The Royal Wolverhampton NHS
NHS Trust

Board Assurance Framework/Trust Risk Register

Agenda Item No: 12.1

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	25th November 2013
Title:	Board Assurance Framework / Trust Risk Register
Executive Summary:	This paper reflects the spread across Board Assurance Framework and Trust Risk Register.
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

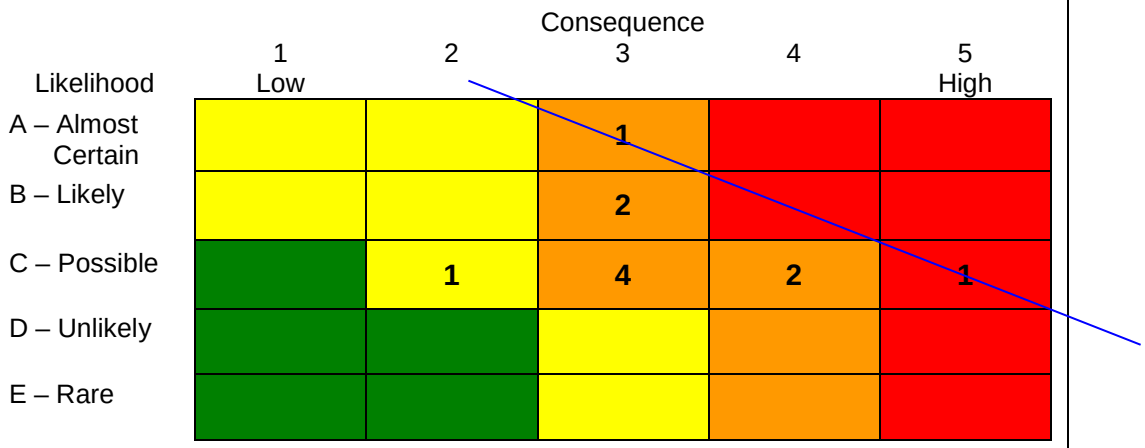
The Board Assurance Framework "provides organisations with a simple but comprehensive method for the effective and focused management of the principal risks that arise in meeting their objectives. It also provides a structure for the evidence to support the Statement on Internal Control" (Integrated 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 (on-going)	11
Risks managed to target level	0

There are currently 11 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:

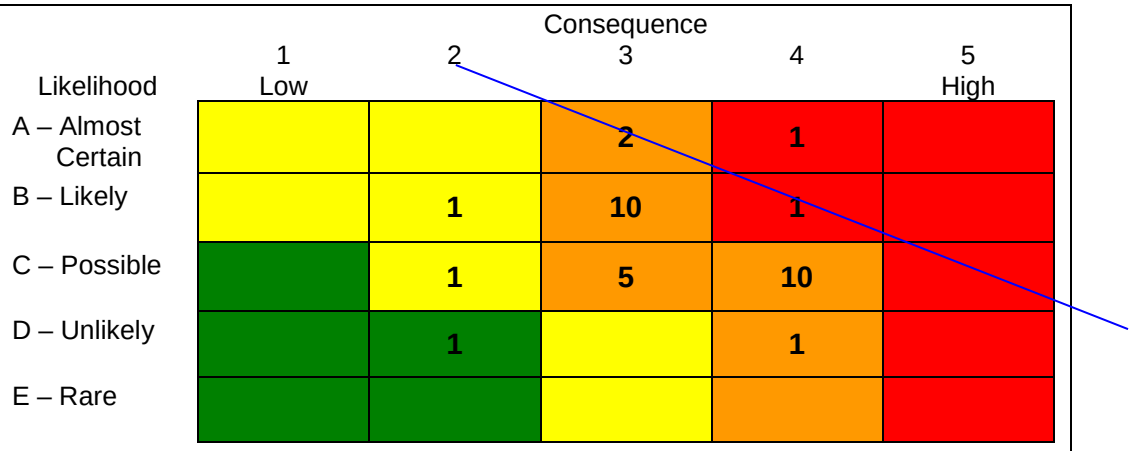
	ID	Risk Title	Lead
RED	2965	Failure to reduce Never Events.	CN

Trust Risk Register – Updates (Appendix B)

Following updates the split of the Trust Risk Register is:

Risks currently being managed (ongoing)	31
Risks managed to target level	2

There are currently 33 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
	943	None adherence to chemotherapy policy and procedures resulting in poor patient and staff experience/confidence.	MD

The following illustrates how risks on the BAF and TRR are mapped against the strategic objectives:

Strategic Objective	BAF				TRR			
	R	A	Y	G	R	A	Y	G
1) To provide our patients & staff with a safe environment.	1	1			1	13		1
2) To be the employer of choice.						3		
3) To achieve a balance between demand & capacity of services		3				4		
4) To progressively improve the image and perception of the Trust								
5) To be in the national NHS top quartile of benchmarks							1	
6) Deliver services within financial allocations		3	1		1	5	1	
7) To be a high quality educator						1		
8) To agree appropriate population catchment areas for RWHT service		1						
9) To develop our position as a tertiary centre								
10) To achieve Foundation Trust status		1				1		
Clinical Negligence Scheme for Trusts						1		

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 (Nov 2013)

Lead Director	Risk	Risk Title	Update	Reasoning / Progress Against Actions
Director of Planning and Contracts	2508 A3	Commissioning responsibility changes - affects contracted income	Action Plan updated	Engagement with development of Integration Transformation Fund to manage impact of transition.
Chief Executive	1501 C4	The Trust does not meet the DH / Monitor requirements to become a foundation trust.	Positive Controls updated. Risk after actions now D3 Yellow.	CQC Inspection completed. Quality summit 19th Nov.
	3330 C4	Impact on RWT from Mid Staffs	Positive Controls updated.	CEO attends Sustainability Board Memorandum of understanding developed with MSFT
Chief Nursing Officer	2965 C5	Failure to reduce Never Events	Gaps in Assurance updated.	Never Event - Gynaecology - Sep 2013

Appendix B: Tracking changes within Trust Risk Register (Nov 2013)

Lead Director	Risk	Risk Title	Update	Reasoning / Progress Against Actions
Chief Nursing Officer	2917 E2	Risk of non-compliance with NHSLA standards - achieving 12/13 CIP	***Risk Closed***	Passed Level 3 Assessment 50/50 Score.
	535 C4	Failure to achieve reductions in HAIs impacting on Trust's reputation and compliance to regulatory standards.	Action Plan updated.	Amend fidaxomyicn business case following TMC presentation
	2448 C3	Failure to have effective systems in place for patients with learning disabilities or requiring application of Mental Capacity Act.	Positive Controls and Action Plan updated.	Work Programme agreed with LD Nurse following induction (May 13). Audit undertaken which led to the implementation of flagging system being set up on PAS (Aug 13). Included information on MCA, DOLS and Consent to Treatment on Induction Programme (Oct 13) Raising awareness regarding Vulnerable patients, MCA, DOLS and Consent to Treatment across the Health Economy. Identification required for an independent trainer for Safeguarding.
	2950 C1	A routine decontamination audit in October 2013 demonstrated poor compliance with decontamination standards putting patients at increased risk of infection.	Risk level now C1 Green. **Risk moved to Directorate Risk Register.**	
Director of Planning and	2929	Failure to deliver CQUINS schemes.	Positive Assurances updated. Current grade	Q2 submission provided to CCG and SSC, initial assessment is that compliance will be

Contracts	C3		now C3 Amber. Risk after actions now D3 Yellow.	in line with Trust self-assessment.
Chief Financial Officer	514 A4	Failure to deliver recurrent efficiency gains and CIPs.	Positive Controls updated.	KPMG appointed with agreed Terms of Reference to identify efficiency opportunities.
	2468 B2	Pay rises and cost pressures	Positive Assurances updated.	Trust Board report on finance position.
	2781 B3	Contractual risks due to tariff changes for emergency threshold.	Positive Controls and Action Plan updated.	Discussions with Commissioners for investment. Engage with Commissioners on winter pressure issues and plans.
Director of Human Resources	3409 D3	Funding allocation from HEE WM for LBR and Second Registration	*****Risk Closed*****	HEWM agreed to place contracts with specific providers on an academic year basis. Trust spending plans for devolved funding reflect the required split of allocations across the financial year.

The Royal Wolverhampton NHS Trust

Board Assurance Framework

November-2013

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										

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 provide our patients & staff with a safe environment.**										
Chief Nursing Officer	O4 2965	Failure to reduce Never Events. Date of origin: 18/05/12	C5 RED	Divisions continue to monitor compliance with all surgical theatres monthly at CQRM / QSC - ongoing (Jan 13) Directorates monitor the use of modified checklists in non surgical areas and reported to QSC and CQRM monthly - ongoing (Jan 13) Scoped the revised DoH Never Event Guidance (Oct 12) with Trust wide systems and processes in place (Jan 13) Reporting monthly through to Trust Board. Quarterly Trust newsletter publication Learning event commenced June 12 - featuring never events. MD and CNO mandated sessions share Never Events and RCA findings and actions - Aug 12 Afpp training delivered Nov 12 Never Events on divisional and directorate risk registers.	Q&S Committee receive monthly assurance of Never Events avoidance progress (Jun 13) Never Event reported in April 2013 - Obstetrics. Now positive assurance on measures received from CCG. Safety checklist policy ratified at policy committee (May 13) CQC final Report confirms no concerns (Mar 13) Monthly audit of the use and quality of completion of WHO safety checklist in non theatre areas show improved compliance (majority > Assurance provided by Divisions re the review of risk potential for all never events at March 13 QSC. Zero Never Events in August 13. Specific action plans post each Never Event in all directorates now completed (Feb 13) Audit of compliance with WHO checklist showing high 90's compliance in August 13. External auditors have audited the draft policy and practice. Report in confirmed and to be presented at Q&S April 13.	Never Event- Cardiac Theatres - May 2013 Never Event - Gynaecology - Sep 2013	AFPP review of Cardiac Theatres. Results of AfPP review and work in progress with HoM in Maternity Cardiac theatres to be managed under main theatres to improve standardisation of practice / compliance with standards.	Jun-13 Nov-13	E2 GREEN	Nov-13	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 Executive Officer	O6 3330	The impact on the Trust of the changes occurring at Mid Staffordshire NHSFT and within the Staffordshire health economy Date of origin: 14/02/13	C4 AMBER	Trust presentation to Wolverhampton City CCG CEO attends Sustainability Board (Nov 13) Memorandum of understanding developed with MSFT (Nov 13) Involvement in the work of the Contingency Planning Team - Aug 13 Contributing to TDA lead work - Sep 13 Internal evaluation of the impact on services both without and with formal service reconfiguration - ongoing as proposals develop. Review of activity movements to anticipate changes in demand for services - ongoing as proposals develop. CEO meetings i/c local MPs	Trust's clinical model has been approved by the National Clinical Group Trust's proposal forms part of Administrator's recommendations			C3 AMBER	Nov-13	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 achieve a balance between demand & capacity of services**										
Chief Operating Officer	O16 2962	Risk of Health Visiting business/system/service failure due to multiple systemic failings. Date of origin: 17/05/12	C3 AMBER	More student Health Visitors taken on. Professional Lead in post Ongoing recruitment and monitoring staff turnover. Reconfiguration of Health Visitor meetings to bi-monthly (internal Chair) and external Performance Review meetings via LAT Issue escalated to NHS England The Chief Operating Officer and the Director of Nursing review the service development programme - leads convene every month to drive service improvements. Directorate and Division will be monitoring HR indicators, complaints and any concerns raised through Safeguarding Team.	CQC unnanounced inspection - all standards assessed were met Compliance against HCP/ Service spec indicators monitored and reported monthly. Ongoing relocation of services into children centres Increase in student numbers	Recruitment behind trajectory - September 2013. Off trajectory with recruitment of Health Visitors Not fully compliant with delivery of the service spec/HCP Some delays in moving to children centres due communinication issues and service reconfiguration	AUGUST 2013- Family Nurse Partnership - a business case has been completed. Further discussion required re the cost implications, as the funding for the programme needs to be identified and agreed.	Jan-14	D2 GREEN	Nov-13	Yes
Chief Executive Officer	O16 3352	Potential for rapid growth of the Trust due to changes in the wider health and social care economy. Date of origin: 09/04/13	B3 AMBER	Nurture existing and new relationships Build flexibility into operating systems Organisational intelligence - primary and secondary care providers Understand timescales to implement step change increases in capacity Review workforce plans	Involvements in key groups reviewing service provision Achievements of contractual obligations				C2 YELLOW	Nov-13	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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Chief Financial Officer	3354	Estates quality and flexibility compromise the ability to respond to fluctuation in demand and the implementation of streamlined clinical pathways. Date of origin: 09/04/13	C3 AMBER	Prioritise programme for capital investment and completion of backlog maintenance Planning application approved for site redevelopment Interim refurbishment programme Creation of a new emergency department				D3 YELLOW	Nov-13	

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:	**Deliver services within financial allocations**										
Director of Planning / Contracting	O6 2508	Commissioning responsibility changes - affects contracted income Date of origin: 03/08/10	A3 AMBER	Director level engagement with the PCT and PCT Clusters (Dec 12) Targeted CCGs as they develop; and developed links with Clusters (Dec 12) Included potentially new configured Trust services in all assessment/reviews (Dec 12) Reviewed current and future contract Portfolios (Dec 12) Reviewed "Everyone Counts: Planning for Patients 2013/14" and PbR guidance for 2013/14 (Jan 13) Implementation of communication strategy across organisation (Jul 13) Revised communication strategy to reflect commissioning changes (Mar 2013) Internal RWT Contract Review/LDP meetings. (Senior managers /Directors agreed negotiations strategy (on-going)	Positive contract negotiations for 2013/14 Heads of Agreement signed by 7th March 2013 Internal RWHT Contract meeting at least once per month Agreement of risk share to support maintenance of overall financial quantum (Apr 13) Mapped on-going changes to commissioning portfolios, monitoring consistency to overarching financial envelope (have been deferred in line with national movement) - Jun 13 Contracts signed with all commissioners in line with national timescales (Jun 13). Meetings every month with Commissioners with action notes		Engagement with development of Integration Transformation Fund to manage impact of transition Negotiation with Commissioners at fortnightly LDP meetings for 2014/15, focus on CCGs. Development of relationships with Non-Wolverhampton collaborative commissioners.	Nov-13 Mar-14 Dec-13	C4 AMBER	Nov-13	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 Planning / Contracting	O16 2927	Failure to deliver against QIPP scheme resulting in lack of investment. Date of origin: 13/04/12	B3 AMBER	Commissioners to provide detailed work plan to support QIPP programme prior to removal of cost from contracts (Mar 13) Management of QIPP programme through established Modernisation Board (Mar 13) Agreed QIPP savings plan with relevant detail to inform impact on divisional planning and budget setting (Apr 13) Agreed a QUIPP work programme for 2014/15 with commissioners, documented within contract through the Service Development Improvement Plan (Oct 13)	Quarterly Contracting Reports to Trust Board Non-agreement of reduction of activity relating to QIPP without an agreed and detailed implementation plan (Mar 13) Modernisation programme Board commenced		Engage commissioners in early discussions around QIPP Programme for 14/15 To identify capacity and resources to deliver the programme.	Dec-13 Dec-13	B3 AMBER	Nov-13	Yes
Chief Financial Officer	O6 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. Date of origin: 13/04/12	C3 AMBER	In 2012/13 re-investment of funds into Trust were secured following negotiations (Mar 13) For 13/14 have secured favourable contracts Contingency plans in place	Financial position of the Trust monitored on Monthly board reports Monitoring referral trends for changes Procurement tenders reviewed to ensure sufficient competition		To identify market opportunities - ongoing To respond to bids put forward by Commissioners - ongoing Additional collaboration with other providers to reduce costs - ongoing Maintain good working relationships and communications with commissioners - ongoing		C2 YELLOW	Nov-13	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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Chief Executive Officer	O16 3353	'Safeguarding' the Trust for the future - Several significant issues impact at the same time resulting in lack of focus on the "core business" and decisions not consistent with long term strategy. Date of origin: 09/04/13	C2 YELLOW	Local intelligence about service delivery across our wider catchment Opportunity assessment process based around strategic goals Review of organisational impact - short, medium and long term Effective and timely consultation Robust board governance	Involvement in key groups reviewing service provision Relationships i/c Commissioners Achievements of contractual obligations			D3 YELLOW	Nov-13	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. Date of origin: 11/06/08	C3 AMBER	Ensured internal processes are in place to manage increased requirements to follow procurement processes in case of increased requirement to tender (Oct 13) Set up process to monitor Supply2health Website for future opportunities (Oct 13) Worked with shadow Consortia to understand future requirements Explored opportunities with other commissioners to support the TCS agenda (Mar 13) Submitted AQP proposals for Foot Health and Audiology 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 Monitor recent indication of relaxing of outlined stringent tendering requirements (May 13)	Limited extent of choice in Wolverhampton Nuffield for acute care - Quarterly data No new players in the area for acute or community care - Quarterly data Non-Wolverhampton Commissioners requested proposals for specialist community services - Aug 12 Lack of interest by private sector in development with the region - Quarterly data Worked with Public Health to manage the impact of the transfer of Lifestyle Services to the Local Authority Commissioners approved AQP submissions - Sep 2012		Review further AQP proposals - on-going Bi-monthly communication with GP community via a newsletter Monitor development of extended competition rules outlined as a result of the Health Act, with implications of proposed widening of requirements to tender services Use refinements to NHS Choices & Choose & Book to 'sell' services - on-going Maximise opportunities to sell services via new Web Site - on-going	Mar-14	D2 GREEN	Nov-13	Yes

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Trust Objective:		**To achieve Foundation Trust status**								

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 Executive Officer	O16 1501	The Trust does not meet the DH / Monitor requirements to become a foundation trust. Date of origin: 05/11/07	C4 AMBER	External review of Quality Governance has been completed (inc follow up review) Aug 13. Process for review and comments on documentation via Trust Board - ongoing Programme for Communication with staff, patients and public - ongoing TDA performance monitoring and self-certification process - monthly Board Action Plan to address issues related to deferral - ongoing Trust is engaging in the work of the CPT in relation to Mid Staffordshire Hospitals NHS Foundation Trust. Review of Monitor's Compliance Framework against Trust performance report monthly Periodic updates i/c Monitor Assessment Team Preparation for CQC inspection Revised sustainability timeline reported to TDA monthly Review of Monitor's Risk Assurance Framework against Trust performance report CQC Inspection completed. Quality summit 19th Nov.	Achieved milestones to date on sustainability timeline New NEDs in post Chair commenced 6 March 2013	Monitor letter deferring Trust - Oct 12	Action Learning From TDA FT Network Regular review of Monitor Board minutes and reports - ongoing	D3 YELLOW	Nov-13	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;

The Royal Wolverhampton NHS Trust

Trust Risk Register

November-2013

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										

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Trust Objective:		**Clinical Negligence Scheme for Trusts**								

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Chief Operating Officer	O4 494	Following Birth Rate Plus Audit, Audit of midwifery staffing Feb 2012, this has identified a defect of 4.25WTE midwives and 3.1 band 3 maternity support workers to achieve a 90/10 split within the midwifery workforce. This audit is based on 2011/2012 birth data of 4117 deliveries. The risk is that there is a recognised staffing shortage to comply with meeting the birth rate plus midwife to delivery ratios.This defect is in addition to the current vacancies within the service. The shortage could have a potential impact upon the quality and safety of care given particularly in periods of high activity. Update from Division Governance Meeting (12 June 2013): Actively recruiting staff therefore risk rating to be reviewed. Date of origin: 01/07/04	C4 AMBER	Business Case to Trust Management Committee - September 2013. Escalation policy developed and ratified at Directorate in order to support and guide staff during times of increased activity, reduced staffing and potential closure of the unit. Contingency plans invoked at times of increased activity Senior midwifery manager on-call 24hr 7 days a week Weekly midwifery establishments are reviewed by the Head of Midwifery All staffing incidents notified to Head of Midwifery. Ongoing monitoring via incident reporting system for staffing related incidents Bank usage where indicated which is authorised by the matron. Support from HR to explore alternative recruitment methods All staffing breaches and adverse outcomes are reported via senior nurse performance meeting monthly by Head of Midwifery. Staffing is a monthly agenda item on the operational meetings chaired by the head of midwifery	Funding for birthrate plus business case has been agreed to be provided substantively in 2014/15 funding. Staff have been appointed to the vacancies, awaiting start dates Bank hours and requirements are monitored weekly satisfying the senior Directorate team in relation to the management of risk. Will be signed off weekly by Head of Midwifery or Directorate Manager. The Wolverhampton Strategic Oversight Group for Obstetrics and Gynaecology continues to meet and receive reports on progress following the Health Care Commission enquiry. Interviews for band 5 &6 midwives have taken place and we continue to advertise and recruit into vacant posts	Adverse outcomes associated with sub-optimal staffing, are identified through incident reporting.	Recruit and appoint to vacancies with ward areas Explore alternative recruitment methods with HR Reducing midwifery non clinical activities to increase clinical midwifery availability.	Dec-13 Jan-14 Dec-13	C1 GREEN	Nov-13	

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Trust Objective:		**To provide our patients & staff with a safe environment.**									
Medical Director	943	None adherence to chemotherapy policy and procedures resulting in poor patient and staff experience/confidence. Date of origin: 27/02/06	B4 RED	Chemotherapy Prescribing MDT monthly meeting to discuss all off Formulary chemotherapy treatment requests. Chemo register in place for all prescribers Formulary of agreed prescriptions in place RCA conducted for incidents as required, action plans implemented as indicated by findings and lessons shared Pharmacy scrutiny of prescription that are non compliant with formulary Policy CP8 and procedure in place Annual validation of nursing staff competence	External review by HAQU, no concerns raised Audit of NICE guidance - 18 audits on plan for 13/14 National Cancer pt satisfaction survey Quality system in place to ensure version control of all departmental documentation	Self assessment against peer review measures identified some issues - work plan in place to address Concerns raised by staff members through formal and informal routes Audit of practice	Undertake audit of non formulary prescribing - process and clinician External review of individual cases/systems and processes Audit of attendence at Formulary group Full HAQU accrediation inspection planned Introduction of E-Prescribing	Dec-13 Dec-13 Jan-14 Nov-13 Apr-14	C4 AMBER	Nov-13	

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	1862	Trust wide consent audits reveal failures within the division to follow a 2 stage consent process and correctly complete DOH consent forms. Date of Origin: 08/07/08	C4 AMBER	Divisional Medical Director (Surgery) is the Trust Lead for Consent within the Trust Staff training on consent available. Standardised DOH consent forms in use across the Trust. Consent Audit 2010/11 has been combined with the documentation audit. This would allow directorates that document consent within the notes to be able to evidence 2-stage consent. Trust junior doctor induction changed so that doctors undertake induction and mandatory training prior to starting. Delegated consent lists kept by all relevant directorates Divisional Patient Information Ratification Committee. CDs compile directorates delegated consent lists with each new medical intake		2012/13 audits continue to show poor compliance with the consent process Consent forms not being correctly completed. Recurring themes highlighted through annual audit. Complete up-to-date delegated consent lists not held within directorates.	Awaiting implementation of the consent policy To rephase the wording of this risk Implement updated consent policy when approved Re-design the consent form	 Nov-13 May-14 May-14	E3 YELLOW	Nov-13	

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 Nursing Officer	O7 2448	Failure to have effective systems in place for patients with learning disabilities or requiring application of Mental Capacity Act. Date of origin: 01/06/10	C3 AMBER	Audit undertaken which led to the implementation of flagging system being set up on PAS (Aug 13) Work Programme agreed with LD Nurse following induction (May 13) Included information on MCA, DOLS and Consent to Treatment on Induction Programme (Oct 13) Revised training programme for safeguarding and MCA - Jun 13 Implementation of the Safeguarding Adults Multi Agency Policy & Procedures for the West Midlands 2012 (Jun 13). Improved access to best interest assessors - Jun 12 New Safeguarding Adults at Risk intranet site with easy access to all relevant resources and information - Nov 12 Appointment made to Learning Disability Specialist Nurse (May 13)	MCA and DOLs application numbers - ongoing	Specific aspects of WMQRS Peer review care of vulnerable adults in hospital - Jan 2012 Safeguarding referrals where allegations are upheld against the organisation in relation to Learning Disabilities - ongoing.	Raising awareness regarding Vulnerable patients, MCA, DOLS and Consent to Treatment across the Health Economy Identification required for an independent trainer for Safeguarding.	Jan-14 Jan-14	D3 YELLOW	Nov-13	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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Chief Nursing Officer	O16 2482	Failure to learn from national / local organisations experience e.g. Francis report. Date of origin: 17/06/10	D4 AMBER	Developed further mapping of assurances and gaps to the Francis report response (Oct 13) Francis Report on agenda on May 13 Trust Board OP10 reviewed to strengthen investigation and review of serious incidents (Jul 13) Trust process for escalation of risks identified Review of incident and complaint trends at Quality and Safety Committee The Trust has a process for review of external reports to apply local actions, learning or improvement. Francis due to go to TB in Sept Risks from Compliance/performance reporting is monitored/escalated via Compliance Committee monthly. Prepared info pack based on PWC information for other Trusts previously inspected (Oct 13) Supported CQC announced inspection (Oct 13) Sustainability plan is established for NHSLA compliance	CQC responsive review follow up report - March 2012 CQC registration without conditions (General and Mental Health) - Feb 2012 CQC visit in Jan 13 resulting report identified significant improvements. Full compliance with standards. No concerns identified.	CQC responsive review follow up report - March 2012	Board to consider next steps and evaluate the Francis report at a future forum to be arranged	Dec-13	E2 GREEN	Nov-13	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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Medical Director	2604	Trustwide VTE audits continue to demonstrate poor compliance with VTE policy and procedures, leading to an increased risk of VTE and compromised patient care. Date of origin: 14/12/10	B3 AMBER	Prompt cards being given to all medical staff as they start ward rounds and to the nursing teams at each hand over. New anti co-agulation sheet in place All RCA's will now go via the VTE committee - this should improve the standard of RCA's and action plans Mandatory training for junior doctors accessible from the KITE site. VitalPac tool includes VTE risk assessment VTE risk assessment in use VTE nurses in place	Update (12 Nov 2012): Divisional Medical Director (Surgery) to discuss with Medical Director to include risk on Trust Risk Register. During April 2013 the % of admisson assessed for VTE was 96.51 this has increased to 97.32 for July 2013. During April 2013 the % of 1st assessments within 4 hours was 74.45 this has increased to 80.63 for July 2013. July 2013 - The re-assessment in 24 hours is at 8%. Multidisciplinary project team have developed an action plan in respopnse to NPSA patient safety alert. June 12 - NHSLA self assessment for the division - scored 'green'.	Trustwide VTE audit showed poor compliance with policy Actions are still needed to achieve compliance with NPSA alert Poor compliance of risk assessment completed 24 hours after initial risk assessment; evidenced by health record checks	Daily circulation and follow up of non-compliance	D3 YELLOW	Nov-13	

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 Nursing Officer	O4 2680	Interpreting & Translation Service - risk of over performance against central budget held by patient experience. Date of origin: 29/03/11	A3 AMBER	Implemented risk assessments and centralising of face to face interpreting in top 3 areas of usage (Jan 13) Developed KPIs to monitor weekly usage (monitored monthly) Current process in place to direct face to face/telephone translation services Commenced action plan to implement same model as pilot across Trust Identified high users and engage to review working practices and demonstrates reduction in overspend.	No evidence of patient or staff concerns from 3 pilot areas (Mar 13) Reduction in overspend by 60% from last year end Ensured Matrons in OPD and user inpatients understand control resources (May 13) Continue to monitor telephone face to face bookings (May 13) Ensured all 2 way telephones placed in areas are available and are used (May 13)	Whilst considerable improvements have been seen in spend, this srill falls behind CIP and overspend combined	Awaiting for financial update re budget, spend figures going to finance committee	Jan-14	C1 GREEN	Nov-13	

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	2828	Quality of nursing care offered on A5 and A6. Difficulty recruiting staff within existing blueprint. Staffing levels are below those recommended by HURST tool, high dependency of patients. High level of incident forms submitted regarding inability to give core care due to staff shortages. Patients returned to ward A5 from the trauma list in the evening as list runs till 9.00pm. Negative historical reputation of A5 and A6 makes bank staff reluctant to work on these wards, putting pressure on ward staff to cover. Date of origin: 07/10/11	C4 AMBER	Recruited to a Matron post, commences mid October 2013 Substantive appointment to band 7 role A5 New acting band 7 for A6 (July 2013) has backing of team Mentor in place for band 7 for both A5 and A6 T&O specific advertisments agreed to recruit up to blueprint Implementation of remedial action plan Matron KPI's Monitor incidents Review of all aspects of care/setting/leadership Band 5 nurses released from winter pressure ward Reconfiguration of elective/non elective Orthopaedic beds in September 2013 Ongoing recruitment of registered nurses however not yet at full establishment Demential outreach service actively supporting the ward Reviewed dependency in April 2013. Business case developed however further work required. More frequent visits by PALS to seek realtime patient feedback and address any issues as they arise	Head of Nursing and Director of Nursing met with staff on A6 to discuss concerns July 2013 Leadership walkaround July 2013 Reduction in Datix incident reports Flow Co-ordinator Band 6 in post August 2013 - working well All sickness absence being appropriately managed and is reducing May 2013 - appraisal rate improved for nursing staff on A5 Leadership walk round in May 2013 reported positive patient feedback by PALS, EDs and NED's present	Nursing staff not able to undertake training to enhance patient care due to time constraints and continually being pulled to work clinically on the wards due to staff shortages Substantive postholder for A6 not working on ward for 1 year, disciplinary in progress Bank shifts often not filled, other than by own staff Appraisal rate for nurses on A6 is less than 40% Pressure ulcer incidents continue on A5 Amber incidents of safe staffing levels - staffing levels and care still being received weekly Mixed feedback from patients regarding negative and positive experiences	Re-advertise and recruit a Professional Development Sister to organise and run Orthopaedic training programme (Matron considering this post as there were no successful applicants)	Dec-13	E2 GREEN	Nov-13	

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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				Matron portfolio reviewed and assistant Matron identifed to provide additional support and work clinically - February 2013 Practice Development Team support ward as required Implemented supervisory band 7.						

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Chief Operating Officer	2898	Patients having to wait in ambulance off load area to be seen in ED due to a lack of space. The risk is to patient safety, experience, privacy, dignity and comfort. Date of origin: 27/02/12	C3 AMBER	OBC for new department to be submitted to October 2013 Trust Board. Majors open Nov 13 May 13 Plans approved for interim ED building The area has telephone access and is " for purpose" regarding equipment ie oxygen points, suction, resus equipment Sept 13 - Recruited additional nursing staff as part of Interim new build Sept 13 - CDU open 24/7 Aug 13 - When there are extra patients on the corridor, the ambulance crew stay with the patient until the patient is handed over/bed becomes available Escalation process in place to ensure appropriate action is taken to prevent the delay of safe treatment for patients visiting the A&E dept (policy available on A&E intranet page) Corridor nurses on duty to attend patients on the corridor (Original) - Increased staffing Feb 13 - Additional equipment has been ordered to support the additional activity. i.e blood pressure machines, ECG and 6 additional trolleys etc	Improved A&E performance Quarter 2. Feb 13 - no near misses or complaints raised regarding the corridor. Dec 12 - When AOA has more than 9 patients (as per flow chart/protocol) HALO will cohort. Number are dependant on clinical need. Once HALO can no longer cohort - crews will be held. WMAS and division are aware of this. Dec 12 - Theatres are contacted to assist with provision of trolleys	Patients do sometimes wait in corridor - October 2013. December 2012 - Due to increased utilisation of the AOA patients are remaining on the corridor and are ultimately being assessed, treated and discharged from the corridor.	Build new ED Review trends in numbers of patients using AOA and identify actions	May-16 Jan-14	D3 YELLOW	Nov-13	

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				(Original) - IT ' on loan' for corridor (Original) - Nurse staff allocated and built into workforce (Original) - Patients are only placed in the corridor if absolutely necessary Aug 13 - Purchased more trollies Capacity team allocated a nurse for AOA in AMU - If greater than nine patients in AOA in ED utilising AOA nurse from AMU is explored						
Chief Operating Officer	3256	Premises at West Park (Audiology) are unsuitable for clinical service delivery - lack of adequate soundproofing and inability to maintain ambient temperatures in clinical rooms. Date of origin: 04/10/12	B3 AMBER	Signs are in place in clinical area and corridor requesting silence at all times. Incident trends being monitored along with complaints	Options appraisal completed and being taken forward by COO Accreditation feedback session was very positive and praised team Analysis shows that there are a low level of reported incidents re. noise disturbance and there have been very few formal complaints ove the past 12 months.	Service unable to guarantee that patients will get an accurate hearing test as noise levels cannot be controlled fully. Informal complaints/comments have been made and recorded.	Estates to cost work to be undertaken	Nov-13	E2 GREEN	Nov-13	

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Chief Operating Officer	3299	Safer Childbirth and NHSLA requirement for 60hr dedicated labour ward consultant presence for less than 4000 deliveries per year. 98hr presence is required for 4000-5000 deliveries. Current staffing provision is 40hrs consultant presence dedicated to labour ward only. Additional 20hrs consultant presence includes emergency gynaecology cover which is outside the safer childbirth/NHSLA requirement. Therefore the maternity unit is currently non compliant with this. Date of origin: 30/01/13	C4 AMBER	Emergency gynaecology lists are 2-5pm Monday, Wednesday and Friday to avoid risk of out of hours emergency gynae surgery. No elective gynacology work planned over weekends	Sept 2013 - The business case has been redone but Consultants want to input into the timetable so it has not yet been resubmitted. However births remain under 4,000 and predicted to stay so at present. This will be monitored through datix incident reporting June 2013 - There are just under 4000 deliveries per year This will be reviewed by the risk management/governance committee on a quarterly basis			D3 YELLOW	Nov-13	

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Medical Director	3370	Poor compliance with completion of Trust annual clinical audit plan (2012/13) resulting in gaps in assurance in relation to clinical practice and completion of actions from previous audits. Adverse impact on compliance with CQC standards, NHSLA standards and Quality Account performance. Poor completion/update of the Trust clinical audit database to inform reporting and lack of engagement in the process by Junior doctors, resulting in audits being started but not completed. Date of origin: 24/04/13	B3 AMBER	Agreement with Divisions to limit number of local audits on plan to 10 per directorate for 13/14 plan. 13/14 Audit plans signed off by division Refresher training on Clinical Audit database for Governance Officers - Jun 13 Reviewed the current role - Audit Convenor (Jul 13) Attendance at CAC by convenors tmonitored and fedback to Clinical and Divisional Directors. Provided further training to Governance Officers to improve consistency in their approach to clinical audit MD wrote to all consultants, CD's, convenors regarding role (Jul 13) Clinical Audit progress report to Compliance cttee and CAC (2 monthly) All Trust wide audits on the plan are completed centrally Governance officers follow up audit plans with Directorates and Audit Convenors on a monthly basis Divisional sign off of Directorate Clinical Audit Plans Monthly status report on completion of audit plan (Aug 13).	Improved accuracy of reporting re completion to Directorates and Divisions on monthly basis	Poor attendance by audit convenors at the Clinical Audit Committee Limited progress/ accountability for improvement or actions	Bd 6 to review position of NICE audit status Refine database and functionality to improve search and reporting facility	Sep-13 Dec-13	D2 GREEN	Nov-13	

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Medical Director	3486	Possible inappropriate oncological treatment of patients with colorectal cancer between 2007 and 2009. Challenge in to the conclusions of an audit taken into treatment of patients with colorectal cancer in 2009 has been made by a staff member using the Trusts whistleblowing policy. Date of origin: 03/09/13	C4 AMBER				To have an external review of the previous audit and practice and management of colo-rectal cancer between 2007-2009 by an expert in this field Currently identifying an appropriate specialist to undertake the review		C3 AMBER	Nov-13	
Medical Director	3494	Lack of interventional radiology rota for Black Country Vascular network. Date of origin: 06/09/13	C4 AMBER	Actively discussing the implementation of the emergency interventional rota with the vascular network lead Patients who require out of hours emergency interventional radiology management will be referred to an alternative vascular centre			Discussion with Medical Director and Vascular Clinical Services Lead arranged for November 2013 to discuss When clinically required, arrange for transfer of patients to an alternative centre for management	Nov-13	D2 GREEN	Nov-13	

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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. Date of origin: 07/03/05	C4 AMBER	PCR for C-Diff testing from March 2011 Introduced 2% chlorhexidine in alcohol for surgical skin preparation and monitor associated reduction in infection rate - Jan 13 Screening Policy in Trust implemented, updated comms Nov 12 Screening Programme in Community in place Nov 12 IV team in place Mar 13 Surgical Site Infection Surveillance Team in place Mar 13 Robust surveillance system in placeJ Mar 13 Monitored the increase in C-Diff post PCR testing and discussed with commissioners Oct 12 PREVENT Bronze standard achieved by Care Homes - Mar 2013 Appointed Data Analyst for IPT - March 2012 MRSA admission screening pilot in care homes commenced and completed October 2011 Revised Outbreak Mangement Plan to include dehydration clinical pathway in place advised from Wolverhampton Care homes for dehydration as a result of norovirus symptoms over Winter 2011/12 - Oct 12	Achieved C difficile objective for 2012/13 April 13 CQC Visit - January 2013 HPA quarterly report of MESS data ongoing. 2011/12 best year to date for the reduction of MSSA bacteraemia, DRHAB's and MRSA acquisition Aug 12 Current C-diff and MRSA bacteraemia YTD performance -Aug12 Successful Nursing Times award for infection prevention in community Nov 2011. MRSA rates currently on trajectory Oct 12 MRSA admission screening pilot in care homes commenced October 2011 <1% colonised Oct 12 MRSA Screening for Podiatry Nail screening pilot - 0% MRSA detected April 2012 MRSA early discharge screening Pilot October 2011 - 1/260 positive ICNet NG in place to provide ectroinic alerts. MRSA screening retraining rolled out Reduction in HCAIs other than MRSA bacteremia - Jan 13	National guidelines recommends of Fidaxomicin for C difficile (May 13) Rising community cases of C difficile which could impact on trust numbers. There is a lack of evidence against which PCR positive specimens will be EIA positive and therefore reportable under the new testing algorythm	Present antimicrobial prescribing strategy Train GP's/consultants in the use of Fidaxomicin Amend fidaxomyicn business case following TMC presentation	Jan-14 Dec-13 Dec-13	E4 AMBER	Nov-13	Yes

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				CDI Assurance process updated. Monthly reporting to IPCC on trends - Mar 13 Action plan in place for Hygiene Code to be monitored by IPCC quarterly - reported to IPCC Sept 12 Action plan for reduction in HABs and DRHABs reviewed Mar 13 C difficile ward round in place and sustained Mar 13 MRSA bacteraemia action plan agreed and presetnted to IPCC Sept 12 - Nov 12 Urinary Catheter policy agreed at IPCC Oct 12					

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Trust Objective:	**To be the employer of choice.**										
Chief Operating Officer	O12 1713	Failure to effectively maximise workforce productivity. Date of origin: 03/06/08	B3 AMBER	RAG rated tool to monitor compliance against Job Plans has been developed. Reported to Workforce Group in September 2013. Areas to be contained with SPA allocation - agreed Job plan audit developed Implementation of monitoring procedure to ensure consistency of approach across Divisions. Performance targets including pay costs v clinical income. Locum Bank Project Team set up - terms of reference/scope developed. Action plan for implementation. Medical Bank introduced	Consultant Job Planning Framework agreed. Implementation in progress . Interim Job Planning Audit indicated a number of actions now addressed.	April 2013 - Audit Report RSM Tenon identifies areas for improvement. Medical agency costs not reducing - May 2013. Slow progress in terms of Job Plan completion - June 2013	Re-issue requriement for Job Plan completion and clarify links to pay progression and CEA Awards - a joint communication to be issued by Chief Operating Officer and Medical Director. Action Plan to address the issues identified by the job plan audit. Monitor Bank fill rates performance - ongoing Review of medical rotas with potential to introduce electronic rostering system. Compliance against framework to be monitored and completion rates reproted to Chief Operating Officer and Medical Director - June 2013 and ongoing. Clinical Directors to be targeted to complete all Job Plans in areas by the end of March 2014 - a joint letter is to be issued by the COO and MD.	Jul-13 Jul-13 Sep-13 Mar-14	C2 YELLOW	Nov-13	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	O14 1742	Failure to learn from staff survey. Date of origin: 11/06/08 Date to meet risk after actions: 31/05/14	B3 AMBER	Chatback 2013 completed (end July 2013) Results cascaded to Managers/Directors/Senior Managers in Sept 2013 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 staff survey 2013 being conducted Sept - Dec 2013. Results due in Feb 2014 Staff feedback has been incorporated into the Trust Board quality & safety dashboard thereby aligning staff engagement with patient safety agenda. Key Staff Survey indicators included in HR KPIs	Chatback 2013 results received end August 2013 show marked improvement on 2012; local action plans being developed. KPI in annual plan. 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.(March 2012) Turnover below National average and within Trust target. (as at Sept 2012)	Results received from 2012 staff survey - 45% response rate still leaves us in lowest 205 of Acute Trusts. Chatback staff survey results showed a decline in performance for 2012.	Results from 2013 National Survey due in February 2014	Feb-14	D3 YELLOW	Nov-13	Yes

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Chief Nursing Officer	3430	Lack of accurate status position on litigation for internal reporting due to: * Poorly documented processes * Lack of system to access to physical and electronic files The potential outcome(s): * Delay in processing claims leading to increased legal costs * Risk that NHSLA will not be informed of/indemnify claims that have not been properly reported * Lack of learning by organisation and failure to respond to known risks Date of origin: 24/06/13	B3 AMBER	Review of Legal Services Department commissioned from external solicitors (Oct 13) Sub contract agreed to cover gap in Legal Services whilst sick leave continues (Jul 13) Extended full time hours contract for Legal Services Manager (June 13)	Good progress made on file entries on datix. Updates continue on file closures and the update of costs and lessons on datix in progress (Oct 2013) Audit of Claims policy in Feb 13 showed good compliance (small sample of 2 files per month) Day to day work is maintained	Poor compliance seen in May 13 audit report for provision of medical records Slow progress to instigate new processes due to staff movement, long term sick leave and changes in interim bank staff employed	Final report awaited and delayed	Nov-13	D2 GREEN	Nov-13	

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Trust Objective:		**To achieve a balance between demand & capacity of services**								
Chief Operating Officer	O6 1714	Failure of other agencies to support discharge process. Date of origin: 03/06/08	B3 AMBER	Action Plan from RSM Tenon audit. Daily discharge meeting to review and agree actions aimed at improving discharges and relationships with social care. Daily bed state shows current position Annual 'Reimbursement funds' agreement Action Plan to implement workshop outcomes Business Case for Integrated patient flow team through Reablement funding - approved October 2013. Project Manager posts appointed. Evaluation shows improvements in length of stay. Evaluate impact of Best Practice Wards roll-out agreed. Daily review of all medical outliers. CHC assessment training completed - April 2013 Health Economy Winter Plan Surge Meetings throughout Winter.	Reduction in patients waiting for continuing Healthcare Assessments. Delayed discharges reducing from April 2013. - September 2013	Fluctuations in numbers of patient delays, especially Staffordshire	Joint working with South Staffs Partnership Trust now underway to improve Discharge Planning for South Staffs patients - August 2012 Chief Operating Officer met with Birmingham & Black Country Chief Operating Officer to discuss joint working with Mental Health Services June 2013 May 2013 meeting with Senior Managers of South Staffordshire to discuss joint working. April 2013 Escalation Meetings with Directors of Social Care - Wolverhampton and Staffordshire. Winter plan for TDA submitted September 2013. Health Economy Surge Plan sign off in August 2013 - includes partnership working.	D2 GREEN	Nov-13	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	2639	- Risk that PCT do not reinstate Community Dermatology Services - Risk the current Service not being able to sustain increased capacity long term - Risk of increased costs of having to have extra clinics - Risk that Community Service will fail to deliver full service again - Reduced Consultants levels because workload was expected to drop. This hasn't happened so now short staffed - Haven't been able to develop the service Date of origin: 08/02/11	B3 AMBER	Providing additional clinics to address the number of referrals Monitor referrals to see the long term impact of the suspended service Other services to be reviewed to balance out the services offered to patients Directorate Manager attending waiting list meetings to monitor waiting lists for the Service Monitoring of spending on a monthly basis Addressed shortfalls in staffing resources by using bank, overtime and waiting list initiatives to deliver service	Secretarial staff have agreed to undertake additional hours No delays for Community patients. Extra clinics have been put in place to manage Community Services including for fasttrack patients	Secretarial staff have expressed concerns and worries regarding the volumes of work coming through the department CCG have given notice to tender for Community Dermatology - August 2013 Risk that current service not being able to sustain increased capacity long term	Monitoring the ability to deliver a service at Outreach Clinic Commissioners to tender for contract	Feb-14 Apr-15	D3 YELLOW	Nov-13	
Chief Operating Officer	O19 2719	There is no real time bed management. Retrospective admissions on PAS can have a significant impact on electronic testing and potentially e-discharge systems which could lead to a potential impact on patient care/safety. Date of origin: 23/05/11	A3 AMBER	Review of ward clerk cover underway - Completion - August 13. Communication plan to remind staff to ensure timely and appropriate admission onto PAS and other Trust Clinical systems - Jan13. Ward Clerk proposal produced Aug 13 - requires further discussion - ongoing. Awareness has been raised. Detailed plan to resolve being formulated - complete March 2013.	E-discharge rates are improving - September 2013	Further investigations carried out and this confirmed that some process redesign is necessary to achieve timely discharges on the system Patients still entered retrospectively on PAS, especially after weekends.	May 2013 review of weekend entries onto PAS in conjunction with CQUIN scheme for 2013/14. Introduction of Safe Hands Project will assist with real time bed management July 2013. Long term review of real time bed management and link to I.T. Strategy.		B3 AMBER	Nov-13	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	3051	There are insufficient capacity (medical beds) for the volume of medical patients leading to outliers and the unplanned utilisation of additional unfunded beds. There are a number of risks in association to these: Risk of patient harm due to the lack of timely review by the appropriate medical team. Staffing pressures within ward areas with capacity beds that remain in use, as well as increased staff stress and levels of sickness. Also inappropriate nursing skill mix, resulting in inconsistent standards of care. Increased cost pressures due to continued/extended use of capacity beds outside of agreed timescale's. Potential adverse media attention due to the continued/extended use of capacity beds within the Division. Not achieving targets, standards, KPI's. Not achieving activity income Increased cancelled operations leading to poor patient experience. Date of origin: 13/07/12	B3 AMBER	B7 opened Nov 13 New reporting framework incorporating Operating Framework and Monitor requirements now in place with data presented to Trust Board on a monthly basis Operational protocol agreed at Divisional level from March 13 Additional capacity open and staffed appropriately Monthly scheduled CIP review meetings with Directorates Utilisation of staff from base wds, flexible capacity team and bank staff Arrangement in place to ensure medical team review outliers by contacting the Consultant base ward and or medical secretary Ward A6 has 22 ringfenced 'elective' orthopaedic beds Increase efficiency and release resource through ambulatory care, enhanced recovery and surgical site surveillance Full review of planned waiting list undertaken. Recovery Action Plan completed and revised trajectory submitted to the LAT - April 2013 A&E targets monitored daily and reported to TMT & Trust Board monthly		Increase in number of patients breaching 18 week referral to treatment time. September 2013. Deviation of winter plan - use of Cardio beds Beds remain open on Beynon Ward at weekend.	Improve discharge arrangement with Social Care, especially South Staffordshire. Review of nursing workforce review for a Weekend Flow Co-ordinator for Orthopaedic Trauma Risk assessment for clinical areas receiving medical outliers and update annually Plans in place for additional winter capacity. Quality meetings with Matrons to ensure patients are outlied to suitable areas.	Nov-13 Oct-13 Dec-13	D4 AMBER	Nov-13	

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**								
Chief Financial Officer	O16 1739	Failure to develop Service Line Reporting across the Trust. Date of origin: 11/06/08	C4 AMBER	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. SLR reports to be distributed on a monthly basis. Contribution levels set end of Q2. Board received latest briefing in July 2013. Updated contributions using 2012/13 tariff now available.		Need to develop better apportionment basis for some direct and indirect costs, as part of PLICS roll out Dec 12	Ongoing Monthly Information Shared - ongoing. 2012/13 plans have been agreed in April and are monitored - Patient level Costing is being implemented in the Trust which will enable more in depth SLR to be provided - ongoing	D3 YELLOW	Nov-13	Yes
Chief Financial Officer	O16 2468	That pay, price rises and cost pressures will be higher than assumptions. Date of origin: 09/06/10	B2 YELLOW	2013/14 plan includes cost pressures, pay awards and 2013/14 incremental drift impact. 2013/14 financial plan has modelled impact of pay and non pay cost pressures. Long term financial model has assessed financial impact for 5 year period to 2016/17	Trust Board report on finance position (Nov 13)		Monitor budgetary position closely through operational finance group/TMT and Trust Board - ongoing	C2 YELLOW	Nov-13	Yes
Chief Financial Officer	O6 2781	Contractual risks due to tariff changes for emergency threshold. Negotiations have taken place with Commissioners to ensure that funds are re-invested with RWT to mitigate risk. Date of origin: 18/08/11	B3 AMBER	System in place to alert when issues occur. Reserve set against risk. Discussions with Commissioners for investment (Nov 13)			Monitor new contract terms on a monthly basis through contract meetings with CCG - ongoing. Engage with Commissioners on winter pressure issues and plans	C2 YELLOW	Nov-13	

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	O6 2893	Complex series of Pathology developments/tenders may not be achieved or won which could lead to loss of income. Integration with Walsall may not be realised. Failure to achieve benefits of new build. GP tender has ceased. Risk to achievement of CIP/QIPP for Acute Trust and CCG. Date of origin: 16/02/12	C4 AMBER	Built into CIP 2016 Appointment Project Manager - January 2013. Regular meetings with Walsall Executive. New Build Project Board chaired by Deputy Chief Operating Officer. Establishment of Exec led Pathology Steering Group - ongoing September 2013 Strategic review of options led by CEO, Executives and Pathology Leads - September/October 2013.	Benefits Realisation paper scheduled for November 2013. New build open March - April 2013 Pathology Steering Group meets bi weekly to discuss risks.	Financial costs not yet produced. Specification not yet produced. No formal agreement with Walsall - September 2013.	Project structure with Walsall agreed and first meetings taken place. Workstreams have been agreed and will commence in July. The financial model will be included in paper to be submitted to both Trust Boards for approval in November 2013 Engagement with the TSA with regard to Staffordshire options - September 2013.	Dec-13 Dec-13	D3 YELLOW	Nov-13	

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	O16 2929	Failure to deliver CQUINS schemes Date of origin: 13/04/12	C3 AMBER	Monthly assurance report presented to Operational Managers at Contracting & Commissioning Forum and Operational Finance Group, for review and discussion on how to improve performance (Oct 13) Q2 Evaluation complete, Q3 requirements circulated Dec 12 Dementia CQUIN requirements now agreed with commissioner - Jan 13 Reviewed all CQUIN targets and reappraised initial risk assessment - Jan 13 Full finanical assessment undertaken and values shared Contracting / Commissioning group standing agenda item Lead coordinators identified Assessment made of costs to deliver Leads allocated for draft CQUINS to review deliverability and levels of risk (Apr 13) CQUINS agreed in contract following review of risk and deliverability May 13 Monthly assurance reports introduced from Q1 (July 13)	2) Q3 sign off received from local CCG and from SSC. Responses are in-line with Trust Self-Assessment (March 13). 5) Q4 agreement reached on CQUINs for both CCG and SSC (Jun 13) 6) Q2 submission provided to CCG and SSC, initial assessment is that compliance will be in line with Trust self-assessment (Nov 13) 4) Q4 data returned on time for Commissioner sign off May 13. 3) Financial risk assessment undertaken, initial assessment is significantly lower than 2012/13 CQUINS (April 13). 1) All Q3 data returned on time. Positive Assurances given by Commissioners at Q3 sign off (Feb 13)		Ongoing discussion with Dementia directorate, divisions WCPCT / CCG to agree solution - to be fully declared on quarter 4 - ongoing Proposals for 2013/14 CQUINS shared with RWT leads for comment and assessment of deliverability A designated Senior Operation Manager and Senior Nurse and senior Lead Manager to agree to support Quality leads- ongoing Setting up and implementing audits - ongoing	Mar-13	D3 YELLOW	Nov-13	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 Financial Officer	3176	Commissioners raising issue of patient activity over performance and their ability to pay. Date of origin: 16/10/12	C3 AMBER	Monitor through monthly contract performance reports and meetings Contractual meeting to analyse and discuss the forecast level of over performance To ensure details of contract performance are understood by RWT managers and Commissioners	Contract meetings - monthly ongoing	Performance query letters from commissioners - monthly ongoing	Escalate to Directors to resolve when appropriate - ongoing	B3 AMBER	Nov-13	
Chief Financial Officer	O16 514	Failure to deliver recurrent efficiency gains and CIPs. Date of origin: 07/03/2005.	A4 RED	Monthly reporting against projects including to Trust Board KPMG appointed with agreed Terms of Reference to identify efficiency opportunities (Nov 13) Change Program Board (Executive Director led) The Trust has invested in a new system solution from "TriSolve" which will enable scheme implementers to have more direct involvement in the reporting of their schemes and be held to account. Each project has an executive director lead	Trust Board Reports & Minutes include CIPs - monthly ongoing	Finance report to Trust Board. Report of the Change Programme Board to Trust Board.	Monitor closely through CIP programme board - ongoing Identify 'new' projects and programmes in advance - ongoing	B3 AMBER	Nov-13	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 a high quality educator**										
Director of Human Resources	O16 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. Date of Origin: 19/01/11	C4 AMBER	Working Group set up to examine medical (PG/UG) education funding model (Sept 2013) Close monitoring of funding levies LETBs/LETCs now authorised Representation on any appropriate workstreams Liaison with LETBs and LETCs as they are developed HR Director now appointed to LETC (Sept 2012)	Review at HR Sub Group + E&T Committee NMET allocation for RWT received	Unable to make further plans due to review of MPET is completed SIFT underfunded for 2013 as transition to full fundling not expected until years 3 & 4 workforce planning input to LETC needs strengthening Lack of direction from DOH (ongoing)	Develop Liaison with LETB/LETC (ongoing)	Dec-13	C3 AMBER	Nov-13	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 achieve Foundation Trust status**									

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?
Medical Director	O16 2922	Maintenance of a minimum accreditation of level 2 or higher for the IGToolkit v11 - 2013/14 in line with national guidance. Date of origin: 11/04/12	C3 AMBER	IG Lead recruited 2. Internal audit recommendation made Sept 12 & Jan 13- Streamline evidence by uploading to one section where key documents are asked for to avoid duplication of evidence in the IGToolkit. completed 20/02/2013 Evidence updated - drafts removed. as per internal audit (Feb 2013) TMT approval of IGTookit final submisison scores for 2012/13 (22/03/2013) Progress monitoring- monthly basis (completed up to 22/03/2013) Monthly IGSG Monitoring of actions against toolkit for v11 ICO external audit of Data Protection and Security compliance- Yellow(resonable assurance) rating given IG lead has monthly meetings with requirement leads to maintain progress against action plans. Leads have completed action plans to maintain level 2 and achieve level 3 compliance for v10 IGToolkit. Requirement leads exception reporting monthly to IGSG on any issues relating to maintaining level 2 or achieveing level 3	New IG Lead in post 16/9/2013 - regular review of evidence included in toolkit. 3. Internal audit recommendation Made Sept 12 & Jan 13- "□The documentation contained in shared folders and accessed via a link referred to prior years e.g. V8 2010/11, therefore, their relevance in respect of IGToolkit V10 needs to be assured. - completed Gap anlaysis done in July 2012 results fed back to requirement leads and action plans have been put in place to address any gaps in assurance identified IGToolkit return made at 31st October 2012 - all requirements were at level 2 or at level 3 Draft internal audit report released 31/08/2012 advises there is a robust structure in place to support and drive the information governance agenda and provide the Trust with assurance that effective information governance processes are in place within the Trust.	Requirement leads are not uploading to IG Toolkit in timely manner with evidence Out of date evidence remaining on toolkit - requires updating. This gives potentially a false compliance figure.	Progress monitoring Audit	Feb-14 Oct-13	D2 GREEN	Nov-13	

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?
				Internal re-audit of 10 standards took plance Dec 2012- report provided Jan 2013 31st October performance update submission has been reviewed by Caldicott Guardian before submission 31/10/2012- all req level 2 or above							

Risk Managed to Target Level

Trust Objective: To provide our patients & staff with a safe environment.

Chief Financial Officer	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 i.e. property arrangements in line with White Paper with PCT being abolished by April 2013 Date of origin: 21/10/10	D2 GREEN	Engagement of Solicitor support External Support is being employed to review the condition of the Estates where Services from WCPCT are undertaken. RWT and PCT have agreed transfer properties (Jan 13) 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		Outstanding issues re land at Pond Lane to be resolved	Mar-14	D2 GREEN	Nov-13	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 in the national NHS top quartile of benchmarks**									

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 1717	Failure to maintain re-registration by the CQC periodic review. Date of origin: 03/06/08	C2 YELLOW	Developed ward to board outcome metrics available for ward staff to use in improving standards of care aligned to CQC framework (Sep 13) Undertake quarterly Divisional Reviews Trust CQC visit (Jan 13) provided positive feedback. Final report awaited (Jan 13) Ongoing - Performance Management Framework in place that is monitored through Trust Management Team and Trust Board. NHS Instittute for Innovation Better Care Better Value benchmark Findings implemented of Newtons Review re: Outpatients. Phase One complete. Phase Two complete Feb 2012. NHS Performance Framework - Quarterly to Trust Board Workforce review of Nursing and Midwifery - Aug 12 Aug 12 - CQC standards have been mapped against Information Governance standards, NHSLA standards, Performance and quality indicators; in order to triangulate self-assessment and strengthen assurance of on-going monitoring.	62 day cancer target now within target. Continue to monitor at thrice weekly meetings - Sept 2012 C Diff target now on target - national guidance released April 2012 CQC returned positive report following unannounced inspection on 25/01/13 (Mar 13) Final report from the outcome 21 records visit (March 12) found that the Trust is compliance with the relevant aspect of the visit (i.e. maintenance of HAS 1 forms) - no recommendations made. CQC Reports - Privacy, Dignity and Nutrition - Responsive Review - March 2012 Change to Quality metrics requires a re-mapping to CQC standards Trust CQC visit (Jan 13) provided positive feedback. Final report confirms no concerns with standard compliance. (Mar 13) Internal Audit of trust arrangements for ongoing compliance monitoring - IA Summary: the Board can take reasonable assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective. Sept 2012	Delays in Transfer of Care above internal target of 3.5% Sept 2012 (national target <5 - above in Sept 2012 only) Length of Stay is above target - Sept 2012	Develop ward to board outcome metrics available for ward staff to use in improving standards of care aligned to CQC framework Enact governance review recommendations	Dec-13 Dec-13	C2 YELLOW	Nov-13	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?
				CQC action plan incorporating use of who checklist and modified checklist for use outside of theatres in place following unannounced visit and being monitored to closure via QSC and Trust Board - Aug 12	Service Improvement initiatives - Productive Theatre CQC standards are 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.					

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;