NHS
Worcestershire Acute Hospitals NHS Trust

Date of meeting	15 March 2018
Paper number	G1

Board Assurance Framework

For approval:		For assurance:	x	To note:	

Accountable Director	Michelle McKay CEO		
Presented by	Michelle McKay CEO	**Author**	Kay Darby, Interim Director of Governance

Alignment to the Trust's strategic priorities					
Deliver safe, high quality, compassionate patient care	√	Design healthcare around the needs of our patients, with our partners	√	Invest and realise the full potential of our staff to provide compassionate and personalised care	√
Ensure the Trust is financially viable and makes the best use of resources for our patients	√	Develop and sustain our business	√		

Alignment to the Single Oversight Framework					
Leadership and Improvement Capability	√	Operational Performance	√	Quality of Care	√
Finance and use of resources	√	Strategic Change	√	Stakeholders	√

Report previously reviewed by		
Committee/Group	Date	Outcome
Risk Management Group	24/01/2018	Revisions to Corporate Risk Register and high level risks
People & Culture Committee	19/02/2018	No changes
Quality Governance Committee	22/02/2018	Proposed a reduction to R1.1 and performance metrics for 1.2 to be reviewed and a reduction considered at next meeting
Finance & Performance Committee	26/02/2018	Revision to direction of travel and transfer of R4.2 to P&C.

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	Y	BAF number(s)	ALL

Level of assurance and trend				
		√	↑ ↓ →	
	Significant			
	Limited			
	None			
	Not applicable	x		

Worcestershire Acute Hospitals NHS Trust

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Recommendations	Trust Board is asked to approve the BAF and the Corporate & High Level Risk Register.

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Executive Summary

The BAF and Corporate & High Level Risk registers are provided to update the Trust Board on the management of the Trust's principal risks and underpinning corporate and high level operational risks.

The Trust Board is asked to review and approve the BAF and Corporate and High level risk registers in relation to:

- Risk rating, key performance indicators, rationale for the score, controls, assurances, gaps in controls and assurances, and mitigating actions.

Background

The Board Assurance Framework sets out the principal risks to the Trust achieving its objectives. It provides a structure and process that enables the organisation to focus on those risks that might compromise achieving its most important annual objectives; and to map out both the key controls that should be in place to manage those objectives and confirm the Board has gained sufficient assurance about the effectiveness of those controls.

The BAF is reviewed at Board committees as follows:

- Quality Governance Committee R1.1, R1.2, R1.3 & R2.1
- Finance & Performance Committee R4.1 & R4.2
- People & Culture R3.1, R3.2, & R4.3
- Trust Board R5

The Trust Leadership Group reviews the BAF risks, Corporate and High level Risks.

The Corporate Risk Register (CRR) contains those risks which have the potential to impact on the organisation as a whole, score 12 and above & exceed the risk appetite for that category of risk. They may be identified at Division, Directorate or Executive level.

The High Level Risk Register contains those risks held at divisional level that exceed a score of 15 or above and have potential to have significant impact on a Division or department.

Since the BAF was last reviewed by the Trust Board in January 2018, the BAF has been reviewed by the assurance committees and the following changes are recommended for approval.

Implications

1.0 BAF amendments

1.1. Quality Governance Committee (BAF Risks 1.1,1.2,1.3 & 2.1)
The committee was asked to consider and endorse a reduction in risk rating for BAF risk 1.2, for approval by the Board. The committee considered it needed to review more relevant KPIs before it can recommend a reduction in this risk rating. This will be considered at the next meeting.
1.2 People &Culture Committee (BAF Risks 3.1, 3.2 & 4.3)

The Trust has undertaken a number of high impact actions to mitigate the people and culture related risks and these include:

- All board and executive team roles have now been filled
- Directorate responsibilities have been split to make the spans of control more manageable
- The Trust has developed a 3 year people and culture strategy
- The Trust has developed a comprehensive recruitment and retention plan which is targeted at the medical and nursing workforce
- The Trust has commissioned a 3 year culture change programme which was launched in October 2017

1.3 Finance & Performance Committee (BAF Risk 4.1)
The following revision is proposed:

- the direction of travel is reduced from "increasing" to "stable". The rationale is as follows:
  - Revised Financial Outturn for 2017/18 of £57.9m (pre Sustainability and Transformation Funding) was approved by the Board in January 2018 and has been officially submitted to NHS Improvement.
  - Months 8, 9 and 10 have delivered against the Financial Recovery Plan that has been approved by Board and agreed with NHS Improvement.

The F&P Committee are also recommending the following:

- The transfer of risk R4.2 to the People and Culture Committee for oversight

2.0 Review of Linked Risks
A reconciliation of the Corporate and High Level risks linked to the BAF risks has been carried out. The changes are recommended as follows:

R1.1
- 3340 the risk rating has reduced from 15 to 8 so it is removed from BAF.

R1.2
- 3340: the risk rating has reduced from 15 to 8 so it is removed from BAF.
- 3419 the risk rating has reduced from 16 to 6 so it is removed from BAF.

R1.3
- 3395 is closed so is removed from the BAF
- 3524 closed and amalgamated into R3603 *Risk of Information loss or compromise due to inadequate cyber security* (Risk Rating 12)

R2.1
- 3289 the risk rating has reduced from 20 to 8 so it is removed from BAF.
- 3331 the risk rating has reduced from 15 to 12 so it is removed from BAF.
- 2790 closed so it is removed from BAF.

R3.1
- 2711 closed so it is removed from BAF.

R3.2
- 2711 closed so it is removed from BAF.

R4.1
- 3486: the risk rating has reduced to 9 so it is removed from BAF. The residual risk would be incorporated into 3291
- 3487: closed so it is removed from BAF.
- 2744: the risk rating increased from 16 to 20
- 2856: the risk rating has reduced to 12 so it is removed from the BAF.
- 3291: the risk rating is assessed as 16

R4.2
- 2711 closed so it is removed from BAF.

R4.3
- 2711 closed so it is removed from BAF.

R5
- No changes are recommended.

3.0 Review of Controls, Assurances, Gaps in Controls & Assurances and Mitigating actions

Directors have updated controls, assurances, gaps in controls and assurances and mitigating actions.

Trust Board is asked to review the Controls, Assurances, Gaps in Controls & Assurances and Mitigating actions.

4.0 Revisions to the Corporate Risks and High level Risks

Since the last report to Trust Board the Trust Risk Management Group has approved the following changes to the Corporate Risk Register (CRR):

Risk 3518 - Risk of preventable permanent visual loss to patients presenting with giant cell arteritis. This will be deescalated from the CRR once GP pathway communicated. The score will also be reduced.

Risk 2957 – Risk of healthcare acquired infections due to inadequate or ineffective performance and quality of cleaning in clinical areas. This has been reviewed with a reduction in score from 16 to 12 due to improved infection, prevention and control position. Recommend remains on CRR as trust wide issue.

Risk 3484 – here is a risk of sub optimal patient care in surge areas. This has been updated to reflect the challenges faced in surge areas

Risk 2299 - Patients not receiving follow-ups within clinically stipulated timescale, may result in loss of vision. Risk increased to 16 due to timeframe to resolve the backlog.

Risk 2744 - Ageing CR (computed radiography) units could fail. This could be catastrophic for plain film services on the Alexandra site. This will be closed once the equipment on

order is installed.

Risk 2634 Patients with mental health illness in ED may have reduced quality of care and delay in assessment. Discussions with Health and Care Trust Executive are ongoing.

Risk 3428 removed from CRR due to improved position

Risk 3487 removed from CRR as risk eliminated

Risk 2709 – Risk of delayed admission to critical care as unit full. Risk increased to 16 following 2 incidents

Recommendations
The Trust Board is asked to approve the BAF and Corporate and High Level Risk Register
Appendices BAF & Corporate and High Level Risk Register

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Board Assurance Framework
February 2018
Version 27.2

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Risk Heat Map				Current Score (likelihood x impact, arrow indicates any movement since last report) No Movement since last report ↔							
Strategic Objective	**Priorities**	**Risks**	**Outset Scores**	**<=9**	**10**	**12**	**15**	**16**	**20**	**25**	**Target Score**
1. **Deliver safe, high quality compassionate patient care**	P1.1 Embed and assure the revised ward to board governance structures and processes and improve the identification and management of risk	R1.1 If we do not have in place robust clinical governance for the delivery of high quality compassionate care, we may fail to consistently deliver what matters to patients- which may impact on patient experience (including safety & outcomes) with the potential for further regulatory sanctions.	4x5=20					**4 x 4 = 16** ↓			**2x4=8**
	P1.2 Develop a more robust improvement, quality and safety culture across the Trust, including learning when things go wrong	R1.2 If we do not have a clear improvement journey vision that engages staff and builds improvement capability, we may fail to deliver sustained change and improvements required.	5 x 4 = 20						**5 x 4 = 20** ↔		**2x4 = 8**
	P1.3 Ensure the appropriate measures are taken to address all the quality and safety concerns identified by the CQC	R1.3 There is a risk that patient safety and performance may be adversely affected due to weaknesses in systems and processes	4x4=16						5 x 4 = 20 ↑		**3 x 3 = 9**
2. Design healthcare around the needs of our patients, with our partners	P2.1 Improve urgent care and patient flow pathways across the whole system to ensure the care is delivered by the right person in the right place first time P2.2 Ensure the Trust meets its agreed trajectories for patient access and operational performance improvement in urgent and elective care	R2 Unless we work with our health and social care partners to understand flow across the system, then we may have inadequate arrangements in place to manage demand (activity)- which may impact on the system resilience and internal efficiencies impacting on delivery of contractual performance (4hr access standard; RTT; Cancer etc)	4x5=20						**4 x 5 = 20** ↔		**3x3=9**
3. Invest and realise the full potential of our staff to provide compassionate and personalised care	P3.1 Develop leadership capacity and capability at all levels within the organisation	R3.1 If we do not have in place a suitably qualified and experienced leadership team (across sub board levels including Divisional and Directorate) then we may fail to deliver the required improvements at pace- with the potential for further deterioration in patient care & experience & escalated regulatory enforcement actions	4 x 4 = 16			**3 x 4 = 12** ↓					**2x2=4**
	P3.2 Develop at all levels an organizational culture and set of behaviours that embody the Trust's values	R3.2 If we do not deliver a cultural change programme we may fail to attract and retain staff with the values and behaviours required to deliver the high quality care we aspire to.	**3 x 5 = 15**				**3 x 5 = 15** ↔				**2 x 2 =4**
4. Ensure the Trust is financially viable and makes the best use of resources for our patients.	P4.1 Systematically improve efficiency and sustain financial performance ensuring that the Trust delivers its financial control total.	R4.1 If we do not have in place effective organisational financial management, then we may not be able to fully mitigate the variance and volatility in financial performance against the plan leading to failure to deliver the control total, impact on cash flow and long term sustainability as a going concern.	3x4=12						**5x4 =20** ↑		**2x3=6**

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	P4.2 A compelling vision for the Trust and a workforce strategy that supports the retention of current staff recruitment to vacancies and development of new roles	R4.2 If we do not resource our clinical staff rotas at ward/departmental level then we will not meet patient needs consistently- with the potential for reduced quality & co-ordination of care provision, negative impact on patient flow & access targets: long term impact on staff resilience; poor retention of staff & inability to attract staff.	**5 x 4 = 20**					**4 x 4 = 16** ↓			**3 x 3 = 9**
		R4.3 If we do not have a workforce strategy that addresses organizational development, values and behaviours as well as workforce development and recruitment we will not be able to provide care that meets the needs of our patients; meets the internal workforce demands and fills our vacancies.	**4 x 3 = 12**			**4 x 3 = 12** ↔					**2 x 3 = 6**
5. Develop and sustain our business	Develop a 5 year clinical service strategy that supports the clinical and financial sustainability goals described in the Herefordshire and Worcestershire STP. Strengthen our collaboration and partnership working with other providers in Worcestershire and beyond to ensure local access to a full range of high quality services.	R5 If we are unable to secure the support of our clinical workforce, community and STP stakeholders for the 5 year clinical strategy, we may not be able to make the changes required to ensure long term viability of services.	4x4=16					**4 x 4 = 16** ↔			**3x3=9**

Mapped to Single Oversight Framework

1. Leadership and Improvement Capability	2. Operational Performance	3. Quality of Care	4. Finance and use of resources	5. Strategic Change	6. Stakeholders
Invest and realise the full potential of our staff to provide compassionate and personalised care	**Design healthcare around the needs of our patients, with our partners**	**Deliver safe, high quality compassionate patient care**	**Ensure the Trust is financially viable and makes the best use of resources for our patients.**	**Develop and sustain our business**	**Design healthcare around the needs of our patients, with our partners**

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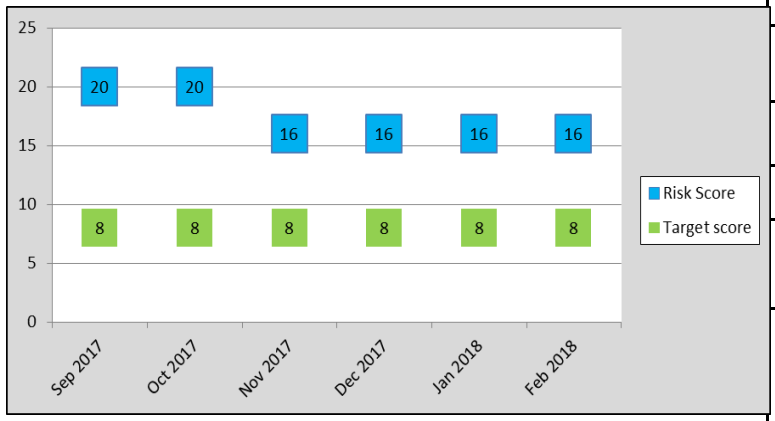
Risk Description	**Principal Risk:** The Trust fails to deliver safe, high quality compassionate patient care to our patients					**Risk ID**	R1.1
Risk Details	If we do not have in place robust clinical governance for the delivery of high quality compassionate care, we may fail to consistently deliver what matters to patients- which may impact on patient experience (including safety & outcomes) with the potential for further regulatory sanctions.						
Executive lead	**Chief Medical Officer**	**Last Reviewed**	**February 2018**	**Target Date**	**July 2018**	**Review Group**	**QGC**
CQC Domain(s)	**Safe**	**Caring**	Responsive	**Effective**			**Well Led**
Corporate Objective(s)	**1**	**2.**	3	**4**			5

Risk Rating: Likelihood x Severity	
Initial Risk Score	20
Current Risk Score	16
Target Risk Score	8
Risk Appetite	Low
Direction of travel	↓



Relevant Key Performance Indicators		
Metric	**Trust compliance January 2018**	**Target**
Complaints responded to within 25 days	40.43%	85%
No of complaints with further concerns	TBD	TBD
Reduction in Number of serious incidents	TBD	TBD
P M Review completion	60%	>60%
HMSR (rolling 12 mths) SHMI (rolling 12 mths)	102.60 (Dec-16 to Nov-17)- Improving 1.0401 (July-16 to June-17) Band 2 As expected	Improving Band 3 better than expected
Compliance with NEWs Audit Compliance with Observations Accuracy (adult inpatient) NEWs Escalation (snap) % 2222- calls appropriately escalated % Unplanned admissions ICU with appropriate Escalation (adults only)	84% 98% 98% 88% 80% 93%	100% 95% 95% 95% 85% 90%
National Clinical Audits Audits with an action plan	100%	100%
Friends and Family Test A&E Score Acute Score Outpatients Score	85.62% 93.75% 91.23%	Top Quartile

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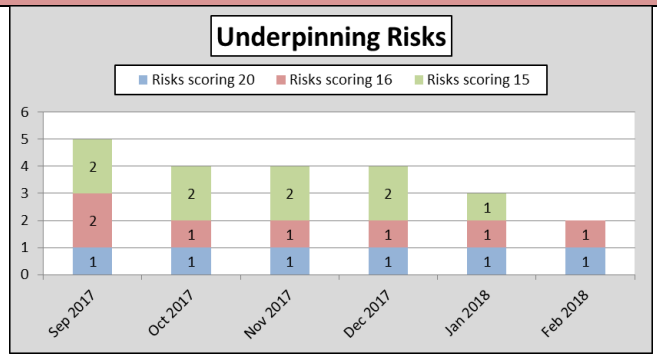
Rationale for current score	
The Trust Clinical Governance systems are not fully embedded from Ward to Board. There is a lack of understanding of risk within the organization. The current process for managing complaints is in need of review. The Trust has been rated as Inadequate by the CQC and is currently in Special Measures.	
Controls: what are we currently doing about the risk?	**Assurances: how do we know if the things we are doing are having an impact?**
Quality Improvement Plan reviewed at Quality Improvement Board Quality Governance Committee receives monthly reports from Divisions. National SI reporting system Trust BAF identifying risks to Trust objectives Corporate Risk Register Risk Management Strategy Risk awareness session held with the Board 6/06/17 & BAF discussion held 08/08/17	Review of KPIs at the following Divisional performance and Accountability meetings Quality Improvement Board Clinical Governance Group Quality Governance Committee Quality Improvement Review Group NHSI performance Review meetings Complaints targeted approach with Divisions SI performance monitoring
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
Corporate Governance systems and process under review. Additional support required. Review of risk maturity required Exploring support required to strengthen Clinical Governance systems and processes. Engaging support of NHSI to develop a patient experience strategy	Review Divisional Governance meetings to ensure capability exists within the Divisions and provide training as required. Develop agreed proforma with KPI's that all Divisions must report on through their Clinical Governance meetings up to CGG. Support sought from OUH for Risk Maturity review. Seeking additional Governance support for a six month period.

Related High Risks (15 and above and DATIX ID)

2591	**Medicine Risk Register:** EDS not completed in a timely manner	20
3325	**Corporate Risk Register:** There is a risk that stroke patients may not get timely assessment, diagnosis and treatment.	16



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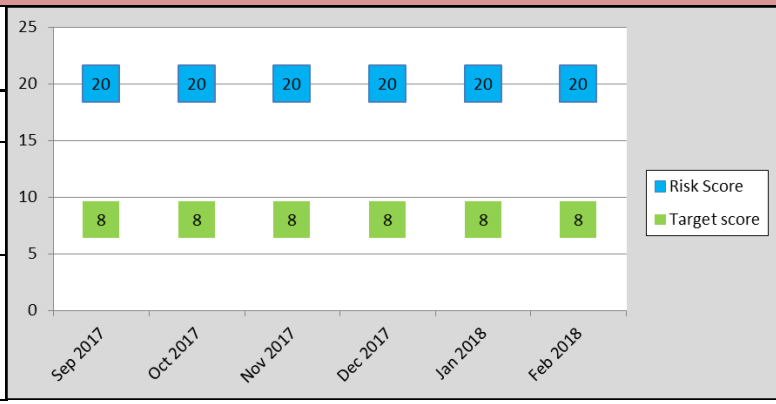
Risk Description	**Principal Risk:** The Trust fails to deliver safe, high quality compassionate patient care to our patients					**Risk ID**	R1.2
Risk Details	If we do not have a clear improvement journey vision that engages staff and builds improvement capability, we may fail to deliver sustained change and improvements required.						
Executive lead	**Chief Nurse**	**Last Reviewed**	**February 2018**	**Target Date**	**July 2018**	**Review Group**	**QGC**
CQC Domain(s)	**Safe**	Caring		Responsive		**Effective**	**Well Led**
Corporate Objective(s)	**1**	2		3		**4**	**5**

Risk Rating: Likelihood x Severity		
Initial Risk Score	20	
Current Risk Score	20	
Target Risk Score	8	
Risk Appetite	Moderate	

Relevant Key Performance Indicators		
Metric	**Trust compliance January 2018**	**Target**
F&F Test (Q2 17/18) Re care & treatment Re place to work	Likely/extremely likely 60% 43%	70%
Discharges before 10:00	8%	15%
Number of staff training in improvement methodology	0	TBA
CQC Well Led Domain	Inadequate	Requires improvement

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Direction of travel	

Number of collaborative improvement projects	TBD	TBD
QI Strategy in place Divisional Improvement plans in place	In Draft In Development	Yes
Improvement methodology training plan in place	Yes	Yes

Rationale for current score

The Trust does not currently have a Quality Improvement Strategy and agreed QI methodology. There is limited QI capability within the organization.

Controls: what are we currently doing about the risk?	Assurances: how do we know if the things we are doing are having an impact?
Quality Improvement Plan and Quality Improvement Board in place to monitor progress. Draft Quality Improvement Strategy presented to QGC Draft Patient and carer experience strategy presented to Trust Board January 2018 SQuID system in place Quality Improvement methodology training plan in place and being progressed Harm review panels chaired by CNO/CMO well established Medicines management summit held in November 2017 Medicines Management Audit Plan NED & Exec programme of Safety walkabouts Exec quality audit programme Quality Impact Assessment process in place Senior Nurse statement of intent in relation to Quality monitoring	KPI's for PMO projects KPIs for QIP projects Annual staff survey report. Monthly QIP exception reports Frailty Improvement 4ward programme Mandated professional standards Ward round/board round QIRG review of Improvement methodology NHS I review of IPC. Performance now green Oxford University Hospitals Trust Risk review report – progressed to Level 2 CQC report of visit in November 2018 shows improvement in 10 areas across Medical and Urgent & Emergency Care
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
Quality Improvement Strategy in draft Patient Experience Strategy in Draft Divisional quality improvement plans not in place No improvement plan in place for staff survey Risk Improvement plan to improve risk maturity score from 2 to 3 in draft	Draft QI strategy to be approved by Trust Board March 2018. Patient Experience strategy to be approved at QGC February 2018 Divisional Quality improvement plans to be developed March 2018 Risk Improvement Plan to be finalized – February 2018

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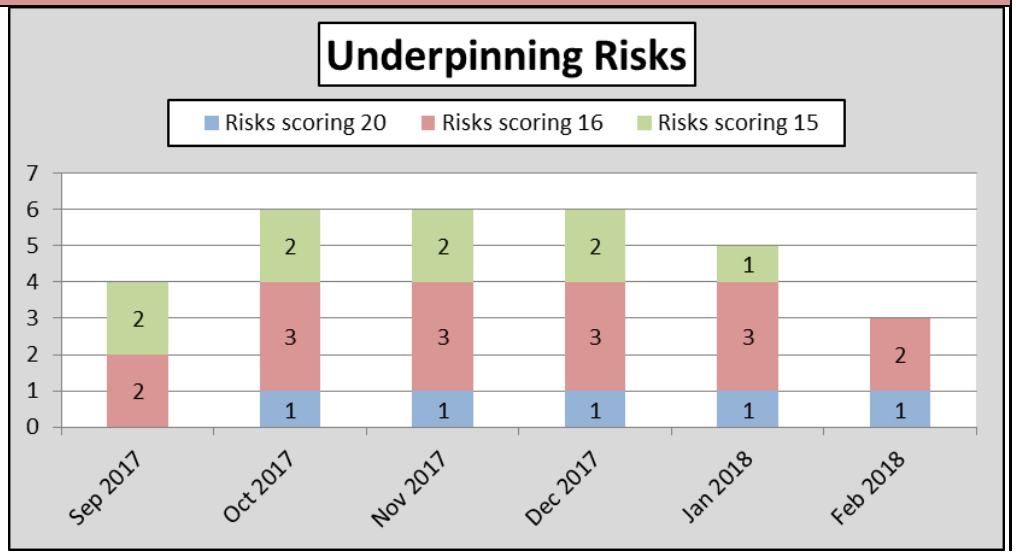
Related High Risks (15 and above and DATIX ID)		
2976	**SCSD Risk Register:** Failure to achieve JAG Accreditation	16
3482	**Corporate risk register**: There is a risk that patient safety, effectiveness and management may be compromised in ED	20
2957	**Corporate risk register**: Risk of HCAI due to inadequate or ineffective performance and quality of cleaning in clinical areas	16



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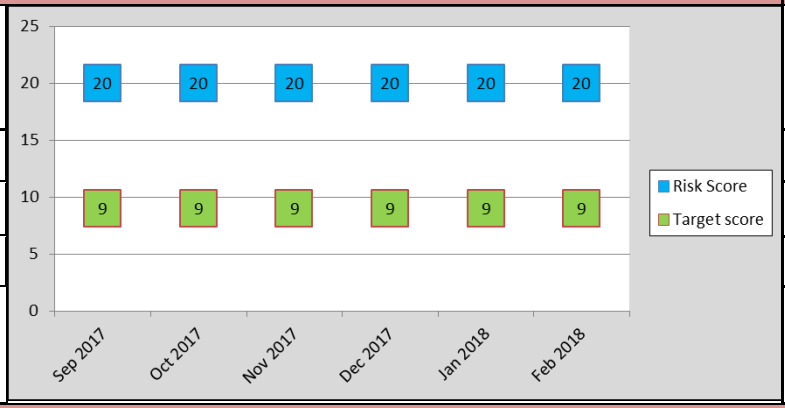
Risk Description	**Principal Risk:** There is a risk that patient safety and performance may be adversely affected due to weaknesses in systems and processes						Risk ID	R1.3
Risk Details	There is a risk that patient safety and performance against objectives may be adversely affected. This is caused by weaknesses in Trust systems and processes that are unknown or undetected prior to an incident occurring. The effect has potential for delays in communication, diagnosis, treatment and follow up within and without of the organisation. The impact is an increased patient safety risk, increased reputational risk, failure to meet objectives and likelihood of complaint/claim.							
Executive lead	Chief Medical Officer	Last Reviewed	February 2018	Target Date	Dec 2018	Review Group	QGC	
CQC Domain(s)	**Safe**	Caring	Responsive	**Effective**	Well Led			
Corporate Objective(s)	1	2	3	4	5			

Risk Rating: Likelihood x Severity	
Initial Risk Score	16
Current Risk Score	20
Target Risk Score	9
Risk Appetite	Low
Direction of travel	↑



Relevant Key Performance Indicators		
Metric	**Trust compliance January 2018**	**Target**
Risk assessment of Clinical Information Systems Number of recommended actions completed	3 out of 42 actions complete	42

Rationale for current score

Recent serious incident has highlighted significant weaknesses in a communication system with external stakeholders. At present, it is unclear whether this has resulted in patient harm.
The Trust needs to be assured that adequate controls are in place to prevent serious incidents within Trust systems and processes. It is unknown when a similar incident could occur.

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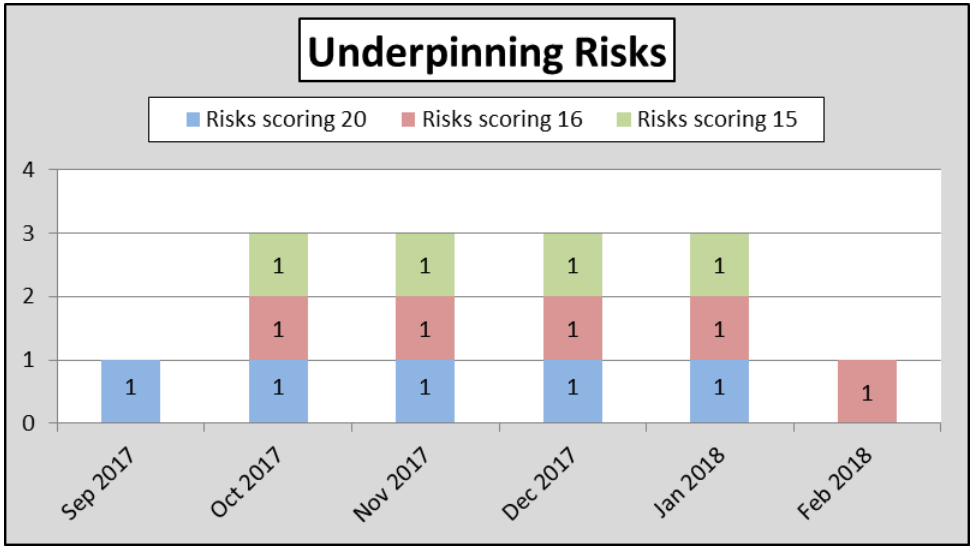
Controls: what are we currently doing about the risk?	Assurances: how do we know if the things we are doing are having an impact?
Audit of electronic system for clinic letter generation and circulation with an associated action plan Harm review where communication with patients and or GPs has failed	Monthly backlog reports from Bluespier. Harm reviews of all letters underway - weekly reports on progress. Review scheduled by Internal audit
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
The Trust is unclear whether other systems may fail No audit of electronic reporting systems Staff training position unclear	Staff training is required to reduce the existing problem Identification of current systems and audits already undertaken to formulate gap analysis. There is a need to secure an external review of all patient data systems to ensure there are no other gaps in controls across the Trust.

Related High Risks 15 and above and DATIX ID)

3522	**Corporate risk register**: There is a risk that patient safety and performance may be adversely affected due to weaknesses in systems and processes	16



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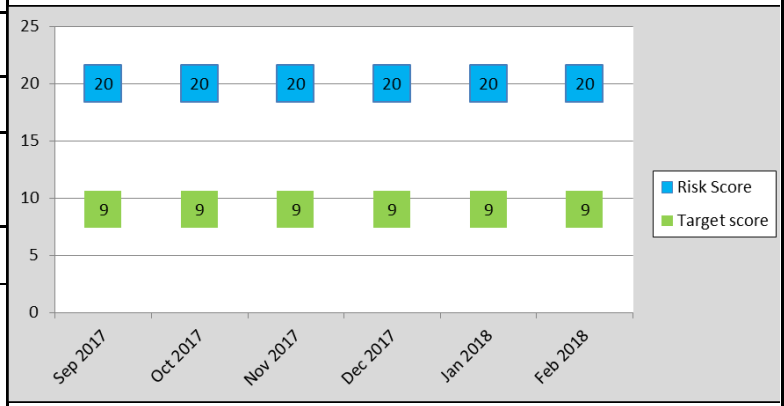
Risk Description	**Principal Risk :** The Trust is unable to design healthcare around the needs of our patients, with our partners					**Risk ID**	R2.1
Risk Details	Unless we work with our health and social care partners to understand flow across the system, then we will have inadequate arrangements in place to manage demand (activity) which will impact on the system resilience and internal efficiencies impacting on delivery of contractual performance (4hr access standard; RTT; Cancer etc.)						
Executive lead	**Chief Operating officer**	**Last Reviewed**	**February 2018**	**Target Date**	**Sept 2018**	**Review Group**	**QGC**
CQC Domain(s)	**Safe**	Caring		**Responsive**	**Effective**		Well Led
Corporate Objective(s)	1		**2**	3	4		5

Risk Rating: Likelihood x Severity	
Initial Risk Score	20
Current Risk Score	20
Target Risk Score	9
Risk Appetite	High
Direction of travel	⟺



Relevant Key Performance Indicators		
Metric	**Trust compliance January 2018**	**Target**
Emergency Access Standard	73.28%	95%
Non-elective stranded patients	47.27%	15%
12hour breaches	8	0
Number of DTOC patients	51	As good as or better than the national average
Referral to Treatment	84.46%	92%
Cancer 62 day	71.88% (Dec-17 validated) 69.37% (Jan-18 unvalidated)	85%
Diagnostics	2.74%	<1%

Rationale for current score

The Trust is not currently meeting any of the national performance standards and has significant problems with flow of urgent care patients.

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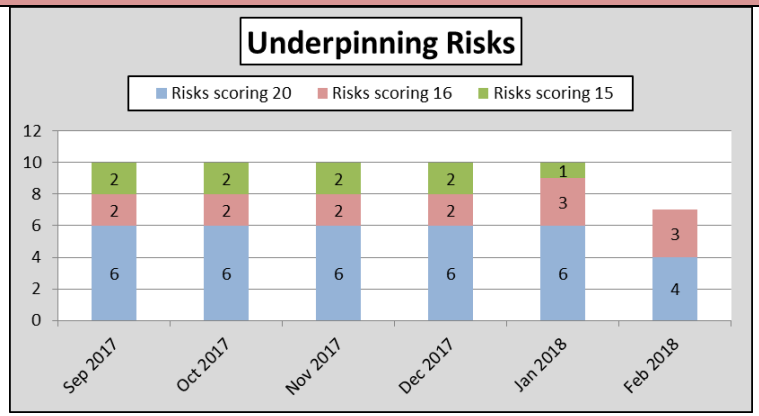
Controls: what are we currently doing about the risk?	Assurances: how do we know if the things we are doing are having an impact?
A comprehensive Patient Flow work stream has been created. It has five key projects underpinned by Internal Professional Standards: Winter Plan RTT Recovery Plan Cancer Plan Diagnostic Plan System Level Plan and Escalation Framework	Integrated Performance Report Compliance with the 4 hour ED standards Weekly Urgent Care & Flow Dashboard Weekly Cancer Dashboard to Cancer & RTT PTL meetings Elective access Board A&E Delivery Board Urgent care escalation Meeting with NHSI Weekly Cancer Assurance call (NHSI & CCG) Monthly Cancer Board
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
Failure to adhere to internal professional standards, escalate and follow escalation policy Limited impact of whole system working Lack of out of hospital pathways Insufficient workforce to deliver Plans PMRs with divisions are not fully effective	Ensure all internal processes are followed in line with internal policies. Continue to push system partners to develop strategies to ensure patients receive care in the right place at the right time. Ensure implementation of Winter plan initiatives within the set timescales. Implement revised PMRs to hold divisions to account for performance – Corporate Governance Structure approved at TLG 7 February 2018 to be implemented April 2018

Related High Risks (15 and above and DATIX ID)

2148	**Corporate Risk Register:** Patients may be harmed following a delay in diagnosis due to lack of appointment capacity within Endoscopy	20
2709	**Corporate Risk Register**: Risk of delayed admission to critical care from full unit	16
2981	**Medicine Risk Register:** Capacity	20
3482	**Corporate Risk Register:** There is a risk that patient safety, effectiveness and management may be compromised in ED.	20
2299	**Corporate Risk Register:** Patients not receiving follow-ups within clinically stipulated timescale, may result in loss of vision	16
3361	**Medicine Risk Register:** SIAN area -ED WRH	20
3483	**Corporate Risk Register:** Patients may be harmed due to delays in treatment/waiting times	16



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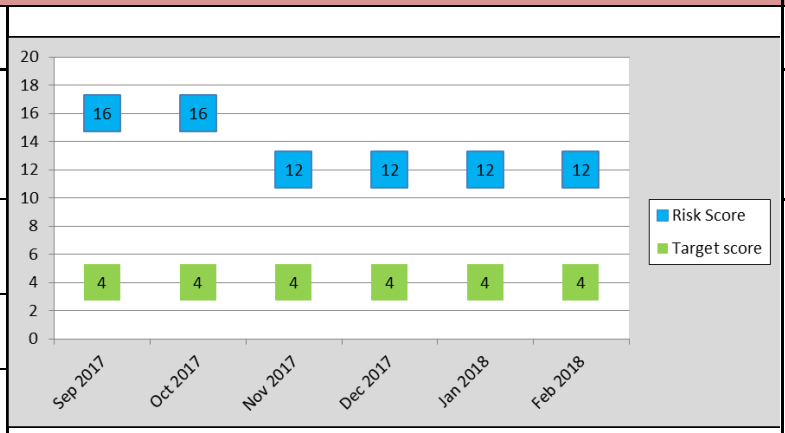
Risk Description	**Principal Risk:** Failure to invest and realise the full potential of our staff to provide compassionate and personalised care					**Risk ID**	R3.1
Risk Details	If we do not have in place a suitably qualified and experienced leadership team (across sub board levels including Divisional and Directorate) then we may fail to deliver the required improvements at pace with the potential for further deterioration in patient care & experience & escalated regulatory enforcement actions						
Executive lead	**Chief Executive Officer**	**Last Reviewed**	**February 2018**	**Target Date**	**April 2018**	**Review Group**	**P&C**
CQC Domain(s)	**Safe**	**Caring**	Responsive	**Effective**			**Well Led**
Corporate Objective(s)	1	2	**3**	4			5

Risk Rating: Likelihood x Severity		
Initial Risk Score	16	
Current Risk Score	12	
Target Risk Score	4	
Risk Appetite	High	
Direction of travel		

Relevant Key Performance Indicators		
Metric	**Trust compliance January 2018**	**Target**
CQC well led domain rating	Inadequate	Requires Improvement
Fit and Proper Persons Test is completed for all of the leadership team	100%	100%
4Ward	Baseline N/A	Net Leadership score of 50% for EP2 Net Culture score of 45% for CP1

Rationale for current score

The Trust has only recently appointed substantively to the majority of its Executive Director positions and a number of the NEDs are new in post. In addition there are significant gaps in capability within the current divisional leadership teams.

Controls: what are we currently doing about the risk?	**Assurances: how do we know if the things we are doing are having an impact?**
Executive Team appointed NEDs appointed.	Accountability Framework in development Staff survey results

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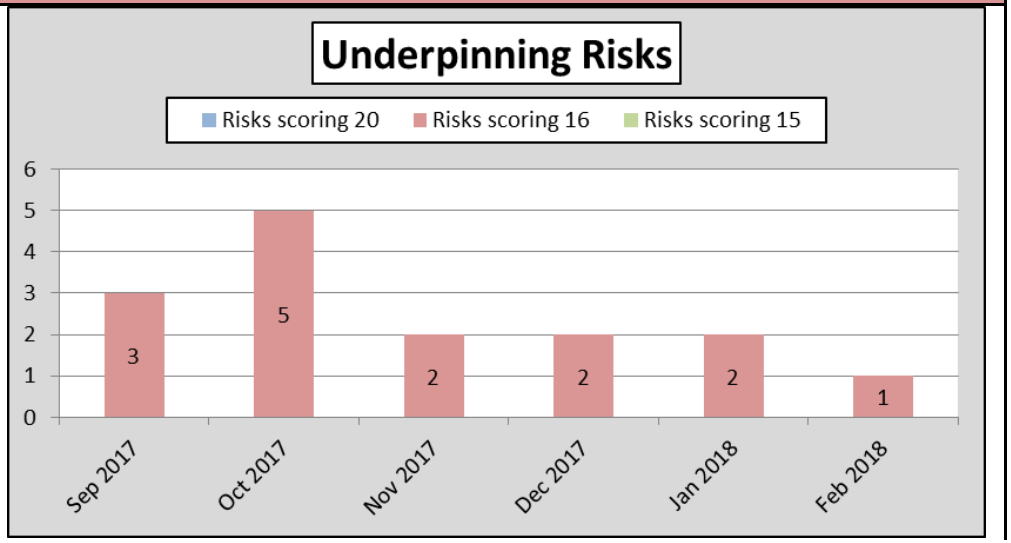
Board development Programme Culture Change programme (4Ward) including one-on-one coaching for TLG and Board Trust Leadership Group	FFT CQC rating on Well Led domain Appraisal and mandatory training KPI's Net Leadership score Net culture score Board workforce sub-committee
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
Recruitment plan not fully embedded. Lack of overarching workforce strategy Lack of Trust wide Training needs analysis	Develop workforce strategy that addresses recruitment issues and has a clear OD element within it to address leadership gaps. Ensure 4Ward culture change programme is fully supported.

Related High Risks (>14 and DATIX ID)

3485	**Corporate risk register**: There is a risk that the Trust is unable to deliver safe and effective care due to medical and nursing vacancies	16



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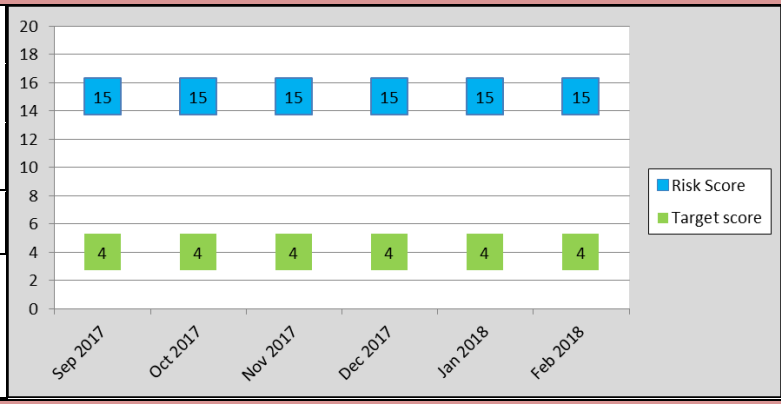
Risk Description	**Principal Risk:** Failure to invest and realise the full potential of our staff to provide compassionate and personalised care					**Risk ID**	R3.2
Risk Details	If we do not deliver a cultural change programme we may fail to attract and retain staff with the values and behaviours required to deliver the high quality care we aspire to.						
Executive lead	**Chief Executive Officer**	**Last Reviewed**	**February 2018**	**Target Date**	**Sept 2018**	**Review Group**	**P&C**
CQC Domain(s)	**Safe**	**Caring**	Responsive	**Effective**			**Well Led**
Corporate Objective(s)	1	2	**3**	4			5

Risk Rating: Likelihood x Severity		
Target Risk Score	4	
Initial score	15	
Current score	15	
Risk Appetite	Significant	
Direction of travel	⟺	



Relevant Key Performance Indicators		
Metric	**Trust compliance January 2018**	**Target**
4Ward Net leadership and culture scores	TBD	Net leaderships core for EP2- 50% Net culture score for CP1- 45%
Board leadership score	TBD	
NHS Staff Survey 2017 Staff Engagement Metrics	Likely/extremely likely 60% 43%	70%

Rationale for current score

There are significant cultural and behavioral issues within the Trust that require action. The Trust has engaged external support to deliver a cultural change programme over the next three years.

Controls: what are we currently doing about the risk?	**Assurances: how do we know if the things we are doing are having an impact?**
Delivery partner appointed to deliver cultural change programme Culture Committee in place. Board development Programme Trust Leadership Group and Board one-on-one coaching	Accountability Framework in development Staff survey results Staff FFT CQC rating on Well Led domain

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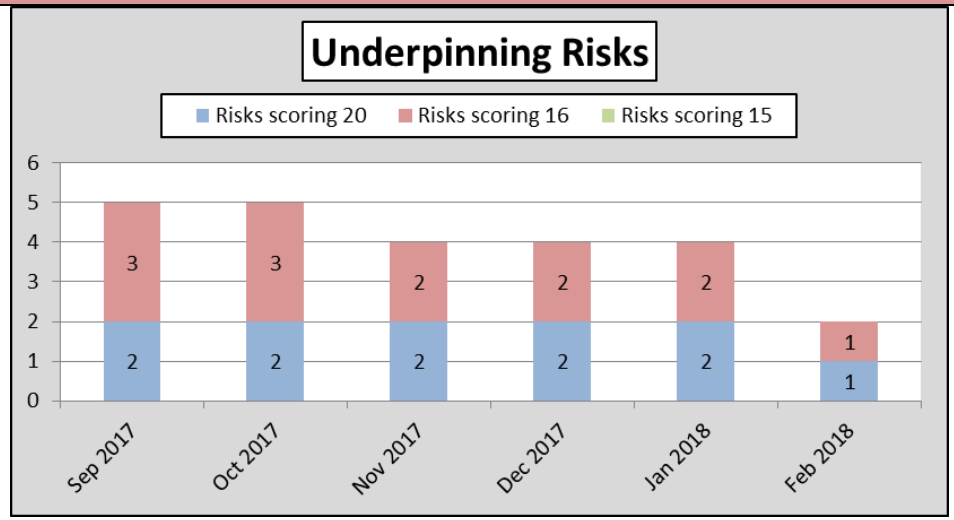
4ward programme	Appraisal and mandatory training KPI's Net Leadership scores Patient feedback, themes from complaints
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
Lack of overarching workforce strategy 4Ward programme not fully rolled out	Develop workforce strategy that addresses recruitment issues and has a clear OD element within it to address leadership gaps. Deliver cultural change programme.

Related High Risks (15 and above and DATIX ID)

3485	**Corporate Risk Register:** There is a risk that the trust is unable to deliver safe and effective care due to medical and nursing vacancies	16
2791	**Corporate Risk Register:** Inappropriate staffing levels	20



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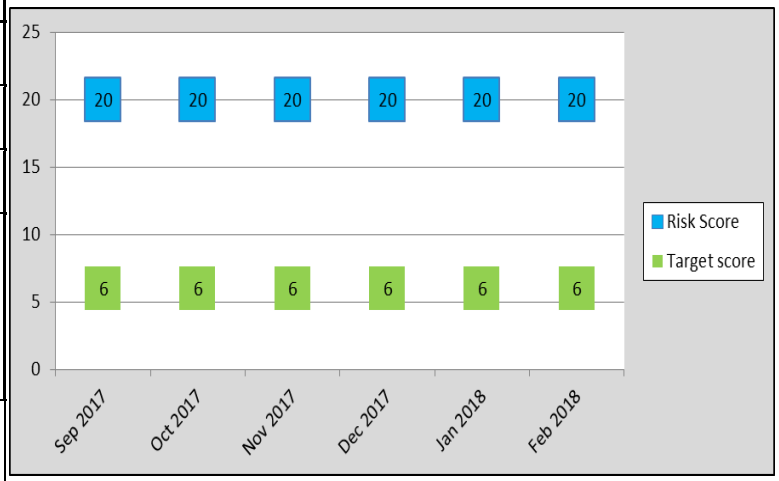
Risk Description	**Principal Risk:** The Trust is unable to ensure financial viability and make the best use of resources for our patients.				**Risk ID**	R4.1	
Risk Details	If we do not have in place effective organizational financial management, then we may not be able to fully mitigate the variance and volatility in financial performance against the plan leading to failure to deliver the control total, impact on cash flow and long term sustainability as a going concern.						
Executive lead	**Chief Finance Officer**	**Last Reviewed**	**February 2018**	**Target Date**	**March 2018 +1/4ly gateway checks**	**Review Group**	**FPC**
CQC Domain(s)	**Safe**	**Caring**	Responsive	**Effective**			**Well Led**
Corporate Objective(s)	1	2	3	**4**			**5**

Risk Rating: Likelihood x Severity	
Initial Risk Score	12
Current Risk Score	20
Target Risk Score	6
Risk Appetite	Moderate
Direction of travel	↑



Relevant Key Performance Indicators

Metric	**Trust compliance December 2017**	**Target**
Compliance with monthly control total	Q1 Target achieved Q2 & Q3 target missed	Per the financial plan
CIP delivery in Line with Plan	Not compliant at End of December	Per the financial plan
Operational Metrics linked to STF	Partially compliant at End of September	Per the agreed trajectories
Compliance with Capital Resource Limit (Forecast)	N/A	Per the financial plan
Carter productivity data through model hospital	Model Hospital key opportunity areas identified and being developed into action plans aligned to medium term financial plan	TBA
Better Payment practice Code	Performance deteriorated over Q2 & Q3. Expected to stabilise in Q4. Not compliant	95%

Rationale for current score

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The Trust has robust monitoring of financial management in place reported through fortnightly confirm and challenge sessions and monthly Performance meetings up to Finance and Performance Committee. There are risks to the control total in both 2017/18 and into 2018/19 due to the scale of improvement required within the Trust, the continued high use of temporary staff and provision of additional capacity

Controls: what are we currently doing about the risk?	Assurances: how do we know if the things we are doing are having an impact?

Finance and Performance Committee ensuring that risks are being acted on. 2017/18 Financial Outturn revised to £57.9m pre STF has been approved by the Board in January 2018.
 	
Detailed Financial Recovery Plan is in place:
• Divisional plans focused on:
  ○ Cost control actions – Medical Staff, Job Planning, Additional Sessions & Agency Control, Nurse roster management, Agency Cap, automated procurement system
  ○ Detailed budget analysis at directorate level (monthly)
  ○ Activity Data Quality, recording and coding
• Corporate led grip and control initiatives including implementation of financial recovery authorization limits as outlines in SFIs / SoD
• Finance training to be refreshed with all budget managers to ensure compliance with Trust procedures
• Identification of non-recurrent benefits to mitigate financial risks in 2017/18
 	
Strengthened Governance
• Fortnightly confirm and challenge sessions established with CFO (Clinical Divisions and Corporate Departments). Escalated to weekly where performance is not on track
• Increased frequency of meetings with NHSI regional team to oversee progress (Delivery Board / PRM)
• Meetings with NHSI national team
 	
CIP programme integrated with Model Hospital and focus on key projects with highest potential return
• Active engagement with national NHSI Model Hospital team to maximize results
• Acceleration of key projects (theatre productivity, E-Rostering etc) with support of 4Ward culture programme
• Turnaround Director in post and driving development of Medium Term Financial Strategy and Recovery Plan
 	
Close monitoring of performance against capital programme and strengthened capital expenditure controls. Any approved schemes not yet committed are being reviewed through Capital Prioritisation Group and reported to FPC. Schemes linked to loan funding are held until a decision on the Trust's Loan Application is received. The loan application has been
	Monitoring of development and performance against CIP targets
	Monthly finance reports with detailed analysis of performance v control total and actions identified in Financial Recovery plans
	Numbers of breaches of agency cap
	Weekly review of RTT remediation plans
	External review through NHSI, internal audit and benchmarking
	Better Payment Practice Code performance
	Minimum cash balances against plan
	Monitoring of debt levels
	Capital spend variance to CRL
	Months 8,9 and 10 have delivered against the agreed Financial Recovery Plan which will deliver the revised forecast outturn (FOT)

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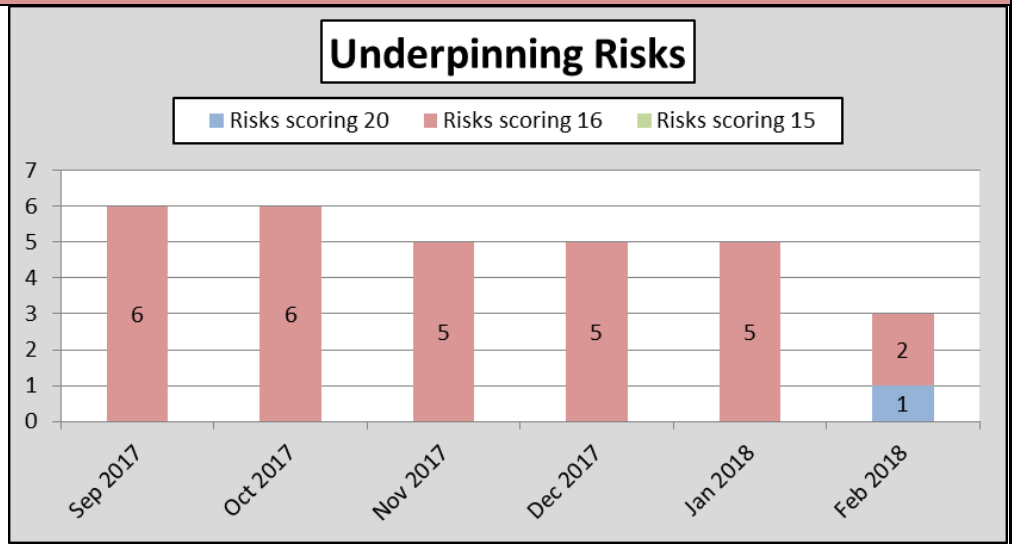
resubmitted during January 2018 to request emergency release of £5m across Q4 2017/18 and Q1 2018/19 to progress critical schemes. Daily Cashflow forecasting and rephasing of cash draw down requirements in line with FOT.	
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
QIA process for CIPs not embedded Further use of resources of model hospital	Ensure QIA meetings are timely and effective. Ensure all CIP projects and FRP actions have completed and signed off PIDs & QIAs. NHSI lead presented Model Hospital Opportunities to Trust in September 2017 and will do a follow up review of the 2018/19 plan in March 2018. Key areas of opportunity to be converted into plans as [part of medium term financial planning

Related High Risks (15 and above and DATIX ID)

3481	**Corporate Risk Register:** Lack of capital resources prevents the Trust from transforming operations	16
2744	**Corporate Risk Register:** There is a risk that the CR units could fail. This could be catastrophic for plain film service delivery to the Alexandra site	20
3291	**Corporate Risk Register:** there is a risk that the financial deficit is worse than planned	16



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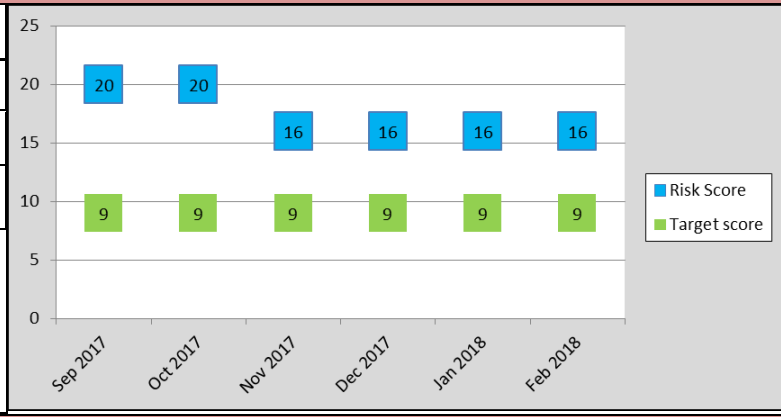
Risk Description	**Principal Risk:** The Trust is unable to ensure financial viability and make the best use of resources for our patients.					**Risk ID**	R4.2
Risk Details	If we do not resource our clinical staff rotas at ward/departmental level then we will not meet patient needs consistently with the potential for reduced quality & co-ordination of care provision, negative impact on patient flow & access targets: long term impact on substantive staff resilience; appropriate deployment of staff and poor retention of staff & inability to attract staff.						
Executive lead	**People & Culture Director**	**Last Reviewed**	**February 2018**	**Target Date**	**April 2018**	**Review Group**	**P&C**
CQC Domain(s)	Safe		**Caring**	**Responsive**	**Effective**		**Well Led**
Corporate Objective(s)	1		2	3	**4**		5

Risk Rating: Likelihood x Severity	
Initial Risk Score	20
Current Risk Score	16
Target Risk Score	9
Risk Appetite	Moderate
Direction of travel	↓



Relevant Key Performance Indicators

Metric	**Trust compliance January 2018**	**Target**
Vacancies	7.45%	8% or less
Turnover rate	10.94%	10<>12%
Sickness absence rates	4.94%	
Compliance with Safer staffing	96.2% (day) 103% (night)	95%
Agency Staff - Medics (WTE) Indicative	105	<=85

Rationale for current score

The Trust is in Special Measures so will struggle to attract and retain staff.

Controls: what are we currently doing about the risk?	**Assurances: how do we know if the things we are doing are having an impact?**
Prospective staff rotas Recruitment plan developed and being implemented. Use of temporary staff to cover vacancies where possible.	HR workforce reports & Score Card Agency use/ shift fill rate. Performance against recruitment trajectory

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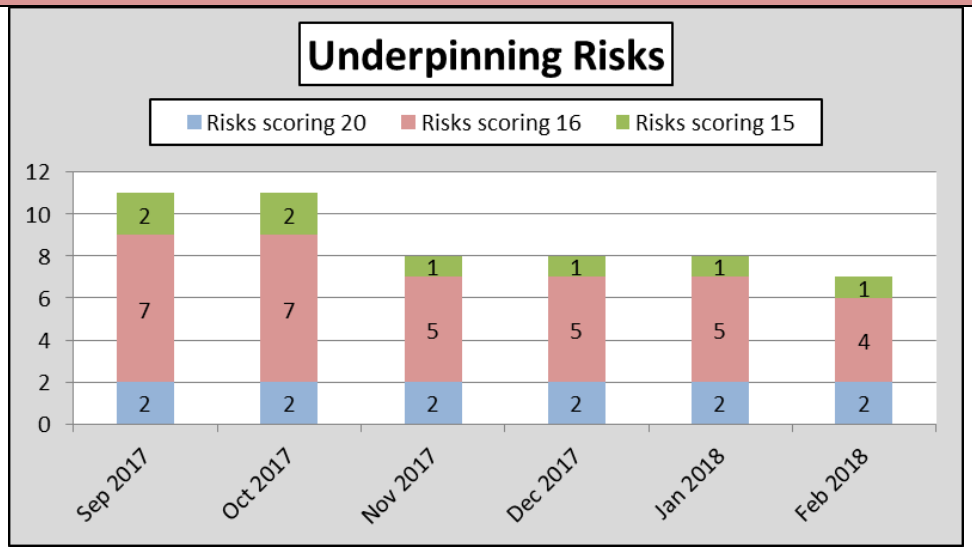
Vacancy rates monitored through Performance and Accountability meetings Business cases agreed for new Consultant posts being recruited to. People and Culture strategy developed	Staff survey FFT Recruitment KPIs Turnover rate Board workforce sub-committee
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
	Sharpen focus on nursing recruitment

Related High Risks (15 and above and DATIX ID)

2791	**Corporate Risk Register:** Inappropriate staffing levels	20
3170	**Medicine Risk Register:** Lack of seven day Consultant review in respiratory high care	15
3292	**Corporate Nursing, Governance and Risk:** Poor fill rate from our temporary staffing provider NHSP resulting in reduced staffing levels below the required and safe level.	16
3296	**Medicine Risk Register:** Gastroenterology cover at the Alexandra Hospital	16
3484	**Corporate Risk Register:** Potential sub optimal care in overflow wards due to staffing	16
3485	**Corporate Risk Register:** There is a risk that the trust is unable to deliver safe and effective care due to medical and nursing vacancies	16
3505	**Human Resources Risk:** Inability to recruit Clinical Staff	20



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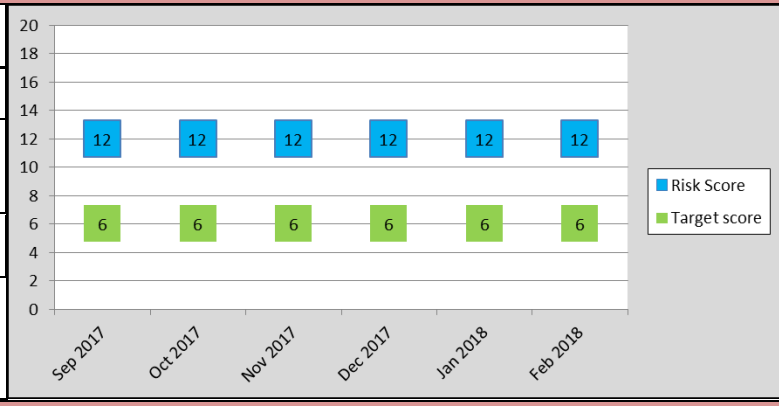
Risk Description	**Principal Risk:** The Trust is unable to ensure financial viability and make the best use of resources for our patients.					**Risk ID**	R4.3
Risk Details	R4.3 If we do not have a workforce strategy that addresses organizational development, values and behaviours as well as workforce development and recruitment we will not be able to provide care that meets the needs of our patients; meets the internal workforce demands and fills our vacancies.						
Executive lead	**People & Culture Director**	**Last Reviewed**	**February 2018**	**Target Date**	**April 2018**	**Review Group**	**P&C**
CQC Domain(s)	Safe	**Caring**		**Responsive**	**Effective**		**Well Led**
Corporate Objective(s)	1	2		3	**4**		5

Risk Rating: Likelihood x Severity		
Initial Risk Score	12	
Current Risk Score	12	
Target	6	
Risk Appetite	High	
Direction of travel	⟺	



Relevant Key Performance Indicators		
Metric	**Trust compliance January 2018**	**Target**
People & Culture Strategy in Place	Yes	Approved Strategy
P&C Strategy Implementation plan in place	Yes	Implementation plan
Workforce score card in place	Yes	Score Card

Rationale for current score

The Trust lacks a strategic workforce plan that identifies new roles and plans to develop these. In addition the relationship with HEE, the West Midlands Academic Health Science Network and local Universities needs strengthening.

Controls: what are we currently doing about the risk?	**Assurances: how do we know if the things we are doing are having an impact?**
Prospective staff rotas Recruitment and Retention Plan developed People and Culture Committee established	HR workforce reports Agency use/ shift fill rate. Performance against recruitment trajectory Staff survey

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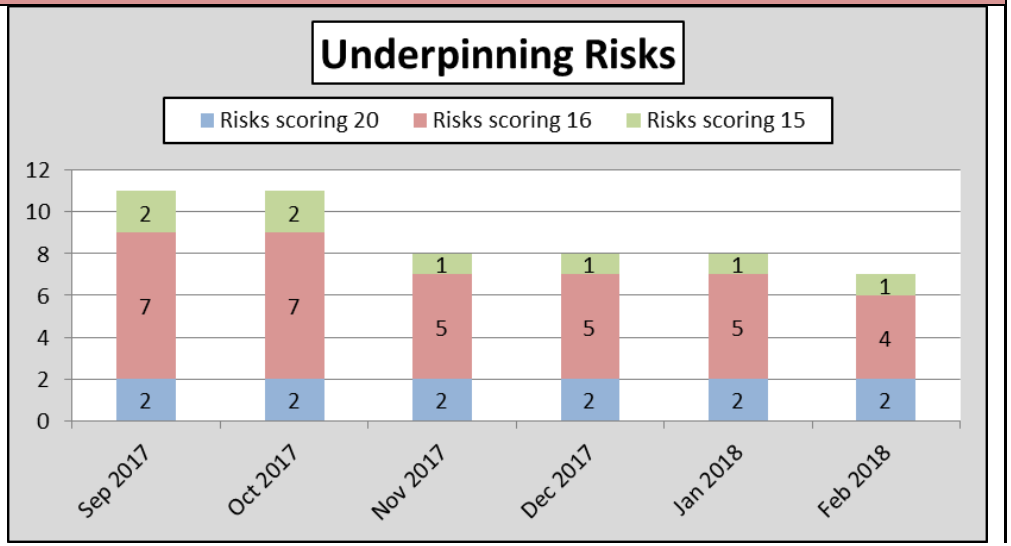
Use of temporary staff to cover vacancies where possible. Vacancy rates monitored through Performance and Accountability meetings Business cases agreed for new Consultant posts with recruitment underway. The Trust does have a small number of Physicians Assistants in place and a clinical lead identified to progress this work. People and Culture strategy developed	FFT Recruitment KPIs Turnover rate Board workforce sub-committee
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
Weak relationships with HEE and local Universities	Strengthen links with HEE and local Universities. Set trajectories for developing new roles

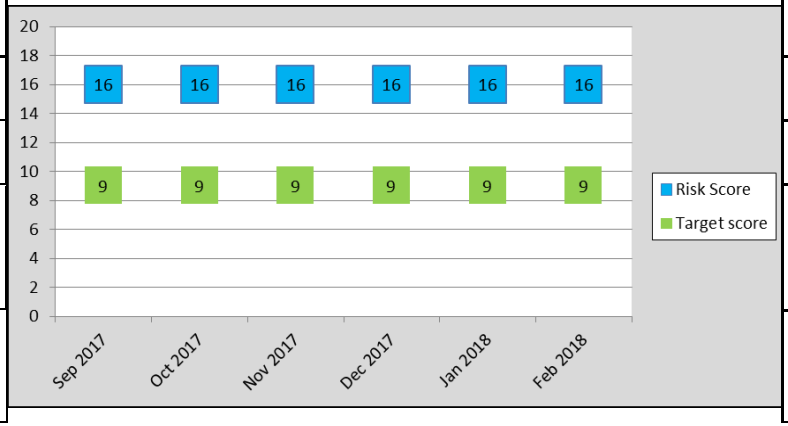
Related High Risks (15 and above and DATIX ID)

2791	**Corporate Risk Register:** Inappropriate staffing levels	20
3170	**Medicine Risk Register:** Lack of seven day Consultant review in respiratory high care	15
3292	**Corporate Nursing, Governance and Risk:** Poor fill rate from our temporary staffing provider NHSP resulting in reduced staffing levels below the required and safe level.	16
3296	**Medicine Risk Register:** Gastroenterology cover at the Alexandra Hospital	16
3484	**Corporate Risk Register:** Potential sub optimal care in overflow wards due to staffing	16
3485	**Corporate Risk Register:** There is a risk that the trust is unable to deliver safe and effective care due to medical and nursing vacancies	16
3505	**Human Resources Risk:** Inability to recruit Clinical Staff	20



Risk Description	**Principal Risk:** The Trust is unable to develop and deliver a long term sustainable clinical services strategy					**Risk ID**	R5
Risk Details	If we are unable to secure the support of our community and STP stakeholders for the clinical services strategy, we may not be able to make the changes required to ensure long term viability of services						
Executive lead	**Director of Strategy and Planning**	**Last Reviewed**	**February 2018**	**Target Date**	**3 years**	**Review Group**	**Strategy & Planning Group/Trust Board**
CQC Domain(s)	Safe	**Caring**		**Responsive**		**Effective**	**Well Led**
Corporate Objective(s)	1	2		3		4	**5**

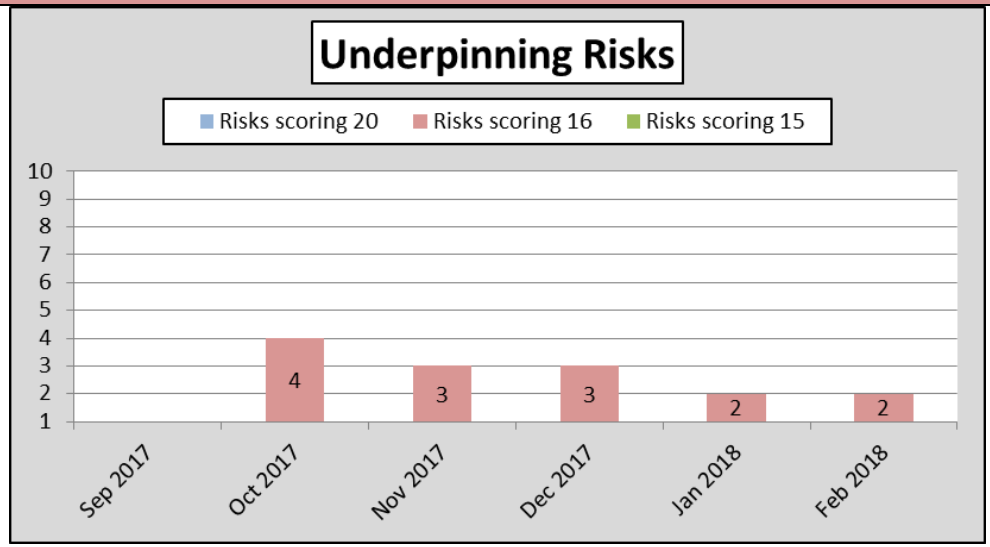
Risk Rating: Likelihood x Severity	
Initial Risk Score	16
Current Risk Score	16
Target Risk Score	9
Risk Appetite	High
Direction of travel	⟺



Relevant Key Performance Indicators		
Metric	**Trust compliance January 2018**	**Target**
Board approved clinical strategy	In development	Approved strategy
Enabling strategies in place e.g. estates. workforce	In development	Approved strategies
Related medium term financial sustainability plan	In development	Approved plan
Achievement of Trust agreed financial control totals going forward	In plans	Trust meets agreed totals

Rationale for current score	
The Trust has recently completed the FoAHSW programme but the impact on the clinical and financial viability of services has been confined to a small number of Trust specialties. As a three site Trust with a significant underlying financial deficit and ongoing recruitment challenges there is the need for a more far reaching, more radical strategy for Trust sites and services. Currently the STP plans are also underdeveloped There is an issue that as NHSE resources are aligned with STPs the pace of change will increase and the Trust needs to have a clear clinical services strategy for inclusion in the STP that it can use STP mechanisms and processes to support and drive. There is a risk from competing priorities for clinical leadership capacity to develop the strategy.	
Controls: what are we currently doing about the risk?	**Assurances: how do we know if the things we are doing are having an impact?**
The Trust is engaged in the STP at Partnership Board level and at Delivery Board level and is leading three of the key STP work streams. The Trust has convened a Clinical Council reporting to the Strategy & Planning Group for the purpose of 1. Overseeing full implementation of the FoAHSW model 2. Sponsoring and overseeing the development of the Trust clinical service strategy and 3. Overseeing the sustainability of clinical services at the Trust The Council will review the recommendations from the Herefordshire and Worcestershire STP Clinical Reference Group and ensure alignment with the Trust's strategic clinical service priorities. (Financial) Recovery Steering Group in place Two year operating plan 2017-2019 (being refreshed Feb/Mar 2018) Risk based capital prioritisation plan	Improvement in the clinical and financial sustainability of Trust services and the financial sustainability of the Trust overall. 4ward programme outcomes Operating plan 2017-19 reviewed by NHSI
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
No current overarching clinical strategy however development work has started Enabling strategies at varying degrees of completeness and progressing Turnaround Director engaged and (Financial) Recovery Plan at advanced stage of development	First draft of high level clinical strategy to be developed by March 31st 2018 Further develop enabling strategies to support implementation of clinical strategy Plans on a page for all recovery work-steams to be in place by 1st April 2018 2017-19 operating plan to be refreshed based on revised NHSI Guidance issued in Feb 2018

Related High Risks (15 and above and DATIX ID)		
3481	**Corporate Risk Register:** Lack of capital resources prevents the Trust from transforming operations	16
3483	**Corporate Risk Register:** Patients may be harmed due to delays in treatment/waiting times	16



CRR and all other high risks 05032018

CRR in grey

Enc G1 attachment

ID Link	Opened	Title	Description	Controls (Assurance)	Likelihood (initial)	Risk level (initial)	Rating (initial)	Likelihood (current)	Risk level (current)	Rating (current)	Likelihood (Target)	Risk level (Target)	Rating (Target)	Review date
2858	08/04/2015	15 minutes triage in ED - WRH	Risk: 95% of patients are not assessed within the national 15 minute standard; Cause: Surges of attendances create bottle necks due to size of SIAN, triage capacity and exit block from ED. Effect: Patient safety risk, delay impacts on patient experience, overcrowding in SIAN area, failure to meet national target; Impact: increased patient complaints, potential fines on CCGs for ambulance handover delays, reduced staff morale, difficult nursing conditions in overcrowded environment, local and national scrutiny creating additional assurance requirements	Flexibility in minors nurse to triage to increase triage number Ed Early indicator report is now available to highlight any surge in capacity affecting triage times. Dedicated Senior Nurse for Initial assessment Escalation processes to support redeployment of ED and corporate staff to ED during surges in activity/ peak activity periods. ED expansion offers two cubicles for triage for increased activity Nursing establishment increased in line with department expansion streaming / triage protocols currently in review Real time monitoring of TTIA , by ED coordinator and ED manager/ capacity hub. HALO available in department to support timely ambulance handover	Likely	High	16	Likely	High	16	Unlikely	Moderate	8	24/04/2018
3296	30/08/2016	There is a risk of patient	Risk: There is a risk of patient harm at the Alexandra Hospital due to gaps in the consultant gastro physicians rota. Cause: This is due to Consultants having increased on-call duties to cover GIM Effect: Patients may receive sub optimal care Impact: There is an increased risk of patient harm	Cross site Consultant working Locum Consultant to be based on Ward 9/12	Possible	Moderate	12	Likely	High	16	Possible	Moderate	9	02/04/2018
2744	18/11/2014	Ageing CR (computed radiography) units could fail. This could be catastrophic for plain film services on the	RISK There is a high risk that Radiology would be unable to provide a plain film X-ray at all on the Alexandra site. This is due to the potential failure of the CR (computed radiography) units, due to age, lack of spares and continued unreliability. The X-ray rooms are also at risk of failure due to age and on going poor reliability. CAUSE There are 4 CR units purchased in 2002/2006. There is a lack of parts for these units nationally because of their age and the manufacturer has advised us that they cannot guarantee to be able to keep these units running and serviceable. Replacement is and has been a priority for over 3 years, to ensure viability of a plain film service on this site. These units were identified as requiring replacement 2012/2014 with an 8 year expected life.	In the event of all A&E CR units failing, then take image cassettes down to the Orthopaedic centre for processing – unsustainable. All incidences of equipment failure are reported and investigated. 3 CR units reduces risk of failure of all Planned preventative maintenance is in place	Likely	Moderate	12	Almost certain	High	20	Rare	Very low	2	06/04/2018

ID Link	Opened	Title	Description	Controls (Assurance)	Likelihood (initial)	Risk level (initial)	Rating (initial)	Likelihood (current)	Risk level (current)	Rating (current)	Likelihood (Target)	Risk level (Target)	Rating (Target)	Review date
			EFFECT Lack of X-ray service would have a severe and likely catastrophic effect to patient care and safety and the viability of the whole Hospital site would be placed at risk. For example Chest x-rays and skeletal x-rays could not be done on this site. A&E, ITU, CCU, Theatres and all In Patients could not work safely. Other areas such as Out Patients could not deliver a service. Failure of the CR units means that radiology would be unable to process an image. Whilst equipment is still running, there are constant breakdowns. One of the CR units now has no spares at all. A similar issue occurred at Kidderminster only a few years ago(a non acute site, total failure of all CR units and had a major impact on that site. It is now possible that The Alexandra site could have a similar situation. The high throughput multiplate CR reader in the A&E rooms is now having frequent breakdowns, a key piece of equipment due to its high capacity. Should X-ray examinations require repeating then this is notifiable to the CQC due to the increased unnecessary dose of radiation to the patient. IMPACT Missed pathology, possible death, poor patient experience, complaints, damage to reputation. The site could not function as an acute site. Patient safety/harm issue. It is likely that all A&E and in patients would have to be transferred to WRH. This would have major reputational damage to the Trust and operational problems to all sites. This would lead to an impact on waiting times, backlog, diagnosis and treatment. The capital equipment replacement programme is well behind due to lack of capital.	Escalated to corporate risk register									
2816	25/02/2015	Bluespier Server Speed Issues Causing operational difficulties and inconsistent documentation of operative records	The speed that the Bluespier software program runs at Redditch Theatres is causing operational difficulties. Due to the regularity that the program is not operational, the theatre peri-operative document is not being completed within the Bluespier program, causing non-uniformity countywide in the perioperative care pathways Unable to complete electronic WHO on Bluespier in real time	Papers copies for the failure of bluespier	Almost certain	High	15	Almost certain	High	15	Unlikely	Low	4	30/03/2018
2689	25/06/2014	Breaching national	Risk: Patients will not be processed within the national emergency access standard of 4 hours and patients will not be admitted within 12 hours of their decision to admit. Cause: Insufficient staff in ED to process patients, insufficient staff in acute medicine to clerk and admit patients, insufficient capacity within the hospital to maintain continuous flow of patients through the ED, lack of alternative pathways to stream patients. Effect: Poor patient experience, impact on patient safety through overcrowding, delays in treatment. Impact: local and national scrutiny resulting n increased workload to provide assurance. Impact on staff morale and turnover.	A GP is now working in ED Band 7 leadership increased in ED Majors Admin Assistant in post Additional locum support sought when required for evenings and weekends Real time monitoring of breaches by ED management and capacity hub. Process in place to monitor and validate potential and actual breaches Process in place in EDs to identify potential breaches and escalate to capacity hub and management team. Monitoring of speciality referral to arrival times to ensure early specialist opinion where required Review and validation of decision to admit times from clinical documentation Review of flow processes from ED to assessment units and assessment units to base wards. Senior Nurse leadership to capacity hub. Monthly internal monitoring of progress against CQUIN targets at directorate meetings Additional Consultant shifts to ED during peak periods. safety matrix completed 2 hrly in ED to identify periods of overcrowding / potential risk of overcrowding ED expansion in progress to increase physical space at WRH ED. Implementation and ongoing development of ambulatory emergency care units on both sites	Likely	High	16	Almost	High	15	Likely	Moderate	12	20/03/2018

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				reverse boarding system in operation in ED to support flow from ambulance handover to majors cubicles										
				Weekly harm reviews performed for patients who have waited over 15 minutes for initial triage										
2981	09/07/2015	Capacity	There is a risk of cancellation of scheduled procedures due to opening of inpatient areas when the "full hospital protocol " is actioned. This could result in cancer patients having procedures cancelled from Laurel 2 procedure room if alternative accommodation can be found. This can result in other procedures having been re-scheduled or cancelled or requiring them to be rearranged if the day case is used to accommodate patients. Patients are at times also boarded within wards as an "extra" patient Risks - 2411,2562,2964,3106,3224,1637,2716,3257,3406 have all been linked to this risk and closed and will be managed via this main risk.	Full hospital policy to be utilised	Almost certain	High	15	Almost	High	20	Possible	Moderate	9	06/04/2018
				Staff to consider reverse boarding if required to board patients who are clinically unstable										
				Staff to escalate to capacity hub concerns regarding allocation of patients										
				Matrons complete annual ward risk assessments, this includes risk of boarding patients within the ward area.										
				SAFER bubble is used within all ward areas to ensure smooth discharge process.										
				Weekly monitoring of ward based audits through SNAP										
				Matron of area to monitor staffing levels daily identifying any gaps and escalating as appropriate										
				Executive approval to be given for boarding of patients on ward										
				Wards who are requested to board a patient - to consider reverse boarding if appropriate.										
				Capacity team complete individual risk assessments for patients who are to be transferred to surge areas										
				Evergreen wards to use SOP for area regarding accepting patients for transfer										
				Any major issues to be escalated immediately to both the DMT and DM of the Directorate										
				Use of these areas to be monitored and discussed at monthly DMT meeting.										
2875	05/05/2015	Co-horting patients under WMAS care	Risk: There is a risk of delay to acute medical treatment in the Emergency Dept. if downstream flow patients do not have a timely handover of from WMAS to the Acute Trust. Cause: The exit block is caused due to a lack of base ward beds causing overcrowding Effect: This results in delays at the point of handover between WMAS and the Acute Trust which may result in patient harm (ranging from minor through to fatality) Increased pressure on WMAS and reduced capability to respond to further calls Impact: Decreased staff morale, increased sickness, retention issues Poor patient experience Reputational damage Negative effect on relations between WMAS and Acute Trust	Regular reviews and of DTOC lists in a timely way by all Divisions and Directorates to improve patient flow.	Almost certain	High	25	Almost certain	High	15	Likely	Moderate	12	03/04/2018
				Daily Consultant ward rounds and forward discharge planning by MDT.										
				There are 2 cubicle spaces in the SIAN area to support the initial assessment of patients, which will aid privacy and dignity										
				There are a number of dedicated cubicle spaces within the Majors area to aid privacy and dignity										
				Senior Initial Assessment Nurse 24/7 (SIAN)										
				HALO stationed in ambulance offload area										
				Evergreen homeward bound ward has been opened October 2016 to accommodate patients who are MFFD awaiting pathway 1 and 2.										

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				Developing of AEC role to enable nursing staff /Consultant to select appropriate patients who have attended ED overnight and can be "pulled" for treatment and assessment in triage.										
3291	17/08/2016	Deficit is worse than planned and threatens the Trust's	If the Trust does not have appropriate financial controls and discipline the finance position is at risk. Key risks centre around delivering planned levels of income within the cap and collar arrangements and keeping expenditure within budgeted levels. This includes delivering CIP targets, ensuring CQUIN achievements, minimizing fines and securing the STF. Impact: - Inability to meet planned deficit at year end or meet cash requirements will have a resultant impact onto Continuity of Service (COS) - Liquidity Problems - Reputational damage and confidence in Board - Will trigger further action by NHS Improvement (NHSI) - Risk of lack of investment in the environment/facilities/equipment supporting patient care	Monthly reports to Finance and Performance Committee Executive accountability Financial reporting to highlight key issues and facilitate corrective action Divisional management structures & divisional performance management monthly Robust CIP plans signed off and divisional performance reviews Monthly review of CIP plan delivery by PMO with divisions and escalation of issues to Finance & Performance Committee Monthly CIP update to Finance & Performance Committee Expenditure controls Contract Management Board (CMB) Monthly income and activity reconciliations with CCGs Joint CIP/QIPP committee Enhanced approvals processes for agency spend Financial Recovery programme	Likely	High	16	Likely	High	16	Possible	Moderate	12	28/02/2018
3476	06/04/2017	Demand for CT outstripping capacity leading to delays in performing CT imaging	There has been a significant increase in demand for both inpatient and outpatient CT. The demand for CT imaging now outstrips the available capacity within radiology. Steps have been taken to provide extra scanning by performing WLI sessions, but this is proving insufficient to prevent delays and is unsustainable. As a result there are significant delays developing in the booking of patients for CT scans, which is particularly impacting upon patient on the 2ww cancer pathways.		Likely	High	16	Likely	High	16	Unlikely	Low	4	28/02/2018
2769	06/01/2015	Failure to achieve respiratory national targets	If the Respiratory Consultant vacancies and support structure are not approved by the trust then the Directorate is at risk of being unable to achieve national targets. For example 18 weeks, cancer 2WW and 62 day cancer targets. Consultants and nursing teams are unable at present to provide adequate support to other wards which are accommodating respiratory patients which is resulting in sub-optimal care being provided to these patients .	At present the Directorate has three long term and two short term locum consultants in post . Fully established at WRH from 20 November On Alex site 2 locums in post whilst recruiting substantively	Likely	High	16	Likely	High	16	Likely	Moderate	12	31/03/2018
3363	21/11/2016	Failure to deliver timely care to patients admitted for elective procedures and on	RISK Delays in elective treatment may lead to harm CAUSE 1. Availability of surgical beds is limited due to a large volume of medical outliers. 2. Elective procedures are cancelled to accommodate emergency admissions 3. Theatre lists are not run efficiently which limits the number of patients that can be operated on in one session EFFECT Potential inability to provide appropriate care, unable to meet national RTT and cancer targets IMPACT Negative impact on patient safety and patient experience Potential for reputational damage Delays in treatment Increased likelihood of complaints and litigation Admission to a non-specialty bed can also lead to an increased LOS. Delays in treatment also result in failure to achieve emergency access targets.	Review of pathway and targeted plans to reduce wait at points of care such as 1st OPA. Prioritisation of category 1 patients to ensure timely treatment despite current restrictions Other categories of patients are being assessed and prioritised according to clinical need Movement of all appropriate surgery from WRH to KTC & AGH and independent sector where able Maintain a functioning TAU on WRH & AGH sites	Likely	Moderate	12	Almost certain	High	15	Unlikely	Low	6	31/03/2018
2871	27/04/2015	If RTT and non RTT reports	During 2015 a programme of work was undertaken to move from calculating RTT waiting times using local logic to using clock stops on OASIS. New RTT reporting will go live on 1/12/15. The new reporting will only be as good as the data which is entered into Oasis, and the systems which support this. The Transformation Team have been allocated to lead the transformation required to ensure new reporting is as accurate as possible.	Validation process for RTT records Exec led working group in place to deal with Non RTT issues Clinical engagement in Non RTT programme	Likely	High	16	Likely	High	16	Possible	Low	6	28/02/2018

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			Transfer to new RTT reporting is reliant on the completion of a number of tasks which are outside of the Information Team's control: - Validating the cohorts (closed and those that remain open) - Data Quality issues being reviewed and acted upon by the Operations. -Processes being implemented within the Trust to support the delivery of new reporting i.e. clinical review on patients that have died whilst on the waiting list. - System configuration changes preventing data issues, operation testing etc. The non RTT waiting list has 350,000 open records which are not included on the PTL which only shows RTT waiters. A number of these records should be closed, some are incorrectly recorded as Non RTT when they should be RTT and these patients may not be treated in a timely manner which may result in patient harm.	IT and training engaged in future proofing NHS I IST engaged at early stage in project. Recommendations being followed									
3505	18/05/2017	Inability to recruit Clinical	If we do not have in place effective organisational financial management, then we may not be able to fully mitigate the variance and volatility in financial performance against the plan leading to failure to deliver the control total, impact on cash flow and long term sustainability as a going concern. RISK	Development of Trust Internal Bank Development of a Recruitment Campaign to address all Medical and Nursing Vacancies	Almost certain	High	20	Almost	High	20	Unlikely	Low	6	30/11/2017
3631	27/11/2017	Increased spend for NHSP tier 1 and 2	In the month of November 2017 the Trust has spend 1.3 million in bank/ agency this is a 50% increase in spend compared to 12 months previously with no additional capacity open at this point. Controls regarding Eroster efficiency and NHSP bookings are not being adhered to. 1. confirm and challenge taken place at ward level. 2. Data and performance presented to DDN's and MDT at NHWAG 3. £2200 saved in last 2 weeks. 4. Need to build efficiency in Froster and NHSP		Likely	High	16	Likely	High	16	Possible	Very low	3	01/03/2018
3577	30/08/2017	Lack of Emergency Medical and Acute Medicine staff at night leading to long waits	Risk: Delays in decision making regarding patient care and breaching national EAS targets. Cause: insufficient medical staff on site overnight in ED and Acute Medicine. Effect: Delays processing patients, poor patient experience, patient safety, increased pressure on staff in the mornings Impact: Increased patient complaints, low morale causing increased turnover of staff, local and national scrutiny, overcrowded department		Likely	High	16	Likely	High	16	Rare	Very low	3	10/04/2018
3014	26/08/2015	Lack of resources - Sleep service	If the trust does not maintain the sleep service contracts due to capacity issues then the trust will loose a substantial income. If this contract is lost, the trust would also lose income from the diagnostics through to the consultant referrals.	The Trust follows the BTS guidelines for patients with Sleep Apnoea Trust Sleep Apnoea Pathway 18 week pathway	Likely	Moderate	12	Likely	High	16	Possible	Moderate	9	30/03/2018
3170	02/03/2016	Lack of seven day Consultant review in respiratory high	Risk: There is a risk of suboptimal medical review within the respiratory consultant establishment at weekends Cause: This is caused by an inadequate consultant establishment Effect: With the effect that patients may receive sub optimal medical review at weekends Impact: An increased risk of patient harm and safety incidents and potential delay in discharge This is an acknowledged risk within Medicine see risk 2791	Treatment plans for the weekend are written within the patients notes . Nursing staff are aware of escalation process of deterioration of patient. At the Alexandra hospital patients are assessed over the weekend by the general medical consultant on call.	Almost certain	High	15	Almost certain	High	15	Possible	Moderate	9	31/03/2018
3570	21/08/2017	Long term reliance on agency theatre practitioners in order	RISK-Long term reliance on agency theatre practitioners in order to maintain minimum staffing levels in theatres CAUSE- Theatres are experiencing a chronic shortage of staff alongside an increasing demand for surgical capacity. A review of the establishment has revealed that even if fully recruited theatres would struggle to meet the current activity. EFFECT- potential to delay patient treatment. Inefficient service. Financial impact IMPACT- financial Cooperation from the surgical teams is necessary in order to properly plan resources and staffing and to limit poorly utilised lists. It is anticipated that theatres will rely on agency staffing for some time.	Theatres attendance at regional and national recruitment events Specific Theatres open days Radio and newspaper advertising Attendance a regional and international recruitment events Rolling recruitment adverts Theatre scheduling forward look to identify weekly staffing requirements Long term agency bookings NHS Professional staff bank paying competitive hourly rate NHSP electronic staff/agency booking system New affiliation and partnership with Coventry University to provide ODP training and CPD modules	Likely	Moderate	12	Likely	High	16	Possible	Low	6	30/03/2018
3293	23/08/2016	MRI Scanner room at WRH does not have required MHRA 4 level of entry	To further reduce the possibility of risk to patients or staff by accidental/unauthorised access to the MRI scan room. This is by means of a further risk assessment and consideration to other physical means to prevent this or by reducing access to staff who are able to swipe into that area.		Unlikely	Moderate	10	Possible	High	15	Rare	Low	5	30/03/2018

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2870	24/04/2015	No provision of Out of Hours Interventional Radiology	The Trust is unable to provide the out of hours interventional radiology service due to shortage of interventional radiologists and supporting staff. This is a nationally recognised problem in the UK. Currently there are trusts providing this service by combining the work force of adjacent trusts and making a network solution. The patients who would benefit from this service are 1) those with life threatening bleeding, who could be managed with relatively simple embolisation procedure rather than a major surgery with prolonged recovery period, 2) patients with abscess collections that could be drained by key hole procedure 3)treating blocked kidneys in an emergency	Consultant Surgeon to Consultant Surgeon referrals Ad hoc out of hours interventional service	Likely	High	16	Likely	High	16	Rare	Very low	1	31/05/2018
3403	31/01/2017	Patient harm as a result of delayed or incorrect cancer/ clinical trials medicines as a	due to an inability to recruit and retain highly skilled specialist chemotherapy pharmacists, particularly at the AH site, the patients attending MBS, RS, and GS run the risk of either delayed or inaccurate chemotherapy or clinical trials. this could lead to harm from disease progression or drug toxicity	competency programme for all pharmacy staff involved in preparing chemotherapy QAAPS compliant QA process of the preparation of chemotherapy regular external (EL 97(52)) audit of QA process to identify compliance and improvements competency programme for all nursing staff involved in the collection and administration of chemotherapy	Likely	High	16	Likely	High	16	Unlikely	Moderate	8	30/03/2018
3545	14/07/2017	Patient harm as a result of delayed or incorrect	Despite numerous attempts, the pharmacy team have not been able to recruit to clinical pharmacists posts at the Alexandra hospital. The team will have two more vacancies within the team from September onwards due to pharmacists leaving the trust. There will therefore be a risk that the team cannot maintain a robust, safe and responsive (patient flow)service to inpatients at the Alexandra hospital.	weekly review of vacancies and recruitment progress Monthly review at STF	Likely	High	16	Likely	High	16	Unlikely	Low	6	31/08/2018
3537	07/07/2017	Patient harm due to delayed, incorrect or unavailable	despite repeated recruitment rounds, the WA pharmacy service is failing to recruit to key roles in aseptic, clinical and operational teams. this risk is apparent at both sites. in July 2017, the key groups affected are Chemotherapy Pharmacists at AH, Clinical Pharmacists at AH, and Assistants and Technicians at the WRH. This failure to recruit is now leading to a rising turnover in smaller more highly specialised teams. (e.g. Aseptics and Clinical at AH). failure to maintain a satisfactory pharmacy workforce will lead to delays, a reduction in safety, a reduction in patient care and increased potential of failure to supply the right medicine	weekly review of vacancies and recruitment progress escalation of daily staffing shortages to pharmacy management via huddles liaison with key directorates to identify and manage workload changes	Likely	High	16	Likely	High	16	Unlikely	Low	6	30/04/2018
2791	04/02/2015	Patients may be at risk of harm due to staffing	Risk: Recruitment difficulties within both medical and nursing staff Cause: National issues with recruitment to many medical and nursing specialities. Effect of IR35 and national capped rates for locums. There may be local factors related to Trust reputation or reputation of specific services. Effect: Difficulty providing safe patient care at all times; increased waiting times for OP services, RTT, 2WW (especially respiratory service); adverse effect on patient flow; poor staff morale Impact: Risk of patient harm; impaired patient flow; risk of poor patient experience and complaints Risk 3422 has also been linked as the trust has initiated a trust agency cap then the Division may find it increasingly challenging to fill vacant locum slots and since 1st April 2017 the introduction of IR35 further caused a problem with booking of medical staff. In Emergency Medicine, Acute Medicine, Respiratory, Gastroenterology, Geriatrics, Stroke, Diabetes, general and specialist nursing staff, the division will be unable to safely operate two fully functioning Emergency Departments. Respiratory, Gastroenterology, Acute Medicine, Diabetes and Stroke service will also be unable to provide a safe service. Gastro have been unable to recruit into their vacant Consultant post at the Alex which has resulted in no gastro service now being available at the Alex. Patients will have to wait longer for cardiac and respiratory specialised investigations. There is the potential risk of thoracic medicine suffering 52 week breeches due to a depleted Consultant base and inability to recruit Locum Consultants with the trusts agency cap. Gaps in the weekend rota will lead to a delay in patient clerking of patients and medical review. Management plan not being established in a timely fashion . Emergency Medicine/ED are experiencing a reduced AEC service and causing limited decision making overnight in ED due to gaps in rota of middle grades. There is no OPAL service currently in place in ED. The Division is facing extreme difficulty in further recruitment of locums as CV's which are received in medical staffing all have hourly rates about the trusts capped rates. Since the trusts introduction of capped rates plus 20% the Division has 14 medics resign. The Division is continuing	Robust monitoring of morbidity and mortality rates Task & Finish groups implemented as individual risks heighten Robust communications with other departments that affect the daily working of the services (diagnostics/ surgery etc.) Maintenance of Deanery training status Monitoring of adherence to national and local guidelines Monitoring of adherence to governance processes and patient safety standards Daily discussions within the Division regarding medical staffing with escalation to the executive team as required. Assess, plan and monitor activity across both sites Monitoring of risk matrix indicators (ED and Acute Medicine) Development of a workforce plan document Weekly meeting now held with deputy director of ops and HR to discuss/monitor and progress any issues.	Likely	High	16	Almost certain	High	20	Possible	Moderate	9	01/04/2018

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			to meet face to face with locum staff and discuss benefits of converting to trust bank to date 84% of locums have been met. If the staffing rotas are not covered adequately by skilled and competent staff on both sites, patient safety and quality of care will be compromised. The risk to patient safety and quality of care significantly increases with rapid turnover of short term locum staff and/or an over-reliance on locum staff. If the quality of staff skills and competency is not of a high standard, morbidity and mortality rates will rise, affecting outcomes for patients. This overarching risk covers the following key areas: •ED, Acute Medicine, Respiratory, Diabetes , Gastroenterology, Geriatric and Stroke Consultant rotas •ED Middle Grade Medical Staffing rotas •Adherence to national performance indicators and local guidelines to ensure safe patient care may in turn suffer •Inability to maintain Deanery training status •Maintenance of high quality care . Effective management/effectiveness of Evergreen 1 and 2. The above issues are all interlinked and the inability to maintain parts of the above may lead to disruption to the provision of unscheduled care services. To ensure robust Divisional Management of this risk all Speciality and Directorate risks pertaining to staffing issues have been linked to this risk and will be managed through this risk, which will include any local actions and controls established . Risks- 2714,1719,2861,2307,2785,3017,2692,2696,2723,3141. Risk 3252 is being managed as a separate risk bespoke to stroke.	The Medical Division has established a regular "medical staffing meeting" to enable the Division to micro-manage any issue that have arisen within specialities regarding recruitment. Weekly agency task force meeting to review agency usage with plans for reducing Nursing staff to complete nursing app daily and ensure if triggering red narrative is included Review potential to embed Band 4 Nursing Associates on each ward Ensure Senior involvement at recruitment events by working closely with professional development Executive team have agreed to honour Dr's pay rates where they agree to join the trust bank A document detailing benefits of joining the trusts bank has been given to all substantive clinical leaders Band 6 staffing co-ordinator has been appointed to co-ordinate all medical staffing rotas Staff are supported with managing sickness and appropriate referral to OH made Business continuity plan states that Consultants if required are expected to act down Recruitment drive with HR team including recruitment package (consultants), work with HCL (junior doctor overseas recruitment with Skype interviews), direct overseas recruitment (trip July 2017) has reduced vacancies at both consultant and junior doctor levels Respiratory consultants at WRH now fully recruited to complement Progress with stroke consultant and junior doctor recruitment (1.6 substantive, 1 long term Trust locum starting Nov 2017, further long term overseas candidate can start following IELTS/MRCP completion). Additional transfer of consultant funding to specialist nurse (4 appointed and in post from Oct 2017) to support service Progress with acute medicine consultant and junior doctor recruitment Engagement with HEE with regard to trainee issues. Monthly junior doctor and registrar forum meetings. Continued weakness in recruitment in geriatrics (consultant), gastroenterology (consultant) and diabetes/endocrine (consultant) – locums are in place for some but not all (gastroenterology). Nurse endoscopists appointed and trained to help with some of the diagnostic work within gastroenterology										

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				Introduction of diagnostic lung cancer MDT to improve 2WW work in respiratory										
				ECIP review of respiratory workload October 2017 completed										
3483	24/04/2017	Patients may be harmed due to delays in treatment/waiting times	RISK There is a risk of inappropriate patient pathway management and extended waiting times CAUSE Poor data quality, lack of training and/ or utilisation of reports by end users EFFECT This has resulted in a historic backlog of non RTT pathways that require significant validation Data quality issues remain on RTT pathways IMPACT Patient treatment can be delayed if the pathways are not managed consistently and to the waiting list rules. This can result in patient harm due to delayed treatment. Also reputational risk to the organisation. This risk is linked to risk 2871.	Weekly Patient Target List meetings to track patients through treatment pathways- head of patient access	Possible	High	15	Likely	High	16	Unlikely	Moderate	8	27/04/2018
				Non RTT validation work stream tracked through RTT steering group, led by COO										
				Intensive Support Team recommendations have been translated into a project plan, monitored through RTT steering group.										
2299	09/05/2012	Patients not receiving follow-ups within clinically stipulated timescale, may	Risk There is a risk that patients not receiving follow-ups within clinically stipulated timescale, may result in loss of vision or reduced vision. Cause Follow-up appointments were 3/12 behind until August 2011. Ophthalmology KTC took over Acute Eye Service for the county August 2011 and a senior consultant retired in February 2012 and has not yet been replaced, thus we have lost 10 General clinics per week, equating to approximately 80 patients per week. We are now 8 months behind with general ophthalmology follow-up appointments (to include Glaucoma patients, at risk of irreversible sight loss if their condition is not managed effectively. Sept 2017 Approximately 70,000 patients are seen a year by the service, supported by 130 members of staff The department have seen a number of challenges over the past year: •An increase in referrals to the service •A change in patient case mix – an increase in patients with sight threatening conditions Loss of consultant and specialty doctor and recruitment delays The service has been steadily growing and although proactive work has been undertaken to maximise the staffing and facilities but the service now are no longer able to cope and a number of issues have arisen. National picture with increasing referrals - likely to continue. Effect As at June 2017 8,376 patients are waiting past their target date for follow up appointments. The ophthalmology department have changed the way in which their outpatient follow up data is collated. This has identified a large number of patients that are waiting over their target date for appointments. This is unacceptable to the department and actions are being taken to tackle the problem. Every patient that attends a follow up outpatient appointment and has waited over their target date a harm review is completed. These harm reviews are collated and actioned and make recommendations where financial input is required. Impact Increased risk of loss of vision Poor patient experience Increased patient safety issue Increased risk of complaints and litigation Increased risk of negative media attention and reputational damage	Specialist nurses appointed and being trained to undertake procedures and follow-up patients	Almost certain	High	20	Likely	High	16	Possible	Very low	3	19/03/2018
				Administrative and Clinical validation of 'overdue' patients being undertaken										
				Monthly WLI activity continues										
				Specialist nurse training continues to release consultants to create capacity										
				A full action plan is in place to address the risk and trajectories have been set at 150 patients per month										
				Trigger for harm review										
				Prospective clinic form										
				Additional consultant appointed to support reduction in backlog										
				SOP on clinical risk to ensure high risk patients are seen within agreed timescales										
2634	17/02/2014	Patients with Mental health illness in ED may have reduced quality of care and delay in assessment	Risk: There is a risk that the Elgar Unit (provision of mental health services at night) may be closed. Cause: As the requirement for cover is countrywide the unit is not always open and is unable to respond to ED requests to assess patients. Effect: This results in a variable standard for mental health patients attempting to access services out of hours Impact: This will lead to poor patient experience , reduced patient safety and quality of care and delay in appropriate assessment.	patients receive an initial assessment by ED staff. If deemed to be at risk of harming self or others , close observation may be initiated. This includes calling on security staff where appropriate.	Almost certain	High	20	Almost certain	High	15	Likely	Moderate	12	07/03/2018
3292	22/08/2016	Poor fill rate from our temporary staffing provider NHSP resulting in reduced staffing levels below the required and safe level.	The current provider for our temporary staffing is NHSP. The risk is that the current fill rates are poor which doesn't provide assurance that patient safety and the quality of care maintained in the clinical areas. The finance and senior nursing team are monitoring improvements. The number of vacancies, variable sickness levels and difficulty recruiting all provide a combined very high risk to the provision of optimal patient care.	The safer staffing app provides a system for planned review and timely escalation to action by senior nurses up to the chief nurse. An SOP has been completed and is due to be circulated.	Likely	High	16	Likely	High	16	Unlikely	Low	4	30/04/2018

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				ward/departments have an agreed safer staffing template and if it is envisaged that shift staffing levels may fail below this. Then escalation to Matrons /DDN's will take place to ensure that staffing gaps are addressed.										
3638	01/12/2017	Poor utilisation and efficiency of Eroster system impacting on spend and safe staffing	The nursing workforce are not currently utilising the Eroster system effectively which is impacting on the ineffective/inefficient utilisation of substantive staff and over utilisation of bank/agency staff resulting in significant over spending on our bank staff. The current spend for the month of October 2017 was £1.1 million which is 50% more than last year with no additional capacity in place at the time. One of the inefficiencies is that staff have to manual request bank shifts which is time consuming and an inefficient use of their time. Electronic systems are available to pull gaps in the roster to our bank provider when the roster is released 6 weeks in advance of shifts. This would support the shifts in being filled by the bank and not agency if they were released earlier.		Likely	High	16	Likely	High	16	Possible	Low	6	30/04/2018
2709	19/08/2014	Risk of delayed admission to critical care as unit full	RISK There is risk of potential harm to critically ill patients requiring admission to critical care. CAUSE Transfer of patients ready for ward step-down is often delayed due to capacity pressures across the site. EFFECT Patients who do not need critical care are occupying critical care beds potentially delaying admissions for patients who do have critical care needs. Linked standards Guidelines for the Provision of Intensive Care Services (GPICS). Standard 2.11 states that Discharge from Critical Care to a general Ward must occur within 4 hours of the decision. Standard 2.12 states that Discharge from Critical Care must occur between 0700hrs and 2159hrs. Time from decision to admit to admission should be less than 4 hours. IMPACT Increased safety risk to patients. GPICS guidelines are not currently being met by the Trust. Potential reputation damage. MSA RATES WILL CONTINUE UNTIL FLOW ENABLES PT TRANSFERS	Escalation of wardable patients by the Divisional representative at the daily bed meetings. Patient flow work stream Risk mitigated by critical care outreach being available to support ICU patients not on ICU	Likely	High	16	Likely	High	16	Unlikely	Moderate	8	02/04/2018
3341	08/11/2016	Risk of patient harm and potential catastrophic risk of	There are key risks that are contributing to the risk score of 15. These include: *Lack of assurance around cleanliness of the clinical environment leading to seeding of the environment with strains of C.difficile. *Lack of assurance around effective antimicrobial stewardship. *Increased length of stay due to development of symptomatic C.difficile. *Increased risk of life threatening pseudomembranous colitis. *Lack of assurance of effective and consistent hand hygiene and compliance with hand hygiene policy.	IPC enteric precautions audit check if case identified Policy and Protocol for management of C.difficile and prevention of spread D&V rapid risk assessment tool All new cases reviewed by IPCT and ward staff advised on management Weekly review of inpatient C.difficile cases by IPCT C.difficile included in IPC and Trust dashboards Enteric precautions check list undertaken for any toxin attributable case Antimicrobial Stewardship training part of mandatory training Hydrogen peroxide fogging available for room / bay decontamination	Likely	High	20	Possible	High	15	Unlikely	Low	6	16/04/2018
3574	29/08/2017	Risk of patients radiotherapy planning, checking and treatment delivery is delayed due to performance of Mosaiq / raystation applications	Risk of patients radiotherapy planning, checking and treatment delivery is delayed due to performance of Mosaiq / raystation applications. Cause intermittent performance of applications possibly due to network performance over citrix between UHCW trust and WAHT. Effect - Patients may not receive optimal care so potentially delay to patients treatment Impact - Postpone apt start dates, poor patient experience, breach of national cancer waits guidelines, increase safety risk, staff morale and retention of staff, reputation of the organisation, Not delivering trust objectives	Allowing longer time for processes to be delivered	Almost certain	High	15	Almost certain	High	15	Rare	Very low	1	30/03/2018
3433	20/02/2017	Risk to patient safety as no nursing support for interventional cases on the	RISK: CAUSE: EFFECT: IMPACT:	insistence of nursing staff to accompany the patients and help monitor patient during the procedure IR Sedation Policy in place all sedation to be prescribed in advance by radiologist	Likely	Moderate	12	Likely	High	16	Unlikely	Low	4	06/04/2018

ID Link	Opened	Title	Description	Controls (Assurance)	Likelihood (initial)	Risk level (initial)	Rating (initial)	Likelihood (current)	Risk level (current)	Rating (current)	Likelihood (Target)	Risk level (Target)	Rating (Target)	Review date
			There is no departmental nurse for interventional radiology on the Alex site placing patients at risk as they cannot be properly monitored/sedated. The ATR's to appoint these have been rejected by the Trust.	appropriately trained HCP to prepare and administer sedation (usually radiographer										
3361	21/11/2016	Standards of care for patients in the SIAN area.	Risk: There is a risk of a poor patient experience and suboptimal care in the SIAN area Cause: This is caused by a corridor space being used for patient care. Effect: The effect is that patient privacy and dignity are compromised in a draughty area where skin checks cannot be made and pts own drugs are kept on the trolley Impact: The resulting impact is increased patient safety issue, increased likelihood of complaints and poor pt experience. Impact on standards relating to: oPatient Safety (Link to 2875) oConfidentiality oPrivacy & Dignity oInformation Governance oTimely assessment This risk includes all aspects that relate to the Senior Initial Assessment Nurse are of ED where patients are cohorted. It follows an internal inspection where the following issues were raised: Privacy and dignity is compromised Confidentiality/ IG compromised and the computer screen cannon be locked as it is in constant use Access to resus Patients own medications are kept with them on the trolley The area is cold and draughty Skin checks cannot be done in this area which means delays to skin mapping and on-going pressure area checks	Access to the department is now restricted via the ambulance doors which minimises the draught and contributes to maintaining privacy and dignity Portable screens are used to maintain privacy and dignity Patients with greater dignity needs are prioritised to move into other areas of the department Bloods trolley is kept clean and tidy with the sharps boxes kept on temporary closure and all items in packets in the drawers To purchase a flip screen to be placed over the computer whilst staff members are away from the desk Collaboration between the SIAN and HALO officer will enable careful placement of patients in the department Risk assessment to be undertaken by ED Pharmacy lead to determine the risk of patients keeping their own drugs with them on the trolley Vs them being kept in the clinical room Pressure ulcer prevention in ED is being re-considered in the Caring Safely group. To include a re-evaluation of documentation used and use of high spec mattresses Patients own medications are placed in a green pharmacy bag	Almost certain	Moderate	10	Almost certain	High	20	Almost certain	Moderate	10	18/04/2018
3481	20/04/2017	The Trust has insufficient capital fund to maintain	Risk There is a risk that the Trust has insufficient capital funding to maintain equipment and estate at the required level. Cause This is caused by a reduction in internally generated funds for capital investment. There is also a requirement to repay previous capital loans compounded by a lack of availability of national funding despite loan requests being made. Effect The effect is an inability to maintain the full range of equipment and estate to the required level at the appropriate times resulting in some schemes being deferred. Also, insufficient funding available to invest in strategic projects. Impact Increased patient safety risk Negative impact on the patient experience	Monthly reports to Finance and Performance Committee Capital Prioritization Group meets monthly to review situation Engagement with STP groups and submission of bids for STP capital Working with NHSI to secure PDC/ loan funding as swiftly as possible Submitting capital bids as appropriate opportunities arise Regular monthly monitoring of capital spend and commitments	Likely	High	16	Likely	High	16	Possible	Moderate	12	28/02/2018
2976	09/07/2015	There is a risk of reduced income from endoscopy & non compliance of standards due to failure to achieve JAG Accreditation	RISK - There is a risk of reduced income from endoscopy & non compliance of standards due to failure to achieve JAG Accreditation CAUSE - Physical environment is non-compliant with JAG Standards in order to improve patient flow and experience. Unable to meet national waiting time standards. New JAG standards from April 2017 are not being met EFFECT - Poor patient experience, delay in diagnosis, IMPACT - Financial impact of loss of best practice tariff, reduction in patient safety, Poor patient experience, loss of reputation		Likely	High	16	Likely	High	16	Rare	Very low	1	02/04/2018
3484	24/04/2017	There is a risk of sub optimal patient care in surge areas	RISK There is a risk that patients receive sub optimal care when being cared for in surge areas. CAUSE According to full hospital protocol, there will be additional areas used to support patient care. Without appropriate staffing, resource, risk assessment and escalation care could be compromised. EFFECT This could result in sub optimal care for patients with an increased patient safety risk Potential for delays and cancellation of treatment Potential omissions in care IMPACT Increased likelihood of patient harm	Plus one protocol and escalation process SOPs for the management of medicines SOPs for AEC and Medical Day Care SOP for use of Endoscopy as a surge area SOP to be followed when patient moved to a surge area	Almost certain	High	20	Likely	High	16	Possible	Moderate	12	09/03/2018

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			Poor patient experience Increased likelihood of complaints	SOP in place for the Staffing App Daily quality audits required in additional capacity areas Safer staffing analysis- managed in real time through the safe staffing App Individual patient risk assessments prior to patient being transferred to the ward Ward environmental risk assessments, including infection prevention and control										
3629	22/11/2017	There is a risk that breast imaging capacity will be lost	RISK: There is a risk that breast imaging capacity will be lost at the Alex site impacting on breast 2ww targets, breast screening performance standards and breast surgical cases. CAUSE: The mammography equipment is over the recommended age for replacement and is considered to be end of life by the supplier. There is likely to be significant downtime with this equipment. The footprint of new digital mammography equipment is too big to fit into the existing accommodation so replacement cannot be considered until new accommodation is found. EFFECT: Increasing downtime while the supplier sources replacement parts will impact on 2ww capacity, screening round length and cancellation of breast surgical cases. If the equipment is not repairable then there will be no breast imaging service on the Alex site. IMPACT: -Failure to meet breast 2ww targets. - Failure to meet screening kpi's - potential patient safety risks due to inadequate imaging for breast surgical specimens. - Poor patient experience - Damage to reputation	Mobile mammography unit sited at the Alex for short term Investigate alternative capacity on other sites Investigate options for new accommodation so that equipment can be replaced	Possible	Moderate	12	Almost certain	High	20	Unlikely	Low	4	16/03/2018
3635	30/11/2017	There is a risk that	RISK - There is a risk that endoscope decontamination machines at KTC are going to fail due to age and no longer compliant CAUSE - Equipment is old and outdated. Replacement parts now obsolete EFFECT - Will be unable to provide endoscopy services at KTC if system breaks down IMPACT - Damage to reputation of organisation. Detriment to patient and staff safety. Poor patient experience. Increased waiting list. Financial risk due to loss of income.	Service contract Move scopes to other sites for decontamination Relocate patients to other sites	Almost certain	High	15	Almost	High	15	Unlikely	Low	4	13/04/2018
3637	30/11/2017	There is a risk that inpatients	RISK - There is a risk that outlying inpatients cared for in Endoscopy recovery do not have adequate provision and staffing to provide safe care. CAUSE - lack of beds on the wards, increased demand in Emergency department. Due to winter pressures and closure of TAU, this may possibly be an reoccurring issue. Current vacancies in Endoscopy establishment causing staffing issues. EFFECT - Inpatient not receiving medication or medical review or nursing care in a timely manner, delays in running of endoscopy lists-not enough bed capacity, cancellation of elective endoscopy procedure, Staff staying late waiting for night staff cover, staff anxiety being asked to nurse acute admissions and not familiar with treatment pathways. IMPACT - Patient safety, reputation of the organisation, poor patient experience, low staff moral and staff sickness due to anxiety, financial loss due to cancelled elective procedures, breach of single sex accommodation	Source additional staff Delay elective procedures Immediate line managers supporting endoscopy staff addressing concerns and gaps in skills and knowledge Asked relatives to bring in patient's own medication	Likely	High	16	Likely	High	16	Likely	Moderate	12	30/03/2018
3522	26/06/2017	There is a risk that patient safety and performance may	Risk There is a risk that patient safety and performance against objectives may be adversely affected. Cause This is caused by weaknesses in Trust systems and processes that are unknown or undetected prior to an incident occurring. Effect The effect has potential for delays in, communication, diagnosis, treatment and follow up within an without of the organisation. Impact The impact is an increased patient safety issue, increased reputational risk, failure to meet objectives and likelihood of complaint/claim.	An external review commissioned of Trust systems Internal harm review conducted Internal audit review completed November 2017 draft report to go to committee Group to be established to progress actions Group established	Almost certain	High	20	Likely	High	16	Unlikely	Moderate	8	30/03/2018
3482	24/04/2017	There is a risk that patient safety, effectiveness and	RISK There is a risk that patient safety, effectiveness and management may be compromised in ED due to exit block. This is a continuation of the corporate risk 1941 which has been RED on the risk register 2010 which has hundreds of linked incidents/complaints and serious incidents related to the overcrowding of the ED. The ED has only 20 adult cubicles but often has over 30 patients waiting for hospital beds. This leads to over 20 patients waiting in the corridor and an inability to off load ambulances. Sick patient might no even have trolleys and have to stay in the waiting room. When the department is overwhelmed it leads to increased mortality and morbidity. Also it leads to difficulty in retaining staff due to an environment where one can not give the best care to patients. There is also a financial cost as patients spend so long in the ED they are never admitted. An estimation of £250 000 is lost every month on tariffs CAUSE This could be caused when patient clinical demand in ED department exceeds capacity; ED becomes overcrowded and overwhelmed due to long delays in patient flow to inpatient facilities admission leading to chronic overcrowding within the department	Escalation policy for when department reaches capacity Clinical teams escalate appropriately according to policy in order to manage patient care Safety briefings/handover Bed meetings Safer staffing app Escalation matrix as part of the full hospital protocol Trialling the bed meetings in the ED department.	Almost certain	High	20	Almost certain	High	20	Unlikely	Moderate	8	04/05/2018

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			overcrowding within the department. EFFECT Local and international evidence identifies that an overcrowded Emergency department leads to increased in length of stay, morbidity and mortality. Inability to offload from ambulances leading to delays in triage. Delay in diagnosis and treatment. Patient privacy and dignity is being affected as patients are managed in non-clinical areas such as corridors and an overriding negative impact on the patient experience. Staff working under extreme pressure and has a negative influence on morale. IMPACT Increased patient safety risk Increased likelihood of 4 and 12 hour breaches Reputation al damage Increased media attention Increased likelihood of incidents, complaints and litigation. Difficulty in recruitment and retaining staff. Poor patient experience	Plus one process now in place Professional standards agreed for all staff. Cultural change programme commenced, signature behaviours launched.										
2148	15/08/2011	There is a risk that patients may be harmed following a	RISK There is a risk patients may be harmed following a delay in diagnosis due to lack of appointment capacity within the Endoscopy service. CAUSE This is caused by an increase in the number of 2ww referrals leading to a lack of capacity. In addition there is an increase in demand for all procedures. EFFECT The Directorate cannot achieve the 2ww standard for Endoscopy within normal working hours. WLI are required to avoid delay in diagnosis and treatment and to achieve the 2ww standard. This has resulted in increased activity affecting surveillance patients, waiting times and JAG accreditation. NB: Change in JAG standard (the waiting times for 'urgent' patients has been reduced from 3-4weeks to 2weeks). 9/1/17 there are 2300 patients on the waiting list without a TCI date. 2ww, 31/62 day cancer pathway, routine diagnostic and surveillance waiting times. National waiting time standards are not being met. IMPACT Patients may be harmed due to delay Sub-optimal patient experience Delay in diagnosis Staff are covering weekend WLI lists in addition to normal working week leading to tiredness and possible	WLI introduced to address capacity on all 3 sites 3rd room at WRH commissioned - introduction of some lists, 26/06/15 environmental work completed. Nurse Endoscopist at WRH who undertakes additional lists and backfills when Consultant absent. 26/06/15 update - Nurse Endoscopist vacancy, out to advert. Weekly review of templates to ensure appointment slots are used appropriately Outsourcing to Southbank Private hospital to minimise risk of breach Outsourcing to Droitwich BMI Private hospital to minimise risk of breach QIA for endoscopy insource and outsource	Likely	High	16	Almost certain	High	20	Possible	Moderate	9	30/03/2018
3325	26/10/2016	There is a risk that stroke patients may not get timely assessment, diagnosis and	RISK There is a risk that stroke patients may not get timely assessment, diagnosis and treatment. CAUSE Not all patients are pre alerted to ED Not all potential stroke patients are screened using the established ROSIER score CT Scans are not always requested in a timely fashion Patients with non thrombolysable strokes are not immediately seen be the stroke service even within hours. Specialist stroke assessment is only available in working hours and 5 days a week Out of hours assessment is by non-specialist medical registrars. Most of whom have not had any specialist training in hyper acute stroke assessment and the use of thrombolysis. They have not received training on the support offered by the AG~WSS network Beds are not always available on Stroke or Hyper acute stroke unit TIA Clinics only available 5 days per week Use of assessment bay as surge capacity Lack of 7 day access to Allied Health Professionals No dedicated SALT input. Consequently patients may be fed enterally when they could be taking modified food. No dedicated psychology service Large number of non stroke patients occupying beds within the stroke unit either because of incorrect initial diagnosis or overall hospital bed management EFFECT They may not receive optimal care which may lead to long term disability and increased mortality. They may have increased length of stay They may have an increased risk of early complications Delays in diagnosis of Stroke Patients at risk of not being given Thrombolysis in a timely manner Higher risk of short term complications on non stroke wards Patients managed in a non-specialist environment High length of stay in acute stroke unit and fragmentation of ongoing care Patients develop a long term disability High mortality of acute stroke patients Lack of supporting information to GP's to provide ongoing continuity of care, possible increase in re-attendance as a consequence.	Stroke dashboard populated with validated information which aligns Trust performance with SSNAP Member of Avon/Glos Stroke network which provides out of hours Thrombolysis support All medical Regs offered training in administering Thrombolysis and can contact the network for out of hours support. All network consultants have remote access to PACS and CT scans. Patients undergoing Thrombolysis currently managed within ED resus area Patients brought by WMAS with an onset time are pre-alerted to ED Therapy outreach provided to outlying pts Clinical guideline on administration of Thrombolysis available New consultant clinical lead appointed June 2017 Expansion of CNS team (2WTE-6WTE) SOP developed Production of business case to expand MDT Collaborative working with Health Economy Partners	Likely	High	20	Likely	High	16	Unlikely	Low	6	31/03/2018

ID Link	Opened	Title	Description	Controls (Assurance)	Likelihood (initial)	Risk level (initial)	Rating (initial)	Likelihood (current)	Risk level (current)	Rating (current)	Likelihood (Target)	Risk level (Target)	Rating (Target)	Review date
			Lack of follow up letters impact on follow up clinics/consultant not aware of reason for attendance.	Executive agreement for use of HASU bed and assessment area agreed										
3485	24/04/2017	There is a risk that the Trust is unable to deliver safe and effective care due to nursing	RISK There is a risk that the Trust is unable to deliver safe and effective care due to the number of qualified nurse vacancies across the organisation CAUSE This is caused by the significant number of nursing vacancies are due to: 1. An increased number of nurses to patient ration following the implementation of the Shelford Nursing Tool 2. A national shortage of nurses due to the Government stopping the nursing bursaries 3. There is no longer funding from HEE to second existing staff within the Trust to commence nurse training 4. The Trust has been unable to utilise the apprenticeship levee to second Trust staff for training due to our University providers waiting to map the soon to be launched nurse education standards to the apprenticeship course 5. National data suggest that in the last 12 months an increasing number of nurses under the age of 40 are leaving the nursing profession due to the pressure of the role. Effect Potential impact on the delivery of safe and effective care We have nearly 250 qualified nurses who are 55 and over who could retire now There is a National shortage of nurses which is impacting on the Trust being able to close the vacancy gap in a timely manner. Due to the changes in funding for nurse training or seconding existing staff this is further impacting financially on the Trust's ability to close the workforce gap. Impact Poor staff morale Potential to see increased sickness within the workforce Staffing gaps could potentially impact on the delivery of safe and effective patient care There is also a financial impact on the development and implementation of new roles and supporting staff to commence nurse training to enable a sustained nursing workforce for the future 3. Ageing workforce which have arisen due to difficulty in recruiting and sustaining nursing posts despite a raft of initiatives being implemented EFFECT This has led to an increased reliance on locum and agency staff with difficulty releasing substantive staff for mandatory training. There is also an associated increase in sickness levels due to staff working additional hours leading to fatigue and increased stress levels IMPACT Patient safety and effectiveness of care will be compromised. Increased likelihood of incidents and complaints Reputational damage A negative financial impact associated with increased use of agency and locum staff	Workforce Strategy- underpinned by Recruitment and retention strategy for Nursing for the Trust Divisional retention and recruitment plans- Sub specialty specific plans for retention, recruitment and Agency/ Locum fill rate Divisional profile of medical and nursing staffing vacancies and workforce plans to provide required fill rate, with HR and Finance support. Trust Leadership Group which formally review critical gaps in staffing as a forward view to support timely management of temporary staffing, so that clear plans agreed regarding IR35 and requirements with Cap rate are considered alongside patient safety concerns. Electronic system in place to provide ward to board assurance on daily staffing levels, the safer staffing app The development and implementation of new roles to support the gaps in the nursing workforce, housekeepers, ward administrators, associate nurses, nursing associates Trust specific recruitment events held quarterly Attendance at regional and national recruitment events The Trust utilises our internal Bank and Agency staff to ensure that our patients receive safe and effective care Monthly nursing and midwifery and AHP meeting to develop and implant operational actions	Likely	High	16	Likely	High	16	Unlikely	Moderate	8	01/03/2018
3623	07/11/2017	There is a risk that we will be unable to provide portable x-rays at WRH	Risk - There is a risk that we will be unable to provide portable x-rays at WRH. Cause - Processors (CR35 and CR85) and CR readers are end of life and parts are not guaranteed to be available in the event of a breakdown. Siemens stopped supporting them in 2015 and Agfa are now working on 'best endeavours' for the CR35 and CR85. Effect - Inability to provide portable x-rays at WRH for our more vulnerable patients resulting in delay in diagnosis and treatment. Impact - This will result in inability to treat sick patients as they will not have a CXR to diagnose from. This increases risk of mortality. There will be a poor patient experience and increase in complaints. This would lead to damage of the Trusts reputation. Radiation doses are higher for CR portable x-rays versus DR portable x-rays	2 sets of equipment. Potential to cannibalise from old equipment. Newtown processor as last resort.	Possible	Low	6	Almost certain	High	15	Rare	Very low	1	30/03/2018
3618	02/11/2017	There is a risk to patient safety and experience due to the change in focus of the patient group and the corresponding nursing s	There is a risk to patient safety and experience due to the change in focus of the patient group and the corresponding nursing speciality competencies. Cause- Change of directorate/ speciality from frailty to oncology. Effect- Staff now require up skilling and oncology competencies. Impact- Patient care and safety- Delayed care due to staff needing extra support from specialist nurses- Staff may become anxious about their competence.	New link nurse roles. Support from specialist nurses. Staff booked on training . Specialist nurses providing 1:1 training in real time on the ward	Almost certain	High	15	Almost certain	High	15	Rare	Very low	1	30/03/2018
2591	22/11/2013	Uncompleted EDS's may lead to poor handover to GPs on	Risk Follow-up treatment and understanding of reason for admission may be compromised if patients are discharged without a completed EDS Cause Pressure to discharge patients to stimulate flow EDS's left until completion of ward rounds (cultural)	Datix monitoring and response (internal) Trust representative at PFC weekly meeting for discharge issues (with feedback loop to learn from issues and improve practice)	Possible	Moderate	9	Almost certain	High	20	Rare	Very low	3	28/02/2018

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			Medically fit patients with incomplete EDS discharged out of hours as a response to required capacity to create flow and keep site safe out of hours Effect Potential patient harm if continuity of care is compromised Potential increase in re-admission rates Reputational issue for Acute Trust (Unsafe discharges)	Agree and implement internal professional standards Design and agree discharge process (to include agreed risk assessment and required follow up actions if patients are discharged without an EDS										
3646	15/12/2017	Failure to improve the supporting processes, training, systems and reporting for managing RTT and NON RTT pathways	There is a risk that patients will not receive timely treatment if they are on the wrong waiting list or may not receive any treatment if they are not visible on any waiting list. This is caused by poor processes surrounding operational waiting list management, inconsistent data capture, lack of user knowledge and application of the RTT/NON RTT rules, limited validation in the Patient Administration system and untrusted reporting. This will result in patients not being treated/followed up within national standards, sustained data quality issues that result in expensive Programmes of data cleansing and incorrect externally reported waiting lists. The impact is the potential of significant harm for patients and reputational damage to the Trust.	There is a substantive Validation Team whom delivers data quality and audit functions on the Incomplete waiting list. However, maintenance of this process is impractical across all waiting lists due to the volume and breadth of the data quality issues. Project group in place to the end of March/April 2018 Issues Log for ICT, Processes, Data Quality, Training and Information/Reporting Audit system developed to monitor Non RTT/RTT pathways Data Quality Staff in post within the Information department Reporting Suite to be developed for all pathways	Possible	Moderate	12	Possible	Moderate	12	Unlikely	Low	6	30/03/2018
2873	30/04/2015	If staff do not receive appropriate safeguarding training there is a risk that patients at risk of harm may not be identified	Risk There is a risk that if staff do not complete appropriate training there is a risk that patients at risk of harm may not be identified. Cause In 2015 the Trust experienced a delay in utilising and embedding the Intercollegiate document (2014)requirements. This resulted in the need for a staff eligibility matrix to be developed and a renewal of the training provision. Effect The Trust was not meeting the required guidelines for training Staff were not always able to recognise and respond to safeguarding issues. There was a shortfall in appropriate training by level with an associated risk to patients. Impact The Trust was in breach of section 11 of the Children's Act 2014 and at risk of not meeting the requirements of the Care Act 20016 for Adults. Increased patient safety risk Poor patient/carer experience Increased risk of complaints with associated reputational damage and media interest. Potential financial implications. Previous notes As a result of staff not completing safeguarding training at a level appropriate to their role (as per Intercollegiate Document 2014 & WSAB competence Framework), opportunities to identify patients at risk of harm will be missed. This could result in adverse events and associated complaints, legal & regulatory issues, financial penalties, and reputation damage.	Training sessions set up to meet demand for whole workforce to level 2 Children's safeguarding of NHS requirements Performance monitored in Mandatory Training section of Trust Performance Dashboard Level 1 classroom training sessions being delivered Trust wide on a monthly basis by Associate Nurse / Lead Nurse Safeguarding booklet provided in locum packs Level 5 training completed by Safeguarding Lead Level 4 training in place for named staff Level 3 training in place for Children's as a taught face to face session Level 2 elearning training in place as provided by NHSE Level 1 provided at Induction ands via pay slips leaflet in August 2017	Likely	High	16	Possible	Moderate	12	Unlikely	Moderate	8	01/03/2018
2980	09/07/2015	If the Trust does not implement a single unified electronic maternity information system patient safety & income will be advert	Risk : If the Trust does not implement a single unified electronic maternity information system patient safety and income will be adversely affected and there will be a delay in progressing to the LMS which is a key part of the Sustainability and Transformation Plan. Cause : The K2 Guardian system has been implemented for intrapartum care, but an electronic solution to cover all aspects of maternity care, including community services, has not been found. In part this is due to issues with the chosen supplier, and in part due to a lack of capital. External funding has been sought as part of the Local Maternity Strategy, but if this is not forthcoming there are no other sources of capital available. Impact : Staff continue to use a mixture of paper and electronic notes, as well as the hand held patient record kept by the mothers. Data collection for antenatal and post natal care is not done electronically, leading to potential loss of income. A full set of clinical records is not available in a single place, leading to patient safety concerns if key information is overlooked. Paper notes are eventually scanned to EZNotes, but only after significant delays, and with costs incurred Effect : Inefficient systems leading to duplication of workload, risk of clinical incidents and complaints, and loss of income	Nov 2015 Band 6 midwife identified to take over from project midwife when she leaves end of December 2015. Handover underway. Documentation audits monthly of K2 system Post natal purple notes are returned to the acute trust following discharge by community midwife. These are then scanned and uploaded to EZNotes All medical and maternity staff are aware of the need to access multiple sources of clinical information	Almost certain	High	15	Likely	Moderate	12	Unlikely	Very low	2	02/04/2018
2957	17/10/2017	Risk of HCAI due to inadequate or ineffective performance and quality of cleaning in clinical areas	Risk of HCAI due to inadequate or ineffective performance and quality of cleaning in clinical areas Cause This is caused by inadequate staffing and training at the WRH site. Inadequate checking/supervisory/management overview Effect	Nursing quality audits x 3 days a week by Matrons Hand hygiene audit programme in place	Likely	High	16	Possible	Moderate	12	Unlikely	Moderate	8	14/03/2018

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			Increased patient safety risk due to inadequate cleaning Impact Poor patient experience Increased likelihood of complaints Reputational damage	Housekeeping cleanliness audits in place monthly (and weekly for high risk areas) all sites IPC Team audits include environmental cleanliness element										
3518	16/06/2017	Risk of preventable permanent visual loss to patients presenting with giant cell arteritis	Patients with symptoms of giant cell arteritis require emergency / urgent corticosteroid therapy to prevent evolution of ischaemic complications, most notably blindness. Delay in recognition, treatment and access to diagnostic tests has lead to several poor patient outcomes, including SIs. The risk relates to work carried out in ED, MAU, AEC, SCSD, medicine and surgery plus across Trust sites and requires an integrated approach to mitigate	A Trust-wide pathway for the management of people with suspected GCA	Likely	High	16	Possible	Moderate	12	Rare	Low	4	09/07/2018

Worcestershire Acute Hospitals NHS Trust

Date of meeting	15 March 2018
Paper number	G2

Standing Financial Instructions (SFIs) and Scheme of Delegation

For approval:	✓	For assurance:		To note:	

Accountable Director	Jill Robinson, Chief Finance Officer		
Presented by	Jill Robinson, Chief Finance Officer	**Author**	Katie Osmond, Assistant Director of Finance Lynne Walden, Head of Financial Planning & Financial Services

Alignment to the Trust's strategic priorities					
Deliver safe, high quality, compassionate patient care		Design healthcare around the needs of our patients, with our partners		Invest and realise the full potential of our staff to provide compassionate and personalised care	
Ensure the Trust is financially viable and makes the best use of resources for our patients	✓	Develop and sustain our business			

Alignment to the Single Oversight Framework					
Leadership and Improvement Capability		Operational Performance		Quality of Care	
Finance and use of resources	✓	Strategic Change		Stakeholders	

Report previously reviewed by		
Committee/Group	Date	Outcome
FPC	26th February 2018	Recommend for Approval

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	N	BAF number(s)	

Level of assurance and trend			
		√	↑ ↓ →
	Significant		
	Moderate		
	Limited		
	None		
	Not applicable	√	

Recommendations	The Board are asked to: • Approve the Standing Financial Instructions and Scheme of Delegation for implementation effective 1st April 2018 • Note the proposed roll out process as part of the 2018/19 budget sign off process.

NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	15 March 2018
Paper number	G2

Executive Summary

The purpose of this paper is to seek approval of the Board for the revised Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD).

Once approved, the documents will be relaunched within the Organisation, with a mandated sign up process for Budget Holders/Budget Managers.

Background

NHS Trusts are required by law to make Standing Orders (SOs), which regulate the way in which the proceedings and business of the Trust will be conducted. The supporting Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD) identify who in the Trust is authorised to do what.

Standing Financial Instructions (SFIs) are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They identify the financial responsibilities that apply to everyone working for the Trust. The Scheme of Delegation (SoD) describes the powers which the Board reserves to itself and those which are delegated to officers.

The SFIs and SoD were last reviewed in August 2017 and were agreed subject to some minor requested changes.

Issues and options

During February 2018, in light of the Trust's financial position, and the Grip and Control work, a full review and refresh of these documents has been undertaken, including:

- Benchmarking the SFIs and SoD to another NHS Trust, seen as a best practice example;
- A key Stakeholder review of the documents, including all Finance & Performance Committee members, Chair of the Audit & Assurance Committee, Executive Directors and other key stakeholders.

At the February Finance and Performance Committee, the Committee recommended that the Board receive the updated documents for approval, following the conclusion of the key stakeholder review.

The Board is responsible for giving final approval to updated versions of the Standing Financial Instructions and Scheme of Delegation.

Subject to agreement by the Board, these will be issued to all Budget Managers and Budget Holders as part of the budget sign off process for 2018/19. All Budget Managers and Budget Holders will be required to sign for receipt, and acknowledge their responsibilities to adhere to them.

The communications team are providing support to make the core principles of these documents more readily accessible to staff.

Worcestershire Acute Hospitals NHS Trust

Date of meeting	15 March 2018
Paper number	G2

Recommendations
The Board are asked to: • Approve the Standing Financial Instructions and Scheme of Delegation for implementation effective 1st April 2018 • Note the proposed roll out process as part of the 2018/19 budget sign off process.
Appendices

App1: Standing Financial Instructions
App 2: Scheme of Delegation

NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	15 March 2018
Paper number	G3

Audit and Assurance Committee Assurance Report

For approval:		For assurance:	x	To note:	

Accountable Director	Steve Williams Audit and Assurance Committee Chairman		
Presented by	Steve Williams Audit and Assurance Committee Chairman	**Author**	Kimara Sharpe Company Secretary

Alignment to the Trust's strategic priorities					
Deliver safe, high quality, compassionate patient care	x	Design healthcare around the needs of our patients, with our partners		Invest and realise the full potential of our staff to provide compassionate and personalised care	
Ensure the Trust is financially viable and makes the best use of resources for our patients	x	Develop and sustain our business			

Alignment to the Single Oversight Framework					
Leadership and Improvement Capability		Operational Performance		Quality of Care	
Finance and use of resources	x	Strategic Change		Stakeholders	

Report previously reviewed by		
Committee/Group	Date	Outcome
Not applicable		

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	Y	BAF number(s)	All

Level of assurance and trend			
		√	↑ ↓ →
	Significant		
	Limited	√	
	None		
	Not applicable		

Recommendations	The Trust Board is requested to note the report for assurance.

Date of meeting	15 March 2018
Paper number	G3

Executive Summary

The Committee at its meeting on the 20 February, discussed the following items:

- **External audit progress report**: The Lead Partner reported that the initial scoping audit had been undertaken and there were no major issues identified. The joint seminar held with Finance staff was appreciated.
- **Internal audit progress report**: Progress is slightly behind plan due to the late agreement of the plan. The plan will be finished in time to be included within the Head of Internal Audit opinion for the Annual Report. A new process for chasing outstanding actions has been implemented and it is expected that these numbers will come down. Cybersecurity will form part of the audit programme for 2018/19.
    - RTT (data quality): the Head of Clinical Performance and Patient Access attended the meeting to give an up to date position statement and she outlined the work she has undertaken. There has been extensive training and revision of the forms. Assurance was gained from the presentation. It was agreed that a follow up audit would be undertaken in the first quarter of 2018/19.
    - Delayed discharges and delayed transfers of care: The Deputy Chief Operating Officer (COO) reported that considerable work has been undertaken since the audit was undertaken (December 2016/January 2017). Weekly multi-organisational meetings take place which has helped the understanding of the challenges. She outlined the support she has in place to improve the adherence to the red-green systems which includes a seconded experienced COO from NHSI. The discharge planning policy is about to be approved. She also outlined the clinical engagement she has in place. Stranded patient reviews now take place on each site and is overseen by the A&E delivery board. She was content that the processes were in place but further clinical engagement was required. The timing of the follow up audit would be discussed further.
    - Complaints follow up: This audit remains as limited assurance. The audit reviewed the use of Datix which was not being used as the policy requires. A further meeting will be taken forward to determine the blocks to the use of the policy and to consider changes to the policy and /or procedures. This will be initiated by Internal Audit. The report has been circulated to QGC members for information.
    - Off payroll and IR35: Full assurance was given for this audit.
    - Medical revalidation: The review shows that progress has been made. However some job plans are outstanding but this is under control within the HR department.
    - Mandatory training: Moderate assurance was given. Two high level recommendations were made in respect of alerts and trajectories. These have now been addressed.
    - Risk assessment of clinical information systems: This risk assessment was initiated following the GP letters incident. The review focussed on seven main clinical systems. The Head of internal Audit reported that he was concerned about the lack of viewing and action of abnormal test results and the IT performance of Mosaiq, the oncology IT system. It was noted that while there were some IT issues, a large component of the weaknesses raised is the lack of consistent use of the systems by trust staff with some notable pockets of resistance. The Director of Asset Management has developed an action plan to address the concerns raised. The progress will be tracked by TLG. The mechanism for wider board assurance will be picked up by the Director of Finance and Chief Executive.
- **Anti-fraud**: There are currently six open referrals. These are being progressed by the Anti-Fraud officer. Two have been closed since the last meeting. The Officer also presented a self-assessment against national fraud standards for procurement. There are 33 expected controls and nine were raised as possible areas of review with some recommendations as to how internal control can improve the systems and processes. A management response will be developed.
- **Security report**: Significant assurance was given with this report.

Date of meeting	15 March 2018
Paper number	G3

- **BAF**: the Interim Director of Governance presented the report and she highlighted the changes made which were agreed at the previous Board meeting.
- **Self-Assessment**: The Committee will undertake a self –assessment of its effectiveness and report to the next meeting the results.

Background

The Audit and Assurance Committee has been established to critically review the governance and assurance processes upon which the Trust Board places reliance, ensuring that the organisation operates effectively and meets its strategic objectives. Membership is three non-executive directors.

Issues and options

The Audit and Assurance Committee members have identified a theme relating to the use of Datix as a reporting tool. This will be taken forward by the Director of Finance through the Trust Leadership Group.

Recommendations

The Trust Board is requested to note the report for assurance