The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	23rd September 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

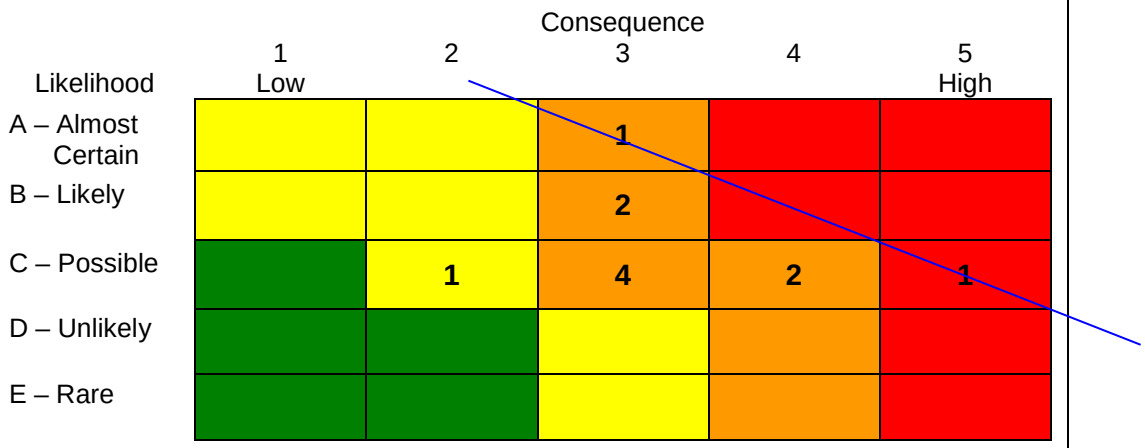
The Board Assurance Framework "provides organisations with a simple but comprehensive method for the effective and focused management of the principal risks that arise in meeting their objectives. It also provides a structure for the evidence to support the Statement on Internal Control" (Integrated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

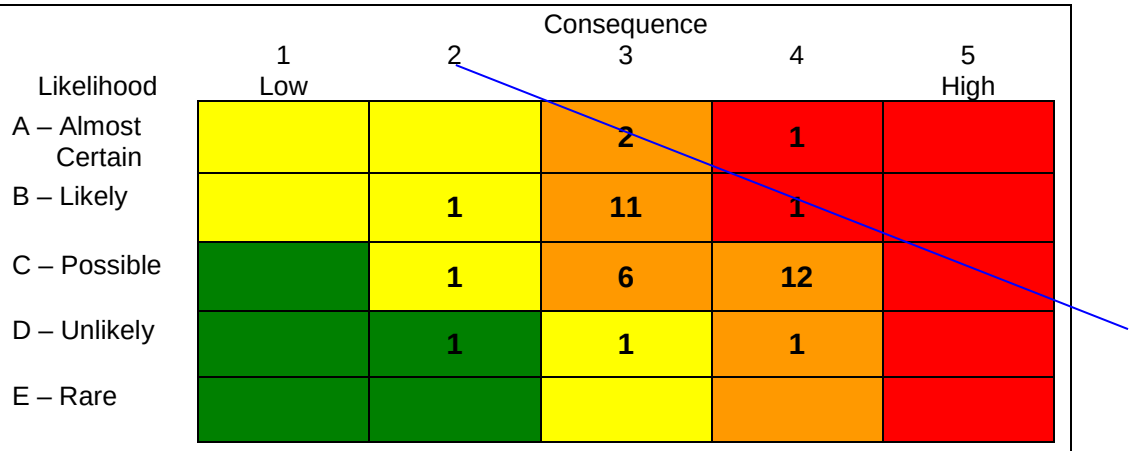
	ID	Risk Title	Lead
RED	2965	Failure to reduce Never Events.	CN

Trust Risk Register – Updates (Appendix B)

Following updates the split of the Trust Risk Register is:

Risks currently being managed (ongoing)	36
Risks managed to target level	2

There are currently 38 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	16		
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	4	2	
7) To be a high quality educator						2		
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						3		

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 (Sep 2013)

Lead Director	Risk	Risk Title	Update	Reasoning / Progress Against Actions
Chief Nursing Officer	2965 C5	Failure to reduce Never Events	Positive Assurances updated.	Zero Never Events in August 13. Audit of compliance with WHO checklist showing high 90's compliance in August 13. Never Event reported in April 2013 - Obstetrics. Now positive assurance on measures received from CCG.
	2449 D3	Inadequate and ineffective systems to Safeguard Vulnerable Adults. Risk includes the current absence of a Non-Executive Director on the Joint Safeguarding Adults Committee [JSAC]	***Risk closed***	This was agreed at the last JSAG meeting on the 11th July 2013 and the lead further informed the Compliance Committee that this risk would be closed.
Director of Planning and Contracts	1734 C3	Introduction of other health providers in the market as a result of Any Qualified Provider leads to a greater shift of activity.	Action Plan updated	Set up process to monitor Supply2health Website for future opportunities
	2508 A3	Commissioning responsibility changes - affects contracted income	Action Plan updated	Negotiation with Commissioners at LDP meetings; focus on CCGs
	2927 B3	Failure to deliver against QIPP scheme resulting in lack of investment	Positive Assurances updated.	To agree a QIPP work programme with commissioners, documented within contract through the Service Development Improvement Plan.
Chief Executive Officer	1501 C4	Foundation Trust Application Process	Positive Controls and Positive Assurances Updated	External review of Quality Governance has been completed (inc follow up review) Aug 13. Board Action Plan to address issues related to deferral – ongoing Review of Monitor's Risk Assurance Framework Revised sustainability timeline reported to TDA monthly Preparation for CQC inspection Periodic updates i/c Monitor Assessment Team
	3330 C4	The impact on the Trust of the changes occurring at Mid Staffordshire NHSFT and within the Staffordshire health economy	Positive Controls and Positive Assurances Updated	Involvement in the work of the Contingency Planning Team – Aug 13 Contributing to TDA lead work – Sept 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 presentation to Wolverhampton City CCG

				Trust's proposal forms part of Administrator's recommendations Trust's clinical model has been approved by the National Clinical Group
	3352 B3	Potential for rapid growth of the Trust due to changes in the wider health and social care economy.	Positive Controls updated	Involvements in key groups reviewing service provision Achievements of contractual obligations
	3353 C2	'Safeguarding' the Trust for the future	Positive Controls and Positive Assurances updated.	Local intelligence about service delivery across our wider catchment Involvement in key groups reviewing service provision Relationships i/c Commissioners Achievements of contractual obligations
Chief Operating Officer	2962 C3	Risk of Health Visiting business/system/service failure due to multiple systemic failings.	Positive Assurances updated.	Reconfiguration of Health Visitor meetings to bi-monthly (internal Chair), and external Performance Review meetings via LAT (external Chair).

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

Lead Director	Risk	Risk Title	Update	Reasoning / Progress Against Actions
Chief Nursing Officer	2482 D4	Failure to learn from national / local organisations experience e.g. Francis report.	Action Plan updated.	Francis due to go to TB in Sept Support CQC announced inspection. Prepare info pack based on PWC information for other Trusts previously inspected.
	535 C4	Failure to achieve reductions in HAIs impacting on Trust's reputation and compliance to regulatory standards.	Gaps in Assurance Action Plan updated.	Rising community cases of C difficile which could impact on trust numbers. Take Fidaxomicin Business case to Contracts and Commissioning Group
	1717 C2	Failure to maintain re-registration by the CQC periodic review.	Positive controls and Action Plan updated.	Developed ward to board outcome metrics available for ward staff to use in improving standards of care aligned to CQC framework Prepare for CQC inspection. Enact governance review recommendations.
	2680 A3	Interpreting & Translation Service - risk of over performance against central budget held by patient experience.	Gaps in Assurances and Action Plan updated.	Financial evidence that practice hasn't changed. Prepare recovery plan exploring options to devolve budget to managers using service
	2917 C4	Risk of non-compliance with NHSLA standards - achieving 12/13 CIP	Positive Controls, Positive Assurances, Gaps in Assurance and Action Plan updated.	To do list circulated for staff groups Some further criterion have turned green. Achieved level 3 for supervision of medical staff (within standard 5). Live records check challenges continue to

				be recording of early warning signs track and trigger, delegated consent training records, VTE 24hr assessment, complete DNAR and falls documentation. Continue to provide audit results feedback and raise awareness of documentation performance. Further spot checks planned.
	2950 B3	Avoidable pressure ulcers continue	Positive Assurances and Action Plan updated.	Revised pressure ulcer policy in place - Sep 13 Incidents of avoidable pressure ulcers are reducing and reported quarterly to Board. ST data correlates to incidents data (Sep 13) Provide hybrid mattresses on every bed in Trust - PID going to CPB Oct 13 Review service specification for community equipment and take 'in house' from ILS.
	3385 C3	Device Related Hospital Acquired bacteramia cases increase	Positive Assurances updated.	In patient denominator data acquired (Sept 13).
	3430 B3	Legal Services Risk	Action Plan updated	Final report awaited and delayed – expected Sept 13
Director of Planning and Contracts	2929 D3	Failure to deliver CQUINS schemes.	Positive Assurances updated.	Received notification from both CCG and SSC that Q1 CQUIN money will be paid in full
Director of Human Resources	1742 B3	Failure to learn from staff survey.	Action Plan updated.	National Survey 2013 commences 23/09/13. Results from 2013 National Survey due in February 2014.
Chief Operating Officer	494 C4	Midwifery Staffing	Action Plan updated.	Business Case to go to TMT in September
	2828 C4	Quality issues within T&O Directorate	Positive controls and Action Plan updated.	Reconfiguration of elective/non elective Orthopaedic beds in September. To discuss at Directorate Gov meeting closure of this risk and amalgamation with risk 2712
	2893 C4	Complex series of Pathology developments / tenders may not be achieved or won which could lead to loss of income.	Positive controls, positive assurances, Gaps in Assurances and Action Plan updated.	Establishment of Exec led Pathology Steering Group – ongoing Sept 2013. Strategic Review of options led by CEO, Execs and Pathology Leads – September/October 2013. Regular meetings with Walsall Executive. Benefits realisation paper scheduled for October 2013. Specification not yet produced. Financial costs not yet produced. Engagement with the TSA with regard to Staffordshire options –September 2013. Deadline set for production of financial – October 2013.
	2898 C3	Patients having to wait in ambulance off load area to be seen in A&E due to a lack of space. The	Action Plan updated.	Implement use of pre fab building to increase capacity. Building work has begun. Planned November 2013. Recruitment of additional staff for CDU and

		risk is to patient safety, experience, privacy, dignity and comfort		majors.
	1714 B3	Failure of other agencies to support discharge process.	Positive Assurances and Action Plan updated.	Delayed discharges reducing from April 2013 – September 2013. Health Economy Surge Plan sign off in August 2013 – includes partnership working.
	3051 B3	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:	Positive controls, positive assurances, Gaps in Assurances and Action Plan updated.	Recovery Action Plan completed and revised trajectory submitted to the LAT – April 2013. Updated September 2013. Reduction of cancelled operations in July 2013. A&E target achieved for July 2013. Beds remain open on Beynon Ward at weekend. Ring fence 22 'elective' beds from September 2013. Plans in place for additional winter capacity. Quality meetings with Matrons to ensure patients are outlied to suitable areas.
	2639 B3	Failure of Community Dermatology Service	Gaps in Assurance updated.	CCG have given notice to tender for Community Dermatology.
	2719 A3	Timeliness of PAS Admission	Positive controls updated.	Ward Clerk proposal produced Aug 13 – requires further discussion – ongoing.
Medical Director	943 B4	Chemotherapy administration	***New risk***	None adherence to chemotherapy policy and procedures resulting in poor patient and staff experience/confidence.
	2922 D2	IG Toolkit Level 2 Maintenance	Positive Controls updated	IG Lead recruited
	3494 C4	Lack of interventional radiology rota for Black Country Vascular network	***New risk***	
	3486 C4	Possible inappropriate oncological treatment of patients with colorectal cancer between 2007 and 2009.	***New risk***	

The Royal Wolverhampton NHS Trust

Board Assurance Framework

September-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;

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 provide our patients & staff with a safe environment.**										
Chief Nursing Officer	O4 2965	Failure to reduce Never Events.	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	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	Sep-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	C4 AMBER	Trust presentation to Wolverhampton City CCG 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	Sep-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.	C3 AMBER	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 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.	Compliance against HCP/ Service spec indicators monitored and reported monthly. Ongoing relocation of services into children centres Increase in student numbers	Not fully compliant with delivery of the service spec/HCP Some delays in moving to children centres due communinication issues and service reconfiguration	Directorate to develop plans re Band 3 staff Recruit to 2 x Team leader posts Discussion with CCG re funding for Band 3 support worker AUGUST 2014 - 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.	Sep-13 Nov-13 Sep-13 Jan-14	D2 GREEN	Sep-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.	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	Sep-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	3354	Estates quality and flexibility compromise the ability to respond to fluctuation in demand and the implementation of streamlined clinical pathways,	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	Sep-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**										
Director of Planning / Contracting	O6 2508	Commissioning responsibility changes - affects contracted income	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		Negotiation with Commissioners at LDP meetings; focus on CCGs Development of relationships with Non-Wolverhampton collaborative commissioners.	Mar-14 Dec-13	C4 AMBER	Sep-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?
Director of Planning / Contracting	O16 2927	Failure to deliver against QIPP scheme resulting in lack of investment.	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)	Quarterly Contracting Reports to Trust Board Non-agreement of reduction of activity relating to QIPP without an agreed and detailed implementation plan (Mar 13) To agree a QIPP work programme with commissioners, documented within contract through the Service Development Improvement Plan. Modernisation programme Board commenced		To agree a QIPP work programme with commissioners, documented within contract through the Service Development Improvement Plan. To identify capacity and resources to deliver the programme.	Jul-13 Dec-13	B3 AMBER	Sep-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.	C3 AMBER	In 2012/13 re-investment of funds into Trust have been secured following negotiations (Mar 13) For 12/13 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 SHA / Commissioners - ongoing Additional collaboration with other providers to reduce costs - ongoing Maintain good working relationships and communications with commissioners - ongoing		C2 YELLOW	Sep-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.	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	Sep-13	Yes
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.	C3 AMBER	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 Ensure internal processes are in place to manage increased requirements to follow procurement processes in case of increased requirement to tender Use refinements to NHS Choices & Choose & Book to 'sell' services - on-going Maximise opportunities to sell services via new Web Site - on-going Set up process to monitor Supply2health Website for future opportunities	Jul-13 Sep-13 Oct-13	D2 GREEN	Sep-13	Yes

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Trust Objective:	**To achieve Foundation Trust status**									
Chief Executive Officer	O16 1501	The Trust does not meet the DH / Monitor requirements to become a foundation trust.	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 Revised Tripartite Formal Agreement for FT Timetable (Mar 13)	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	C3 AMBER	Sep-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

September-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

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

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Director of Human Resources	O16 2858	(amalgamated with risk 883 - Local Induction). NHSLA Level 3. Achievement required for standard 3. relates to standard requirement of 95% compliance in mandatory training and induction. Currently poor compliance with NHSLA level 3 standard 3 in regard to mandatory training and local induction.	C3 AMBER	e-learning packages available as alternative to face to face training monthly compliance reports issued for all TNA topics training compliance discussed at divisional/directorate meetings as part of governance agenda patient moving and handling included on TI Junior doctors induction programme incorporates all mandatory training elements and sanctions agreed for non-compliance increased publicity around individual responsibility to undertake mandatory training via desktops and posters request for local induction information has been requested as part of appraisal audit monthly IMTG with SMEs monitoring action plans reporting frequency for all minimum data set topics now monthly for all subjects repeated non compliance reports escalated to divisional team Local induction audit assessed NHSLA project group and Project Board monitoring progress for standard 3	increased compliance for most topics as evidenced by monthly reports JDI includes all mandatory training requirements monthly audit of local induction returns (ongoing) all NHSLA minimum data set topics now included in performance repository for TMT report (Oct 2012) Increased compliance for most topics as evidenced by monthly reports Improvements in mandatory topics compliance NHSLA level 2 achieved (Nov 2012)	audit shows that study leave forms are being approved by managers despite mandatory training being outstanding 95% compliance standard not achieved in certain mandatory training subjects (ongoing) audit continues to highlight issues with local induction returns and poor compliance with OP41. (ongoing) reporting frequency for all minimum data set topics now monthly for all subjects (ongoing) lack of evidence that escalation reports get acted upon at divisional level	Progress monitoring Inanimate manual handling e-learning review link trainer framework and TNA	 Oct-13 Oct-13	D3 YELLOW	Sep-13	

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				e-learning pack now available for investigation of incidents, complaints and claims level 1 content. Times to be adverstised extra manual handling sessions to target low complaince areas local induction amnesty in February to improve compliance LCC level 2 training: Taraget group identified by Governance. Gov team to chase up staff who are non compliant Individuals that are non compliant with Local Induction have been e-mailed to IPOD draw for anyone green for all Mandatory Training in July/August extra training sessions being delivered Further e-learning packs compiled for alternative to face to face training for CRT and general consent training					

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Chief Nursing Officer	O16 2917	Potential Loss of savings if NHSLA assessment not achieved. Sub risks (2832/2763) merged with escalated risk for monitoring.	C4 AMBER	Governance Scorecard is updated to include NHSLA indicators for Consent, Being Open and Clinical Audit (May 2013). Schedule of NHSLA audit reports to committees completed (May 13) Level 3 sub group meetings completed. Monitoring of results to continue up till assessment Sep 13 (May 13). Prospective monitoring of policies (NHSLA) monthly basis to inform Project Board L3 PID drafted (Dec 2012) TMT approval Jan 2013 (Includes formation of a Project Board and steering group) - Jan 13 Internal action plan developed and monitored by steering group (Mar 13) Reviewed audit results and actions for improvement - Re-audit as necessary (Mar 13). Tracking all actions via Health assure and Project Group to Closure (May 13). Continue to exception report to NHSLA Project Board areas of concern for action. Live prospective audits issued to divisions from July 13	NHSLA pre-assessment meeting held on 07/05/13 with assessor. Reassurance and confirmation that the Trust is on the right track towards Level 3 judging from the sample audits reviewed. However compliance needs to show improvement prior to assessment in Sep 13 (May 13). Some further criterion have turned green. Achieved level 3 for supervision of medical staff (within standard 5).	Feb 13 transfer audit results showing less than 50% compliance (May 13). Uptake has increased compliance with process remains low (May 2013) Unable to show improvements in some audit results - Jun 13 Internal monitoring currently show predominantly red/amber scores at L3 - Jun 13 Low compliance rates following trustwide audits are not yet improved - indicating policy implementation. (Mar 13) Live record checks as at June 13 showed improved uptake of the audits by Directorates however some are sub 50% compliance rates. Monthly monitoring in place. (Apr 13) Live records check challenges continue to be recording of early warning signs track and trigger, delegated consent training records, VTE 24hr assessment, complete DNAR and falls documentation.	Continue to provide audit results feedback and raise awareness of documentation performance. Further spot checks planned.	C3 AMBER	Sep-13	

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				Compliance gaps from audit are monitored by policy leads and escalated to divisional management teams to influence change/action - ongoing Monitoring of policies, data collection and audit production (Feedback provided to all authors) Divisions to manage local accountability for audit improvement (Jul 13) Resource for a fixed term post to support CNST and NHSLA from Oct 12. To do list circulated for staff groups (Sep 13)					

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Chief Operating Officer	O4 494	High Level Amber. 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 (10 October 2012): Business case not approved by TMT Update from Division Governance Meeting (12 June 2013): Actively recruiting staff therefore risk rating to be reviewed.	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 activiry, 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 Closure of the MLU to re deploy staff Reducing midwifery non clinical activities to increase clinical midwifery availability. Business Case to go to TMT in September	Oct-13 Oct-13 Oct-13 Sep-13	C1 GREEN	Sep-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.	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 Review feedback processes within the Directorate Test out raising concerns with staff Mandate attendence to Formulary meetings Audit of attendence at Formulary group Review treatment regime for specific cohort of patients RCA to be undertaken into recent incident. RCA outcomes may influence process and practice. Full HAQU accrediation inspection planned Introduction of E-Prescribing	Dec-13 Oct-13 Oct-13 Oct-13 Sep-13 Jan-14 Oct-13 Sep-13 Nov-13 Apr-14	C4 AMBER	Sep-13	

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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.	C4 AMBER	Medical Director for Division 1 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.	Implement updated consent policy when approved Re-design the consent form	May-14 May-14	E3 YELLOW	Aug-13	

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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.	C3 AMBER	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 Implementation of an agreed learning disabilities IT alert system to identify patients with LD - Aug 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.	Implementation of referral system. Increase communication resources at ward and departmental level. LD training incorporated into preceptorship programme. Undertake an audit of learning disabilities IT alert system and outcomes Develop a work programme for the LD nurse which indicates audit of outcomes for patients with LD - ongoing Further communication with organisation and Mental Capacity Act Requirements	Mar-13	D3 YELLOW	Sep-13	Yes

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Chief Nursing Officer	O16 2482	Failure to learn from national / local organisations experience e.g. Francis report.	D4 AMBER	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. Risks from Compliance/performance reporting is monitored/escalated via Compliance Committee monthly. 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	Develop further mapping of assurances and gaps to the Francis report response Support CQC announced inspection Prepare info pack based on PWC information for other Trusts previously inspected. Francis due to go to TB in Sept	Oct-13 Sep-13 Sep-13 Sep-13	E2 GREEN	Sep-13	Yes

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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 ie property arrangements in line with White Paper with PCT being abolished by April 2013.	C4 AMBER	Engagement of Solicitor support External Support is being employed to review the condition of the Estates where Services from WCPCT are undertaken. 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		Conditions survey of other properties where RWT is tenant Conditions surveys of transfer properties to be undertaken - ongoing Department of Health guidance now delayed transfer to 1 April 2014. Trust has baseline information and have commence negotiations from 1st September 2012 with PCT.	Feb-13 Apr-13	C3 AMBER	Sep-13	Yes
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.	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 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			D3 YELLOW	Sep-13	

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Chief Nursing Officer	O4 2680	Interpreting & Translation Service - risk of overperformance against central budget held by patient experience.	A3 AMBER	Face to face pilot with 3 departments (Dec 12) complete. Implemented centralised plan across all departments to reduce face to face interpreting (Apr 13) Implemented risk assessments and centralising of face to face interpreting in top 3 areas of usage (Jan 13) Developed KPIs to monitor weekly usage (Jan 13) Current process in place to direct face to face/telephone translation services Commenced action plan to implement same model as pilot across Trust Updated policy and criteria to clarify process for interpreting services Changed face to face provider to improve service Improved audit trail for use of interpreting services for monitoring purposes checked weekly 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)	Financial evidence that practice hasn't changed (Sep 13)	Face to Face only authorised by Matron / DM Prepare recovery plan exploring options to devolve budget to managers using service	Oct-13	C1 GREEN	Sep-13	

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Chief Operating Officer	2828	There are concerns in relation to the quality of care within the T&O Directorate. Investigation into complaints and incidents has raised concerns as to whether the care on the Orthopaedic wards are consistently at the highest standard, leading to risks of compromised patient care and increased levels of incidents and complaints, as well as poor staffing. 13.02.2013 Report to Divisional Governance: -Continuing concerns however extended matron and Directorate manager portfolios believed to be sustainable within current resource in the medium term (6 months), - Temporary nurse management for both ward A5 and A6 sustainable for 4 months, - Ward nursing staffing shortfall, - Increased patient dependency particularly on A5 April 2013 - Dependency review confirms increased dependency on A5 in relation to trauma and dementia caseload.	C4 AMBER	Band 7 on A5 recruited to Implementation of remedial action plan Matron KPI's Monitor incidents Monitor complaints 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. 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 Matron portfolio reviewed and assistant Matron identifed to provide additional support and work clinically - February 2013 Practice Development Team support ward as required Implementing supervisory Band 7 by end of June 2013	Head of Nursing and Director of Nursing met with staff on A6 to discuss concerns Leadership walkaround July 2013 Interview process commenced for Matron position High incidence of Grade 3 pressure ulcers in April 2013 however all found to be unavoidable 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 Appraisal rate for nurses on A6 is less than 40% Pressure ulcer incidents continue on A5 Increase in amber breaches of safe staffing levels February 2013 - Increased patient dependency, especially on A5 Mixed feedback from patients regarding negative and positive experiences	To discuss at Directorate Gov meeting closure of this risk and amalgamation with risk 2712	Sep-13	E2 GREEN	Sep-13	

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Chief Operating Officer	2898	Patients having to wait in ambulance off load area to be seen in A&E due to a lack of space. The risk is to patient safety, experience, privacy, dignity and comfort	C3 AMBER	May 13 Plans exist for new 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 CDU is now open - September 2013. 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 (Original) - IT ' on loan' for corridor	September 2013 - CDU open 24 hours per day. 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	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. December 2012 - Lack of trolleys to offload patients due to additional capacity and AOA being utilised.	To build new ED Impement use of pre fab building to increase capacity - Building work has begun. Planned November 2013. Recruitment of additional staff for CDU and majors.	Dec-15 Nov-13	D3 YELLOW	Sep-13	

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				(Original) - Nurse staff allocated and built into workforce (Original) - Flow chart developed to "release" ambulance crews and have handover (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					

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Chief Nursing Officer	O4 2950	Patients at risk of developing avoidable pressure ulcers in the Trust.	C3 AMBER	Contract specification includes Nursing home education from May 13 by our TV staff Mercury advance mattress trial commenced 29/7/13 on c15	Incidents of avoidable pressure ulcers are reducing and reported quarterly to Board. ST data correlates to incidents data (Sep 13) 39% of Trust have achieved over 100 days since last avoidable P.U by 01/04/13 Weekly pressure ulcer review meeting with CNO to determine accountability to implement learning organisation wide - Feb 12 Monthly circulation of "days without avoidable pressure ulcer" to all wards and depts (Jun 13) Reviewed equipment resource provision and improve community equipment provision (out of hours) and maintenance to community (Apr 13) Revised pressure ulcer policy in place - Sep 13 Employed a data analysis to assist with data trends - June 12	25% of Trust have not achieved Ambition - Feb 13	Review working of TVNs dedicated to high risk areas. Measure days for each ward between avoidable PU's. Provide hybrid mattresses on every bed in Trust - PID going to CPB Oct 13 Review service specification for community equipment and take 'in house' from ILS Business case in progress	Oct-13 Oct-13 Nov-13 Oct-13	D2 GREEN	Sep-13	
Chief Operating Officer	3256	Premises at West Park are unsuitable for clinical service delivery - lack of adequate soundproofing and inability to maintain ambient temperatures in clinical rooms.	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 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	Sep-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.	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		To re-submit business case to Contracts & Commissioning once Consultants have had an opportunity to input into the timetable.	Oct-13	D3 YELLOW	Sep-13	

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Chief Nursing Officer	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.	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).		Poor attendance by audit convenors at the Clinical Audit Committee Incompleteness of data on the Clinical audit database does not enable accurate reporting Lack of progress with audits against the annual audit plan Limited progress/ accountability for improvement or actions	Bd 6 to review position of NICE audit status	Sep-13	D2 GREEN	Sep-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	3385	There was a rise in the numbers of DRHAB's surveyed in 2012/13 compared to the previous year.	C3 AMBER	Structured approach to investigation agreed with matrons (June 13) All RCA's to be attached to DATIX reports (June 13) All cases entered on DATIX (June 2013) RCA's reviewed at IP governance meetings.(July 13) Quarterly reporting to IPCC (June 13) Twice monthly surveillance data reviewed (June 13)	All haematology lines electronically monitored (Sept 13) Clinical Haematology unit DRHAB's decreased (Sept 13) In patient denominator data acquired (Sept 13)		Devise action plan to reduce urinary catheter use and present to TMT	Oct-13	D3 YELLOW	Sep-13	
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.	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	Sep-13	
Medical Director	3494	Lack of interventional radiology rota for Black Country Vascular network.	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			When clinically required, arrange for transfer of patients to an alternative centre for management		D2 GREEN	Sep-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	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 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 Take Fidaxomicin Business case to Contracts and Commissioning Group	Oct-13 Sep-13	E4 AMBER	Sep-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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				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					

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.**										
Chief Operating Officer	O12 1713	Failure to effectively maximise workforce productivity.	B3 AMBER	Areas to be contained with SPA allocation - agreed Job plan audit developed Job Planning Steering Group set up to ensure robust job planning process led by Medical Director. Implementation of monitoring procedure to ensure consistency of approach across Divisions. Performance targets including pay costs v clinical income. 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 . Performance management system, quarterly reviews of Divisions and monthly reports to Trust Board - October 2012. 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 September 2013 - a joint letter is to be issued by the COO and MD.	Jul-13 Jul-13 Sep-13 Jul-13	C2 YELLOW	Sep-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?
Director of Human Resources	O14 1742	Failure to learn from staff survey.	B3 AMBER	Chatback 2013 completed (end July 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 Chatback conducted in Summer 2012 to ensure momentum is maintained. Results received Sept 2012. Cascaded to Managers/Directors/Senior Managers in Oct 2012. 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 Divisional/Directorate Staff Survey reports discussed at HR subgroup and distributed to Divisional and Directorate managers and matrons and Divisional / Directorate action plans developed. Results from national 2012 survey were presented to TMT, Trust Board, HR Sub Committee and Senior Managers Briefing in March 2013.	Chatback 2013 results received end August 2013 show marked improvement on 2012; local action plans to be developed. KPI in annual plan. Results for 2012 positive; 20 out of 28 indicators show us above average when compared to other Acute Trusts (April 2013) 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 National Survey 2013 comences 23/09/13.	Feb-14 Oct-13	D3 YELLOW	Sep-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	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	B3 AMBER	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)	Audit of Claims polocy in Feb 13 showed good compliance (small sample of 2 files per month) Day to day work is maintained	Slow progress to instigate new processes due to staff movement, long term sick leave and changes in interim bank staff employed	Review of Legal Services Department commissioned from external solicitors. Review department structure once review complete Final report awaited and delayed	Aug-13 Sep-13	D2 GREEN	Sep-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.	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 Integrated patient flow team through Reablement funding - Project Manager posts appointed, and has commenced work with Social Services to expand dedicated Social Work input - commences January 2013. 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. Health Economy Surge Plan sign off in August 2013 - includes partnership working.	D2 GREEN	Sep-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 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	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. Risk that current service not being able to sustain increased capacity long term	Monitoring the ability to deliver a service at Outreach Clinic Additional nurse led clinics being set up to manage review clinic capacity Agree full service specification and contract Agree interim contract	Dec-13 Oct-13 Sep-13 Dec-13	D3 YELLOW	Sep-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.	A3 AMBER	Review of ward clerk cover underway - Completion - Jan-Feb13. 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 - July 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	Sep-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 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.	B3 AMBER	New reporting framework incorporating Operating Framework and Monitor requirements now in place with data presented to Trust Board on a monthly basis Recovery Action Plan completed and revised trajectory submitted to the LAT - April 2013. Updated September 2013 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 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	Reduction of cancelled operations in July 2013. A&E Target achieved for July 2013. Improvement in Cancer Standards April 2013	Increase in number of patients breaching 18 week referral to treatment time. July 2013. Beds remain open on Beynon Ward at weekend.	Improve discharge arrangement with Social Care, especially South Staffordshire. Review West Park usage to reduce LoS Risk assessment for clinical areas receiving medical outliers and update annuallt Increase efficiency and release resource through ambulatory care, enhanced recovery and surgical site surveillance Expansion of Appleby Unit completed Ring fence 22 'elective' beds from September 2013. Plans in place for additional winter capacity. Quality meetings with Matrons to ensure patients are outlied to suitable areas.	 Oct-13 Oct-13 Jul-13 Sep-13	D4 AMBER	Sep-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**								
Chief Financial Officer	O16 1739	Failure to develop Service Line Reporting across the Trust.	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. SLR pilots to be set up. Rollout plan to be proposed. Contribution levels set end of Q2. Board received latest briefing in January 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	Sep-13	Yes
Chief Financial Officer	O16 2468	That pay, price rises and cost pressures will be higher than assumptions.	B2 YELLOW	2012/13 plan includes cost pressures, pay awards and 2012/13 incremental drift impact. 2012/13 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			Monitor budgetary position closely through operational finance group/TMT and Trust Board - ongoing	C2 YELLOW	Sep-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.	B3 AMBER	System in place to alert when issues occur. Reserve set against risk.			Monitor new contract terms on a monthly basis through contract meetings with PCT / CCG - ongoing.	C2 YELLOW	Sep-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	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.	C4 AMBER	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 October 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 September/October Engagement with the TSA with regard to Staffordshire options - September 2013. Deadline set for production of financial October 2013.	D3 YELLOW	Sep-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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Director of Planning / Contracting	O16 2929	Failure to deliver CQUINS schemes	D3 YELLOW	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)	Q3 sign off received from local CCG and from SSC. Responses are in-line with Trust Self-Assessment (March 13). Q4 agreement reached on CQUINs for both CCG and SSC (Jun 13) Q4 data returned on time for Commissioner sign off May 13. Financial risk assessment undertaken, initial assessment is significantly lower than 2012/13 CQUINS. 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	B3 AMBER	Sep-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	3176	Commissioners raising issue of patient activity over performance and their ability to pay.	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 PCT commissioners	Contract meetings - monthly ongoing	Performance query letters from commissioners - monthly ongoing	Escalate to Directors to resolve when appropriate - ongoing	B3 AMBER	Sep-13	
Chief Financial Officer	O16 514	Failure to deliver recurrent efficiency gains and CIPs.	A4 RED	Monthly reporting against projects including to Trust Board 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. Deloitte HDD report - Sep 2012	Monitor closely through CIP programme board - ongoing Identify 'new' projects and programmes in advance - ongoing	B3 AMBER	Sep-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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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.	C4 AMBER	Close monitoring of funding levies LETBs/LETCs now authorised Representation on any appropriate workstreams Liaison with LETBs and LETCs as they are developed CEO has nominated a senior RWT individual to sit on LETC (Sept 2012)	Review at E&T Committee NMET allocation for RWT received HR Sub Reports LETBs formed Chief Executive of Black Country LETC appointed; Paula Clarke HEE CEO now appointed HR Director now appointed to LETC	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)	Await LETB/LETC authorisation process Develop Liaison with LETB/LETC (ongoing) MPET review	Oct-13 Oct-13 Oct-13	C3 AMBER	Sep-13	Yes
Director of Human Resources	3409	No confirmation of/information on annual funding allocation from HEE WM for LBR and Second Registration and Sponsorship across Nursing, Midwifery, AHPs and Healthcare Scientists. Impact leading to; lack of clarification/notification of commissioning intent impacts on viability of academic provision with our partners, potential inability of staff to take up training opportunities due to short notice, potential inability for managers to release staff due to short notice, if activity doesn't take place due to lack of/reduced funding potential impact upon patient safety	B3 AMBER	Close liaision with HEE WM and Black Country LETC Annual TNA completed to identify and prioritise activity	Commenced prioritisation process of LBR TNA requests with Divisional Nurses based on 12/13 allocation Alerted heads of service that LBR TNA may be in jeopardy Academic partners alerted to lack of information to Trusts to support commissioning intent affecting viability and application timelines for their course provision Commenced selection process for sponsorship subject to final funding agreement Received notification of funding				B3 AMBER	Sep-13	

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?

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.	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 Prepare for CQC inspection Enact governance review recommendations Service Improvement initiative - bed capacity meets demand - modelling implementation commenced. Capacity and Social Services integration project commenced	Dec-13 Sep-13 Sep-13 Jun-13	C2 YELLOW	Sep-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;

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.	D2 GREEN	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	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.		Monitoring of actions against action plan on monthly basis to assure on target. Audit	Feb-14 Aug-13	D2 GREEN	Sep-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						

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;