The Royal Wolverhampton Hospitals NHS Trust

Trust Board Report

Meeting Date:	26th March 2012
Title:	Board Assurance Framework / Trust Risk Register
Executive Summary:	
Action Requested:	To inform the Board of updates to the Board Assurance Framework (AF) and Trust Risk Register.
Report of:	Chief Nursing Officer
Author: **Contact Details:**	Governance IM&T Lead Tel: 01902 695114 Email:
Resource Implications:	None identified
Public or Private: **(with reasons if private)**	Public Session
References: **(eg from/to other committees)**	
Appendices/ **References/** **Background Reading**	
NHS Constitution: **(How it impacts on any decision-making)**	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: - Equality of treatment and access to services - High standards of excellence and professionalism - Service user preferences - Cross community working - Best Value - Accountability through local influence and scrutiny

Background Details

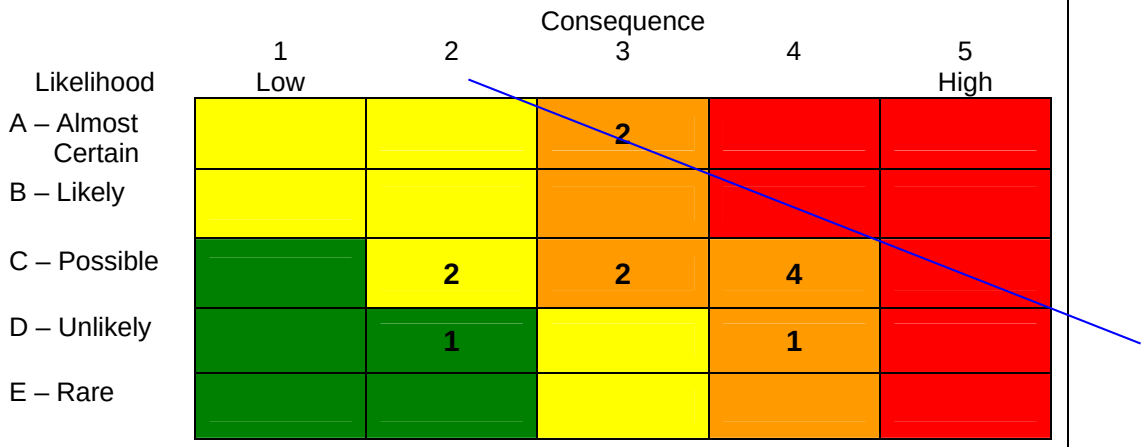
The Board Assurance Framework "provides organisations with a simple but comprehensive method for the effective and focused management of the principal risks that arise in meeting their objectives. It also provides a structure for the evidence to support the Statement on Internal Control" (Integrated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

Board Assurance Framework – Updates (Appendix A)

Following updates the split of the Assurance Framework is:

Risks currently being managed (ongoing)	10
Risks managed to target level	2

There are currently 12 risks contained within the Assurance Framework which are distributed across the Trust categorisation matrix as below:



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

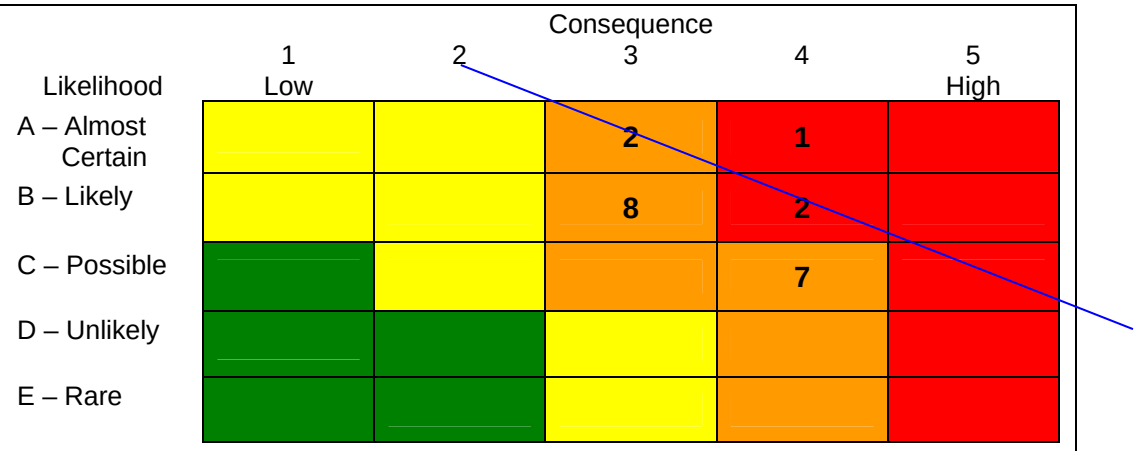
*****No current red risks on the Board Assurance Framework*****

Trust Risk Register – Updates (Appendix B)

Following updates the split of the Trust Risk Register is:

Risks currently being managed (ongoing)	20
Risks managed to target level	0

There are currently 20 risks contained within the Trust Register which are distributed across the Trust's categorisation matrix as below:



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

	ID	Risk Title	Lead
RED	514	Failure to deliver recurrent efficiency gains and CIPs.	FD
	1739	Failure to develop Service Line Reporting.	FD
	2761	Lack of LSMS support for TCS transferred community services.	COO

Recommendation(s)

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

Appendix A: Tracking changes within Board Assurance Framework (March 2012)

Lead Director	Risk	Risk Title	Update	Reasoning / Progress Against Actions
Chief Nursing Officer	1717	Failure to maintain re-registration by the CQC periodic review..	Positive Assurances updated	CQC registration without conditions - Apr 2011
	2482	Failure to learn from national / local organisations experience e.g. Francis report.	Action plan updated.	Sustainability plan in draft format for review at Compliance Committee. Monitor complaints , claims and incidents through I.C,C commencing March 2012
Finance Director	2807	Delivery of the CRL for 2011/12 Capital Programme	Positive controls updated.	Current estimate of likely outurn is £18.5m. Risk accepted by TMT and TB as consequence of late start to Pathology contract.
Chief Executive	1501	Foundation Trust Application Process	Positive Assurances updated. Residual Grade now B2 Yellow.	CQC full compliance following re-inspection

Appendix B: Tracking changes within Trust Risk Register (March 2012).

Lead Director	Risk	Risk Title	Update	Reasoning / Progress Against Actions
Chief Operating Officer	1713	Failure to effectively maximise workforce productivity.	Positive controls updated.	Job Plan audit developed.
	1714	Failure of other agencies to support discharge process.	Gaps in Assurance updated.	Patients with excessive length of stay - February 2012.
	1716	Failure to achieve targets in accordance with the operating framework (waiting times, CQC etc.)	Positive controls, Positive and Gaps in Assurances updated.	Continue weekly meetings with Divisions and weekly monitoring of waiting times. TAL performance maintained, continue to monitor daily. Early warning of potential to fail Three A&E KPI's are above target – February 2012 Excessive breaches in A&E Standards – February 2012.
	2492	Failure to ensure that inpatient, outpatient, day case and theatre capacity meets demand.	Gaps in Assurance updated.	Extra capacity being opened on an ad hoc basis – February 2012
	2791	Lack of LSMS support for TCS transferred community services.	**Current grade now B4 Red.**	
	2891	Loss of GP Direct Access Work	***New Risk**	Networking groups of pathology services in the SHA Central and West region are highly likely to be centralised. Current proposals suggest two hub pathology sites within the region (awaiting agreement). There is a risk of losing GP direct access work if RWHT is not selected as a pathology hub. This potential activity reduction will lead to loss of income and overcapacity of pathology services on site.
	2893	Failure to be selected as a hub site.	***New Risk**	Networking groups of pathology services in the SHA Central and West region are highly likely to be centralised. Current proposals (awaiting agreement) suggest two hub pathology sites within the region (with or without direct access work). There is a risk that commissioners do not decide

				to make RWHT a pathology hub. This potential activity reduction will lead to loss of income and overcapacity of pathology services on site. There would also be potentially significant impact on staffing structure.
Medical Director	2572	Information Governance training risk	Gaps in Assurance and Action Plan updated.	Compliance dropped from 94% Oct 2011, 93% Nov 2011, 92% Dec 2011, 91% Jan 2012, 89% Feb 2012, on 07.03.12 score was 93%. Weekly reports from Education and Training to manage compliance in Feb and March 2012. Weekly AUB sent out to all staff to publicise training and Trust need for 95% compliance. Managers have regularly been given lists of staff members who are required to undertake IG Training.
Chief Nursing Officer	535	Failure to achieve reductions in HAIs impacting on Trust's reputation and compliance to regulatory standards.	Positive controls and Action Plan updated.	Appointed Data Analyst for IPT - March 2012. Exercise the effectiveness of revised IP team structure supporting the divisions. Develop a business case for centralised intravenous team to reduce DRHAB.
	2448	Failure to have effective systems in place for patients with learning disabilities or requiring application of Mental Capacity Act.	Positive and Gaps in Assurances updated.	Specific aspects of WMQRS Peer review care of vulnerable adults in hospital - Jan 2012.
Director of HR	2474	Requirement to protect Consultant teaching time relating to undergraduate medical students	**Risk taken off Trust Risk Register due to current grade being D4 Amber.**	
Finance Director	2570	Inadequate estates as part of the Transfer of Community Services.	Positive controls updated.	Negotiations continuing re potential properties to transfer. Date for transfer now delayed due to DH.
	2782	Capital Resource limit achievement at risk.	***Risk Closed***	Part of Board Assurance Framework.

The Royal Wolverhampton Hospitals NHS Trust

Board Assurance Framework

March-2012

A1	A2	A3	A4	A5
B1	B2	B3	B4	B5
C1	C2	C3	C4	C5
D1	D2	D3	D4	D5
E1	E2	E3	E4	E5

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Risk Lead	ID	Principal Risk		Controls	Positive Assurances	Gaps in Assurance/Control	Action Plan that addresses Gaps in Control		Residual Risk Level		
Risks Currently Being Managed											
Trust Objective:		**To provide our patients & staff with a safe environment.**									
Chief Nursing Officer	O7 2449	Inadequate and ineffective systems to Safeguard Vulnerable adults.	C4 AMBER	First phase of "Creating best practice wards" using a rapid improvement approach across a number of other safety work streams Database of referrals maintained through Safeguarding Lead. Deputy Chief Nurse Safeguarding Lead for newly formed acute and community organisation Internal audit through RSM Tenon to support improvement in processes Revised safeguarding policy and framework for safeguarding training Analysis of safeguarding allegations supporting improvements in: *Discharge planning / *Pressure ulcer prevention Developed and agreed key performance indicators for safeguarding adults in place	Specific aspects of Internal audit review - Jan 2012 Decrease in safeguarding allegations since June/July 2011. Audits against improvements in discharge planning and pressure ulcer prevention - Feb 2012 Progress against best standards in "creating best practice" wards	Specific aspects of Internal audit review - Jan 2012 Safeguarding allegations substantiated - since June 2011 Complaints upheld - since June 2011	Continue to implement "creating best practice wards" and plan further role out across other wards Analysis of workforce review of nursing and midwifery. Continue to share lessons learnt via the JHSVA Committee throughout the organisation - ongoing	Feb-12 Mar-12	D3 YELLOW	Mar-12	Yes

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcome 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Nursing Officer	O16 2482	Failure to learn from national / local organisations experience e.g. Francis report.	D4 AMBER	Governance unit reviewed external reports of other organisations learning and cross referenced to local actions.	CQC registration without conditions (General and Mental Health) - Feb 2012		Monitor complaints , claims and incidents through I.C,C commencing March 2012 Sustainability plan in draft format for review at Compliance Committee	 Apr-12	E2 GREEN	Mar-12	Yes

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcome 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Trust Objective:		**To be the employer of choice.**								

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcome 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Director of Human Resources	2831	Loss of critical services due to industrial action of staff	C4 AMBER	Ongoing arrangements are in place for the Trust to be linked to local, regional and national intelligence to inform contingency planning. Silver Command Operating procedure for IA in place. Agreement with Unions re Exemptions reached. Communications Plan developed and in place Ongoing regular updates on workforce analysis of Union membership within Trust; Monitoring of Workforce plans Review of 'lessons learnt' has taken place, formal report to go the EPC and TMT Jan 2012. Incorporated a more detailed section for the Loss of Staff in the Trust Business Continuity Strategy, which also identifies critical and non critical services and reference is made to the various employment policies. Discussions taken place with staff agenices to clarify the availability of agency staff in the situation of industrial action. Agreed legal principles and duties in respect of industrial action enabling Trust to ensure that obligations are met by Trade Unions, employees and the Organisation.	Industrial Action occured on 30/11/11. Sitrep reporting on state of hospital submitted to SHA/GP clusters for assurance. 17% of staff striked.		Await National Outcome of further discussions re Public Sector Pensions	C3 AMBER	Mar-12	

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcome 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
				Contingency Planning Awareness Sessions to Managers / Heads of departments across the Trust completed. Skills / competencies of available staff i.e. assessing workforce capacity completed. Staff skills audit re-evaluated with the integration of community services and an understanding of our medical staff / Consultant progammed activities. Operation planning meeting takes place every week to discuss and agree plans that need to be taken in preparedness for industrial action. Review undertaken in relation to the Trust's critical and non critical services across the Trust including the community provider services in the event of IA. Action completed in relation to identify the impact on staff and local staffing plans. Management Guidance has been produced. Silver Command to be instigated from 10pm on 29/11/11. HR established a creche facility for staff requiring support in relation to child care arrangements.					

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcome 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
				Training sessions have been established to offer ward and porter training to staff and volunteers.							
Trust Objective:		**To achieve a balance between demand & capacity of services**									
Director of Planning and	O6 2699	Not realising the benefits with the integration of the two organisations. Impact of movement to GP Consortia Commissioning - included in Risk 2508.	C4 AMBER	Development of a Benefits Realisation Plan. Action Plan - Apr-11 Re-launch of process to generate ideas and capture work in progress Share success, ideas and tools through a microsite on the intranet - Monthly Change Programme Board established Jan 2012 TCS Steering Committee established - Jul-11 Programme reviewed and project tracker now introduced showing 6 month work programme - Sep-11 Report to Trust Board in Jul 2011 to update on progress and outline projects - Oct-11 TMT approved revised Programme Management arrangements. Aligns Benefits Realisation and Cost Improvement Programme - Nov 11 Exec lead identified - Apr-11	Presentations and project proposals have now been delivered for the Integrated Patient Flow Team, Revised Children's Urgent Care pathway and the Integration of Procurement teams.		Reviewing potential monitoring tool to improve access to information and performance management	Feb-12	C4 AMBER	Feb-12	Yes

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcome 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	O16 2765	High levels of sickness and maternity leave affecting Health Visiting capacity within Bilston team.	C3 AMBER	Accommodation alternatives are still being sourced There is a city wide work plan in place to support the Bilston Team, with some routine work being delivered by other teams across the city. Routine clinics are being covered via a city wide rota. One GPs practice caseload is being covered by a neighbouring team. Saturday morning clinics have been set up and devoted to outstanding 2 year developments for the Bilston Team. Management staff have been moved into the base to do clinical work There is an individual action plan for the Bilston team now in place. The Health Visiting service has been reconfigured across the whole of the city and staff have been moved and allocated new caseloads. Health Visitor on phased return to work will manage in coming post and assess records as capacity allows prior to transferring to school health. Accommodate teams within local Children's Centres Review & reconfiguration of caseloads to support vulnerable families. Phased return to work for 3wte planned	The backlog of outstanding work is decreasing The daily workload is being managed and dealt with. Daily attendance with direct supervision and support from senior health visiting co-ordinator. The co-ordinator will make daily checks against the actions within the interim work plan and ensure that the named health visitors are fulfilling their responsibilities. Health visiting co-ordinators to escalate any concerns to the Children's senior management team. Weekly meeting between health visiting co-ordinator and Children's management team in place to monitor and assure. Interim work plan has been developed and agreed inclusively with the Bilston Health Visiting team. Improved staff morale Reduced backlog of developmental assessments Work and team more organised Team have greater control and confidence in work schedule and priorities	Routine and universal work for this team is being supported city wide using the vacant caseload policy. Recently recruited staff member retracted acceptance offer Other caseload and student pressure and the resignation of HV staff across the city prevented part-time HV from commencing on 03/02/10 Potential solutions are hampered by further sickness absence.	External review of service (delayed due to service reorganisation). Report expected by the end of February 2012. Trained one Clinical Practice Teacher in September 2011, two to be trained in January 2012, with a further two planned for September 2012. Accept as many HV students as possible to manage over the next 12 months. Recruitment for new health visiting staff is ongoing. To review more appropriate accommodation to accommodate the larger HV workforce To prepare Bilston team as a suitable area to take Health Visitor Students Continue to seek more appropriate accommodation for team On-going recruitment of HV staff Recommencement of Saturday development clinics Close monitoring of caseload and team by HV co-ordinator Interim work plan under regular review and will be extended until medium term plan is enacted - ongoing. To continue to manage return to work processes aligned to the presentation of this risk - ongoing.	Feb-12 Sep-12 Jan-12 Apr-12 Sep-12	C2 YELLOW	Mar-12	

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcome 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
				0.7wte interim support identified from other location Non- essential visits postponed IPM or Digital pens data to be inputted within 5 working days. Identify any outstanding training. Group supervision may be beneficial to team in addition to 1-1 supervision. Move from corporate caseloads into identified named caseloads. All children transferring into the area to be reviewed and actioned. All primaries will be managed city wide on a Rota basis. Health Visitor making primary contact will remain responsible for the child for 6-8 weeks. Due to continued capacity issues development checks will be managed as indicated on vacant caseload policy. Nursery Nurse will offer support to the team on Friday's to complete development checks. Resident Health visitors to manage their own and vacant caseload child protection and safeguarding children	Team more confident in ability to manage workload					

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcome 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
				Retained 4 out of 5 wte Health Visitors across the teams. This has enabled other teams to support Bilston in areas such as clinic cover. Increased managerial support to re-audit and re-prioritize caseload has resulted in a more manageable workload Provision of additional clerical support to provide non-clinical support to HVs Reorganisation of city-wide staffing Return to full duties by staff member following long term sickness absence Robust sickness absence monitoring and management of staff by HV Co-ordinators Recruitment of HV staff continues - 1.4 WTE experienced HVs to commence in January 2012. Additional Saturday morning clinics commenced to increase capacity and to address the back-log of 9 month and 2 year developmental assessment Detailed caseload analysis undertaken by the clinical team to determine key issues					

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcome 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

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				Two band 7 HV Co-ordinators moved to the Bilston team to facilitate and support the change process and clinically support the unexpected sickness absence of new team members From 3rd October 2011, city-wide staff reorganisation; new team WTE requirements based upon public health indices of deprivation, caseload analysis, children subject to safeguarding plans, GP numbers All general clinics being managed by additional Health Visitors from neighbouring team due to further short term sickness absence					
Trust Objective:		**To progressively improve the image and perception of the Trust**								
Chief Executive Officer	O1 1733	Sustained critical press coverage leading to reduction of public confidence in services.	C2 YELLOW	Communication Strategy & Policy Proactive press releases 'Setting the Record Straight' in place Communications Manager in post Regular update and monitoring to TMT/TB - Monthly Trust Board meetings are open to the public - Monthly	Trend continues with considerably more positive (plus neutral) coverage than negative. 71% positive and neutral and 29% negative coverage January coverage shows more positive (plus neutral) coverage than negative. 96% positive and neutral and 4% negative. Positive coveragefor Infection Prevention Clinical Performance against National Targets	Occassional negative coverage.		D2 GREEN	Feb-12	Yes

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcome 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Trust Objective:	**Deliver services within financial allocations**										
Director of Planning and	O6 2508	Commissioning responsibility changes - affects contracted income	A3 AMBER	Review 'NHS Bill'; Operating framework and PbR tariffs for 2012/13 - Dec-11 Negotiation with Commissioners at LDP meetings; focus on CCGs (on-going) Internal RWHT Contract Review/LDP meetings. (Senior managers /Directors to agree and implement negotiations strategy (on-going)	Action Plan in place - monitored Formal LDP meetings every 2 weeks with action notes Meetings every 2 weeks with action notes		Director level engagement with the PCT and PCT Clusters - meeting arranged - on-going Target CCGs as they develop; and develop links with Clusters - on-going Review current and future contract Portfolios. Include potentially new configured Trust services in all assessment/reviews. Revise Communication Strategy to reflect commissioning changes.	 Mar-12	C4 AMBER	Feb-12	Yes
Director of Finance & Information	2807	Failure to deliver the agreed Capital Resource Limit (CRL) for 2011/12 Capital Programme due to delay in start on site date for Pathology Project.	A3 AMBER	Monthly monitoring and reporting to CRG, TMT and Trust Board CRL being actively managed whilst ensuring all projects in programme provide Value for Money. Current estimate of likely outturn is c£18.5m. Risk accepted by TMT and TB as consequence of late start to Pathology contract.	Capital Review Group		Monitor spend against revised Plan	Mar-12	D1 GREEN	Mar-12	
Trust Objective:	**To be a high quality educator**										
Director of Human Resources	2626	Implications of Government White Paper "Liberating the NHS" on the provision of educational funding levies and that NHS organisations will become responsible for the funding of education and training for their own staff.	C4 AMBER	Representation on any appropriate workstreams Liaison with LETBs and LETCs as they are developed	Review at E&T Committee HR Sub Reports	Lack of direction from DOH	Develop Liaison with LETB/LETC Review implications at HR Sub Group	Oct-12 Oct-12	C3 AMBER	Mar-12	

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcome 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

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Trust Objective:	**To achieve Foundation Trust status**									
Chief Executive Officer	O16 1501	The Trust does not meet the DH / Monitor requirements to become a foundation trust.	C3 AMBER	Continue to work with CQC and other bodies to understand the Trust's mortality figures - ongoing Process for review and comments on documentation via Steering and Trust Board - ongoing Programme for Communication with staff, patients and public - ongoing SHA performance monitoring and self-certification process - monthly Detailed minutes and action notes - ongoing monthly Board development programme - monthly Review of Monitor's Compliance Framework against Trust performance report	CQC full compliance following re-inspection Feb 12 Trust Management Team and Trust Board monthly update Completed stage 2 HDD Membership recruitment above trajectory Delivery of Action Plan Milestones		Board Development Sessions Action Learning From SHA FT Network Assessment against DoH Board Governance Assurance Framework Undertake further review of mortality outlier alerts Complete actions as identified in plans submitted to CQC in response to Responsive Review/ DANI review Regular review of Monitor Board minutes and reports	C2 YELLOW	Mar-12	Yes

Risk Managed to Target Level

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcome 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

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Trust Objective:	**To be in the national NHS top quartile of benchmarks**										
Chief Nursing Officer	O16 1717	Failure to maintain re-registration by the CQC periodic review.	C2 YELLOW	Undertake quarterly Divisional Reviews Performance Management Framework in place that is monitored through Trust Management Team and Trust Board. NHS Instittute for Innovation Better Care Better Value benchmark NHS Performance Framework - Quarterly to Trust Board	62 day cancer target now within target. Continue to monitor at thrice weekly meetings - March 2012 CQC registration without conditions - Apr 2011 CQC Reports - Privacy, Dignity and Nutrition - Responsive Review - March 2012	C Diff target not on target due to PCR testing - March 2012 Delays in Transfer of Care above internal target periodically (target below 6) Feb 2012 Length of Stay is above target - Feb 2012	Action Plans for CQC report - ongoing Workforce review of Nursing and Midwifery Develop Trust audit to test outcome compliance Internal audit (i.e RSM Tenon) of trust arrangements for ongoing compliance monitoring - Awaiting report. Bi monthly compliance reporting to compliance committee - with actions for shortfalls. Implement findings of Newtons Review re: Outpatients. Phase One complete. Phase Two - July 2011 Service Improvement initiative - bed capacity meets demand - modelling implementation commenced Service Improvement initiatives - Productive Theatre - ongoing CQC standards are being mapped against Information Governance standards, NHSLA standards, Performance and quality indicators and trust wide audits; in order to triangulate self-assessment and strengthen assurance of on-going monitoring.	 May-12 May-12 Aug-11	C2 YELLOW	Mar-12	Yes

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcome 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

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Trust Objective:	**To agree appropriate population catchment areas for RWHT service**										
Director of Planning and	O6 1734	Introduction of other health providers in the market as a result of Any Qualified Provider leads to a greater shift of activity.	D2 GREEN	Weekly review of interactive commissioning map (H) Flexible services and low Waiting Times for all first appointments (on-going) Promoting choice through Web Site & NHS Choices - Nov 2010 (on-going) Market Research & Marketing Strategy Marketing Report - Trust Board - Jan 2012 Review DoH Any Qualified Provider proposals (as each document is published)	Limited extent of choice in Nuffield for acute care No new players in the area for acute or community care Maintain and grow referrals for all specialties Lack of interest by private sector in development with the region		Produce Quarterly Market Share analysis report Review PCT Cluster commissioning intentions with regard to Any Qualified Provider. Use refinements to NHS Choices & Choose & Book to 'sell' services - on-going Maximise opportunities to sell services via new Web Site - on-going Work with shadow Consortia to understand future requirements - on-going Explore opportunities with other commissioners to support the TCS agenda - on-going	Mar-12	D2 GREEN	Feb-12	Yes

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Trust Risk Register

March-2012

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B1	B2	B3	B4	B5
C1	C2	C3	C4	C5
D1	D2	D3	D4	D5
E1	E2	E3	E4	E5

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Risk Lead	ID	Principal Risk		Controls	Positive Assurances	Gaps in Assurance/Control	Action Plan that addresses Gaps in Control		Residual Risk Level		
Risks Currently Being Managed											
Trust Objective:		**To provide our patients & staff with a safe environment.**									
Director of Finance & Information	O6 2570	Inadequate estates as part of the Transfer of Community Services - WCPCT provider Services with effect from 1 April 2011. Legal consequences of a potential estates transfer ie property arrangements in line with White Paper with PCT being abolished by April 2013.	C4 AMBER	Engagement of Solicitor support External Support is being employed to review the condition of the Estates where Services from WCPCT are undertaken. Negotiations continuing re potential properties to transfer. Date for transfer now delayed due to DH. Monthly Project Board meetings with extensive RWHT representation.	Outcome of Due Diligence exercise		Site by site analysis underway as to condition of property occupied. Detailed individual / lease negotiations to take place Sept to Dec 2011 with legal support.	Dec-11	C3 AMBER	Mar-12	Yes
Chief Nursing Officer	O7 2448	Failure to have effective systems in place for patients with learning disabilities or requiring application of Mental Capacity Act.	C4 AMBER	Revised training programme for safeguarding and MCA. Revised Safeguarding policy in place A temporary lead is in place for learning disabilities with objectives to improve standard of assessment for care.	Specific aspects of WMQRS Peer review care of vulnerable adults in hospital - Jan 2012 MCA and DOLs application numbers	Specific aspects of WMQRS Peer review care of vulnerable adults in hospital - Jan 2012 Safeguarding referrals where allegations are made against the organisation in relation to Learning Disabilities.	Develop and train five extra best interest assessors for the organisation. Learning disabilities lead post now made substantive. Continually improve and sustain levels of MCA training Implement agreed learning disabilities IT alert system to identify patients on admission to receive specialist nurse support	Mar-12 Apr-12 May-12 Mar-12	D3 YELLOW	Mar-12	Yes

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcome 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Nursing Officer	O8 535	Failure to achieve reductions in HAIs impacting on Trust's reputation and compliance to regulatory standards.	C4 AMBER	PCR for C-Diff testing from March 2011 Supervision of junior doctors re IP practices/ skills/ training HCC-DH Self Assessment Hygiene Code Screening Policy in Trust implemented Screening Programme in Community in place PREVENT Bronze standard achieved by Care Homes - Mar 2011 Appointed Data Analyst for IPT - March 2012 IP lead nurse in post - Team restructure aimed at delivery. CDiff plan reviewed end of September 11 and enhanced with a range of actions aimed at reduction of incidence Rapid improvement programme - creating best practice wards includes an infection prevention work stream MRSA admission screening pilot in care homes commenced October 2011 MRSA Screening for Podiatry Nail screening pilot Commenced July 2011 - 0% infection rate. MRSA early discharge screening Pilot commenced October 2011 - 1/260 positive	CQC Visit report - May 2011 HPA quarterly report of MESS data ongoing. Current C-diff and MRSA bacteraemia YTD performance - March Successful Nursing Times award for infection prevention in community Nov 2011. MRSA rates currently on trajectory Feb 2012 DRHAB's - Low numbers of MRSA pos Ph on admission to care homes 1/260 screened - Dec 2011 Reduction in HCAIs other than MRSA bacteremia - March 2012	PCR testing has increased the numbers of C-Diff due to more accurate testing (sensitivity) - Feb 11 Lack of data explaining CDI - Sep 2011	Monitor the increase in C-Diff post PCR testing and discuss with commissioners - ongoing Exercise the effectiveness of revised IP team structure supporting the divisions. Develop a business case for centralised intravenous team to reduce DRHAB Implementing CDI Assurance process. Change delivery of IP through team / division.	 Jun-12 Jul-12 Feb-12	C4 AMBER	Mar-12	Yes

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcome 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

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				Revised Outbreak Mangement Plan to include dehydration clinical pathway in place Action plan in place for Hygiene Code to be monitored by IPCC quarterly - reported to IPCC Nov 2011. Action plan for reduction in HABs and DRHABs developed. Chronic wound screening commenced Dec 2011						
Trust Objective:		**To be the employer of choice.**								
Chief Operating Officer	O12 1713	Failure to effectively maximise workforce productivity.	B3 AMBER	Areas to be contained with SPA allocation - agreed Job plan audit developed Job Planning Steering Group set up to ensure robust job planning process led by Medical Director. Implementation of monitoring procedure to ensure consistency of approach across Divisions. Performance targets including pay costs v clinical income. Medical staffing review	Consultant Job Planning Framework agreed. Implementation in progress. Performance management system, quarterly reviews of Divisions and monthly reports to Trust Board.	High agency medical costs. Previously there was inconsistency of application of approach. Capacity failing to meet demand.	Action Plan to address the issues once identified by job plan audit. Review of medical rotas and introduce Locum Bank. Project Team set up - terms of reference/scope to be agreed together with action plan for implementation.	C2 YELLOW	Mar-12	Yes

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcome 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Director of Human Resources	O14 1742	Failure to learn from staff survey.	B3 AMBER	Key Indicators in staff survey covered by Trust policies (eg appraisal, harassment and bullying, etc). Staff Governors in constitution have voice to influence direction of Trust Action plan to learn from past survey constructed Staff feedback has been incorporated into the Trust Board quality & safety dashboard thereby aligning staff engagement with patient safety agenda. Chatback was completed in July/August 2011. Process underway to cascade results and to develop action plans. This will enable us to monitor progress against key metrics from staff survey. Key Staff Survey indicators included in HR KPIs Divisional/Directorate Staff Survey reports discussed at HR subgroup and distributed to Divisional and Directorate managers and matrons and Divisional / Directorate action plans developed. Staff survey results presented at Trust Board, TMT and senior managers briefings.	KPI in annual plan. ChatBack 2011 results show improvement in most areas. Action plans to further improve results in place. Overall staff engagement measured for the second time (based on response to 3 questions). RWHT scored 3.72/5 being highly engaged staff. This was in the highest (best) 20% when compared with similar Trusts. Turnover below National average and within Trust target.	Results received from 2010 staff survey; response rate was (328 staff) 39% (in the lowest 20% of Acute Trusts) compared with 49% in 2009. Feedback from Managers requesting more specific Specialty breakdown.	Results will be fed to Divisions and action plans drawn up at a Divisional level. Results from 2011 survey will be presented at TMT, Trust Board, HR Sub Committe and Senior Managers Briefing	Mar-12 Jun-12	D3 YELLOW	Mar-12	Yes

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcome 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

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Director of Human Resources	1693	Equal Pay Claims/ET's/Collective Grievances - Potential Significant Cost to the Trust	C4 AMBER	NHSLA and Trust solicitors supporting defence Regular liaison with solicitors meetings set up with individuals and trust solicitiros to gather mor information	claims reduced to 40 Regular analysis as part of audit process Robust ruling in support of AFC systems from ET in test case		Continue work with solicitors stage 2 investigations commenced July 2010. active case management of cases still underway		D3 YELLOW	Mar-12	
Trust Objective:		**To achieve a balance between demand & capacity of services**									
Chief Operating Officer	O6 1714	Failure of other agencies to support discharge process.	B3 AMBER	Action Plan from RSM Tenon audit. Internal Audit Project to commence October 2010 Integrated patient flow team through Reablement funding Weekly discharge meeting. Daily bed state shows current position Annual 'Reimbursement funds' agreement Action Plan to implement workshop outcomes PCT Supporting Project Manager Health Economy Winter Plan ECG Meeting	Show reduced delayed discharges Weekly delayed discharge report	Patients with excessive length of stay - February 2012	Training and awareness sessions on services within Community Services - ongoing. Integrated patient flow team through Reablement funding - recruiting to Project Manager posts. Action for Best Practice wards with dedicated social worker input. LEAN Project Managing Complex Discharges - ongoing. Evaluate impact of Best Practice Wards and agree next steps	Mar-12	D2 GREEN	Mar-12	Yes

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcome 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	2840	From 1st Dec 11: *Extra activity for NX A&E as result of Stafford A&E closing overnight.	B3 AMBER	Upgrade 1 ward area Review physical environment Appoint to staffing gaps Review staffing and staffing model Develop monitoring system for effects of additional demand Order equipment Weekly performance monitoring of A&E at director and operational level. Trust has access to data re: attenders at Stafford A&E on which to base measures at NX.			Establish workflow Liaise with PCT on coping strategies Extra ward to open (C3) as requested		Mar-12	

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcome 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	2761	Lack of LSMS support for TCS transferred community services. Lack of Senior Fire Safety Advisor support for TCS transferred community services.	B4 RED	Interim arrangement established with PCT to provide professional support only until end of April 2012 Head of Governance and Head of Estates established interim proposal to utilise existing internal resource to reduce risks until end of March 2012 Front line security services provided via APCOA (RWHT) Discussions held between Divisional Manager E&F with Head of Governance and Legal Services to try to formulate effective interim arrangements, between RWH and Wolves PCT. Option Appraisal completed - option 3 preferred option - Secure budget uplift from cost pressure discussions 2012/13	Effective arrangements are not in place.	Notification from PCT (Sarah Southall) interim arrangements not sustainable beyond April 2012 Notification from Head of G&LS that fire/security remit in staff transferred may be removed end of March 2012 Current Fire Safety Officer resources inadequate to fulfill responsibilities under Regulatory Reform (Fire Safety) Order 2005 No resilience plan in place/available during the absence of the Security &/or Fire Safety Advisor	Option 3 - preferred & discussed with COO/DoF Escaltion of risk to COO	Feb-12 Feb-12	E4 AMBER	Mar-12	

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcome 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	O16 2492	Failure to ensure that inpatient, outpatient, day case and theatre capacity meets demand.	C4 AMBER	Cancer now within trajectory - continue to monitor weekly. Monthly monitoring of increased demand in relation to GP/Dental referrals and in particular those outside Wolverhampton. Monthly monitoring of increased demand from outside Wolverhampton for Stroke and Cancer Services Annual delivery plans developed based on contracted activity and agreed targets for waiting times and quality indicators. Monitoring of access targets, activity, waiting times and other quality indicators on a weekly and monthly basis Winter plan in place which includes access to flexible capacity Working with primary care and other agencies to improve timeliness of discharge Implementation of the Productive Series Programme to ensure efficient and effective wards and departments Work with external consultants on service changes to improve outpatient utilisation, theatre utilisation and increase day case rates	Cancer targets achieved - continue to monitor closely and report to TMT and Trust Board in performance report. Quarterly assessment, risk rating and remedial action identified by Exec Director lead for all business outcomes in the annual plan Evidence that performance is discussed at weekly COO meeting with agreed actions to rectify underperformance Performance reports to TMT and Trust Board monitors performance against plan Reports to SHA and other agencies Daily meetings to support effective management of capacity Evidence of RCAs on cancelled operations	Extra capacity being opened on an ad hoc basis - February 2012	Currently reviewing Length of Stay by HRG Utilise the findings of the Capacity to deliver bed reductions/CIP plans.	Mar-12	D3 YELLOW	Mar-12	Yes

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcome 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
				Capacity management team in place to facilitate timely admissions and discharges.							
Chief Operating Officer	O19 2719	PAS Admissions are often updated on to PAS retrospectively - 13% of admissions Jul-Oct 2010 where entered more than 24hours after the admission actually happened - this will have a significant impact on systems such as eDischarge and ePrescribing and should be done real-time to ensure patient Safety (wristband).	A3 AMBER			Nothing further gleaned from recent investigation. The risk is to be re-evaluated.	Awareness has been raised. Detailed plan to resolve being formulated.	Sep-11	B3 AMBER	Mar-12	Yes

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcome 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

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Trust Objective:		**To progressively improve the image and perception of the Trust**								

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcome 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	O16 1716	Failure to achieve targets in accordance with the operating framework (waiting times, CQC etc.) undermining continuous improvement in quality. leading to lack of confidence in our ability to deliver services.	B3 AMBER	Targets monitored and managed weekly where possible otherwise monthly or (some) quarterly - ongoing. Review alternate recruitment to vacant medical posts. Review staffing patterns in relation to peak time of activity. Full review of planned waiting list undertaken. A&E targets monitored daily and reported to TMT & Trust Board monthly Review of national targets in a prospective KPI's introduced for data collection and recording. Performance Management enhanced Escalation policy regarding A&E. Directoate activity trajectories and capacity plans. TAL performance maintained, continue to monitor daily Continue weekly meetings with Divisions and weekly monitoring of waiting times COO Report weekly/monthly Cancer Network engaged in definition and breach analysis Review of definitions of Cancer Systems Vs 18 weeks.	A&E targets achieved Early warning of potential to fail Ratings Sustained performance On an ongoing basis and daily monitoring of hot spot areas	Three A&E KPI's are above target - February 2012 Excessive breaches in A&E standards - February 2012	A&E KPI's monitored daily. Working group set up to ensure all compliance aspects are covered. Review staffing patterns in relation to peak time of activity Review escalation process Review alternate recruitment to vacant medical posts. Action plan developed, implemented and monitored at Directorate meetings- ongoing Targets monitored and managed weekly where possible, otherwise monthly or (some) quarterly - ongoing.	D3 YELLOW	Mar-12	Yes

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcome 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

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				Weekly review of Cancer Waiting Time in a prospective manner.							
Trust Objective:		**Deliver services within financial allocations**									
Chief Operating Officer	2893	Networking groups of pathology services in the SHA Central and West region are highly likely to be centralised. Current proposals (awaiting agreement) suggest two hub pathology sites within the region (with or without direct access work). There is a risk that commissioners do not decide to make RWHT a pathology hub. This potential activity reduction will lead to loss of income and overcapacity of pathology services on site. There would also be potentially significant impact on staffing structure.	C4 AMBER	Communication regarding networking with senior members of the trust management team RWHT representation at networking meetings	Completion of the build includes the partnership working capability Stratergy involving senior management of the trust in network forums		Contruction of Integrated pathology build Pathology management to attend networking group meetings Inform trust senior management team about outcomes from networking meetings	Feb-13 Dec-12 Dec-12	C4 AMBER	Mar-12	
Chief Operating Officer	2891	Networking groups of pathology services in the SHA Central and West region are highly likely to be centralised. Current proposals suggest two hub pathology sites within the region (awaiting agreement). There is a risk of losing GP direct access work if RWHT is not selected as a pathology hub. This potential activity reduction will lead to loss of income and overcapacity of pathology services on site.	C4 AMBER	Pathology management attend networking discussions Monitor progress of networking through pathology directorate and integrated pathology build steering group	Stratergy involving senior members of the Trust in network forums. Completion of the integrated pathology build		Continue dialogue with network group and communicate with senior members of the trust Integrated pathology build	Apr-13 Feb-13	C4 AMBER	Mar-12	

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcome 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

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Director of Finance & Information	O16 514	Failure to deliver recurrent efficiency gains and CIPs.	A4 RED	Monthly reporting against projects including to Trust Board Cost Improvement Program Board (Executive Director led) Each project has an executive director lead	Trust Board Reports & Minutes include CIPs	Finance report to Trust Board. Deloitte HDD report.	Monitor closely through CIP programme board Identify 'new' projects and programmes in advance - ongoing		B3 AMBER	Feb-12	Yes
Director of Finance & Information	O16 1739	Failure to develop Service Line Reporting across the Trust.	B4 RED	SLR reports to be distributed on a monthly basis. SLR pilots to be set up. 2011/12 plan to be agreed and monitored against. Rollout plan to be proposed.		Timescales and priorities to be determined when 1st phase report considered. Need to develop better appointment bases for some direct and indirect costs.	Briefing to Board took place in May 2011. Monthly figures now produced within 3 weeks of month end. Contribution targets to be set in August.	Aug-11	D3 YELLOW	Feb-12	Yes
Director of Finance & Information	O16 2468	That pay, price rises and cost pressures will be higher than assumptions.	B3 AMBER	2011/12 plan includes cost pressures; VAT and pay awards. 2011/12 financial plan has modelled impact of pay and non pay pressures.			Monitor budgetary position closely through operational finance group/TMT and Trust Board		C2 YELLOW	Feb-12	Yes
Director of Finance & Information	2781	Contractual risks due to tariff changes for emergency threshold.	B3 AMBER	System in place to alert when issues occur. Reserve set against risk.					C2 YELLOW	Feb-12	

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcome 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

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Trust Objective:	**To be a high quality educator**										
Director of Human Resources	2475	Management of work experience placements, induction, paperwork, revisiting Trust Work Experience Policy and insufficient auditable information trail. . Lack of information of students on placement within the Trust in relation to Health and Safety issues.	B3 AMBER	audit trail identified and all relevant paperwork for the Trust placements to be copied and sent to Judith Turner update of students on placement Paperwork under review Continuing partnership with work experience team at PCT Revisiting Trust Work Experience Policy Temporary support in place to support work experience - ended April 2011	Risk Reviewed at E&T Managers Meeting Auditable trail and paperwork now in place Some work experience occurs and is managed appropriately in accordance with appropriate Trust/individual safeguards. Directors briefing to be compiled	No dedicated team to support Work Experience lead Workload unmanageable within current resources No community budget to support activity.	Review policy and communicate policy. Director's Briefing Options appraisal to be drawn up Audit Ensure regular student placement updates from PCT Ensure paperwork is updated accordingly Supporting PCT Team Partnership with PCT Work Experience Policy Audit the process and report to HR Sub on findings. Secure funding for work experience support - organisation, queries and placements, monitoring and audit. Organisational support for work experience to be decided Continue to review risk at HR Governance meeting	Mar-12 Jun-10	D3 YELLOW	Mar-12	

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcome 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

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Medical Director	O12 2572	Unable to implement the DoH e-learning tool for Information Governance Mandatory Training fully, failing to achieve 95% compliance for all staff. Scoring a level 1 on any IGToolkit requirement means the Trust will receive a red unsatisfactory rating. Also put on Governance Department risk register	A3 AMBER	IG Training report take to IGSG Monthly. IG training will change from being once only required to annual requirement in Trust policy OP41 from 2010. National Requirmeent of IGToolkit The IG training tool repleaced training on the KITE local education website Refresher module has been launched Nov-11 IG Officer emailed / managers directly re compliance Jan/Feb 2012 Training reminders for Jan-Mar implemented. Training options have been differentialted for staff needs, E-learning, paper and face to face training avaliable Clarification from IG Policy team at DoH, staff who completed training between April-June 2011 count for the financial year 11/12 .	Oct 2011 Training report shows Trust overall IG training total including community at 94% IG Refresher trainign launched Nov 2011- avaliable via KITE site Training report submit to IGSG Dec 2011 around compliance levels IG training materials being used in on Mandatory training days, Trust Induction, Junior doctors induction and Quick induction, KITE. Training compliance improved from 54% May 2011 to 98% June 2011 Training Database scrutinise staff training and inform mangers of non compliance monthly. TNA for IG training reviewed by IGSG Aug 2011 and monitored at IGSG. Training data from PCT regarding TCS staff training compliance recieved June 2011	No resourses for IG or IG training transfered through TCS. No training contingency if 1 IG officer is unavaliable Increased training need following TCS and increase in number of Trust staff Compliance dropped from 94% Oct 2011, 93% Nov 2011, 92% Dec 2011, 91% Jan 2012, 89% Feb 2012, on 07.03.12 score was 93%.	Information Governance E-learning module will be available within OLM is being rolled out as a project to transform training, and IG will be incorporated. Managers have regularly been given lists of staff members who are required to undertake IG Training.	Mar-11	B3 AMBER	Mar-12	Yes

CQC standards: Outcome 1 Respecting and involving people who use services; Outcome 4 Care and Welfare of people who use services; Outcome 6 Cooperating with other providers; Outcome 7 Safeguarding people who use services from abuse; Outcome 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;