The Royal Wolverhampton NHS Trust	NHS

Trust Board

Meeting Date:	31st Jul 2017
Title:	Board Assurance Framework / Trust Risk Register
Executive Summary:	BAF Key Issues **0 new risks.** **4 red risks**: **SR1** - Workforce - Recruitment and Retention of staff across the Trust and in particular the future pipeline of nursing and medical staff **SR8** - That there is a failure to deliver recurrent CIP's. **SR9** - That the underlying deficit that the Trust has (in 2017/18) is not eliminated in medium term to bring the Trust back to financial surplus. **SR10** - That the Trust fails to generate sufficient cash to pay for its commitments. Trust Risk Register Key Issues **1 new risk:** 4767 - Hip Fracture Best Practice Tariff (COO) **2 risks removed:** 4650 - CICT Model change (COO) 4709 - Beynon Centre - Unsuitable Paediatric Environment (COO) **6 red risks:** 4161 - Shortage of Qualified Nurses across the Division (COO) 2080 - Risk to quality of patient care: reduced manpower (COO) 4718 - Safeguarding Team Staffing (CNO) 4711 - CCH - Handling Medical Gas Cylinders (COO) 4661 - Lack of robust system for review and communication of test results (MD) 4472 - Delays in Cubicle Assessment and Triage (COO). 4113 - Division 1 failure to achieve CIP target (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 Annual Governance Statement".

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:

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

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

	ID	Risk Title	Lead
RED	SR1	Workforce - Recruitment and Retention of staff across the Trust and in particular the future pipeline of nursing and medical staff	HRD
	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)	32
Risks managed to target level	0

There are currently 32 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		1 risk	12 risks	3 risks	1 risk
3 – Possible		2 risks	5 risks	6 risks	
2 – Unlikely					
1 – Rare					

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

	ID	Risk Title	Lead
RED	2080	Risk to quality of patient care: reduced manpower	COO
	4661	Lack of robust system for review and communication of test results	MD
	4711	CCH - Handling Medical Gas Cylinders	COO
	4718	Safeguarding Team Staffing	CNO
	4113	Division 1 failure to achieve CIP target	COO
	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		1		
2) Proactively seek opportunities to develop our services				
3) To have an effective & well integrated organisation that operates efficiently		5		
4) Maintain financial health - appropriate investment enhancement to patient services	1	3		
5) Attract, retain & develop our staff & improve employee engagement	2	3	1	
6) Create a culture of compassion, safety & quality	3	12	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 (Jul 2017)

Lead Director	Risk	Risk Title	Field updated	Update made
Chief Nursing Officer	3644	Failure to make an improvement in compliance gaps with CQC standards.		
			Action Plan - **New**	Audit of safeguarding and complaints regarding discharge communication as a theme.
			Action Plan - **New**	Development of E-learning training package for DOLS
			Action Plan - **New**	Purchase of MCA/DOLS Educational material
			Action Plan - **New**	Gap analysis of NHSI 'Developmental reviews of leadership and Governance using the well led framework guidance for NHS Trusts' to be presented to Board
			Action Plan - **New**	Collaborative working with CCG regarding information/education to care homes and carers regarding safeguarding requirements for PI's
			Positive Assurance - **New**	Discharge action plan on track and presented to PSIG July by HofN's.
	4718	Safeguarding Team Staffing		
			Action Plan - **New**	To regularly contact the chair of the groups and review urgent actions post meetings
Chief Operating Officer	2898	Patients having to wait in ED in the Ambulance off load area		
			Gap in Assurance - **New**	Highest volume of pts seen in unit on single day experienced in month. 500+ pts and 160+ ambulances
			Action Plan - **New**	Developing nurse led RAT
	4767	Hip Fracture Best Practice Tariff		
			*****New risk*****	If the trust fails to achieve all 5 mandatory criteria for the Hip Fracture Clinic Best Practice Tariff, then this will potentially lead to poor clinical outcomes for patients. Also, if the best practice criteria are not achieved this will result in the Directorate failing to achieve additional income of BPT.
	4696	Unreported Imaging Studies		
			Positive Assurance - **New**	0 locums have successfully been employed
			Gap in Assurance - **New**	Approximately 6284 non-urgent imaging studies unreported July 2017 (inclusive of 772 CT scans and 1881 MRI scans)
	4472	Delays in Cubicle Assessment and Triage		
			Positive Assurance - **New**	1 NHS 2 year locum appointed to start 01/09/17
			Positive Assurance - **New**	1 substantive adult consultant appointed to start 01/09/17
	4650	CICT Model change		
			*****Risk closed*****	

	4709	Beynon Centre - Unsuitable Paediatric Environment		
			Risk deescalated to Directorate risk register	14/07/2017 – Deputy COO agreed that this can now be removed from the Divisional Risk Register
	4599	Emergency Services Governance Arrangements		
			Positive Assurance - **New**	NICE guidance is progressing
			Positive Assurance - **New**	SI numbers have decreased in month
			Action Plan - **New**	ED action plan and risk register to form the template for the fortnightly review meetings
	2080	Risk to quality of patient care: reduced manpower		
			Positive Assurance - **New**	ACSG matron role secondment appointed to (6 month initially)
			Gap in Assurance - **New**	64 WTE trained nursing vacancies remain (37 jobs offered but staff not in post yet)
			Gap in Assurance - **New**	Some deterioration in compliance with Special Measures action plan on A7 & A8
			Action Plan - **New**	C22 action plan to address urgent concerns to be developed and implemented
			Action Plan - **New**	Meet with Director of Nursing to review all CNS job plans
	4161	Shortage of Qualified Nurses across the Division		
			*****Risk Downgraded*****	Was RED now AMBER
			Positive Assurance - **New**	General Surgery nearly fully established. T&O fully established for beds open and ICCU have no vacancies
			Action Plan - **New**	Commencement of nursing workforce strategy
	4715	Dermatology Service		
			Positive Assurance - **New**	Monitoring and light clinics moved to NXH for 12 months
			Gap in Assurance - **New**	1 x substantive consultant on long term planned sick leave which started in Feb 17
			Gap in Assurance - **New**	1 x B2, 2 x Bd7 and 1 x Bd5 vacancy
			Gap in Assurance - **New**	2 x B5 Nursing staff on maternity leave
			Gap in Assurance - **New**	1 x full time and 1 x part time locum consultant due to start in August 2017 have now declined
			Action Plan - **New**	Band 7 Specialist Dermatology nurse advert out for recruitment
			Action Plan - **New**	Directorate to draw up plan to address gap caused by locum duo who declined contract
	3069	Risk of Never Events within Division 1: Risks to Patient Safety and Trust reputation		
			Gap in Assurance - **New**	1st NE in 17/18 reported to CCG – CCH/Theatres (wrong site surgery – regional block administered to wrong limb) reported (Datix ID: 179911) occurred June 2017

			Action Plan - **New**	RCA investigation to be undertaken into the NE Wrong Site Surgery (wrong block) Datix 179911
Chief Financial Officer	4791	Unplanned activity leading to financial pressures		
			Action Plan - **New**	Business case for agreed additional activity to be formulated by specialty and submitted to Contracts and Commissioning Group.
	4794	The 2016/17 year end invoice		
			Action Plan - **New**	Issue was raised at the quarterly review meeting with NHS Improvement on 13 July 2017. Directors of both organisations were present and it was agreed that NHS Improvement would now escalate further for a conclusion.

The Royal Wolverhampton NHS Trust

Board Assurance Framework 2017/18

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.

- (Red) - The origin of the strategic (principle) risk is significantly impacting on the risk.
- (Amber) - The origin of the strategic (principle) risk is still impacting on the risk to a limited extent.
- (Green) - 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.

- (Red) - Effective control partially in place and thus only impacting in a limited way on the mitigation of the strategic risk.
- (Amber) - Effective control in place but only partially impacting on the mitigation of the strategic risk
- (Green) - 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 2017/18 (JUL)

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 2	SCORE AT QUARTER 3	SCORE AT QUARTER 4	SCORE AT QUARTER 1	MOVEMENT Q1 TO Q2	SINCE LAST UPDATE	CURRENT RISK & SCORE AT QUARTER 1 (17/18)	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	20	20	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	12	16	16	12	→	→	12				✓		
SR6b	Black Country or Staffordshire STP has an adverse impact on RWT income or services	Director of Strategic Planning and Peformance	15	9	9	9	9	→	→	9				✓		
SR8	That there is a failure to deliver recurrent CIP's	Chief Operating Officer	20	20	20	20	20	→	→	20				✓		
SR9	That the underlying deficit that the Trust has (in 2017/18) is not eliminated in medium term to bring the Trust back to financial surplus.	Chief Financial Officer	15	20	20	20	20	→	→	20				✓		
SR10	That the Trust fails to generate sufficient cash to pay for its commitments	Chief Financial Officer	20	20	20	20	16	→	→	16				✓		
SR11	Condition of the existing Estate - Quality and flexibility	Chief Financial Officer	12	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 INITIAL RISK SCORE	PREVIOUS QUARTER RISK SCORE	CURRENT RISK	TARGET RISK SCORE	CURRENT ASSURED LEVEL	Movement
	5x3=15	3x5=15	20	5x2=10		

What is the strategic risk to be controlled?

REF	STRATEGIC RISK	EXECUTIVE DIRECTOR	BOARD COMMITTEE	CURRENT ASSURED LEVEL	Movement
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 Workforce	Finance and Performance		

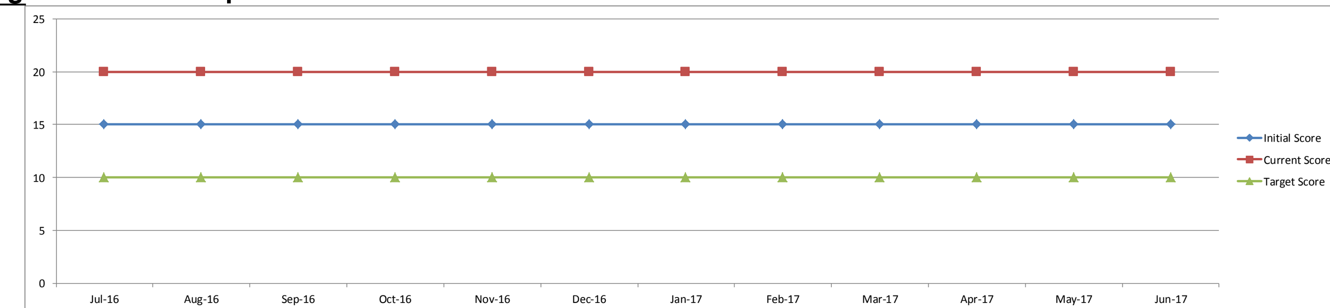
OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC OBJECTIVE

RISK TITLE	RISK No.	GRADE	OPERATIONAL RISK DESCRIPTION
Consultant Job Plans	1713	4 x 3 = 12 amber	Failure to effectively maximise workforce productivity; failure to routinely review consultant job plans.
Recruitment and retention of Nursing staff - Division 2	2080	5 x 4 = 20 red	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 or harm.
Qualified Nurse staffing levels - Division 1	4161	5 x 3 = 15 red	If there are reduced qualified nursing staffing levels across the Division then there is a risk to patient safety and quality of care.
Unable to recruit substantive Dermatology consultants	4715	5 x 3 = 15 red	If the Trust is unable to recruit substantive Dermatology consultants it will not be possible to provide the right level of care for patients.
Vacancies in consultant or non-consultant medical staff across Division 1.	4529	4 x 3 = 12 amber	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.

IMPACTS / CONSEQUENCES OF THE RISK?		ORIGINS OF THE RISK?	
REF		**REF**	
IC 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.	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.
IC 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.	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.
IC3	Ability to attract suitability qualified staff and retain them with the potential for costs involved in attracting and retaining staff becoming unaffordable.	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. The potential impact of Brexit is not quantified.
IC4	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, reduced staffing, impacting patient care and remaining staff morale and satisfaction.	O4	Shortage of workforce supply and competition from other NHS Providers and agencies - who may have stronger benefits or workforce initiatives.

Ref	Controls *What are the controls in place to mitigate these risks?*	*Level of assurance (L1, L2, L3)	Where and how often reported/monitored?
C1	Recruitment and recruitment initiatives (including Overseas) for **Doctors** to complement local and national recruitment.	L2	Workforce Assurance Group, Resourcing Operational Group, TMC, TB
C2	Recruitment and recruitment initiatives (including Overseas) for **Nurses** to complement local and national recruitment.	L1, L2	Workforce Assurance Group, Resourcing Operational Group, TMC, TB
C3	Staffing establishment reviewed regularly through the annual workforce plan to provides a clear route/organisational plan for bringing in future workforce pipelines.	L1, L2, L3	Workforce Assurance Group, NHSI
C4	Progress report on Trustwide workforce review to include the development of new roles.	L2	Workforce Assurance Group
C5	Develop a strategic approach to People Management and employee engagement and measure outcmes of people and OD strategy.	L2	Workforce Assurance Group

***Level 1 = Operational/Level 2 = internal oversight/Level 3 = Independent Assurance**



What are the positive assurances (actual as opposed to potential) received?				
Control Ref	Date Assurance provided	POSITIVE ASSURANCE		COMMENT
		What is the source for assurance?	What assurance is provided?	
C1	01/01/2017 June 17	1. Workforce Assurance Group - Resourcing and Medical Workforce Updates. 2. Executive HR Report to TMC and Trust Board. 3. Medical Resourcing Group established to review Medical Recruitment and Retention Actions.	At Jan 2017 EEA workforce was 2.5% of the whole Trust workforce, retention rates have been reviewed and there is continued monitoring of retention rates. - Agencies are used to source UK and overseas doctors in addition to the standard recruitment routes within the UK. Overseas medical recruiment continues and has increased. - In addition, for medical staff the Trust has introduced a Clinical Fellowship programme to attract medics into the Trust securing 73 new starters to June 2017. Clinical Fellow recruitment has increased. Retention of staff was the focus of Chatback 2016. The Trust exit process has been reviewed and has been refreshed. Chatback 2017 focused on Trust vision and values - there is a report to WAG and Trust Board on the issues identified.	R&R split for Medics C1 and Nursing C2.
C2	01/05/2017 June 17	1. Workforce Assurance Group 2. Nurse Steering Group reviews Nurse Recruitment and Retention Actions. 3. Safer Staffing Updates in Chief Nurse Update report to TMC and Trust Board. 4. Executive HR report to TMC and Trust Board.	The International recruitment campaign to the Philippines has secured 43 new starters with PIN to July 2017 . A further 13 candidates remain in the pipeline. The national recruitment campaigns have secured 19 trainee Nursing Associates and 28 offers in March 2017 for RNs with September 2017 start date.Retention of staff was the focus of Chatback 2016. The Trust exit process has been reviewed and has been refreshed. Chatback 2017 is focusing on Trust vision and values. A new group is being established to review the Attraction and Retention Stragey for the Trust.	
C3	01/05/2017 June 17	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 Workforce. 5. Trust CIP Workforce Programme Updates on a monthly basis to include E-roster and Agency/Bank/Locum analysis.	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 CIP Workforce Progaramme has a workstream to control the use of agency, locum and bank staff - AndTrust wide resource review is planned. - E-rostering established to ensure staffing levels on wards are optimised. -Discussions with Allocate have taken place to review the use of Job Planning Module to provide a control and baseline for medical staffing.	There is now some evidence that the spend on agency is decreasing - NHSI have reviewed the Trust agency data - assurance is now looked for that the permanent workforce spend is also being controlled and is not rising as a result.
C5,C6	01/09/2016 June 17	People and Organisation Development Strategy 2016-2020 progress report to Worforce Assurance Group	People and Organisation Development Strategy 2016-2020 KPI to be reported have been agreed.	

NEGATIVE ASSURANCES are …					Jun 17 Status
What are the negative assurances received?					Update received
Control Ref	Date Assurance provided	NEGATIVE ASSURANCE (include reasoning as appropriate)	ACTION PLAN	ACTION LEAD	AGREED DEADLINE
C1	01/01/2017 June 17	Length of time from interview to start date over 6 months.	- At Jan 2017 EEA workforce is 2.5% of the whole Trust workforce, retention rates have been reviewed and there is continued monitoring of retention rates. - Agencies are used to source UK and overseas doctors in addition to the standard recruitment routes within the UK.	Chief Nurse Medical Director	Ongoing
C1, C2	Jun-17		Trustwide Workforce CIP Resourcing review to be intiated through FRB.	Director of Workforce Medical Director Chief Nurse	Ongoing
C1, C2	Jun-17	Further develop Recruitment and Retention focus	Develop monitoring of length of time to recruit (advert to appointment timescale) Develop Steering group to target ' work progress. Develop electronic exit interviews. Establish and report on a Workforce stabillity index (focus on outlying depts) Consider/develop other retention measures.	Director of Workforce	Work in development - TBC
C2	Jun-17	There is no Recruitment and Retention Strategy for Doctors.	Develop a Recruitment and Retention Strategy for Doctors.	Director of Workforce Medical Director	Aug-17
C3	Jun-17	Longer term plans to establish a central resourcing and temporary staffing function that handles internal bank and external agency placement requests for all. Exploratory meetings with stakeholders were completed by April 2017.	The Workforce CIP Group reviews the action plan and deliverables for the PID on Agency, Locum and Bank use - this is done on a monthly basis. Regional work has been initiated to balance safe staffing provision and compliance with agency cap.	Director of Workforce	Sep-17
C3	Jun-17	Controls over agency and locum use require further control in place in order to have a planned and financially sustainable approach to temporary staffing, including to: - review compliance and spend levels against cap levels - review of the effectiveness of controls systems (ie business process, IT, monitoring) - review the operation and effectiveness of internal bank	This is montiored on a monthly basis at Workforce CIP with target for 2017-2018 year of £2 million reduction.	Deputy Director of HR	01/10/2016 Approved Delivery for 206-2017 year on target - Stretch target set for 2017-20-18 year
C5	Jun-17	The People and Organisation Development Strategy 2016-2020 has outcomes, measures and metrics. Engagement and Culture and Organisation Development require further action planning in order to ensure improved employee engagement, involvment and satisfaction are reflected in improved retention figures to result in increased tenure and improved patient experience within the Trust. KPI reporting against the People and OD Strategy is not yet commenced.	The outcomes within the strategy on Organisaiton Development and Engagement and Culture are being developed and action planning is underway in order to ensure employee engagement, involvement and wellbeing have a positve impact on retention and ultimately upon patient experience. The next step is to report on metrics and KPIs to provide Board assurance on Trends.	Deputy Director of HR	Aug-17

ASSURANCE FRAMEWORK

Strategic Objective: Maintain Financial Health - appropriate investment enhancement to patient services.

STRATEGIC (PRINCIPLE) RISKS		LIKELIHOOD x CONSEQUENCE = RISK SCORE				CURRENT ASSURED LEVEL	*Movement*
		INITIAL RISK SCORE	PREVIOUS QUARTER RISK	CURRENT RISK SCORE	TARGET RISK SCORE		
		3x4=12	4x4=16	4x3=12	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 3 = 12	⬇

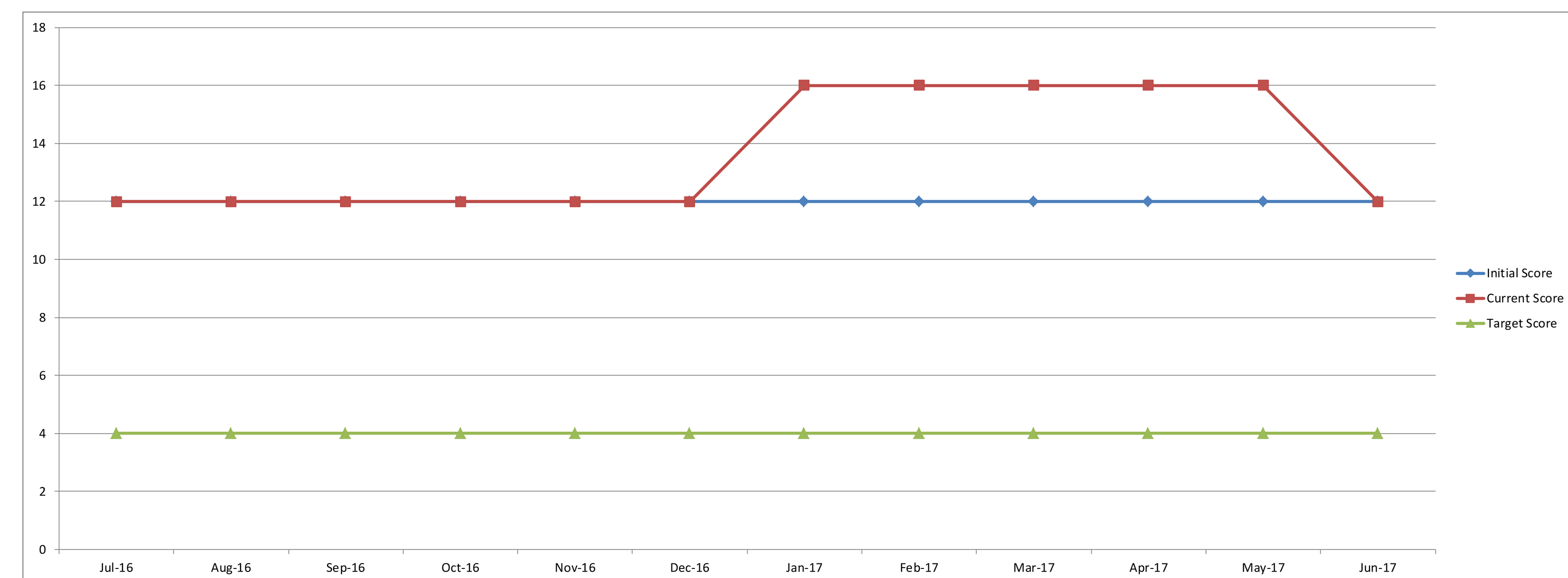
OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC OBJECTIVE?

RISK TITLE	RISK No.	GRADE	OPERATIONAL RISK DESCRIPTION
Division 1 failure to achieve CIP target for 2016/2017.	4113	4 x 5 = 20 red	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.
Capital Programme under threat	4584	3 x 4 = 12 amber	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.

IMPACTS / CONSEQUENCES OF THE RISK?		ORIGINS OF THE RISK?	
REF		REF	
IC 1	Inability to maintain Quality and Safety	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
IC 2	Inability to deliver operational and commissioner targets	O2	Failure to identify and deliver savings, efficiencies or additional income to ensure the transaction is sustainable on an going basis.
IC 3	Inability to meet 18 week RTT		
IC 4	STP may not deliver the financial surpluses to resolve the underlying financial affordability gap.		

Ref	Controls *What are the controls in place to mitigate these risks?*	*Level of assurance (L1, L2, L3)	Where and how often reported/monitored?
C1	Monitoring of the financial position through activity and income to Finance and Performance	L1, L2	Reported F&P (monthly)
C2	Transformation report on theatres and in particular efficiency opportunities at Cannock	L1, L2	Board Performance Report (monthly)
C3	Updates on Sustainability and Transformation Plans	L2	Service Line Reporting taken to F&P for regular updates.
C4	Full benefits realisation of MSFT transaction to be detailed.	L2	Internal Audit report to Audit Committee (as per 2017/18 plan)
C5	External and internal Financial Control audits	L3	Reports to Audit Committee (4 times a year)

***Level 1 = Operational/Level 2 = internal oversight/Level 3 = Independent Assurance**



What are the positive assurances (actual as opposed to potential) received?				
Control Ref	Date Assurance provided	POSITIVE ASSURANCE		COMMENT
		What is the source for assurance?	What assurance is provided?	
C1	Apr-17	Trust Board finance and Performance report and supplementary reports	Detailed focus on the the risk as it affects the Trust and updated actions in place.	
C2	Sep-16	FRB reports through to TMC	Ongoing reports that the CIP programme is being delivered so that the underlying deficit is addressed.	
C1, C4	Sep-16	Reports to Finance and Performance on underlying financial contribution to £6m service deficit.	Detailed finanical reports detailing the improvement of the underlying financial position.	

NEGATIVE ASSURANCES are …					Jul 17 Status
What are the negative assurances received?					Update received
Control Ref	Date Assurance provided	NEGATIVE ASSURANCE (include reasoning as appropriate)	ACTION PLAN	ACTION LEAD	AGREED DEADLINE
C1		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	Ongoing
C1		The Trust shared the original business case and letters of correspondence from NHS Improvement on the MSFT deficit funding 23rd January 2017 and an updated business with regard to the MSFT transaction on 27 March 2017 and NHS Improvement are supportive but have not identified the financial resources.	The issue was raised at the quarterly review meeting with NHS Improvement on 13th July 2017. The regional team fully supported the Trsut and would continue to raise with NHS Improvement nationally and the DH. This has not yet been fully approved and paid however.	Kevin Stringer	
C2		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
C1, C4		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

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**		
	15	9	9	0		

What is the strategic risk to be controlled?

REF	STRATEGIC RISK	EXECUTIVE DIRECTOR	BOARD COMMITTEE	CURRENT ASSURED LEVEL	Movement
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		

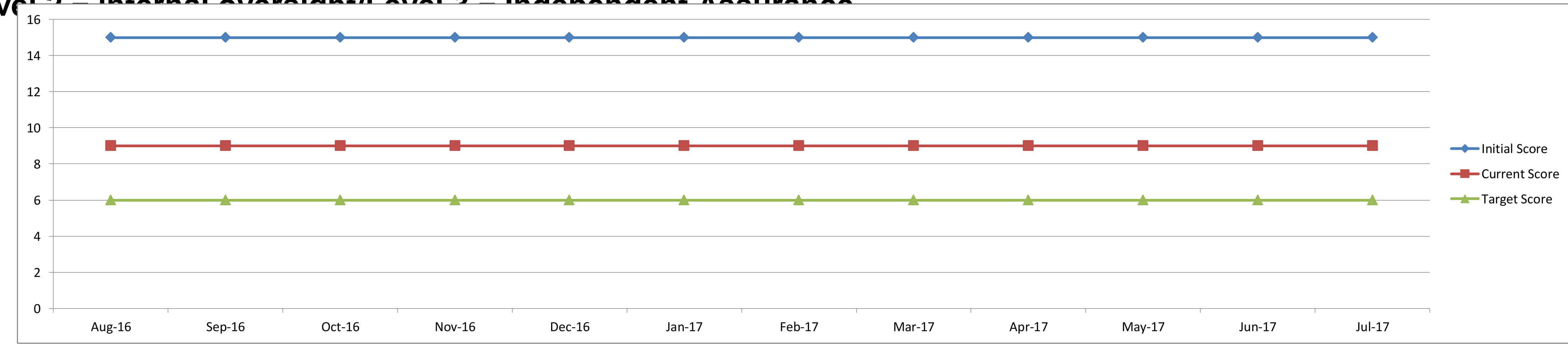
OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC OBJECTIVE

RISK TITLE	RISK No.	GRADE	OPERATIONAL RISK DESCRIPTION
Significant financial pressure in the NHS Capital programme.	4584	Amber	Due to significant financial pressures in the NHS the Capital programme presented to the Trust in April may be under threat if the CRL is not approved by NHSI.

IMPACTS / CONSEQUENCES OF THE RISK?		ORIGINS OF THE RISK?	
REF		**REF**	
IC 1	This will result in reduced income for the Trust	O1	All Trusts are required to participate in Strategic Transformation programmes.
IC 2	Commissioners may decommission services		

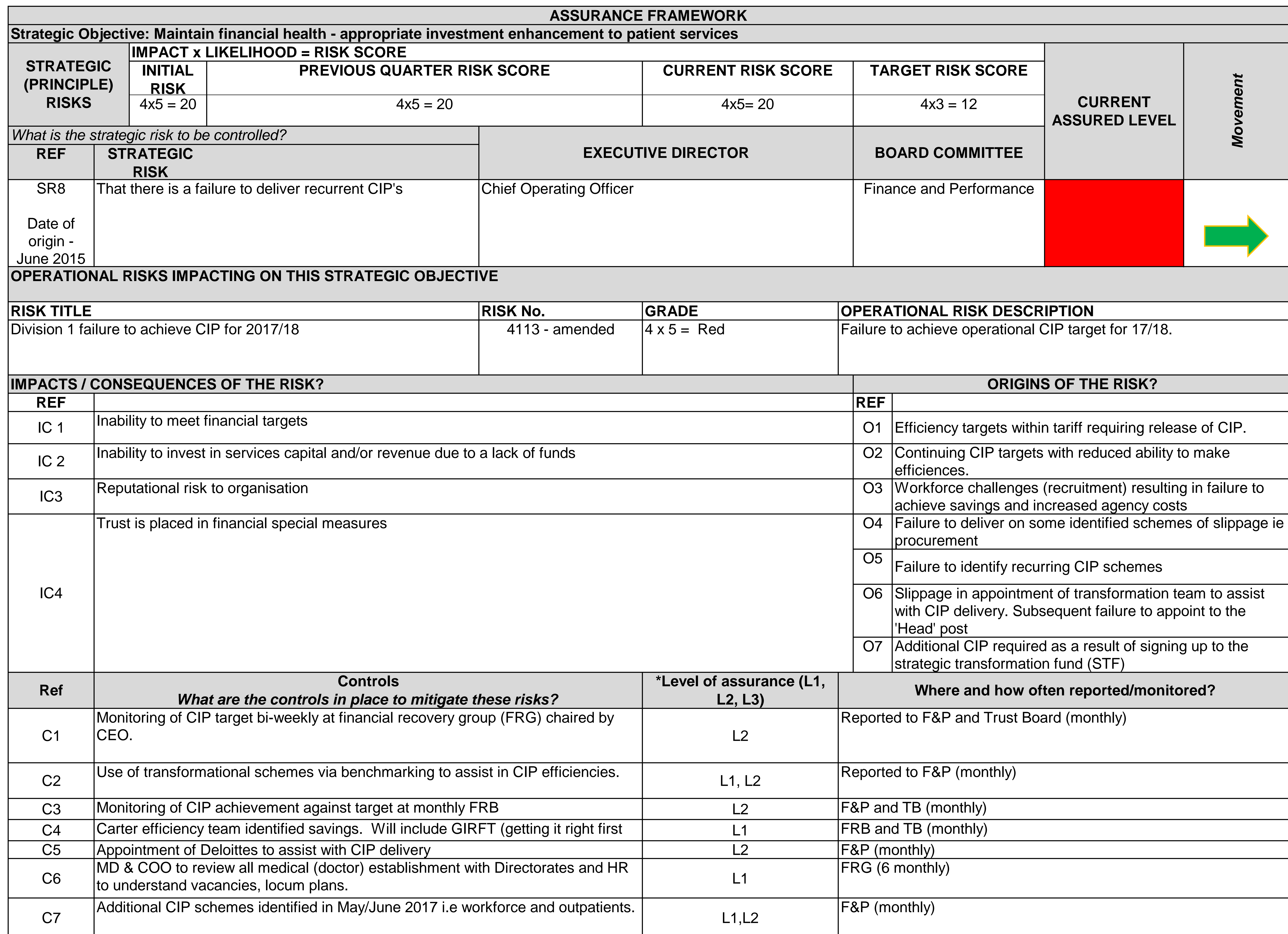
Ref	Controls *What are the controls in place to mitigate these risks?*	*Level of assurance (L1, L2, L3)	Where and how often reported/monitored?
C1	Stafforshire STP published in December 16, Black Country STP published November 16, updates to be reported.	L2	Reported to F&P and Trust Board (monthly)
C2	Staffordshire STP - Clinical and managerial staff engaged in orthopaedics and ophthalmology workstreams and estates director invovled in estates workstream	L1, L2	Reported to F&P
C3	Black Country STP - CEO or Director of Strategic Planning and Performance attends Sponsor Group.	L2	Reported to F&P and TB
C4	Finance Lead attends Staffordshire and Black Country STP workstreams providing a report as and when appropriate.	L2	Reported to F&P

***Level 1 = Operational/Level 2 – internal oversight/Level 3 – Independent Assurance**



What are the positive assurances (actual as opposed to potential) received?				
Control Ref	**Date Assurance**	**POSITIVE ASSURANCE**		**COMMENT**
		What is the source for assurance?	***What assurance is provided?***	
C1	01/09/2016 June 17	Director STP progress report	Current STP submissions have not identified any adverse impact on the Trust	
C2	Jun-17	Staffordshire STP and Black Country STP update.	Progress feedback to Directors on workstreams on an as and when basis.	
C3	Jun-17	Sponsor group update	Discussion commenced around the development of RWT as the main provider of specialist services in the Black Country.	

NEGATIVE ASSURANCES are …					**Jul 17 Status**
What are the negative assurances received?					Update received
Control Ref	**Date Assurance provided**	**NEGATIVE ASSURANCE (include reasoning as appropriate)**	**ACTION PLAN**	**ACTION LEAD**	**AGREED DEADLINE**
C1		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	01/07/2016 and ongoing



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	**PREVIOUS QUARTER RISK SCORE**	**CURRENT RISK SCORE**	**TARGET RISK SCORE**	
	4x5 = 20	4x5 = 20	4x5= 20	4x3 = 12	

What is the strategic risk to be controlled?

REF	STRATEGIC RISK	EXECUTIVE DIRECTOR	BOARD COMMITTEE	CURRENT ASSURED LEVEL	Movement
SR8 Date of origin - June 2015	That there is a failure to deliver recurrent CIP's	Chief Operating Officer	Finance and Performance		

OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC OBJECTIVE

RISK TITLE	RISK No.	GRADE	OPERATIONAL RISK DESCRIPTION
Division 1 failure to achieve CIP for 2017/18	4113 - amended	4 x 5 = Red	Failure to achieve operational CIP target for 17/18.

IMPACTS / CONSEQUENCES OF THE RISK?		**ORIGINS OF THE RISK?**	
REF		**REF**	
IC 1	Inability to meet financial targets	O1	Efficiency targets within tariff requiring release of CIP.
IC 2	Inability to invest in services capital and/or revenue due to a lack of funds	O2	Continuing CIP targets with reduced ability to make efficiences.
IC3	Reputational risk to organisation	O3	Workforce challenges (recruitment) resulting in failure to achieve savings and increased agency costs
IC4	Trust is placed in financial special measures	O4	Failure to deliver on some identified schemes of slippage ie procurement
		O5	Failure to identify recurring CIP schemes
		O6	Slippage in appointment of transformation team to assist with CIP delivery. Subsequent failure to appoint to the 'Head' post
		O7	Additional CIP required as a result of signing up to the strategic transformation fund (STF)

Ref	**Controls** ***What are the controls in place to mitigate these risks?***	***Level of assurance (L1, L2, L3)**	**Where and how often reported/monitored?**
C1	Monitoring of CIP target bi-weekly at financial recovery group (FRG) chaired by CEO.	L2	Reported to F&P and Trust Board (monthly)
C2	Use of transformational schemes via benchmarking to assist in CIP efficiencies.	L1, L2	Reported to F&P (monthly)
C3	Monitoring of CIP achievement against target at monthly FRB	L2	F&P and TB (monthly)
C4	Carter efficiency team identified savings. Will include GIRFT (getting it right first	L1	FRB and TB (monthly)
C5	Appointment of Deloittes to assist with CIP delivery	L2	F&P (monthly)
C6	MD & COO to review all medical (doctor) establishment with Directorates and HR to understand vacancies, locum plans.	L1	FRG (6 monthly)
C7	Additional CIP schemes identified in May/June 2017 i.e workforce and outpatients.	L1,L2	F&P (monthly)

***Level 1 = Operational/Level 2 = internal oversight/Level 3 = Independent Assurance**

What are the positive assurances (actual as opposed to potential) received?				
Control Ref	Date Assurance provided	POSITIVE ASSURANCE		COMMENT
		What is the source for assurance?	*What assurance is provided?*	
C1	Jun-17	FRG reporting	Focus on key workstreams which includes Theatres, Outpatients, Workforce, Pharmacy, Pathology and back office (procurement)	CIP target is phased into the latter part of the year, additional theatre CIP agreed.
C2	Jun-17	FRG reporting	CIP schemes continue to be indentified (mainly non recurrent). PIDs agreed by Directors and PSIG.Carter deep dive reviewed by Executive Directors to focus on schemes in Division 1 and 2.	Non-recurrent CIP in Qtr 1 higher than forecast.
C3	Jun-17	FRB CIP reporting	CIP continues to be identified	See Above. Recurrent schemes under achieved.
C4	Jun-17	CIP Report	CIP report in April identified Cardiology and Rheumatlogy for first Carter efficiencies. Further reviews of specialties following Carter methodology have been undertaken.	Schemes have been reviewed. Will now include GIRFT schemes.
C4	Jun-17	Product lines standardised by Procurement.	Catalogue lines reduced and further review on-going	Director of Finance (Procurement)
C5	Jun-17	FRG reporting to F&P	Deloitte onsite (June 16) and extended for 6 months. FRP developed - actions commenced formal sign off. Regular FRG report to F&P.	Contract extended until Sept 17. Failed to appoint into post. Further extention requested.
C6		Progress update	Meetings identifying plans for recruitment use of clinical fellows and also where gaps in directorate planning.	Resource meetings completed April 17. Control meetings to commence from July 17.
C7	Jul-17	New details in existing report	Additional CIP include GIRFT, CSSD, Theatres	See C1.

NEGATIVE ASSURANCES are …

What are the negative assurances received?					Jul 17 Status Update received
Control Ref	Date Assurance provided	NEGATIVE ASSURANCE (include reasoning as appropriate)	ACTION PLAN	ACTION LEAD	AGREED DEADLINE
C1	Jun-17	There remains a CIP target with no plans for achievement	All areas reviewing plans. Focusing on 17/18 delivery. Update to F&P and Trust Board in July.	Head of Transformation	Jun-17
C2	Jun-17	There is a shortfall against recurrent CIP.	All groups in FRB have an action plan for delivery.	Head of Transformation	Jun-17
C3	Jun-17	As a result of agreeing (STF) control totals additional CIP is required.	All Trust members to identify CIP when possible - Link to C1. Focus now on 17/18 plan and delivery.	All (COO)	Jun-17
C4	Jun-17	Carter efficiencies are not yet confirmed	Continuing work to 'realise' what has been identified and ascertain potential savings. Work is ongoing.	Director of Strategy & Medical Director	Ongoing
C5	Jun-17	Failure to appoint transformational lead post	Continue with Deloittes	Director of Strategy	Sep-17
C6	Jun-17	Agency spend variance from control total.	Focus on reduction in agency spend, medical i.e. clinical fellowship, recruitment. Non medical appointment to post. Reductions in agency coming online. Also with IRS35 changes.	Chief Operating Officer	April 17 ongoing
C3		FIP 2 (NHSI) Finance Improvement - Trusr considering joining FIP 2, matching process currently underway.	Closed - Trust did not join FIP 2.	CEO/FD	Apr-17

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	PREVIOUS QUARTER RISK SCORE	CURRENT	TARGET RISK		
	5x3 = 15	5x4 = 20	5x4= 20	5x2 = 10		

What is the strategic risk to be controlled?

REF	STRATEGIC RISK	EXECUTIVE DIRECTOR	BOARD COMMITTEE	CURRENT ASSURED LEVEL	Movement
SR9 Date of origin - June 2015	That the underlying deficit that the Trust has (in 2017/18) is not eliminated in medium term to bring the Trust back to financial surplus	Chief Finance Officer	Finance and Performance	(red)	(green arrow →)

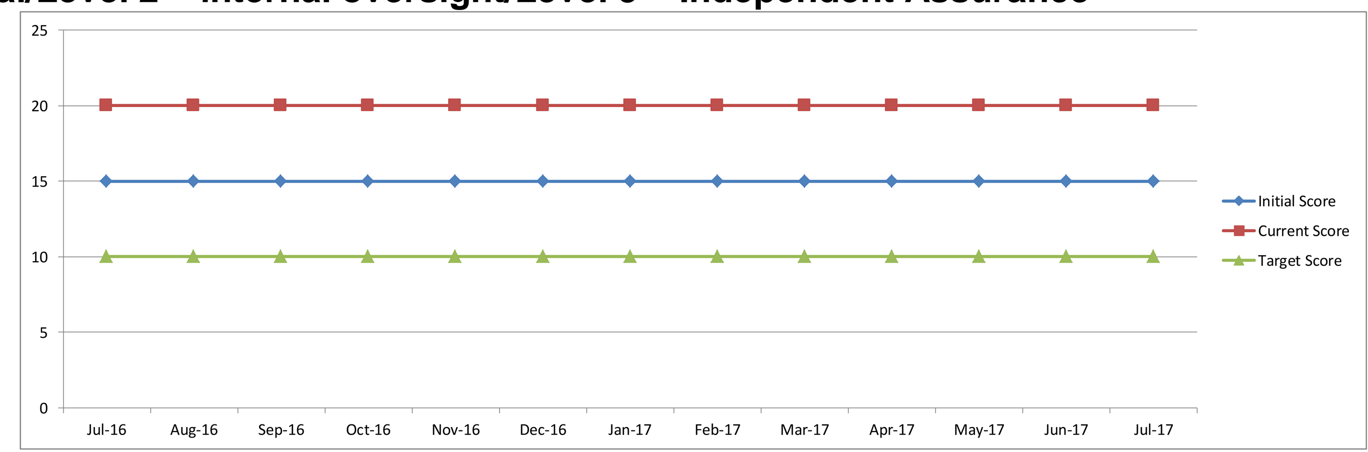
OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC OBJECTIVE

RISK TITLE	RISK No.	GRADE	OPERATIONAL RISK DESCRIPTION
Division 1 failure to achieve CIP target	4113	4 x 5 = 20 red	If Division 1 are unable to achieve the identified CIP target for 2017/2018 then there are implications for the financial position of the Trust
Capital Programme under threat	4584	3 x 4 = 12 amber	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.

REF	IMPACTS / CONSEQUENCES OF THE RISK?	REF	ORIGINS OF THE RISK?
IC 1	That the Trust will be placed into recovery and turnaround by NHSI	O1	Lack of fully detailed Recurrent Cost/Efficiency Improvement Programme in 2016/17
IC 2	The Trust could have to apply for a working capital loan to the Independent trust Financing Facility for working capital/financing That the Trust is judged as not sustainable		
IC3	Reputational risk to organisation		

Ref	Controls ***What are the controls in place to mitigate these risks?***	*Level of assurance	Where and how often reported/monitored?
C1	Further detailed Efficiency/Productivity plans from Divisions and Departments.	L1	Reported to F&P and Trust Board (monthly)
C2	Detailed plans to deliver to contracted levels of activity	L1	Reported to F&P
C3	On-going identification and delivery of Carter initiatives on staffing, estates, procurement and pharmacy/medicines.	L1	Reported to FRB
C4	Action on Agency Costs as per TDA guidance on capping arrangements.	L1	Reported monthly to F&P
C5	Receipt of Deloitte report on Trust CIP and Transformation Programme. Management capacity. Clear list of actions identified.	L2	Reported to F&P
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.	L2	Reported to F&P

***Level 1 = Operational/Level 2 = internal oversight/Level 3 = Independent Assurance**



What are the positive assurances (actual as opposed to potential) received?				
Control Ref	**Date Assurance provided**	**POSITIVE ASSURANCE**		**COMMENT**
		What is the source for assurance?	***What assurance is provided?***	
C1		Finance and Performance TPEG report	Further efficiency from deep dive reviews being identified. FRB is being reconstituted to look solely at the £10.5 recurring CIP gap and the PIDs that have been approved will be reported on at Operational Finance Group.	
C3	May-17	FRB report to Finance and Performance Committee and the Board	Further opportunities have been identified	
C4	Jul-17	FRB report to Finance and Performance Committee and the Board	Balance scorecard now being produced on key issues as per NHS Improvement best practice. Month 3 financial reports show that the level of agency spend has reduced to £983k in June from an average of £1.3m per month in 2016/17.	
C5		Finance and Performance then Trust Board	Positive report on the process for tracking and reporting CIP schemes received	

NEGATIVE ASSURANCES are …					**Jul 17 Status**
What are the negative assurances received?					Update received
Control Ref	**Date Assurance provided**	**NEGATIVE ASSURANCE (include reasoning as appropriate)**	**ACTION PLAN**	**ACTION LEAD**	**AGREED DEADLINE**
C1		Business case on fellowship programme still needs finalising to identify how additional posts can reduce Agency Costs.	Complete business case for discussion and agreement	Medical Director and Director of Workforce	Jun-17
C2		Activity levels are below planned levels for April and May 2017.	To recover activity to contracted levels.	Deputy COO Division 1 and supporting Group Managers	Sep-17
C2 (A)		There is a potential for further income loss due to the effect of the Physician A/B model and implementation of AEC/frailty model (Further loss of £5m - £8m).	To engage with commissioners about a funding arrangement that protects the Trust.	CFO/DoSPP	On-going

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	PREVIOUS QUARTER RISK SCORE	CURRENT	TARGET RISK		
	5x4 = 20	5x4 = 20	4x4= 16	3x3 = 9		

What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR	BOARD COMMITTEE	CURRENT ASSURED LEVEL	Movement
REF	**STRATEGIC**				
SR10 Date of origin - June 2015	That the Trust fails to generate sufficient cash to pay for its commitments.	Chief Finance Officer	Finance and Performance		

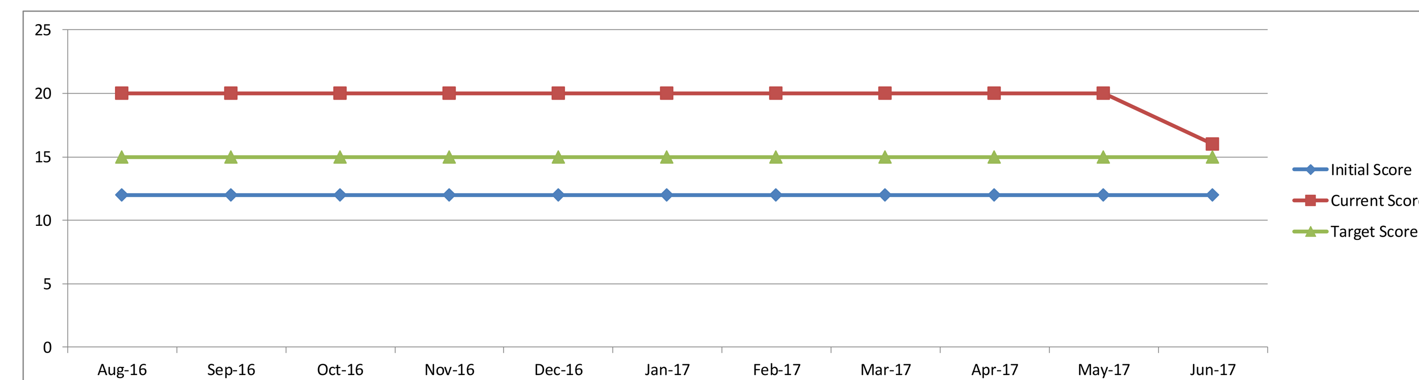
OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC OBJECTIVE

RISK TITLE	RISK No.	GRADE	OPERATIONAL RISK DESCRIPTION
Division 1 failure to achieve CIP target for 2016/2017.	4113	4 x 5 = 20 red	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.
Capital Programme under threat	4584	3 x 4 = 12 amber	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.

IMPACTS / CONSEQUENCES OF THE RISK?		**ORIGINS OF THE RISK?**	
REF		**REF**	
IC 1	Inability to meet financial targets	O1	Cost Pressure/business case investment for the Trust
IC 2	Inability to invest in services and potential to be unable to settle payments due to lack of cash	O2	Continuing CIP targets with reduced ability to make efficiencies.
		O3	Brought forward CIP achieved non-recurrently in previous years

Ref	Controls *What are the controls in place to mitigate these risks?*	*Level of assurance (L1,	Where and how often reported/monitored?
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.	L2	Reported to F&P and Trust Board (monthly)
C2	Revised Annual Plan submitted to NHS Improvement reflecting Trust Board agreement to 2017/18 control target in March 2017.	L2, L3	Reported to F&P
C3	Mitigation plan for Capital expenditure to be discussed and agreed at Finance and Performance.	L2	Report to F&P in July
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.	L2	Report to F&P on September
C5	Monitor and report on Trust to Trust debt to NHS Improvement	L3	Monthly at IDM. NHS I to provide regional oversight/support.

***Level 1 = Operational/Level 2 = internal oversight/Level 3 = Independent Assurance**



What are the positive assurances (actual as opposed to potential) received?				
Control Ref	Date Assurance provided	POSITIVE ASSURANCE		COMMENT
		What is the source for assurance?	*What assurance is provided?*	
C1		Trust Board Finance report reporting actual cash against plan.	The Trust reported that it was £5m ahead of its year end plan at the end of 2016/17 which places the Trust in a stronger starting position that had been originally planned.	
C2		Key elements of the plan, phasing and risks identified in the plan to NHSI in March	Detailed planning for the delivery of the 2017/18 financial planning is shown	
C6		Reducing aged debt report	There has been a small reduction in the aged debt at Walsall Healthcare and there is now an agreement to overheads with regard to previous years should now remove further impediments to payment.	

NEGATIVE ASSURANCES are …					**Jul 17 Status**
gative assurances received?					Update received
Control Ref	**Date Assurance provided**	**NEGATIVE ASSURANCE (include reasoning as appropriate)**	**ACTION PLAN**	**ACTION LEAD**	**AGREED DEADLINE**
C1		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	Ongoing
C2		If the Trust is not able to deliver against the financial plan phasings then this would put the £9.9m STF payment in jeopardy which would increase the deficit. The first 2 months details that the Trust is behind its internal business plan phasings which could impact on the NHSI phasings	Ongoing monitoring and agreeing mitigation actions at Operational Finance Group and F&P.	COO and CFO as appropriate	Ongoing

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	PREVIOUS QUARTER RISK SCORE	CURRENT RISK SCORE	TARGET RISK		
	4x3 = 12	4x3 = 12	3x3= 9	3x3 = 9		

What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR	BOARD COMMITTEE	CURRENT ASSURED LEVEL	Movement
REF	**STRATEGIC**				
SR11 Date of origin - June 2015	Condition of the existing Estate - Quality and flexibility	Chief Finance Officer	Finance and Performance	(amber)	(down arrow)

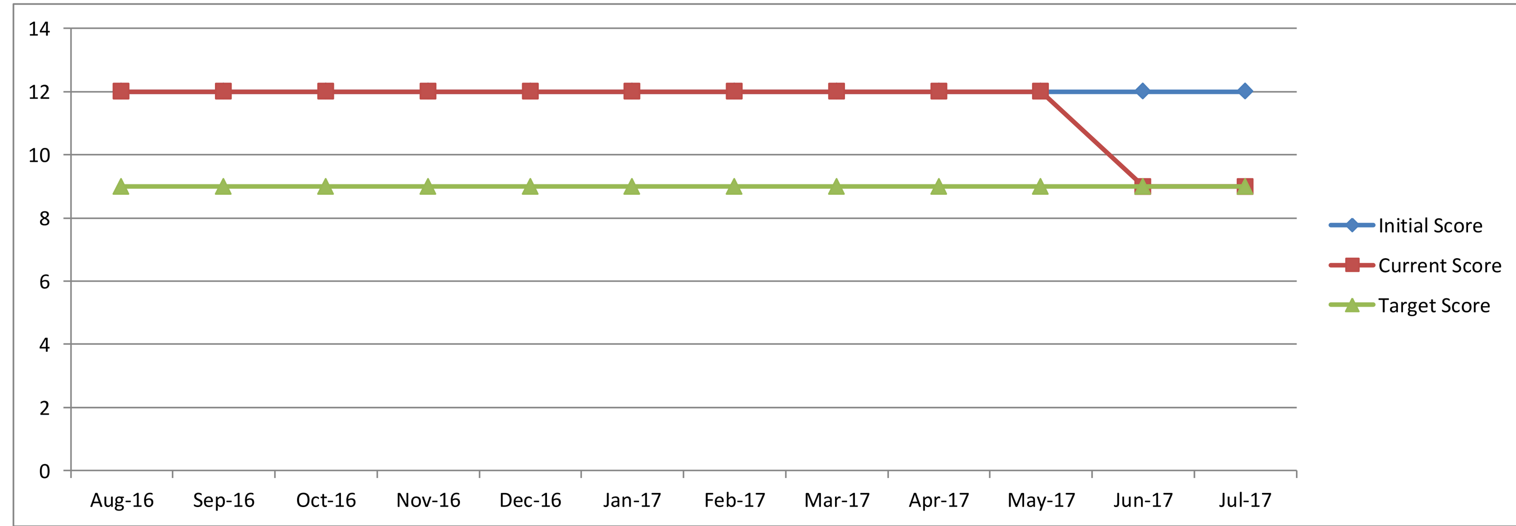
OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC OBJECTIVE

RISK TITLE	RISK No.	GRADE	OPERATIONAL RISK DESCRIPTION
Capital Programme under threat	4584	3 x 4 = 12 amber	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.

IMPACTS / CONSEQUENCES OF THE RISK?		ORIGINS OF THE RISK?	
REF		**REF**	
IC 1	Inability to maintain Quality and Safety	O1	Ability to find resource to invest in retained Estate
IC 2	Inability to deliver operational and commissioner targets	O2	Reduced income from commissioners

Ref	Controls *What are the controls in place to mitigate these*	*Level of assurance (L1, L2, L3)	Where and how often reported/monitored?
C1	Five Year Capital Plan.	L2	Yearly at Board around February as part of the planning round unless any issues cause the strategy to be required to be reviewed earlier.
C2	2017/18 capital programme has identified high risk backlog	L2	Quarterly to F&P
C3	Further work on estates rationalisation as part of updated clinical strategy.	L2	Quarterly to F&P

***Level 1 = Operational/Level 2 = internal oversight/Level 3 = Independent Assurance**



What are the positive assurances (actual as opposed to potential) received?				
Control Ref	**Date Assurance provided**	**POSITIVE ASSURANCE**		**COMMENT**
		What is the source for assurance?	***What assurance is provided?***	
C1	Mar-17	5 year capital programme presented to Board	Trust Board discussion on the estates strategy, 5 year capital programme and phasing. Board approved 5 year Capital programme.	
C2	Mar-17	Annual capital Programme submitted for Board approval	Risk Assessed Annual Capital Programme. An application is being made to increase the CRL using the Trust's working capital to enhance the capital programme for 2017/18 to NHS I. Detailed backlog maintenance programme to be identified for 2017/18 spend by August CRG for approval. Action to be taken by Head of Estates Development in conjunction with Head of Estates.	
C3	Jul-16			

NEGATIVE ASSURANCES are …					**Jul 17 Status**
What are the negative assurances received?					Update received
Control Ref	**Date Assurance provided**	**NEGATIVE ASSURANCE (include reasoning as appropriate)**	**ACTION PLAN**	**ACTION LEAD**	**AGREED DEADLINE**
C1		On-going 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
C2		Material reduction in CRL due to reduced depreciation from Aletrnative Site Revaluation made in 2016/17.	Bid to NHS Improvement to request increase in CRL back to original value	Chief Finance Officer	Bid by End of Jun 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:	**Be in the top quartile for all performance indicators**										
Chief Operating Officer	4286	(*Provisionally Agreed by TMC- Awaiting confirmation from COO*) If the Trust fails to achieve all 14 mandatory criteria for the Diabetes Best Practice Tariff, then this will potentially lead to poor clinical outcomes for children. Also, if the best practice criteria are not achieved in 90%+ of patients then this could result in the Paediatric Diabetes Service incurring a financial loss of £400,000+ of income and poor outcome for patients. Date of Origin: 14/08/2015 Date of escalation: 22/05/2017	3 x 4 = 12 AMBER	1) Cover Mon - Fri for discussion with Diabetes Team within 24hrs and new patients seen by next working day 2) Working with schools to develop educational programme targeted for patients (24/08/2016) 3) Letter sent to all parents informing of availability of drop in clinic Fri 2-4pm - (24/08/2016) Drop in clinic available for patients with Diabetes. 4) Interim support from dieticians and family youth worker (24/08/2016) 5) BPT compliance monitored monthly and quarterly using in house systems. (24/08/2016) 6) Compliance is reported through the Governance and Business structure. (24/08/2016) 7) BPT Best Practice standards met for 2015/2016.	5) Partial achievement 7/14 criteria (H-N) (07/04/2017) vacancies outstanding X2. 3) Positive feedback from parents following attendance at drop-in sessions. (07/04/2017) 5) Quarter 4 review has shown that the directorate is on track to deliver BPT. (07/04/2017) 7) Additional support enabled compliance to BPT standards for 2017 - 07/04/17	1) Insufficient staff to cover weekends 07/04/17 2) There are a number of patients whose education programme are still outstanding. 07/04/17 1-5) Unable to meet criteria re: 4 clincial appts in the financial year and 8 contacts in the financial year due to nursing vacancies (running at 50% capacity) (07/04/17) situation status remains the same. 1-4) Unable to meet criteria re: HbA1 measurements in financial year due to high DNA rates (07/04/2017) pending update from Consultant. 1 - 5) Posts remain vacant presently - post has been advertised. Risk upgraded to High Amber (07/04/2017) 7) Present service level will not enable compliance to BPT for 2017 (07/04/2017) - Risk upgraded following discussions at Governance meeting on the 10th February 2017.	1) Demand and capacity exercise to be undertaken to plan for 2017/2018 1) Business case required to resource 24 hour cover on call (31/01/2017	Sep-17 Sep-17	2 x 1 = 2 GREEN	Jul-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?
Trust Objective:		**To have an effective & well integrated organisation that operate**									
Chief Operating Officer	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. Revised DTOC position agreed for reduction by Sept 2017.	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 2) Development of discharge Assess Sceme (PID Comp Mar 17). Lead by LA-supported by ED Delivery Board. 7) Development of Trusted assessor model - linked to 2 - Led by LA.	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 2&7) Implementation of Wolverhampton Task and Finish Group established; agreed PID and timescale for recovery Sept 17	2) Increase in delays for Wolverhampton Feb 17 3) Increase in delays for DST in Staffordshire (Sept - Mar 17) 6) Increase in delays for access to HARP re-ablement team Jan 17.	2) Discussions with social care partners for 7 day services to be available 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 - Sept 17 3) Increase monitoring and review of patients with social care to delays on-going. 1) Work with LA to ensure that any additional monies allocated in Spring budget (17) are directed towards achieving reduction in DTOC's.	Aug-16 May-17 Jan-16 Sep-17 May-17 May-17	3 x 3 = 9 AMBER	Jul-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	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 May 2017	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 Jun-17 Sep-16 Jun-17	2 x 3 = 6 YELLOW	Jul-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	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. Date of origin: 28/04/16 Date of escalation = 17/06/16	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 and it is documented on the consent form (01/03/17) 7. All patients who have had valve surgery since January 2013 have been contacted and told of the risk of contracting Mycobacterium Chimera. There is a dedicated national helpline for patients to contact should they have any queries (March 2017)	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 1-7) Action for med physics: A new fix is being released; A vaccum will be required to be inserted into theatres, estates to be contacted. 1-7) Action for med physics: A new fix is being released; associated costs to be provided to DM	Sep-17 Dec-17 Dec-17	3 x 2 = 6 YELLOW	Jul-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	4596	If a patient with acute cholecystitis is not having surgery within 1 week, then this may result in recurrent admissions with the same problems and / or complications relating to gallstones such as pancreatic cholangitis and gallbladder empyema. Date of origin: 09/08/16 Date of escalation = 06/02/17	4 x 3 = 12 AMBER	1. CEPOD list to deal with these cases (Aug 2016) 2. Meeting taken place with UHB regarding change to UGI pathway (May 2017)	1. (09.08.16) There are no positive assurances	1. (09.08.16) No dedicated hot gallbladder theatre slots available 1. (09.08.16) Patients are presenting with complications of gallstones 1. (09.08.16) Local audit showing recurrent admissions	1. Appoint 3rd UGI Surgeon to support acute hot gallbladder list 1. Secure an acute hot gallbladder list 1. Directorate to produce a Business Case to address requirements - 1. Theatre capacity - separate CEPOD List, 2. 3rd Consultant, 3. Anaesthetic Time 2. Further discussions to take place re: UGI pathway	Dec-17 Dec-17 Dec-17 Aug-17	2 x 2 = 4 YELLOW	Jul-17	Yes
Chief Operating Officer	4599	If there are staffing issues within the Emergency Dept, especially substantive shortages within the Medical team, along with increased numbers of patients attending, leading to significant pressure on the staff within ED. This will lead to an inability to engage fully with Governance processes. This will result in potential compromised patient care, inability to provide assurance in relation to the Governance agenda and financial penalties as a result of missed targets re RCA's and DoC.	4 x 3 = 12 AMBER	1) Matron has set up a group to ensure all nursing actions are addressed and learning is shared across the team 2) Review of Governance work streams at the Divisional Governance meetings, incuding NICE, External guidance, Audit, Risk 3) Monitoring of all SUI/Audit actions through to completion 4) Performance meetings in place 5) Directorate Governance meeting in place and attended by Directorate Management Team 6) Staff member identified to provide Governance support 2 days per week 7) Process in place to review re-attendances for potential SUI's proactively	5) Governance meetings taking place regularly 2) Identified post 2xdays per week to provide Governance support 2) Extra ACP's now in post 1) Pre Governance meetings now established and working well 3) Number of SUI actions is reducing 4) Adult Cons post recruited to 5) Directorate manager post appointed Apr 17 2) NICE guidance is progressing 2) SI numbers have decreased in month	5) Occasions when members of the Management team unable to attend meeting or stay for whole meeting 3) Significant number of SUI actions overdue/dates amended 2) Number of NICE and External Reviews that remain outstanding 2) L.Gardiner has to be used clincallly 2) Increase in number of SI's within ED (9 since Jan 17)	3, 4) Action plan devised to complete all outstanding SUI actions by end of Feb 17 - due date extended to July 17 2) Directorate to clear backlog and implemement robust process to manage processes 5) ED action plan and risk register to form the template for the fortnightly review meetings	Jul-17 Jul-17 Aug-17	2 x 3 = 6 YELLOW	Jul-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?
Trust Objective:	**Maintain financial health - appropriate investment enhancement**										
Chief Operating Officer	4113	If Division 1 are unable to achieve the identified CIP target for 2017/2018 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 =	4 x 5 = 20 RED	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	Sep-17 Sep-17 Sep-17 Sep-17 Sep-17	2 x 3 = 6 YELLOW	Jul-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 Financial Officer	4791	Activity that has not been planned materialises throughout the year as a result of other local trusts having quality/ capacity/ reputational issues. The financial risk is that the cost to provide the extra capacity might be at a premium and might not be covered by the additional income. Some evidence that this is happening with maternity, neurology and ophthalmology. Date of origin: 19th Jun 2017 Date of escalation: 19th Jun 2017	4 x 2 = 8 AMBER	1) Discussions have taken place with other providers and with commissioners of these services therefore, the impact of the problem can be anticipated to an extent.		1) The Trust does not have this activity in the plan for the year and has therefore not necessarily got the capacity to absorb the activity without incurring a cost premium.	Identify service related issues and align capacity with additional service demand. Seek to put CVOs in place with commissioners in order to allow the Trust to better plan capacity. Business case for agreed additional activity to be formulated by specialty and submitted to Contracts and Commissioning Group.	3 x 1 = 3 GREEN	Jul-17	Yes
Chief Financial Officer	4793	Risk to the income of the Trust as new clinical coding categories has been introduced (HRGv4+). There has been some evidence at month one that coding issues have contributed to an income shortfall. Date of origin: 19th Jun 2017 Date of escalation: 19th June 2017	3 x 3 = 9 AMBER	1) Undertake an exercise to check the clinical coding for all activity that the Trust delivers and ensure it reflects the depth of coding required by HRG4+ to get the correct payment.		1) The resources to systematically check all of the Trust's coding are not easily available.	1) Ensure that directorates are aware of the financial consequence of insufficient coding. 2) Analyse monthly data to pick out priority areas to target the Trust's limited resource to resolve coding issues. 3) Ensure that directorates notify the operational finance group of known coding issues with a plan for resolving the issue.	2 x 2 = 4 YELLOW	Jul-17	Yes
Chief Financial Officer	4794	The 2016/17 year end invoice for £4.8m is not paid and the debt has to be written off. Date of origin: Mar 2017 Date of escalation: 19th Jun 2017	3 x 3 = 9 AMBER	2) Escalate as necessary 1) Continue to follow up on debt		1) Currently arbitration process has stopped	1) Issue was raised at the quarterly review meeting with NHS Improvement on 13 July 2017. Directors of both organisations were present and it was agreed that NHS Improvement would now escalate further for a conclusion.	3 x 3 = 9 AMBER	Jul-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?
Trust Objective:	**Attract, retain & develop our staff & improve employee engagemen**										
Chief Operating Officer	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 agreed by LNC Mar 17	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 - Apr 17 4) Medical agency costs slowly reducing 1) Audit review still raised concerns - 2016	1) Agreement with LNC to be confirmed 1) Appointment of Deputy Medical Director to lead on job planning process in each division 1) Develop business case for recording of DCC/SPA's	Mar-17 Apr-17 Sep-17	3 x 2 = 6 YELLOW	Jul-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	1) Ongoing active recruitment exercises - including overseas 8) Use of Nurse Bank when required 3) Defined minimum safe staffing levels now in place 5) Modified dependency tool for inpatient areas commenced 9) Staffing incidents reviewed on monthly basis 10) Closed additional Ward 3 at West Park Hospital (June 16) 4) B7's have daily staffing meetings	8) HCA's are available via Bank 3) Safe staffing levels are being maintained across acute wards, some issues with NRU 3) Band 7 vacancies filled, 1 remains 3,9) Internal transfer pool introduced across the Trust as part of the retention strategy 1) Change to recruiting processes to speed up the process 3) Daily staffing template produced at 4pm detailing all registered staffing 3) All B7s trustwide filling OOH rota first, then managing in-hours gaps, including putting themselves in if necessary 1) OSCI ward working well - 4 staff passed with 100% pass rate 1) ACSG matron role secondment appointed to (6 month initially)	1) 64 wte trained nursing vacancies remain (37 jobs offered but staff not in post yet) 8) Insufficient RN's available on Bank, backfilled by HCA 1) Nationallly we are an outlier re safe staffing levels 3) Weekends and nights remain an issue in relation to staffing numbers 3) Delay to skill mix review in ED due to RCN reviewing tool being used. 1) Cancer Svs/Derm Matron vacancy not appointed to, out to advert again 9) Some deterioration in compliance with Special Measures action plan on A7 & A8	3) Skill mix review to be completed across the organisation - outstanding areas are Specialist areas and ED 9) A7/A8 working through local 'special measures' action plan. 9) C22 action plan to address urgent concerns to be developed and implemented 3) Meet with Director of Nursing to review all CNS job plans	Aug-17 Aug-17 Aug-17 Sep-17	4 x 3 = 12 AMBER	Jul-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	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. Date of origin: 23/04/16 Date of escalation = 17/05/16	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) Number of vacancies remain across the Division including within Radiology, Anaesthetics and Head &Neck (May 2017) 1+2) Theatres sessions owed (May 2017)	1+2) Continue with Fellowship Programme 1) DCOO and DMD to discuss targeted recruitment radiology (overseas) with HR department	Aug-17 Aug-17	2 x 2 = 4 YELLOW	Jul-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	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. Date of origin: 19/05/16 Date of escalation = 17/06/16	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 5. IP training is being escalated at IPCG (Feb 2017) 6.Non-compliance with Mandatroty Training is being challenged at Quality Assurance Meetings with Directorates (Feb 2017)	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) Jan Mandatory training report has shown compliance for local induction as 69.7% (March 17)	1.Ongoing Divisional challenge of Directorate performance at the Directorates Quality Assurance Meetings	Dec-17	2 x 2 = 4 YELLOW	Jul-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	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	3 x 2 = 6 YELLOW	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). Additional meetings Feb-Mar 17.	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 - Positive feedback from staff (nurses and doctors) in Oncology following job plan change 3) Changes to job plans means that Phys B now works to 10pm. Oncology provide 'Cons of the week'. 3) Inclusion of Acute Physicians and additional Paediatric Cons in ED improves the likelihood of medical and children patients having early first assessment, plan and treatment 3) Formal Delegation processes in some directorates (Resp and C/E) means that essential to see pts are identified and prioritised by Cons and others seen by juniors	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 core standards not met in all areas or all directorates, July 2016 Trust wide results showed 72 and 77% (vs 90% target) 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 1)Financial implications for revised way of working not agreed. Mar 17. 3) Cons across the Trust believe that some tests (notably MRI) are not available	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 1.2.3) Acheive full compliance with standards - Await outcome of audit 1) Business case required to understand implications - actions loss of 7 day services (Apr 17) 3) Support services e.g. therapy pharmacy, community services asked to review 7 day working 3) Recruit in areas where vacancies mean that rotas to achieve 7ds cannot be achieved 3) Reduce bed base in medicine therefore reducing workload of Respiratory Directorate 3) Improve junior doctor provision at weekends	Aug-17 Jun-17 Jun-17 Aug-17 Jun-17 Aug-17 Jul-17 Sep-17	2 x 2 = 4 YELLOW	Jul-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?
					3) Short term funding from NHS E means that additional Cons and juniors can be funded at weekends in high priority areas Resp and C/E 3) Radiology have defined weekend provision for immediate and urgent diagnostic tests 3) Reduced admissions across both Paeds and Medicine following Cons introduction in ED 3) Trial on Resp ward improved compliance from 50 to 70% with use of proforma 3) Pharmacy successful short term funding bid to pilot expansion of services to emergency portals . Therapies are compliant.					

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	4718	If there is a shortage of staff in the safeguarding team this will result in: 1. Delays in providing safeguarding advice and responding to queries raised by staff and concerns raised via Multi Agency Safeguarding Hub (MASH). 2.Inability to attend all safeguarding meetings either internally or externally to the Trust 3.Inability to work proactively with staff on wards/ in community to ensure key safeguarding messages are disseminated 4.Inability to provide safeguarding supervision to key staff who work with vulnerable clients 5.Delay in providing face to face safeguarding adult and children training. 6.Delay in training staff on key agenda issues, for e.g. Child Sexual Exploitation, Domestic Violence, Slavery, FGM and PREVENT training. There is an Inability to respond to delivering Safeguarding Adult Training as outlined in the Intercollegiate Doc for Adults 2016. Date of origin: 03/03/17 Date of escalation: 25/04/17	5 x 3 = 15 RED	1) Regular review of staff available to work (Jan 2017) 2) Tasks/Meetings are prioritised (Jan 2017) 3) MASH information for adult cases: Allocated to SG admin initially and referred to SG adult named professonals if available to respond to. (Jan 2017) 4) Regular review of safeguarding legislation/CQC action plans, CCG assurance framework and Safeguarding Board partnership programme to prioritise workload of team. (Jan 2017) 5) Safeguarding supervision provided to Maternity staff, HV's, School Nurses and FNP (Jan 2017) 6) Safeguarding training is available: Level 1 - Induction (face to face) and face to face., Level 2 - via e-learning, Level 3 - via face to face for children and adults (Jan 2017) 7) External trainers have been enlisted to offer delivery of PREVENT and DV training (Jan 2017) 8)_ Safeguarding Children Team Leader (Band 8a) recruited (April 2017)		1) Only 1 of 4 vacant posts occupied. 3 staff not at work. (Jan 2017) 1), 2) 4) Certain meetings are not always attended or represented: For e.g. WSCB training and development group, WSAB training group, WSCB quality & performance group, MASH Meetings, RWT variety of meetings. (Jan 2017) 3) Quality of information required by MASH not addressed (Jan 2017) 5) Safeguarding supervision is available to certain staff only. (Jan 2017) 5) Adult safeguarding supervision is not provided. (Jan 2017) 5) Scope of remaining RWT Safeguarding Children and Adult supervision requirements unclear. (Jan 2017) 6) Bespoke training is not delivered due to capacity within the team. (Jan 2017) 7) External trainers are time limited to finish by April 2017 (Jan 2017) 8) Unavailability of post holder (April 2017)	2) To regularly contact the chair of the groups and review urgent actions post meetings. 6) SG Adult training delivery to be reviewed 8) Existing named nurse to continue to cover Safeguarding Children Team Leader role 1) to 7) To present updated business case to C&C	Aug-17 Sep-17 Oct-17 Jul-17	1 x 3 = 3 GREEN	Jul-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?

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	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) 3 new Consultants (2 Paeds/ 1 ED) in position March 2017 [10/03/17] 12) Plan agreed to reconfigure department to reduce congestion in ambulance off load area [10/05/17]	1) Operational use of surge cubicles achieved at times of increased demand [12/06/17] 4) No major issues/incidents reported with the RAT room [12/06/17] 13) Nurse led RAT working well [12/06/17]	2) Delays in patient transfer - linked to bed availability / bedflow / waiting to be transferred [12/06/17] 1) Increase in number of ambulances [12/06/17] 12) Continued congestion within the ambulance off load area at peak times - department reconfiguration work not yet commenced [12/06/17] 2) Highest volume of pts seen in unit on single day experienced in month, 500+ pts and 160+ ambulances	1, 2) Continue with daily bed meetings 1-11) Continue with recruitment of substansive medical and nursing staff 12) Review of staffing in line with reconfiguration of department to be undertaken 12) Reconfiguartion of department to ease congestion in ambulance offload area to be undertaken 3) Developing nurse led RAT	Jul-17 Jul-17 Aug-17 Sep-17 Sep-17	2 x 3 = 6 YELLOW	Jul-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?
				13) Nurse led RAT is being trialled in ED [12/06/17]						

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	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 and compliance with five steps to safer surgery greater than 95% - There has been 100% compliance achieved between Aug 2015 - Apr 2017. 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 6. 5th NE in 16/17 reported to CCG - Theatres/T&O Cannock (wrong prosthesis) reported (Datix ID: 174038) occured Mar 2017	2. Opthalmology Staff to undertake Human Factors Training from AFPP 2. Programme of Human Factors Training for Theatre Staff 6. RCA Investigation to be undertaken into the NE Wrong Site Surgery (wrong block) Datix:179911	Aug-17 Aug-17 Sep-17	2 x 4 = 8 AMBER	Jul-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?
				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		5. Monthly monitoring and compliance with five steps to safer surgery greater than 95% - 90% compliance was achieved in May 2017. 5. Monthly monitoring data of compliance with WHO checklist and Procedural Safety Checklist - Mar -May 17 - 92% compliance 6. 1st NE in 17/18 reported to CCG - CCH/Theatres (wrong site surgery - regional block administered to wrong limb) reported (Datix ID: 179911) occured June 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	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	3 x 2 = 6 YELLOW	2) Signs are in place in clinical area and corridor requesting silence at all times (May 2017) 3) Incident trends being monitored along with any complaints on a monthly basis (May 2017) 1) Introduction of insert earphones and Sound Level meters to monitor sound levels (May 2017) 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. (May 17) 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. (May17) 1) Inserts do not provide adequate attenation to overcome the issue of the environment (May17) 4) When noise reaches >35dBA testing has to stop (May17) 1-4) UKAS visit took place on 13/11/15 - accreditation for diagnostic testing at West Park withdrawn, (May17) 5) Business case on hold due to closure of West Park [May17] 4) Noise logs not produced following withdrawal of UKAS accreditation [May17]	1-5) Plans for relocation of service to be confirmed	Jul-17	1 x 2 = 2 GREEN	Jul-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	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. 9) Monitoring of metrics regards Quality / Performance issues monthly identifying trends and themes of non-compliance	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) Action Plan now closed - outstanding actions addressed and monitored via monthly report to PSIG 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. 4) Safer staffing fill rates remain transient particularly for nights 9) Falls with serious harm continue to rise 7) A noticeable increase regards information / handover / communication related to discharge, particularly those going to residential/nursing homes are being cited in safeguarding referrals against the Trust. 9) Rising Mortality HSMR and SHMI rates are being reported in National data sets 10) Inpatient survey results show an average score of 76.7 which is a deterioration from 2015. Scoring is in the bottom 20% on 11 questions.	5) Trust is taking part in the workforce collaborative led by DOH (Lord Carters team) to receive and share good practice Complete QRV visits for all inpatient areas Information sharing events regards inspection for VI practices 7) Current review of Mortality review process and coding. Roll out of Falls collaborative inititaves tested via pilot areas Action Plan to be developed regarding National Inpt Survey results Audit of safeguarding and complaints regarding discharge communication as a theme Development of E-learning training package for DOLS Purchase of MCA/DOLS Educational material Gap analysis of NHSI 'Developmental reviews of leadership and Governance using the well led framework guidance for NHS Trusts' to be presented to Board Collaborative working with CCG regarding information/education to care homes and carers regarding safeguarding requirements for PI's	 Dec-17 Aug-17 Nov-17 Aug-17 Oct-17 Aug-17 Aug-17 Aug-17 Aug-17	2 x 2 = 4 YELLOW	Jul-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?
					6) E-roster upgrade to version 10 live from 13/02/17 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. 7) Biannual skill mix review - slight improvement in vacancy rates 9) April 17 has seen an increase in referrals for MCA/DoLS following audit and training events 5) Draft report received regards CQC announced inspection to the Phoenix walk in centre - overall positive outcome 7) CQC checklist now in use operationally - led by Matrons and the triumvirate team Discharge action plan on track and presented to PSIG July by HofN's.					

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 4475 (Cardio) and 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	4 x 3 = 12 AMBER	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 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. 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	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/changed nationally (Aug 16) 1. Vacancies at Cannock have now been nearly filled 2. 20 nurses recruited at recent RCN event, approx 10 for Div 1 2. 20 new nurses from the Phillipines starting within Trust 1. Vancancies for trained staff slowly decreasing month on month (May 2017) 5. T&O now fully established for open beds (June 2017)	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) 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 1-14 Produce a SOP in regards to Enhanced Care Policy 1-15. Action Plan to remove all agency spend in theatres (plan to complete by Dec 17) 5. Active recruitment being pursued to open another 6 trauma beds 1. Commencement of nursing workforce strategy	Sep-17 Sep-17 Aug-17 Dec-17 Sep-17 Sep-17	2 x 2 = 4 YELLOW	Jul-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?
				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 transfer staffing pool (aimed to retain staff) (Aug 2016) 14. Appointed to Nursing Associate posts - to start end of Jan 17 (Jan 2017)	14. In place - one Nursing Associate for each 28 bedded ward area (June 2017) 1-10 - General Surgery nearly fully established, T&O fully establish for beds open and ICCU have no vacancies (July 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	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 Date of escalation = 15/04/16	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 [10/05/17] 2) System upgrade for automatic trigger developed (15/12/16) 17) 15 new starters (nursing) in Jan/Feb [16/02/17] 15,17) 2 further consultants in place April17 (equates to 1 ED post as shared with Paeds) [10/05/17] 17) 14 new nursing posts offered following interviews [10/05/17] 17) 3-4 new nurses to start between Jun-Sep17 [10/05/17] 17) 1 NHS 2 year locum appoointed to start 01/09/17 (CESR Dr) [12/07/17] 17) 1 substantive adult consultant appointed to start 01/09/17 [12/07/17]	1,2) Inability to meet Department of Health guidance - Average 55 breaches a day in the 4 hour target due to first assessment delays (Approx. 498 breaches identified from April breach report due to first assessment delays). [10/05/17] 1, 2) Inability to achieve 2 hour assessment and 15 minute triage.[10/05/17] 3) Huddles not currently taking place consistently 24/7 [10/05/17] 4,5) Staff not always available to be reallocated [10/05/17] 6) Bed availability linked to delays in Emergency Department [10/05/17] 7) Medical and nursing vacancies, sickness and reliance on locum doctors resulting in gaps on rotas. [10/05/17] 8) Patients may not be seen straight away on arrival but on average within 20 minute. However can be delayed due to flow constraints. [10/03/17] 10) UCC not impacting on pt numbers and delays in assessments [10/05/17] 17) A number of the nursing posts offered are to newly qualified staff so unable to start until Sept17 [10/05/17]	1,2,4,8) Revised RAT SOP (nurse led RAT) to be discussed and approved at Directorate Governance meeting 7) Continue with recruitment of medical staff 1,2,4,8) Nurse led overnight RAT SOP being developed	Sep-17 Sep-17 Sep-17	1 x 4 = 4 YELLOW	Jul-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?
				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] 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. Date of origin: 29/04/16 Date of escalation = 17/05/16	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. Incident identified with migration over to electronic system where patient did not receive timely suveillence (Datix No awaited) (May 2017)	1&2. Monitor ongoing incidents	Aug-17	2 x 2 = 4 YELLOW	Jul-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	4565	If the use of Agency staffing continues across the Divisions (due to being unable to recruit to sustentative posts) 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. Date of origin: 22/06/16 Date of escalation = 28/07/16	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). 7. HoN reviewing Nursing Overspend Report for Theatres (Feb 2017)	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) 7. Reducing overspend in Theatres (Feb 2017) 2. 35 Clinical Fellows (May 2017) 2. Nursing vacancies reduced across the Trust (May 2017)	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 Apr - 17 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. Medical vacancies remain unchanged although many posts pending start dates (May 2017)	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 4. Ensure exclusion of GP Integration locum spend 2. Actively recruiting to Bank for Theatres trained staff 1-7. Action Plan for cummulative reduction of agency spend in theatre in place with no agency spend by December 2017	Jun-17 Jun-17 Jun-17 Jun-17 Aug-17 Dec-17	x =	Jul-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?
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. Date of origin: 17/11/16 Date of escalation = 17/11/16	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 2) There is a policy for urgent and critical findings (June 2017) 2) A flag is also added to the report which will send in the subject matter of the e-mailed report ***Urgent Findings*** or Unexpected Significant Findings, this will alert the referring consultant (June 2017) 2) There is now also a Cancer Suspicious flag which can also be attached (June 2017) 3) There are a list of tests that fall into the urgent action category, the clinicans are telephoned about these. Other less urgent abnormal results are highlighted as such in TD Web when they are reviewed (June 2017)	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 5) Incidents continue to be reported where the reviewing if abnormal results has been delayed with significant consequences to patient outcome 3) No further action can be taken by Pathology until ICE is implemented (June 2017)	1-4) Implement the ICE system, ensuring it addresses the current gaps in review of reports	Nov-17	x =	Jun-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	4665	If the X-ray and CR processing equipment at Cannock Hospital (which is over 13 years old) is not replaced within the Capital Programme then due to the age of the equipment there is an increased possibility that there will be equipment breakdowns/failures which could then directly impact the service offered. Also, patients are currently not in receipt of the advances in technology which a new machine could offer them i.e. lower doses of radiation and a speedier/quicker service. Date of origin: 17 November 2016 Date of escalation: 26 April 2017	3 x 4 = 12 AMBER	1) Maintenance Contract in place (£17,000 per annum) (Oct 2016) 2) Access to Mobile Imaging (if required) (Oct 2016)	1) Breakdowns are usually fixed within 24 hours under the contract - this is on a 'fix as you go' basis. (Oct 2016) 2) There is a mobile X-ray unit iat CCH which can be brought down to the X-ray room and used there to continue the service for patients (Oct 2016)	1) Any breakdown will cause a disruption to the service offered to patients. Breakdowns encountered with CR Readers 2; X-ray Equipment 5 (Jun 2017) 2) No focus choice on mobile x-ray units and reliance on ageing CR processing equipment (Oct 2016)	1) & 2) To continue to monitor any equipment breakdown	Sep-17	2 x 2 = 4 YELLOW	Aug-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	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 2) Locum Consultant Radiologists are being employed 3) Clinical Fellows are being employed 4) Regular meetings between Clinical Director and Group Manager 5) Waiting list initiatives for Trust Radiologists on going	2) 0 locums have successfully been employed 3) 2 Clinical Fellows have been selected 4) Review meetings are happening fortnightly	1) Approximately 6284 non-urgent imaging studies unreported July 2017 (inclusive of 772 CT scans and 1881 MRI scans) 1) Poor patient experience if patients and doctors are unsure when their scans are reported 2), 3), 4) & 5) Demand for reporting imaging studies is higher than expanded reporting capacity	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 1,2,3,4 & 5) Monitor outsourcing work and assess impact on reducing outstanding numbers 1,2,3,4 & 5) SS to provide report to Division re imaging waiting times	Dec-17 Dec-17 Sep-17 Sep-17 Sep-17	2 x 4 = 8 AMBER	Jul-17	Yes
Chief Operating Officer	4711	Porters manage the large medical gas cylinders between the medical gas store and the hospital site. Adverse weather conditions; traffic hazards and time pressures could lead to the risk of serious injury to staff/public. This will lead to potential of personal injury claims and litigation. Date of origin: 01.02.2017 Date of escalation: 08/05/17	4 x 4 = 16 RED	1) Manual Handling Hazard Assessment - JULY 2017 2) Manual Handling Risk Assessment undertaken at induction - JULY 2017 3) Cylinder cradles trolleys or cradles are used to transport medical gas cylinders - JULY 2017 4) Trust Training records are regularly reviewed by managers - JULY 2017 5) Staff raise any concerns at the local Hotel Services Risk Management meeting - JULY 2017	1, 2, 4) No incidents reported in the previous month - JULY 2017	5) Medical gas storage facilities is in-adequate - JULY 2017 3) New method of moving medical gas cylinders required - JULY 2017	5) Estates to support Porter in establishing a new storage facilities/trolley 3) Motorised trolley to be purchased	Sep-17 Sep-17	3 x 2 = 6 YELLOW	Jul-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	4715	If the Trust is unable to recruit substantive Dermatology consultants it will not be possible to provide the right level of care for patients. Currently there is only 1 long term locum covering at CCH and 2 Consultants covering NXH. This will result in a decrease in the number of patients that can be seen; loss of recognition as a teaching centre; loss of reputation; increase in the number of complaints; increase costs due to the employment of locums. Date of origin: 22/2/17 Date of escalation: 18/04/17	3 x 4 = 12 AMBER	5) Utilisation of nursing staff to support (Feb 17) 4) Ensure capacity available for suspected cancer patients (Feb 17) 3) Ensure inappropriate referrals are returned to GP with appropriate reason (Feb 17) 2) Assessment of nursing skills (Feb 17) 1) Managing activity on a daily basis (Feb 17) 6) Review provision of Teledermatology Service (Feb 17) 7) Use of locum staff	1, 4) WLI to meet demand. Planned to continue (July 17) 4) All Fast track patients who can't be found a slot are being seen by a specific consultant (July 17) 2) Monitoring and light clinics moved to NXH for 12 months (July 17)	2) 2 x B5 Nursing staff on maternity leave (July 17) 1, 4) 1 x substantive consultant on long term planned sick leave which started in Feb 17 (July 17) 2) 1 x B2, 2 x Bd7 and 1 x Bd5 vacancy (July 17) 7) 1 x full time and 1 x part time locum consultant due to start in August 2017 have now declined (July 17)	1,4) Discussion with secondary provider to support activity 1, 6) Contracting team at RWH to advise Seisdon CCG Teledermatology Project cannot be supported 2) Band 7 Specialist Dermatology nurse advert out for recruitment 7) Directorate to draw up plan to address gap caused by locum duo who declined contract	Aug-17 Aug-17 Sep-17 Jul-17	3 x 3 = 9 AMBER	Jul-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?
Medical Director	4734	The Trust currently has elevated mortality statistics (the HSMR and SHMI are both significantly higher than normal). This does not correlate with any evidence within the Trust to suggest excess mortality rates or preventable deaths in RWT. The Trust needs to investigate. Date of origin: 03/04/17 Date of escalation: 03/04/17	4 x 3 = 12 AMBER	1) All statistics and data underpinning mortality are looked at MRG (monthly) and MoRAG (bimonthly) 2) The Trust requires all directorates to follow the mortality policy (OP87) and formally review deaths on a monthly basis and categorise deaths according to NCEPOD 3) All alerting diagnostic categories are formally investigated with retrospectives case note reviews to identify the level of care provided to patients. 4) Additional work is being undertaken to investigate the elevated mortality statistics and to review care delivered to patients and clinical pathways as follows; i) an independent company has been commissioned to take a data analysis and independent coding exercise, ii) an independent retrospective case note review will be undertaken to review robustness of RWT case note reviews iii) an independent review of clinical pathways will be undertaken, iv) targeted support by the clinical support unit to help analyse reasons behind alerting diagnostic area.			1) Review outcomes of MRG and MoRAG 2) Continue work between Clinical Coding and clinicians regarding accuracy of coding 3) Ensuring the mortality policy (OP87) is correctly followed across the organisation 4) Address any issues resulting from additional pieces of work	2 x 2 = 4 YELLOW	Jun-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	4756	If the activity continues above 5000 births, then it will have a detrimental effect on patient safety and experience. This will potentially result in challenges and limitations due to: 1/ Physical size & configuration of the building 2/ Medical staffing 3/ Midwifery staffing (and ancillary staffing) 4/ Theatre capacity & staffing 5/ Safeguarding 6/ Screening In addition to safety concerns there may also be an impact on patient experience. NB; Please see Notepad	3 x 4 = 12 AMBER	1) Number of women having Mid Trimester scans giving EDD data is being monitored and indicates predicted monthly activity in relation to births 2.5.17 2) The number of women booking at RWT is being monitored by Antenatal Payment By Results (PBR) 2.5.17	1) Predicated births/booking are recorded on the Maternity Dashboard, RAG - rated and discussed at monthly Governance & Risk Management meeting (14.7.17) 2) Close observation of activity in relation to number of predicted births (14.7.17)	1,2) Activity levels are variable and uncontrollable due to births occurring at varying gestations and women transferring in from other units (14.7.17)	2) Seek approval to negotiate with CCG's at the following G.P's - other service providers in Walsall, Sandwell, Burton and Dudley that the Community Midwives promote their local services to encourage women to book at their local unit	Oct-17	3 x 2 = 6 YELLOW	Jul-17	Yes
							2) Gain 4 extra beds by converting the discharge lounge into a postnatal recovery bay	Sep-17			
							2) Abandon labour, delivery, postnatal room (LDP) model on the MLU	Sep-17			
							1,2) Liaise with Neonatal Services to utilise/staff to full capacity on the TC Ward	Oct-17			
							1,2) Recruitment of Midwives to fill vacancies (currently 7 WTE vacancies and 1 Band 7 vacancy) and achieve 1:30 Birthrate Plus ratio	Sep-17			
							1,2) Review discharge planning on Ward D10 to make the process more efficient	Aug-17			
							1,2) Continue to monitor activity via dashboard	Dec-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	4767	If the trust fails to achieve all 5 mandatory criteria for the Hip Fracture Clinic Best Practice Tariff, then this will potentially lead to poor clinical outcomes for patients. Also, if the best practice criteria are not achieved this will result in the Directorate failing to achieve additional income of BPT.	4 x 3 = 12 AMBER	1) Informatics pulls a report twice a month for validation of BPT 2) The patient remains under the care of an orthopaedic consultant who can track their care ensuring key aspects are not missed 2)Gap in the ortho-geriatrician support currently filled by Associate Specialist - when not available consultant to consultant discussion with the Geriatrician.	2) BPT criteria is available on the ward for junior doctors	1) Currently informatics does not have access to the NHFD which would make reporting much more streamlined. They currently use a datasheet which is time consuming 2) BPT criteria not available in notes 2) The Directorate does not have 7 day cover from orthogeriatrician	1) BPT reports to be reviewed quarterly at Governance Meetings Jun-17 2) Directorate to devise BPT checklist Sep-17	x =	Jul-17	