The Royal Wolverhampton NHS Trust	

Trust Board

Meeting Date:	30th January 2017
Title:	Board Assurance Framework / Trust Risk Register
Executive Summary:	<u>BAF Key Issues</u> **0 new risks.** **5 red risks**: **SR1** - Workforce - Recruitment and Retention of staff across the Trust and in particular the future pipeline of nursing and medical staff **SR4** - Risk of adverse impact on the Trust following service transfer in November 2014 due to underlying financial gap of £6million **SR8** - That there is a failure to deliver recurrent CIP's. **SR9** - That the deficit plan for 2016 is not achieved and the medium term financial plan fails to bring the Trust back to surplus. **SR10** - That the Trust fails to generate sufficient cash to pay for its commitments. <u>Trust Risk Register Key Issues</u> **3 new risks:** 4616 - Safeguarding Risk Due to a Backlog and Inadequate Filing of Antenatal Summary Tracer Cards (COO) 4696 - Unreported Imaging Studies (COO) 4650 - CICT Model change (COO) **3 risks removed:** 4545 - Demand Outstrips Capacity for MRI scanning (COO) 2781 - Contractual risks due to tariff changes for emergency threshold (CFO) 4581 - Fines for contract performance (CFO) **4 red risks:** 4161 - Shortage of Qualified Nurses across the Division (COO) 2080 - Risk to quality of patient care: reduced manpower (COO) 4661 - Lack of robust system for review and communication of test results (MD) 4472 - Delays in Cubicle Assessment and Triage (COO).

Action Requested:	To inform the Committee 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

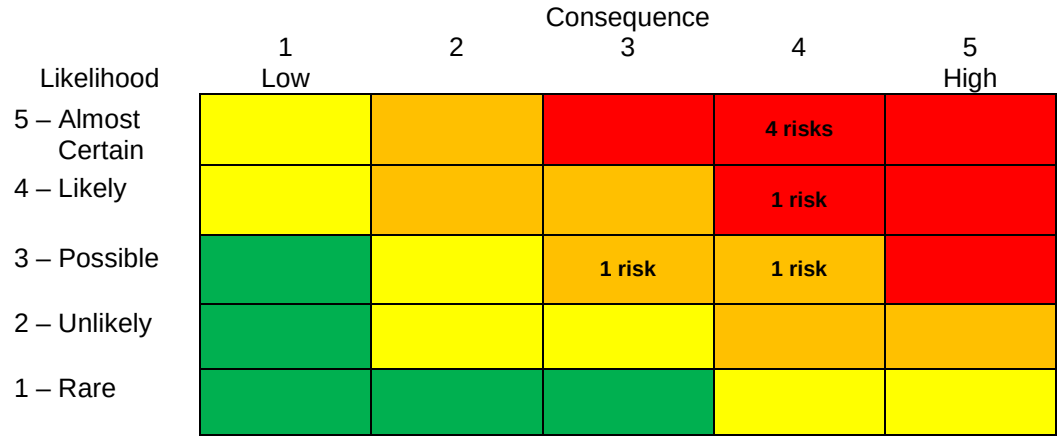
The Board Assurance Framework "provides organisations with a simple but comprehensive method for the effective and focused management of the principal risks that arise in meeting their objectives. It also provides a structure for the evidence to support the Statement on Internal Control" (Integrated 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	0

There are currently 7 risks contained within the Assurance Framework which are distributed across the Trust (5x5) 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	SR1	Workforce - Recruitment and Retention of staff across the Trust and in particular the future pipeline of nursing and medical staff	HRD
	SR4	Risk of adverse impact on the Trust following service transfer in November 2014 due to underlying financial gap of £6million	CFO
	SR8	That there is a failure to deliver recurrent CIP's	COO
	SR9	That financial balance (and surplus) is not achieved.	CFO
	SR10	That the Trust fails to generate sufficient cash to pay for its commitments	CFO

Trust Risk Register – Updates (Appendix B)

Following updates the split of the Trust Risk Register is:

Risks currently being managed (on-going)	29
Risks managed to target level	2

There are currently 31 risks contained within the Trust Register which are distributed across the Trust's (5x5) categorisation matrix as below:

Likelihood	Consequence 1 Low	2	3	4	5 High
5 – Almost Certain			**1 risk**	**1 risk**	
4 – Likely			**16 risks**	**2 risks**	
3 – Possible			**3 risks**	**5 risks**	
2 – Unlikely			**1 risk**		
1 – Rare			**1 risk**		**1 risk**

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	4161	Risk to patient safety and quality of care reduced staffing levels across the Division	COO
	2080	Risk to quality of patient care: reduced manpower	COO
	4661	Lack of robust system for review and communication of test results	MD
	4472	Delays in Cubicle Assessment and Triage	COO

The following illustrates how risks on the TRR are mapped against the strategic

objectives:

Strategic Objective	TRR			
	R	A	Y	G
1) Be in the top quartile for all performance indicators				
2) Proactively seek opportunities to develop our services				
3) To have an effective & well integrated organisation that operates efficiently		6		
4) Maintain financial health - appropriate investment enhancement to patient services		4		
5) Attract, retain & develop our staff & improve employee engagement	1	4		
6) Create a culture of compassion, safety & quality	3	10	2	1

Recommendation(s)

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

Appendix B: Tracking changes within Trust Risk Register (January 2017)

Lead Director	Risk	Risk Title	Field updated	Update made
Chief Nursing Officer	2680	Overspend on interpreting and translation budget could lead to inadequate funding and service to patients.		
			Positive Assurance - **Updated**	Dec - Dec 2016: No complaints received - Dec 2016
			Gap in Assurance - **Updated**	Year 2016/17 budget is £178.179. (£162.435) - Dec 2016
			Gap in Assurance - **New**	Evidence of failure of the Trust to cancel interpreter when the hospital appointments are cancelled
	535	If the Trust fails to achieve reductions in Healthcare Associated Infections then this will directly impact on the Trust's NHS reputation.		
			Risk downgraded to Yellow.	Back on trajectory for C diff for the last 4 months.
	3644	Failure to make an improvement in compliance gaps with CQC standards.		
			Positive Assurance - **New**	Submission of CHPPD data monthly. Dashboard available of Year benchmarking data.
			Action Plan - **New**	Information sharing events regards inspection for VI practices
			Action Plan - **New**	Complete QRV visits for all inpatient areas
Chief Operating Officer	4523	Failing Heater Cooler Units		
			Positive control - **New**	Patients are informed before every case of the risk.
			Positive Assurance - **New**	No patients have declined the procedure as a result of being open
	4466	Ward B8 Shower Improvements		
			Action Plan - **New**	Business case to be produced to fund improvements for the additional bathrooms that were not costed as part of the original business case
	4616	Safeguarding Risk Due to a Backlog and Inadequate Filing of Antenatal Summary Tracer Cards		
			New risk	There is currently a backlog of approximately 1000 Antenatal Tracer Cards (used by Community Midwives to document the initial vulnerability risk assessment for all pregnant women i.e., domestic violence/abuse) which are waiting to be filed within the main case-notes, dating back to 2014.
	4696	Unreported Imaging Studies		
			New risk	If non-urgent imaging studies are not reported within the timescale of 3 - 6 weeks, delays may have an impact on timely patient management. Ideally imaging should be reported as soon as they are undertaken but this is not possible given the national crisis of staff.

	4650	CICT Model change		
			New risk	If the cessation of the integrated Local Authority rehab assistant model within Community Integrated Care Team occurs on 21/11/16 there will be a reduction in rehab assistants to provide social care and therapy exercise programme for patients currently on the caseload and for patients referred to the service in the future.
	2080	Risk to quality of patient care: reduced manpower		
			Positive Assurance - **New**	Internal transfer pool introduced across the Trust as part of the retention strategy
			Positive Assurance – **New**	New matron recruited for ACS, awaiting start date
			Positive Assurance – **New**	Change to recruiting processes to speed up the process
			Positive Assurance - **New**	C15 have shown an improvement following implementation of action plan for special measures
			Gap in Assurance - **New**	57.46 wte trained nursing vacancies remain (36 jobs offered but staff not in post yet)
			Gap in Assurance - **New**	CHU risk (2780) escalated to 12 and incorporated in to this risk
			Gap in Assurance - **New**	ACS Matron - job recruited to, but not in post yet
	3256	Premises at West Park do not conform to professional standards for Audiology		
			Positive control - **New**	Business case developed and sent to Group Manager
	4528	Incomplete Health Records on Clinical Web Portal		
			Positive control - **New**	Process for both access to patient records as well as the process for when there is a need to have a complete patient scanned has been circulated by Patient Access
			Action Plan - **New**	Process for access to paper records be included in the updated version of the Health Records Policy
	4545	Demand Outstrips Capacity for MRI scanning		
			Risk downgraded to Yellow. **Removed from TRR.**	Now managed on departmental risk register.
	2898	Patients having to wait in ED in the Ambulance off load area		
			Positive control - **New**	ED attend daily escalation meeting and provide performance data (including number of ambulances/ patients requiring escalation etc.)
			Positive control - **New**	2 paediatric consultants due to start March 2017
			Gap in Assurance - **New**	Agreement in place to take 5 extra ambulances a day from County Hospital
	3069	Risk of Never Events within Division1: Risks to Patient Safety and Trust reputation		
			Gap in Assurance - **New**	4th NE in 16/17 reported to CCG - Theatres (retained foreign object) reported (Datix ID: 169339) occurred Dec 2016
	4161	Shortage of Qualified Nurses		

		across the Division	Positive control - **New**	Appointed to Nursing Associate posts - to start end of Jan 17
			Action Plan - **New**	Continue to ensure Matron attendance at both the Friday Morning Meetings and Friday 4pm Bed Meeting
	4308	Emergency Buzzer Security		
			Positive control - **New**	All nursing and medical staff are on high alert as aware of problems with emergency buzzers.
			Positive control - **New**	Business case has now been approved for Estates to ensure just one system in operation.
			Positive Assurance - **New**	Work in progress to amalgamate Emergency buzzer as one on A21
	4472	Delays in Cubicle Assessment and Triage		
			Positive control - **New**	Recruitment ongoing
			Positive Assurance - **New**	System upgrade for automatic trigger developed
Chief Finance Officer	2781	Contractual risks due to tariff changes for emergency threshold.		
			Risk closed	No longer a risk due to negotiated agreements on emergency threshold with Staffordshire CCGS and a year-end agreement with Wolverhampton CCG.
	4581	Fines for contract performance		
			Risk closed	Taken off register as NHS England proposed no fines in year-end forecasts and have confirmed in writing that they will not fine Trust.
	4583	Delivery of improvement trajectories		
			Gap in Assurance - **New**	1) Q3 forecast year-end now submitted which accepts Q3 &Q4 payments not achievable
			Target grade now RED	
	4584	Significant financial pressures in the NHS		
			Positive Assurance - **New**	3) M9 capital plan shows revised phasings and cash position now positive

The Royal Wolverhampton NHS Trust

Board Assurance Framework 2016/17

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

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

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

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

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

Potential/Actual origins impact level

The extent to which the origins of the risk currently impact on the strategic risk.

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

Controls

The extent to which the controls in place are satisfactory in impacting mitigation of the strategic risk.

- Effective control partially in place and thus only impacting in a limited way on the mitigation of the strategic risk.
- Effective control in place but only partially impacting on the mitigation of the strategic risk
- Effective control in place and positively impacting on the mitigation of the strategic risk.

Movement
The direction from last reported quarter

- Indicates improvement from last reported quarter
- Indicates same level from last reported quarter
- Indicates slippage or further required work from last reported quarter
- New item added since last quarter

ROYAL WOLVERHAMPTON NHS TRUST

BOARD ASSURANCE FRAMEWORK 2016/17 (JAN)

The Royal Wolverhampton NHS Trust

CORPORATE OBJECTIVES RISK MATRIX

			RISK SCORES: LIKELIHOOD x CONSEQUENCE = TOTAL							STRATEGIC OBJECTIVES					
REF	STRATEGIC RISK	ASSURANCE TO	INITIAL RISK SCORE	SCORE AT QUARTER 1	SCORE AT QUARTER 2	SCORE AT QUARTER 3	MOVEMENT Q3 TO Q4	SINCE LAST UPDATE	CURRENT RISK & SCORE AT QUARTER 4	Be in the top quartile for all performance indicators	Proactively seek opportunities to develop our services	To have an effective & well integrated organisation that operates efficiently	Maintain financial health - appropriate investment enhancement to patient services	Attract, retain & develop our staff & improve employee engagement	Create a culture of compassion, safety & quality
SR1	Workforce - Recruitment and Retention of staff across the Trust and in particular the future pipeline of nursing and medical staff.	Director of Human Resources and Organisational Development	15	15	20	20	→	→	20	✓	✓	✓		✓	✓
SR4	Risk of adverse impact on the Trust following service transfer in November 2014 due to underlying financial gap of £6million	Chief Financial Officer	12	8	12	16	→	→	16			✓			
SR6b	Black Country or Staffordshire STP has an adverse impact on RWT income or services	Director of Strategic Planning and Peformance	15	N/A	9	9	→	→	9				✓		
SR8	That there is a failure to deliver recurrent CIP's	Chief Operating Officer	20	20	20	20	→	→	20				✓		
SR9	That the deficit plan for 2016 is not achieved and the medium term financial plan fails to bring the Trust back to surplus.	Chief Financial Officer	15	15	20	20	→	→	20				✓		
SR10	That the Trust fails to generate sufficient cash to pay for its commitments	Chief Financial Officer	20	20	20	20	→	→	20				✓		
SR11	Condition of the existing Estate - Quality and flexibility	Chief Financial Officer	12	12	12	12	→	→	12				✓		

ASSURANCE FRAMEWORK

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

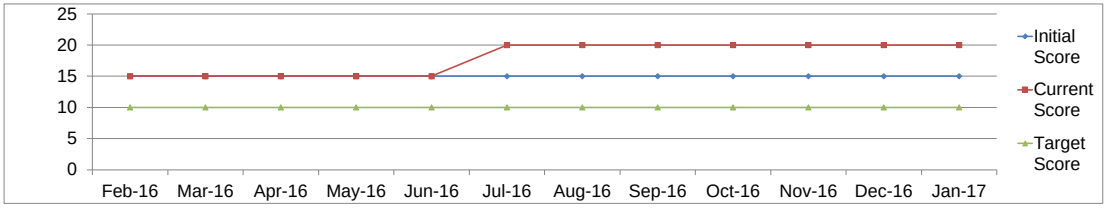
STRATEGIC (PRINCIPLE) RISKS	IMPACT x LIKELIHOOD = RISK SCORE					CURRENT ASSURED LEVEL	Movement
	INITIAL RISK SCORE	PREVIOUS QUARTER RISK SCORE	CURRENT RISK SCORE	TARGET RISK SCORE			
				Mar-16	Mar-17		
	5x3=15	3x5=15	4x5=20	5x2=10	5x2=10		

What is the strategic risk to be controlled?

REF	STRATEGIC RISK	EXECUTIVE DIRECTOR	BOARD COMMITTEE
SR 1 Date of origin - May 2015	Workforce - Recruitment and Retention of staff across the Trust and in particular the future pipeline of nursing and medical staff.	Director of Human Resources and Organisational Development	Finance and Performance

POTENTIAL IMPACTS / CONSEQUENCES OF THE RISK		IMPACT ON *CQC Domains (State Domain name)*	
REF	***What are the key potential consequences (up to 4) of the risk?***		**Indicate by X to those applicable**
PC 1	Potential over reliance on agency / locum resource which may lead to quality issues and may lead to the temporary medical workforce cost become unaffordable.	**Effective**	X
PC 2	Inability to deliver the future workforce plan with the potential that the Trust is unable to provide the level of service it is commissioned for and putting quality of patient experience and outcomes at risk.	**Response**	X
PC3	Ability to attract suitability qualified staff and retain them with the potential for costs involved in attracting and retaining staff becoming unaffordable.	**Well Led**	X
PC4	Potential for employee engagement indicators to decline (eg satisfaction, motivation) and for negative indicators (sickness, incidents greater than peer group upper quartile) which may lead to quality and cost issues.	**Effective**	X

REFERENCES TO KEY OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC RISK		IMPACT LEVEL	Movement
Potential or actual origins that have led to the risk ...	***What are the most significant origins (up to 10) which could or have led to the risk?***		
REF	**ORIGIN**	**RAG**	
O1	Reduction in the number of Doctors in Training coming through the deanery. There are recruitment gaps for some specialities increasing reliance on temporary workforce and locum, the market is highly competitive.		
O2	Lower interest medical training as a career - number of nurses leaving profession, increasing levels of voluntary turnover for Band 5 nurses in particular. Number of doctors in training leaving the profession before FY2 has increased nationally.		
O3	There is a national shortage of trained nurses and medics in the UK. The cost of attracting and retaining EU and non-EU staff is significant and the length of time from interview to start date is 6 months on average and up to a year for non-EU staff.		
O4	Competition from other NHS Providers - who may have stronger credentials in either Research and Development, benefits or workforce initiatives. Reduced staffing and impact on patient care and impact on remaining staff morale and satisfaction.		



Key Assurances received					
Report ref	**Controls**	**Positive assurance** **What is the report that provided assurance?**	**Date last assurance provided:**	**RAG**	**Comments**
C1	Overseas recruitment initiatives for Nursing and Medical Staff: - 5 European cohorts recruited over the last two years close work with HEWM - at Jan 2017 EEA workforce is 2.5% of the whole Trust workforce, continued monitoring of retention rates. - International recruitment campaign to the Philippines (November '15 and January '16) - continued montioring of converstion rates and agency contract. - For medical staff we mostly interview candidates via Skypem regularly engage recruitment/search and selection agencies to source UK and overseas doctors in addition to the standard recruitment routes within the UK. _ For medical staff the Trust has introduced a Clinical Fellowship programme to attract medics into the Trust.	1. Workforce Assurance Group - Resourcing and Medical Workforce Updates. 2. Executive HR Report to TMC and Trust Board. 3. Safer Staffing Updates in Chief Nurse Update report to TMC and Trust Board.	Monthly Report	Red	Length of time from interview to start date over 6 months. Currently only a small number of staff in post - discussion ongoing with NMC.
	Retention initiatives for Nursing and Medical Staff: - Approved Recruitment and Retention Strategy for Nursing 2016 - 2020 and governance process in place. - Work initiated through Medical Workforce Group to get a Recruitment and Retention Strategy for Medics and govenance process in place. - The 2016 Chatback survey specifically asks whether staff see themselves working at the Trust in a year's time - follow up work intiiated. - The findings of the National Staff Survey were followed up with further qualitative research to determine the impact on retention of staff satisfaction with worklife balance and on the workforce race equality standard reported outcomes.	1. Workforce Assurance Group - Resourcing and Medical Workforce Updates. 2. Nurse Steering Group reviews Nurse Recruitment and Retention Actions. 3. Medical Resourcing Group established to review Medical Recruitment and Retention Actions. 4. Executive HR report to TMC and Trust Board.	Monthly Report		
C2	Review of staffing establishment takes place through the annual workforce plan and this is reviewed regularly : - Nurse Recruitment team maintain a blueprint of nursing vacancies and placements. - Medical Recruitment maintain and report on medical staffing establishment and vacancy levels. - NHSI return of Workforce Plan submitted - scenario planning initiated supported by HEE. - Clinical Fellowship Programme established to assist with recruitment of posts at 'middle grade junior doctor level' and to provide a new career path for medical roles. - Trust Efficiency Progaramme has a workstream on workforce to plan efficiencies and controls for use of agency staff and sickness - E-rostering project group established to ensure staffing levels on wards are optimised - date for deployment for nursing resource secured - implementation February 2017.	1. Workforce Assurance Group - Resourcing and Medical Workforce Updates. 2. Executive HR Report to TMC and Trust Board. 3. Finance & Performance Committee 4. Update reports to Executive Directors through Director of HR and OD 5. Trust Efficiencey Programme Update.	Monthly Report	Amber	
C3	Strengthen employer credentials through rebranding exercise - i.e. build up a Recruitment and Retention Strategy that clearly highlights the benefits of working in the organisation and that has a clear plan for bringing in future pipelines. Retention of staff was explored in Chatback 2016 to establish steff intention to remain with the Trust. The Trust exit process has been reviewed and will be refreshed.	1. Workforce Assurance Group 2. Executive HR Report to TMC and Trust Board	Monthly Report	Amber	
C4	Strengthen Trust approach to employee engagement building on national and local survey data - understand variances in workforce groups.	1. Workforce Assurance Group 2. Executive HR Report to TMC and Trust Board	Monthly Report	Amber	
C5	Develop a strategic approach to People Management for the remaining period of the five year plan with clear metrics to measure outcomes. People and Organisation Development Strategy 2016-2020 goes to Trust Board in September 2016. The People and Organisation Development Strategy 2016-2020 was approved at Trust Board in Septe mber 2016.	1. People and Organisation Development Strategy 2016 - 2020. Measures and supporting metrics completed. Supporting Action Plans in Progress.	Completed	Amber	

The GAPS IN CONTROL / NEGATIVE ASSURANCES are …	**Jan 2017 Status:**
	Update received

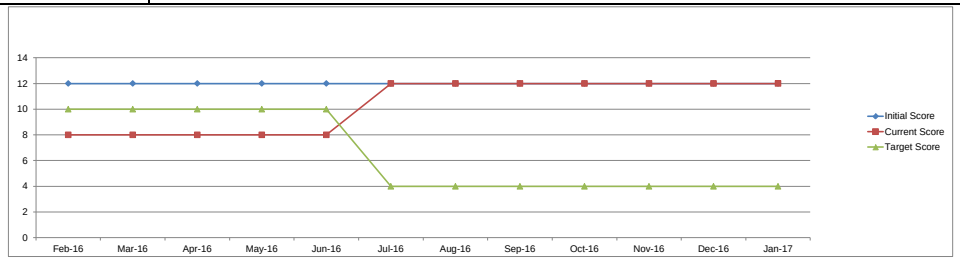
What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

REF	GAP (include reasoning for the gap described)	ACTION PLAN / COMMENTS	ACTION LEAD	AGREED DEADLINE
C1	There are concerns about the number of Filipino nurses that are actually able to complete the process of gaining IELTS, CBT and NMC registration and gaining a visa to travel to the UK and the lenght of time this process takes. **The Trust had 24 Philipinne nurses by the end of 2016.** There are concerns nationally about the ability to retain nursing and medical staff within the profession, particularly for doctors in training. The focus is on retaining and developing existing staff within the workforce and growing own talent internally. Further work on the retention strategy has taken place. The impact of the EU referendum on recruitment and retention of key staff groups has not been quantified yet, nationally or locally. The impact of changes to the Tier 2 Visa process have not yet been quantified and a decision has yet to be made on the financial sustainabiliyt of international recruitment.	There are regular monitoring meetings with the Recruitment Agency who have also been asked to provided potential start dates for each candidates to the Trust. **The Agency now provide provisional/aspirational start dates for candidates as part of their weekly reporting and this is also discussed at fortnightly meetings the International Director at the Agency.** Review meetings with Managing Director and Trust Executives are scheduled quarterly and took place in June and September 2016. **A further meeting is set for February 2017.** Discussions with NMC to highlight concerns about IELTS with provision of evidence of how a change in the rules in relation to the way pass rates are calculated would positively impact on the number of non-EU nurses passing and being able to gain entry to the UK and thereby work at the Trust. **Meeting took place on the 11th March 2016 and discussions were positive. The NMC representatives have been sent more information from the Trust. There has now been an amendment to the rules relating to IELTS - this will apply retrospectively and will increase the candidates available to proceed with their application to the NMC.** **A Nurse Recruitment and Retention Strategy with action plan has been approved and will now be made available on the Trust intranet from February 2017.**	CG/SA LH/CE CG	Jan-17
C2	Longer term plans to establish a central temporary staffing function that handles internal bank and external agency placement requests for all departments requires investment in systems to support. Exploratory meetings with providers have been scheduled - to complete by March 2017. Further work is required to balance safe staffing provision and compliance with agency cap.	For medical locums, this is in line with the implementation of the new Locum Management Framework and System live in March 2016. There have been a number of measures put in place since the last BAF update to improve and increase the visibility of the issues the Trust is facing regarding medical resourcing. These include 1) Doctors in Training Contract Implementation Group 2) Medical Workforce Group (established to provide a strategic approach to recruitment and retention of medics 3) Project Initiation Document to ensure effective use of locum and agency use across Trust (including medics) was approved in October 2016 and has a project plan defined to bring the Trust close to Agency Cap by 2018. All controls and measures are based on a collaborative cross-Trust approach to mitigating workforce risks.	SA	March 2017 March 2017
C3	The strategy for recruitment and retention is in development and the metrics for measuring outcomes are being developed to support the effective delivery of the action plan.	Metrics defined for measuring the effectiveness of the Strategy were approved at Trust Board during September. Plan to be monitored at Nurse R&R Steering Group. The group has approved the Strategy - Policy Group ratified the strategy in January 2016. Strategic Recruitment and Retention Plan for Medical staffing to be developed by the Medical Workforce Steering Group. The annual workforce planning process took a targetted approach to identifying key workforce recruitment and retention issues across the Trust used scenario planning to identify future workforce requirements over two year planning period. The plan met validation via NHSI portal including the narrative.	CG	26/09/2016 Completed
C4	Emergency Department remains a particular concern. Strengthen controls over agency and locum use and develop a planned approach to temporary staffing: - review compliance and spend levels against cap levels - Review effectiveness of controls systems (ie business process, IT, monitoring) - Review the operation and effectiveness of internal bank	The Trust Efficiency Programme has a workstream on Workforce which is planning efficiencies around resourcing including locum, agency and bank spend. The PID was approved in October 2016 and the project plan for delivery is progressing.	CG/SA LH/CG	Oct-16
C5	The People and Organisation Development Strategy 2016-2020 needs strengthening with outcomes, measures and metrics. The outcomes on Engagement and Culture and Organisation Development require further definition and action planning in order to ensure action to improve employee engagement, involvment and satisfaction are reflected in improved retention figures, increased tenure and improved patient experience within the Trust.	Several meetings have taken place to define the detailed actions, the work was completed by 31st August 2016. The strategy was received and approved at TMC and Trust Board during September, and following some final updates will be launched during February 2017. Policy Group received the People and OD Strategy in January 2017 and will formally ratify the Strategy in February 2017.	CG	Completed Sept-16

ASSURANCE FRAMEWORK							
Strategic Objective: To have an effective & well integrated organisation that operates efficiently							
STRATEGIC (PRINCIPLE) RISKS	**LIKELIHOOD x CONSEQUENCE = RISK SCORE**					**CURRENT ASSURED LEVEL**	***Movement***
	INITIAL RISK SCORE	**PREVIOUS QUARTER**	**CURRENT RISK SCORE**	**TARGET RISK SCORE** Jan-17	Mar-17		
	3x4=12	4x4=16	4x4=16	2x2=4	2x2=4		
What is the strategic risk to be controlled?							
REF	**STRATEGIC RISK**		**EXECUTIVE DIRECTOR**	**BOARD COMMITTEE**			
SR4 Date of origin - March 2015	Risk of adverse impact on the Trust following service transfer in November 2014 due to underlying financial gap of £6million		Chief Financial Officer	Finance and Performance		**4 x 4 = 16**	

POTENTIAL IMPACTS / CONSEQUENCES OF THE RISK		**IMPACT ON *CQC Domains (State Domain name)***	
REF	***What are the key potential consequences (up to 4) of the risk?***		**Indicate by X to those applicable**
PC 1	Inability to maintain Quality and Safety	**Safe**	X
PC 2	Inability to deliver operational and commissioner targets	**Caring**	X
PC 3	Inability to meet 18 week RTT	**Effective**	X
PC 4	STP may not deliver the financial surpluses to resolve the underlying financial affordability gap.	**Response**	X
		Well Led	

REFERENCES TO KEY OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC RISK		**IMPACT LEVEL**	***Movement***
Potential or actual origins that have led to the risk …	***What are the most significant origins (up to 10) which could or have led to the risk?***		
REF	**ORIGIN**	**RAG**	
O1	Disaggregation of Mid-Staffordshire NHS Foundation Trust on 1.11.14 and transfer of services to RWT on the basis of the Trust Special Administrator Recommendations.		
O2	Failure to identify and deliver savings, efficiencies or additional income to ensure the transaction is sustainable on an going basis.		



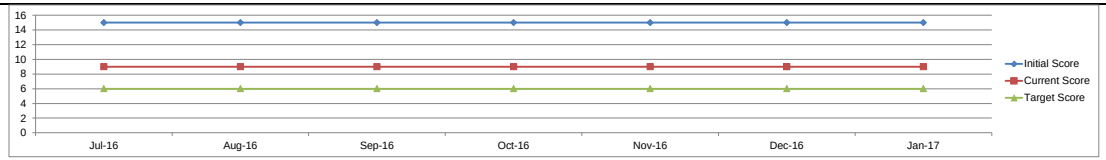
Key Assurances received					
Report ref	Controls	Positive assurance What is the report that provided assurance?	Date last assurance provided:	RAG	Comments
C1	Monitoring of the financial position through activity and income to Finance and Performance	Trust Board finance report and supplementary reports	Aug-16		On-going - supplementary report now circulated to all Board Members.
C2	Transformation report on theatres and in particular efficiency opportunities at Cannock	TPEG reports through to TMC	Sep-16		On-going reporting in place
C3	Updates on Sustainability and Transformation Plans	Reports to Finance and Performance on underlying financial contribution to £6m service deficit.	Sep-16		Service Line Reporting taken to F&P for regular updates.
C4	Full benefits realisation of MSFT transaction to be detailed.	Report to Finance and Performance and then to Trust Board	Apr-17		Due April 2017

The GAPS IN CONTROL / NEGATIVE ASSURANCES are …					Jan 2017 Status:
					Update received
What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?					
REF	GAP (include reasoning for the gap described)	ACTION PLAN	ACTION LEAD	AGREED DEADLINE	
	Funding beyond 29 months (8 months to go) is not yet established. Staffordshire CCG (LHE) to identify	STPs have now replaced the Transformation Board and the £6million underlying financial gap for the transferring services is part of the financial challenge for the Staffordshire/Stoke Sustainability and Transformation footprint. Regular attendance to influence the aims and deliverability of the plans is crucial to the successful mitigation of this risk.	Mike Sharon	On-going	On-going
	Activity levels at Cannock Chase Hospital still not at full implementation model. (Anaesthetic/recovery restraints)	Paper to Trust and Finance & Performance Committee detailing current levels of achievement.	Sultan Mahmud/ Gwen Nuttall	Dec-16	Report to F&P in January 2017
	Given the lack of Progress within the Staffordshire STP - The Trust will be formally raising this through the Control Total Process with NHS Improvement.	Trust flagged expected continuation of MSFT funding for a further 2 years in its financial and written submission to NHS Improvement in December 2016.	Kevin Stringer	Dec-16	Deadline achieved - awaiting response from NHS Improvement

ASSURANCE FRAMEWORK							
Strategic Objective: Maintain financial health - appropriate investment enhancement to patient services							
STRATEGIC (PRINCIPLE) RISKS	**IMPACT x LIKELIHOOD = RISK SCORE**					**CURRENT ASSURED LEVEL**	***Movement***
	INITIAL RISK SCORE	**PREVIOUS QUARTER RISK SCORE**	**CURRENT RISK SCORE**	**TARGET RISK SCORE** Mar-16	Mar-17		
	15	n/a	9	0	6		
What is the strategic risk to be controlled?							
REF	**STRATEGIC RISK**		**EXECUTIVE DIRECTOR**	**BOARD COMMITTEE**			
SR6b Date of origin - July 2016	Black Country or Staffordshire STP has an adverse impact on RWT income or services		Director of Strategic Planning & Performance	Finance and Performance			

POTENTIAL IMPACTS / CONSEQUENCES OF THE RISK		**IMPACT ON *CQC Domains (State Domain name)***	
REF	***What are the key potential consequences (up to 4) of the risk?***		
PC 1	This will result in reduced income for the Trust.	**Safe**	
PC 2	Commissioners may decomission services	**Caring**	
		Effective	X
		Response	
		Well Led	

REFERENCES TO KEY OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC RISK		**IMPACT LEVEL**	***Movement***
Potential or actual origins that have led to the risk …	***What are the most significant origins (up to 10) which could or have led to the risk?***		
REF	**ORIGIN**	**RAG**	
O1	All Trusts are required to partcipate in Strategic trnasformation Programmes		
2			



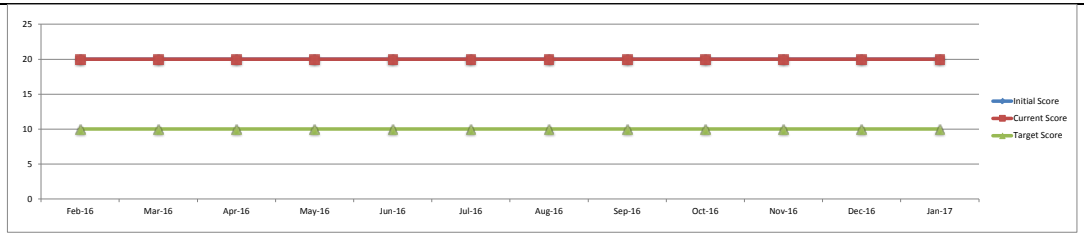
Key Assurances received					
Report ref	Controls	Positive assurance What is the report that provided assurance?	Date last assurance provided:	RAG	Comments
C1	Current STP submissions have not identified any adverse impact on the Trust	Report to F&P	Sep-16		
C2	RWT Directors are fully involved in development of Black Country STP and laregely involved in Staffordshire STP	Report to F&P	Sep-16		
C3	Further STP submission due on 21 October, draft for comment expected on 18th October	Report to F&P	Oct-16		
C4	Clinical and manageriual staff engaged in orthopaedics and ophthalmology workstreams and estates director invoivled in estates workstream	Report to F&P	Oct-16		
C5	Black Country STP to be published on 21 November	Report to Board	Nov-16		
C6	Stafforshire STP published in December	Report to F&P	Jan-17		

The GAPS IN CONTROL / NEGATIVE ASSURANCES are …					Jan 2017 status:
					Update Received
What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?					
REF	GAP (include reasoning for the gap described)	ACTION PLAN	ACTION LEAD	AGREED DEADLINE	
NA1	Need to strengthen Staffordshire engagement	Ensure engagement of clinical teams in planned care workstream and strengthen relationship with Staffordshire commissioners and GPs	Director of Strategic Planning & Performance	Jul-16	
NA2					

ASSURANCE FRAMEWORK								
Strategic Objective: To maintain the financial health of the organisation and seek appropriate investment opportunities that enable further enhancement of patient services								
STRATEGIC (PRINCIPLE) RISKS	**IMPACT x LIKELIHOOD = RISK SCORE**					**CURRENT ASSURED LEVEL**	***Movement***
	INITIAL RISK SCORE	**PREVIOUS QUARTER RISK SCORE**	**CURRENT RISK SCORE**	**TARGET RISK SCORE**			
				Jun-16	Mar-17		
	4x5=20	4x5=20	4x5=20	4x4=16	4x3=12		
What is the strategic risk to be controlled?							
REF	**STRATEGIC RISK**		**EXECUTIVE DIRECTOR**	**BOARD COMMITTEE**			
SR8 Date of origin - June 15	That there is a failure to deliver recurrent CIP's		Chief Operating Officer	Finance & Performance Committee		**4 x5 = 20**	

POTENTIAL IMPACTS / CONSEQUENCES OF THE RISK		**IMPACT ON *CQC Domains (State Domain name)***	
REF	***What are the key potential consequences (up to 4) of the risk?***		**Indicate by X to those**
PC 1	Inability to meet financial targets	**Safe**	X
PC 2	Inability to invest in services due to lack of funds	**Caring**	X
PC3	|Reputational risk to organisation	**Effective**	X
PC4	Trust is placed in financial special measures.	**Response**	X
		Well Led	X

REFERENCES TO KEY OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC RISK		**IMPACT LEVEL**	***Movement***
Potential or actual origins that have led to the risk …	***What are the most significant origins (up to 10) which could or have led to the risk?***		
REF	**ORIGIN**	**RAG**	
O1	Efficiency targets within tariff requiring release of CIP.	RED	
O2	Continuing CIP targets with reduced ability to make efficiences.	RED	
O3	Workforce challenges (recruitment) resulting in failure to achieve savings	RED	
O4	Failure to deliver on some identified schemes of slippage ie procurement	RED	
O5	Failure to identify recurring CIP schemes	RED	
O6	Slippage in appointment of transformation team to assist with CIP delivery	RED	
O7	Additional CIP required as a result of signing up to the strategic transformation fund (STF)	RED	



Key Assurances received					
Report ref	**Controls**	**Positive assurance** **What is the report that provided assurance?**	**Date last assurance provided:**	**RAG**	**Comments**
C1	Monitoring of CIP target at monthly Transformational Programme Efficiency Group (TPEG).	workshops (Oct) will be worked up (PID) and reviewed. Oct/Nov for inclusion. Workforce group has PID for sickness/rostering and agency spend - agreed Oct.	Dec-16	AMBER	However, the CIP target is phased into the latter part of the year
C2	Use of transformational schemes via benchmarking to assist in CIP efficiencies	CIP schemes continue to be identified (mainly non recurrent). PIDs agreed by Directors and PSIG.	Dec-16	AMBER	Mainly non-recurrent
C3	Monitoring of CIP achievement against target at monthly FRB	Small CIP continuing to be identified	Oct-16	RED	underachievement
C4	Carter efficiency team identified savings	CIP report in April indentified cardiology & rheumatology for first Carter efficiencies	Nov-16	RED	Schemes moved into 16/17
C5	Appointment of Deloittes to assist with CIP delivery	Deloittes onsite (June 16) Focus, Theatres, outpatients & management of transformation team. Revised report present to October F&P Committee. FRP developed - actions commenced formal sign off. Nov F&P and Board.	Oct-16	RED	contract-extended until Mar 17
C6	Turst to implement financial recovery group - led by CEO - (FRG)	FRG will be established, meeting bi-weekly. Will review major CIP scemes. Implement further measures re vacancies, procurement, management of bank/agency.	01/11/2016	AMBER	1st meeting 23/11/16
	Financial recovery plan developed.	Presented to Trust Board & NHSI	01/11/2016	RED	Recovery plan still has gaps

The GAPS IN CONTROL / NEGATIVE ASSURANCES are ...	**Jan 2017 Status:**
	Update received

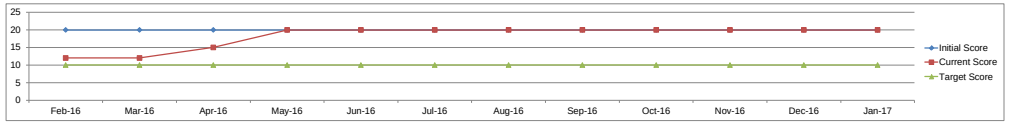
What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

REF	**GAP (include reasoning for the gap described)**	**ACTION PLAN**	**ACTION LEAD**	**AGREED DEADLINE**
NA1	There remains a transformational CIP target with no plans for achievement.	Being reviewed via the Transformation Steering Group. Additional actions following the workshops in Oct have been added. Most of these have been costed.	Head of Transformation	Dec-16
NA2	There is a shortfall against recurrent CIP achievement	Being reviewed via the Transformation Steering Group. All groups in FRB have an action plan for delivery.	Head of Transformation	Mar-17
NA3	Carter efficiencies are not yet confirmed	Continuing work to 'realise' what has been identified and assertain potential savings. Work is on-going	Finance Director	On-going roll out programme
NA4	Failure to appoint to Transformation Lead post	Re-advertise November 16. Continue with Deloittes.	Director of Strategy	Feb-17
NA5	Unidentified CIP for 16/17	All Trust members to identify CIP when possible - Link to NA1	ALL (COO)	On-going
NA6	Additional CIP required as a result of STF	As above - Link to NA 1	ALL (COO)	On-going
NA7	Product lines standardised by procurement	Catalogue lines reduced	Director of Finance (procurement)	01/01/2017
NA8	Agency Spend variance from control total	Focus on reduction in agency spend, medical i.e. clinical fellowship, recruitment. Non-medical appointment to post	Chief Operating Officer	April 17 - on-going

ASSURANCE FRAMEWORK								
Strategic Objective: To maintain the financial health of the organisation and seek appropriate investment opportunities that enable further enhancement of patient services								
STRATEGIC (PRINCIPLE) RISKS	**IMPACT x LIKELIHOOD = RISK SCORE**					**CURRENT ASSURED LEVEL**	***Movement***
	INITIAL RISK SCORE	**PREVIOUS QUARTER RISK SCORE**	**CURRENT RISK SCORE**	**TARGET RISK SCORE**			
				Jan-16	Mar-17		
	5x3=15	5x4 = 20	5x4 = 20	5x3=15	5x2=10		
What is the strategic risk to be controlled?							
REF	**STRATEGIC RISK**		**EXECUTIVE DIRECTOR**	**BOARD COMMITTEE**			
SR9 Date of origin - June 15	That the deficit plan for 2016 is not achieved and the medium term financial plan fails to bring the Trust back to surplus.		Chief Financial Officer	Finance and Performance Committee		**5 x 4 = 20**	

POTENTIAL IMPACTS / CONSEQUENCES OF THE RISK		**IMPACT ON *CQC Domains (State Domain name)***	
REF	***What are the key potential consequences (up to 4) of the risk?***		**Indicate by X to those**
PC1	That the Trust will be placed into recovery and turnaround by NHSI	**Safe**	x
PC2	The Trust could have to apply for a working capital loan to the Independent trust Financing Facility for working capital/financing support/capital loans as a result of the deficit plan. This could place onerous conditions on the Board in receiving this.	**Caring**	x
PC3	That the Trust is judged as not sustainable	**Effective**	X
		Response	x
		Well Led	X

REFERENCES TO KEY OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC RISK		**IMPACT LEVEL**	***Movement***
Potential or actual origins that have led to the risk …	***What are the most significant origins (up to 10) which could or have led to the risk?***		
REF	**ORIGIN**	**RAG**	
O1	Lack of fully detailed Recurrent Cost/Efficiency Improvement Programme in 2016/17	5x4 = 20	



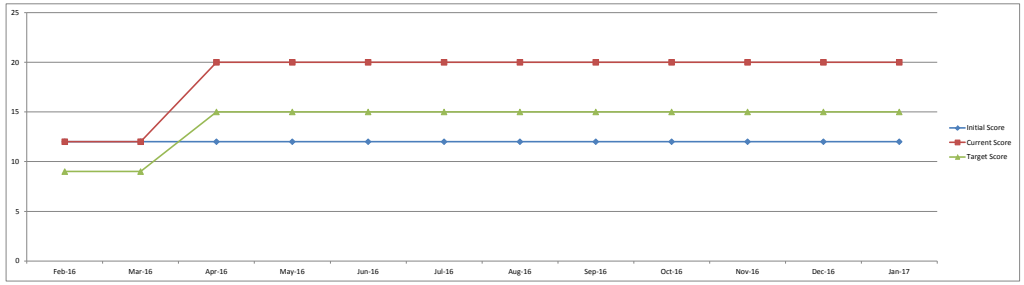
Key Assurances received					
Report ref	Controls	Positive assurance What is the report that provided assurance?	Date last assurance provided:	RAG	Comments
C1	Further detailed Efficiency/Productivity plans from Divisions and Departments	Finance and Performance TPEG report	Monthly reporting		Monthly
C2	Detailed plans to deliver to contracted levels of activity	Finance and Performance report on activity and income from Divisions	Monthly reporting		Monthly
C3	On-going identification and delivery of Carter initiatives on staffing, estates, procurement and pharmacy/medicines.	Finance and Performance TPEG report	Monthly reporting		Monthly
C4	Action on Agency Costs as per TDA guidance on capping arrangements	Finance and Performance TPEG report	Monthly reporting		Monthly
C5	Receipt of Deloitte report on Trust CIP and Transformation Programme Management capacity. Clear list of actions identified.	Finance and Performance then Trust Board	Reported in July, Further update in October.		Action plan progressing
C6	Update of Long Term Financial Model for discussion at Finance and Performance and then Trust Board on medium term financial plans. This will include a high level assessment of the STPs as they could impact on the organisation.	Finance and Performance then Trust Board	To be reported in September 2016		Update given - financial gap not resolved at STP until 2020
C7	Generation and agreement of recovery plan	Finance and Performance, TMC and then Trust Board	Oct-16		Update Given and discussed at Board
C8	Establishment of a Finance Recovery Board in place from 23/11	Reports to Finance and Performance and Trust Board	Monthly reporting		Meets bi-weekly
C9	Further iteration of financial plan required to bring the Trust back into recurring surplus.	Financial plan and discussion at January F&P	Jan-17		

The GAPS IN CONTROL / NEGATIVE ASSURANCES are ...					Jan 2017 Status:
What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?					Update Received
REF	GAP (include reasoning for the gap described)	ACTION PLAN	ACTION LEAD	AGREED DEADLINE	
NA1	Junior Drs contract to be costed. Currently delayed awaiting new calculator.	Determine if gaps can be filled with Trust grade Drs/locums rather than agency	Costing contract and Trust Fellow programme - DCFO. Plan of action - Divisions	End Sept	Costing model released Nov 16 and currently being reviewed in Trust.
NA2	Manpower plan and consequences of STPs/Agency mitigations/CIP to be co-ordinated through central group reporting to appropriate Sub-Committee	Agreement of process for manpower issues for various workstreams to be co-ordinated through a central point.	Interim HR Director co-ordinating	End Sept	

ASSURANCE FRAMEWORK							
Strategic Objective: To maintain the financial health of the organisation and seek appropriate investment opportunities that enable further enhancement of patient services							
STRATEGIC (PRINCIPLE) RISKS	**IMPACT x LIKELIHOOD = RISK SCORE**					**CURRENT ASSURED LEVEL**	***Movement***
	INITIAL RISK	**PREVIOUS QUARTER**	**CURRENT RISK SCORE**	**TARGET RISK SCORE** Jan-17	Mar-17		
	5 x 4 = 20	5 x 4 = 20	5 x 4 = 20	5 x 3 = 15	3x3=9		
What is the strategic risk to be controlled?							
REF	**STRATEGIC RISK**		**EXECUTIVE DIRECTOR**	**BOARD COMMITTEE**			
SR10 Date of origin - June 15	That the Trust fails to generate sufficient cash to pay for its commitments		Chief Finance Officer	Finance & Performance Committee		**5 x 4 =20**	

POTENTIAL IMPACTS / CONSEQUENCES OF THE RISK		**IMPACT ON *CQC Domains (State Domain name)***	
REF	***What are the key potential consequences (up to 4) of the risk?***		**Indicate by X to those applicable**
PC 1	Inability to meet financial targets	**Safe**	x
PC 2	Inability to invest in services and potential to be unable to settle payments due to lack of cash	**Caring**	x
		Effective	X
		Response	x
		Well Led	X

REFERENCES TO KEY OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC RISK		**IMPACT LEVEL**	***Movement***
Potential or actual origins that have led to the risk …	***What are the most significant origins (up to 10) which could or have led to the risk?***		
REF	**ORIGIN**	**RAG**	
O1	Cost Pressure/business case investment for the Trust		
O2	Continuing CIP targets with reduced ability to make efficiencies.		
O3	Brought forward CIP achieved non-recurrently in previous years		



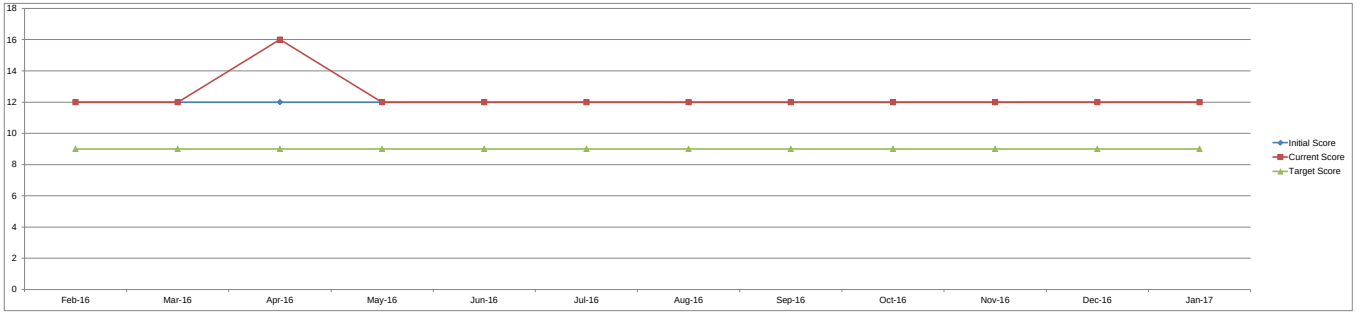
Key Assurances received					
Report ref	Controls	Positive assurance What is the report that provided assurance?	Date last assurance provided:	RAG	Comments
C1	On-going monitoring of cash by Finance Department and formal review at monthly Finance Committee, Chaired by Chief Financial Officer/Deputy, minuted and reported to the Finance & Performance Committee.	Trust Board Finance report reporting actual cash against plan.	Aug-16		Monthly report in place
C2	Revised Annual Plan submitted to NHS Improvement reflecting Trust Board agreement to 2016/17 control total in June 2016.	Key elements of the plan, phasing and risks put in report to Finance and Performance Committee.	Jul-16		Completed
C3	Mitigation plan for Capital expenditure to be discussed and agreed at Finance and Performance.	Agreed capital mitigation plan.	Sep-16		Approved by Trust Board
C4	Update of Long Term Financial Model for discussion at Finance and Performance and then Trust Board on medium term financial plans. This will include a high level assessment of the STPs as they could impact on the organisation.	Agreed LTFM and any associated action.	Discussed at development session with F&P Sep 16		Discussed and comments made
C5	Tight monitoring and action on aged debt especially with Trust to Trust debt.	Reducing aged debt report	Sep-16		On-going monitoring by F&P
C6	Difficulties with trust to trust payments raised with NHS Improvement	Reducing aged debt report	Dec-16		On-going escalation with NHS Improvement
C7	Further iteration of financial plan required to bring the Trust back into recurring surplus.	Financial plan and discussion at January F&P	Jan-17		

The GAPS IN CONTROL / NEGATIVE ASSURANCES are ...					Jan 2017 Status:
					Update received
What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?					
REF	GAP (include reasoning for the gap described)	ACTION PLAN	ACTION LEAD	AGREED DEADLINE	
N1	Impact on cash from Financial Plan delivery. CIP is challenging and lack of delivery to target will reduce cash for the Trust significantly.	On-going actions on CIP delivery and links to STP	COO	On-going	Update to F&P monthly

ASSURANCE FRAMEWORK								
Strategic Objective: To maintain the financial health of the organisation and seek appropriate investment opportunities that enable further enhancement of patient services								
STRATEGIC (PRINCIPLE) RISKS	**IMPACT x LIKELIHOOD = RISK SCORE**					**CURRENT ASSURED LEVEL**	***Movement***
	INITIAL RISK SCORE	**PREVIOUS QUARTER**	**CURRENT RISK SCORE**	**TARGET RISK SCORE** Oct-16	**TARGET RISK SCORE** Mar-17		
	4x3=12	4x3=12	4x3=12	4x3=12	3x3=9		
What is the strategic risk to be controlled?							
REF	**STRATEGIC RISK**		**EXECUTIVE DIRECTOR**	**BOARD COMMITTEE**			
SR11 Date of origin - June 15	Condition of the existing Estate - Quality and flexibility		CFO	F&P		**4 x 3 = 12**	

POTENTIAL IMPACTS / CONSEQUENCES OF THE RISK		**IMPACT ON *CQC Domains (State Domain name)***	
REF	***What are the key potential consequences (up to 4) of the risk?***		**Indicate by X to those applicable**
	Inability to maintain Quality and Safety	**Safe**	X
	Inability to deliver operational and commissioner targets	**Caring**	
		Effective	X
		Response	X
		Well Led	X

REFERENCES TO KEY OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC RISK		**IMPACT LEVEL**	***Movement***
Potential or actual origins that have led to the risk …	***What are the most significant origins (up to 10) which could or have led to the risk?***		
REF	**ORIGIN**	**RAG**	
O1	Ability to find resource to invest in retained Estate		
O2	Reduced income from commissioners		



Key Assurances received					
Report ref	Controls	Positive assurance What is the report that provided assurance?	Date last assurance provided:	RAG	Comments
C1	Five Year Capital Plan.	Trust Board discussion on the estates strategy, 5 year capital programme and phasing. Board approved 5 year Capital programme.	Apr-16		
C2	2016/17 capital programme has identified high risk backlog issues and prioritised accordingly for approval by Board	Risk Assessed Annual Capital Programme	Apr-16		
C3	Further work on estates rationalisation as part of updated clinical strategy	Estates Update and Rationalisation plan to Board Development Session	Jul-16		
C4	Further discussion on capital prioritisation to Finance and Performance	Capital prioritisation in case of NHS Improvement not approving CRL for 2016.	Sep-16		Achieved and agreed
C5	Update of Estates Strategy for Board discussion and approval.	Update taking into account MSFT and recent acquisition of GP practices.	To be received January 2016		Draft in place shared with Directors/Chair of F&P. Going to Board in Jan 2017 now

The GAPS IN CONTROL / NEGATIVE ASSURANCES are …					Jan 2017 Status:
					Update Received
What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?					
REF	GAP (include reasoning for the gap described)	ACTION PLAN	ACTION LEAD	AGREED DEADLINE	
NA1	Further discussions commenced with Commissioners with regard to primary care estate strategy	Develop primary care strategy with CCG	Head of Estates Development	First discussion held and now on-going	On-going
NA2	Further discussions regarding consolidation of estate	Board development session on options	Head of Estates Development	Completed July 2016	Additional update Jan 2017.

The Royal Wolverhampton NHS Trust

Trust Risk Register

January-2017

5	10	15	20	25
4	8	12	16	20
3	6	9	12	15
2	4	6	8	10
1	2	3	4	5

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 have an effective & well integrated organisation that operate**									
Chief Operating Officer	Responsive 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& Jan 16 On-going escalation to relevant L.A to ensure proactive response.	4 x 3 = 12 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 4) Engagement of Intensive Support Team to review system and processes (Mar 15) 5) Commission of PWC to undertake review of DTOC and delay proccesses Aug-Sept 15 6) Additional Social workers funded by SRG Agreed - Sept 16	3) Reduction in patients waiting for continuing Healthcare Assessments - Sep 14 2) Integrated Health and Social Care Team commenced January 2014. 2) Yearly review of re-imbursement of funds 6) Implementation of Wolverhampton health economy task & finish group to implement 5 above (Jan 16) 5) Reduction in numbers of delays (Nov - Feb 16)	2) Increase in delays for Wolverhampton October - Dec 16 3) Increase in delays for DST in Staffordshire (Sept - Dec 16) L.A reablement team (HARP) Jan 17	2) Discussions with social care partners for 7 day services to commence in winter 16/17 3) Escalation of delays to L.A Director as necessary - on-going 5) Implementation of Health Economy task and finish group to implement PWC findings - completed 7) Introduction of discharge to assess scheme 3) Increase monitoring and review of patients with social care to delays (Nov 16). 1)Introduction of red/green process - (Jan 17) requires LA input.	Aug-16 Oct-16 Jan-16 Jan-17 Jan-17	3 x 3 = 9 AMBER	Jan-17	Yes

CQC standards: Safe, Effective, Caring, Responsive, Well Led.

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	Safe 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	3 x 3 = 9 AMBER	1) Monitoring of PAS update / use (monthly) (Nov 14) 3) Implementation of safehands bed management (Apr 15) 4) Additional support from Teletracking to optimise use of real time system - (Jan 16) 5) Establishment of task and finish groups to manage and improve. Compliance to real time bed allocation (Aug 16) 2) Ward clerk review to be undertaken as part of transformation project (Nov 16 - Jan 17)	1) All requests for beds via patient flow team (July 15) 1) real time bed management improving mon-fri 5) Improvement in dashboard metrics 3) Use of Safehands, real time bed management system from September 16 (paperless).	1) Patients still entered retrospectively on PAS, especially after weekends. 1) System bugs in safehands causing delays to bed allocation - closed	1) Long term review of real time bed management and link to I.T. Strategy. Closed safehands 1) Communication plan to remind staff to ensure timely and appropriate admission onto PAS and other Trust Clinical systems 4) Appointment (via teletracking) of additional support to assist with real time allocations - commenced - Sept 16 2) Ward clerk review - transformation project (Nov 16 - Jan 17)	Apr-16 Nov-16 Sep-16 Feb-17	4 x 3 = 12 AMBER	Jan-17	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	Safe 3051	(High level risk) If there is insufficient capacity for the volume of patients then this will lead to surgical/medical outliers and the unplanned utilisation of 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 team. * 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 cancellation of elective work * Not achieving activity income * Increased cancelled operations leading to poor patient experience. * Reputation impact patients and external monitoring. Date of origin: 13/07/12 Date of escalation = 17/03/13	4 x 3 = 12 AMBER	1) Monitor arrangement in place to ensure teams review outliers by contacting the Consultant base ward 2) Centralised Patient Flow System - (link to safehands and risk 2719) (May 15) 3) Establishment of daily huddles and consistent use of planned day of discharge - linked to intensive care support team visit 4) ECIST action plan now in place 5) All pts on 18 week pathway discussed on weekly basis to reduce breaches 6) Implementation of PWC plan to improve DTOCs (Jan 16) 7) Revised assessment models in ED to commence Nov 15 8) Opening of SECU and movement of more complex T&O patients at CCH (1.11.16) 9) Transformation workstream focussed on theatre utilisation (Jul 16) 10) Development of stranded patient review Dec 16 - Jan 17	2) Increase efficiency and release resource through ambulatory care, enhanced recovery and surgical site surveillance e.g. day case rates 2) Reduction in breaches due to 'lack of beds' 2) Improvements in planned vs actual day of discharge 8) Reduction in cancelled operations (Apr - Dec16) 3) Reduction in medical outliers (Sept 16) 9) Theatre utilisation increasing at CCH & New Cross Hospital 7) Reduction in admissions via ED dept during financial year (Apr - Dec)	5) Discharge delays waiting for Social Services - particularly South Staffs 3) Increase in Orthopaedic outliers	6) Development of discharge to assess scheme (LA Led) 8) Re-visit to RNOH to confirm anaesthietc process 9) Continue review of theatre productivity 10) Roll out of stranded patient red/green processes	Feb-17 Feb-17 Mar-17	2 x 4 = 8 AMBER	Jan-17	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	4466	If the level access showers to bays and side rooms on Ward B8 constantly fail environmental and infection audits due to dilapidations to the wall coverings, rust to the grab rails and poor design of vanity units throughout and IPS panels are not significantly improved then the ward will continue to fail to meet IP Requirements HTM 0009 - Infection Control, HTM00-02: Sanitary spaces and HTM64: Sanitary Assemblies in the built environment and also this will have negative impacts upon the patients experience.	4 x 3 = 12 AMBER	1. Business case now approved - The showers are due to be upgraded as part of the capital replacement programme 2. Working with Estates & Facilities in short term to ensure environment is clean (June 16) - completed 3. Rigorous cleaning regime in place to improve conditions in the interim (provided by Domestic team) 4. Reporting any remedial works to Estates to improve conditions in the interim	2 - 4, There has not been an increase in infection or falls incidents as a direct result of this risk	1, 2, 3, 4. The ward is continually failing Environmental and Infection Prevention audits	1. Anticipated date for completion of works for the three main bathrooms on the ward 1+2 Business case to be produced to fund improvements for the additional bathrooms that were not costed as part of the original business case	Jan-17 Feb-17	2 x 2 = 4 YELLOW	Jan-17	

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	4523	If Heater Cooler Units used in cardiac surgery harbour mycobacterium chimaera (as a national incident has identified) then the potential outcome may be, cancellation of elective surgery due to unavailability of the required number of machines and a failure of a machine during cardiac procedure.	4 x 3 = 12 AMBER	1. Currently in place is a comprehensive service contract, which provides a loan machine on breakdown of our machines (May 2016) 2. 6 monthly service within comprehensive service (May 2016) 4. Regular in-house cleaning and visual inspection of the water (May 2016) 3. Enhanced disinfection protocol put in place to clean of the HCUs leads to degradation of the heating/cooling coils (May 2016) 5. The department took loan of the last loan machine available in Europe (May 2016) 6. Patients are informed before every case of the risk	2+3. There have been no further HCU failures since the end of April 2016 4. Undertaken on a weekly basis and no bacterium found 6. No patients have declined the procedure as a result of being open	3. New cleaning protocol may result in a potential increase in machine failure and a 4-6 month repair time. 1.There has been one failure (pre-April 2016) and the other machines are showing signs of wear and tear. 5. If another machine was required there is now a waiting list. This would likely mean that no loan equipment is available for future breakdowns	1+3. Continue to monitor	Mar-17	3 x 2 = 6 YELLOW	Jan-17	

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	4650	The integrated Local Authority rehab assistant model within Community Integrated Care Team ceased in Nov 16. There has been a reduction in rehab assistants to provide social care and therapy exercise programme for patients. This is affecting discharges from hospital and delaying therapy intervention potential for experience and increase risk of pressure injuries and falls. Date of Origin: 04/11/16 Date of Escalation:	4 x 3 = 12 AMBER	1. Individual management plan produced for each patient based on need and relevant evidence based best practice (Nov 16) 2. Flexibility of experience and skills in workforce to deliver both health and therapy intervention (Nov 16) 3. Management plans with clear escalation process embedded for therapy and nursing support for patients on caseload (Nov 16) 4. Single Patient record for continuity and communication (Nov 16) 6. Single point of referral/triage into service for integrated model with established patient flows from inpatient settings e.g. A7 and A8 (Nov 16) 6) Monitor effect on patient discharges, re-admissions, LoS from Acute setting (Nov 16)		2. 5 (Nov 16) Rehab assistant input is reduced by 75% following cessation of integrated model. Patients will not get the frequency of practice required to achieve their health and well-being goals and social care information will not be vailable within the single patient record 2. (Nov 16) Reduced capacity in workforce reducing flexibility.	Escalation to LA expedite delays to Harp	Jan-17	2 x 3 = 6 YELLOW	Jan-17	

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:	**Maintain financial health - appropriate investment enhancement**										
Chief Nursing Officer	Effective 2680	Patient Experience Services - Interpreting & Translation Service 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	4 x 3 = 12 AMBER	1) KPIs in place to monitor monthly usage by department - Dec 2016 2) Interpreting Policy updated and ratified in March 2016 - Dec 2016 3) Interpreting costs provided by provider by Division for information to services - Dec 2016 4) Training for staff on use of telephony equipment to support telephone interpreting - Dec 2016 5) Scoping of all services by provider to ensure knowledge of services and systems available - Dec 2016	1) Dec - Dec 2016: No complaints received - Dec 2016 2) Information currently being compiled to provide detailed analysis for each division concerning the amount of costs incurred - DEC 2016 1) Evidence of failure of the Trust to cancel interpreter when the hospital appointments are cancelled - Dec 2016	2) Year 2016/17 budget is £178.179. (£162.435) - Dec 2016 1) Need to implement the use of risk assessments by directorates when booking face to face interpreters - DEC 2016 1) Evidence from RMC indicates growth in migrant community accessing services requiring interpreting and range of languages required - DEC 2016 1) Evidence of failure of the Trust to cancel interpreter when the hospital appointments are cancelled - DEC 2016	3) Currently rolling out the interpreting policy via awareness sessions (in conjunction with the provider). 1) Head of Service to review risk. 1) Consider business case regards validated interpreting usage 4) Awareness raising with directorates to ensure familiarity with services available and policy 3) Meeting with Trust transformation lead to explore further ways of significantly reducing overspend	Mar-17	3 x 1 = 3 GREEN	Jan-17	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	Well Led 4113	Division 1 failure to achieve CIP target for 2016/2017. Set at £7.3m which when adding in the brought forward of £4.1m gives a target of £11.4m then there are implications for the financial position of the Trust. Linked to BAF risk SR8. Date of origin: 07/04/15 Date of escalation = 09/10/15 & June 16	4 x 3 = 12 AMBER	3. Vacancy control panel in place (Oct 2015) and higher restrictions being applied (Jan 2017) 2. Directorates holding monthly Financial Forecasting meetings and discussing CIP at Directorate meetings (Oct 2015) 1. Increased PMO resources to support delivery of the Trusts efficiency programme (June 2016) 6. Trust roll-out of Carter methodology now in place (June 2016) 4. Monitored by the Financial Recovery Board (FRB) 5. CIP confirm and challenge meetings in place (Sept 2016) 7. Member of Service Re-design Team aligned to Division 1 Programme to provide structure and targeted support to operational teams in their delivery of CIP 7. Division involved in Trust transformation projects - Key aspect - Theatres (Dec 16) 8) All agency requests above £120 P.H to be approved by COO/CEO	2, 3 & 4. Structure in place to discuss and identify opportunities to create efficiencies and business growth 3. VCP meetings held weekly and posts go through this process 7. If there is a risk that impacts on a team's ability to deliver their CIP schemes then the member of Service Re-deisgn Team would be available to support as and when required at the Quality Meetings.	2 & 3. Unidentified CIP still remains (Nov 16)	1-6) Continue with process to identify and deliver efficiencies 2) Review of year to date underspends with a view to take non-recurrent to CIP 2+5) PIDs are forthcoming to the finance team as a matter of urgency 1) Divisional Management Team to meet with CDs collectively to discuss growing the business, increasing utilisation of theatres and OPD 1-7) Division to be involved in Financial Recovery Board chaired by CEO	Mar-17 Mar-17 Mar-17 Mar-17 Mar-17	2 x 3 = 6 YELLOW	Jan-17	

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	4583	Delivery of improvement trajectories for the £10.6m STF payment. 70% of the payment is triggered by finance plan delivery and 30% from Access targets (although further clarity on mechanism is required for areas such as Agency payments). Date of Origin: 01/06/16 Date of escalation: 01/06/16	3 x 4 = 12 AMBER	1) Secure clarity on operating rules for payments from NHSI - in particular cumulative performance. 2) Delivery of the improvement trajectories throughout the year. Trust has secured the first quarterly (April - June 2016) payment. 3) STF payment for Q2 now achieved but there are delivery issues against improvement trajectories. Trust will appeal those once appeal system released.	1) First and then subsequent payments from NHSI. 2) Continued monitoring against improvement trajectories. 3) Forecast Year End from divisions and recovery plan now indicating 16/17 control total will be unachievable	1) Q3 forecast year-end now submitted which accepts Q3 &Q4 payments not achievable		5 x 4 = 20 RED	Jan-17	
Chief Financial Officer	4584	Due to significant financial pressures in the NHS the Capital programme presented to Trust Board in April may be under threat if the CRL is not approved by NHSI. Date of Origin: 01/06/16 Date of escalation: 01/06/16	3 x 4 = 12 AMBER	1) Work up mitigation plan in case the CRL is reduced. 2) Continue dialogue with NHSI convincing them of the requirement to agree the CRL. 3) Mitigation plan actioned and £4.5m of capital plan deferred.	1) Agreement of CRL by NHSI 2) Board approval of updated capital programme. 3) M9 capital plan shows revised phasings and cash position now positive			3 x 3 = 9 AMBER	Jan-17	

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:	**Attract, retain & develop our staff & improve employee engagemen**										
Chief Operating Officer	Well Led 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	4 x 3 = 12 AMBER	2) Areas to be contained with SPA allocation have been agreed 4) Usage reports for medical bank 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 1) New Job Planning Policy to be agreed by LNC (Sept 16)	1) Job Planning Audit indicated a number of actions now addressed 1) Training commenced on new job planning process - Feb 16	1) Slow progress in terms of Job Plan completion - Sept16 4) Medical agency costs slowly reducing 1) Audit review still raised concerns - 2016	1) Trust to use pilot job planning module - associated with revalidation process - completed 2) Report to Trust Board - May 16 1) Agreement with LNC to be confirmed 1) Appointment of Deputy Medical Director to lead on job planning process in each division	May-15 May-16 Jan-17 Jan-17	3 x 2 = 6 YELLOW	Jan-17	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	2080	If the Trust is unable to recruit and retain sufficient nursing staff across the Division then there will be reduced quality of care for patients, including increased risk of falls from harm. (Linked to local risks 2780 CHU, 4272 Therapy Svs, 4321 DN's, 3431 CofE) Date of origin: 02/01/09 Date of escalation = 12/01/16 On BAF	5 x 4 = 20 RED	7) Ongoing active recruitment exercises - including overseas 8) Use of Nurse Bank when required - increased rates till June 16 for ED 3) Defined minimum safe staffing levels now in place 5) Modified dependency tool for inpatient areas commenced 2) Cohort 1, 2 & 3 of new staff now on wards 9) Staffing incidents reviewed on monthly basis 10) Closed additiona Ward 3 at West Park Hospital (June 16) 3) All B7s trustwide have been advised to fill OOH rota first, then manage any gaps in-hours including putting themselves in if necessary 3) Daily staffing template produced at 4pm detailing all registered staffing (Friday's template includes weekend plus Monday am) 3) B7's have daily staffing meetings 3) Skill mix review conducted for inpatient areas 7) 4 more staff from the Phillipines arrived to complete OSCI and IELTS 7) Reduction in number of vacancies	6) HCA's are available via Bank 3) Metrics framework developed to maintain professional stds when under staffing pressures 3) Safe staffing levels are being maintained across acute wards 3) Band 7 vacancies have all been filled 7) Empty bays on A5 & A6 used as practice area for IELT training 3) Skill mix review underway 3,9) Internal transfer pool introduced across the Trust as part of the retention strategy 3) New matron recruited for ACS, awaiting start date 7) Change to recruiting processes to speed up the process 9) C15 have shown an improvement following implementation of action plan for special measures	9) 57.46 wte trained nursing vacancies remain (36 jobs offered but staff not in post yet) 6) Insufficient RN's available on Bank, backfilled by HCA 9) Nationallly we are an outlier re safe staffing levels 3) Weekends remain an issue in relation to staffing numbers 3) CHU risk (2780) escalated to 12 and incorporated in to this risk 7) ACS Matron - job recruited to, but not in post yet	8) Further support to be given to staff that failed IELTS. Exam to be paid for by RWHT 3) Skill mix review to be completed across the organisation - outstanding areas are Specialist areas, ED and CNS reviews 9) C15/A7/A8 working through local 'special measures' action plan. 7) Development of Nursing Associate Post - impact to be assessed.	Feb-17 Feb-17 Feb-17	4 x 3 = 12 AMBER	Jan-17	

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	4529	If there are vacancies in consultant or non-consultant medical staff across the Division, this will compromise the provision of a safe, effective elective service and to the safe staffing of on-call rotas. In that circumstance there may be a need to try to employ locum medical staff with the potential problems of high cost and uncertain quality. Please note: Risk 4239 (Obs & Gynae), Risk 4467 (Cardio) staffing risks have been linked to this overarching Divisional medical staffing risk.	4 x 3 = 12 AMBER	1. Division approached HR re: targeted recruitment for Consultants (May 2016) 2. Division are working with the Fellowship Programme to enhance recruit of non-Consultant Doctors (May 2016)	2) Some clinical fellowship appointed - Aug 16	1) Some reduction in medical spend - Aug 16	1+2. Continue with Fellowship Programme 1) DCOO and DMD to discuss targeted recruitment radiology (overseas) with HR department	Jan-17 Jan-17	2 x 2 = 4 YELLOW	Jan-17	
Chief Operating Officer	4540	If there is non-compliance with Mandatory Training across the Division then individuals are potentially not up-to-date with the most recent information to support their skills/ knowledge in these specific key areas. Impact of which would be quality and safety of patient care, safety of staff whilst at work, non-compliance with Trust policies and procedures which will result in a breach of contract and potentially disciplinary sanctions being implemented.	3 x 3 = 9 AMBER	1. Line Managers receive Mandatory Training Compliance Reports and discuss/challenge compliance with individual staff members (June 2016) 2. Divisional compliance is reported by the Divisional HR Manager at Team Meetings and Buisness Forum Meetings (June 2016) 3. HoN - Division 1 had written to non-compliant nursing staff members to advise of need to complete training or formally explain non-compliance (June 2016) 4. Divisional Management Team are meeting with non-compliant medical staff members	1-4) Improvements made in IP compliance (Sept 16) 1-4) Divisionally all of the mandatory training completion rates have increased since June 2016 (Sept 16)	1) Baseline for mandatory training increased to 9590 - some green areas now look red. Nov 16	1.Ongoing Directorate challenge at the Directorates Quality Assurance Meetings 1-3 HoN's are working closely with database team to resolve some of the IT and process issues	Mar-17 Feb-17	2 x 2 = 4 YELLOW	Jan-17	

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	4609	(High level risk) 7 day service (7DS) core standards on initial and daily consultant review of non-elective patients. IF failure to meet standards THEN there is an increased risk of patient safety RESULTING IN reduced safety, efficiency and patient experience at weekends COE = 3847, Diabetes = 3765, Renal = 4034, Respiratory = 3705 Date of origin: April 2014 Date of escalation: April 2014 Updated to include all directorates June 2016	4 x 3 = 12 AMBER	3) Systems in place across medicine prioritising patient safety over the weekend 2) Project manager appointed to co-ordinate 7DS developments across both Divisions 1) Signed up as early implementers for national 7DS programme (21/06/16) 4) Meeting with directorates to review 7DS provision (sept - Nov 16)	1) National 7DS audit shows compliance in care standards across many directorates 1) Cons delivered ward rounds in place across all medical specialties 3) Clinical directors feel that they have addressed safety issues resulting from reduced Cons resources at weekends. 2) Communication provided to RWT staff re 7DS 4) Revised rota's from specialties being produced.	3) In areas unable to deliver face-to-face Cons ward rounds over the 7 day period, patient experience and efficiency/patient flow may be sacrificed 1) 7DS care standards not met in all areas or directorates 1) Varying level of input per patient falling short of face-to-face requirement in directorates with larg bed bases 3) Drop in discharge numbers at the weekend	3) Job planning to address resource gap between current job plans and requirements to deliver core stds. Business cases to be developed for additional Cons resource where gaps cannot be closed within existing resource 2) Repeat 7DS audit to be undertaken and results to be reported 1) Work ongoing in medical specialties to quantify ward round PA's required to deliver core standards - Resp, Onc & Haem, Cof E and Pharmacy 1.2.3) Acheive full compliance with standards	Dec-16 Dec-16 Dec-16 Mar-17	3 x 2 = 6 YELLOW	Jan-16	

Trust Objective: Create a culture of compassion, safety & quality

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	Safe 2836	Lab 2 (13 years old) is scheduled for upgrade in April 2017, due to recent consistent breakdowns there has been a loss of activity due to patient cancellations	4 x 3 = 12 AMBER	1. Fortnightly meetings occurring with Estates 2. Regular communication maintained with Phillips		1. The recent breakdowns have resulted in a loss of activity equating to £15,000 per week	1. Lab 2 to be replaced	Apr-17	3 x 2 = 6 YELLOW	Jan-17	

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	Caring 2898	(High level risk) If patients have to wait in ambulance off load area to be seen in ED due to a lack of staff and lack of 'flow' through the hospital then there will be a risk to patient safety, experience, privacy, dignity and comfort to patients Link to risk 3051- Insufficient bed capacity Date of origin: 27 Feb 2012 Date of escalation: 25 Feb 2013	4 x 3 = 12 AMBER	3) Daily monitoring process in place to ensure appropriate action is taken to prevent the delay of safe treatment for patients 1) Increased capacity within ED by use of surge corridor (1/7/2016) 2) Monitoring of ED targets in place (waiting times and ambulance handover times) 4) Rapid Assessment and Triage room in place 6) Internal protocol to support the management of patients in AOA in place (available on the intranet) 7) Esclation plan in place 8) When required staffing is reviewed and adjusted to include ambulance off load area [08/11/16] 9) Increased Consultant cover until 02:00am [08/11/16] 10) ED attend daily escalation meeting and provide performance data (including number of ambulances/ patients requiring escalation etc) [06/01/17] 11) 2 paediatric consultants due to start March 2017 [06/01/17]	1) Operational use of surge cubicles achieved at times of increased demand [06/01/17] 4) No major issues/incidents reported with the RAT room [06/01/17]	2) Delays in patient transfer - linked to bed availability / bedflow / waiting to be transferred [06/01/17] 1) Increase in number of ambulances [06/01/17] 2) Agreement in place to take 5 extra ambulances a day from County Hospital	1, 2) Continue with daily bed meetings 1-9) Continue with recruitment of substansive medical and nursing staff	Mar-17 Mar-17	2 x 3 = 6 YELLOW	Jan-17	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	3069	If a Never Event occurs within the Division this may result in an adverse outcome, there is potential for severe harm and/or patient death and also reputational impact including increased external monitoring Date of origin: 19/07/12 Date of escalation = 17/11/15	3 x 4 = 12 AMBER	7. Monitoring and circulation of incident notification reports to all senior staff for review 8. Trustwide learning via a "Lessons Learned" sheet in the monthly IGR, Risky Business Newsletter and the CLIP Group. 10. Regular scrutiny of Directorate risk registers and minutes of Directorate governance meetings at the Quality Meetings 3. Review completed of all documentation and Theatre protocols/procedures amalgamating where possible 1. Perioperative care plans are in place across the Trust 11. Agreed communication strategy with Division 2 to share/raise awareness of never events and lessons learnt 5. Monitoring of Policy OP100 and monthly audit of WHO Checklist for agreed procedures. Directorates providing assurance of the shortfalls in performance at Directorate Governance Meetings and Quality Meetings. 6. New NE Guidance 15/16 being used for NE classification	5. Monthly monitoring data of compliance with WHO checklist and Procedural Safety Checklist - During Nov 2016 there has been 100% compliance. 5. Monthly monitoring and compliance with five steps to safer surgery greater than 95% - There has been 100% compliance achieved between August 2015 - Nov 2016. 10. Risk Registers continue to be reveiwed as part of the Quality Assurance Meetings (July 16) 8. Lessons Learnt included within IGR Lesson Learnt page and circulated across the Directorates. Risky Business newsletter contained lesson learnt from incident. Quarterly reporting to CLIP Group continues (July 2016) 12. Review of NE action plans highlighted that of the last three NE the majority of actions had been completed and there was evidence of completion	6. 1st NE in 16/17 reported to CCG - Maternity NE (retained tampon) reported (Datix ID: 158830) occured May 2016 6. There have been three Never Event incidents 2 x Wrong Site Surgery and 1 x Retained foreign object) reported and investigated during 2015 12. There are still some actions where evidence of completion needs to be obtained. 6. 2nd NE in 16/17 reported to CCG - Radiology NE (wrong ankle injected) reported (Datix 165455) occured August 2016, reported as NE Sept 2016 6. 3rd NE in 16/17 reported to CCG - Opthalmology (wrong eye injected) reported (Datix 166680) occured Oct 2016 6. 4th NE in 16/17 reported to CCG - Theatres (retained foreign object) reported (Datix ID: 169339) occured Dec 2016	2. Opthalmology Staff to undertake Human Factors Training 6. AFPP to review Opthalmology Theatres 1-12. CCG Quality Review Visit of Never Events to take place on the 20th January 2017	Apr-17 Mar-17 Jan-17	2 x 4 = 8 AMBER	Jan-17	

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?
				9. Policy for the management of retained swabs now in place 2. Implementation of Human Factor training across the Trust 4. Provision of bespoke training for individual theatre teams using simulation and actors to identify poor practice and encourge staff to speak out. 12. Review of NE action plans at Divisional Governance Meeting							
Chief Operating Officer	O16 3256	If the premises at West Park, ENT OPD and Cannock (Audiology) are deemed unsuitable for clinical service delivery (lack of adequate soundproofing and an inability to maintain ambient temperatures in clinical rooms) then there is risk of loss of contract(s), compromised patient care and potential complaints and litigation Date of origin: 04/10/12 Date of escalation = 06/03/13	4 x 3 = 12 AMBER	2) Signs are in place in clinical area and corridor requesting silence at all times (Feb 2016) 3) Incident trends being monitored along with any complaints on a monthly basis (Feb 2016) 1) Introduction of insert earphones and Sound Level meters to monitor sound levels (Feb 2016) 4) Noise logs are undertaken during testing - compiled and produced each month (as per UKAS requirements) (Feb 2016) 5) Business case developed and sent to Group Manager [Nov 16]	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. (Nov 16) 1-4) Accreditation feedback session was very positive and praised team (Oct16)	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. (Nov 16) 1) Inserts do not provide adequate attenation to overcome the issue of the environment (Nov 16) 4) When noise reaches >35dBA testing has to stop (Nov 16) 1-4) UKAS visit took place on 13/11/15 - accreditation for diagnostic testing at West Park withdrawn, (Nov 2015) 5) Awaiting approval of business case and completion of business case proforma by finance [Nov 16]	1-5) Business case to be reviewed and financial proforma completed	Feb-17	1 x 2 = 2 GREEN	Jan-17	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	Well Led 3644	Failure to make an improvement in compliance gaps with CQC standards. Date of origin: 14/01/14 Date of escalation = 14/01/14	3 x 3 = 9 AMBER	2) Monitor recruitment plan (Nov 14) report to Trust Board monthly 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) Monitor IMR quarterly (Nov 2014) 6) Monitor staffing establishments nursing reviewed and re-calculated bi-annually 5) Compliance to action plan refreshed (Jan and Apr 2015). Compliance reported through Trust Governance framework 7) CQC action plan continues to be reviewed on monthly basis and report to QSAG monthly. 8) Governance framework around CQC fundamental standard is now in progress.	3) Initial business case was approved by the Board and the CCG to fund additional nursing staff, investment now in place. Decrease in vacancies. 4) Overseas recruitment saw 19 European nurses commence employment W/C 11/1/16 5) Nursing and Midwifery KPIs moved to Health Assure reporting and emailed out to ward sisters/matrons and HoNs monthly. 6) Refurbishment of Mortuary body store and viewing room due mid April 2015 1) 80% of all actions identified from the June 2015 visit have now been closed. 2) A system of internal review is in development to run mini CQC audits 7) CQC intelligence monitoring report for Dec '14 indicated low risk (6) 4) Philippines trip Dec 15 saw 223 posts offered - awaiting IELTS and CBT passes before visa's can be applied for - so far 8 have been requested. Further trip planned Jan 16. 6) Eroster scoping meeting took place 14/1/16 this will be report to an workforce efficiency steering group	1) Electronic Rostering demonstrates more work needs to be done on using e roster to fully to maximise staff resource 2) Sickness absence needs to be driven down to Trust average in all ward areas. 3) Vacancy rates remain high in some areas 3) Skill mix review has been undertaken as per annual programme, outcome, no business case required at this time, given the number of vacancies in the organisation.	5) Monitor monthly staffing submitted on Unify to NHSE to check Trust is compliant with 80% or above fill rate for staffing planned versus actual 5) Identify absence above 3% and have plans in place to manage on each ward 4) Open/recruitment day scheduled for 25/4/15 5) Trust is taking part in the workforce collaborative led by DOH (Lord Carters team) to receive and share good practice 6) Upgrade of current E-roster system to web based version planned for Sep-Nov 2016 7) Information sharing events regards to inspection for Acute services commence Oct/Nov 16 7) Safeguarding to review MCA/DOLS training needs and information available for staff 7) Safeguarding to undertake audit regarding MCA/DOLS Complete QRV visits for all inpatient areas Information sharing events regards inspection for VI practices	 Jan-17 Jan-17 Jan-17 Jan-17 Dec-17 Feb-17	2 x 2 = 4 YELLOW	Jan-17	

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?
					6) Eroster business case will be submitted to C&C Feb 16 for upgrade to V10 and cloud access to improve efficiency and access. 2) Agreement of NMC to reduce IELTS level for Nursing professionals 7) CQC steering group ceased 6) E-roster manager appointed 6) E-roster upgrade planned to commence Sep 16 - Jan 17 8) Submission of CHPPD data monthly. Dashboard available of Year benchmarking data.					

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	4161	If there are reduced qualified nursing staffing levels across the Division then there is a risk to patient safety and quality of care. Please note: Risk 2828 (T&O), Risk 4475 (Cardio), Risk 4553 (Children Services's) staffing risks have been linked to this overarching Divisional staffing risk. Date of origin: 13/05/15 Date of escalation = 18/11/15	5 x 3 = 15 RED	1. Recuitment strategy in place which includes as agreed at NOG presence at local Uni open days to promote RWT opportunities 2. Pursuing overseas recruitment (EU and outside EU) 3. Staff are being re-deployed daily across the Division as per Safer Staffing Escalation Procedure, escalation process has been streamlined. 4. Developed a programme for Band 7s with a support programme wrapped around to assist with attrition and development 5. 12 beds closed on the T&O ward to improve the ratio /reduce the burden on current staff members 6. Increasing Band 2 support to manage qualified shortfall 7. Scrutinising staffing levels daily and moving /re-deploying staff across the Division as necessary 8. Open meetings with HoN to commence each month for staff to talk with a Senior Nurse about concerns, general info etc as a way to hopefully retain staff 9. Monthly red round days by HoN to be visible and listening to staff and the pressures they face as a way of support and quality checking.	1 + 10. Utilising bank where possible and increasing HCA cover as necessary 3. Safer escalation - Areas are amber or green. No area has been red. 4. Positive feedback from Band 7s who have attended programme 2. Continuing to support offered applicants. 10. No known issues with staffing since commencement 8. Continuing with meetings staff have attended so far 9. Positive feedback received re: red round days 10. IELTs expected levels have now been reduced (Aug 16) 1. Vacancies at Cannock have now been nearly filled (Aug 16)	1+2. Regional/Overseas recruitment via Health England/NHS England is not providing the numbers/volume of nurses required. Only 5/9 are now coming to the Trust. 1. Peak annual leave season, unable to cover bank shifts. 2. Trustwide position: Philippines recuitement successful but long lead in time for staff to arrive in UK 1. Nursing vacancies still high (Aug 16) 8. Static position in T&O - unable to re-open beds 1. Surgical Recuitment Open Day, 64 attendances only 1 trained appointable for Cannock (Oct 16)	2. Await anticipated start of staff from Phillipines 14) Assess the impact on staffing levels of Nursing Associate posts 10 +11) Continue to ensure Matron attendance at both the Friday Morning Meetings and Friday 4pm Bed Meeting	Apr-17 Apr-17 Apr-17	2 x 2 = 4 YELLOW	Jan-17	

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?
				10. NMC Challenge by Chief Nurse re: IELTs 11. Friday morning meetings taking place for Matrons to check staffing across the Trust for the weekend to assure safety 12. Matron Rep from both Divisions attends the Friday 4pm Bed Meeting to provide assurance of staffing safety (Aug 16) 13. There is now a trustwide staffing pool (aimed to retain staff) (Aug 2016) 14. Appointed to Nursing Associate posts - to start end of Jan 17 (Jan 2017)						

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	4308	If the emergency buzzer is not heard in some areas of the Ward (A21) and not resolved then this may result in delays in staff reaching the patient in an emergency situation as two separate emergency buzzer systems have been installed. This could result in: - Patient harm due to delay in responding to buzzer - Increased complaints Date of origin: 16/09/2015	3 x 4 = 12 AMBER	2) Issue escalated to Estates as 2 separate systems installed (08/12/2016) 1) Incidents monitored via monthly Governance meetings (08/12/2016) 3) Staff are made aware of difficulty in hearing the buzzer from some areas of the ward (08/12/2016) 4) CRG approved the case for funding to one system on A21 (08/12/2016) 1) All nursing and medical staff are on high alert as aware of problems with emergency buzzers. (08/12/2016) 4) Business case has now been approved for Estates to ensure just one system in operation. 08/12/2016	Work in progress to amalgamate Emergency buzzer as one on A21 (08/12/2016)	1) Incidents are occurring where a no response or a delay in response to activation of emergency buzzers have occured. (08/12/2016) 3) 24 hour reception cover not available and refurbishment not undertaken (08/12/2016) 3) Weekend cover is not guaranteed (08/12/2016)	1&2) Ward refurbishment and update Sept 16- likely to be closed afterwards	Jan-17	1 x 1 = 1 GREEN	Jan-17	

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	4472	If patients wait over 2 hours for assessment in cubicles in the Emergency Department and wait over 15 minutes for triage, then an urgent clinical need may not be identified within appropriate timescale's, which could compromise patient care. Date of Origin: 24/02/2016	4 x 4 = 16 RED	1) National guidance in place (15 minutes for triage & 2 hours for assessment) 2) Use of MSS to monitor times for triage and assessment 3) Huddles held with ED management, Consultant in charge, Nurse co-ordinator and nurse change at regular intervals to monitor times and implement actions to reduce waiting times and escalate as appropriate using escalation plan. 4) Reallocation of doctors to areas with high waiting times if appropriate 5) Reallocation of nurse to support triage nurse 6) Bed meetings held at regular intervals where status of Emergency Department is discussed with representatives of both Divisions to facilitate flow 7) Monitoring staffing ratios and man-power plans regularly reviewed 8) Rapid Assessment process in place for ambulance arrivals from 10am until 10pm where a senior decision maker reviews the patient upon arrival 9) Acute Physician team available to support department from 10am until 21.30 every day 10) UCC opened on 1st April 2016	9) No concerns raised re Acute Physician support [06/01/17] 15) Recruitment ongoing - further interviews for nursing posts scheduled for w/c 09/01/17 [06/01/17] 2) System upgrade for automatic trigger developed (15/12/16)	1,2) Inability to meet Department of Health guidance - Average 56 breaches a day in the 4 hour target due to first assessment delays. [06/01/17] 1, 2) Inability to achieve 2 hour assessment and 15 minute triage.[06/01/17] 3) Huddles not currently taking place consistently 24/7 [06/01/17] 4,5) Staff not always available to be reallocated [06/01/17] 6) Bed availability linked to delays in Emergency Department [06/01/17] 7) Medical and nursing vacancies, sickness and reliance on locum doctors resulting in gaps on rotas. [06/01/17] 8) Patients may not be seen straight away on arrival but on average within 20 minute. However can be delayed due to flow constraints. [06/01/17] 10) UCC not impacting on pt numbers and delays in assessments [06/01/17] 7) Nursing vacancies - 7.37 WTE B5 and 3.6 WTE support assistants vacancies [06/01/17]	1,2,4,8) Develop and implement a revised RAT SOP to improve flows within the area , 2, 8) Await action plan from Patient flow workshops 7) Continue with recruitment of nursing staff	Jan-17 Jan-17 Jan-17	1 x 4 = 4 YELLOW	Jan-17	

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) Zone B SOP in place 12) Powerpoint presentation around National ED standards included in new starters induction and within annual mandatory training sessions 14) Human factors training undertaken [08/11/16] 13) Joint triage model in place with UCC [08/11/16] 15) Medical and nurse staffing managed via the risk regsiter (risk 2374 & 4496) [08/11/16] 16) Human factors training undertaken [06/01/17] 17) Recruitment ongoing [06/01/17]						
Chief Operating Officer	4528	If Clinical Web Portal does not contain full copies of patient's notes/health records if seen before 2013 as well as all Paediatric admissions then incomplete health records may be the only record available for inpatient and outpatient encounters. Lack of a comprehensive record may impact on the accuracy and/or timeliness of clinical decision making.	4 x 3 = 12 AMBER	1. Ability to request paper notes (May 2016) 2. Process for both access to patient records aswell as the process for when there is a need to have a complete patient scanned has been circulated by Patient Access (Dec 16)		1. Datix Incidents reported 1. Records are not always available for elective clinics, even if they are available this creates a time lag within	1. Process for access to paper records be included in the updated version of the Health Records Policy	Feb-17	2 x 2 = 4 YELLOW	Jan-17	

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	4559	If the manufacturer of long LUER connected needles for non-neuraxial procedures is unable to supply the needles for longer than 3 months then the Trust will be forced to either cancel patients requiring the use of these needles or use needles labeled 'For Spinal Use' which is in contravention of NHS/PSA/D/2014/002	1 x 5 = 5 YELLOW	1 - The administration of chemotherapy is only done by 2 trained individuals within the Radiology department (June 2016) 2 - Trust has a small supply of 'specialty' needles (June 2016) reserved for small use areas 3 - The proposed new supply of 'Not For Spinal' needles has a CE mark 4- The distribution of 'SPINAL' Needles is restricted to identified staff for identified procedures 5- (07-07-16) All staff bulettin sent to Trust 6- (19/07/16) Poster produced for distribution across Trust	2 - An alternative supply is available, but these needles are labelled 'For Spinal Use' - see risk 4558 (June 2016) 1, 2 - There is a minimal risk of injecting the wrong substance intrathecally - only 1 incident in 2001 has been recorded in the UK and there have been no reported incidents in this Trust ((June 2016) 2 - There are enough supplies of the 'Specialty' labelled needles for Radiology and Oncology provided that we get new supplies in October at the latest (June 2016) 1 - Chemotherapy supplied by Sterile Services is recorded in a register and securely delivered to Radiology	2 - Appleby Suite and Orthopaedic theatres at NX and Cannock - (which are the major users in the Trust) have reached the end of their supply (June 2016)	2+3 - The availability of the new supplies to be monitored 4 - Manange the distribution of 'Spinal' needles to specific areas and for specific procedures 3 - Obtain the CE document for the Blue Box supplies 2 - Monitor incidents involving Spinal and Specialty needles	Oct-16 Oct-16 Oct-16 Oct-16	1 x 3 = 3 GREEN	Jan-17	
Chief Operating Officer	4565	If the use of Agency staffing continues across the Division then there is potential for an impact upon the continuity of patient care and service being delivered. Also, as staffing is dependent on the market place this may also result in an unavoidable breach in the agency cap levels.	4 x 3 = 12 AMBER	4. Reported at Ops Finance Group 3. Utilisation of fellowship programme 2. Recruitment Strategy in place 1. Agency spend reviewed monthly at Directorate/Divisional Meetings 6) Establishment of workforce group to review/monitor use of medical locums/agency (Oct 16) 5) Overseas recruitment for some specialties (radiology).	2) Recruitment to Paed ED and adult ED post in Nov 16 1-4) Some reduction in agency spend in ED and other specialties as clinical fellows come on line (oct 16)	2) Many areas now are experiencing national shortages i,e Radiologists/Anaesthetists 1-4) Very slight reduction in vacancies over the last couple of months however it continues to be a significant challenge (Oct 16) 1-4) Locum spend for non-clinical posts has increased in Sept/Oct 2) Significant recruitment gaps in clinical workforce 1) No significant reduction in agency spend (medical)	2. Continue to implement Recruitment Strategy 2+3. Request further support nationally - collaborative working with other organisations 1. Focus on reducing agency spend in non-clinical areas initially	Mar-17 Mar-17 Mar-17	x =	Jan-17	

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	4616	There is currently a backlog of approximately 1000 Antenatal Tracer Cards (used by Community Midwives to document the initial vulnerability risk assessment for all pregnant women i.e., domestic violence/abuse) which are waiting to be filed within the main case-notes, dating back to 2014. The backlog has accumulated due to there not being a formal process in place and ward clerk absences/sickness, vacancy, and maternity leave. As a result of the backlog, there is a possibility that staff within Maternity will be unaware of any previous or current risks highlighted with regards to domestic violence and the vulnerability status of the pregnant woman. This could potentially result in: 1. A safeguarding adverse incident (patient and/or baby) 2. Exposing the staff to violence and aggression from the partner 3. Possibility of emotional abuse to the unborn baby 4. Incomplete case notes resulting in non-compliance with CQC audit requirements	3 x 4 = 12 AMBER	1; The filing priority will be focused upon the women who are currently pregnant whereby there is anything documented within the vulnerability section 2; There is a process in place for any safeguarding concerns whereby the midwife documents her findings within the social section within the case notes. This is highlighted with a purple divider titled social notes 3; The backlog of antenatal tracer cards is reducing as from 14th November due to clerical staff being paid extra to contract hours to request case notes and file tracer cards. 4; New system launched 1.11.16 to ensure that this does not happen again whereby antenatal tracer cards are filed within the hospital casenotes when the woman attends for her 1st initial dating scan 10-13 weeks gestation. 5; Access and availability to case notes is much improved since maternity reception has been refurbished with racking to allow extra storgae for case notes. Completed 1.11.16. 6. Designated person tasked with filing the tracer cards	2) A recent audit has confirmed that the antenatal tracer cards are fled within the case notes (Nov 2016) 1,2,3) There have been no adverse incidents reported as a direct result of a tracer card having not been filed. 4) Audit repeated 25.11.16 and the results show that the process is working 5) Case notes belonging to women who are low risk are still located within the main health care records department and are not readily accessible. The long term plan will be to have all case notes filed within maternity reception irrespecive of patient risk status. 6) 80% of the antenatal tracer cards have now been filed 1) The new system in place (Oct 2016) ensures that antenatal tracer cards are filed following booking with the community midwife irrespective of risk and vulnerability.	4) Although a recent audit has shown a signifianct decrease in the number of tracer cards awaiting filing, it is likely to be a further 6 months before 100% have been filed.	Monitor with health records progress with the filing	Mar-17	1 x 3 = 3 GREEN	Jan-17	

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?
				7. CCG quality visit and the back log of fling is included on the action plan and will be monitored through directorate governance.							
Medical Director	4661	Lack of robust effective system for the communication of high risk or abnormal/ unexpected investigation results, and evidence of receipt, review and actions taken by clinicians. Risk of delayed or missed opportunities for diagnoses and appropriate treatment for patients, which could result in Serious Incidents, litigation and complaints	4 x 4 = 16 RED	5) Monitoring via incident reporting 4) Directorate/ specialty local 'safety net' procedures to ensure results are received and reviewed 3) Pathology local procedure(s) for the escalation of abnormal results 2) Radiology local procedure(s) "Communication of Critical and/ or Unexpected Findings to Referring Doctors" 1) Trust wide Policy CP50 for the Management of Risks Associated with Clinical Diagnostic Tests and Screening	5) Small proportion of incidents to number of investigations undertaken	1-4) Audit of local safety net procedures demonstrated significant gaps 2) Size of Radiology reports is significant resulting in inbox limits being frequently exceeded	2) Set up task and finish group to review the remaining issues re Radiology reporting, to agree and implement a robust system to ensure Radiology test results are reviewed appropriately 1-4) ICE implementation Steering group to consider configuration of ICE system to allow a robust system to ensure test results are reviewed appropriately 1-4) Implement the ICE system, ensuring it addresses the current gaps in review of reports	Nov-16 Dec-16 Feb-17	x =	Jan-17	

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	4696	If non-urgent imaging studies are not reported within the timescale of 3 - 6 weeks, delays may have an impact on timely patient management. Ideally imaging should be reported as soon as they are undertaken but this is not possible given the national shortage of staff. Date of origin: 5 January 2017 Approved by Division: 28 Dec 2016 Accepted onto Trust Risk Register: 5 Jan 2017	3 x 4 = 12 AMBER	1) Monitoring of unreported scans/imaging studies on a weekly basis (Dec 2016) 2) Locum Consultant Radiologists are being employed (Dec 2016) 3) Clinical Fellows are being employed (Dec 2016) 4) Regular meetings between Clinical Director and Group Manager (Dec 2016) 5) Waiting list initiatives for Trust Radiologists on going (Dec 2016)	2) 3 locums have successfully been employed (Dec 2016) 3) 3 Clinical Fellows have been selected (1 started and the others going through their credentialing and Home Office procedures (Dec 2016) 4) Review meetings are happening fortnightly (Dec 2016)	1) Approximately 4000 non-urgent imaging studies unreported (Dec 2016) 1) Poor patient experience if patients and doctors are unsure when their scans are reported (Dec 2016) 2), 3), 4) & 5) Demand for reporting imaging studies is higher than expanded reporting capacity (Dec 2016)	1), 2), 3), 4) & 5) To set up a link between RWT and a private reporting IT company to allow images and reports to be outsourced. The private company will be provided with the volume of work in order for the external company to the resources in place 1) To consider amending appointment letter to inform patients of delays in reporting non urgent imaging due to nationwide shortage of Radiologists 1), 2), 3), 4) & 5) Offer opportunities to Radiologists from other localities to work in our Trust. Radiology will liaise with HR about the possibility of head hunting Radiologists from other Trusts 1), 2), 3), 4) & 5) To revisit plan to recruit 7 or 8 Radiologists 1), 2), 3), 4) & 5) Educate referrers periodically on requesting only appropriate imaging studies. Clinical Directors will be contacted about this via e-mail to help with reducing inappropriate demand for imaging studies	Jan-17 Feb-17 Dec-17 Dec-17 Feb-17	2 x 4 = 8 AMBER	Jan-17	

Risk Managed to Target Level

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:	**Create a culture of compassion, safety & quality**									

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	Safe 535	If the Trust fails to achieve reductions in Healthcare Associated Infections then this will directly impact on the Trust's NHS reputation. The TDA visited the Trust to assess against HCAI and found significant environmental concerns (Resolved July 15). The trust remains off trajectory for C difficile (Jan 17) but regained monthly trajectory in September 2016. This has been sustained (Jan 17) The risk is that compliance to the regulatory standards and objectives will not be achieved. Date of origin: 07/03/05 Date of escalation = 02/03/15	2 x 3 = 6 YELLOW	1) MRSA Screening Policy in Trust audited monthly Jan 17 2) Care home patients in community screened for MRSA in response to concerns indicated by CCG/Public Health/IP teams Jan 17 3) Action plan in place for Hygiene Code to be monitored by IPCG quarterly -Jan 17 4) Device related bacteraemia reduced from 68 in 14/15 to 54 in 15/16 Jan 17 5) PCR data for Clostridium difficile monitored monthly through IPCG Jan 17 6) Care home participate in infection prevention and control audit and education. Jan 17 7) CDI Assurance process updated. Monthly reporting to IPCG on trendsJan 17 8) IV Team assist investigation on all device realted infection Jan 17 9) Surgical site infection surveillance monitored continuously Jan 17 10) Toxin positive Clostridium difficle numbers reported to commissioners monthly Jan 17 11) Training plan to care homes in place with numbers collated quarerly Jan 17	1) Fidaxomicin in use for 1st recurrance of CDI Jan 17 1) No avoidable MRSA bacteraemia case year to date Jan 17 1) Care home prevelance within normal range Jan 17 1,2) Environment Audit scores averaging 91%, and conducted monthly Jan 17 1) Community cases of C difficile stabilised Jan 17 2) Code of Practice Green in all 10 areas (Jan 17) 1) CDI on monthly trajectory from September 16-Jan 17	1,2) Catheter associated urinary tract infection surveillance not currently in place Jan 17 1,2) Urinary catheter process for removal not fully understood Jan 17 1) MRSA screening data not automatically fed due to lack of HL7 feed Jan 17 1) Breached annual expectation for CDI 16/17 Jan 17	1-6) Deliver objective 6 annual programme of work (inlcudes CDI elements) 1) Deep clean theatres and resolve Estates issues	Mar-17 Mar-17	2 x 3 = 6 YELLOW	Jan-16	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?
				12) Urinary catheter policy audited at least six monthly Jan 17 13) Able to identify high risk areas for MRSA and develop action plan to reduce issues Jan 17 14) Matrons and ward sisters auditing the environment monthly Jan 17 Deep clean programme in theatres commenced Nov 16 in progress Jan 17					

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	4558	If there is a 3 month gap before the Trust can obtain supplies of long hollow bore needles labeled 'Not For Spinal Use' or 'Specialty', patients will not receive treatment for some radiology, oncology, plastics, orthopaedic, breast surgery and chronic pain conditions unless the Trust accepts the liability for using identical long hollow bore needles labeled 'Spinal for off label use. The consequence is that the Trust will be forced to cancel patients requiring these procedures or if liability is accepted that a noxious substance is injected into tissue or a joint space.	1 x 3 = 3 GREEN	1 - Procedures that use these needles are only undertaken by trained individuals (June 2016) 2 - Procurement are monitoring the usage of the needles (June 2016) 3 - To initially only supply the 'For Spinal Use' needles to the Orthopaedic Speciatly Manager and Appleby suite Treatment room Sister for control of distribution (June 2016) 4 - Supplier is sourcing the 'Not For Spinal Use' needles (June 2016) 5 - Intrathecal chemotherapy procedures will only take place within radiology and the syringes prepared by Sterile services are securely delivered to the Radiology department (June 2016) 6 - The new supplier has a CE mark for the needles (June 2016) 7 - Procurement is monitoring the stock level and distribution of 'Specialty' Needles (June 2016)	1 - No incidents have been reported 2, 3, 4 - There are enough supplies of the 'Specialty' labelled needles for Radiology and Oncology provided that we get new supplies in October at the latest 5.Chemotherpay supplised by Sterile Services is recorded in a register and securely delviered to Radiology	2 - The supply of 'Specialty' Needles is diminishing 1 - Appleby Suite and Orthopaedic theatres at NX and Cannock - (which are the major users in the Trust) have reached the end of their supply and procurement have ordered the 'For Spinal Use' labelled needles.	4- The supplier to source the relabelled 'Not For Spinal Use' needles 3,4,6,7 - Update PSIG 3,4,6,7 - Review monthly until supplies arrive 3,4,6,7 - Monitor incidents	Aug-16 Aug-16 Oct-16 Oct-16	1 x 3 = 3 GREEN	Jan-17	