The Royal Wolverhampton Hospitals NHS Trust

Trust Board Report

Meeting Date:	24th September 2012
Title:	Board Assurance Framework / Trust Risk Register
Executive Summary:	
Action Requested:	To inform the Board of updates to the Board Assurance Framework (AF) and Trust Risk Register.
Report of:	Chief Nursing Officer
Author: **Contact Details:**	Governance IM&T Lead Tel: 01902 695114 Email:
Resource Implications:	None identified
Public or Private: **(with reasons if private)**	Public Session
References: **(eg from/to other committees)**	
Appendices/ **References/** **Background Reading**	
NHS Constitution: **(How it impacts on any decision-making)**	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: - Equality of treatment and access to services - High standards of excellence and professionalism - Service user preferences - Cross community working - Best Value - Accountability through local influence and scrutiny

Background Details

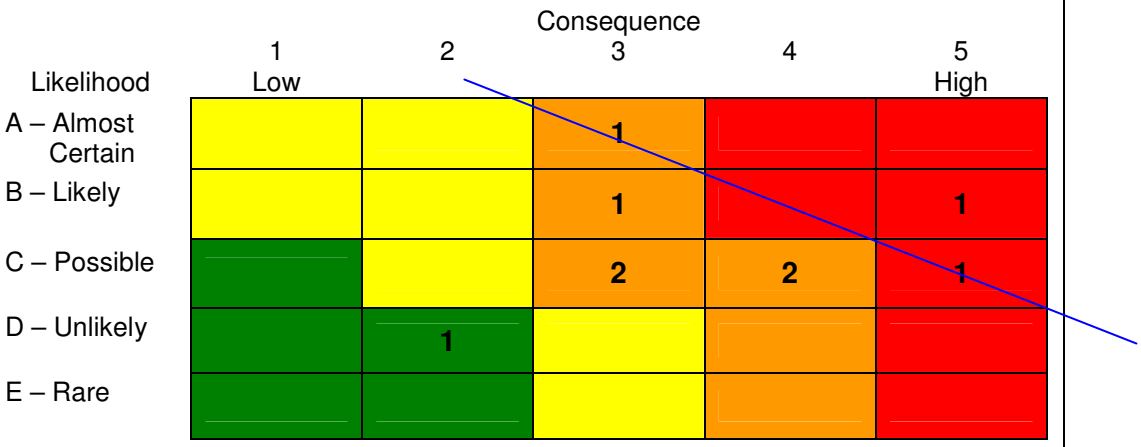
The Board Assurance Framework "provides organisations with a simple but comprehensive method for the effective and focused management of the principal risks that arise in meeting their objectives. It also provides a structure for the evidence to support the Statement on Internal Control" (Integrated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

Board Assurance Framework – Updates (Appendix A)

Following updates the split of the Assurance Framework is:

Risks currently being managed (ongoing)	8
Risks managed to target level	1

There are currently 9 risks contained within the Assurance Framework which are distributed across the Trust categorisation matrix as below:



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

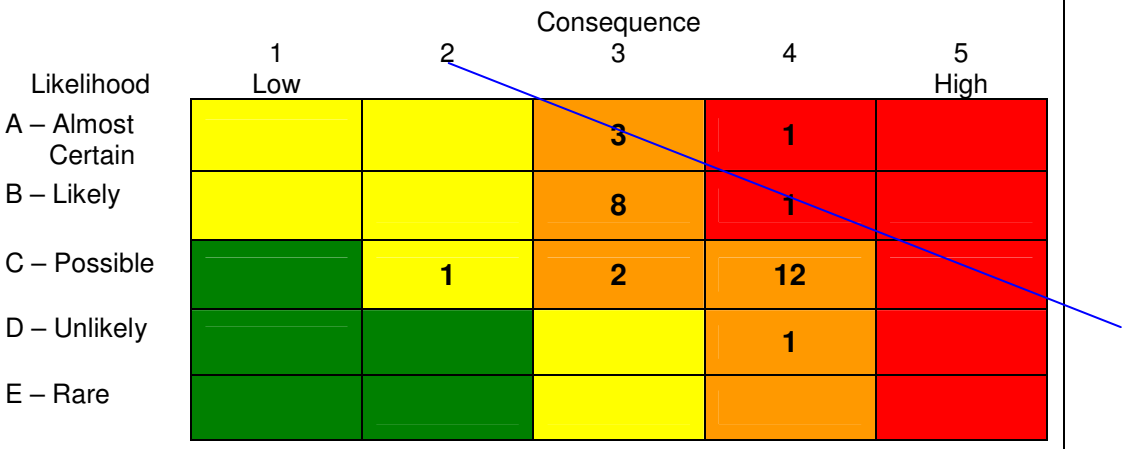
	ID	Risk Title	Lead
RED	2962	Health Visiting Services	COO
	2965	Failure to reduce Never Events	CNO

Trust Risk Register – Updates (Appendix B)

Following updates the split of the Trust Risk Register is:

Risks currently being managed (ongoing)	28
Risks managed to target level	1

There are currently 29 risks contained within the Trust Register which are distributed across the Trust's categorisation matrix as below:



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

	ID	Risk Title	Lead
RED	514	Failure to deliver recurrent efficiency gains and CIPs.	FD
	1739	Failure to develop Service Line Reporting.	FD

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 (September 2012)

Lead Director	Risk	Risk Title	Update	Reasoning / Progress Against Actions
Director of Planning and Contracting	2699 C4	Integration with PCT	Positive assurances updated.	Internal auditor review identified no recommendations.
Chief Nursing Officer	2449 C4	Inadequate and ineffective systems to Safeguard Vulnerable adults.	Positive assurances updated.	Analysis of workforce review of nursing and midwifery - completed for inpatients.
	2965 C5	Failure to reduce Never Events	Positive controls, positive assurance and action plan updated.	Reporting monthly through Quality and Safety and Trust Board via Q&S Report - Aug 12. MD and CNO mandated sessions share Never events and RCA findings and actions - Aug 12 Never Event Campaign underway reported through Q&SC - Aug 12 116 days without Never Event (Aug 12) Specific action plans post each Never event e.g. Obs and Gynae - Aug 12 Review of perioperative care plan with wards use of surgical checklists with any interventional procedure outside operating theatre to be developed and monitored via divisions and directorates - ongoing
Chief Operating Officer	2962 B5	Risk of Health Visiting business/system/service failure due to multiple systemic failings.	Positive controls and Positive Assurances updated.	A meeting has been arranged early September with the Director of Nursing for the Black Country Cluster to discuss some of the professional issues being raised by the Health Visiting service, and how these compared regionally. The Team Leader Job Description has been reviewed and the final draft is with the respective staff. Caseloads/clinic rationalisation - mapping work has been completed. Alternative accommodation reviewed with plans to relocate the service as per service redesign action plan. Review and evaluation of specific work streams as part of the work of steering group i.e., strategic, workforce, management and business functions (moved across from 'What else can we do') Strategic work stream to link/ integrate service model with measures outlined in "A Call to Action" (moved across from 'What else can we do') Workforce work stream to assess staff numbers, skill mix and competencies (moved across from 'What else can we do') Management and business work streams to ensure core business functions are fulfilled and KPI's to be developed to support this work (moved across from 'What else can we do') 27/08/2012 - Health Visiting review meeting – actions on schedule for

				completion. 24/08/2012 – Health visiting review meeting – action deadlines reviewed and new deadlines agreed – on schedule for completion.

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

Lead Director	Risk	Risk Title	Update	Reasoning / Progress Against Actions
Chief Operating Officer	1713 B3	Failure to effectively maximise workforce productivity.	Action plan updated.	Monitor Bank fill rates performance. Action Plan to address the issues once identified by job plan audit. Dec-12. Review of medical rotas with potential to introduce electronic rostering system. Mar-13.
	2492 C4	Failure to ensure that inpatient, outpatient, day case and theatre capacity meets demand.	Positive Assurances updated.	Discussed at weekly COO meeting
Chief Nursing Officer	535 C4	Failure to achieve reductions in HAIs impacting on Trust's reputation and compliance to regulatory standards.	Gaps in Assurance updated.	There is a lack of evidence against which PCR positive specimens will be EIA positive and therefore reportable under the new testing algorithm
	1717 C2	Failure to maintain re-registration by the CQC periodic review.	Positive controls updated.	Workforce review of Nursing and Midwifery - Aug 12.
	2482 D4	Failure to learn from national / local organisations experience e.g. Francis report.	Action plan updated.	3 Action remain open. For further review at October QSC.
	2680 A3	Interpreting & Translation Service - risk of over performance against central budget held by patient experience.	Positive controls and action plans updated.	Process is applied consistently now. Audit trail now in place, high users targeted and queried why used interpreting for number of hours. Main areas remain Appleby, BSS and Eye infirmary. Continue to scope use of electronic translation with IT and new Apple Vitalpac devices - Sept Process in place in Appleby, BSS to undertake risk assessment and only fund one hour of interpreting unless risk assessed by sister/manager with escalation to matron.
	2917 C4	Risk of non-compliance with NHSLA standards - achieving 12/13 CIP	Positive controls updated.	Resource for a fixed term post to support CNST and NHSLA from Oct 12.
Director of HR	1693 C4	Equal Pay Claims/ET's/Collective Grievances - Potential Significant Cost to the Trust	Action plan updated.	Action re independent reports moved to assurances-controls – completed. Still awaiting update from Solicitors.
	1742 B3	Failure to learn from staff survey.	Action Plan updated.	Action re results from 2011 survey taken into consideration with chatback results and action planned moved to Assurance Controls. Action re results from 2011 survey presented to TMT, TB, HR Sub and SMB

				moved to Assurance-controls.
	2626 C4	Implications of Liberating the NHS White Paper on Educational Levies	Positive Assurance updated	CEO to nominate very senior RWHT individual to sit on LETC- to allow appropriate representation
	2831 C4	Loss of critical services due to industrial action of staff	Positive assurances and action plan updated.	Action re results from 2011 survey taken into consideration with chatback results and action planned moved to Assurance Controls – completed. Action re results from 2011 survey presented to TMT, TB, HR Sub and SMB moved to Assurance-controls – completed.
	2858 C3	Lack of compliance with NHSLA Level 3 Standard 3	Positive controls and action plan updated	Extra training sessions being delivered. Aug 12 Further e-learning packs compiled for alternative to face to face sessions for CRT and General Consent training-Sept 12
	3081 A3	Insufficient budget to provide manual handling training to meet NHSLA Level 3 Standards	***New risk***	Insufficient manual handling budget to provide manual handling training to meet NHSLA level 3 standards. Extra budget required to meet demand and satisfy 95% compliance.
Director of Planning and Contracting	2929 C3	Failure to deliver CQUINS schemes	Positive Assurances updated.	Health economy meeting to review Q1 performance on specific scheme indicator positive
Medical Director	2922 C4	IG Toolkit Level 2 Maintenance	Positive controls, positive assurances, gaps in assurance and action plan updated.	31st July baseline submission reviewed and approved by IGSG on 10/07/2012 before submission. IG Lead and Governance Team Leader to re-evaluate 10 internally audited requirements before October submission and Decembers re-audit, to check any actions suggested have been taken by leads. Draft internal audit report released 31/08/2012 advises evidence submitted for IG Toolkit is not robust enough to support the Trust's assessment at this time.3 recommendations to improve IG evidence are outlined. Internal audit recommendation- Streamline evidence by uploading to one section where key documents are asked for to avoid duplication of evidence in the IG Toolkit. Internal audit recommendation-References to policies need to refer to current versions, and documentary evidence of approval by a recognised Group, Committee or Board need to be uploaded to the IG Toolkit. 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. Targeted implementation of actions by leads and sponsors and assurance that projected timescales of implementation will be achieved. Internal audit to be repeated to re-assess a further 10 domains in Dec 12.

The Royal Wolverhampton Hospitals NHS Trust

Board Assurance Framework

September-2012

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

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Risk Lead	ID	Principal Risk		Controls	Positive Assurances	Gaps in Assurance/Control	Action Plan that addresses Gaps in Control	Residual Risk Level		
Risks Currently Being Managed										

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	O7 2449	Inadequate and ineffective systems to Safeguard Vulnerable adults.	C4 AMBER	New Safeguarding Adults at risk intranet site with easy access to all relevant resources and information First phase of "Creating best practice wards" using a rapid improvement approach across a number of other safety work stream - Nov 11 Database of referrals maintained through Safeguarding Lead - Aug 11 Deputy Chief Nurse Safeguarding Lead for newly formed acute and community organisation - Apr 11 Internal audit through RSM Tenon to support improvement in processes - Sept 11 Revised safeguarding policy and framework for safeguarding training - Jun 11 Analysis of safeguarding allegations supporting improvements in: *Discharge planning / *Pressure ulcer prevention - Jun 11 Developed and agreed key performance indicators for safeguarding adults in place - Nov 11 Analysis of workforce review of nursing and midwifery - completed for inpatients	Specific aspects of Internal audit review - Jan 2012 Decrease in safeguarding allegations since June/July 2011. Audits against improvements in discharge planning and pressure ulcer prevention - Feb 2012 Progress against best standards in "creating best practice" wards - Jul 2012	Specific aspects of Internal audit review - Jan 2012 Safeguarding allegations substantiated - since June 2011 Complaints upheld - since June 2011	Employ substantive learning disabilities nurse with a liaison link with Sandwell BCP Mental Health Services - Delayed until September 2012 due to recruitment issues. Continue to implement "creating best practice wards" and plan further role out across other wards - ongoing Continue to share lessons learnt via the JHSVA Committee throughout the organisation - ongoing	Sep-12	D3 YELLOW	Sep-12	Yes

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

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Nursing Officer	O4 2965	Failure to reduce Never Events.	C5 RED	Reporting monthly through Quality and Safety and Trust Board via Q&S Report - Aug 12 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 Never Event Campaign underway reported through Q&SC - Aug 12	116 days without Never Event (Aug 12) Specific action plans post each Never event e.g. Obs and Gynae - Aug 12	Never event occurrence May 12.	Review of perioperative care plan with wards use of surgical checklists with any interventional procedure outside operating theatre to be developed and monitored via divisions and directorates - ongoing Divisional and Directorate action plans Divisional and Directorate Risk Registers	 May-12 May-12	D4 AMBER	Sep-12	Yes

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

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Trust Objective:	**To achieve a balance between demand & capacity of services**									
Director of Planning / Contracting	O6 2699	Not realising the benefits with the integration of the two organisations. Impact of movement to GP Consortia Commissioning - included in Risk 2508.	C4 AMBER	Development of a Benefits Realisation Plan. Action Plan - Apr-11 Re-launch of process to generate ideas and capture work in progress Share success, ideas and tools through a microsite on the intranet - Monthly Change Programme Board established Jan 2012 Programme reviewed and project tracker now introduced showing 6 month work programme - Sep-11 Launched revised PID/QIA - May 2012 Implemented monitoring tool to improve access to information and performance management - May 2012 Report to Trust Board in to update on progress and outline projects - July-11 and Oct-11 TMT approved revised Programme Management arrangements. Aligns Benefits Realisation and Cost Improvement Programme - Nov 11 Exec lead identified - Apr-11	Black Country System Plan - evidence of Benefits Realisation Internal auditor review identified no recommendations - Aug 12 Established revised targets for 2012/13 via Change Programme Board All schemes have now been migrated and are live in the new electronic monitoring system which will provide greater assurance and monitoring of plan. Monthly TMT and Trust Board reports		On-going monitoring of projects via Change Programme Board.	C4 AMBER	Sep-12	Yes

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

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	O16 2962	Risk of Health Visiting business/system/service failure due to multiple systemic failings.	B5 RED	Management support to the service is under review. The Chief Operating Officer and the Director of Nursing are leading the service development programme - leads convene every two weeks to drive service improvements. Weekly briefing of the Head of Nursing by the Matron. Head of Nursing met with Health Visitor Co-ordinators on 11th June to discuss any identified immediate risks which they are aware of, and a communication process will be agreed at that meeting. Directorate and Division will be monitoring HR indicators, complaints and any concerns raised through Safeguarding Team.	01/06/2012 - Health Visiting review meeting - actions on schedule for completion 15/06/2012 - Health Visiting review meeting - actions on schedule for completion 29/06/2012 - Health Visiting review meeting - actions on schedule for completion 24/08/2012 - Health Visiting review meeting - action deadlines reviewed and new deadlines agreed - on schedule for completion 27/08/2012 - Health Visiting review meeting - actions on schedule for completion		Leadership changes implemented from early July. Organisational Development programme established to ensure full engagement of Health Visiting workforce. Stakeholder Workshop planned for 12 September 2012 to inform the action plans. Health Visiting Service Improvement Board established to oversee the work programme, chaired by Chief Operating Officer with Multi Agency attendance.	D2 GREEN	Sep-12	Yes

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

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
				Directorate have been tasked with monitoring the service and reporting to the Division information contained within a suite of business and safety key performance indicators. These indicators were submitted to the Division for sign off and Divisional monitoring of compliance will commence weekly thereafter. The Directorate are required to provide an exception report to Health Visitor Service Improvement Steering Committee fortnighly. Regular communication sessions with Health Visitors are being planned. The employment of an external consultant, to lead business and culture changes on a short term basis, is currently being explored. Some internal management changes have already been implemented to support recommendations. Stakeholder event being held in Septemeber 2012 to discuss future of health visiting services in the organisation Rapid appriasal process to be undertaken by SHA 3 days in September 2012.						

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?
				A meeting has been arranged early September with the Director of Nursing for the Black Country Cluster to discuss some of the professional issues being raised by the Health Visiting service, and how these compared regionally. The Team Leader Job Description has been reviewed and the final draft is with the respective staff. Caseloads/clinic rationalisation - mapping work has been completed. Alternative accommodation reviewed with plans to relocate the service as per service redesign action plan.						
Trust Objective:		**Deliver services within financial allocations**									
Director of Planning / Contracting	O6 2508	Commissioning responsibility changes - affects contracted income	A3 AMBER	Review 'NHS Bill'; Operating framework and PbR tariffs for 2012/13 - Dec-11 Negotiation with Commissioners at LDP meetings; focus on CCGs (on-going) Internal RWHT Contract Review/LDP meetings. (Senior managers /Directors agreed negotiations strategy (on-going)	Contracts signed with all commissioners by 31 March 2012 Positive contract negotiations for 2012/13 Internal RWHT Contract meeting at least once per month Meetings every 4 weeks with Commissioners with action notes		Director level engagement with the PCT and PCT Clusters - meeting arranged - on-going Target CCGs as they develop; and develop links with Clusters - on-going Review current and future contract Portfolios. Include potentially new configured Trust services in all assessment/reviews. Revise Communication Strategy to reflect commissioning changes.	Sep-12	C4 AMBER	Sep-12	Yes

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

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Director of Planning / Contracting	O16 2927	Failure to deliver against QIPP scheme resulting in lack of investment.	B3 AMBER	Established joint programme Board with Commissioners. Agreed 2012/13 QIPP work programme.	April Trust Board report does not indicate any immediate risk.		To agree a QIPP work programme with commissioners To agree a QIPP work programme with commissioners To identify capacity and resources to deliver the programme - ongoing	Sep-12	B3 AMBER	Sep-12	Yes
Director of Finance & Information	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	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 Additional collaboration with other providers to reduce costs Maintain good working relationships and communications with commissioners - ongoing	Jul-12 Jun-12	C2 YELLOW	Sep-12	Yes

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

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Trust Objective:	**To achieve Foundation Trust status**									
Chief Executive Officer	O16 1501	The Trust does not meet the DH / Monitor requirements to become a foundation trust.	C3 AMBER	Process for review and comments on documentation via Trust Board - ongoing Programme for Communication with staff, patients and public - ongoing SHA performance monitoring and self-certification process - monthly Detailed minutes and action notes - ongoing monthly Board development programme - monthly Review of Monitor's Compliance Framework against Trust performance report monthly	Reactivation of application with Monitor. Trust Management Team and Trust Board monthly update Membership recruitment above trajectory Delivery of Action Plan Milestones		Action Learning From SHA FT Network Completion of HDD Stage 3. Continue structured Board Development Programme Undertake further review of mortality outlier alerts Regular review of Monitor Board minutes and reports	C2 YELLOW	Sep-12	Yes

Risk Managed to Target Level

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

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Trust Objective:	**To agree appropriate population catchment areas for RWHT service**									
Director of Planning / Contracting	O6 1734	Introduction of other health providers in the market as a result of Any Qualified Provider leads to a greater shift of activity.	D2 GREEN	Weekly review of interactive commissioning map (H) Established GP liaison office and webpage 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 - Trust Board - Jan 2012	Limited extent of choice in Nuffield for acute care No new players in the area for acute or community care Non-Wolverhampton Commissioners requested proposals for specialist community services Maintain and grow referrals for all specialties Lack of interest by private sector in development with the region		Review further AQP proposals - on-going Produce Quarterly Market Share analysis report Produce Quarterly Market Share analysis report - on-going Use refinements to NHS Choices & Choose & Book to 'sell' services - on-going Maximise opportunities to sell services via new Web Site - on-going Work with shadow Consortia to understand future requirements - on-going Explore opportunities with other commissioners to support the TCS agenda - on-going	D2 GREEN	Sep-12	Yes

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

The Royal Wolverhampton Hospitals NHS Trust

Trust Risk Register

September-2012

A1	A2	A3	A4	A5
B1	B2	B3	B4	B5
C1	C2	C3	C4	C5
D1	D2	D3	D4	D5
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Trust Objective:	**Clinical Negligence Scheme for Trusts**										
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 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 monitoring progress for standard 3 extra training sessions being delivered Further e-learning packs compiled for alternative to face to face training for CRT and general consent training	monthly audit of local induction returns all NHSLA minimum data set topics now included in performance repository for TMT report	lack of compliance to all subjects 95% compliance standard not achieved in certain mandatory training subjects audit continues to highlight issues with local induction returns and poor compliance with OP41. reporting frequency for all minimum data set topics now monthly for all subjects	Progress monitoring Further e-learning packs compiled for alternative to face to face sessions for CRT and General Consent training Extra Training Sessions delivered Roll out screen dump daily from live database extra resource for extra reporting	 Sep-12 Oct-12 Oct-12 Oct-12	D3 YELLOW	Sep-12	

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

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief 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	Review of Feb 12 level 2 self-assessment completed and fed back for redress of gaps. Trust audits used to reveal compliance problems which are then followed up and monitored. Project and small working groups are trouble shooting problems Escalation of risk to Trust risk register Ongoing compliance monitoring and reporting at NHSLA Steering group, Compliance Committee and TMT Self assessment to implement policy into practice Monitoring of policies and audit production (Feedback provided to all authors) Professional Heads identified as facilitiators for evidence gathering Confirm & Review process with standards leads Mapping all audit/monitoring requirements completed - monitored through NHSLA Project Group Project Plan to implement requirements at all levels in place Independent review of compliance evidence undertaken. 17/4/2012 & 29/6/2012)	NHSLA Policy Pack communicated across whole trust to inform all staff of new policies Confirmation from NHSLA assessor that any policies not harmonised is acceptable as long as this has been approved by a Trust Level committee with rationale - timescales for harmonsation must be included. Ongoing monitoring/reporting of position to TMT/Divisions/Directorates.	Level 2 self assessment show poor local implementation of policy - Feb 12 Poor completion and follow up of audit actions - Apr 12 Unable to show improvements in some audit results - Apr 12 Internal monitoring currently show predominantly red/amber scores - Apr 12 12 months evidence of audit unavailable prior to audit (Nov 2012) - Risk 2832 (Merged with escalated risk July 2012) NHSLA policies not fully being integrated with Community Services following TCS (Risk 2763) (Merged with escalated risk July 2012) Diagnostic and Screening, Health Records and Complaints Audit monitoring reports will miss the August deadline	Review of level 1 and 3 compliance and readiness for assessment in progress. Resource identified to support improvement work required and a Maternity re-assessment at level 2 this financial year. NHSLA Level 3 Sub Group - review all monitoring reports prior to submission - ongoing Monitor progress against milestones through NHSLA Project Group Ongoing monitoring of Directorates against Divisional Governance Strategy (Level 2) Review Divisional Governance Strategies to strengthen requirements of NHSLA (Draft to be in place by end of July) Workshops for Policy Leads/Authors to attend re: monitoring reports Preparation packs prepared and disseminated to all key staff in relation to the Appendix D checks that will be undertaken on the day of the assessment. Undertake health records spot checks against Appendix D to inform position, feedback to directorates/divisions where improvements will be required in order to prepare for live records check on the day of assessment. Communication to TMT/SMB/Divisions at all stages Draft Level 3 Audit reports across all standards for review by end of August	Jul-12 Nov-12 Nov-12 Nov-12 Jul-12 Jul-12 Jul-12 Nov-12 Nov-12 Sep-12	C3 AMBER	Sep-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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				121 Support provided to all policy/audit leads Governance Officers supporting within Directorates re: monitoring against divisional governance strategy (L2 work) 'To Do' list produced and communicated to Divisions/Directorates Weekly meeting in place with Chief Nursing Officer to monitor progress/escalate issues. Resource for a fixed term post to support CNST and NHSLA from Oct 12.			Benchmarking Pre assessment visit to be used to test compliance in specific areas - ongoing Perform risk assessment Review audit results and actions for improvement prior to assessment visit - Re-audit as necessary.	Jul-12 Apr-12 Apr-12 Jun-12			
Trust Objective:		**To provide our patients & staff with a safe environment.**									
Chief Nursing Officer	O7 2448	Failure to have effective systems in place for patients with learning disabilities or requiring application of Mental Capacity Act.	C4 AMBER	Revised training programme for safeguarding and MCA - Jun 11 Revised Safeguarding policy in place - Jun 11 Improved access to best interest assessors - Jun 12	Specific aspects of WMQRS Peer review care of vulnerable adults in hospital - Jan 2012 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 made against the organisation in relation to Learning Disabilities - ongoing.	Undertake an audit of learning disabilities IT alert system and outcomes Learning disabilities lead post now made substantive and to include liaison with Sandwell BCP mental health services - Delayed until September 2012 due to recruitment issues Implement agreed learning disabilities IT alert system to identify patients on admission to receive specialist nurse support	Oct-12 Sep-12 Aug-12	D3 YELLOW	Sep-12	Yes

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

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Nursing Officer	O16 2482	Failure to learn from national / local organisations experience e.g. Francis report.	D4 AMBER	Governance unit reviewed external reports of other organisations learning and cross referenced to local actions. Monitor complaints, claims and incidents through I.C.C commenced March 2012.	CQC responsive review follow up report - March 2012 CQC registration without conditions (General and Mental Health) - Feb 2012		3 Action remain open. For further review at October QSC. Sustainability plan in draft format for review at Compliance Committee	Oct-12 Apr-12	E2 GREEN	Sep-12	Yes
Director of Finance & Information	O6 2570	Inadequate estates as part of the Transfer of Community Services - WCPCT provider Services with effect from 1 April 2011. Legal consequences of a potential estates transfer ie property arrangements in line with White Paper with PCT being abolished by April 2013.	C4 AMBER	Engagement of Solicitor support External Support is being employed to review the condition of the Estates where Services from WCPCT are undertaken. Negotiations continuing re potential properties to transfer. Date for transfer now delayed due to DH. Monthly Project Board meetings with extensive RWHT representation.	Outcome of Due Diligence exercise		Site by site analysis underway as to condition of property occupied. Detailed individual/lease negotiations to take place with legal support during 2012 to fit with revised DH timetable. Department of Health guidance now delayed transfer to 1 April 2013. Trust has baseline information and will re-commence negotiations from 1 June 2012 with PCT.		C3 AMBER	Sep-12	Yes

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

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Chief Nursing Officer	O4 2680	Interpreting & Translation Service - risk of overperformance against central budget held by patient experience.	A3 AMBER	Current process in place to direct face to face/telephone translation services Updated policy and criteria to clarify process for interpreting services Changed face to face provider to improve service Changed telephone provider to improve service and screening of enquiries Circulated reports to divisions regularly to highlight costs incurred Raised awareness of new process Improved audit trail for use of interpreting services for monitoring purposes Recharge to directorates where appointments cancelled but interpreting service not cancelled Identified high users and engage to review working practices.	Audit trail now in place, high users targeted and queried why used interpreting for number of hours. Main areas remain Appleby, BSS and Eye infirmary - Aug 12. Process is applied consistently now - Aug 12	Lack of awareness of the process within directorates No consequence to divisions for overspend	Continue to scope use of electronic translation with IT and new Apple Vitalpac devices. Process in place in Appleby, BSS to undertake risk assessment and only fund one hour of interpreting unless risk assessed by sister/manager with escalation to matron. Scoping use of electronic translation Limited face to face with risk assessment process	Sep-12 Jul-12 Jul-12	C2 YELLOW	Sep-12	

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

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Director of Planning / Contracting	O6 2731	* Harm to vulnerable patients during a heatwave. A heatwave will affect the high risk groups i.e. older age individuals, individuals suffering from chronic and severe illness and such patients on chemotherapy with dehydration problems. * Staff shortages to support service delivery during a heatwave if it lasts more than a few days. * Laboratories, pharmaceutical storage and food storage areas may be adversely affected by increasing temperatures during heatwaves. * IT servers overheating and disruption to e-mail communications may occur during heatwaves which will affect service / business delivery. * Heatwave period has now concluded and therefore no longer required to be on the assurance framework needs to be picked up again next year. All plans remain in place in case, and is posted on the Emergency preparedness intranet site.	C4 AMBER	Heatwave Plan update for 2012 including Community service provision. SHA monitoring implemented. Action plan in place with key lead identified for implementation in the event of a heatwave. Ensured the enactment of business continuity plans in the event of a heatwave occurring.	SHA Monitoring sheet for Level 2 enacted (26 June 2011). SHA Assurance template submitted 1 July 2011. All actions are in place in readiness for a heatwave - heatwave period ends 15 Sept 2011. Regular weather reporting across the Trust has taken place since June 2011.		Implementation of the Heatwave plan during 1st June -15th September to give assurance that the actions within the plan are complied with - now implemented	Sep-12	C2 YELLOW	Sep-12	Yes

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Medical Director	O6 2920	Provision of Vascular services at RWHT following centralisation of the service off-site and concerns over the required level of vascular surgery support to other clinical specialties including those in the Heart and Lung Centre.	C4 AMBER	Clinicians from RWHT are actively participating in the project group which is developing the implementation plan of vascular network service provision across the Acute Trusts of the Black Country and promoting details of the level of support required to the group.	To be reviewed when centralisation of vascular surgery is implemented.	To be reviewed when centralisation of vascular surgery is implemented. Aug 12 - no incidents reported from RWH	Scope resource implications of Phase 1 for RWH Develop and agree SLA for backfill at RWH during Phase 1 Scope implications of Phase 2 implementation Monitor incidents related to non-availability of cover To review and agree the governance arrangements around the implementation proposals regarding patient safety and service provision across RWHT, prior to the network service plan being implemented operationally.	Aug-12 Sep-12 Dec-12 Jul-12	E2 GREEN	Sep-12	
Chief Nursing Officer	O4 2950	Unable to achieve no avoidable pressure ulcers by December 2012 across the health economy.	B3 AMBER	Increased Tissue Viability Specialist Team capacity agreed with a business case - Jun 12 Organisational wide pressure ulcer prevention plan - Apr 12 Pressure ulcer prevention training now mandatory specific - Jun 12 Communication campaign to all professional groups - ongoing Weekly pressure ulcer review meeting with CNO to determine accountability to implement learning organisation wide - Feb 12 Revised pressure ulcer policy in place - Jun 12	Regional intensive support team visit from SHA and positive feedback - Jun 12	Fluctuation in numbers of avoidable pressure ulcers from April 11 to current position - ongoing	Increase communication within the organisation regarding pressure ulcer prevention - ongoing Strengthen the wound care link role to develop competency and change culture Review equipment resource provision and improve community equipment provision and maintenance. Develop a tissue viability resource guidance on intranet. Strengthen sharing of action plans following investigation and manage capability as required - ongoing. Develop a paediatric/ neonates pressure ulcer prevention policy. Develop an e-learning package	Aug-12 Sep-12 Aug-12 Sep-12 Sep-12	D3 YELLOW	Sep-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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Chief Nursing Officer	O8 535	Failure to achieve reductions in HAIs impacting on Trust's reputation and compliance to regulatory standards.	C4 AMBER	PCR for C-Diff testing from March 2011 Supervision of junior doctors re IP practices/ skills/ training HCC-DH Self Assessment Hygiene Code - Jul 12 Screening Policy in Trust implemented Screening Programme in Community in place IV team PID agreed at TMT and in development - May 12 Surgical Site Infection Surveillance Team agreed at TMT and in development. - May 12 Robust surveillance system in place.- May 12 Monitored the increase in C-Diff post PCR testing and discussed with commissioners Jun 12 PREVENT Bronze standard achieved by Care Homes - Mar 2011 Appointed Data Analyst for IPT - March 2012 IP lead nurse in post - Team restructure aimed at delivery. CDiff plan reviewed end of September 11 and enhanced with a range of actions aimed at reduction of incidence Rapid improvement programme - creating best practice wards includes an infection prevention work stream	CQC Visit report - May 2011 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 Jul 12 MRSA admission screening pilot in care homes commenced October 2011 MRSA Screening for Podiatry Nail screening pilot - 0% MRSA detected April 2012 MRSA early discharge screening Pilot October 2011 - 1/260 positive Reduction in HCAIs other than MRSA bacteremia - Aug 12	PCR testing has increased the numbers of C-Diff due to more accurate testing (sensitivity). The impact of this is still to be quantified - Jun 12 There is a lack of evidence against which PCR positive specimens will be EIA positive and therefore reportable under the new testing algorythm	Develop pathways for the use of indwelling urethral catheters to minimise unnecessary usage Develop pathways and extended training for care of chronic wounds to reduce incidence and reoccurrence Evaluate the effectiveness of revised IP team structure supporting the divisions.	Aug-12 Sep-12 Sep-12	C4 AMBER	Sep-12	Yes

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				MRSA admission screening pilot in care homes commenced 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 - Jun 12 Implemented CDI Assurance process. Quarterly reporting to IPCC on trends - Jul 12 Action plan in place for Hygiene Code to be monitored by IPCC quarterly - reported to IPCC Nov 2011. Action plan for reduction in HABs and DRHABs developed.					
Trust Objective:		**To be the employer of choice.**								
Director of Human Resources	1693	Equal Pay Claims/ET's/Collective Grievances - Potential Significant Cost to the Trust	C4 AMBER	NHSLA and Trust solicitors supporting defence Independent reports concluded, appropriate challenge in place and await outcome. Regular liaison with solicitors meetings set up with individuals and trust solicitiros to gather mor information	claims reduced to 15 Regular analysis as part of audit process Robust ruling in support of AFC systems from ET in test case		Continue work with solicitors Update awaited from Solicitors. Stage 2 investigations commenced July 2010. active case management of cases still underway	D3 YELLOW	Sep-12	

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Chief Operating Officer	O12 1713	Failure to effectively maximise workforce productivity.	B3 AMBER	Areas to be contained with SPA allocation - agreed Job plan audit developed Job Planning Steering Group set up to ensure robust job planning process led by Medical Director. Implementation of monitoring procedure to ensure consistency of approach across Divisions. Performance targets including pay costs v clinical income. Medical staffing review 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.	High agency medical costs. Previously there was inconsistency of application of approach. Capacity failing to meet demand.	Action Plan to address the issues once identified by job plan audit. Monitor Bank fill rates performance - ongoing Review of medical rotas with potential to introduce electronic rostering system.	Dec-12 Mar-13	C2 YELLOW	Sep-12	Yes

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Director of Human Resources	O14 1742	Failure to learn from staff survey.	B3 AMBER	Key Indicators in staff survey covered by Trust policies (eg appraisal, harassment and bullying, etc). Staff Governors in constitution have voice to influence direction of Trust Action plan to learn from past survey constructed Staff feedback has been incorporated into the Trust Board quality & safety dashboard thereby aligning staff engagement with patient safety agenda. Chatback was completed in July/August 2011. Reports cascaded and action plans developed. 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 2011 survey were presented to TMT, Trust Board, HR Sub Committee and Senior Managers Briefing. Results from 2011 survey taken into consideration with Chatback results and action planned.	KPI in annual plan. ChatBack 2011 results show improvement in most areas. Action plans to further improve results in place. Overall staff engagement measured for the second time (based on response to 3 questions). RWHT scored 3.72/5 being highly engaged staff. This was in the highest (best) 20% when compared with similar Trusts. Turnover below National average and within Trust target.	Results received from 2011 staff survey; response rate was (374 staff) 45% (in the lowest 20% of Acute Trusts) compared with 39% in 2010. Feedback from Managers requesting more specific Specialty breakdown.	National survey being conducted in Autumn/Winter 2012. ChatBack conducted in Summer 2012 to ensure momentum is maintained. Results due in early September. Cascade and action planning will then commence in September.	Mar-13 Sep-12	D3 YELLOW	Sep-12	Yes

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Director of Human Resources	O12 2831	Loss of critical services due to industrial action of staff	C4 AMBER	Ongoing arrangements are in place for the Trust to be linked to local, regional and national intelligence to inform contingency planning. Silver Command Operating procedure for IA in place. Agreement with Unions re Exemptions reached. Communications Plan developed and in place Ongoing regular updates on workforce analysis of Union membership within Trust; Monitoring of Workforce plans Review of 'lessons learnt' has taken place, formal report to go the EPC and TMT Jan 2012. Incorporated a more detailed section for the Loss of Staff in the Trust Business Continuity Strategy, which also identifies critical and non critical services and reference is made to the various employment policies. Discussions taken place with staff agenices to clarify the availability of agency staff in the situation of industrial action. Agreed legal principles and duties in respect of industrial action enabling Trust to ensure that obligations are met by Trade Unions, employees and the Organisation.	Industrial Action occured on 30/11/11. Sitrep reporting on state of hospital submitted to SHA/GP clusters for assurance. 17% of staff striked. Industrial Action by UNITE occurred on 10th May 2012; no impact on service delivery. Action plans in place but nil return on sitrep report. Industrial Action by doctors in June 2012, minimal impact on service delivery.		Ongoing monitoring of Trade Union websites. Ongoing information sharing/dialogue with Staffside. Await National Outcome of further discussions re Public Sector Pensions - Ongoing	C3 AMBER	Sep-12	Yes

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				Contingency Planning Awareness Sessions to Managers / Heads of departments across the Trust completed. Skills / competencies of available staff i.e. assessing workforce capacity completed. Staff skills audit re-evaluated with the integration of community services and an understanding of our medical staff / Consultant progammed activities. Review undertaken in relation to the Trust's critical and non critical services across the Trust including the community provider services in the event of IA. Action completed in relation to identify the impact on staff and local staffing plans. Management Guidance has been produced. Creche facility for staff requiring support in relation to child care arrangements has been arranged and can be implemented at short notice. Training sessions have been established to offer ward and porter training to staff and volunteers.					

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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. Internal Audit Project to commence October 2010 Weekly discharge meeting. 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. Evaluate impact of Best Practice Wards roll-out agreed. PCT Supporting Project Manager Health Economy Winter Plan ECG Meeting	Show reduced delayed discharges Weekly delayed discharge report	Patients with excessive length of stay - February 2012	Joint working with South Staffs Partnership Trust now underway to improve Discharge Planning for South Staffs patients. Training and awareness sessions on services within Community Services - ongoing. LEAN Project Managing Complex Discharges - ongoing.	D2 GREEN	Sep-12	Yes

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Chief Operating Officer	O16 2492	Failure to ensure that inpatient, outpatient, day case and theatre capacity meets demand.	C4 AMBER	Cancer now within trajectory - continue to monitor weekly. Monthly monitoring of increased demand in relation to GP/Dental referrals and in particular those outside Wolverhampton. Monthly monitoring of increased demand from outside Wolverhampton for Stroke and Cancer Services Annual delivery plans developed based on contracted activity and agreed targets for waiting times and quality indicators. Monitoring of access targets, activity, waiting times and other quality indicators on a weekly and monthly basis Winter plan in place which includes access to flexible capacity Working with primary care and other agencies to improve timeliness of discharge Implementation of the Productive Series Programme to ensure efficient and effective wards and departments Work with external consultants on service changes to improve outpatient utilisation, theatre utilisation and increase day case rates	Cancer targets achieved - continue to monitor closely and report to TMT and Trust Board in performance report. Quarterly assessment, risk rating and remedial action identified by Exec Director lead for all business outcomes in the annual plan Evidence that performance is discussed at weekly COO meeting with agreed actions to rectify underperformance Performance reports to TMT and Trust Board monitors performance against plan Reports to SHA and other agencies Daily meetings to support effective management of capacity Evidence of RCAs on cancelled operations Discussed at weekly COO meeting	Winter capacity continues to be open beyond planned period	Patient Productivity Programme commenced with enabling work streams	D3 YELLOW	Sep-12	Yes

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				Capacity management team in place to facilitate timely admissions and discharges.							
Chief Operating Officer	O19 2719	PAS Admissions are often updated on to PAS retrospectively - 13% of admissions Jul-Oct 2010 where entered more than 24hours after the admission actually happened - this will have a significant impact on systems such as eDischarge and ePrescribing and should be done real-time to ensure patient Safety (wristband).	A3 AMBER			Further investigations carried out and this confirmed that some process redesign is necessary to achieve timely discharges on the system. Nothing further gleaned from recent investigation. The risk is to be re-evaluated.	Awareness has been raised. Detailed plan to resolve being formulated.	Sep-11	B3 AMBER	Sep-12	Yes
Chief Operating Officer	O6 2840	From 1st Dec 11: *Extra activity for NX A&E as result of Stafford A&E closing overnight.	B3 AMBER	Upgrade 1 ward area Review physical environment Appoint to staffing gaps Review staffing and staffing model Develop monitoring system for effects of additional demand Order equipment Weekly performance monitoring of A&E at director and operational level. Trust has access to data re: attenders at Stafford A&E on which to base measures at NX.			On-going monitoring of impact		C2 YELLOW	Sep-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 progressively improve the image and perception of the Trust**									

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

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

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

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
				Cancer Network engaged in definition and breach analysis Review of definitions of Cancer Systems Vs 18 weeks. Weekly review of Cancer Waiting Time in a prospective manner.							
Trust Objective:		**Deliver services within financial allocations**									
Director of Finance & Information	O16 1739	Failure to develop Service Line Reporting across the Trust.	B4 RED	Reports are being issued monthly and clinical engagement has been improved which has enabled the content of the reports to be improved and be more useful. SLR reports to be distributed on a monthly basis. SLR pilots to be set up. 2011/12 plan to be agreed and monitored against. Rollout plan to be proposed. Board received latest briefing in April 2012. Updated contributions using 2012/13 tariff now available.		Timescales and priorities to be determined when 1st phase report considered. Need to develop better appointment bases for some direct and indirect costs.	Ongoing Monthly Information Shared - ongoing. Contribution levels to be set end of Q1. 2012/13 plans will be agreed in April and then monitored against Patient level Costing is being implemented in the Trust which will enable more in depth SLR to be provided.	Jun-12	D3 YELLOW	Sep-12	Yes

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

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Director of Finance & Information	O16 2468	That pay, price rises and cost pressures will be higher than assumptions.	B3 AMBER	2012/13 plan includes cost pressures, pay awards and 2012/13 incremental drift impact. 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		C2 YELLOW	Sep-12	Yes
Director of Finance & Information	O6 2781	Contractual risks due to tariff changes for emergency threshold.	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-12	
Chief Operating Officer	O6 2893	Risk that GP workload will not be retained following the commissioning tender for GP services. This potential activity reduction will lead to loss of income and overcapacity of pathology services on site. There would potentially be significant impact on staffing structure.	C4 AMBER	Communication regarding GP tender with senior members of the trust management team Royal Wolverhampton Hospitals NHS Trust & another local pathology provider to tender for GP services	Completion of the pathology build includes the partnership working capability Strategy involving senior management of the trust in obtaining the GP workload	Joint GP bid relies on agreement of Chief Executives from both Trusts	Produce tender for GP work- due date unknown at present (see details); date will require review by due date given. Contruction of Integrated pathology build Inform trust senior management team of progress of GP tender bid	Sep-12 Mar-13 Dec-12	D3 YELLOW	Sep-12	

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Director of Planning / Contracting	O16 2929	Failure to deliver CQUINS schemes	C3 AMBER	Full finanical assessment undertaken and values shared Contracting / Commissioning group standing agenda item Lead coordinators identified Assessment made of costs to deliver Quarter 1 results/review meeting agreed with Commissioners. Health economy meeting to review Q1 performance on specific scheme indicator			Head of Commissioning & Contracting to focus as priority in August 2012. 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	Aug-12	C3 AMBER	Sep-12	Yes
Director of Human Resources	3081	Insufficient manual handling budget to provide manual handling training to meet NHSLA level 3 standards. Extra budget required to meet demand and satisfy 95% compliance	A3 AMBER	overbook each course by a few places with the expectation that a certain amount of places will be DNA to utilise expected DNA places and ensure best value DNA letters issued to individuals and their managers including information on cost of training areas of high DNA rates have letters sent to DMD/CD/Matron/Div Manager/Div Nurse Extra training sessions released for acute and community staff	increased attendance at manual handling training courses	DNAs on paid for training places currently run at % (often due to urgent clinical presures) thus adding to shortfall issues Current activity for booking training has increased (due to NHSLA 95% compliance) across the organisation to meet target and budget predictions estimate that the budget will have a £10,000 shortfall TCS budget does not meet clinical staff needs	Extra training sessions released Review SLA with Local Authority Assign earlier training dates to those who are listed as "red" Ascertain the viability of further train the trainers sessions Reduce admin costs by loading MH booklet on KITE Publicise 1 day initial training	Oct-12 Oct-12 Oct-12 Oct-12 Oct-12 Oct-12	D3 YELLOW	Sep-12	

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

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Director of Finance & Information	O16 514	Failure to deliver recurrent efficiency gains and CIPs.	A4 RED	Monthly reporting against projects including to Trust Board 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	Finance report to Trust Board. Report of the Change Programme Board to Trust Board. Deloitte HDD report.	Monitor closely through CIP programme board Identify 'new' projects and programmes in advance - ongoing		B3 AMBER	Sep-12	Yes
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	Representation on any appropriate workstreams Liaison with LETBs and LETCs as they are developed	Review at E&T Committee HR Sub Reports LETBs formed Chief Executive of Black Country LETC appointed; Paula Clarke HEE CEO now appointed CEO to nominate senior RWT individual to sit on LETC	workforce planning input to LETC needs strengthening Lack of direction from DOH	Develop Liaison with LETB/LETC	Oct-12	C3 AMBER	Sep-12	Yes

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

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Trust Objective:	**To achieve Foundation Trust status**										
Medical Director	O16 2922	Maintenance of a minimum accreditation of level 2 or higher for the IGToolkit v10 - 2012/13 in line with national guidance.	C4 AMBER	IG lead set up monthly meetings with requirement leads to maintain progress against action plans. Governance officers (gov dept) have performed a confirm and review of v9 evidence in June 2012, to highlight any gaps in assurance to Requirement leads and infomr 2012/13 action plans. IGToolkit v10 released 04/06/2012 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 31st July baseline submission has been reviewed and approved by IGSG before submission 10/07/2012	Evidence evaluation results fed back to requirement leads and action plans have been put in place to address any gaps in assurance identified. IGToolkit submission at July 2012 saw only req 112 on training go back down to a level 1 IGToolkit Standards have not significanly changed between v9 and v10. Evidence uploaded into the IGToolkit for v9 will roll over to be used for v10 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.	IGT leads to confirm evidence has been reviewed by checking the review box. on IGT online- Only some leads had done this at July 12, evidence of review by leads/sponsors is not present.(required for standard 101) Draft internal audit report released 31/08/2012 advises evidence submitted for IGToolkit is not robust enough to support the Trust's assessment at this time.3 recommendations to improve IG evidence are outlined Internal audit recommendation- Evidence in draft, undated or out of date to be removed and current evidence uploaded to the IGToolkit. Internal audit recommendation- Streamline evidence by uploading to one section where key documents are asked for to avoid duplication of evidence in the IGToolkit. Internal audit recommendation- References to policies need to refer to current versions, and documentary evidence of approval by a recognised Group, Committee or Board need to be uploaded to the IGToolkit.	Progress monitoring Audit	Oct-12 Jan-13	D2 GREEN	Sep-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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Risk Managed to Target Level											
Trust Objective:	**To be in the national NHS top quartile of benchmarks**										
Chief Nursing Officer	O16 1717	Failure to maintain re-registration by the CQC periodic review.	C2 YELLOW	Undertake quarterly Divisional Reviews Performance Management Framework in place that is monitored through Trust Management Team and Trust Board. NHS Instittute for Innovation Better Care Better Value benchmark NHS Performance Framework - Quarterly to Trust Board Workforce review of Nursing and Midwifery - Aug 12	62 day cancer target now within target. Continue to monitor at thrice weekly meetings - March 2012 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 registration without conditions - Apr 2011 CQC Reports - Privacy, Dignity and Nutrition - Responsive Review - March 2012	C Diff target not on target due to PCR testing - March 2012 Delays in Transfer of Care above internal target periodically (target below 6) Feb 2012 Length of Stay is above target - Feb 2012	Develop Trust audit to test outcome compliance Internal audit (i.e RSM Tenon) of trust arrangements for ongoing compliance monitoring - Awaiting report. Bi monthly compliance reporting to compliance committee - with actions for shortfalls. Implement findings of Newtons Review re: Outpatients. Phase One complete. Phase Two - July 2011 Service Improvement initiative - bed capacity meets demand - modelling implementation commenced Service Improvement initiatives - Productive Theatre - ongoing CQC standards are being mapped against Information Governance standards, NHSLA standards, Performance and quality indicators and trust wide audits; in order to triangulate self-assessment and strengthen assurance of on-going monitoring.	May-12 Aug-11	C2 YELLOW	Sep-12	Yes

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