The Royal Wolverhampton Hospitals NHS Trust

Trust Board Report

Meeting Date:	23rd May 2011
Title:	Board Assurance Framework
Executive Summary:	
Action Requested:	To inform the Committee of updates to the Board Assurance Framework (AF).
Report of:	Director of Nursing & Midwifery
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

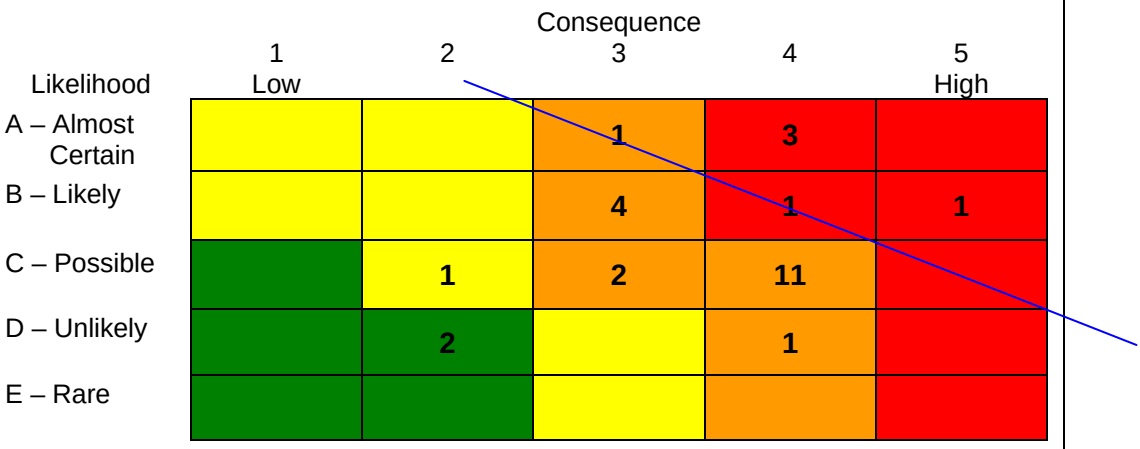
The Board Assurance Framework "provides organisations with a simple but comprehensive method for the effective and focused management of the principal risks that arise in meeting their objectives. It also provides a structure for the evidence to support the Statement on Internal Control" (Integrated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

Board Assurance Framework - Updates (Appendix A)

Following these changes the split of the Assurance Framework is:

Risks currently being managed (ongoing)	24
Risks managed to target level	3

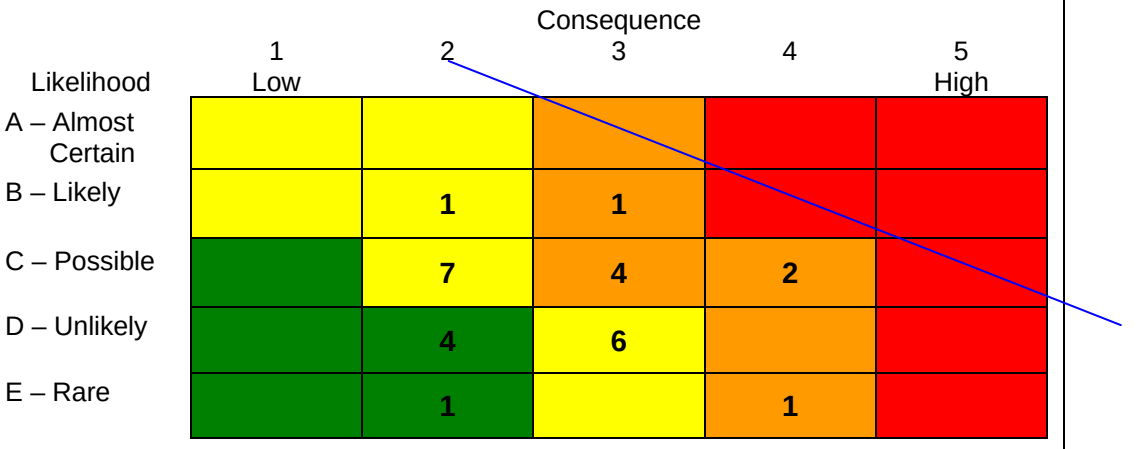
There are currently 27 risks contained within the Assurance Framework which are distributed across the Trust Categorisation matrix as below:



Utilising the Trust's Categorisation Matrix (Risk Plot above) as a way of pragmatically prioritising the Trusts 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
	1320	Results of diagnostic tests may not be seen by Doctor.	COO
	1739	Failure to develop Service Line Reporting	FD
	2572	Information Governance training risk	MD
	2464	Effect of national debt	FD

If all of the actions proposed to manage/reduce the risks contained within the AF are completed then the Target Risk Rating will be achieved and the 27 risks would then be distributed across the Trust Categorisation matrix as below:



Board Assurance Framework – Trust Risk Register split

In response to feedback received from Monitor relating to Board awareness of significant strategic and high level operational risks, changes have been adopted to create a trust risk register to report and manage high level operational risks at board level The Trust risk register will be composed of risks graded red or high amber risks (i.e Grade A3, B3 and C4) from director portfolios or escalated from divisional risk registers. The board assurance framework containing strategic risks will remain as a separate document reviewed and managed by the Board. To achieve this, the Executive team (on 11th May 2011) conducted an exercise to formulate a Trust Risk Register which involved splitting the current Board Assurance Framework and scoping of risks within Director portfolios.

Following these changes the split of the Board Assurance Framework is:

Risks on the Trust Risk Register	16
Risks on the Board Assurance Framework	11

High level Operational risks

The following are considered to be high level (RED) operational risks. All operational risks are discussed at a directorate and divisional level.

	ID	Risk Title	Lead
	1854	Non reporting of Plain film examinations.	Head of Radiology
	920	Non reporting of Plain film examinations.	Head of Radiology

The Trust has developed a mechanism to enable the use of one common risk number within Datix in cases where risks are to be escalated from lower to high levels for management. As a result please note that risk 1854 (at a Divisional level) and risk 920 (at a Directorate level) is reported as such for audit trail but will be merged into one entry (risk 1320) on the Datix system in future reports.

Recommendation(s)

- The Committee considers the report and endorses that the Trust Board: accepts the changes presented within the Assurance Framework.

Appendix A: Tracking changes within Assurance Framework

Lead Director	Risk	Risk Title	Update	Reasoning / Progress Against Actions
Chief Operating Officer	1542	Emergency preparedness	****Transferred****	Moved to the Director of Planning and Contracting risk register
	1713	Failure to effectively maximise workforce productivity.	Action plan updated	Review the guidance on Consultant Job Planning/Appraisal Framework – July 2011. Implementation of monitoring procedure to ensure consistency of approach across Divisions – September 2011.
	1714	Failure of other agencies to support discharge process.	Action plan updated	LEAN Project Managing Complex Discharges - ongoing Action Plan from RSM Tenon audit
	1735	Improving Outcomes Guidance – Darzi Report	Inherited from CEO risk register. Positive Assurances updated. **Moved to Directors portfolio**	Cancer peer review outcomes Clinical outcomes – colorectal surgery. Moved to the Chief Operations Officer's risk register
	1965	Monthly Contract Financial Reconciliation	****Transferred****	Moved to the Director of Planning and Contracting risk register
	2492	Capacity meeting demand	Action Plan updated.	Delivery of the Business Case of the single emergency portal project. Jul-11
	2508	Commissioning responsibility changes - affects contracted income	Positive controls updated	Agreed WCPCT to formally discuss at all monthly Contract Review Meetings ~~(~~'from August 2010,'~~)~~ (and throughout 2011/12)
	2509	Failure to have an effective management governance process and systems in place for the vertical integration of Wolverhampton primary care provider services.	Action Plan updated.	BTA signed off 31 March 2011. First Phase of TCS complete. Harmonise polices Jul-11 Performance management arrangements in place for both organisations Apr-11 Develop an Annual Plan with KPIs May-11
Director of Nursing and Midwifery	2449	Inadequate and ineffective systems to Safeguard Vulnerable adults.	Positive controls and Action Plan updated.	Trust Board training for Safeguarding delivered 11/4/11 Review off complaint policy to cover safeguarding adult process. CQC action plan. Sept 11
	2450	Inadequate preparation for all Graduate nurse training in Wolverhampton from September 2011.	Action Plan updated. **Moved to Directors portfolio**	Workforce plan (delayed) - post TCS organisation to have workplan developed by new DDN&M.
	2482	Failure to learn from national / local organisations	Positive controls updated.	12 recommendations made Francis report gap analysis – grading now reduced to 3 amber and 9 green as at April 11. From April 11 a Compliance Committee is established with remit to review the broad spectrum of compliance with national guidance, inquiry and external review reports.
Chief Executive	1501	Foundation Trust Application Process	Gaps in Assurance updated.	CQC unplanned visit and responsive review
	1734	Introduction of other health providers in the market as a result of Any Qualified Provider leads to a greater	Action plan updated	Work with Shadow Consortia to understand future requirements. Explore opportunities with other commissioners to support the TCS agenda.

		shift of activity.		
	1735	Improving Outcomes Guidance – Darzi Report	Positive Assurances updated. ****Transferred****	
Director of Human Resources	1102	Employment Tribunal and Collective Grievance equal pay claims.	Action Plan updated. **Moved to Directors portfolio**	Meeting with Trust legal team rescheduled from March 2011 to April 2011
Director of Finance	514	Failure to deliver recurrent efficiency gains and CIPs.	Positive controls updated	"Progess chaser" appointed June 09 – deleted.
	1586	Failure to safeguard person identifiable data.	Positive controls updated. **Moved to Directors portfolio**	IG Toolkit is now level 2 on all measures apart from Training. Pseudonymisation policy went to the Information Governance Steering Group on 11th April. This outlines processes in Information to only use patient identifiable data unless need established for patient names etc to be used.
	1587	Failure to have resilient information technology systems.	Positive controls updated. **Moved to Directors portfolio**	Network core replacement fully implemented and tested
	1737	Inadequate activity and financial reporting leading to inappropriate decisions	Positive controls and Gaps in Assurance updated.	SLR reports to be discussed on a monthly basis. SLR plan for 11/12 to be put in place and agreed. Income and expenditure timescales for reporting to directorates now at 8 working days. Activity-related variances addressed in 2010/11 i&e plan. Finance report to Trust Board. Internal and External audit reports.
	1738	Failure to manage expenditure budgets.	Positive controls updated. **Moved to Directors portfolio**	2011/12 budgets to be signed by managers, to show commitment to control within funds.
	1739	Failure to develop Service Line Reporting across the Trust.	Positive controls updated.	SLR reports to be distributed on a monthly basis. SLR pilots to be set up. 2011/12 plan to be agreed and monitored against. Rollout plan to be proposed.
	2468	Pay rises and cost pressures.	Positive controls updated.	2011/12 financial plan has modelled impact of pay and non pay pressures. 2011/12 plan includes cost pressures; VAT and pay awards.
	2700	Integration of Patient Administration System	Inherited from Director of Planning and Contracting risk register. **Moved to Directors portfolio**	Integration of Patient Administration System for Acute and Community Services
Director of Planning and contracting	1542	Emergency preparedness	Inherited from COO risk register. Positive controls and Positive Assurances updated. **Moved to Directors portfolio**	Annual Exercise and Training Programme in place and Induction awareness. Major Incident Plan and Action Cards updated 2010. Emergency Preparedness Strategy approved at June 2009 Trust Board - due for renewal 2013. CBRN Plan and Action Cards - updated 2010.

				Emergency Planning Committee chaired by COO meets quarterly. Sub-Group structure developed with clinical leads for MI, BCM and Pandemic Flu. Audit of National Capability Survey 2010/2011. Assessments of EP made at Induction. Feedback from Exercises: Babysnatch, Exercise Cupid, Exercise Egress.
	1965	Monthly Contract Financial Reconciliation	Inherited from COO risk register. Positive controls, positive assurances and Gaps in Assurances updated. **Moved to Directors portfolio**	Further work on the impact of 2011/12 tariffs ongoing between Health Economy partners, and Risks will therefore need to be reviewed each month. Monthly Reconciliation Meetings will be called in ~~2010/11~~ 2011/12 where appropriate. Collaborative agreements always reached by local Health Economy partners for each month (no need for dispute resolution. WCPCT/HCS monthly data and monthly financial payments do not match RWHT monthly SLAM reports, i.e. impact of introducing ~~2010/11~~ 2011/12 National Tariff and Local Tariff arrangements.
	2699	Integration with PCT	****New risk****	Not realising the benefits with the integration of the two organisations. Impact of movement to GP Consortia Commissioning.
	2700	Integration of Patient Administration System	****New risk**** ****Transferred****	Integration of Patient Administration System for Acute and Community Services

The Royal Wolverhamtpon Hospitals NHS Trust

Board Assurance Framework

May-2011

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 / Contol	Action Plan that addresses Gaps in Control		Residual Risk Level		
Risks Currently Being Managed											
Trust Objective:		**To provide our patients & staff with a safe environment.**									
Director of Nursing & Midwifery	2449	Inadequate and ineffective systems to Safeguard Vulnerable adults.	C4 AMBER	Database for referral collection under development through Safeguarding lead Governance arrangements are being reviewed currently and will inform the internal audit report which will commence September 2010 Deputy Director of Nursing and Midwifery leading Safeguarding across health economy Trust Board training for Safeguarding delivered 11/4/11 Safeguarding to be part of Deputy Director of Nursing and Midwifery's portfolio post April 11 Action plan reflecting internal audit findings Policy Strategy Training plan	Internal audit review Safeguarding database population	Internal audit review Safeguarding referrals to local authority Complaints	Review off complaint policy to cover safeguarding adult process. CQC action plan. CQC Action Plan. Post TCS implementation plan	Sep-11 Apr-11	D3 YELLOW	May-11	

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; Outcom 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 Nursing & Midwifery	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 12 recommendations made Francis report gap analysis - grading now reduced to 3 amber and 9 green as at April 11 From April 11 a Compliance Committee is established with remit to review the broad spectrum of compliance with national guidance, inquiry and external review reports. QSC and BAC to review bimonthly action progress for Francis report Commissioner review of Paeds / A&E / EAU post CQC Report Mid Staffs. Action plan from Francis report with Director leads.	CQC registration without conditions (General and Mental Health)	Incidents Complaints	QSC and BAC to review bimonthly action progress for Francis report - ongoing	E2 GREEN	May-11	
Trust Objective:		**To achieve a balance between demand & capacity of services**								
Director of Planning and Contracting	2699	Not realising the benefits with the integration of the two organisations. Impact of movement to GP Consortia Commissioning - included in Risk 2508.	C4 AMBER	Development of a Benefits Realisation Plan. Action Plan. Benefits Realisation Sub Group established. TCS Steering Committee being set up. Exec lead identified		Commissioning impacts not realised as part of the transfer.	Development of a combined performance assurance framework for RWHT and WCPCT provider services. To be developed - KPIs progress reports. Action Plan.	D3 YELLOW	May-11	

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; Outcom
8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Trust Objective:		**Deliver services within financial allocations**									
Director of Finance & Information	1737	Inadequate activity and financial reporting leading to inappropriate decisions	C3 AMBER	Improved reporting system SLR reports to be discussed on a monthly basis. SLR plan for 11/12 to be put in place and agreed. Income and expenditure timescales for reporting to directorates now at 8 working days Activity-related variances addressed in 2010/11 i&e plan Reports available throughout organisation and monthly to Trust Board. Operational Finance reports and meetings. Reporting systems for activity that drives income and for expenditure distribution.	Internal Audit Report - Financial Reporting	Finance report to Trust Board. Internal and External audit reports.	Month 5/6 information to be distributed before December 24. Continue to develop relationships between activity and key expenditure variables	Dec-10	C2 YELLOW	May-11	Yes
Director of Estates Development	2451	Imposed reduction in Capital Funding as a result of National Policy/Spending Cuts.	C4 AMBER	2010/11 SHA confirmed CRL LTFM position Fall-back Programme Five year / ten year Capital Programme Business cases for all schemes submitted for approval	Regular reports to Trust Board, Trust Management Team and Estates Strategy Board Monitoring impact of changes in 2010/11 Programme on future years programmes Monitoring spend in current years Capital Programme on a monthly basis	Fall-back position may be insufficient to cope with any imposed reductions	Input fall-back Programme into LTFM as sensitivity	Jun-10	C4 AMBER	May-11	

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; Outcom 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 Finance & Information	2464	That will be an impact due to the economic climate. As a result of the national debt and action being taken to reduce it by the coalition government the Trust may see: -Reduction in NHS income -Suppliers unable to meet their obligations -Health related impact	A4 RED	Effective contract negotiation Robust CIP schemes Continual review of efficiency Close review of debtor/creditor position Monitor referral trend	No increase in efficiency targets from government		Downside plan in LTFM constructed. Continual review of position. Review '50 day' budget and respond accordingly.	C2 YELLOW	May-11	
Chief Operating Officer	2508	Commissioning responsibility changes - affects contracted income	A3 AMBER	Review White Paper(s)/consultation papers at Director & senior management level. Agreed WCPCT to formally discuss at all monthly Contract Review Meetings 'from August 2010,' (and throughout 2011/12) Agreement reached draw up action and implementation plan to minimise future risk.	Action Plan in place and reviewed.		Target GP Consortia as they develop. Review current and future contract Portfolios. Include potentially new configured Trust services in all assessment/reviews. Revise Communication Strategy to reflect commissioning changes.	B2 YELLOW	May-11	

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; Outcom 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	1501	The Trust does not meet the DH / Monitor requirements to become a foundation trust. The organisation will not deliver the Integrated Business Plan and associated documentation by the due date to enable a successful application to Monitor. Changes to Monitor's requirements for CIP percentages for the years to be assessed as part of the FT application are presenting a significant issue for the Trust.	C3 AMBER	Detailed project plans developed for Steering Group Process for review and comments on documentation via Steering and Trust Board Programme for Communication with staff, patients and public Detailed minutes and action notes. Board development programme Review of borad memorandum / self certification process Review of Monitor's Compliance Framework against Trust performance report	Monthly monitoring by Steering Group Project plan tracking progress Trust Management Team and Trust Board monthly update Completed HDD Membership recruitment above trajectory Secretary of State approval given for application to be passed to Monitor Application submitted to Monitor Batching meeting held with Monitor Delivery of Action Plan Milestones	CQC unplanned visit and responsive review	Board Development Sessions Action Learning From SHA FT Network Monthly monitoring HDD Action Plan Sub Group Contact made with DH Intensive support Team (Cancer)for review/ support in achieving target Contact made with North West England SHA Cancer Network for examples of good practice Action learning from Foundation Trust Network Regular review of Monitor Board minutes and reports Bi weekly monitoring meetings with divisional managers; weekly review of performance as part of COO performance meeting; locum consultant appointments to create additional capacity Monthly monitoring FT Steering Group and Trust Board	C3 AMBER	May-11	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; Outcom 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**										
Chief Executive Officer	4.2a 1733	Sustained critical press coverage leading to reduction of public confidence in services.	D2 GREEN	Communication Strategy & Policy Ongoing relationship with local reporter developed Proactive press releases Communications Manager in post Regular update and monitoring to TMT/TB Trust Board meetings are open to the public	Maternity Service & Awards Positive coveragefor Infection Prevention Clinical Performance against National Targets National In-Patient Survey 2007 results rate the level of care received as good or excellent.	Occassional negative coverage.	Regular update and monitoring to TMT/TB - ongoing		D2 GREEN	May-11	Yes
Trust Objective:	**To be in the national NHS top quartile of benchmarks**										
Director of Nursing & Midwifery	5.4, 5.5 1717	Failure to achieve re-registration by the CQC periodic review.	C2 YELLOW	Service Improvement initiative - 5 new LIA Projects as part of waive two. Performance Management Framework in place that is monitored through Trust Management Team and Trust Board. NHS Instittute for Innovation Better Care Better Value benchmark NHS Performance Framework - Quarterly to Trust Board	62 day cancer target now within target. Continue to monitor at thrice weekly meetings. Evidence of achievement of target	C Diff target not met Stroke threshold not published yet, so no assurance will be met Cancelled operations above internal target DNA & New to Review rates above target. Delays in Transfer of Care above internal target Length of Stay is above target 62 day cancer target not achieved	Undertake 4 service reviews during 2010/11 Undertake quarterly Divisional Reviews - ongoing. Participation in PCT led projects to improve discharge. C Diff - new initiative (Acumentive) - complete and ongoing Implement findings of Newtons Review re: Outpatients. Phase One complete. Phase Two - July 2011 Service Improvement initiative - continue to improve Stroke Services in line with NSF - ongoing Service Improvement initiative - bed capacity meets demand Service Improvement initiatives - Productive Theatre	Mar-11 Feb-11 Jul-11 May-11 May-11	C2 YELLOW	May-11	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; Outcom 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Trust Objective:		**To agree appropriate population catchment areas for RWHT service**								
Director of Planning and Contracting	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	Flexible services and low Waiting Times Promoting choice through Web Site & NHS Choices Market Research & Marketing Strategy Marketing Report - Trust Board	Limited extent of choice in Nuffield No new players in the area Maintain and grow referrals for all specialties Lack of interest by private sector in development with the region		Use refinements to NHS Choices & Choose & Book to 'sell' services Maximise opportunities to sell services via new Web Site Work with shadow Consortia to understand future requirements Explore opportunities with other commissioners to support the TCS agenda	D2 GREEN	May-11	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; Outcom
8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

The Royal Wolverhamtpon Hospitals NHS Trust

Trust Risk Register

May-2011

A1	A2	A3	A4	A5
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Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Risk Lead	ID	Principal Risk		Controls	Positive Assurances	Gaps in Assurance / Contol	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; Outcom
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Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?

Trust Objective: **To 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; Outcom
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Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Director of Nursing & Midwifery	535	Failure to achieve reductions in HAIs impacting on Trust's reputation and compliance to regulatory standards.	C4 AMBER	PCR testing from March 2011 C-Diff Action Plan informed by learning from other organistaions re reducing C Diff -ie prescribing and cleaning policies etc 2nd request made to Trust Supervision of junior doctors re IP practices/ skills/ training HcC / DoH self assessment tool against Hygiene Code HCC-DH Self Assessment Hygiene Code Screening Policy in Trust implemented Screening Programme in Community Review MRSA cases for potential allocation to other Acute Trusts. PR Campaign Temporary Practice Development Nurses x 3 in clinical areas to monitor practice and invasive devices. Action plan in place for Hygiene Code to be monitored by IPCC quarterly - ongoing Action plan for HABs and DRHABs developed Action Plan for C-Difficile to be implemented - plan developed and implementation commenced	CQC Visit report HPA quarterly report of MESS data. Current YTD performance MRSA rates currently on trajectory. 2008/2009 Performance - 18 against allowance of 15 Achieved DoH target -> 15 in year 2007/08. Won showcase hospital status for DoH rapid review panel implementation HSJ Awards x2 - November 2007 Best annual performance YTD ever Record of >500 days without MRSA Daily Desktop dashboard Over 600 days without MRSA bacteraemias National (BJN) International (Oxford) awards for I.P. 2007 DoH recognition of performance Reduction in HCAIs other than MRSA bacteremia.	PCR testing is likely to increase the numbers of C-Diff due to more accurate testing (sensitivity). MSSA bacteremias C-Diff cases increasing	Monitor the increase in C-Diff post PCR testing and discuss with commissioners - ongoing Post TCS implementation plan led by new Deputy Director of Nursing and Midwifery - ongoing	C4 AMBER	May-11	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; Outcom 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?
				Appointed p/t Microbiologist Vacancies in IPT filled and seconded staff in post. Increased PAs appointed in Microbiology. IPT workload refocused to Divisional Action Plans. Hand Hygiene 'police'. 5 CEO led awareness sessions.					

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; Outcom
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Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Chief Operating Officer	1320	Results of diagnostic tests may not be seen by Doctor.	B5 RED	New PACS system implemented on 7th February 2011 All Consultant Radiologists informed that when critical or unexpected findings are identified the Consultant responsible for the patient should be informed, where they are not available the on-call Cons for the specialty should be contacted, in the unlikely event of both being unavailable, the on-call physician or surgeon should be contacted Testing is still ongoing based on feedback and changes requested by Clinicians Images assessed by referrers; referrer evaluation form completed if Radiologist report required. Business Plan to recruit 2 new Radiographer posts agreed TMT June 2009. The Trust has a policy that referring clinicians should review diagnostic results and enter their evaluation into medical record.	Referrer evaluation system Consultant alert system and review of images Recruit to approved additional Radiographer posts. Two appointed. Further interviews January 2011.	Audits have shown that referring clinicians do not always record their evaluation in the medical records. Incident reports, complaints, claims	Development of protocol clarifying referrer responsibilities in relation to requested reports - now developed, to be rolled out by 30/04/11 Implement the audit trail function within PACS system	Apr-11 Jun-11	D2 GREEN	May-11	Yes
Director of Estates Development	2414	Failure to obtain approval of the Business Case for the Pathology project	C4 AMBER	Capital Review Group meetings, Executive meetings and Trust Board Project team meetings Project programme	SHA approval for OBC received		Submit full Business Case	Jan-11	E4 AMBER	May-11	

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; Outcom
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Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?		Risk after actions	Date Last Reviewed	TB Accept Risk?
Director of Nursing & Midwifery	2448	Failure to have effective systems in place for patients with learning disabilities or requiring application of Mental Capacity Act.	C4 AMBER	Training programme Annual plan Policy Review with PCT arrangements to add in Sept 2010 timescale	Reduction in complaints	% staff trained in MCA / LD Internal audit report	Patient identification system of learning disability patients - still waiting agreement from GP's - ongoing and outstanding Review MCA guidance with PCT	 Apr-11	D3 YELLOW	May-11	
Director of Finance & Information	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.	Outcome of Due Diligence exercise		Awaiting guidance on clarity of asset transfer in the opearing framework on 15th December. Capacity idenitified to work on the estate post 15th December. Negotiate with the PCT on the transfer		C3 AMBER	May-11	
Trust Objective:		**To be the employer of choice.**									
Chief Operating Officer	1713	Failure to effectively maximise workforce productivity.	B3 AMBER	Performance targets including pay costs v clinical income. Medical staffing review	Reduction in Agency costs. Performance management system, quarterly reviews of Divisions and monthly reports to Trust Board.	Internal Audit Report High agency costs. Inconsistency of application of approach. Capacity failing to meet demand.	Implementation of monitoring procedure to ensure consistency of approach across Divisions Review the guidance on Consultant Job Planning/Appraisal Framework Spot audit of existing Job Plans. Action Plan to address the issues. Initiate the Medical Staffing Review.	Sep-11 Jul-11 Mar-11 Jun-11 Mar-11	C2 YELLOW	May-11	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; Outcom
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	1742	Failure to learn from staff survey.	B3 AMBER	Indicators in staff survey covered by Trust policies (eg appraisal, harassment and bullying, etc). Staff Governors in constitution Action plan to learn from past survey constructed 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. Staff survey results presented at Trust Board, TMT and senior managers briefings.	Standard agenda item for review at Trust Performance Reviews. Divisional reports to the HR Sub and TMT. 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.	Results received from 2010 staff survey; response rate was (328 staff) 39% (in the lowest 20% of Acute Trusts) compared with 49% in 2009. Feedback from Managers requesting more specific Specialty breakdown.	Proposed Action Plan reviewed and developed for consultation of future Chat Back Sessions Aligning staff engagement work with patient safety agenda Results will be fed to Divisions and action plans drawn up at a Divisional level. Results from 2010 survey will be presented at TMT, Trust Board, HR Sub Committe and Senior Managers Briefing	Apr-11 Sep-11 Jun-11	D3 YELLOW	May-11	Yes
Trust Objective:		**To achieve a balance between demand & capacity of services**									
Chief Operating Officer	1714	Failure of other agencies to support discharge process.	B3 AMBER	Internal Audit Project to commence October 2010 Weekly discharge meeting. Daily bed state shows current position Annual 'Reimbursement funds' agreement Action Plan to implement workshop outcomes PCT Supporting Project Manager Health Economy Winter Plan ECG Meeting	Show reduced delayed discharges Weekly delayed discharge report		Action Plan from RSM Tenon audit Single Emergency Portal Project underway. 1st phase concentrating on pathway modelling A&E and EAU - ongoing LEAN Project Managing Complex Discharges - ongoing		D2 GREEN	May-11	Yes

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	2492	Failure to ensure that inpatient, outpatient, day case and theatre capacity meets demand.	C4 AMBER	Cancer Action Plan in place and monitored. Now within trajectory - continue to monitor thrice weekly. Monthly monitoring of increased demand in relation to GP/Dental referrals and in particular those outside Wolverhampton. Monthly monitoring of increased demand from outside Wolverhampton for Stroke and Cancer Services Annual delivery plans developed based on contracted activity and agreed targets for waiting times and quality indicators. Monitoring of access targets, activity, waiting times and other quality indicators on a weekly and monthly basis Winter plan in place which includes access to flexible capacity Working with primary care and other agencies to improve timeliness of discharge Implementation of the Productive Series Programme to ensure efficient and effective wards and departments Work with external consultants on service changes to improve outpatient utilisation, theatre utilisation and increase day case rates	Cancer targets achieved - continue to monitor closely and report to TMT and Trust Board in performance report. Quarterly assessment, risk rating and remedial action identified by Exec Director lead for all business outcomes in the annual plan Evidence that performance is discussed at weekly COO meeting with agreed actions to rectify underperformance Performance reports to TMT and Trust Board monitors performance against plan Reports to SHA and other agencies Daily meetings to support effective management of capacity Evidence of RCAs on cancelled operations	Slippage in performance cancer targets. Some KPIs above target i.e. cancelled operations, delayed discharges. Slippage in performance of cancer targets.	Utilise the findings of the Capacity to deliver bed reductions/CIP plans. Delivery of the Business Case of the single emergency portal project	Sep-11 Jul-11	D3 YELLOW	May-11	

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; Outcom
8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

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				Capacity management team in place to facilitate timely admissions and discharges.							
Chief Operating Officer	2509	Failure to have an effective management governance process and systems in place for the vertical integration of Wolverhampton primary care provider services.	C4 AMBER	Business Continuity Plan drawn up. Further items being added BTA signed off 31 March 2011. First Phase of TCS complete. Engagement in the TCS Programme Board. Project Managers for all 3 organisations, RWHT, Wolverhampton City Primary Care & Sandwell Mental Health & Social Care FT appointed. Executive sponsors identified from each of the Organisations involved for Trust CEO has been named as the Programme link with the PCT. HR Strategy & TUPE process - now complete and Organisational Development Strategy	Post Transaction Implementation Integration Plan. Timelines for process implementation of TCS developed. Transaction Board Progress Report to TMT. Progress reports monitored at TCS Board.	Through the risk/issue log as part of the Trust Transaction Board update.	Develop an Annual Plan with KPIs Performance management arrangements in place for both organisations Harmonise policies Maintain relationship with WCPCT - ongoing	May-11 Apr-11 Jul-11	C2 YELLOW	May-11	

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; Outcom 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

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Trust Objective:	**To progressively improve the image and perception of the Trust**										
Chief Operating Officer	5.4, 5.5 1716	Failure to achieve targets in accordance with the operating framework (waiting times, HCC, S4BH etc.) undermining continuous improvement in quality. leading to lack of confidence in our ability to deliver services.	C4 AMBER	Review of national targets in a prospective manner. KPI's introduced for data collection and recording. Performance Management enhanced Escalation policy regarding A&E. Directoate activity trajectories and capacity plans. Targets monitored weekly where possible, otherwise monthly or (some) quarterly. COO Report weekly/monthly Cancer Network engaged in definition and breach analysis Review of definitions of Cancer Systems Vs 18 weeks. Weekly review of Cancer Waiting Time in a prospective manner.	Cancer targets achieved and maintained. Continue to monitor daily and escalate as appropriate. TAL now resolved, performance notice lifted. Continue monitoring daily. Earning warning of potential to fail Ratings Sustained performance On an ongoing basis and daily monitoring of hot spot areas	Slippage in performance - Cancer targets	Review annual plan and performance report to ensure that all compliance aspects are covered. Targets monitored and managed weekly where possible, otherwise monthly or (some) quarterly	May-11	D3 YELLOW	May-11	Yes
Trust Objective:	**Deliver services within financial allocations**										
Director of Finance & Information	514	Failure to deliver recurrent efficiency gains and CIPs.	A4 RED	Monthly reporting against projects including to Trust Board Cost Improvement Program Board (Executive Director led) Each project has an executive director lead	Trust Board Reports & Minutes include CIPs	Finance report to Trust Board. Deloitte HDD report	Monitor closely through CIP programme board Identify 'new' projects and programmes in advance - ongoing		C3 AMBER	May-11	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; Outcom 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

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Director of Finance & Information	1739	Failure to develop Service Line Reporting across the Trust.	B4 RED	SLR reports to be distributed on a monthly basis. SLR pilots to be set up. 2011/12 plan to be agreed and monitored against. Rollout plan to be proposed.			Briefing to Board	Dec-10	C3 AMBER	May-11	Yes
Director of Finance & Information	2468	That pay, price rises and cost pressures will be higher than assumptions.	B3 AMBER	2011/12 plan includes cost pressures; VAT and pay awards. 2011/12 financial plan has modelled impact of pay and non pay pressures.			Monitor budgetary position closely through operational finance group/TMT and Trust Board		C2 YELLOW	May-11	
Director of Finance & Information	2571	Failure to receive sufficient cash with the WCPCT transfer of Provider Services by April 2011.	C4 AMBER	Negotiation with WCPCT for financial support/allocation.	Outcome of Due Diligence exercise		No cash transfer to be made. Principle to be agreed that all liabilities pre 31 March 11 funded by PCT.	Mar-11	C2 YELLOW	May-11	

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; Outcom 8 Cleanliness and Infection control; Outcome 12 Requirements relating to workers; Outcome 16 Assessing and monitoring the quality of service provision;

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Trust Objective:		**To be a high quality educator**									
Medical Director	2572	Unable to implement the DoH e-learning tool for Information Governance Mandatory Training fully, failing to achieve 95% compliance for all staff. Scoring a level 1 on any IGToolkit requirement means the Trust will receive a red unsatisfactory rating.	A4 RED	IG training will change from being once only required to annual requirement in Trust policy from 2010. The IG training tool is being replaced on the local education website as being to only method of e-learning for IG. The IG training tool materials are being used on the mandatory training day for new starters from October 2010. Training using the IG tool is being actively promoted via KITE, AUB, Governance Forum and Senior Mangers briefing.		TCS staff need to be trained. Numbers to train will go up. Overall % will go down.	Regular communication to go out on IGTT compliance. Managers are performance managed on their department's attainment and compliance by the Divisional management team. Over time the compliance of IG training via the toolkit will rise in percentage terms of the total IG training achieved. Information Governance E-learning module will be available within OLM from Dec 2010. OLM is being rolled out as a project to transform training, and IG will be incorporated.	Jun-11 Mar-11 Mar-11	B3 AMBER	May-11	

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; Outcom
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