The Royal Wolverhampton
NHS Trust

Board Assurance Framework/ Trust Risk Register December 2017

Agenda Item No: 11.1

Safe & Effective | Kind & Caring | Exceeding Expectation

The Royal Wolverhampton NHS Trust	

Trust Board

Meeting Date:	29th January 2018
Title:	Board Assurance Framework / Trust Risk Register
Executive Summary:	<u>BAF Key Issues</u> **0 new risks.** **5 red risks**: **SR1** - Workforce - Recruitment and Retention of staff across the Trust and in particular the future pipeline of nursing and medical staff **SR4** - Risk of adverse impact on the Trust following service transfer in November 2014 due to underlying financial gap of £6million **SR8** - That there is a failure to deliver recurrent CIP's. **SR9** - That the 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. <u>Trust Risk Register Key Issues</u> **1 new risk:** 4903 - Risk of non-compliance with Thoracic Service Specification (COO) **3 risks removed:** 2898 - Patients having to wait in ED in the Ambulance off load area (COO) 4715 - Dermatology Service (COO) 4866 - £1.362m risk in the income plan (CFO) **5 red risks:** 2080 - Risk to quality of patient care: reduced manpower (COO) 4661 - Lack of robust system for review and communication of test results (MD) 4472 - Delays in Cubicle Assessment and Triage (COO). 4113 - Division 1 failure to achieve CIP target (COO) 4903 - Risk of non-compliance with Thoracic Service Specification (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

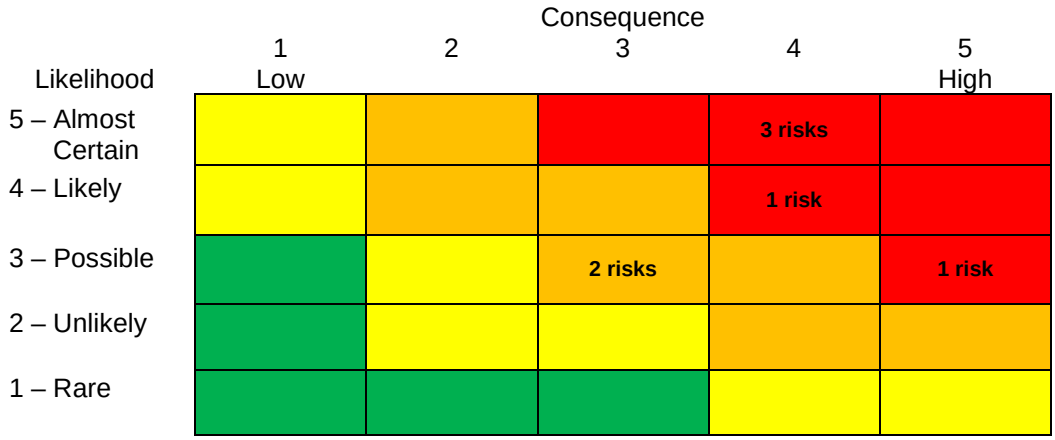
The Board Assurance Framework "provides organisations with a simple but comprehensive method for the effective and focused management of the principal risks that arise in meeting their objectives. It also provides a structure for the evidence to support the Annual Governance Statement".

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:



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)	34
Risks managed to target level	0

There are currently 34 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	14 risks	2 risks	2 risks
3 – Possible		1 risk	3 risks	8 risks	
2 – Unlikely		1 risk	1 risk		
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
	4113	Division 1 failure to achieve CIP target	COO
	4472	Delays in Cubicle Assessment and Triage	COO
	4866	Risk of non-compliance with Thoracic Service Specification	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		6		
4) Maintain financial health - appropriate investment enhancement to patient services	2	2		
5) Attract, retain & develop our staff & improve employee engagement	1	2	1	
6) Create a culture of compassion, safety & quality	2	15	2	

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 (Nov 2017)

Lead Director	Risk	Risk Title	Field updated	Update made
Chief Nursing Officer	4841	Risk of CPE becoming endemic in clinical areas		
			Positive Controls – **New**	Isolation matrix reviewed and relaunched
			Positive Assurance – **New**	Understanding of impact of isolation due to high risk of CPE on bed utilisation
	3644	Failure to make an improvement in compliance gaps with CQC standards.		
			Positive Controls – **New**	Monitor recruitment and retention via WODG and Board monthly
			Positive Controls – **New**	Actions regards environment are monitored via the environmental group monthly
			Positive Controls – **New**	Staffing breaches are reviewed by the HoN/M monthly and reported via PSIG monthly
			Positive Controls – **New**	Internal audit has reviewed the internal action plan in 2016 and process in 2017
			Positive Controls – **New**	CQC actions which remain ongoing are monitored via relevant Trust level groups e.g recruitment & retention and Medicines Management group which are then reported to the relevant sub board committee
			Positive Controls – **New**	Fundamental standards are reviewed & monitored by the designated specialist groups and bi annually by the sponsor which then reports to QSAG
			Positive Controls – **New**	HON/M monitor quality performance metrics on a monthly basis for trends and themes, these are further analysed via PSIG
			Positive Assurance – **New**	Overseas recruitment has seen a further 4 potential nurse candidates from the Philippines arrive Jan 18, March OSCE is booked for March 2018 – this will add to the current total of 54 qualified Philippine nurses currently in post.
			Positive Assurance – **New**	Action plan closed and remaining actions are being addressed via MMG and Recruitment and Retention steering group
			Positive Assurance – **New**	QRV process is now embedded and refined, plan formulated for ongoing inspections 2018
			Positive Assurance – **New**	CQC insight report shared with Divisions for information, Dec 2018 shows a slight decline in the safe domain, remaining domains remain stable
			Positive Assurance – **New**	E-roster version 10 now rolled out across all inpatient areas as of 2017
			Positive Assurance - **New**	Significant reduction in falls since commencing with the falls collaborative in Jan 2017
			Gap in Assurance - **New**	E-roster accountability meetings exploring usage and analysing metrics indicates some areas for improvement
			Action Plan - **New**	Action plans to be developed to support National Maternity and CYP survey outcomes Feb 2017
			Action Plan - **New**	Overseas recruitment to be explored March 2017

			Action Plan - **New**	Council of Members work plan to be agreed for 2018 Feb 2018
	4718	Safeguarding Team Staffing		
			Action Plan - **New**	To prioritise and attend meetings
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		
			Positive Assurance – **New**	£7.8m CIP delivered at month 9, £4.5m recurrent
			Positive Assurance – **New**	Theatre efficiency programmed achieved £1.2million
	4903	Risk of non-compliance with Thoracic Service Specification		
			New risk	If the Directorate are unable to meet the new NHSE service specification for thoracic work then thoracic work will no longer be commissioned at this Trust from April 2019. This will result in a loss of income circa £2,000,000 of income for the Trust per year.
	3069	Risk of Never Events within Division 1: Risks to Patient Safety and Trust reputation		
			Action Plan - **New**	RCA Investigation to be undertaken into the NE Retained Foreign Object (tampon) Datix:185875
			Action Plan - **New**	RCA Investigation to be undertaken into the NE Wrong Site Surgery (Facet joint injection) Datix:187201
	4529	Vacancies in Medical Staffing		
			Positive Controls – **New**	Recruitment in place
			Gap in Assurance - **New**	Locum expenditure increased month on month Oct/Nov/Dec 17 but still significantly decreased overall
	2898	Patients having to wait in ED in the Ambulance off load area		
			Risk moved from TRR to Directorate Risk Register	
	4161	Shortage of Qualified Nurses across the Division		
			Positive Assurance – **New**	On review - all green now
			Positive Assurance – **New**	Continuing to recruit new areas
			Action Plan - **New**	Review SOP for enhanced rates for ICCU staff
			Action Plan - **New**	Pilot 'Stay' Interviews within Paediatrics Directorate
	4523	Failing Heater Cooler Units		
			Gap in Assurance - **New**	3 & 4 Two machines confirmed as infected Datix 188066 Nov 17 & Dec 17
	4849	CT reporting		
			Positive Controls – **New**	Two tier reporting system now in place to enable reporting of all CT heads within 1 hour

			Positive Controls – **New**	Ongoing recruitment of radiologists
			Positive Assurance – **New**	CTs are being reported within 1 hr
			Positive Assurance – **New**	Two further Radiologists due to commence in post Jan18
	2080	Risk to quality of patient care: reduced manpower		
			Positive Assurance - **New**	Fill rates have been reviewed and weekly e-roster meetings now taking place with Director of Nursing
			Positive Assurance - **New**	Band 7 appointed to ward A7
			Action Plan - **New**	Retention group formed to look at how to improve retention across the organisation. findings to be communicated to Division
			Action Plan - **New**	Skill mix review to be undertaken in Feb 18
	4706	Infrastructure/environment in Nucleus Theatres		
			Action Plan - **New**	Final determination to be made as to whether Theatre 5 remains closed
	4711	CCH - Handling Medical Gas Cylinders		
			Positive Assurance - **New**	Medical gas cylinders trolley delivered to trust
			Gap in Assurance - **New**	Basic staff training required prior to using this equipment
	4767	Hip Fracture Best Practice Tariff		
			Positive Controls – **New**	Whiteboard put up in seminar room with NOF patients/ BPT elements to identify gaps
			Positive Assurance - **New**	Discussed daily at trauma meeting
	4599	Emergency Services Governance Arrangements		
			Positive Controls – **New**	Incident reporting and governance covered as part of junior doctors induction
			Positive Controls – **New**	Date of governance meeting has been amended to enable attendance by wider team
			Positive Assurance - **New**	SUI actions saved on w drive for easier access to all
	4696	Unreported Imaging Studies		
			Action Plan - **New**	Await response from Division post escalation regarding the lack of infrastructure to support the implementation of the 5 additional clinical fellows
			Action Plan - **New**	Continue to utilise waiting list initiatives
	4756	Increased Activity in Relation to Forecasted Number of Births		
			Action Plan - **New**	Continue to monitor birth activity as a result and decline inappropriate bookings
	4375	NX87 Heart Centre - Fire Safety		
			Action Plan - **New**	Undertake additional maintenance work to reduce the number of outstanding work

				packages
			Action Plan - **New**	8 outstanding Directorates to complete local actions (B2, B4, B5, B8, B10, B11, B12, B14)
	4411	NX08 McHale Building - Fire Safety		
			Action Plan - **New**	Remove or relocate combustible storage.
			Action Plan - **New**	Carry out remedial fire stopping works
			Action Plan - **New**	Undertake additional maintenance work to reduce the number of outstanding work packages
			Action Plan - **New**	Directorates to complete local actions (MPCE, Div 2 Offices, 1st Floor Admin, Estates Workshop, Tech Services)
	4412	NX09 McHale Building - Fire Safety		
			Action Plan - **New**	5 Directorates to complete local actions (MPCE, Div 2 Offices, 1st Floor Admin, Estates Workshop, Tech Services)
			Action Plan - **New**	Remove or relocate combustible storage.
			Action Plan - **New**	Carry out remedial fire stopping works
			Action Plan - **New**	Undertake additional maintenance work to reduce the number of outstanding work packages
	4528	Incomplete Health Records on Clinical Web Portal		
			Action Plan - **New**	Non-STEIS investigation being undertaken Datix: 185209
	4565	Delivery of Agency Expenditure		
			Gap in Assurance - **New**	Locum expenditure has increased during Nov and Dec 2017
	4472	Delays in Cubicle Assessment and Triage		
			Action Plan - **New**	Div 2 undertaking demand and capacity tool to look at rota
			Action Plan - **New**	Directorate Management team asked to identify additional level of support required
	4715	Dermatology Service		
			Risk moved from TRR to Directorate Risk Register	Chief Operating Officer to re-rated risk as 9
Chief Financial Officer	4791	Unplanned activity leading to financial pressures		
			Action Plan - **New**	Meeting to discuss Oncology transfer with specialist commissioners arranged for Mid Jan
	4794	The 2016/17 year end invoice		
			Action Plan - **New**	NHS I confirmed at telephone conference on 19 Jan 2018 that the issue was being put on the arbitration list for national escalation with NHS England
	4866	£1.362m risk in the income plan		

			Risk closed	Guidance from NHS Improvement received 11 Jan setting out accounting treatment such that this is no longer a risk.

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.

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

Controls

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

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

Movement
The direction from last reported quarter

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

ROYAL WOLVERHAMPTON NHS TRUST

BOARD ASSURANCE FRAMEWORK 2017/18 (JAN)

The Royal Wolverhampton NHS Trust

CORPORATE OBJECTIVES RISK MATRIX

			RISK SCORES: LIKELIHOOD x CONSEQUENCE = TOTAL								STRATEGIC OBJECTIVES					
REF	STRATEGIC RISK	ASSURANCE TO	INITIAL RISK SCORE	SCORE AT QUARTER 3	SCORE AT QUARTER 4	SCORE AT QUARTER 1	SCORE AT QUARTER 2	MOVEMENT Q2 TO Q3	SINCE LAST UPDATE	CURRENT RISK & SCORE AT QUARTER 3 (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	16	16	12	12	→	↑	15				✓		
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	16	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				CURRENT ASSURED LEVEL	Movement
	INITIAL RISK SCORE	PREVIOUS QUARTER RISK SCORE	CURRENT RISK	TARGET RISK SCORE		
	5x3=15	3x5=15	20	5x2=10		

What is the strategic risk to be controlled? REF	STRATEGIC RISK	EXECUTIVE DIRECTOR	BOARD COMMITTEE
SR 1 Date of origin - May 2015	Workforce - Attracation, 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.
IC5	With the potential for increased competition with other NHS organisations there is the posibility of salary escalation along with the wider issue of NHS competitive pay compared with the private sector		

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 & OD Committee, Resourcing Operational Group, TMC, TB
C2	Recruitment and recruitment initiatives (including Overseas) for **Nurses** to complement local and national recruitment.	L1, L2	Workforce & OD Committee, 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 & OD Committee, NHSI
C4	Progress report on Trustwide workforce review to include the development of new roles.	L2	Workforce & OD Committee
C5	Develop a strategic approach to People Management and employee engagement and measure outcomes of people and OD strategy.	L2	Workforce & OD Committee

***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 & OD Committee - Resourcing 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 recruitment 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 & OD Committee 2. Recruitment and Retention steering group. 3. Safer Staffing Updates in Chief Nurse Update report to TMC and Trust Board. 4. Executive HR report to TMC and Trust Board.	International Phillipine campaign closed in January 2018 - 54 registered nurses have joined the Trust. The Trust appointed 19 Trainee Nursing Associates in 2017, the funding stream has now changed to a 2 year apprenticeship programme and 15 offers have been made to commence training March 2018. Proposals are being considered in respect of future cohorts. Employee engagement indicators are stable within the Trust, detailed work on retention and the Trust values have been reviewed within the newly established Attract and Retain Steering Group.	
C3	01/05/2017 June 17	Workforce & OD Committee - Resourcing 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 Programme has a work stream 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	01/09/2016 June 17	People and Organisation Development Strategy 2016-2020 progress report to Workforce Assurance Group	People and Organisation Development Strategy 2016-2020 KPI to be reported have been agreed.	

NEGATIVE ASSURANCES are …					**Jan 18 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. (Medical & Overseas Nursing	- 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	Closed
C1, C2, C3	Jan-18	Current overseas nurse recruitment comes to an end in early 2018/19	Develop an options approach for the future of overseas recruitment	Director of Workforce	Apr-18
C1, C2	Sep-17	Lack of a consistent/coordinated approach to the provision of staff benefits	An approach to staff benefits to be established	HR Manager (Workforce)	01/11/2017 **Complete**
C1, C2	Dec-17	Lack of a consistent/coordinated approach to the provision of staff benefits	Following the agreement of additional resource, implementation of the staff benefits approach.	HR Manager (Workforce)	May-18
C1, C2	Oct-17	The benefits of employment with the NHS are not adequately promoted	As part of improving attraction and recruitment, review and enhance the trust communication of the benefits of working within the NHS	Senior Resourcing Manger Head of Communications	Mar-18
C1, C2	Jun-17		Trust wide Workforce CIP Resourcing review to be initiated through FRB.	Director of Workforce Medical Director Chief Nurse	Ongoing
C1, C2	Jun-17	Further develop Recruitment and Retention reporting 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 stability index (focus on outlying depts)	Deputy Director of HR	01/11/2017 **Complete**
	Dec-17		Develop monitoring of length of time to recruit (advert to appointment timescale) Develop electronic exit interviews.	Senior Resourcing Manger	Apr-18
C1, C2	Sep-17	There is no single coordinated central mechanism for recruitment across the Trust	Explore the option of centralising recruitment for the Trust	Senior Resourcing Manger	01/11/2017 **Complete**
C1, C2	Dec-17	There is no single coordinated central mechanism for recruitment across the Trust	Following the support of the business case, establish a centralised recruitment approach for RWT	Senior Resourcing Manger	May-18
C1, C2	Dec-17	There is no single coordinated central mechanism for recruitment across the Trust & a need to further focus on effective reporting	Review the option of procuring an electronic tool (such as TRAC) to improve recruitment processes & reporting	Senior Resourcing Manger	May-18
C1, C2	Sep-17	The Trust lacks an integrated marketing approach to make best use of electronic media and events to improve attraction	Review options for improved marketing in order to enhance attraction	Senior Resourcing Manger	Mar-18

C1, C2	Sep-17	With regards to some roles within the Trust there is a lack of consistency and standardisation	Develop a project plan to establish a more consistent and coordinated approach to recruiting to generic roles	Deputy Director of HR	Oct 2017 **Complete**
C1, C"	Oct-17	With regards to some roles within the Trust there is a lack of consistency and standardisation	Implement agreed action plan.	Deputy Director of HR	Mar-18
C3	Sep-17	There is a need to review the organisational employment model to support greater flexibility, recruitment & attraction	Establish and promote and enhanced employment model	Deputy Director of HR	Feb-18
C4, C5	Sep-17	There is no formal board committee responsible for the wider workforce agenda	Revise the ToRs for WAG to move it into a formal board committee responsible for Workforce & OD	Director of Workforce	**Complete**
C1	Jan-18	The current corporate induction is not fully focused on onboarding new staff in order to improve retention	Undertake a full review of corporate induction in order to support improved retention of staff	Senior Resourcing Manger Head of Communications	Apr-18
C4, C5	Jun-17	There is no strategic approach to focus on attraction and retention.	Develop a draft Trust approach to Attraction and Retention for all staff.	Director of Workforce	Feb-18
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. **Closed following NHSI letter on collaborative bank (see new action below)**	Director of Workforce	01/09/2017 **Closed**
C3	Dec-18	Longer term plans to establish a central resourcing and temporary staffing function that handles internal bank and external agency placement requests for all. New NHSI requirement to establish BC collaborative bank.	Review options and support for a single collaborative bank mechanism across the BC	Director of Workforce	Apr-18
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 (i.e. business process, IT, monitoring) - review the operation and effectiveness of internal bank	This is monitored on a monthly basis at Workforce CIP with target for 2017-2018 year of £2 million reduction.	Deputy Director of HR	Apr-18
C3	Sep-17	Variability in rates for medical locums across the West Midlands	In collaboration with other WM Trusts, with a particular focus in the BC, establish common (lower rates) for medical locums	Director of Workforce	Nov 2017 **Implemented 6th Nov - Complete**
C4, C5	Sep-17	There is no strategic approach to the implementation of apprentices across the Trust	Develop a Trust approach to the application of apprentices across the organisation	Director of Workforce	Feb-18
C1, C2	Nov-17	No consistent and coordinated mechanism to review & monitor job planning across the Trust	Explore options for establishing electronic job planning across the Trust	Senior Resourcing Manger	Mar-18
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, involvement 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 Organisation Development and Engagement and Culture are being developed and action planning is underway in order to ensure employee engagement, involvement and wellbeing have a positive 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	Ongoing

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?			EXECUTIVE DIRECTOR	BOARD COMMITTEE		
REF	**STRATEGIC RISK**					
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	**3 x 5 = 15**	

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	L2	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. The Trust raised an invoice to Department of Health for the £6m in October which has re-engaged NHS Improvement.	

NEGATIVE ASSURANCES are …					**Jan 18 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 Trust and would continue to raise with NHS Improvement nationally and the DH. This has not yet been fully approved and paid however. The Trust was asked to confirm its position recently on CIP in a letter to NHS Improvement when the risk of the £6m was again highlighted to the Regional Delivery and Improvement Director (Dated 7th Sept). The Trust has ensured in all of its correspondence with NHS I that the risk has been clearly articulated. At the conference call with NHS I on 19 September the regional tier wanted the Trust to chase the DoH for payment (Jan 18).	Kevin Stringer	Ongoing
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**		
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.	
C4	Oct-17	Staffordshire STP and Black Country STP update.	Written update on latest developments provided to F&P Committee	

NEGATIVE ASSURANCES are …					**Jan 18 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**		
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. Increase in underlying deficit.
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. Failure to achieve previous year
IC4	Trust is placed in financial special measures	O4	Failure to deliver on some identified schemes of slippage ie procurement, outpatients.
		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 via hospital model. Includes GIRFT (getting it right first time)	L1	FRB and TB (monthly)
C5	Appointment of Deloittes to assist with CIP delivery ie outpatients.	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 continued throughout the year.	L1,L2	F&P (monthly)
C8	COO and DSPP reviewed all non-medical agency in September 2017. Action plan to reduce all non-medical agency by December 2017.	L1,L2	Workforce Group, FRB & 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	Jan-18	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. Theatre presentation at FRB provided assurance on progress.
C2	Jan-18	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. Identification of schemes for 18/19 commenced.
C3	Jan-18	FRB CIP reporting	CIP continues to be identified	See Above. Recurrent schemes under achieved.
C4	Jan-18	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. GIRFT clinical excellence group has met and developed programme of review (action - Jan 18).
C4	Jan-18	Product lines standardised by Procurement.	Catalogue lines reduced and further review on-going	Links with UHNM established.
C5	Jan-18	FRG reporting to F&P	Deloitte onsite (June 16) and extended March 2018. FRP developed - actions commenced formal sign off. Regular FRG report to F&P.	Contract extended until March 2018. Failed to appoint into post.
C6	Jan-18	Progress update	Meetings identifying plans for recruitment use of clinical fellows and also where gaps in directorate planning.	Resource meetings completed April 17 - completed report produced September 17. Deloitte report on impact of clinical fellows received. Action plan in place for Obstetrics and Gynaecology and Anaesthetics (Jan 18). Control meetings to commence from July 17.
C7	Jan-18	Workforce & FRG	Review of non-medical agency (32 posts). Forecast only 7 posts to remain at the end of December.	Weekly review of non-medical will be undertaken by COO. Agency forecast to be within capped limit. 11 posts remain at Dec 17 plans for 4 to increase Mar 18.

NEGATIVE ASSURANCES are …

Jan 18 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	Jan-18	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 November.	Head of Transformation	Jun-17
C2	Jan-18	There is a shortfall against recurrent CIP.	All groups in FRB have an action plan for delivery.	Head of Transformation	Jun-17
C3	Jan-18	As a result of agreeing (STF) control totals additional CIP is required.	All Trust members to identify CIP when possible - Link to C1.	All (COO)	on-going
C4	Jan-18	Carter GIRFT efficiencies are not yet confirmed	Continuing work to 'realise' what has been identified and ascertain potential savings. Work is ongoing.	Deputy Medical Director	Jan 18 on-going
C5	Jan-18	Failure to appoint transformational lead post	Continue with Deloittes	Director of Strategy	Nov-17
C6	Dec-18	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 online.	Chief Operating Officer	Nov-17
C3	Jun-17	FIP 2 (NHSI) Finance Improvement - Trust 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**
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

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.

IMPACTS / CONSEQUENCES OF THE RISK?		ORIGINS OF THE RISK?	
REF		**REF**	
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	Sep-17	FRB report to Finance and Performance Committee and the Board	Further opportunities have been identified. Work with External Consultancy now identified further efficiencies in Outpatients, Nurse bank/e-rostering and role standardisation.	
C4	Nov-17	FRB report to Finance and Performance Committee and the Board	Balanced scorecard now being produced monthly on key issues as per NHS Improvement best practice. Month 5 (August) spend was £1m continuing the reduction from last year which was an average of £1.3m per month. The Trust is now predicting that it will be within its Agency target of £10.9m showing a circa £5m reduction year on year. Fellowship report shows £1million savings on mid-grade doctors.	
C5		Finance and Performance then Trust Board	Positive report on the process for tracking and reporting CIP schemes received	

NEGATIVE ASSURANCES are …					**Jan 18 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**
C2 (A)	Sep-17	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. The Trust has now finalised the case and will take to Jan 18 F&P for discussion and onward submission to the CCG (Jan 18).	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		**EXECUTIVE DIRECTOR**		**BOARD COMMITTEE**			
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**	**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	L2	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. F&P Committee have requested internal audit to review cash procedures and reporting so that additional assurance can be given and any gaps to best practice reported (Jan 18).	
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 plan is shown	
C5	Sep-17	Reducing aged debt report	All undisputed old year debt with Walsall Healthcare Trust (circa £1m) now paid. The Trust has responded in kind with payment of its undisputed old year debt.	

NEGATIVE ASSURANCES are …					**Jan 18 Status**
ative 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	Sep-17	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 5 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
C5	Nov-17	Walsall Trust debt now continuing to build since last payment. At 10th Nov the net debt was £1.3m.	Initiate escalation process	CFO/DCFO	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**			
REF	**STRATEGIC**						
SR11 Date of origin - June 2015	Condition of the existing Estate - Quality and flexibility		Chief Finance Officer	Finance and Performance			

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	Sep-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. Detailed backlog survey being developed from FY 18/19 to identify urgent backlog.	
C3	Sep-17	Further work on estates rationalisation as part of updated clinical strategy.	A structured 'Property Management' function under Estates (Development) being advanced alongside the clinical service strategy. Regular Property Management reporting has now commenced and includes community accommodation functions. Utilisation information is to be developed further. Room booking and agile working systems and options are being investigated. Business Case due for Feb 18.	

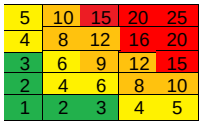
NEGATIVE ASSURANCES are …					**Jan 18 Status**
What are the negative assurances received?					Update received
Control Ref	**Date Assurance provided**	**NEGATIVE ASSURANCE (include reasoning as appropriate)**	**ACTION PLAN**	**ACTION LEAD**	**AGREED DEADLINE**

C1	Sep-17	On-going discussions commenced with Commissioners with regard to primary care estate strategy	Develop primary care strategy with CCG. Ongoing discussions with commissioners, Local Authority and BCPFT as part of the Local Estates Framework (LEF). A joint service strategy is being developed to consider community estates rationalisation with local partners. Joint service strategy with Local Authority, BCPFT and Wolverhampton CCG has now been completed. Recommendations contained within the strategy for joint hub working are being explored. The development of a business case for such a hub is currently being procured. A new software system is being procured to record occupancy and report on occupancy. It is expected that for the system to be implemented and fully populated it could take 6-12months. Separate piece of work is underway to research space requirement and availability around the trust in order to satisfy existing need.	Head of Estates Development	Joint Service Strategy has now been completed. Date for Hub business case yet to be confirmed.
C3	Sep-17	Lack of supporting information with regards to long term plan with regards to services. Also lack of information on space and room occupancy.	Monitor service strategy development. Develop business case for capital and revenue requirements required to manage occupancy and utilisation of space.	Head of Estates Development	Oct-17

The Royal Wolverhampton NHS Trust

Trust Risk Register

January-2018



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										

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:		**Be in the top quartile for all performance indicators**									
Chief Operating Officer	4286	If the Trust fails to achieve all mandatory criteria for the Paediatric Diabetes Best Practice Tariff then this will potentially lead to poor clinical outcomes for patients. Also, if the Best Practice is not achieved this will result in the directorate failing to achieve additional income of BPT. 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 (07/08/2016) 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) Workforce review completed, blue prints amended (10/10/2017) 8) Ward Receptionist post agreed through TMC (10/10/2017)	7) Partial achievement 7/14 criteria (H-N) vacancies outstanding X2 (19/12/2017) 3) Positive feedback from parents following attendance at drop-in sessions. (19/12/2017) 5) Additional support enabled compliance to BPT standards for 2017 (19/12/17) 6) BPT Best Practice standards met for 2015/2016 (19/12/2017). 4) Informally, the Dietetic Team have agreed to provide support (19/12/2017)	1, 7) Insufficient staff to cover weekends (19/12/17) 2) There are a number of patients whose education programme are still outstanding (19/12/17). 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) situation status remains the same (19/12/2017) 1-4) Unable to meet criteria re: HbA1 measurements in financial year due to high DNA rates pending update from Consultant (19/12/2017) 1 - 5) Posts remain vacant presently - post has been advertised. Risk upgraded to High Amber (19/12/2017) 7) Present service level will not enable compliance to BPT for 2017 (19/12/2017)	7) Actively recruiting to nursing vacancies. 8) Actiively recruiting to Ward Receptionist post	Jan-18 Jan-18	2 x 1 = 2 GREEN	Jan-18	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. Superceded by revised trajectory for Wolverhampton DTOC submitted as part of better care fund bid - September 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) Roll out of discharge assess in Dec/Jan. Led by LA-supported by ED Delivery Board Sept - Dec 2017. 7) Development of Trusted assessor model - linked to 2 - Led by LA. 8) DTOC reduction part of health economy better care fund plan April 2017. 9) Engagement with weekly Staffordshire DTOC meeting (Dec 17).	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. 8) DTOC numbers (bed day delays) reducing for Wolverhampton in Nov/Dec	2) Challenge with brokerage in Staffordshire.	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 3) Increase monitoring and review of patients with social care to delays on-going. 4) Escalation to NHSI to assist with Staffordshire delays.	Jan-18 Oct-17 Jan-18 Nov-17	3 x 3 = 9 AMBER	Jan-18	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 completed. Pilot for weekend working commences Feb 18.	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 - closed in post 2) Ward clerk review - transformation project revised date Sept - Dec 2017 - closed completed	Apr-16 Feb-18 Sep-16 Dec-17	2 x 3 = 6 YELLOW	Jan-18	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 (March 2016) 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) 8. Directorate now have 5 machines, 1 of these is on loan (Oct 17)	2+3. There have been no further HCU failures since the end of April 2016 (Jan 18) 6 & 7. No patients have declined the procedure as a result of being open (Jan 18) 5 & 8. 2 machines would have to breakdown at the same time to provide issues however the chances of this are miniscule now that the Department have 5 in total (Jan 18)	3. New cleaning protocol may result in a potential increase in machine failure and a 4-6 month repair time. (Jan 18) 1.There has been one failure (pre-April 2016) and the other machines are showing signs of wear and tear. (Jan 18) 3 & 4 Two machines confirmed as infected Datix 188066 Nov 17 & Dec 17 (Jan 18)	1+3. Continue to monitor 1-4) Livarova to attend to undertake new fix on machine 1-8) Present Business case written for new machines from a different manufacturer	Apr-18 Feb-18 Feb-18	3 x 2 = 6 YELLOW	Jan-18	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 does not have cholecystectomy within 1 week (as recommended by NICE QS104) and a patient with gallstone pancreatitis is does not have cholecystectomy within 2 weeks (as recommended by NCEPOD in Treat the Cause) the patient is at increased risk of recurrent admissions with complications of gallstones, potentially serious morbidity and an increased risk of mortality. 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 has 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. 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 1-2 Change SLA with Stoke to bring additional resources from current RWT Consultant and buy service from Stoke	Feb-18 Feb-18 Feb-18 Apr-18	2 x 2 = 4 YELLOW	Jan-18	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	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 (22/08/16) 2) Review of Governance work streams at the Divisional Governance meetings, incuding NICE, External guidance, Audit, Risk (22/08/16) 3) Monitoring of all SUI/Audit actions through to completion (22/08/16) 4) Performance meetings in place (22/08/16) 5) Directorate Governance meeting in place and attended by Directorate Management Team (22/08/16) 6) Staff member identified to provide Governance support 2 days per week (22/08/16) 7) Process in place to review re-attendances for potential SUI's proactively (22/08/16) 8) Ongoing recruitment [07/09/17] 9) Governance pre meets in place (14/11/16) 10) CD had additional admin day [10/10/17] 11) Incident reporting and governance covered as part of junior doctors induction [04/12/17]	5) Governance meetings taking place regularly [16/01/18] 9) Pre Governance meetings now established and working well to review SUI actions and risks [16/01/18] 3) Number of SUI and SUI actions is reducing [16/01/18] 4) 1 Adult ED Consultant commenced substantively from Mid October 2018 taking the substantive establishment to 5 PEM,9.5 Adult [16/01/18] 1) Bd6/7 nursing forums taking place regularly and working well [16/01/18] 3) Action plan now reviewed in Divisional Friday morning meeting [16/01/18] 3) Local audit of SUI actions is showing good compliance, with exception of Discharge checklist [16/01/18] 3) HOT reporting of radiological results in place [16/01/18] 8) Cons interviews scheduled in Jan 18 [16/01/18] 3,4) SUI actions saved on w drive for easier access to all [16/01/18]	3) Significant number of SUI actions overdue/dates amended [16/01/18] 2) Number of NICE and External Reviews that remain outstanding [16/01/18] 8) 2 ACPs have left the department [16/01/18] 3) Actions are taking a considerable amount of time to implement/ close [16/01/18] 9) Difficulties in reviewing whole agenda at pre meet due to the volume of outstanding SUI actions/ number of RCAs to be reviewed and signed off [16/01/18] 7) No process in place to ensure re-attenders report is reviewed in the absence of governance lead [16/01/18] 3) Significant increase in SIs reported in October - 7 [16/01/18] 3) Local audit of SUI actions is showing poor compliance with Discharge checklist [16/01/18] 3,4) SUI actions reviewed weekly but based on avalability of CD [16/01/18]	6,7) Directorate to agree process to ensure incidents are reviewed and reported when the Governance lead is on leave	Jan-18	2 x 3 = 6 YELLOW	Jan-18	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) Date of governance meeting has been amended to enable attendance by wider team [04/12/17]							
Chief Operating Officer	4862	Currently, there is an increase in demand for neonatal cots at Levels 1, 2, 3, which exceeds agreed commissioned activity and funded nursing establishment. If funding and service commissioning is not increased then this will lead to delays in delivering high risk ladies, transfer intrauterine cases and repatriation of RWT babies resulting in the potential for an adverse outcome for mother and/ or baby leading to increase in legal cases as a result of harm.	4 x 3 = 12 AMBER	1) Neonatal and Obstetric teams working together to plan and prioritise planned cases according to clinical need (15/09/2017) 2) Liaising with neighbouring Trust to initiate intrauterine transfers from RWT when clinically safe (15/09/2017) 3) Additional staffing sought through Trust bank and current workforce (15/09/2017) 4) Loan of essential equipment from Trust within the network (15/09/2017) 5) Actions implemented/lessons learnt from RCA 2017/10549 (175503) - Transfer the most stable babies out where possible to reduce risk of an emergency enroute (Oct 17)	4) Equipment available for loan from other Trusts (19/12/2017) 1) Obstetric and Neonatal teams planning ahead and agreeing delivery times (19/12/2017)	1,2) Incident reports have been received concerning lack of staff and equipment. (19/12/2017) 4) Availability of spare equipment from other Trusts not guaranteed due to their own pressures. (19/12/2017) 2) Neighbouring Trusts cannot always accommodate babies at request due to their own pressures (19/12/2017) 3) Additional staffing cannot always be found leading to increase in stress of those working. (19/12/2017) 3) There are number of incidents relating to staff and over capacity on monthly basis. (19/12/2017) 4) There are ongoing incidents relating to the lack of clinical equipment to support activity, i.e., machines providing ventiliation support. (19/12/2017). 3) 88 patients were refused admission for various reasons. (19/12/2017).	1-5) Business plan production for additional nursing and medical consultant staff to open additional four cots this should include succession planning for ANNPs	Jan-18	3 x 2 = 6 YELLOW	Jan-18	

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 = 09/10/15 & June 16	4 x 5 = 20 RED	3. Vacancy control panel in place (Oct 2015) and higher restrictions being applied (Jan 17) 2. Financial Forecasting meetings now include Confirm & Challenge CIP so that there is a consistent approach to Directorate financial position/challenge (Sept 17) 1. Increased PMO resources to support delivery of the Trusts efficiency programme (June 16) 4. Monitored by the Financial Recovery Board (FRB) (Oct 2017) 5. 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 6. Operating Theatre Efficiency Group (OTEG) set-up and running for 12 months. Each Directorate setting up 'Local' sub-groups (Sept 17) 7. All agency requests above £120 P.H to be approved by COO/CEO 8. Division involved in Financial Recovery Board chaired by CEO (Nov 2017) 9. PIDs are forthcoming to the Finance team (Nov 2017)	2, 3 & 4. Structure in place to discuss and identify opportunities to create efficiencies and business growth (Oct 17) 3. VCP meetings held weekly and posts go through this process (Oct 17) 5. 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. (Oct 17) 1-9. £7.8m CIP delivered at month 9, £4.5m recurrent (Jan 18) 6. Theatre efficiency programmed achieved £1.2million (Dec 17)	2 & 3. Unidentified CIP still remains (Oct 17).	1-9) Continue with process to identify and deliver efficiencies 2) Review of year to date underspends with a view to take non-recurrent to CIP 1) Divisional Management Team to meet with CDs collectively to discuss growing the business, increasing utilisation of theatres and OPD 1-9) Trust commencing roll-out of Clinical Excellence Programme to cover Carter, GIRFT and Model Hospital, led by Deputy Medical Director	Apr-18 Apr-18 Apr-18 Apr-18	2 x 3 = 6 YELLOW	Jan-18	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. (June 17)		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. (Sept 17)	Identify service related issues and align capacity with additional service demand. (June 17) Seek to put CVOs in place with commissioners in order to allow the Trust to better plan capacity. (June 17) Business case for agreed additional activity to be formulated by specialty and submitted to Contracts and Commissioning Group. (June 17) Business Cases for transfer of oncology services from S&WB and Stroke from Walsall being constructed for internal approval. Meeting to discuss Oncology transfer with specialist commissioners arranged for Mid Jan	 Jan-18	3 x 1 = 3 GREEN	Jan-18	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 (June 17) 1) Continue to follow up on debt (June 17)		1) Currently arbitration process has stopped (Sept 17)	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. (Sept 17) 2) NHS I informed Trust at IDM 31 Aug that the debt was now being escalated out of region for conclusion (Sept 17) NHS I confirmed at telephone conference on 19 Jan 2018 that the issue was being put on the arbitration list for national escalation with NHS England (Jan 18)	 Jan-18	3 x 3 = 9 AMBER	Jan-18	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	4903	If the Directorate are unable to meet the new NHSE service specification for thoracic work then thoracic work will no longer be commissioned at this Trust from April 2019. This will result in a loss of income circa £2,000,000 of income for the Trust per year.	4 x 5 = 20 RED	1.Trust have requested that NHSE reconsider codes used to determine number of eligible resections . (Nov 17) 2. 13/12/17 Medical Director held discussions with Walsall Manor Hospital to increase referral cases to RWT (Jan 18) 3. Frozen section samples to be communicated from lab to theatres within one hour (Jan 2018)		1. Awaiting decision of NHSE (Jan 18)	3. Audit of compliance to be undertakenLead: Katy New 1-3) Business Case to be presented to TMC for approval	Mar-18 Jan-18	1 x 5 = 5 YELLOW	Jan-18	
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 - Dec 17 3) RAG rated tool to monitor compliance against Job Plans has been developed and now shared with directorates Sept 17. 1) Job plans continue to be reviewed and sign off by DMD / MD- ongoing 1) New Job Planning Policy agreed by LNC Mar 17 5) Job Planning updates to be presented to clinical excellence group (Jan 18)	1) Job Planning Audit indicated a number of actions now addressed 1) Training commenced on new job planning process - Feb 16 4) Medical agency costs reducing Dec 17. 1) Increase in number of 'signed off' job plans October 2017	1) Slow progress in terms of Job Plan completion - Apr 17 1) Audit review still raised concerns - closed Dec 17	1) Develop business case for recording electronic tool to assist with job planning. 1) Internal audit to review progress made on job planning (Jan-Mar 2018) 5) Further update to Audit Committee in progress.	Mar-18 Mar-18 Feb-18	3 x 2 = 6 YELLOW	Jan-18	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, 4160 Renal, 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 (Jan 16) 8) Use of Nurse Bank when required (Jan 16) 3) Defined minimum safe staffing levels now in place revised October 2017 5) Modified dependency tool for inpatient areas commenced (Jan 16) 9) Staffing incidents reviewed on monthly basis (Jan 16) 10) Closed Ward 3 at West Park Hospital (June 16) 4) Closed ward B7 (June 2017)	8) HCA's are available via Bank (Jan 18) 3) Safe staffing levels are being maintained across acute wards (Jan 18) 3,9) Internal transfer pool introduced across the Trust as part of the retention strategy (Nov 17) 1) Change to recruiting processes to speed up the process (Nov 17) 3) Daily staffing template produced at 4pm detailing all registered staffing (Jan 18) 3) All B7s trustwide filling OOH rota first, then managing in-hours gaps, including putting themselves in if necessary (Jan 18) 1) ACSG matron role substantively recruited (Jan 18) 9) Q3 review of A7&A8 has shown improvement. ABC check now being implemented (Jan 18) 1) Implementing proactive recruitment approach (Jan 18) 1) Fill rates have been reviewed and weekly eroster meetings now taking place with Director of Nursing (Jan 18) 9) Band 7 appointed to ward A7 (Jan 18)	1) 46.5 wte trained nursing vacancies remain (Jan 18) 8) Insufficient RN's available on Bank, backfilled by HCA (Jan 18) 1) Nationallly we are an outlier re safe staffing levels Jan 18) 3) Weekends and nights remain an issue in relation to staffing numbers (Jan 18) 1) Recruited staff are newly qualified which can lead to mentorship and training pressures (Jan 18) 1) 31.53 HCA vacancies remain	9) A7/A8 working through local 'special measures' action plan. 1) Retention group formed to look at how to improve retention across the organisation. findings to be communicated to Division 3) Skill mix review to be undertaken in Feb 18	Dec-17 Feb-18 Mar-18	4 x 3 = 12	Jan-18	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	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	2. Review of Obs & Gynae rota's underway as a result of increased activity (Sept 2017) 3. Baseline resourcing meetings held to review vacancies and expenditure, identify recruitment opportunities within Directorates explore alternative solutions including future workforce planning and forecasting (Sept 17) 4. Trust is part of West Mid's Project to reduce Locum Agency use and Pay (Dec 2017) 5. Trust part of Junior Doctors in-training streamlining group (Dec 2017) 1. Recuitment in place (Dec 17)	1-5) Some reduction in medical spend (Sept 17) 1-5) Medical workforce vacancy rate further reduced to 12.61% (Dec 2017) 1-5) Radiology vacancies have reduced to 5 - 3 x Consutlant interviews in Jan 2018 (Dec 2017)	1-5) Number of vacancies remain across the Division including within Radiology, Anaesthetics and Head & Neck (Sept 2017) 1-5) Locum expenditure increased month on month Oct/Nov/Dec 17 but still significantly decreased overall (Dec 17)	1-4. Continue with Fellowship Programme 1. Actively recruiting radiology (overseas) with Resourcing Team 1. Continue campaign with regular adverts 1-5. Developing roles to support medical rota (ANPs and ACCPs) 1. Radiology interviewing for 6 Clinical Fellow posts	Apr-18 Apr-18 Apr-18 Apr-18 Apr-18	2 x 2 = 4 YELLOW	Jan-18	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	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	2 x 2 = 4 YELLOW	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 (Nov 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), Level 2 - via e-learning, Level 3 - via face to face for children (Jan 2017) 7) Safeguarding Children Team Leader in place (December 2017) 8) Post safeguarding case support is provided as required as required (Nov 2017)	1) 3 of 4 posts have been recruited. (1x start 20/11/17, 1x start 4/12/17 and 1x start dateTBC) (Jan 2018) 3) Quality of information required by MASH has been addressed by response to the review (includes introduction of RAG rating for safeguarding enquiries (Jan 2018) 3) All cases are referred (Jan 2018) 8) No issues identified (Jan 2018)	1), 2) & 4) Certain meetings are not always attended or represented. e.g. MASH Meetings, RWT variety of meetings. (Jan 2018) 5) Safeguarding supervision is available to certain staff only due to staffing shortages in Maternity Services. Compliance for supervision has dropped (compliance figure 68% in Q3 17/18) (Jan 2018) 5) & 7) 1 to 1 adult safeguarding supervision is not proactively provided (this is currently not covered in protocol) (Jan 2018) 5) Scope of remaining RWT Safeguarding Children and Adult supervision requirements unclear. (Jan 2018) 1) 1 of 4 posts not yet recruited to (Safeguarding Adults Lead) (Jan 2018) 6) Insufficent training sessions (Jan 2018) 4) CQC review of July 2016 identified the need to recruit a named midwife (Jan 2018)	1) to 8) To continue to regularly contact the chair of the groups and review urgent actions post meetings. 1) to 8) SG Adult training delivery to be reviewed 1) To advertise, recruit and start in post 5) Review Safeguarding supervision protocol 4) Liasing with the Head of Midwifery to confirm budget for the post 4) To recruit named midwife/Safeguarding Adults Lead to be in post 1), 2) & 4) To prioritise and attend meetings	Feb-18 Apr-18 Apr-18 Feb-18 Feb-18 Apr-18 Feb-18	1 x 2 = 2 GREEN	Jan-18	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	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	5. Monitoring and circulation of incident notification reports to all senior staff for review 6. Trustwide learning via a "Lessons Learned" sheet in the monthly IGR, Risky Business Newsletter and the CLIP Group. 8. Regular scrutiny of Directorate risk registers and minutes of Directorate governance meetings at the Quality Meetings 2. Review completed of all documentation and Theatre protocols/procedures amalgamating where possible 1. Perioperative care plans are in place across the Trust 9. Agreed communication strategy with Division 2 to share/raise awareness of never events and lessons learnt 3. 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. 4. New NE Guidance 15/16 being used for NE classification 7. Policy for the management of retained swabs now in place	10. No trends identified (Oct 2017) 6. 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 (Oct 17) 3. Monthly monitoring and compliance with WHO checklist use - There has been 100% compliance achieved during Dec 17 (Jan 18) 11. Staff supported to undertake PCM training in Maternity & T&O (Dec 17)	4. There have been three Never Event incidents 2 x Wrong Site Surgery and 1 x Retained foreign object) reported and investigated during 2015 4. 5 x NE in 16/17 reported to CCG - 1. Maternity NE (retained tampon) reported (Datix ID: 158830), 2. Radiology NE (wrong ankle injected) reported (Datix 165455), 3. Opthalmology (wrong eye injected) reported (Datix 166680) 4. Theatres (retained foreign object) reported (Datix ID: 169339) 5. Theatres/T&O Cannock (wrong prosthesis) reported (Datix ID: 174038) occured Mar 2017 3. Monthly monitoring and compliance with five steps to safer surgery greater than 95% - 90% compliance was achieved in May 2017. 3. Monthly monitoring data of compliance with WHO checklist and Procedural Safety Checklist - 83% for full completion (Jan 2018) 4. 6 x NE incidents reporting in 17/18 reported to CCG from April 2017 (175581,179911,181941,185875 186479 and 187201) (Dec 17)	1-11. All theatre staff to undertake Human Factors Training from AFPP 2. Programme of Human Factors Training for Theatre Staff under-development 1-11. Staff continue to undertake PCM training 6. RCA Investigation to be undertaken into the NE Wrong Site Surgery (tooth) Datix:186479 6. RCA Investigation to be undertaken into the NE Retained Foreign Object (tampon) Datix:185875 6. RCA Investigation to be undertaken into the NE Wrong Site Surgery (Facet joint injection) Datix:187201	Apr-18 Jan-18 Apr-18 Jan-18 Jan-18 Feb-18	2 x 4 = 8 AMBER	Jan-18	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?
				10. New qualitative and observational WHO checklist being used in Theatres (Oct 17) 11. Continue to support the Sign up to Safety campaign - T&O and Maternity participation (Oct 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 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 and retention via WODG and Board monthly 3) Monitor monthly performance through the nursing midwifery KPIs for signs of deterioration 4) Actions regards environment are monitored via the environmental group monthly 1) Monitor IMR quarterly 6) Staffing breaches are reviewed by the HoN/M monthly and reported via PSIG monthly 5) Internal audit has reviewed the internal action plan in 2016 and process in 2017. CQC actions which remain ongoing are monitored via relevant Trust level groups e.g recruitment & retention and Medicines Management group which are then reported to the relevant sub board committee. 7) CQC action plan continues to be reviewed on monthly basis and report to QSAG monthly. 8) Fundamental standards are reviewed & monitored by the designated specialist groups and bi annually by the sponsor which then reports to QSAG. 9) HON/M monitor quality performance metrics on a monthly basis for trends and themes, these are further analysed via PSIG.	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 has seen a further 4 potential nurse candidates from the Philippines arrive Jan 18, March OSCE is booked for March 2018 - this will add to the current total of 54 qualified Philippine nurses currently in post. 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 closed and remaining actions are being addressed via MMG and Recruitment and Retention steering group 2) QRV process is now embedded and refined, plan formulated for ongoing inspections 2018 7) CQC intelligence monitoring report for Dec '14 indicated low risk (6) 6) Eroster scoping meeting took place 14/1/16 this will be report to an workforce efficiency steering group	1) E-roster accountability meetings exploring usage and analysing metrics indicates some areas for improvement 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) 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 Collaborative working with CCG regarding information/education to care homes and carers regarding safeguarding requirements for PI's Action plans to be developed to support National Maternity and CYP survey outcomes Feb 2017 Overseas recruitment to be explored March 2017 Council of Members work plan to be agreed for 2018 Feb 2018	Sep-17	2 x 2 = 4 YELLOW	Jan-18	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 version 10 now rolled out across all inpatient areas as of 2017 2) Agreement of NMC to reduce IELTS level for Nursing professionals 7) CQC insight report shared with Divisions for information, Dec 2018 shows a slight decline in the safe domain, remaining domains remain stable 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) significant reduction in falls since commencing with the falls collaborative in Jan 2017 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					

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 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 2. Developed a programme for Band 7s with a support programme wrapped around to assist with attrition and development 4. Increasing Band 2 support to manage qualified shortfall 5. Scrutinising staffing levels daily and moving /re-deploying staff across the Division as necessary 6. Friday morning meetings taking place for Matrons to check staffing across the Trust for the weekend to assure safety 7. There is now a trustwide transfer staffing pool (aimed to retain staff) (Aug 2016) 8. Appointed to Nursing Associate posts - to start end of Jan 17 (Jan 2017) 9. Trained and untrained vacancies reviewed by Head of Nursing and reported back to Trust Management Committee (Oct 17) 10. Regular workforce reviews to ensure staffing and service needs match (Oct 2017) 11. Nursing posts being reviewed to further retain staff (Surgical Nurse Practitioners, ACCPs, ANPs) (Oct 2017) 12. Action Plan to remove all agency spend in theatres (Oct 17)	1. Utilising bank where possible and increasing HCA cover as necessary 7. Safer escalation - Areas are amber or green. No area has been red. 2. Positive feedback received from Band 7s who have attended programme 1. Continuing to support offered applicants. 3. 5 T&O beds on Ward A5 have been opened (Oct 2017) 8. From March 2018, all areas will have one Nursing Associate (Jan 2018) 1 + 11.General Surgery nearly fully established, T&O fully established for beds open and ICCU have no vacancies (July 2017) 12. Theatre Agenda spend usage down to 2 staff, on track to completely remove by Dec 2017 (Oct 2017) 13. On review - all green now (Jan 18) 14. Continuting to recuit new areas (Jan 2018)	5. Peak annual leave seasons challenge to cover bank shifts. 1. Trustwide position: Philippines recuitement successful but long lead in time for staff to arrive in UK	1. Review SOP for enhanced rates for ICCU staff 1. Pilot 'Stay' Interviews within Paediatrics Directorate	Mar-18 Aug-18	2 x 2 = 4 YELLOW	Jan-18	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. Beds reconfigured on Ward A5 and A6 and Hilton Main (Oct 2017) 13. Continuing with Weekly e-rosta meetings to ensure scruitny of unused by the ward (Jan 18) 14. Shared Governance has been rolled out to the pilot areas (Jan 18)						
Chief Operating Officer	4375	(NX87) Heart Centre - Fire Safety: As a consequence of shortfalls in structural fire protection (including emergency lighting) and the recent failure of external ACM cladding, fire could spread both externally and internally throughout the building , compromising life safety. Date of origin: July 2017	3 x 4 = 12 AMBER	Implementation of a 4 Stage Risk Mitigation Plan; details include 1) Restricted parking of vehicles to 6m 2) Management of waste in the external compound 3) Increased security and surveillance 4) Augmented Fire Service reponse 5) Increased Trust Fire Response 6) Additional Fire Wardens trained 7) Additional fire exercises and drills 8) Review of fire risk assessments (15 completed, local risks managed by Directorates) 9) Building & Maintenance risks managed by Estates via Planet FM 10) Statutory fire alarm testing (weekly), Fire Damper Testing (Annual)	10) 0 incidents relating to Fire within December 2017 10) 0 Unwanted Fire Signals within December 2017 8) 7 Directorates have completed all local actions (B3, Administration offices, B7m B11, B15, Estates Management (Basement & Roof Plant Rooms) 3) Additional Security Patrols undertaken and recorded	8) 8 Directorates have outstanding local actions 2) Waste compound located under Ambulance Bay 9) 28 Live Planet Work Packages are oustanding	2) Relocate Waste Compound 9) Undertake additional maintenance work to reduce the number of outstanding work packages 8) 8 outstanding Directorates to complete local actions (B2, B4, B5, B8, B10, B11, B12, B14)	2 x 2 = 4 YELLOW	Jan-18	

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	4411	(NX08) McHale - Fire Safety: As a consequence of shortfalls in structural fire protection and the identification of polystyrene foam insulation installed between metal cladding, fire could spread uncontrolled throughout the building effecting critical operational services that could compromise hospital business continuity.	3 x 4 = 12 AMBER	1. Statutory fire alarm testing (weekly), fire damper testing (annual) 2. Review of Fire Risk Assessments (6 areas; MPCE, Div 2 Offices, 1st Floor Admin, Estates Workshop, Tech Services, R&D) 3. Building & Maintenance risks managed by Estates via Planet FM 4. Waste Management 6. Fire Evacuation Drills 5. Fire Warden Training for staff	1. 0 incidents relating to Fire within December 2017 1. 0 Unwanted Fire Signals within December 2017	4. Inappropriate storage of combustible items (waste etc) in basement 2. 5 Directorates have outstanding local actions 3. 13 Live Work Packages are outstanding 3. Breaches in fire stopping in basement area could compromise fire safety	4. Remove or relocate combustible storage. 3. Carry out remedial fire stopping works 3. Undertake additional maintenance work to reduce the number of outstanding work packages 2. 5 Directorates to complete local actions (MPCE, Div 2 Offices, 1st Floor Admin, Estates Workshop, Tech Services)	2 x 2 = 4 YELLOW	Jan-18	
Chief Operating Officer	4412	(NX09) McHale - Fire Safety: As a consequence of shortfalls in structural fire protection and the identification of polystyrene foam insulation installed between metal cladding, fire could spread uncontrolled throughout the building effecting critical operational services that could compromise hospital business continuity.	4 x 3 = 12 AMBER	1. Statutory fire alarm testing (weekly), fire damper testing (annual) 2. Review of Fire Risk Assessments (8 areas ICT, IT, Laundry, Sewing Room, Medical Records, Mortuary, Switchboard, Safeguarding) 3. Building & Maintenance risks managed by Estates via Planet FM 4. Waste Management 6. Fire Evacuation Drills 5. Fire Warden Training for staff	1. 0 incidents relating to Fire within December 2017 1. 0 Unwanted Fire Signals within December 2017	4. Inappropriate storage of combustible items (waste etc) in basement 2. 3 Directorates have outstanding local actions 3. 8 Live Work Packages are outstanding 3. Breaches in fire stopping in basement area could compromise fire safety	2. 5 Directorates to complete local actions (MPCE, Div 2 Offices, 1st Floor Admin, Estates Workshop, Tech Services) 4. Remove or relocate combustible storage. 3. Carry out remedial fire stopping works 3. Undertake additional maintenance work to reduce the number of outstanding work packages	2 x 2 = 4 YELLOW	Jan-18	

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) (15/04/16) 2) Use of MSS to monitor times for triage and assessment (15/04/16) 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. (15/04/16) 4) Reallocation of doctors to areas with high waiting times if appropriate (15/04/16) 5) Reallocation of nurse to support triage nurse (15/04/16) 6) Bed meetings held at regular intervals where status of Emergency Department is discussed with representatives of both Divisions to facilitate flow (15/04/16) 7) Monitoring staffing ratios and man-power plans regularly reviewed (15/04/16) 8) Acute Physician team available to support department from 10am until 21.30 every day (15/04/16) 9) UCC opened on 1st April 2016 (15/04/16) and joint triage model in place.	8) No concerns raised re Acute Physician support [16/01/18] 7) 8 new nurses started Sept17 and 5 further to start before Jan18 [16/01/18] 7) 1 NHS 2 year locum appoointed (CESR Dr) [16/01/18] 14) Nurse led RAT working well, phased implementation in place due to staffing issues [16/01/18] 15) New starters are familiar with the department and its processes/ policies when they start [16/01/18] 7) 1 Adult ED Consultant commencing substantively from Mid October 2018 taking the substantive establishment to 5 PEM,9.5 Adult [16/01/18] 7) 3 PEM Consultants recruited with joint working in Paeds, this ceases in April 2018 with all three posts becoming wholly ED [16/01/18] 217) Reduced reliance on locum agencies (internal staff have knowledge of local policies and processes) [16/01/18]	1,2) Inability to meet Department of Health guidance - 80% compliance in Nov [16/01/18] 1, 2) Inability to achieve 2 hour assessment and 15 minute triage [16/01/18] 3) Huddles not routinely taking place and escalation tool does not include actions to address ratings and does not highlight problem areas [16/01/18] 4,5) Staff not always available to be reallocated [16/01/18] 6) Delays in ED linked to bed availability [16/01/18] 7) Medical and nursing vacancies and sickness/ annual leave resulting in gaps in rota [16/01/18] 8) Consistently at 2 hour wait by evening [16/01/18] 9) UCC not impacting on pt numbers and delays in assessments (on average 27 patients per day redirected to UCC in Nov) [16/01/18]	7) Continue with recruitment of medical staff 14) Nurse led RAT to be officially launched, phased implementation 3) Development of escalation tool (including live escalation tool with feed from MSS to include patient numbers etc, purchase of screen to display live tool, and agreement of process for addressing escalation ratings) 10 Div 2 undertaking demand and capacity tool to look at rota 7) Directorate Management team asked to identify additional level of support required	Jan-18 May-18 Jan-18 Jan-18 Feb-18	1 x 4 = 4 YELLOW	Jan-18	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?
				10) Powerpoint presentation around National ED standards included in new starters induction and within annual mandatory training sessions (15/04/16) 11) Human factors training undertaken [08/11/16] 13) Medical and nurse staffing managed via the risk regsiter (risk 2374 & 4496) [08/11/16] 14) Nurse led RAT and SOP ratified and in place (Sept 17) 15) Where possible, newly qualified starters have their last student placement transferred to RWT ED [07/09/17] 16) System in place to ensure that Cat 2 patients are shown red at 15 minutes [05/10/17] 17) Use of internal bank rather than locum agencies where possible [05/10/17]					

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	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 Incident reported - 185209 non-STEIS investigation underway. There has been identification that the information included in hospital notes not available via clinical web-portal (Dec 17) 1. Records are not always available for elective clinics, even if they are available this creates a time lag within the clinic (Dec 17)	1-2. Monitor ongoing incidents 1-2. Non-STEIS investigation being undertaken Datix: 185209	Apr-18 Feb-17	2 x 2 = 4 YELLOW	Jan-18	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 substantive 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	9) Reported at Ops Finance Group and Finance & Performance 2) Utilisation of fellowship programme 3) Recruitment Strategy in place 1) Agency spend reviewed monthly at Directorate/Divisional Meetings 4) Establishment of workforce group to review/monitor use of medical locums/agency (Oct 16) 5) Overseas recruitment for some specialties (radiology). 6) Focus on reducing agency spend in non-clinical areas initially (Nov 2017). Star chamber review in Sept 17 7) Agency Dashboard are now produced monthly at a Trust and Divisional Level (Nov 2017) 10) The Trust is working collaboratively with other Trusts in the region as part of a Regional Agency Cluster Group to standardise rates of pay and reduce agency spend. This became effective on 30th October 2017 (Nov 2017) 8) GP agency cap limited increased (July 17)	1-10) Significant decrease in Locum expenditure overall (Dec 17) 1-10) Medical workforce vacnacy rate decreased to 12.61% (16.30% in August 2016) (Dec 17) 1-10) Nursing workforce comparison May 2017-August 2017 shows reduction of 6.66 WTE vacancies. Vacancies further reduced from 134.42 in August 17 to 110.73 (shift - 23.69) (Dec 2017) 6) There continues to be a decrease in agency spend in non-clinical areas (Dec 2017) 1-10) Forecast to achieve year end agency cap Dec 17	1-10) Locum expenditure has increased during Nov and Dec 2017 (Dec 17) 1-10) Radiographer x 5, Orthotist x 1 and 2 X Cardiac Investigations HCP in place (Jan 2018)	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 8. Ensure exclusion of GP Integration locum spend 2. Continue scrutiny of CPD to use academic fellowship programme	Apr-18 Apr-18 Apr-18 Apr-18 Apr-18	2 x 2 = 4 YELLOW	Jan-18	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?
				11) Challenge for Bank/Agency requests and more effective use/administration of workforce shift through e-roster (Dec 2017)							
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 =	Jan-18	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	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 under a 'fix as you go' contract. (Jan 2018) 2) There is a mobile X-ray unit at CCH which can be brought down to the X-ray room and used to continue the service for patients. (Jan 2018)	1) Any breakdown causes disruption to the service offered to patients. Breakdowns encountered with CR readers 6; X-ray equipment 3 (Dec 2017) 2) No focus choice on mobile X-ray unit and reliance on ageing CR processing equipment (Jan 2018) 2) X-ray service will not be available if CR processing facilites fail (Jan 2018)	1) & 2) To continue to monitor any equipment breakdown 1) & 2) To be included on the capital programme next year	Feb-18 Apr-18	2 x 2 = 4 YELLOW	Jan-18	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 December 2016 Accepted onto Trust Risk Register: 5 January 2017	3 x 4 = 12 AMBER	1) Monitoring of unreported scans/imaging studies on a weekly basis (Jan 2017) 2) Locum Consultant Radiologists are being employed (Jan 2017) 3) Clinical Fellows are being employed (Jan 2017) 4) Regular meetings between Clinical Director and Group Manager (Jan 2017) 5) Waiting list initiatives for Trust Radiologists on going (Jan 2017)	2) 0 locums have successfully been employed (Jan 2018) 3) 5 Clinical Fellows have been appointed (1 in place) (Jan 2018) 4) Review meetings are happening fortnightly (Jan 2018) 1) Backlog has reduced from 7332 May 2017 to less than 3000 in Jan 2018 (Jan 2018)	1) Just below 3000 non-urgent imaging studies unreported Dec 2017 (inclusive of 421 CT scans and 683 MRI scans) (Dec 2017) 1) Poor patient experience if patients and doctors are unsure when their scans are reported (Jan 2018) 2), 3), 4) & 5) Demand for reporting imaging studies is higher than expanded reporting capacity (Jan 2018) 3) Infrastructure in terms of equipment and office space not currently available for the 5 additional clinical fellows (Dec 2017)	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 3) Await response from Division post escalation regarding the lack of infrastructure to support the implementation of the 5 additional clinical fellows 1,2,3,4 & 5) Continue to utilise waiting list initiatives	Mar-18 Mar-18 Apr-18 Apr-18 Feb-18 Feb-18	2 x 4 = 8 AMBER	Jan-18	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	4706	Longstanding maintenance challenge around infrastructure/environment in Nucleus Theatres, which includes: 1. Sewerage ingress 2. Drainage system 2. Electrical infrastructure 3. Fire safety 4. Operating lights 5. Air-flow/ventilation 6. Storage 7. Infestations Could lead to a risk of patient and staff safety being compromised, non-compliance with external regulations and/or internal standard/ audits and also adverse media publicity and increasing number of raising concerns via local policy.	4 x 3 = 12 AMBER	1. Existing programme of theatre works in place (1 per year) - (Feb 17) 2. All incidents reported to management are escalated to Hotel Services - (Sept 17)	1 + 2. Works on 2nd theatre in programme of works underway (Feb 17)	1 + 2. There continues to be sewage ingress into Theatres (Oct 2017) 1 + 2. In 2017 there were 9 incidents were reported, two during operations, one where sewage dripped onto the scrub nurse, there are also no known consequences for the patients (Sept 17) 1 + 2. In 2017 there were 16 incidents reported on Datix of insects in theatres, two during operations with no known patient consequences (Sept 17)	1. Review and action recommendations from the report received after the Fire Brigade exercise in Oct 2017 1. Await report from the full drainage review and implement required actions 1. Action to remove ceiling - deep clean and then review opportunity to redirect drains to commence shortly 1. Final determination to be made as to whether Theatre 5 remains closed	Jan-18 Jan-18 Jan-18 Jan-18	2 x 1 = 2 GREEN	Jan-18	
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: 01/02/17 Date of escalation: 08/05/17	2 x 3 = 6 YELLOW	1) Manual Handling Hazard Assessment - JAN 2018 2) Manual Handling Risk Assessment undertaken at induction - JAN 2018 3) Cylinder trolley/cradles are used to transport medical gas cylinders - JAN 2018 4) Trust Training records are regularly reviewed by managers - JAN 2018 5) Staff raise any concerns at the local Hotel Services Risk Management meeting - JAN 2018	1, 2, 4, 5) No issues reported in the previous month - JAN 2018 3) Medical gas cylinders trolley delivered to trust - JAN 2018	3) Basic staff training required prior to using this equipment - JAN 2018	3) Basic staff training required for user	Mar-18	3 x 2 = 6 YELLOW	Jan-18	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	Jan-18	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 the increased activity could potentially lead to increasing challenges for staff to provide safe midwifery and medical care. This could also potentially result in increased maternal morbidity and/or mortality. Poor patient experience may also occur due to care being compromised as a result of delays which include medical reviews, treatment/procedures, seeing new admissions, admissions for induction of labour, starting the induction of labour process, transfers to Delivery Suite and/or theatre and delay in antenatal and postnatal transfers to the ward.	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 19.12.17 2) The number of women booking at RWT is being monitored by Antenatal Payment By Results (PBR) 19.12.17 3) 13/11/2017 Birth Activity capped (19/12/17)	1) Predicated births/booking are recorded on the Maternity Dashboard, RAG-rated and discussed at monthly Governance & Risk Management meeting (19.12.17) 2) Close observation of activity in relation to number of predicted births (19.12.17)	1,2) Activity levels are variable and uncontrollable due to births occurring at varying gestations and women transferring in from other units	1,2) Liaise with Neonatal Services to utilise/staff to full capacity on the TC Ward 1,2) Recruitment of Midwives to fill vacancies (currently 5 WTE vacancies) and achieve 1:30 Birthrate Plus ratio 1,2) Continue to monitor activity via dashboard 3. Continue to monitor birth activity as a result and decline inappropriate bookings	Mar-18 Mar-18 Mar-18 Mar-18	3 x 2 = 6 YELLOW	Jan-18	Yes
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 (May 17) 2) The patient remains under the care of an orthopaedic consultant who can track their care ensuring key aspects are not missed (May 17) 3) Clinical Fellow Ortho-geriatrician in post, reviews patients daily (dec 17) 4) BPT reports reviewed at CG meeting quarterly (May 17) 5) Whiteboard put up in seminar room with NOF patients/ BPT elements to identify gaps (nov 17)	1) BPT criteria is available on the ward for junior doctors (Jan 2018) 5) Discussed daily at trauma meeting (Jan 2018)	3) The Directorate does not have 7 day cover from consultant orthogeriatrician (Jan 17) 1-5) BPT met in last 3 months; Sept 66.7%, Oct 70.6% & Nov 78.6% (Jan 2018)	3) Group Manager to submit business case for 2 x Othogeriatrician posts	Jan-18	2 x 3 = 6 YELLOW	Jan-18	

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	4841	CPE is a group of emerging organisms that has become endemic in some areas of the NHS and international healthcare. national policy has not responded to changes in epidemiology. Local processes are in place but there is a significant threat from inter hospital transfers in particularly. Date of risk 17/08/19 Expected date of closure 17/08/18 Escalated 05/10/17	3 x 2 = 6 YELLOW	2) Trust IV team in place supporting bet IV practice Jan 18 1) Electronic monitoring of CPE screens Jan 18 1) 7 day montiriing of IP alters by Infection Prevention Team Jan 18 1) All CPE contacts tagged on ICNet with link to Clinical Web portal Infections alerts Jan 18 1) Higest level of national guidance in Trust Policy Jan 18 2) Electronic observation allowing identification of patients with urinary catehters and Peripheral venous cannuale (Jan 18) 1) Isolation matrix reviewed and relaunched Jan 18	2) CPE performance dashboard developed and cirulated monthly Jan 18 1) CPE screening compliance audits underway Jan 18 1) Known CPE poistive patients being alerted on readmission 7 days/weekJan 18 1) Automated 1) link to Clinical Web Portal on patients requiring screens due to previous alerts Jan 18 2) Understanding of impact of isolation due to high risk of CPE on bed utilisation Jan 18	1) Lack of denominator data for those at high/increased risk of CPE Jan 18 2) Increase in numbers of CPE detected iin 17/18 Jan 18	1) Complete business case for molecular testing for CPE 2) Identify actions that would reduce the use/promt removal of devices	Feb-18 Dec-17	3 x 1 = 3 GREEN	Jan-18	

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	4849	If the Trust is not able to achieve CT reporting for trauma patients within 1 hour then this may lead to delayed diagnosis and treatment of patients and a failure to meet national requirements, potentially resulting in harm to patients and legal action being taken against the Trust . If ED are unable to obtain 1hr reporting for trauma patients out of hours then this will result in the Trust consistently failing to achieve national standards as reflected by the data submitted to the Trauma Audit and Research Network (TARN) and through Peer review. The RCR standard is that the report should be issued by a radiologist within 1 hour of image acquisition which is a recommendation from the Royal College of Radiologists and not an actual regulation. NICE guidelines only state the report should be done as early as possible. Date of origin: 29/08/17 Date of escalation: 31/08/17	3 x 4 = 12 AMBER	3) ED have access to Radiology on call [14/07/17] 2) All scans are reported by Radiology the following day [14/07/17] 1) CT head scans are interpreted by ED Consultants [14/07/17] 4) Audit has been undertaken to compare ED interpretation of CT head scans with radiology report [06/09/17] 5) Two tier reporting system now in place to enable reporting of all CT heads within 1 hour [05/12/17] 6) Ongoing recruitment of radiologists [05/12/17]	4) No significant discrepancies found between ED Consultant interpretation and Radiology report [05/12/17] 5) CTs are being reported within 1 hr [05/12/17] 6) Two further Radiologists due to commence in post Jan18 [05/12/17]	1) Two incidents under investigation involving CT images [04/01/18] 3) Excessive use of on call for emergencies can result in on call sessions being cancelled [05/12/17] 1) WMQRS visit to Radiology in 2016 identified concerns with EDs out of hours CT head scans not being reported by a radiologist [05/12/17] 4) Minor discprenancies in 8 of 72 cases included in the audit [05/12/17] 1-4) Non compliance with NICE CG176: Head Injuries recommendation that CT head scans must be reported within 1 hour [05/12/17] 1-6) There are often delays in remote access to PACS/ loss of connection [05/12/17]	4) Continue with training/ update to ED Consultants in order to reduce discrepancies (adhoc sessions/ training days) 1-6) Identify and solve problems with remote access to PACS 1-3) business case submitted and redrafted on 8.1.18 and awaiting divisional approval	Mar-18 Mar-18 Feb-18	1 x 4 = 4 YELLOW	Jan-18	