The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	28th January 2013
Title:	Board Assurance Framework / Trust Risk Register
Executive Summary:	This paper reflects the spread across Board Assurance Framework and Trust Risk Register. This month these risks have been mapped against the Trust Strategic Objectives.
Action Requested:	To inform the Board of updates to the Board Assurance Framework (AF) and Trust Risk Register.
Report of:	Chief Nursing Officer
Author: **Contact Details:**	Governance IM&T Lead Tel: 01902 695114 Email:
Resource Implications:	None identified
Public or Private: **(with reasons if private)**	Public Session
References: **(eg from/to other committees)**	
Appendices/ **References/** **Background Reading**	
NHS Constitution: **(How it impacts on any decision-making)**	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: - Equality of treatment and access to services - High standards of excellence and professionalism - Service user preferences - Cross community working - Best Value - Accountability through local influence and scrutiny

Background Details

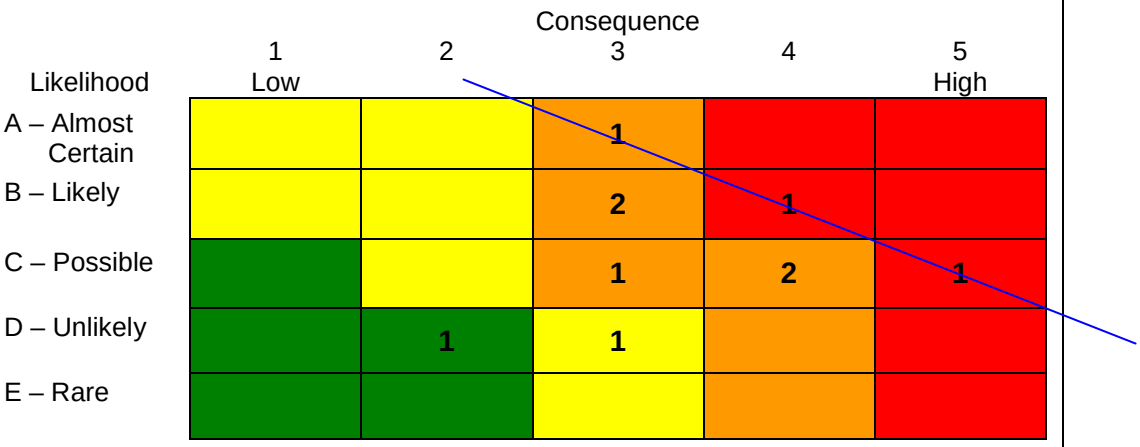
The Board Assurance Framework "provides organisations with a simple but comprehensive method for the effective and focused management of the principal risks that arise in meeting their objectives. It also provides a structure for the evidence to support the Statement on Internal Control" (Integrated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

Board Assurance Framework – Updates (Appendix A)

Following updates the split of the Assurance Framework is:

Risks currently being managed (ongoing)	8
Risks managed to target level	2

There are currently 10 risks contained within the Assurance Framework which are distributed across the Trust categorisation matrix as below:



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

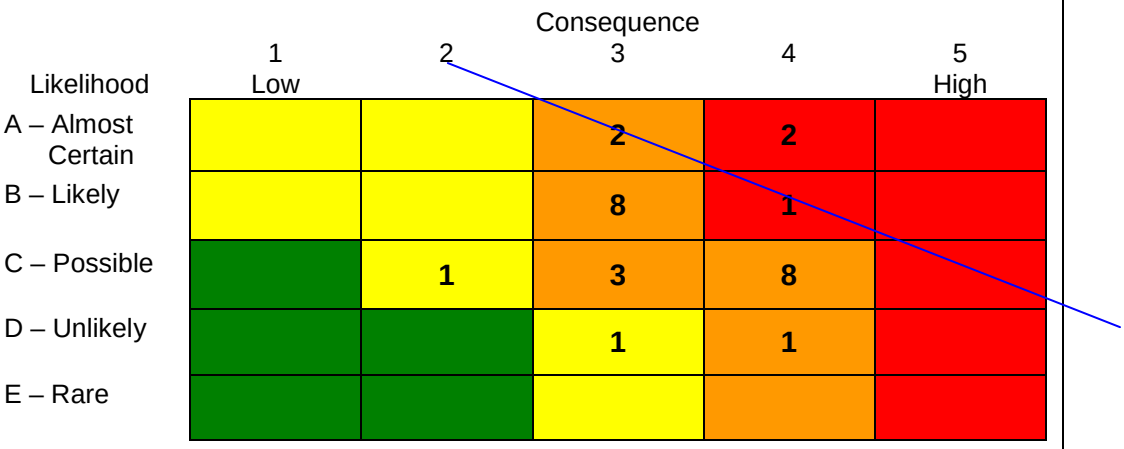
	ID	Risk Title	Lead
RED	2962	Health Visiting Services	COO
	2965	Failure to reduce Never Events	CNO

Trust Risk Register – Updates (Appendix B)

Following updates the split of the Trust Risk Register is:

Risks currently being managed (ongoing)	26
Risks managed to target level	1

There are currently 27 risks contained within the Trust Register which are distributed across the Trust's categorisation matrix as below:



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

	ID	Risk Title	Lead
RED	514	Failure to deliver recurrent efficiency gains and CIPs.	FD
	1739	Failure to develop Service Line Reporting.	FD
	3176	Commissioners raising issue of patient activity over performance and their ability to pay.	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.	1		1			7		
2) To be the employer of choice.						2		
3) To achieve a balance between demand & capacity of services	1	1				3		
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			3	4	1	
7) To be a high quality educator		1				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						2		

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 (January 2013)

Lead Director	Risk	Risk Title	Update	Reasoning / Progress Against Actions
Chief Nursing Officer	2965 C5	Failure to reduce Never Events	Positive controls and Action Plan updated. Residual risk changed to D3 Yellow.	Awaiting CQC Inspection. Provided CQC with update on actions taken. Scoped the revised DoH Never Event Guidance (Oct 12) with Trust wide systems and processes in place. Divisions continue to monitor compliance with all surgical theatres monthly at CQRM / QSC - ongoing
	2449 D3	Inadequate and ineffective systems to Safeguard Vulnerable adults.	Action Plan updated	Unsuccessful recruitment in December 2012 and January 2013. Re-advertising post. Revised completion date February 2013
	3277 B3	Failure to meet Catheter Safety CQUIN requirements	***NEW RISK*** Positive controls and Action Plan updated.	Trained 75% of identified staff by 31/12/12. Place training package on KITE site.
Chief Operating Officer	2962 B4	Risk of Health Visiting business/system/service failure due to multiple systemic failings.	Positive controls and Positive Assurances updated.	The Chief Operating Officer and the Director of Nursing lead the service development programme - leads convene every two weeks to drive service improvements. The move towards paperlite working is ongoing - January 2013. 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.
Director of Planning and Contracts	2508 A3	Commissioning responsibility changes - affects contracted income	Positive Controls and Action Plan updated.	Reviewed “Everyone Counts: Planning for Patients 2013/14” and PbR guidance for 2013/14. Map on going changes to commissioning portfolios, monitoring consistency to overarching financial envelope.
	2699 C4	Impact of movement to GP Consortia Commissioning	Positive Controls, Positive Assurances and Action Plan updated.	Monthly report to Trust Board in to update on progress. Quarterly Contract Commissioning Reports to Trust Board. Align CIP/QIPP Programme with CCG to reduce risks

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

Lead Director	Risk	Risk Title	Update	Reasoning / Progress Against Actions
Chief Operating Officer	1713 B3	Failure to effectively maximise workforce productivity.	Gaps in Assurance and updated.	Medical agency costs not reducing - January 2013.
	1714 B3	Failure of other agencies to support discharge process.	Positive controls updated.	Weekly discharge meeting to review and agree actions aimed at improving discharges and relationships with social care. Integrated patient flow team through Reablement funding – Project Manager posts appointed, and has commenced work with Social Services to expand dedicated Social Work input.
	1716	Failure to achieve	Positive controls and	Early warning of potential to fail

	B3	targets in accordance with the operating framework (waiting times, CQC etc.)	Positive Assurances updated.	On an ongoing basis and daily monitoring of hot spot areas A&E KPI's are above target. A&E KPI's monitored daily. Working group set up to ensure all compliance aspects are covered
	2492 C4	Failure to ensure that inpatient, outpatient, day case and theatre capacity meets demand.	Positive Assurances, Gaps in Assurance and Action plan updated.	Cancer targets achieved - continue to monitor closely and report to TMT and Trust Board in performance report. Deteriorating performance at New Cross A&E re. 4 Hour standard. Increased number of cancelled operations due to capacity.
	2719 A3	Timeliness of PAS Admission	Positive controls, Positive Assurances and Gaps in Assurances updated.	Awareness has been raised. Detailed plan to resolve being formulated - complete March 2013 E-discharge rates are improving - December 2012. Further investigations carried out and this confirmed that some process redesign is necessary to achieve timely discharges on the system.
Chief Nursing Officer	535 C4	Failure to achieve reductions in HAIs impacting on Trust's reputation and compliance to regulatory standards.	Positive controls and Action Plan updated.	Introduced 2% chlorhexidine in alcohol for surgical skin preparation and monitor associated reduction in infection rate. Evaluate 3 months of IPN visiting all patients in the Trust with CDI and report to IPCC. Evaluate all MRSA bacteramia cases to date and update infection prevention annual programme of work. Complete actions from MRSA bacteraemia action plan. Evaluate new treatments for CDI (severe and recurrent cases) for use in the health economy.
	2448 C3	Failure to have effective systems in place for patients with learning disabilities or requiring application of Mental Capacity Act.	Action Plan updated.	Undertake an audit of learning disabilities IT alert system and outcomes - No progress as would be in work schedule of LD Nurse Specialist. Revised completion date March 2013
	2680 A3	Interpreting & Translation Service - risk of over performance against central budget held by patient experience.	Positive Assurances and Action Plan updated.	Implemented risk assessments and centralising of face to face interpreting in top 3 areas of usage. Developed KPIs to monitor weekly usage. Implemented centralised plan across 3 high user departments to reduce face to face interpreting. Monitor staff concerns from 3 pilot areas. Monitor complaints from 3 pilot areas. Agree internal action plan to roll for Trust. Plan to implement across Trust to start

				April 1st. Monitor weekly and monthly face to face interpreting in 3 pilot areas.
	2917 C4	Risk of non-compliance with NHSLA standards - achieving 12/13 CIP	Positive Assurances, Gaps in Assurance and Action Plan updated.	L3 PID drafted (Dec 2012) TMT approval Jan 2013 (Includes formation of a Project Board chaired by CNO). Internal action plan developed whilst waiting on final report. Developed revised reporting structure for NHSLA Steering group and Operational group (to include maternity progress reporting.
	2950 B3	Unable to achieve no avoidable pressure ulcers by December 2012 across the health economy.	Positive Assurances, Gaps in Assurance and Action Plan updated.	Commenced TV posts in AMU and ED. 70% of Trust achieved zero avoidable pressure ulcers by Dec 31 2012. 30% of Trust have not achieved Ambition. Outline Business case to purchase pressure relieving equipment for ED. Redefine contract specification to cover outreach of TVN service to Wolverhampton nursing and residential homes.
	3278 B3	Management of Policies - version control, publication and archive	***NEW RISK***	
Medical Director	2922 C4	IG Toolkit Level 2 Maintenance.	Positive controls and Action Plan updated.	Internal audit of 10 standards Aug 2012 and Internal re-audit of 10 standards in Dec 2012 to monitor progress. ICO external audit Dec 2012- awaiting final report from ICO with recommendations and actions, due 20/02/2013
Director of Planning and Contracts	2929 D3	Failure to deliver CQUINS schemes.	Positive controls updated.	Dementia CQUIN requirements now agreed with commissioner. Reviewed all CQUIN targets and reappraised initial risk assessment.
Director of Human Resources	1742 C4	Failure to learn from staff survey.	Action Plan updated.	National survey now concluded; awaiting results – expected March 2013
Chief Financial Officer	2570 C4	Inadequate estates as part of the Transfer of Community Services - WCPCT provider Services with effect from 1 April 2011.	Positive controls updated.	RWT and PCT have agreed transfer properties
	2781 B3	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.	Description amended.	'Negotiations have taken place with Commissioners to ensure that funds are re-invested with RWT to mitigate risk.'

The Royal Wolverhampton NHS Trust

Board Assurance Framework

January-2013

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

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

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

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Trust Objective:	**To provide our patients & staff with a safe environment.**										
Chief Nursing Officer	O4 2965	Failure to reduce Never Events.	C5 RED	Awaiting CQC Inspection. Provided CQC with update on actions taken - Jan 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 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.	Reduction in Never Events Specific action plans post each Never Event in all directorates.	Last Never Event in Nov 12. Poor compliance with surgical checklists in Obs / Gynae Theatres being addressed by directorate - Jan 13 CQC Report July 12 issued RWT with moderate concern over WHO checklist use and minor concern for checklists used outside of theatre.	Directorates to evaluate next steps following Afpp training	Feb-13	D3 YELLOW	Jan-13	Yes

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

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Trust Objective:	**To achieve a balance between demand & capacity of services**										
Director of Planning / Contracting	O6 2699	Impact of movement to GP Consortia Commissioning - included in Risk 2508.	C4 AMBER	Development of a Benefits Realisation Plan. Action Plan - Apr-11 Re-launch of process to generate ideas and capture work in progress Share success, ideas and tools through a microsite on the intranet - Monthly Change Programme Board established Jan 2012 Programme reviewed and project tracker now introduced showing 6 month work programme - Sep-11 Launched revised PID/QIA - May 2012 Implemented monitoring tool to improve access to information and performance management - May 2012 Monthly report to Trust Board in to update on progress - ongoing. TMT approved revised Programme Management arrangements. Aligns Benefits Realisation and Cost Improvement Programme - Nov 11 Exec lead identified - Apr-11	Black Country System Plan - evidence of Benefits Realisation Quarterly Contract Commissioning Reports to Trust Board - Jan 13 Internal auditor review identified no recommendations - Aug 12 Established revised targets for 2012/13 via Change Programme Board All schemes have now been migrated and are live in the new electronic monitoring system which will provide greater assurance and monitoring of plan. Monthly TMT and Trust Board reports		Align CIP/QIPP Programme with CCG to reduce risks Formulise monitoring arrangements with executive leads On-going monitoring of projects via Change Programme Board - ongoing	Mar-13 Jan-13	C4 AMBER	Jan-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 2962	Risk of Health Visiting business/system/service failure due to multiple systemic failings.	B4 RED	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.	From June 2012 - on going regular Health Visiting meeting to review and update action plan. Meetings and actions on schedule. Acting 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. 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. 05/10/2012 - Sickness absence is improving 05/10/2012 - appraisal rates have improved		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. Health Visitor Steering Group meeting expanded membership to include SHA - October 2012. 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	Jan-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.					

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?
				The CPT Job Description is in draft format and been sent out for comments.							
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) Review 'NHS Bill'; Operating framework and PbR tariffs for 2012/13 - Dec-11 Negotiation with Commissioners at LDP meetings; focus on CCGs (on-going) Internal RWHT Contract Review/LDP meetings. (Senior managers /Directors agreed negotiations strategy (on-going)	Contracts signed with all commissioners by 31 March 2012 Positive contract negotiations for 2012/13 Internal RWHT Contract meeting at least once per month Meetings every 4 weeks with Commissioners with action notes		Map ongoing changes to commissioning portfolios, monitoring consistency to overarching financial envelope Revise Communication Strategy to reflect commissioning changes, once new contracting manager is in post.	Mar-13 Jan-13	C4 AMBER	Jan-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	Established joint programme Board with Commissioners. Agreed 2012/13 QIPP work programme.	Quarterly Contracting Reports to Trust Board Modernisation programme Board commenced		To agree a QIPP work programme with commissioners To identify capacity and resources to deliver the programme.	Jan-13 Jan-13	B3 AMBER	Jan-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	For 12/13 have secured favourable contracts Contingency plans in place	Financial position of the Trust monitored on Monthly board reports Monitoring referral trends for changes Procurement tenders reviewed to ensure sufficient competition		To identify market opportunities - ongoing To respond to bids put forward by SHA / Commissioners Additional collaboration with other providers to reduce costs Maintain good working relationships and communications with commissioners - ongoing	 Jan-13 Mar-13	C2 YELLOW	Jan-13	Yes
Trust Objective:		**To be a high quality educator**									
Chief Nursing Officer	3277	The education and patient assessment requirements of the Catheter Safety CQUIN may not be achieved by the end of March 2013	B3 AMBER	Trained 75% of identified staff by 31/12/12 Re audit planned and comminicated Dec 12 Education plan developed Dec 12 Working group meets monthly Dec12		System to alert database of new patients with catheters not agreed Dec 12 Secondment staff to support the work not in post Dec 12	Reaudit long term catheters Establish a system to collect data on new patients with long term urinary catheters Assess 100% of those with long term urethral catheters Train remianing 25% of staff Place training package on KITE site	Mar-13 Feb-13 Mar-13 Mar-13 Jan-13	D2 GREEN	Jan-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 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 SHA leading the process for recruitment of Chair/NEDs (interview scheduled for 31 January) Process for review and comments on documentation via Trust Board - ongoing Programme for Communication with staff, patients and public - ongoing SHA performance monitoring and self-certification process - monthly 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		Monitor letter deferring Trust - Oct 12	Action Learning From SHA FT Network Regular review of Monitor Board minutes and reports - ongoing	C3 AMBER	Jan-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;

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Trust Objective:	**To provide our patients & staff with a safe environment.**									

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	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 Feb-13	D3 YELLOW	Jan-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?
				Add low risks identified via action planning from peer reviews and audits - Nov 12						
Trust Objective:		**To agree appropriate population catchment areas for RWHT service**								
Director of Planning / Contracting	O6 1734	Introduction of other health providers in the market as a result of Any Qualified Provider leads to a greater shift of activity.	D2 GREEN	Weekly review of interactive commissioning map (H) Established GP liaison office and webpage Submitted AQP proposals for Foot Health and Audiology Flexible services and low Waiting Times for all first appointments (on-going) Promoting choice through Web Site & NHS Choices - Nov 2010 (on-going) Market Research & Marketing Strategy Marketing Report	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 Use refinements to NHS Choices & Choose & Book to 'sell' services - on-going Maximise opportunities to sell services via new Web Site - on-going Work with shadow Consortia to understand future requirements - on-going Explore opportunities with other commissioners to support the TCS agenda - on-going	D2 GREEN	Jan-13	Yes

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

The Royal Wolverhampton NHS Trust

Trust Risk Register

January-2013

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

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

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

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Trust Objective:	**Clinical Negligence Scheme for Trusts**										
Director of Human Resources	O16 2858	(amalgamated with risk 883 - Local Induction). NHSLA Level 3. Achievement required for standard 3. relates to standard requirement of 95% compliance in mandatory training and induction. Currently poor compliance with NHSLA level 3 standard 3 in regard to mandatory training and local induction.	C3 AMBER	e-learning packages available as alternative to face to face training monthly compliance reports issued for all TNA topics training compliance discussed at divisional/directorate meetings as part of governance agenda increased publicity around individual responsibility to undertake mandatory training via desktops and posters request for local induction information has been requested as part of appraisal audit monthly IMTG with SMEs monitoring action plans reporting frequency for all minimum data set topics now monthly for all subjects repeated non compliance reports escalated to divisional team Local induction audit assessed NHSLA project group monitoring progress for standard 3 extra training sessions being delivered Further e-learning packs compiled for alternative to face to face training for CRT and general consent training	monthly audit of local induction returns (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 Cost pressure for manual handling submitted Inanimate manual handling e-learning	 Feb-13 Jan-13	D3 YELLOW	Jan-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 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	Undertake health records spot checks against Appendix D to inform position, feedback to directorates/divisions where improvements will be required in order to prepare for live records check on the day of assessment up to assessment date 26/11/2012 L3 PID drafted (Dec 2012) TMT approval Jan 2013 (Includes formation of a Project Board chaired by CNO) - Jan 13 Internal action plan developed whilst waiting on final report (Dec 12) Developed revised reporting structure for NHSLA Steering group and Operational group (to include maternity progress reporting - Jan 13 Review of Feb 12 level 2 self-assessment completed and fed back for redress of gaps. Bi monthly updates from June 2011 to Compliance Committee Weekly NHSLA Briefings from Deputy CE across trust up to assessment Gap analysis of 12 months evidence of all audits undertaken - actions in place to close gaps (mid October)	First round of monitoring reports received from all policy leads (mid Sept) changes identified and returned to policy leads where necessary Confirmation from NHSLA assessor that any policies not harmonised is acceptable as long as this has been approved by a Trust Level committee with rationale - timescales for harmonsation must be included. (Feb 2012) Level 3 - Supervision of medical staff in training (GMC accreditation) - Sep 12 Level 2 self assessment / review shows improvement (June 2012 & end Aug 2012) Trust achieved level 2 compliance with the General Risk management standards - 28/11/12.	Poor completion and follow up of audit actions - Apr 12 Unable to show improvements in some audit results - Apr 12 Internal monitoring currently show predominantly red/amber scores at L3 - Sept 12 12 months evidence of audit unavailable prior to audit (Nov 2012) - Risk 2832 (Merged with escalated risk July 2012) Low compliance rates following trustwide audits are not being improved - this indicates policies are not embedded within the Trust which does not demonstrate a Level 3 organisation Aug 12 Live record check will impact on compliance with standards and overide any audits in place. The Trust is not currently aware on what the results would be of any live record check undertaken against Appendix D of the NHSLA Standards. Diagnostic and Screening, Health Records and Complaints Audit monitoring reports will miss the August deadline Confirmation and evidence of completed actions prior to assessment date (26/11/2012) (L3)	NHSLA Level 3 Sub Group - review all monitoring reports prior to submission - ongoing up to assessment 2013 Ongoing monitoring of Directorates against Divisional Governance Strategy (Level 2) Draft Internal action plan developed for approval at NHSLA steering group Review audit results and actions for improvement prior to assessment visit - Re-audit as necessary.	Apr-13 Apr-13 Jan-13 Feb-13	C3 AMBER	Jan-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 audits used to reveal compliance problems which are then followed up and monitored by policy leads and escalated to divisional management teams to influence change/action - ongoing Escalation of risk to Trust risk register (March 2012) Ongoing compliance monitoring and reporting at NHSLA Steering group (to end of November 2012) Monitoring of policies and audit production (Feedback provided to all authors) Project plan being prepared for level 3 (General assessment 2013) Completed 31/12/12 Extra NHSLA Project Group meeting dates added prior to assessment (Oct, Nov 2012) Confirm & Review process with standards leads (Jul, Aug, Sept & Oct 2012) Mapping all audit/monitoring requirements completed - monitored through NHSLA Project Group (ongoing to Nov 2012) Project Plan to implement requirements at all levels in place (ongoing to end of November 2012)					

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

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
				Independent review of compliance evidence undertaken. 17/4/2012 & 29/6/2012) 121 Support provided to all policy/audit leads (ongoing to end of November 2012) Governance Officers supporting within Directorates re: monitoring against divisional governance strategy (L2 work to end of Nov 2012) 'To Do' list produced and communicated to Divisions/Directorates Weekly meeting in place with Chief Nursing Officer to monitor progress/escalate issues. Resource for a fixed term post to support CNST and NHSLA from Oct 12. Regular Senior Managers Briefings on NHSLA (July 2011, Oct 2011, Jan 2012, May 2012, Jun 2012, Sept 12, Oct 12) Monthly reports to TMT on NHSLA - March, April, May, June, July, Sept, Oct 2012. NHSLA Policy Pack communicated across whole trust to inform all staff of new policies (Jan 2012) Drop in session chaired by CNO to ensure actions that need to be completed are (ongoing to date of assessment)					

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?
				Decision made to be assessed at Level 2 NHSLA November with a move to Level 3 in April 2013 to minimise financial risk Independent review of evidence/position started W/C 1st October 2012							
Trust Objective:		**To provide our patients & staff with a safe environment.**									
Chief Nursing Officer	O7 2448	Failure to have effective systems in place for patients with learning disabilities or requiring application of Mental Capacity Act.	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	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.	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 Further communication with organisation and Mental Capacity Act Requirements Learning disabilities lead post now made substantive and to include liaison with Sandwell BCP mental health services	Mar-13 Jan-13 Feb-13 Feb-13	D3 YELLOW	Jan-13	Yes
Chief Nursing Officer	O16 2482	Failure to learn from national / local organisations experience e.g. Francis report.	D4 AMBER	Governance unit reviewed external reports of other organisations learning and cross referenced to local actions. Monitor complaints, claims and incidents through I.C.C commenced March 2012. Sustainability plan reviewed at Compliance Committee	CQC responsive review follow up report - March 2012 CQC registration without conditions (General and Mental Health) - Feb 2012		Review scope and operation of ICC meeting Await Francis 2 report due Jan 13	Jan-13 Jan-13	E2 GREEN	Jan-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	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 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 Jan-13 Apr-14	C3 AMBER	Jan-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 Nursing Officer	O4 2680	Interpreting & Translation Service - risk of overperformance against central budget held by patient experience.	A3 AMBER	Agreed face to face pilot with 3 departments (Dec 12) Implemented centralised plan across 3 high user departments to reduce face to face interpreting (Jan 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 Updated policy and criteria to clarify process for interpreting services Changed face to face provider to improve service Changed telephone provider to improve service and screening of enquiries Circulated reports to divisions regularly to highlight costs incurred monthly 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.	Started use of 3 way telephone usage instead of face to face where possible and scoped equipment (Dec 12) Discussed and agreed revising face to face budget with divisions (Dec 12) Reduction in interpreting overspend 12/13 from 11/12 at month 6 by 60%.		Monitor staff concerns from 3 pilot areas Plan to implement across Trust to start April 1st. Agree internal action plan to roll for Trust Monitor complaints from 3 pilot areas Monitor weekly and monthly face to face interpreting in 3 pilot areas	Feb-13 Apr-13 Mar-13 Feb-13 Mar-14	C2 YELLOW	Jan-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?
Medical Director	O6 2920	Provision of Vascular services at RWHT following centralisation of the service off-site and concerns over the required level of vascular surgery support to other clinical specialties including those in the Heart and Lung Centre.	C4 AMBER	Meetings of relevant Clinicians and Managers have been set up at RWT to inform the Trust about Network related issues independently, and also to review the impact of the implementation of the Network on other services at RWT which rely on Vascular Service input - October 2012. Clinicians (Surgeons, Radiologists & Anaesthetists) from RWT are actively participating in the Black Country Vascular Network. A Governance & Operational Framework has been implemented and is under review by the Black Country Vascular Network. Governance and operational risks are discussed at the Network meetings on a regular basis. October 2012 The RWT Clinicians working in the Network continue to actively contribute to the Governance and Operational structure. Incidents continue to be logged when they occur. RWT will continue to monitor the impact of the Network on service provision across the Black Country. In addition the Trust will monitor the impact of the Network on those specialties at RWT which are dependent on Vascular Surgical provision.	The centralisation of Vascular Services and the implementation of the Network commenced July 16th 2012. Governance and operational issues are being discussed and changes to the service made on the basis of the issues identified and risks logged at these meetings. 19 October 2012 The internal RWT meeting has identified its own issues which have been sent through to the service lead at Dudley Group of Hospitals for attention. 19 October 2012	Governance and operational issues have been identified both at Network and local level and these are currently being addressed. The Trust awaits the outcome of these discussions. 19 October 2012 Aug 12 - no incidents reported from RWH		E2 GREEN	Jan-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?
				Governance and operational issues will continue to be discussed within the Network and a Risk Register maintained.							
Chief Nursing Officer	O4 2950	Unable to achieve no avoidable pressure ulcers by December 2012 across the health economy.	B3 AMBER	Developed an e-learning package (Dec 12) Commenced TV posts in AMU and ED - Jan 13 Developed a tissue viability resource guidance on intranet - Oct 12 Increased Tissue Viability Specialist Team capacity agreed with a business case - Jun 12 Organisational wide pressure ulcer prevention plan - Apr 12 Pressure ulcer prevention training now mandatory specific - Jun 12 Communication campaign to all professional groups - ongoing Weekly pressure ulcer review meeting with CNO to determine accountability to implement learning organisation wide - Feb 12 Revised pressure ulcer policy in place - Jun 12	2 month evidence to highlight Trust decline in avoidable PUs. 70% of Trust achieved zero avoidable pressure ulcers by Dec 31 2012. Regional intensive support team visit from SHA and positive feedback - Jun 12	30% of Trust have not achieved Ambition - Jan 13	Outline Business case to purchase pressure relieving equipment for ED Redefine contract specification to cover outreach of TVN service to Wolverhampton nursing and residential homes Increase communication within the organisation regarding pressure ulcer prevention - ongoing Strengthen the wound care link role to develop competency and change culture Review equipment resource provision and improve community equipment provision and maintenance. Strengthen sharing of action plans following investigation and manage capability as required - ongoing.	Feb-13 Apr-13 Feb-13 Apr-13	D3 YELLOW	Jan-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 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 Supervision of junior doctors re IP practices/ skills/ training Oct 12 HCC-DH Self Assessment Hygiene Code - Oct 12 Screening Policy in Trust implemented, updated comms Nov 12 Screening Programme in Community in place Nov 12 IV team PID agreed at TMT and in development - May 12 Surgical Site Infection Surveillance Team agreed at TMT and in development. - May 12 Robust surveillance system in place.- Nov 12 Monitored the increase in C-Diff post PCR testing and discussed with commissioners Oct 12 PREVENT Bronze standard achieved by Care Homes - Mar 2011 Appointed Data Analyst for IPT - March 2012 IP lead nurse in post - Team restructure aimed at delivery.reviewed Oct 12	CQC Visit report - May 2011 HPA quarterly report of MESS data ongoing. 2011/12 best year to date for the reduction of MSSA bacteraemia, DRHAB's and MRSA acquisition Aug 12 Current C-diff and MRSA bacteraemia YTD performance -Aug12 Successful Nursing Times award for infection prevention in community Nov 2011. MRSA rates currently on trajectory 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 Reduction in HCAIs other than MRSA bacteremia - Nov 12	PCR testing has increased the numbers of C-Diff due to more accurate testing (sensitivity). The impact of this is still to be quantified - Jun 12 There is a lack of evidence against which PCR positive specimens will be EIA positive and therefore reportable under the new testing algorythm MRSA bacteraemia in Sept 12 - Oct 12	Evaluate new treatments for CDI (severe and recurrent cases) for use in the health economy. Evaluate 3 months of IPN visiting all patient in the Trust with CDI and report to IPCC. Evaluate all MRSA bacteramia cases to date and update infection prevention annual programme of work Complete actions from MRSA bacteraemia action plan Feedback surgical site infection data to all relevant clinicians	Mar-13 Jan-13 Jan-13 Feb-13 Feb-13	C4 AMBER	Jan-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?
				CDiff plan reviewed end of September 11 and enhanced with a range of actions aimed at reduction of incidence and reviewed Oct 12 Rapid improvement programme - creating best practice wards includes an infection prevention work stream Oct 12 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 Implemented CDI Assurance process. Quarterly reporting to IPCC on trends - Oct 12 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 in place Nov 12 Trail of daily visits to C diff in patients for 3 months by IPN's completed, to repeated regularly Dec 12 C difficile ward round in place and sustained Nov 12					

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

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
				MRSA bacteraemia action plan agreed and presetnted to IPCC Sept 12 - Nov 12 Surgical site infection commenced Sept 12 and ongoing Nov 12 IV Team in place Nov 12 Urinary Catheter policy agreed at IPCC Oct 12							
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 - December 2012.	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 February 2013.	Mar-13 Mar-13 Feb-13	C2 YELLOW	Jan-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/Senio r 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. 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. Chatback staff survey results showed a decline in performance for 2012.	National survey was conducted in Autumn/Winter 2012, results expected in March 2013. Action planning to ocurr once received. Chatback action planning occuring at local level from Oct 2012 (ongoing)	Mar-13	D3 YELLOW	Jan-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. Weekly 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. 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	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	Jan-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 - November 2012 Reports to SHA and other agencies - November 2012 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 - December 2012	Review bed capacity and modelling by January 2013. Review of step down discharge process with CCG and social care - December 2012. Patient Productivity Programme commenced with enabling work streams - September 2012 Increased capacity in Patient Productivity Programme to ensure deliverability of schemes. Review November 2012.	D3 YELLOW	Jan-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	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 - December 2012.	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.		B3 AMBER	Jan-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 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 alternate recruitment to vacant medical posts - November 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. 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	Early warning of potential to fail - December 2012 Sustained performance for other standards - December 2012. On an ongoing basis and daily monitoring of hot spot areas - ongoing	A&E KPI's are above target - December 2012 A&E target not achieved - November & December 2012	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	Jan-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?
				Increased winter pressure resource available and implemented - January 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.	B4 RED	Reports are being issued monthly and clinical engagement has been improved which has enabled the content of the reports to be improved and be more useful. SLR reports to be distributed on a monthly basis. SLR pilots to be set up. Rollout plan to be proposed. Contribution levels set end of Q2. Board received latest briefing in July 2012. Updated contributions using 2012/13 tariff now available.		Need to develop better appointment basis for some direct and indirect costs, as part of PLICS rollout Dec 2012	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.	Jan-13	D3 YELLOW	Jan-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.	B3 AMBER	2012/13 plan includes cost pressures, pay awards and 2012/13 incremental drift impact. 2012/13 financial plan has modelled impact of pay and non pay cost pressures. Long term financial model has assessed financial impact for 5 year period to 2016/17			Monitor budgetary position closely through operational finance group/TMT and Trust Board - ongoing		C2 YELLOW	Jan-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	Jan-13	
Chief Operating Officer	O6 2893	Risk that GP workload will not be retained following the commissioning tender for GP services. This potential activity reduction will lead to loss of income and overcapacity of pathology services on site. There would potentially be significant impact on staffing structure.	C4 AMBER	Communication regarding GP tender with senior members of the trust management team - September 2012 Royal Wolverhampton Hospitals NHS Trust & another local pathology provider to tender for GP services - September 2012	Completion of the pathology build includes the partnership working capability Strategy involving senior management of the trust in obtaining the GP workload - September 2012	Joint GP bid relies on agreement of Chief Executives from both Trusts - August 2012	Produce tender for GP work-due date unknown at present (see details); date will require review by due date given. Construction of Integrated pathology build Inform trust senior management team of progress of GP tender bid	Feb-13 Mar-13 Mar-13	D3 YELLOW	Jan-13	

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

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Director of Planning / Contracting	O16 2929	Failure to deliver CQUINS schemes	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			Ongoing discussion with Dementia directorate, divisions WCPCT / CCG to agree solution - to be fully declared on quarter 4 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	Jan-13	B3 AMBER	Jan-13	Yes
Director of Human Resources	3081	Insufficient manual handling budget to provide manual handling training to meet NHSLA level 3 standards. Extra budget required to meet demand and satisfy 95% compliance	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 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	Feb-13 Jan-13 Dec-12	D3 YELLOW	Jan-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	3176	Commissioners raising issue of patient activity over performance and their ability to pay.	A4 RED	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	Jan-13	
Chief Financial Officer	O16 514	Failure to deliver recurrent efficiency gains and CIPs.	A4 RED	Monthly reporting against projects including to Trust Board Change Program Board (Executive Director led) The Trust has invested in a new system solution from "TriSolve" which will enable scheme implementers to have more direct involvement in the reporting of their schemes and be held to account. Each project has an executive director lead	Trust Board Reports & Minutes include CIPs - monthly ongoing	Finance report to Trust Board. Report of the Change Programme Board to Trust Board. Deloitte HDD report - Sep 2012	Monitor closely through CIP programme board - ongoing Identify 'new' projects and programmes in advance - ongoing		B3 AMBER	Jan-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)	Develop Liaison with LETB/LETC (ongoing)	Jan-13	C3 AMBER	Jan-13	Yes

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

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

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

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Medical Director	O16 2922	Maintenance of a minimum accreditation of level 2 or higher for the IGToolkit v10 - 2012/13 in line with national guidance.	C4 AMBER	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	Gapa 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.	IGT leads to confirm evidence has been reviewed by checking the review box. on IGT online- Only some leads had done this at July 12, evidence of review by leads/sponsors is not present.(required for standard 101) Draft internal audit report released 31/08/2012 advises evidence submitted for IGToolkit is not robust enough to support the Trust's assessment at this time.3 recommendations to improve IG evidence are outlined 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	Progress monitoring	Oct-12	D2 GREEN	Jan-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?
						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					
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)	Policy archive audit (Aug 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 Publication protocol Arrange meeting with heads of Dept to share audit findings and agree risk solutions	Feb-13 Feb-13 Jan-13 Jan-13	D2 GREEN	Jan-13	
Risk Managed to Target Level											

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

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Trust Objective:	**To be in the national NHS top quartile of benchmarks**									

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

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Nursing Officer	O16 1717	Failure to maintain re-registration by the CQC periodic review.	C2 YELLOW	Undertake quarterly Divisional Reviews 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 Final report from the outcome 21 records visit (March 12) found that the Trust is compliance with the relevant aspect of the visit (i.e. maintenance of HAS 1 forms) - no recommendations made. CQC registration without conditions following TCS changes - Apr 2011 CQC Reports - Privacy, Dignity and Nutrition - Responsive Review - March 2012 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 Service Improvement initiatives - Productive Theatre	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 CQC Report following unannounced visit returned Moderate/Minor concerns for outcome 4 & 16 - August 12 CQC issued moderate and minor concern following unannounced review - Sep 12	Change to Quality metrics requires a re-mapping to CQC standards Service Improvement initiative - bed capacity meets demand - modelling implementation commenced. Capacity and Social Services integration project commenced	Mar-13 Jun-13	C2 YELLOW	Jan-13	Yes

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

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
					CQC standards are being mapped against Information Governance standards, NHSLA standards, Performance and quality indicators and trust wide audits; in order to triangulate self-assessment and strengthen assurance of on-going monitoring. RSM Tenon audit report graded green amber. Five of 7 recommendations from Nov 2011 are completed and remaining 2 are progressing.					

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;