The Royal Wolverhampton Hospitals NHS Trust

# Trust Board Report

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| **Meeting Date:** | 28th May 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:**<br>**Contact Details:** | Governance IM&T Lead<br>Tel: 01902 695114 Email: |
| **Resource Implications:** | None identified |
| **Public or Private:**<br>**(with reasons if private)** | Public Session |
| **References:**<br>**(eg from/to other committees)** | |
| **Appendices/**<br>**References/**<br>**Background Reading** | |
| **NHS Constitution:**<br>**(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:<br>- Equality of treatment and access to services<br>- High standards of excellence and professionalism<br>- Service user preferences<br>- Cross community working<br>- Best Value<br>- 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:

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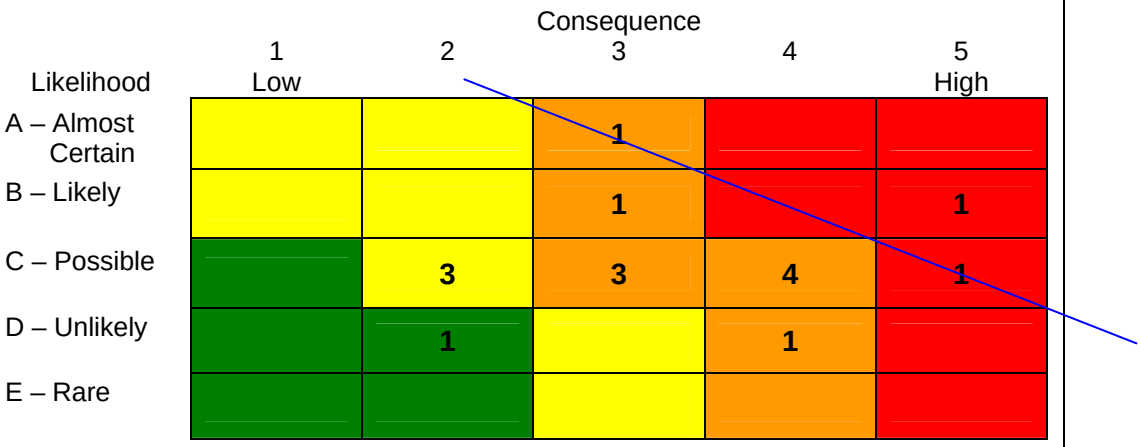
| Risks currently being managed (ongoing) | 13 |
| Risks managed to target level | 3 |

There are currently 16 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:

| | ID | Risk Title | Lead |
|---|---|---|---|
| RED | 2962 | Health Visiting Services | COO |
| | 2965 | Failure to reduce Never Events | CNO |

Trust Risk Register – Updates (Appendix B)

Following updates the split of the Trust Risk Register is:

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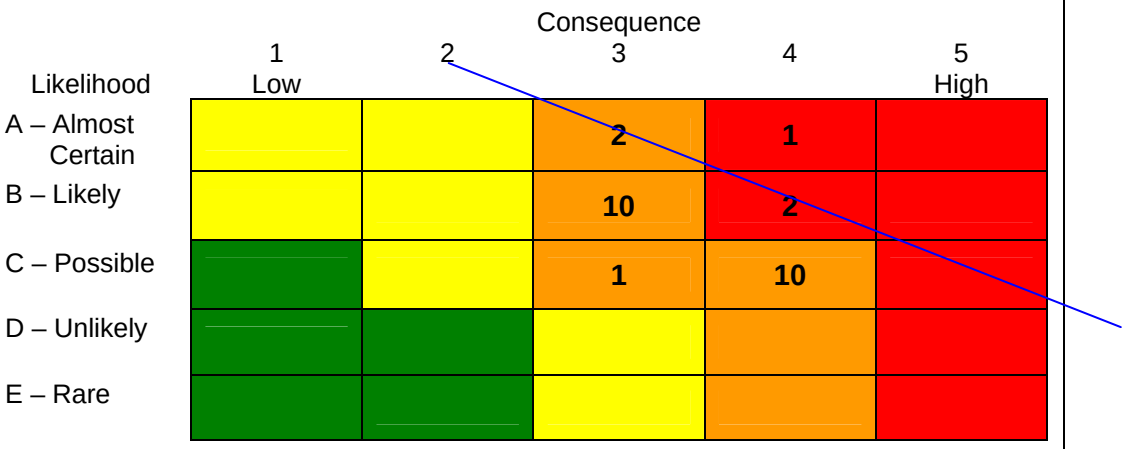
| Risks currently being managed (ongoing) | 26 |
| Risks managed to target level | 0 |

There are currently 26 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 (May 2012)

| Lead Director | Risk | Risk Title | Update | Reasoning / Progress Against Actions |
|---|---|---|---|---|
| Chief Operating Officer | 2765 | High levels of sickness and maternity leave affecting Health Visiting capacity within Bilston team. | Risk Downgraded to C2 Yellow. Positive Controls and Assurances update. | Saturday clinics have recommenced and thus increased the capacity to offer increased numbers of developmental assessments<br><br>Additional clerical support to reduce the data backlog which was affecting activity compliance, and also to increase the clinical capacity of the team.<br><br>Sickness absence is now not an issue in Bilston, therefore improving capacity and staff morale - will be monitored under the standard process. |
| | 2962 | Health Visiting Services | *****New risk***** | Risk of Health Visiting business/system/service failure due multiple systemic failings identified in the recent service review and evaluation report. The issues identified include a lack of progress in the implementation of the national health visitor implementation plan, partnership working, poorly integrated health systems, poorly functioning IT systems, decreased staff morale, increased staff stress levels, lack of management and leadership.<br><br>Increased risk of potential patient (and family) safety concerns as a result of Health Visiting business/system/service failure including a potential increased risk of safeguarding issues not being identified or acted upon in a timely/appropriate fashion.<br><br>Risk of adverse media attention in the event of Health Visiting business/system/service failure and increased patient/family safety issues and safeguarding issues. |
| Director of Planning and Contracting | 1734 | Introduction of other health providers in the market as a result of Any Qualified Provider leads to a greater shift of activity. | Positive Controls, Positive Assurances and Action Plan updated. | Established GP liaison office and webpage.<br><br>Non-Wolverhampton Commissioners requested proposals for specialist community services.<br><br>Produce Quarterly Market Share analysis report – on-going<br><br>Review PCT Cluster commissioning intentions with regard to Any Qualified Provider – May 2012 |
| | 2508 | Commissioning responsibility changes - affects contracted income | Positive Controls and Positive Assurances updated. | Meetings every 4 weeks with action notes.<br><br>Internal RWHT Contract meeting at least once per month. |
| | 2699 | Integration with PCT | Positive Assurances and Action Plan updated. | All schemes have now been migrated and are live in the new electronic monitoring system which will provide greater assurance and monitoring of plan.<br><br>Review of the TCS benefits and process for integration to be undertaken by auditors during 2012/13 work programme. |
| Director of HR | 2831 | Loss of critical services due to industrial action of staff. | Positive Assurance and Action plan updated. | Industrial action by UNITE occurred on 10th May; no impact on service delivery. Action plans in place but nil return on sitrep reported. |

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| | | | | Monitor BMA following notice of ballot action – enhance local plan to accommodate for potential work to rule by doctors. |
| Chief Financial Officer | 2807 | Delivery of the CRL for 2011/12 Capital Programme | ***Risk closed*** | The risk is no longer in existence for 2011/12 and can therefore be removed from the register.<br>Capital Resource Limit achieved for 11/12. |
| | 2928 | Impact of economic environment. | Positive controls updated | For 12/13 have secured favourable contracts |
| Chief Nursing Officer | 2965 | Failure to reduce Never Events | ***New risk*** | |

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

| Lead Director | Risk | Risk Title | Update | Reasoning / Progress Against Actions |
|---|---|---|---|---|
| Chief Operating Officer | 1714 | Failure of other agencies to support discharge process. | Action plan updated. | Integrated patient flow team through Reablement funding – Project Manager posts appointed, awaiting confirmation of start date. |
| | 2492 | Failure to ensure that inpatient, outpatient, day case and theatre capacity meets demand. | Action plan updated. | Utilise the findings of the Capacity to deliver bed reduction/CIP plans |
| | 2719 | Timeliness of PAS Admission | Positive controls updated. | Further investigations carried out and this confirmed that some process redesign is necessary to achieve timely discharges on the system. |
| Chief Nursing Officer | 535 | Failure to achieve reductions in HAIs impacting on Trust's reputation and compliance to regulatory standards. | Positive Controls, Positive Assurances and Action plan updated. | IV team PID agreed at TMT and in development.<br><br>Surgical Site Infection Surveillance Team agreed at TMT and in development.<br><br>Robust surveillance system in place.<br><br>2011/12 best year to date for the reduction of MSSA bacteraemia, DRHAB's and MRSA acquisition |
| | 2680 | Interpreting & Translation Service - risk of over performance against central budget held by patient experience. | *** New risk – upgraded to C3 Amber*** | Lack of engagement with telephone use defaults to face to face interpreting. Top 3 users include maternity, Appleby and OPD. Scoping use of 'I Translate' as electronic device and business case in process to support this to negate need for face to face or telephone unless absolutely necessary, will be proactively managed with stringent risk assessment for use of face to face interpreter. |
| | 2950 | Unable to achieve no avoidable pressure ulcers by December 2012 across the health economy | ***New risk*** | |
| | 2951 | Risk of not reducing the incidence serious and untoward pressure ulcer incidents, wound infection, hospital admissions due to deteriorating wounds, MRSA bacteremia, due to poor capacity and fragmented clinical | ***New risk*** | |

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| | | pathways. | | |
| | 2952 | Patient developing a pressure ulcer due to inadequacies of pressure ulcer prevention equipment. | ***New risk*** | |
| Director of HR | 1693 | Equal Pay Claims/ET's/Collective Grievances - Potential Significant Cost to the Trust | Action plan updated. | Independent reports concluded – appropriate challenge in place and await outcome. |
| | 2475 | Work Experience Support | ***Downgraded to D2 Green*** | |
| | 2858 | Lack of compliance with NHSLA Level 3 Standard 3 | ***New risk*** | NHSLA Level 3. Achievement required for standard 3. Relates to standard requirement of 95% compliance in mandatory training. |
| Chief Financial Officer | 2953 | SQL Cluster | ***New risk*** | Server Capacity exhausted. Additional capacity dependent on new SQL cluster implementation. Projects and live applications significantly at risk until completed. |
| | 2468 | Pay rises and cost pressures | Positive controls updated. | Long term financial model has assessed financial impact for 5 year period to 2016/17 |

# The Royal Wolverhampton Hospitals NHS Trust

Board Assurance Framework

May-2012

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|---|---|---|---|---|
| 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<br><br>Database of referrals maintained through Safeguarding Lead.<br><br>Deputy Chief Nurse Safeguarding Lead for newly formed acute and community organisation<br><br>Internal audit through RSM Tenon to support improvement in processes<br><br>Revised safeguarding policy and framework for safeguarding training<br><br>Analysis of safeguarding allegations supporting improvements in: *Discharge planning / *Pressure ulcer prevention<br><br>Developed and agreed key performance indicators for safeguarding adults in place<br><br>Analysis of workforce review of nursing and midwifery - completed | Specific aspects of Internal audit review - Jan 2012<br><br>Decrease in safeguarding allegations since June/July 2011.<br><br>Audits against improvements in discharge planning and pressure ulcer prevention - Feb 2012<br><br>Progress against best standards in "creating best practice" wards | Specific aspects of Internal audit review - Jan 2012<br><br>Safeguarding allegations substantiated - since June 2011<br><br>Complaints upheld - since June 2011 | Continue to implement "creating best practice wards" and plan further role out across other wards - ongoing<br><br>Continue to share lessons learnt via the JHSVA Committee throughout the organisation - ongoing | D3 YELLOW | May-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.<br>Monitor complaints, claims and incidents through I.C.C commenced March 2012. | CQC responsive review follow up report - March 2012<br>CQC registration without conditions (General and Mental Health) - Feb 2012 | | Sustainability plan in draft format for review at Compliance Committee | Apr-12 | E2 GREEN | May-12 | Yes |
| Chief Nursing Officer | 2965 | Failure to reduce Never Events. | C5 RED | Reporting monthly through Quality and Safety and Trust Board via Q&S Report | | Never event occurrence May 12. | MD and CNO mandated sessions share Never events and RCA findings and actions - ongoing<br>Divisional and Directorate action plans<br>Specific action plans post each Never event e.g. Obs and Gynae - ongoing<br>Divisional and Directorate Risk Registers | <br>May-12<br><br>May-12 | D4 AMBER | May-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 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;

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|---|---|---|---|---|---|---|---|---|---|---|---|
| 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.<br><br>Silver Command Operating procedure for IA in place.<br><br>Agreement with Unions re Exemptions reached.<br><br>Communications Plan developed and in place<br><br>Ongoing regular updates on workforce analysis of Union membership within Trust; Monitoring of Workforce plans<br><br>Review of 'lessons learnt' has taken place, formal report to go the EPC and TMT Jan 2012.<br><br>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.<br><br>Discussions taken place with staff agenices to clarify the availability of agency staff in the situation of industrial action.<br><br>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.<br><br>Industrial Action by UNITE occurred on 10th May 2012; no impact on service delivery. Action plans in place but nil return on sitrep report. | | Monitor BMA following notice of ballot action - enhance local plan to accomodate for potential work to rule by Doctors.<br><br>Await National Outcome of further discussions re Public Sector Pensions | Jun-12 | C3 AMBER | May-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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|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Contingency Planning Awareness Sessions to Managers / Heads of departments across the Trust completed.<br><br>Skills / competencies of available staff i.e. assessing workforce capacity completed.<br><br>Staff skills audit re-evaluated with the integration of community services and an understanding of our medical staff / Consultant progammed activities.<br><br>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.<br><br>Action completed in relation to identify the impact on staff and local staffing plans.<br><br>Management Guidance has been produced.<br><br>Creche facility for staff requiring support in relation to child care arrangements has been arranged and can be implemented at short notice.<br><br>Training sessions have been established to offer ward and porter training to staff and volunteers. | | | | | |



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 achieve a balance between demand & capacity of services** | | | | | | | | | | |
| Director of Planning / Contracting | 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<br><br>Re-launch of process to generate ideas and capture work in progress<br><br>Share success, ideas and tools through a microsite on the intranet -<br><br>Monthly Change Programme Board established Jan 2012<br><br>Programme reviewed and project tracker now introduced showing 6 month work programme - Sep-11<br><br>Report to Trust Board in to update on progress and outline projects - July-11 and Oct-11<br><br>TMT approved revised Programme Management arrangements. Aligns Benefits Realisation and Cost Improvement Programme - Nov 11<br><br>Exec lead identified - Apr-11 | Black Country System Plan - evidence of Benefits Realisation<br><br>Established revised targets for 2012/13 via Change Programme Board<br><br>All schemes have now been migrated and are live in the new electronic monitoring system which will provide greater assurance and monitoring of plan.<br><br>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. | | Review of the TCS benefits and process for integration to be undertaken by auditors during 2012/13 work programme - ongoing<br><br>Launch revised PID/QIA<br><br>On-going monitoring of projects via Change Programme Board.<br><br>Reviewing potential monitoring tool to improve access to information and performance management | <br><br>Apr-12<br><br><br><br>Feb-12 | C4 AMBER | May-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 | 2962 | Risk of Health Visiting business/system/service failure due to multiple systemic failings. | B5 RED | | | | Action plan to be developed based on recommendations made in scoping review and evaluation report | May-12 | D2 GREEN | May-12 | |
| | | | | | | | Multi-disciplinary steering group to be established to support the implementation of action plan (membership to include local authority and commissioners) | Jun-12 | | | |
| | | | | | | | Review and evaluation of specific work streams as part of the work of steering group ie, strategic, workforce, management and business functions | Jun-12 | | | |
| | | | | | | | Strategic work stream to link/integrate service model with measures outlined in "A Call to Action" | Aug-12 | | | |
| | | | | | | | Workforce work stream to assess staff numbers, skill mix and competencies | Aug-12 | | | |
| | | | | | | | Management and business work streams to ensure core business functions are fulfilled and KPI's to be developed to support this work | Aug-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? |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **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<br>Proactive press releases<br>'Setting the Record Straight' in place<br>Communications Manager in post<br>Regular update and monitoring to TMT/TB - Monthly<br>Trust Board meetings are open to the public - Monthly | Trend continues with considerably more positive (plus neutral) coverage than negative. 81% positive and neutral and 19% negative coverage<br>January coverage shows more positive (plus neutral) coverage than negative. 96% positive and neutral and 4% negative.<br>Positive coveragefor Infection Prevention<br>Clinical Performance against National Targets | Occassional negative coverage. | | | D2 GREEN | May-12 | Yes |
| **Trust Objective:** | **Deliver services within financial allocations** | | | | | | | | | | |
| Director of Planning / Contracting | O6 2508 | Commissioning responsibility changes - affects contracted income | A3 AMBER | Review 'NHS Bill'; Operating framework and PbR tariffs for 2012/13 - Dec-11<br>Negotiation with Commissioners at LDP meetings; focus on CCGs (on-going)<br>Internal RWHT Contract Review/LDP meetings. (Senior managers /Directors to agree and implement negotiations strategy (on-going) | Contracts signed with all commissioners by 31 March 2012<br>Positive contract negotiations for 2012/13<br>Internal RWHT Contract meeting at least once per month<br>Meetings every 4 weeks with action notes | | Director level engagement with the PCT and PCT Clusters - meeting arranged - on-going<br>Target CCGs as they develop; and develop links with Clusters - on-going<br>Review current and future contract Portfolios.<br>Include potentially new configured Trust services in all assessment/reviews.<br>Revise Communication Strategy to reflect commissioning changes. | Mar-12 | C4 AMBER | May-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 Planning / Contracting | 2927 | Failure to deliver against QIPP scheme resulting in lack of investment. | B3 AMBER | | April Trust Board report does not indicate any immediate risk. | | To establish a joint programme board with commissioners<br>To agree a QIPP work programme with commissioners<br>To identify capacity and resources to deliver the programme | | B3 AMBER | May-12 | |
| Director of Finance & Information | 2928 | Impact of economic environment. Potential reduction of income and activity due to efficiency requirements placed on commissioners and / or private sector withdraw from the market. | C3 AMBER | For 12/13 have secured favourable contracts<br>Contingency plans in place | Financial position of the Trust monitored on Monthly board reports<br>Monitoring referral trends for changes<br>Procurement tenders reviewed to ensure sufficient competition | | To identify market opportunities - ongoing<br>To respond to bids put forward by SHA / Commissioners<br>Additional collaboration with other providers to reduce costs<br>Maintain good working relationships and communications with commissioners - ongoing | Jun-12<br>May-12 | C2 YELLOW | May-12 | |
| Chief Operating Officer | 2929 | Failure to deliver CQUINS schemes | C3 AMBER | Full finanical assessment undertaken and values shared<br>Contracting / Commissioning group standing agenda item<br>Lead coordinators identified<br>Assessment made of costs to deliver | | | To recruit a Deputy Head of Commisioning<br>A designated Senior Operation Manager and Senior Nurse to be agreed to support Quality leads- ongoing<br>Setting up and implementing audits - ongoing | Jun-12 | C3 AMBER | May-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 | 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<br>Liaison with LETBs and LETCs as they are developed | Review at E&T Committee<br>HR Sub Reports<br>LETBs formed<br>Chief Executive of Black Country LETC appointed; Paula Clarke<br>HEE CEO now appointed | workforce planning input to LETC needs strengthening<br>Lack of direction from DOH | Develop Liaison with LETB/LETC | Oct-12 | C3 AMBER | May-12 | |
| **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<br>Process for review and comments on documentation via Steering and Trust Board - ongoing<br>Programme for Communication with staff, patients and public - ongoing<br>SHA performance monitoring and self-certification process - monthly<br>Detailed minutes and action notes - ongoing monthly<br>Board development programme - monthly<br>Review of Monitor's Compliance Framework against Trust performance report | CQC full compliance following re-inspection Feb 12<br>Reactivation of application with Monitor.<br>Trust Management Team and Trust Board monthly update<br>Membership recruitment above trajectory<br>Delivery of Action Plan Milestones | | Board Development Sessions<br>Action Learning From SHA FT Network<br>Assessment against DoH Board Governance Assurance Framework<br>Undertake further review of mortality outlier alerts<br>Complete actions as identified in plans submitted to CQC in response to Responsive Review/ DANI review<br>Regular review of Monitor Board minutes and reports | | C2 YELLOW | May-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;

| 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? |
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| **Trust Objective:** | **To achieve a balance between demand & capacity of services** | | | | | | | | | |



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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| Chief Operating Officer | O16 2765 | High levels of sickness and maternity leave affecting Health Visiting capacity within Bilston team. | C2 YELLOW | 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.<br><br>Management staff have been moved into the base to do clinical work<br><br>There is an individual action plan for the Bilston team now in place.<br><br>The Health Visiting service has been reconfigured across the whole of the city and staff have been moved and allocated new caseloads.<br><br>Additional clerical support to reduce the data backlog which was affecting activity compliance, and also to increase the clinical capacity of the team<br><br>Saturday clinics have recommenced and thus increased the capacity to offer increased numbers of developmental assessments<br><br>Health Visitor on phased return to work will manage in coming post and assess records as capacity allows prior to transferring to school health. | The backlog of outstanding work is decreasing<br><br>The daily workload is being managed and dealt with.<br><br>Sickness absence is now not an issue in Bilston, therefore improving capacity and staff morale - will be monitored under the standard process<br><br>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.<br><br>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.<br><br>Interim work plan has been developed and agreed inclusively with the Bilston Health Visiting team.<br><br>Improved staff morale<br><br>Reduced backlog of developmental assessments | Routine and universal work for this team is being supported city wide using the vacant caseload policy.<br><br>Recently recruited staff member retracted acceptance offer<br><br>Other caseload and student pressure and the resignation of HV staff across the city prevented part-time HV from commencing on 03/02/10 | External review of service (delayed due to service reorganisation). Report expected by the end of February 2012.<br><br>Trained one Clinical Practice Teacher in September 2011, two to be trained in January 2012, with a further two planned for September 2012.<br><br>Recruitment for new health visiting staff is ongoing.<br><br>To prepare Bilston team as a suitable area to take Health Visitor Students<br><br>September 2012 HV students will commence supervised practice at the end of May, hence will hold a small caseload which will reduce the pressure on HVs who hold large and complex caseloads.<br><br>Close monitoring of caseload and team by HV co-ordinator<br><br>Interim work plan under regular review and will be extended until medium term plan is enacted - ongoing.<br><br>To continue to manage return to work processes aligned to the presentation of this risk - ongoing. | Feb-12<br><br>Sep-12<br><br>Sep-12 | C2 YELLOW | May-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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| | | | | Accommodate teams within local Children's Centres<br><br>Review & reconfiguration of caseloads to support vulnerable families.<br><br>Phased return to work for 3wte planned<br><br>0.7wte interim support identified from other location<br><br>Non- essential visits postponed<br><br>IPM or Digital pens data to be inputted within 5 working days.<br><br>Identify any outstanding training.<br><br>Group supervision may be beneficial to team in addition to 1-1 supervision.<br><br>Move from corporate caseloads into identified named caseloads.<br><br>All children transferring into the area to be reviewed and actioned.<br><br>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.<br><br>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. | Work and team more organised<br><br>Team have greater control and confidence in work schedule and priorities<br><br>Team more confident in ability to manage workload | | | | | |



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| | | | | Resident Health visitors to manage their own and vacant caseload child protection and safeguarding children<br><br>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.<br><br>Increased managerial support to re-audit and re-prioritize caseload has resulted in a more manageable workload<br><br>Provision of additional clerical support to provide non-clinical support to HVs<br><br>Reorganisation of city-wide staffing<br><br>Return to full duties by staff member following long term sickness absence<br><br>Robust sickness absence monitoring and management of staff by HV Co-ordinators<br><br>Recruitment of HV staff continues - 1.4 WTE experienced HVs to commence in January 2012.<br><br>Additional Saturday morning clinics commenced to increase capacity and to address the back-log of 9 month and 2 year developmental assessment<br><br>Detailed caseload analysis undertaken by the clinical team to determine key issues | | | | | |

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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<br><br>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<br><br>1wte experienced qualified HV commencing into post on 16/04/12<br><br>All general clinics being managed by additional Health Visitors from neighbouring team due to further short term sickness absence | | | | | | |



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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<br><br>Performance Management Framework in place that is monitored through Trust Management Team and Trust Board.<br><br>NHS Instittute for Innovation Better Care Better Value benchmark<br><br>NHS Performance Framework - Quarterly to Trust Board | 62 day cancer target now within target. Continue to monitor at thrice weekly meetings - March 2012<br><br>CQC registration without conditions - Apr 2011<br><br>CQC Reports - Privacy, Dignity and Nutrition - Responsive Review - March 2012 | C Diff target not on target due to PCR testing - March 2012<br><br>Delays in Transfer of Care above internal target periodically (target below 6) Feb 2012<br><br>Length of Stay is above target - Feb 2012 | Action Plans for CQC report - ongoing<br><br>Workforce review of Nursing and Midwifery<br><br>Develop Trust audit to test outcome compliance<br><br>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.<br><br>Implement findings of Newtons Review re: Outpatients. Phase One complete. Phase Two - July 2011<br><br>Service Improvement initiative - bed capacity meets demand - modelling implementation commenced<br><br>Service Improvement initiatives - Productive Theatre - ongoing<br><br>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. | <br>May-12<br><br><br>May-12<br><br><br><br><br>Aug-11 | C2 YELLOW | May-12 | Yes |



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| **Trust Objective:** | **To agree appropriate population catchment areas for RWHT service** | | | | | | | | | | |
| Director of Planning / Contracting | 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)<br>Established GP liaison office and webpage<br>Flexible services and low Waiting Times for all first appointments (on-going)<br>Promoting choice through Web Site & NHS Choices - Nov 2010 (on-going)<br>Market Research & Marketing Strategy<br>Marketing Report - Trust Board - Jan 2012<br>Review DoH Any Qualified Provider proposals (as each document is published) | Limited extent of choice in Nuffield for acute care<br>No new players in the area for acute or community care<br>Non-Wolverhampton Commissioners requested proposals for specialist community services<br>Maintain and grow referrals for all specialties<br>Lack of interest by private sector in development with the region | | Produce Quarterly Market Share analysis report<br>Produce Quarterly Market Share analysis report - on-going<br>Review PCT Cluster commissioning intentions with regard to Any Qualified Provider<br>Review PCT Cluster commissioning intentions with regard to Any Qualified Provider.<br>Use refinements to NHS Choices & Choose & Book to 'sell' services - on-going<br>Maximise opportunities to sell services via new Web Site - on-going<br>Work with shadow Consortia to understand future requirements - on-going<br>Explore opportunities with other commissioners to support the TCS agenda - on-going | <br><br>May-12<br><br>Mar-12 | D2 GREEN | May-12 | Yes |



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# The Royal Wolverhampton Hospitals NHS Trust

Trust Risk Register

May-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:** | | | | | | | | | | | |
| Director of Finance & Information | 2953 | Server Capacity exhausted. Additional capacity dependent on new SQL cluster implementation. Projects and live applications significantly at risk until completed. | C4 AMBER | | | | Produce contigency plans as appropriate. Plan to produce a confirmed implementation planfor SQL cluster to include project and application prioritisation for communication and impact analysis. | May-12 | D1 GREEN | May-12 | |
| Director of Human Resources | 2858 | NHSLA Level 3. Achievement required for standard 3. relates to standard requirement of 95% compliance in mandatory training | C3 AMBER | e-learning packages available as alternative to face to face training<br>monthly compliance reports issued<br>training compliance discussed at divisional/directorate meetings as part of governance agenda<br>increased publicity around individual responsibility to undertake mandatory training via desktops and posters<br>NHSLA project group monitoring progress for standard 3 | all NHSLA minimum data set topics now included in performance repository for TMT report | 95% compliance standard not achieved in certain mandatory training subjects<br>reporting frequency for all minimum data set topics nort monthly for all subjects | Progress monitoring<br>New NHSLA Level 3 standard 3<br>Action plans to be drawn up | <br>Oct-12<br>Oct-12 | D3 YELLOW | May-12 | |



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| Chief Nursing Officer | 2950 | Unable to achieve no avoidable pressure ulcers by December 2012 across the health economy. | B3 AMBER | | | | Business case for TVN team | May-12 | D3 YELLOW | May-12 | |
| | | | | | | | Strengthen the wound care link role to develop competency and change culture | Jul-12 | | | |
| | | | | | | | Review equipment resource provision and improve community equipment provision and maintenance. | Jul-12 | | | |
| | | | | | | | Develop a tissue viability resource guidance on intranet. | Jul-12 | | | |
| | | | | | | | Strengthen sharing of action plans following investigation and manage capability as required - ongoing. | | | | |
| | | | | | | | Ratify pressure ulcer policy and clinical practice. | May-12 | | | |
| | | | | | | | Employ a data analysis to assist with data trends | May-12 | | | |
| | | | | | | | Develop a paediatric/ neonates pressure ulcer prevention policy. | Sep-12 | | | |
| | | | | | | | Develop an e learning package | Jul-12 | | | |
| | | | | | | | Communication strategy to change culture | May-12 | | | |



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| Chief Nursing Officer | 2951 | Risk of not reducing the incidence serious and untoward pressure ulcer incidents, wound infection, hospital admissions due to deteriorating wounds, MRSA bacteraemia, due to poor capacity and fragmented clinical pathways. | B3 AMBER | | | | Business case for TVN team to improve capacity and quality care for the patients for the health economy with a less fragmented management structure. | Apr-12 | C3 AMBER | May-12 | |
| | | | | | | | Revised pressure ulcer policy and clinic practice | Apr-12 | | | |
| | | | | | | | Wound care formulary | Apr-12 | | | |
| | | | | | | | Wound policy | May-12 | | | |
| | | | | | | | Strengthen wound care link role | Jul-12 | | | |
| | | | | | | | Stress risk assessment of all staff | Apr-12 | | | |
| | | | | | | | Revise referrals pathways | Jun-12 | | | |
| | | | | | | | Devise TVN documentation that can be scanned onto clinical portal for all service access | Jun-12 | | | |
| | | | | | | | Community TVN clinic to be on clinical portal and all clinical letters | Jun-12 | | | |
| Chief Nursing Officer | 2952 | Patient developing a pressure ulcer due to inadequacies of pressure ulcer prevention equipment. | B3 AMBER | | | | ILS to review their service level agreement, if unsuitable for plans, CRC to plan a business case for the community. 7 day service with same day delivery required. | | C3 AMBER | May-12 | |
| | | | | | | | CRC to review " mattress pitstop "idea to relieve nurses from changing mattresses | | | | |
| | | | | | | | To purchase suitable trolley mattresses for A and E | | | | |



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| Chief Nursing Officer | 2680 | Interpreting & Translation Service - risk of overperformance against central budget held by patient experience. | A3 AMBER | Current process in place to direct face to face/telephone translation services<br>Updated policy and criteria to clarify process for interpreting services<br>Changed face to face provider to improve service<br>Changed telephone provider to improve service and screening of enquiries<br>Circulated reports to divisions regularly to highlight costs incurred<br>Raised awareness of new process | | Process is not applied consistently - face to face translation service is provided when telephone interpreting service would be appropriate.<br>No audit trail in place to identify when service has been provided<br>Lack of awareness of the process within directorates<br>No consequence to divisions for overspend | Improve audit trail for use of interpreting services for monitoring purposes<br>Recharge to directorates where appointments cancelled but interpreting service not cancelled<br>Identify high users and engage to review working practices<br>Scoping use of electronic translation<br>Limited face to face with risk assessment process<br>Developing business case | May-12<br>May-12<br>May-12<br>Jun-12<br>Jul-12<br>Aug-12 | C2 YELLOW | May-12 | |
| **Trust Objective:** | | **Clinical Negligence Scheme for Trusts** | | | | | | | | | |
| Chief Nursing Officer | 2917 | Potential Loss of savings if NHSLA assessment not achieved. | C4 AMBER | Trust audits used to reveal compliance problems<br>Project and small working groups are trouble shooting problems<br>Escalation of risk to Trust risk register<br>Ongoing compliance monitoring and reporting at NHSLA Steering group, Compliance Committee and TMT<br>Self assessment to implement policy into practice<br>Monitoring of policies and audit production | | Level 2 self assessment show poor local implementation of policy - Feb 12<br>Poor completion and follow up of audit actions - Apr 12<br>Unable to show improvements in some audit results - Apr 12<br>Internal monitoring currently show predominantly red/amber scores - Apr 12 | Benchmarking<br>Pre assessment visit to be used to test compliance in specific areas - ongoing<br>Perform risk assessment<br>Review audit results and actions for improvement prior to assessment visit - Reaudit as necessary. | Jun-12<br>Apr-12<br>Jun-12 | B3 AMBER | May-12 | |



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| **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.<br><br>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<br><br>External Support is being employed to review the condition of the Estates where Services from WCPCT are undertaken.<br><br>Negotiations continuing re potential properties to transfer. Date for transfer now delayed due to DH.<br><br>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.<br><br>Site by site analysis underway as to condition of property occupied. Detailed individual/lease negotiations to take place with legal support during 2012 to fit with revised DH timetable.<br><br>Department of Health guidance now delayed transfer to 1 April 2013. Trust has baseline information and will re-commence negotiations from 1 June 2012 with PCT. | Dec-11 | C3 AMBER | May-12 | Yes |
| Medical Director | 2920 | Provision of Vascular services at RWHT following centralisation of the service off-site and concerns over the required level of vascular surgery support to other clinical specialties including those in the Heart and Lung Centre. | C4 AMBER | Clinicians from RWHT are actively participating in the project group which is developing the implementation plan of vascular network service provision across the Acute Trusts of the Black Country and promoting details of the level of support required to the group. | To be reviewed when centralisation of vascular surgery is implemented. | To be reviewed when centralisation of vascular surgery is implemented. | To review and agree the governance arrangements around the implementation proposals regarding patient safety and service provision across RWHT, prior to the network service plan being implemented operationally. | Jul-12 | E2 GREEN | May-12 | |



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| 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.<br>Revised Safeguarding policy in place<br>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<br>MCA and DOLs application numbers | Specific aspects of WMQRS Peer review care of vulnerable adults in hospital - Jan 2012<br>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.<br>Learning disabilities lead post now made substantive.<br>Continually improve and sustain levels of MCA training<br>Implement agreed learning disabilities IT alert system to identify patients on admission to receive specialist nurse support | Mar-12<br>Apr-12<br>May-12<br>Mar-12 | D3 YELLOW | May-12 | Yes |



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| 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<br><br>Supervision of junior doctors re IP practices/ skills/ training<br><br>HCC-DH Self Assessment Hygiene Code<br><br>Screening Policy in Trust implemented<br><br>Screening Programme in Community in place<br><br>IV team PID agreed at TMT and in development<br><br>Surgical Site Infection Surveillance Team agreed at TMT and in development.<br><br>Robust surveillance system in place.<br><br>Monitored the increase in C-Diff post PCR testing and discussed with commissioners<br><br>PREVENT Bronze standard achieved by Care Homes - Mar 2011<br><br>Appointed Data Analyst for IPT - March 2012<br><br>IP lead nurse in post - Team restructure aimed at delivery.<br><br>CDiff plan reviewed end of September 11 and enhanced with a range of actions aimed at reduction of incidence<br><br>Rapid improvement programme - creating best practice wards includes an infection prevention work stream | CQC Visit report - May 2011<br><br>HPA quarterly report of MESS data ongoing.<br><br>2011/12 best year to date for the reduction of MSSA bacteraemia, DRHAB's and MRSA acquisition<br><br>Current C-diff and MRSA bacteraemia YTD performance - April 2012<br><br>Successful Nursing Times award for infection prevention in community Nov 2011.<br><br>MRSA rates currently on trajectory Apr 2012<br><br>DRHAB's - Low numbers of MRSA pos Ph on admission to care homes 1/260 screened - Dec 2011<br><br>Reduction in HCAIs other than MRSA bacteremia - April 2012 | PCR testing has increased the numbers of C-Diff due to more accurate testing (sensitivity) - Feb 11<br><br>Lack of data explaining CDI - Sep 2011 | Exercise the effectiveness of revised IP team structure supporting the divisions.<br><br>Develop a business case for centralised intravenous team to reduce DRHAB | Jun-12<br><br>Jul-12 | C4 AMBER | May-12 | Yes |



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| | | | | MRSA admission screening pilot in care homes commenced October 2011<br><br>MRSA Screening for Podiatry Nail screening pilot Commenced July 2011 - 0% infection rate.<br><br>MRSA early discharge screening Pilot commenced October 2011 - 1/260 positive<br><br>Revised Outbreak Mangement Plan to include dehydration clinical pathway in place<br><br>Implemented CDI Assurance process. Changed delivery of IP through team / division.<br><br>Action plan in place for Hygiene Code to be monitored by IPCC quarterly - reported to IPCC Nov 2011.<br><br>Action plan for reduction in HABs and DRHABs developed.<br><br>Chronic wound screening commenced Dec 2011 | | | | | | |



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| **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<br><br>Job plan audit developed<br><br>Job Planning Steering Group set up to ensure robust job planning process led by Medical Director.<br><br>Implementation of monitoring procedure to ensure consistency of approach across Divisions.<br><br>Performance targets including pay costs v clinical income.<br><br>Medical staffing review<br><br>Locum Bank Project Team set up - terms of reference/scope developed. Action plan for implementation. | Consultant Job Planning Framework agreed. Implementation in progress.<br><br>Performance management system, quarterly reviews of Divisions and monthly reports to Trust Board. | High agency medical costs.<br><br>Previously there was inconsistency of application of approach.<br><br>Capacity failing to meet demand. | Action Plan to address the issues once identified by job plan audit.<br><br>Review of medical rotas and introduce Locum Bank. | C2 YELLOW | May-12 | Yes |



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| 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).<br><br>Staff Governors in constitution have voice to influence direction of Trust<br><br>Action plan to learn from past survey constructed<br><br>Staff feedback has been incorporated into the Trust Board quality & safety dashboard thereby aligning staff engagement with patient safety agenda.<br><br>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.<br><br>Key Staff Survey indicators included in HR KPIs<br><br>Divisional/Directorate Staff Survey reports discussed at HR subgroup and distributed to Divisional and Directorate managers and matrons and Divisional / Directorate action plans developed.<br><br>Staff survey results presented at Trust Board, TMT and senior managers briefings. | KPI in annual plan.<br><br>ChatBack 2011 results show improvement in most areas. Action plans to further improve results in place.<br><br>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.<br><br>Turnover below National average and within Trust target. | Results received from 2011 staff survey; response rate was (374 staff) 45% (in the lowest 20% of Acute Trusts) compared with 39% in 2010.<br><br>Feedback from Managers requesting more specific Specialty breakdown. | ChatBack will be conducted in Summer 2012 to ensure momentum is maintained.<br><br>Results will be fed to Divisions and action plans drawn up at a Divisional level.<br><br>Results from 2011 survey will be presented at TMT, Trust Board, HR Sub Committe and Senior Managers Briefing | Jun-12<br><br>Jun-12<br><br>Jun-12 | D3 YELLOW | May-12 | Yes |



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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<br>Regular liaison with solicitors<br>meetings set up with individuals and trust solicitiros to gather mor information | claims reduced to 40<br>Regular analysis as part of audit process<br>Robust ruling in support of AFC systems from ET in test case | | Continue work with solicitors<br>stage 2 investigations commenced July 2010. active case management of cases still underway<br>Independent reports concluded - approprite challenge in place and await outcome | | D3 YELLOW | May-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.<br>Internal Audit Project to commence October 2010<br>Integrated patient flow team through Reablement funding<br>Weekly discharge meeting.<br>Daily bed state shows current position<br>Annual 'Reimbursement funds' agreement<br>Action Plan to implement workshop outcomes<br>PCT Supporting Project Manager<br>Health Economy Winter Plan<br>ECG Meeting | Show reduced delayed discharges<br>Weekly delayed discharge report | Patients with excessive length of stay - February 2012 | Training and awareness sessions on services within Community Services - ongoing.<br>Integrated patient flow team through Reablement funding - Project Manager posts appointed, awaiting confirmation of start date.<br>Action for Best Practice wards with dedicated social worker input.<br>LEAN Project Managing Complex Discharges - ongoing.<br>Evaluate impact of Best Practice Wards and agree next steps | Mar-12 | D2 GREEN | May-12 | Yes |



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| Chief Operating Officer | 2761 | Lack of LSMS support for TCS transferred community services.<br>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<br><br>Head of Governance and Head of Estates established interim proposal to utilise existing internal resource to reduce risks until end of March 2012<br><br>Front line security services provided via APCOA (RWHT)<br><br>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.<br><br>Optional Appraisal completed - option 3 preferred option - Secure budget uplift from cost pressure discussions 2012/13<br><br>Additional resources allocated in 2012/13 budget. Staffing improvements are now in progress, via a recruitment process. | Effective arrangements are not in place. | Notification from PCT (Sarah Southall) interim arrangements not sustainable beyond April 2012<br><br>Notification from Head of G&LS that fire/security remit in staff transferred may be removed end of March 2012<br><br>Current Fire Safety Officer resources inadequate to fulfill responsibilities under Regulatory Reform (Fire Safety) Order 2005<br><br>No resilience plan in place/available during the absence of the Security &/or Fire Safety Advisor | Option 3 - preferred & discussed with COO/DoF<br><br>Escaltion of risk to COO | Feb-12<br><br>Feb-12 | E2 GREEN | May-12 | |



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| Chief Operating Officer | 2840 | From 1st Dec 11:<br>*Extra activity for NX A&E as result of Stafford A&E closing overnight. | B3 AMBER | Upgrade 1 ward area<br>Review physical environment<br>Appoint to staffing gaps<br>Review staffing and staffing model<br>Develop monitoring system for effects of additional demand<br>Order equipment<br>Weekly performance monitoring of A&E at director and operational level.<br>Trust has access to data re: attenders at Stafford A&E on which to base measures at NX. | | | Establish workflow<br>Liaise with PCT on coping strategies<br>Extra ward to open (C3) as requested | | May-12 | |



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| 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.<br><br>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<br><br>Annual delivery plans developed based on contracted activity and agreed targets for waiting times and quality indicators.<br><br>Monitoring of access targets, activity, waiting times and other quality indicators on a weekly and monthly basis<br><br>Winter plan in place which includes access to flexible capacity<br><br>Working with primary care and other agencies to improve timeliness of discharge<br><br>Implementation of the Productive Series Programme to ensure efficient and effective wards and departments<br><br>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.<br><br>Quarterly assessment, risk rating and remedial action identified by Exec Director lead for all business outcomes in the annual plan<br><br>Evidence that performance is discussed at weekly COO meeting with agreed actions to rectify underperformance<br><br>Performance reports to TMT and Trust Board monitors performance against plan<br><br>Reports to SHA and other agencies<br><br>Daily meetings to support effective management of capacity<br><br>Evidence of RCAs on cancelled operations | Extra capacity being opened on an ad hoc basis - February 2012 | Utilise the findings of the Capacity to deliver bed reductions/CIP plans - ongoing | D3 YELLOW | May-12 | Yes |



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| | | | | 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 | | | Further investigations carried out and this confirmed that some process redesign is necessary to achieve timely discharges on the system.<br>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 | May-12 | Yes |



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



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| 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.<br>Review alternate recruitment to vacant medical posts.<br>Review staffing patterns in relation to peak time of activity.<br>Full review of planned waiting list undertaken.<br>A&E targets monitored daily and reported to TMT & Trust Board monthly<br>Review of national targets in a prospective<br>KPI's introduced for data collection and recording.<br>Performance Management enhanced<br>Escalation policy regarding A&E.<br>Directoate activity trajectories and capacity plans.<br>TAL performance maintained, continue to monitor daily<br>Continue weekly meetings with Divisions and weekly monitoring of waiting times<br>COO Report weekly/monthly<br>Cancer Network engaged in definition and breach analysis<br>Review of definitions of Cancer Systems Vs 18 weeks. | A&E targets achieved<br>Early warning of potential to fail<br>Ratings<br>Sustained performance<br>On an ongoing basis and daily monitoring of hot spot areas | Two A&E KPI's are above target - April 2012 | A&E KPI's monitored daily. Working group set up to ensure all compliance aspects are covered.<br>Review staffing patterns in relation to peak time of activity<br>Review escalation process<br>Review alternate recruitment to vacant medical posts.<br>Action plan developed, implemented and monitored at Directorate meetings- ongoing<br>Targets monitored and managed weekly where possible, otherwise monthly or (some) quarterly - ongoing. | D3 YELLOW | May-12 | Yes |



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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. There is an additional risk that GP workload will also be lost. 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<br>RWHT representation at networking meetings | Completion of the build includes the partnership working capability<br>Stratergy involving senior management of the trust in network forums | | Contruction of Integrated pathology build<br>Pathology management to attend networking group meetings<br>Inform trust senior management team about outcomes from networking meetings<br>Continue dialog with network group | Feb-13<br>Dec-12<br>Dec-12<br>Apr-13 | C4 AMBER | May-12 | |
| Director of Finance & Information | O16 514 | Failure to deliver recurrent efficiency gains and CIPs. | A4 RED | Monthly reporting against projects including to Trust Board<br>Change Program Board (Executive Director led)<br>Each project has an executive director lead | Trust Board Reports & Minutes include CIPs | Finance report to Trust Board.<br>Deloitte HDD report. | Monitor closely through CIP programme board<br>Identify 'new' projects and programmes in advance - ongoing<br>The Trust is investing in a new system solution "TriSolve" which will enable scheme implementers to have more direct involvement in the reporting of their schemes and be held to account. | | B3 AMBER | May-12 | Yes |



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| Director of Finance & Information | O16 1739 | Failure to develop Service Line Reporting across the Trust. | B4 RED | Reports are being issued monthly and clinical engagement has been improved which has enabled the content of the reports to be improved and be more useful.<br>SLR reports to be distributed on a monthly basis.<br>SLR pilots to be set up.<br>2011/12 plan to be agreed and monitored against.<br>Rollout plan to be proposed. | | Timescales and priorities to be determined when 1st phase report considered.<br>Need to develop better appointment bases for some direct and indirect costs. | 2012/13 plans will be agreed in April and then monitored against Patient level Costing is being implemented in the Trust which will enable more in depth SLR to be provided.<br>Board received latest briefing in April 2012. Updated contributions using 2012/13 tariff will be available by the first week in May. | May-12 | D3 YELLOW | May-12 | Yes |
| Director of Finance & Information | O16 2468 | That pay, price rises and cost pressures will be higher than assumptions. | B3 AMBER | 2012/13 plan includes cost pressures, pay awards and 2012/13 incremental drift impact.<br>2012/13 financial plan has modelled impact of pay and non pay cost pressures.<br>Long term financial model has assessed financial impact for 5 year period to 2016/17 | | | Monitor budgetary position closely through operational finance group/TMT and Trust Board | | C2 YELLOW | May-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 | May-12 | |



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| **Trust Objective:** | | **To achieve Foundation Trust status** | | | | | | | | |
| Medical Director | 2922 | Maintenance of a minimum accreditation of level 2 or higher for the IGToolkit v10 - 2012/13 in line with national guidance. | C4 AMBER | Leads have been asked via IGSG to make action plans to address any further gaps in level 2 and detail how to meet level 3 based on v9 IGToolkit standards. | Evidence uploaded into the IGToolkit for v9 will roll over to be used for v10 | IGToolkit Standards may significantly alter or add new requirements between v9 and v10, which may be unachieveable.<br><br>Any work plans put in place before the release of v10 of th eIGtoolkit will be based on v9 standards and may no identify true gaps in assurance<br><br>IGToolkit v10 standards will not be released untill May/June 2012- making it difficult to confirm a work plan against the neew standards untill this time | | D2 GREEN | May-12 | |



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