC Action plan delivery (Nov 14) 2) Monitor recruitment plan (Nov 14) 3) Monitor monthly performance through the nursing midwifery KPIs for signs of deterioration (Nov 14) 4) Monitor capital funded environmental refurbishment in areas highlighted by the CQC requiring improvement	1) DCNO/HoNs/Governance have undertaken a review of areas inspected by the CQC (Nov 14) 1) A system of internal review is in development to run mini CQC audits 1) Latest CQC Intelligence monitoring report for July 14 identifies the trust as low risk. 2) 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. 2) 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. 3) Nursing and Midwifery KPIs moved to Health Assure reporting and emailed out to ward sisters/matrons and HoNs monthly. 4) Capital programme agreed refurbishment in Mortuary and Outpatients	5) Electronic Rostering demonstrates more work needs to be done on using e roster to fully to maximise staff resource 5) Sickness absence needs to be driven down to Trust average in all ward areas.	5) Identify absence above 3% and have plans in place to manage on each ward 5) Matrons are required to double approve rosters before being published. 3) Undertake the NTDA Patient Experience Framework at Board and then divisional level to determine what else Trust can do to improve patient experience 5) Monitor monthly staffing submitted on Unify to NHSE to check Trust achieves 95% fill rate for staffing planned versus actual	D2 GREEN	Nov-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; Outcome 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	O4 2680	Overspend on interpreting and translation budget could lead to inadequate funding and service to patients. Date of origin: 29/03/11 Date of escalation = 16/05/12	A3 AMBER	1) Audit risk assessments use when booking face to face interpreting (Nov 14) 2) KPIs in place to monitor monthly usage by department 3) Monitor interpreting provider who will manage the move to 20% less face to face interpreting usage in 10 months (Nov 14)	3) No adverse incidents or complaints in interpreting reported in Oct 14 (Nov 14)	2) Monthly expenditure overspend 1) No evidence to support use of risk assessments by directorates when booking face to face interpreters	1) Languageline to monitor a sample of risk assessments used in high usage directorates 1) Review how the process is managed for face to face interpreting in high usage directorates and monitor expenditure monthly with directorate 1) Telephones and posters advertising use of Language Line in place	Mar-15 Mar-15	C1 GREEN	Nov-14	Yes
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	Jan-15	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; Outcome 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Trust Objective:	**To achieve a balance between demand & capacity of services**										
Chief Operating Officer	O6 1714	Failure of other agencies to support discharge process resulting in delayed hospital discharge. Date of origin: 03/06/08 Date of escalation = 11/05/11	B3 AMBER	1) Daily discharge meeting to review and troubleshoot internal actions aimed at improving discharges (Nov 2014) 3) Weekly monitoring of formal delayed transfers of care by CCG 2) Monitoring of Winter Plan for 14/15 and expectation on social care response.	2) Integrated Health and Social Care Team commenced January 2014. 2) Health economy Winter plan for 14/15 has received formal sign off by Area Team - Sep 14 3) Reduction in patients waiting for continuing Healthcare Assessments - Sep 14 2) Yearly review of re-imbursement of funds 3) Delayed discharges reducing from April 2013 - Aug 2014.	3) Fluctuations in numbers of patient delays, especially Staffordshire and Walsall	3) Regular meetings with Senior Managers of South Staffordshire to discuss joint working. 2) Discussions with social care partners for 7 day services to commence in winter 2014/15 2) Additional support for South Staffs Social Care approved December 2013.		D2 GREEN	Jan-15	Yes
Chief Operating Officer	O19 2719	Lack of real time bed management and retrospective admissions on PAS can have a significant impact on electronic testing and potentially e-discharge systems leading to a potential impact on patient care/safety. Date of origin: 23/05/11 Date of escalation = 24/05/11	A3 AMBER	1) Monitoring of PAS update / use (monthly) (Nov 14)	1) Awareness has been raised. Detailed plan to resolve being formulated - complete March 2013 and ongoing	1) 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.	1) Introduction of Safe Hands Project will assist with real time bed management. 1) Long term review of real time bed management and link to I.T. Strategy. 1) Communication plan to remind staff to ensure timely and appropriate admission onto PAS and other Trust Clinical systems 1) Scoping review of business processes and staffing underway	Jan-15	B3 AMBER	Jan-15	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; Outcome 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 is 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 =	B3 AMBER	5) Trust transformation projects focussed on elective and non-elective lengths of stay 4) Monitor arrangement in place to ensure medical team review outliers by contacting the Consultant base ward and or medical secretary - October 2013 1) Increase bed capacity (Nov 14) 2) Budget / CIP review meeting (Nov 14) 6) Bed targets monitored daily and reported to TMT and Trust Board Monthly 3) Increase staffing to meet bed capacity (Nov 14) 6) Daily meetings instigated with Ward Sisters to improve delays in discharge	4) 7 day services introduced for most medical specialties 1) Utilisation of staff from base wds, flexible capacity team and bank staff 40 Div 2 - Patients who are outliers are being reviewed by their Drs 1) Winter plan agreed - additional funding available 1) 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. 4) 7 day services required in Care of the Elderly 3) Vacancies on ward 1) Increase bed pressure in Aug 14 5) Reports to Transformation group not yet demonstrated improvement in length of stay - Aug 14	4) Introduction of morning board rounds across wards 1) Ward A6 has 22 ringfenced 'elective' orthopaedic beds 1) Full review of planned waiting list undertaken. 1) Plans in place for additional winter capacity and funding	Dec-14	D4 AMBER	Jan-15	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; Outcome 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) Monitoring of CIP target via Transactional and Transformational schemes via monthly Operational Finance Group meeting (Jan 15) 2) Monitoring the Transformation Programme schemes (Jan 15) 3) Monitoring of finance report at Finance and Performance Committee (Jan 15)		1) Currently forecasting a shortfall in the CIP programme for 2014/15.	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	Jan-15	Yes
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	3) Monitor reserve set to offset potential risk exposure (Nov 14) 1) Monthly monitoring of actual performance against planned levels. 2) Monitor negotiation with commissioners to ensure money re-invested back within the Trust. discussions with CCG in relation to year end position (Jan 15)	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	Jan-15	Yes
Chief Financial Officer	O16 3176	Risk of commissioners inability to pay for activity over performance potentially leading to overspend / loss of income for the Trust. 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) Monitor escalation of actions at operational finance group and contracts commissioning group (Nov 14)	1) Negotiations are currently on-going		1) Escalate to Directors if unable to conclude successfully	B2 YELLOW	Nov-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; Outcome 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;