The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	22nd Apr 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

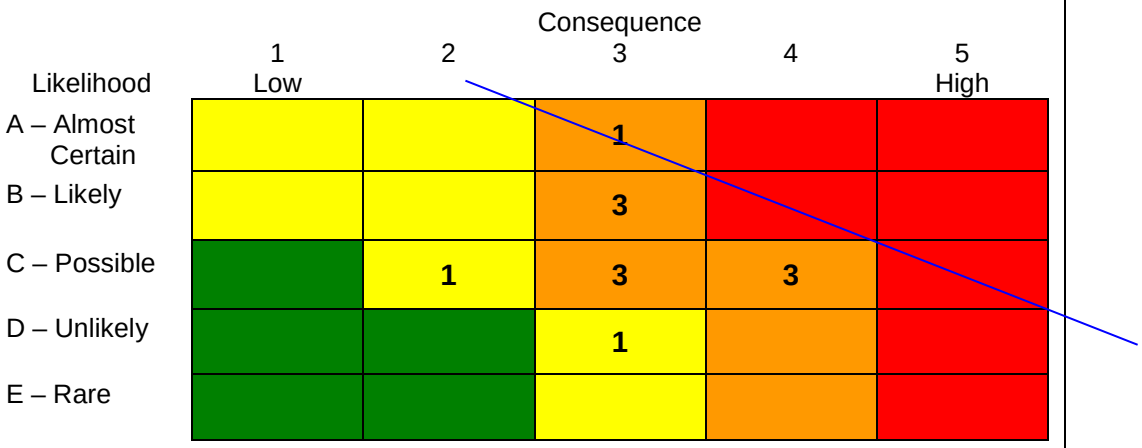
The Board Assurance Framework "provides organisations with a simple but comprehensive method for the effective and focused management of the principal risks that arise in meeting their objectives. It also provides a structure for the evidence to support the Statement on Internal Control" (Integrated 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 (ongoing)	11
Risks managed to target level	1

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

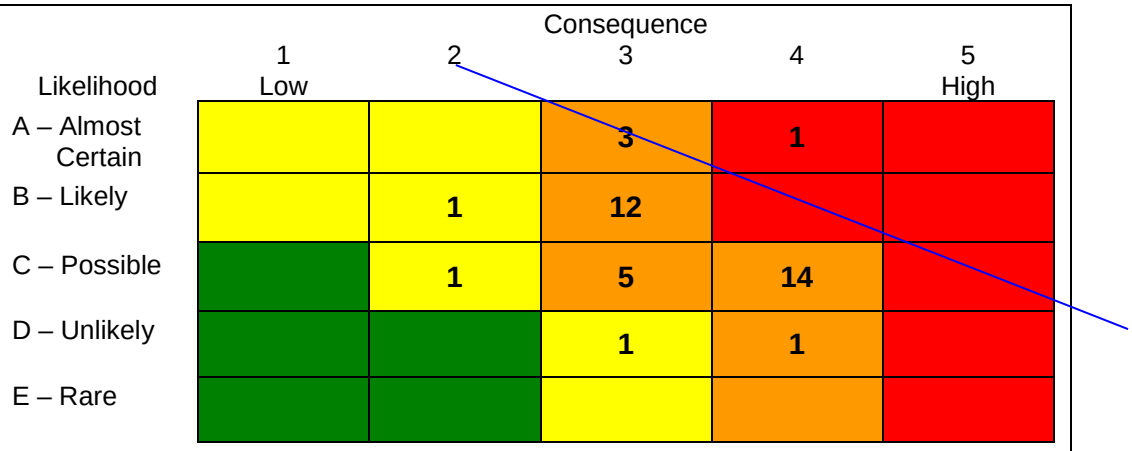


Trust Risk Register – Updates (Appendix B)

Following updates the split of the Trust Risk Register is:

Risks currently being managed (ongoing)	38
Risks managed to target level	1

There are currently 39 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

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.		2	1			12		
2) To be the employer of choice.						2		
3) To achieve a balance between demand & capacity of services		3				8		
4) To progressively improve the image and perception of the Trust						1		
5) To be in the national NHS top quartile of benchmarks							1	
6) Deliver services within financial allocations		3	1		1	6	2	
7) To be a high quality educator						1		
8) To agree appropriate population catchment areas for RWHT service		1						
9) To develop our position as a tertiary centre								
10) To achieve Foundation Trust status		1				2		
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 (Apr 2013)

Lead Director	Risk	Risk Title	Update	Reasoning / Progress Against Actions
Chief Nursing Officer	2965 C4	Failure to reduce Never Events	Positive Assurances, Gaps in Assurance updated.	Q&S Committee receive monthly assurance of Never Events avoidance progress (Apr 13). Never Event from July 2010 reported March 2013.
	3277 B3	Failure to meet Catheter Safety CQUIN requirements	***Risk closed***	
Chief Executive	3330 C4	The Trust does not meet the DH / Monitor requirements to become a foundation trust.	Positive controls and Positive Assurances updated.	Revised Tripartite Formal Agreement for FT Timetable Chair commenced 6 March 2013 Achieved milestones to date on TFA
	3352 B3	Potential for rapid growth of the Trust	***New risk***	Potential for rapid growth of the Trust due to changes in the wider health and social care economy.
	3353 C2	'Safeguarding' the Trust for the future	***New risk***	'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.
Director of Planning and Contracts	2508 C4	Commissioning responsibility changes - affects contracted income	Positive controls, updated.	Agreement of risk share to support maintenance of overall financial quantum.
	2927 B3	Failure to deliver against QIPP scheme resulting in lack of investment.	Positive controls, Positive assurances and Action plan updated.	Agreed QIPP savings plans with relevant detail to inform impact on divisional planning and budget setting.
Chief Financial Officer	3354 C3	Estates quality and flexibility	***New risk***	Estates quality and flexibility compromise the ability to respond to fluctuation in demand and the implementation of streamlined clinical pathways,

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

Lead Director	Risk	Risk Title	Update	Reasoning / Progress Against Actions
Chief Nursing Officer	535 C4	Failure to achieve reductions in HAIs impacting on Trust's reputation and compliance to regulatory standards.	Positive Assurance updated.	Achieved C difficile objective for 2012/13 April 13
	1717 C2	Failure to maintain re-registration by the CQC periodic review.	Positive Assurances and Action Plan updated.	Change to Quality metrics requires a re-mapping to CQC standards. Develop ward to board outcome metrics available for ward staff to use in improving standards of care aligned to CQC framework.
	2680 A3	Interpreting & Translation Service - risk of over performance against central budget held by patient experience.	Positive Assurances and Action Plan updated.	No evidence of patient or staff concerns from 3 pilot areas (Mar 13). Ensure Matrons in OPD and user inpatients understand control resources. Ensure all 2 way telephones placed in areas are available and are used. Continue to monitor telephone face to face

				bookings.
	2917 C4	Risk of non-compliance with NHSLA standards - achieving 12/13 CIP	Action Plan updated.	Schedule of NHSLA audit reports to committees being finalised.
	2950 B3	Unable to continue to maintain Ambition 1 (for avoidable pressure ulcers). 75% achieved by Dec 12.	Positive Controls, Positive Assurances and Action Plan updated.	New contract specification includes home education from May 13. Reviewed equipment resource provision and improve community equipment provision. Continue to monitor number of days since avoidable P.U ward by ward and provide monthly to all wards / matrons. Build audit and evaluation tool and pilot in 2 wards in May 13 to evaluate patient and cost benefits of implementation
Director of Planning and Contracts	2929 D3	Failure to deliver CQUINS schemes.	Positive Controls updated.	Leads allocated for draft CQUINS to review deliverability and levels of risk.
	3176 C3	Commissioners raising issue of patient activity over performance and their ability to pay.	Downgraded to C3 Amber.	Contracts have been monitored and year positions agreed with main commissioner WCCCG.
Director of Human Resource	1742 B3	Failure to learn from staff survey.	Positive and Gaps in Assurance updated.	Results for 2012 positive; 20 out of 28 indicators show us above average when compared to other Acute Trusts (April 2013). Results received from 2012 staff survey - 45% response rate still leaves us in lowest 205 of Acute Trusts.

The Royal Wolverhampton NHS Trust

Board Assurance Framework

April-2013

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

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

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

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Trust Objective:	**To provide our patients & staff with a safe environment.**										
Chief Nursing Officer	O4 2965	Failure to reduce Never Events.	C4 AMBER	Awaiting formal CQC report following unannounced inspection on 24/1/13. 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 Quality and Safety and Trust Board via Q&S Report - Sep 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 Afpp training delivered Nov 12 Never Events on divisional and directorate risk registers.	Q&S Committee receive monthly assurance of Never Events avoidance progress (Apr 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. Specific action plans post each Never Event in all directorates now completed (Feb 13) External auditors have audited the draft policy and practice. Report in confirmed and to be presented at Q&S April 13.	Never Event from July 2010 reported March 2013.	Ratify safety checklist policy at policy committee	May-13	E2 GREEN	Apr-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	3330	The impact on the Trust of the changes occurring at Mid Staffordshire NHSFT and within the Staffordshire health economy	C4 AMBER	Involvement in the work of the Contingency Planning Team - Feb 13 Contributing to TDA lead work - Feb 13 Internal evaluation of the impact on services both without and with formal service reconfiguration - Feb 13 Review of activity movements to anticipate changes in demand for services - Feb 13 Discussions with commissioners as part of the contracting process - Feb 13				C3 AMBER	Apr-13	

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

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

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.	B3 AMBER	Management support to the service has been reviewed. The Heath Town Health Visiting Team moved into Graisley Lane on 18th September 2012. Bids have been submitted against NPET funding for the forthcoming 12 months for 4 additional CPT places plus 25 restorative supervision training places. The Chief Operating Officer and the Director of Nursing lead the service development programme - leads convene every two weeks to drive service improvements. Weekly briefing of the Head of Nursing by the Matron. Directorate and Division will be monitoring HR indicators, complaints and any concerns raised through Safeguarding Team. Regular communication sessions with Health Visitors are undertaken. The employment of an external consultant, to lead business and culture changes on a short term basis. Rapid appriasal process undertaken by SHA 3 days in September 2012.	01/02/2013 - Although improvements seen in performance against HCP and service specification indicators the service remains currently at an Amber rating. 01/02/2013 - Smoking CQUIN - significant improvement in December's performance. 01/02/2013 - CPT Workforce now increased to 4.5 wte with further 0.8 wte in April. From June 2012 - on going regular Health Visiting meeting to review and update action plan. Meetings and actions on schedule. Actions being incorporated into existing plans. Stakeholder Workshop held 12 September 2012 05/10/2012 - Health Visiting review meeting - leadership workstream completion deadline extended to 30/11/2012, slippage acknowledged on the accommodation workstream beyond 31/10/12 - actions on schedule The move towards paperlite working is ongoing - January 2013.		Leadership changes implemented from early July. Organisational Development programme established to ensure full engagement of Health Visiting workforce. Health Visiting Service Improvement Board established to oversee the work programme, chaired by Chief Operating Officer with Multi Agency attendance. 3 workshops chaired by SHA HV lead planned for January and February 2013. Health Visitor Steering Group meeting expanded membership to include SHA - October 2012. Plan for the Implementation Plan Trajectory The turnover of staff remains seems to be higher than other service areas. All managers are expected to review exist interviews and identify common trend analysis. Shared Services to determine how Trainees will be phased in. 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. Include changes to HV services in local authority newsletter and circulate to all HV staff - October 2012	D2 GREEN	Apr-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?
				A meeting in 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. Approval granted for band 5 positions to be offered prior to the training to ensure best applicants are available to the Trust In view of our progress, Sustain suggested that our self assessment scoring form be updated to reflect this A suitable alternative uniform had been found for Health Visitors which meets the needs of the service. A final draft of the Band 6 Job Description has been drawn up. The majority of comments re this JD had been positive.	The admin review has been completed which will support Health Visitors with their move to the Children Centres. Feedback from this review has been positive - January 2013. 01/02/2013 - Sickness absence is 4.16% 05/10/2012 - appraisal rates have improved					

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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				The CPT Job Description is in draft format and been sent out for comments.						
Chief Executive Officer	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				C2 YELLOW	Apr-13	
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	Apr-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) Revised communication strategy to reflect commissioning changes (Mar 2013) 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)	Positive contract negotiations for 2012/13 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) Meetings every 4 weeks with Commissioners with action notes		*Map ongoing changes to commissioning portfolios, monitoring consistency to overarching financial envelope (have been deferred in line with national movement) *Contracts signed with all commissioners by 31 March 2013 (have been deferred in line with national movement) Implementation of communication strategy across organisation	Apr-13 Apr-13 Jun-13	C4 AMBER	Apr-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) Modernisation programme Board commenced		*To agree a QIPP work programme with commissioners, documented within contract through the Service Development Improvement Plan (Deferred in line with national movement) To identify capacity and resources to deliver the programme.	Mar-13 Apr-13	B3 AMBER	Apr-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	Apr-13	Yes
Chief Executive Officer	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	Opportunity assessment process based around strategic goals Review of organisational impact - short, medium and long term Effective and timely consultation Robust board governance					D3 YELLOW	Apr-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:	**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	Weekly review of interactive commissioning map (H) Worked with shadow Consortia to understand future requirements Explored opportunities with other commissioners to support the TCS agenda (Mar 13) 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	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 Commissioners approved AQP submissions - Sep 2012		Review further AQP proposals - on-going Produce Quarterly Market Share analysis report - on-going Bi-monthly communication with GP community via a newsletter Work with Public Health to manage the impact of the transfer of Lifestyle Services to the Local Authority 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 Monitor recent indication of relaxing of outlined stringent tendering requirements Use refinements to NHS Choices & Choose & Book to 'sell' services - on-going Maximise opportunities to sell services via new Web Site - on-going	Jun-13 Jun-13 Jun-13 Apr-13	D2 GREEN	Apr-13	Yes

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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.	C4 AMBER	External review of Quality Governance has been commissioned TDA leading the process for recruitment of NEDs (Mar 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 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 Revised Tripartite Formal Agreement for FT Timetable (Mar 13)	Achieved milestones to date on TFA 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	Apr-13	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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Chief Nursing Officer	O7 2449	Inadequate and ineffective systems to Safeguard Vulnerable adults.	D3 YELLOW	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 Named Dr identified for Adult Safeguarding..Safeguarding portfolio aligned to head of Nurse Education 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	Internal audit through RSM Tenon to support improvement in processes scheduled for June 2013 Employ substantive learning disabilities nurse with a liaison link with Sandwell BCP Mental Health Services - recruitment scheduled for December 2012. 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	Jun-13	D3 YELLOW	Apr-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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				West Midlands strategy and procedures incorporated into Trust procedures and level 1 training (Feb 13) Working towards Peer Review June 2013 Add low risks identified via action planning from peer reviews and audits - Nov 12						

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The Royal Wolverhampton NHS Trust

Trust Risk Register

April-2013

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B1	B2	B3	B4	B5
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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 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 e-learning pack now available for investigation of incidents, complaints and claims extra manual handling sessions to target low complaince areas	monthly audit of local induction returns (ongoing) all NHSLA minimum data set topics now included in performance repository for TMT report (Oct 2012) Improvements in mandatory topics compliance NHSLA level 2 achieved (Nov 2012)	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	Jan-13 Apr-13	D3 YELLOW	Apr-13	

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				local induction amnesty in February to improve compliance extra training sessions being delivered Further e-learning packs compiled for alternative to face to face training for CRT and general consent training							
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	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). 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) Resource for a fixed term post to support CNST and NHSLA from Oct 12.		A few audits fall short of 12 months evidence in place. (Mar 13) Unable to show improvements in some audit results - Feb 13 Internal monitoring currently show predominantly red/amber scores at L3 - Feb 12 Low compliance rates following trustwide audits are not yet improved - indicating policy implementation. (Mar 13) The first report of the Live record check in March 13 showed poor uptake of the audits by Directorates. Monthly monitoring in place. (Apr 13)	Schedule of NHSLA audit reports to committees being finalised. Ongoing monitoring of Directorates against Divisional Governance Strategy (Level 2) - IGR, Scorecards and Divisional monitoring. New round of Level 3 sub group meetings set up with policy leads. Monitor of results ongoing up to assessment in Sept 13.	May-13 May-13 May-13	C3 AMBER	Apr-13	

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Chief Operating Officer	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	C4 AMBER	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 all staffing breaches and adverse outcomes are reported via senior nurse performance meeting monthly by Head of Midwifery. Business Case to be developed for additional staffing requirements as identified in birth rate plus, in line with audit Feb 2012 Staffing is a monthly agenda item on the operational meetings chaired by the head of midwifery	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		Recruit and appoint to vacancies with ward areas Further review of Birth Rate Plus to be undertaken	Apr-13 Apr-13	C1 GREEN	Apr-13	

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Trust Objective:		**To provide our patients & staff with a safe environment.**									
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	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	2008/09 leaflet audit results showed 83% compliance for newly developed/reviewed lealets 2010/11 patient leaflet audit shows >average compliance for explanation of risks & benfits	Consent forms not being correctly completed. Recurring themes highlighted through annual audit. Trust-wide Audit Nov/Dec-09 showed areas requiring improvement to be documentation, legibiility and practical processes. Complete up-to-date delegated consent lists not held within directorates. 2010/11 patient leaflet audit shows poor compliance with regard to inclusion of alternatives to treatment, outcomes of not accepting the proposed outcomes, statement of shared decision making.	Review results of trustwide audit	Dec-12	E3 YELLOW	Apr-13	

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Chief Operating Officer	2215	Maternity have been using Euroking since 2001, however it has become increasingly outdated and difficult to support. The system is held on an unsupported platform, therefore in the event of failure the system will be unusable. Also the existing Euroking does not fulfil requirements for data collection when out in the Community. Data has to be inputted retrospectively. It is not Windows based therefore can't interface with other systems, for example to retrieve blood results, pathology. Also the NHSLA recommend that CTG recordings are kept electronically due to them fading in time, the current system does not have this facility.Due to data not collected at the point of care in community leaves us with gaps in our external reporting to agencies - National screening committee which leaves us non compliant in certain aspects of their data fields.	C4 AMBER	Business Case is being put together to replace existing system Use of a paper based system if Euroking fails Any incidence of the system failing are recorded on a Incident form and entered onto Datix Internal IT Department maintains the system as much as they possibly	A business case is currently being put together to completely replace the existing system. This will need to go through a full tender process which may take considerable time. Business case is going through approval process during March 2013 with decision expected early April 2013	There is a risk that the trust will not approve the business case because of the financial cost. Does not meet NHSLA recommendations to store CTG recordings electronically Business case not approved by TMT	Install Euroking's replacement Business case for replacement maternity system	Jul-13 Apr-13	D2 GREEN	Apr-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 11 Revised Safeguarding policy in place - Jun 11 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 (Mar 13)	Evidence of low risk action planning from Peer Review [Nov 12.] Incidence of complaints citing LD service user or carer - Nov 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 upheld against the organisation in relation to Learning Disabilities - ongoing. Failure to recruit to LD Specialist Nurse. Recruitment 22/2/13	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	Apr-13	Yes
Chief Nursing Officer	O16 2482	Failure to learn from national / local organisations experience e.g. Francis report.	D4 AMBER	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	Gap analysis to be completed against Francis public inquiry report (Feb 13). Requirements to be interlinked toexisting workstreams. Item noted for report through Trust committees. (Apr 13). Consider set up of scrutiny group to review final RCA reports (exception of pressure ulcers and serious falls where an accountability group is already established)	May-13 May-13	E2 GREEN	Apr-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	Apr-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. Update (12 Nov 2012): Divisional Medical Director to discuss with Medical Director to include risk on Trust Risk Register.	B3 AMBER	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	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	Include compliance with VTE risk assessments in Directorate Performance Reviews	Apr-13	D3 YELLOW	Apr-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		Ensure Matrons in OPD and user inpatients understand control resources Ensure all 2 way telephones placed in areas are available and are used. Continue to monitor telephone face to face bookings	C1 GREEN	Apr-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. 25.09.12 Updated - Inconsistency in management due to reconfiguration and changes to leadership (1 vacancy, 1 long-term sick Band 7 - acting Band 7 in situ). 13.02.2013 Report to Divisional Governance: -Continuing concerns include extended matron and Directorate manager portfolios but 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	C4 AMBER	Implementation of remedial action plan Matron KPI's Monitor incidents Monitor complaints Review of all aspects of care/setting/leadership Matron working clinically Band 7 staff member acting up Band 5 nurses released from winter pressure ward Matron portfolio reviewed and assistant Matron identifed to provide additional support - February 2013 Practice Development Team support ward as required Matron's contract extended to mid November	Minimal vacancies as at November 2011 Recruitment of band 6 No rise in the number of complaints / serious incidents in Q2 July 2012 - Some improvements in recent audits for MUST, pressure ulcer care bundles, discharge process, complaints related to ward care All sickness absence being appropriately managed May 212 - appraisal rate improved for nurses and medical staff August 2012 - several letters of thanks and compliments received for both wards, patient feedback improving	Sickness levels - Sickness absence for RN's on D5 and D6 at around 20% and 10% respectively June 2011 - 1 Never Event May 2012 - Letter from Jag Samra detailing concerns raised by junior docs to Deanery Pressure ulcer incidents not abating on D5 December 2012 - Shortfall in nursing staffing levels Dec 2012 and impending maternity leave early 2013 February 2013 - Increased patient dependency, especially on A5 August 2012 - Still concerns over matrix working across both D5 and D6 Ward KPIs adrift on D6 December 2012 - New evidence that sickness absence could improve	Review patient dependency Monthly review and report to Divisional Governance Local workforce review data collection completed, analysis underway	Apr-13 May-13 Apr-13	D3 YELLOW	Apr-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	C4 AMBER	29.02.2012: The area will have telephone access and is " for purpose" regarding equipment ie oxygen points, suction, resus equipment 29.02.2012: There is capacity for 8 pts 29.02.2012: For the next 4 weeks the enabled area (old clinic area) will be utilised as a holding bay instead of the corridor 29.02.2012: There is a chart regarding transferring pts from the main A&E to the holding bay 29.02.2012: Flowchart regarding the process is updated (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 (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	Feb 13 - no near misses or complaints raised regarding the corridor. (Original) - The risk will be partially addressed in the refurbishment Nov 12 - No further near misses reported. Dece 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 - Bank is being utilised at the moment. Dec 12 - Recruitment process in place for existing gaps and additional agreed over establishment interviews 17 December 2012 Dec 12 - Theatres are contacted to assist with provision of trolleys	(Original) - Increasing frequency of incidents 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 - Establishment of nursing staff not able to provide cover past midnight. December 2012 - Increased trolley waits impacting on poor journe,y quality and safety. December 2012 - Lack of trolleys to offload patients due to additional capacity and AOA being utilised.	Explore staffing levels to enable the utilisation of clinic to house patients who require beds within the organisation instead of waiting on the corridor Capacity team allocate a nurse for AOA in AMU - If greater than nine patients in AOA in ED explore utilising AOA nurse from aMU Plans being developed to build new A&E department	Mar-13 Mar-13 Jan-15	D3 YELLOW	Apr-13	

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				Aug 12: Internal escalation process now in place for early warning signs Sept 12 - There is capacity for 9 patients however, if there are any more than 9 the WMAS will manage the patient Nov 12 - This has been discussed at the CORE team meeting and is now on the divisional risk register. Nov 12 - When the corridor is used, Datix incidents are completed and this feeds into the monthly KPI which is sent to the division. Nov 12 - A protocol and escelation plan is place and this has been forwarded to the divisional team, chief nursing officer and circulated to all of the nursing and medical staff in A&E. The protocol identifies the number of patient's per nurse and the levels of escelation required. Jan 13 - Addiitional nurse is working a twilight shift until 12pm and also on nights for 7.5 hours. Jan 13 - Increased staffing levels over Christmas from 8pm - 4am, now this has been agreed to continue for Saturday, Sunday and Monday.					

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Chief Nursing Officer	O4 2950	Unable to continue to maintain Ambition 1 (for avoidable pressure ulcers). 75% achieved by Dec 12.	B3 AMBER	Developed an e-learning package (Dec 12) Commenced TV posts in AMU and ED - Jan 13 Ratify pressure ulcer policy and clinical practice - June 12 Employ a data analysis to assist with data trends - June 12 Develop a paediatric/ neonates pressure ulcer prevention policy. - Dec 12 Develop an e-learning package - Jan 13 Increased Tissue Viability Specialist Team capacity agreed with a business case for 2 years - Jun 12 New contract specification includes home education from May 13. Pressure ulcer prevention training now mandatory specific - Jun 12 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	75% of Trust achieved zero avoidable pressure ulcers by Dec 31 2012. Reviewed equipment resource provision and improve community equipment provision and maintenance to community (Apr 13)	25% of Trust have not achieved Ambition - Feb 13 Increased communication within the organisation regarding pressure ulcer prevention - Feb 13 Challenge wards to achieve x number of days since last avoidable PU (Mar 13)	Scope changing all mattresses to Mercury Advance to ensure consistency across Trust and reduce need to hire in expensive alternative beds. Continue to monitor number of days since avoidable P.U ward by ward and provide monthly to all wards / matrons Build audit and evaluation tool and pilot in 2 wards in May 13 to evaluate patient and cost benefits of implementation	May-13 May-13	D3 YELLOW	Apr-13	

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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	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.	Business case being developed however this is now being reviewed in light of the requirements to meet 'Any Qualified Provider'	Jun-13	E2 GREEN	Apr-13	

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Chief Nursing Officer	O8 535	Failure to achieve reductions in HAIs impacting on Trust's reputation and compliance to regulatory standards.	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	There is a lack of evidence against which PCR positive specimens will be EIA positive and therefore reportable under the new testing algorythm	Develop business case to use fidaxomicin to treat cases of C difficile	May-13	E4 AMBER	Apr-13	Yes

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

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Trust Objective:	**To be the employer of choice.**										
Chief Operating Officer	O12 1713	Failure to effectively maximise workforce productivity.	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 - January 2013. 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.	Medical agency costs not reducing - January 2013. Slow progress in terms of Job Plan completion - January 2013	Re-issue requriement for Job Plan completion and clarify links to pay progression and CEA Awards. Action Plan to address the issues once identified by the job plan audit. Monitor Bank fill rates performance - ongoing Review of medical rotas with potential to introduce electronic rostering system. Clinical Directors to be targeted to complete all Job Plans in areas by the end of June 2013 - a joint letter is to be issued by the COO and MD.	Feb-13 Mar-13 Mar-13 Jun-13	C2 YELLOW	Apr-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	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 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. 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.	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 2011 staff survey; response rate was (374 staff) 45% (in the lowest 20% of Acute Trusts) compared with 39% in 2010. 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.	Outcome from 2012 Survey reported to TMT and TB in March 2013. Communication of 2012 results cascade in progress. Feedback through Divisional structures and incorporate in action planning. Ongoing. Chatback 2013 planned for the summer. Chatback action planning occuring at local level from Oct 2012 (ongoing)	Mar-13 Jun-13 Jul-13	D3 YELLOW	Apr-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?
				Results from 2011 survey taken into consideration with Chatback results and action planned.						
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 desktop review of all medical outliers. CHC assessment training commenced. Health Economy Winter Plan Surge Meetings throughout Winter.	Weekly delayed discharge report - October 2012 Delayed discharges below 5% - January 2013.	Increase in numbers of patient delays - November 2012 Fluctuations in number of patient delays, especially Staffordshire.	Joint working with South Staffs Partnership Trust now underway to improve Discharge Planning for South Staffs patients - August 2012 Training and awareness sessions on services within Community Services - ongoing annual report. LEAN Project Managing Complex Discharges - ongoing (commenced May 2012 as part of the Integrated Patient Flow Team Project)	D2 GREEN	Apr-13	Yes

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

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	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 - January 2013. Quarterly assessment, risk rating and remedial action identified by Exec Director lead for all business outcomes in the annual plan - October 2012 Evidence that performance is discussed at weekly COO meeting with agreed actions to rectify underperformance - November 2012 - on going. Performance reports to TMT and Trust Board monitors performance against plan - February 2013 Reports to SHA and other agencies - November 2012 and ongoing Daily meetings to support effective management of capacity - November 2012 Evidence of RCAs on cancelled operations - November 2012 - on going	Winter capacity was open beyond planned period - Summer 2012. Deteriorating performance at New Cross A&E re. 4 Hour standard - January 2013. Increased number of cancelled operations due to capacity - January 2013.	Review bed capacity and modelling by January 2013. Review of step down discharge process with CCG and social care - December 2012. Increased capacity in Patient Productivity Programme to ensure deliverability of schemes. Review November 2012.	D3 YELLOW	Apr-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?
				Capacity management team in place to facilitate timely admissions and discharges.							
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 May 12: Waiting list and time to treatment is compliant with 18 weeks RTT and a reduction seen in appointments dropping into Intel since November 2011 Trust Doctor due to start in August 2012 No delays for Community patients. Extra clinics have been put in place to manage Community Services including for fasttrack patients	The "as and when" secretary is no longer working in the department due to high volumes of work and the pressure this is causing Secretarial staff have expressed concerns and worries regarding the volumes of work coming through the department Nov 12: No response from Commissioners Risk that current service not being able to sustain increased capacity long term Risk that PCT will not reinstate Community Dermatology Service	Creating standard letters Monitoring the ability to deliver a service at Outreach Clinic Agree full service specification and contract Agree interim contract Scoping exercise of work for Community Clinics Meeting with Finance to discuss financial implications for 2012/13 Agreement of Activity Year Plan	Jul-13 Jul-13 Jul-13 Jul-13 Jul-13 Jul-13 Jul-13		Apr-13	

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

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	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. Implementation - Apr13. Review of administrative admission processes at weekends - linked into the above action. Jan-Mar13. Communication plan to remind staff to ensure timely and appropriate admission onto PAS and other Trust Clinical systems - Jan13. Awareness has been raised. Detailed plan to resolve being formulated - complete March 2013.	E-discharge rates are improving - January 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.	Long term review of real time bed management and link to I.T. Strategy.	B3 AMBER	Apr-13	Yes

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

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	3051	There are insufficient medical beds for the volume of medical patients leading to outliers, as a result there is a risk of patient harm as patients are not reviewed by the appropriate medical team in a timely manner. There are also risks of staffing pressures within ward areas with capacity beds that remain in use. business/service interruptions due to continued/extended/unplanned use of capacity beds (usually utilised for "winter pressures") into spring and summer months resulting in additional staff pressures. Risk of cost pressures due to continued/extended use of capacity beds outside agreed timescale's. Risk of adverse media attention due to the continued/extended use of capacity beds within the Division.	C4 AMBER	Operational protocol agreed at Divisional level from March 13 Additional capacity open and staffed appropriately Oct 12 - An arrangement is in place to ensure medical team review outliers by contacting the consultant's base ward and or medical secretary. July 12 - patient productivity steering group (including patient flow discharge team, CURE, enhance recovery etc) July 12 - capacity bed meetings 3 x per day July 12 review of hospital at home project July 12 - complaints and incidents regularly reviewed (including training) July 12 - stroke pathway in place July 12 - chest pain pathway in place for patients visiting A&E Oct 12 - Operational protocols - identifies the agreed process for opening up additional medical capacity and the appropriate patients to either step-down or out-lie. It also includes staffing requirements. Oct 12 - Utilisation of staffing from base wards, flexible capacity team, and bank staff	July 12 - no single sex accommodation breaches reported July 12 - reduced complaints July 12 - increased activity through same number of beds	July 12 - breaches in minimum staffing levels	Review the results of the Bed modelling work by Information Team Best practice wards - focus on discharge and shared learning A decision to open additional capacity permanently and it is staffed appropriately. Operational protocol to be agreed at divisional level and adhered to by Trust. Business case to fund the Winter plan 2012/13, and locality of additional capacity to be agreed by Trust executive team. Depending on decisions made, staff ,equipment and other resources must be identified and procured.	Apr-13 Mar-13	D4 AMBER	Apr-13	

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

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	3072	Due to the regular use of 'elective' beds to cope with pressures of increased emergency activity, the division may be at risk of underperformance against Trust targets for 2012/13. Risk of cost pressures due to extended use of unfunded capacity Risk of increased level of complaints /claims/incidents as a result of reduced quality of patient experience Inappropriate patients in clinical areas due to need for additional emergency medical capacity. Risk of compliance with CQC/NHSLA/Monitor outcomes/standards & negative patient experience. Linked to Directorate risks: 2739 General Surgery/Urology, 3166 BSSU, 3167 Appleby, 2872 Cardiac day ward & 2256 Gynae ward.	B3 AMBER	Feedback from weekly COO meeting provided to weekly divisional team meeting. Support provided from Performance Management & Compliance team. Monthly finance/activity/CIP/quality meetings with each directorate. Deputy COO and Divisional Medical Director met with CDs T&O and Cardiothoracic directorates developed remedial action plans Established extent of surgical bed occupancy by medical outliers Risk assessment completed and protocols in place for BSSU, Cardiac Day Ward, A10, Gynaecology ward, Appleby & Vascular ward Monthly scheduled CIP review meetings with Directorates	Reduction in incidents and complaints	Incident reports and complaints	Participate in daily quality meetings to identify medical patients who are safe to outlie, follow up appropriateness & quality of transfers Increase efficiency and release resource through ambulatory care, enhanced recovery and surgical site surveillance Undertake bed modelling to inform surgical bedstock configuration Review use of private sector capacity	Mar-13 May-13 Apr-13 Apr-13		Apr-13	

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

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	3157	The current commissioned capacity within Foot Health Services does not meet the current demands placed on the service, currently only high-risk patients can be seen as planned , this means low risk groups are having to wait significantly longer than is recommended for care, placing them at risk of developing avoidable foot conditions , and in turn becoming high-risk, this places the trust at risk of negative media interest and potential risk of litigation	C3 AMBER	GP's regularly updated on service criteria, with implementation of new electronic referral to remove poor or inappropriate referrals Maternity leave covered until May 2013 Complaints monitoring Emergency triage Reporting of adverse complications related to failure of the service being seen patients on time. Monthly Audit of waiting times in holding clinics to monitor increases in waits and numbers on holding clinics			Caseload review to manage capacity with resources and current demands Monitoring of commissioned activity levels Explore additional funding to appoint / skill mix / Bank cover with new vacancies that develop	May-13 May-13 May-13	D3 YELLOW	Apr-13	

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

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	3245	Unplanned utilisation of additional unfunded beds to address capacity problems across the trust. There are a number of risk in association with the usage of additional medical bed capacity: 1. Environment - The wards have basic fixtures and fittings ready for use but are not kept stocked with pharmacy, sterile stores, stationary, kitchen supplies or linen 2.Staffing - The 'flexible capacity team' provide the core staffing for 17 beds they are supplemented by bank staff. Opening above the 17 beds has the potential of depleting other wards of the appropriate nursing skill-mix, resulting in inconsistent standards. Clerical cover is patchy with ward clerks pulled for cover of adhoc hours. Nursing leadership is provided by Divisional Matrons with support from Senior Sisters Medical cover alters each time the ward is opened usually with existing consultant teams remaining in charge of care with locum FY2 cover for daily task. There are risks to the existing patients on the base wards due to reallocation of staffing to ensure minimum safe numbers and skill mix. Staff are under pressure dealing with a number of different medical teams. 3.Operational protocol - the agreement is to transfer patients identified from base medical wards to additional capacity beds who are	A3 AMBER	Operational protocols - identifies the agreed process for opening up additional medical capacity and the appropriate patients to either step-down or outlie. It also includes staffing requirements. Utilisation of staffing from base wards, flexible capacity team, and bank staff An arrangement is in place to ensure medical team review outliers by contacting the consultant's base ward and or medical secretary.			A decision to open additional capacity permanently and it is staffed appropriately. Operational protocol to be agreed at divisional level and adhered to by trust. Business case to fund the Winter plan 2012/13, and locality of additional capacity to be agreed by Trust executive team. Depending on decisions made, staff ,equipment and other resources must be identified and procured	Sep-12 Nov-12 Nov-12 Nov-12		Apr-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?
		medically stable and ready for discharge within 48-72hrs. Patient journey - There continues to be a risk with medical outliers not being reviewed by the appropriate medical team. Nursing staff are often left to make multiple phone calls throughout the day looking for the team that will take responsibility for the patient. Frequently patients are often reviewed towards the latter part of the afternoon. Moving patients, often in the evening and during the night is extremely disruptive. 5. Budget impact - The costs for bank staff, all drug expenditure and non-pay are all going to the Division creating a cost pressure.								

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

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

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 - on going - December 2012 Review staffing patterns in relation to peak time of activity - September 2012 Full review of planned waiting list undertaken. A&E targets monitored daily and reported to TMT & Trust Board monthly - December 2012. and ongoing New reporting framework incorporating Operating Framework and Monitor requirements now in place with data presented to Trust Board on a monthly basis - November 2012 Daily Teleconference re A&E Performance - January 2013. TAL performance maintained, continue to monitor daily - November 2012 Continue weekly meetings with Divisions and weekly monitoring of waiting times - November 2012 COO Report weekly/monthly - November 2012 Increased winter pressure resource available and implemented - January	A&E Target achieved for February 2013. Early warning of potential to fail - January 2013 Sustained performance for other standards - December 2012. On an ongoing basis and daily monitoring of hot spot areas - ongoing	Cancer 62 day slippage - January 2013 A&E KPI's are above target - December 2012 A&E failed 4 hour waiting target for Q4 - April 2013. A&E target not achieved - November & December 2012	Review of outcomes framework and Monitor's draft risk assessment. Framework has been completed to ensure all future requirements are being met. Daily Conference Calls with Commissioners to discuss Health Economy Emergency Care Performance - February 2013. A&E KPI's monitored daily. Working group set up to ensure all compliance aspects are covered - ongoing Review staffing patterns in relation to peak time of activity - September 2012 Revised A&E action plan submitted to CCG & LAT - January 2013. Targets monitored and managed weekly where possible, otherwise monthly or (some) quarterly - ongoing	D3 YELLOW	Apr-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?
				Recovery Action Plan completed and revised trajectory submitted to the LAT - April 2013. Cancer Network engaged in definition and breach analysis. Weekly review of Cancer Waiting Times - on going - November 2012.						
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	Apr-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	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	Apr-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	Apr-13	
Chief Operating Officer	2837	Delay in agreement of expansion business case for 5th linac and additional bunkers to ensure efficient planning and continuity of service for when the replacement programme commences.	B3 AMBER	Options appraisal Draft business case			Monthly monitoring - high amber status	Mar-13	D3 YELLOW	Apr-13	

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

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	O6 2893	Complex series of Pathology developments/tenders may not be achieved or won which could lead to loss of income. Implementation of Cytology Service. Integration with Walsall. Loss of GP workload as a result of SHA tender. Failure to achieve benefits of new build.	C4 AMBER	Appointment Project Manager - January 2013. Appointed as Sub Contractor to HEFT - December 2012. New Build Project Board chaired by Deputy Chief Operating Officer. Pathology Team focussed on delivery of PQQ - February 2013. Establishment of Integration Board - March 2013. Introduction of Integration Board - December 2012. Establishment of Exec led Pathology Steering Group - December 2012	On track to move into new build March 2013. Pathology Steering Group meets bi weekly to discuss risks. Dates confirmed for move into new build	No formal agreement with Walsall - February 2013. Trust Board decision - March 2013.		D3 YELLOW	Apr-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)	Q3 sign off received from local CCG and from SSC. Responses are in-line with Trust Self-Assessment (March 13). 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	Apr-13	Yes

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

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Director of Human Resources	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	C3 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	Additional budget of £10,000 approved increased attendance at manual handling training courses (Oct 2012)	budget overspend due to NHSLA level 3 compliance additional £10k cost pressure raised DNAs on paid for training places currently run at % (often due to urgent clinical presures) thus adding to shortfall issues (July 2012) 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 (ongoing) TCS budget does not meet clinical staff needs (ongoing)	cost pressure raised charge depts for non-attendence Review SLA with Local Authority - ongoing Review of link trainers	Feb-13 Jan-13 Mar-13 Apr-13	D3 YELLOW	Apr-13	
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	Apr-13	

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

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief 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	Apr-13	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 CEO has nominated a senior RWT individual to sit on LETC (Sept 2012)	Review at E&T Committee HR Sub Reports LETBs formed Chief Executive of Black Country LETC appointed; Paula Clarke HEE CEO now appointed HR Director now appointed to LETC	workforce planning input to LETC needs strengthening Lack of direction from DOH (ongoing)	Await LETB/LETC authorisation process Develop Liaison with LETB/LETC (ongoing)	Apr-13 Jan-13	C3 AMBER	Apr-13	Yes

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

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Trust Objective:	**To achieve Foundation Trust status**										
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	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 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	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.	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 below: 1. Internal audit recommendation made Sept 12 & Jan 13- Evidence in draft, undated or out of date to be removed and current evidence uploaded to the IGToolkit.- Predicted completion 20/02/2013 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.-Predicted completion 20/02/2013 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. - Predicted completion 20/02/2013	ICO external audit follow up planned for 20/08/2013	Aug-13	D2 GREEN	Apr-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	3278	The Policy management process from approval to publication is operated through 4 different departments (Governance, TMT administrators, intranet administrators and Medical Illustration) and poses a risk to version control and publication management.	B3 AMBER	Trust policies database (in place prior to risk initiation in Dec 12) Publication protocol V2 identifies Trust secretary as gatekeeper for version management prior to publication. (Jan 13) Policy archive audit (Aug 12) Staff training on policy development, version management and publication provided at SMB (Mar 13)	Policy archive audit showing improvement since February 13 but requires retrospective work to correct earlier versions recorded. (Apr 13)	Disjointed system from final approval to recording and publication of policies (as at risk initiation Dec 12) Gaps in version control, inaccurate policy dating and publication identified (Aug 12)	Training/instruction for Trust staff re policy approval and publication Training/instruction for staff within the process Review policy archive audit results	Mar-13 Mar-13 Apr-13	D2 GREEN	Apr-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;

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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	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. 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	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 Service Improvement initiative - bed capacity meets demand - modelling implementation commenced. Capacity and Social Services integration project commenced	Jun-13 Jun-13	C2 YELLOW	Apr-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?
					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;