The Royal Wolverhampton Hospitals NHS Trust

Trust Board Report

Meeting Date:	27th June 2011
Title:	Board Assurance Framework / Trust Risk Register
Executive Summary:	
Action Requested:	To inform the Board of updates to the Board Assurance Framework (AF) and Trust Risk Register.
Report of:	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

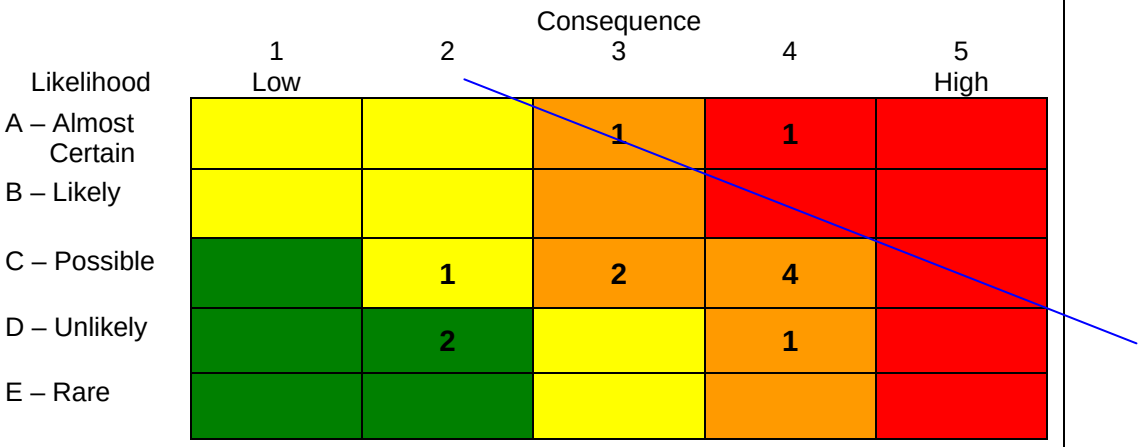
The Board Assurance Framework "provides organisations with a simple but comprehensive method for the effective and focused management of the principal risks that arise in meeting their objectives. It also provides a structure for the evidence to support the Statement on Internal Control" (Integrated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

Board Assurance Framework – Updates (Appendix A)

Following updates the split of the Assurance Framework is:

Risks currently being managed (ongoing)	9
Risks managed to target level	3

There are currently 12 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:

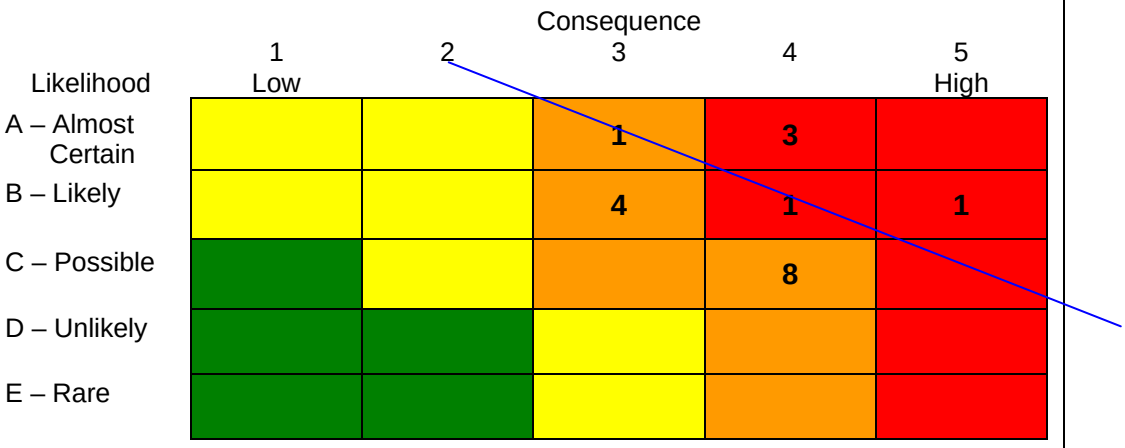
	ID	Risk Title	Lead
RED	2464	Effect of national debt	FD

Trust Risk Register – Updates (Appendix B)

Following updates the split of the Trust Risk Register is:

Risks currently being managed (ongoing)	18
Risks managed to target level	0

There are currently 18 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
	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
	2720	Loss related to best practice tariff for haemodialysis	COO

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 (June 2011).

Lead Director	Risk	Risk Title	Update	Reasoning / Progress Against Actions
Director of Nursing and Midwifery	1717	Failure to achieve re-registration by the CQC periodic review.	Positive controls and Action Plan updated.	Undertake quarterly Divisional Reviews – ongoing. Participation in PCT ked projects to improve discharge. C-Diff – new initiative complete and ongoing. Services Improvement initiative – bed capacity meets demand – modelling implementation commenced.
	2449	Inadequate and ineffective systems to Safeguard Vulnerable adults.	Action Plan updated.	Review of safeguarding policy to reflect post TCS and strengthen controls.
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.	Action plan updated.	Produce Quarterly Market Share analysis report.
	2699	Integration with PCT	Gaps in Assurance and Action plan updated.	Development of a combined performance assurance framework for RWHT and WCPCT provider services. To be developed – KPIs and benefits realisation monitoring tool
	2731	Heatwave planning	*****New risk*****	

Appendix B: Tracking changes within Trust Risk Register (June 2011).

Lead Director	Risk	Risk Title	Update	Reasoning / Progress Against Actions
Chief Operating Officer	1320	Non Reporting of Plain Film Examinations	Action plan updated	Protocol developed clarifying referrer responsibilities in relation to requested reports.
	1713	Failure to effectively maximise workforce productivity.	Action plan updated	~~Spot audit of existing Job Plans.~~ ~~Initiate the Medical Staffing Review~~
	1716	Failure to achieve targets in accordance with the operating framework (waiting times, HCC, S4BH etc.).	Positive controls, positive assurance, Gaps in Assurance and Action plan updated.	A&E targets monitored daily and reported to TMT & Trust Board monthly. A&E targets achieved Two A&E KPIs are above target ~~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 - ongoing A&E KPIs monitored daily. Working group set up to ensure all compliance aspects are covered.
	2720	Financial risk - loss related to best practice tariff for haemodialysis	*****New risk*****	PAS Admissions are often updated on to PAS retrospectively - 13% of admissions Jul-Oct 2010 where entered more than 24hours after the admission actually happened - this will have a significant impact on systems such as eDischarge and ePrescribing and should be done real-

				time to ensure patient Safety (wristband).
Director of Nursing	2448	Failure to have effective systems in place for patients with learning disabilities or requiring application of Mental Capacity Act.	Gaps in Assurance and Action Plan updated.	Safeguarding referrals. Review MCA guidance with PCT – in progress.
Director of Human Resources	1742	Failure to learn from staff survey.	Positive controls	Divisional/Directorate Staff Survey reports discussed at HR subgroup and distributed to Divisional and Directorate managers and matrons and Divisional / Directorate action plans developed. KPI in annual plan. Proposed Action Plan reviewed and developed for consultation of future Chat Back Sessions - Roll out chatback July 2011. Analysis to be carried out during 2011 (pre next survey) to identify ways of incentivising staff to complete survey. To be discussed at Hr Sub and JNC.
Director of Finance	2719	Timeliness of PAS Admission	***New risk***	PAS Admissions are often updated on to PAS retrospectively - 13% of admissions Jul-Oct 2010 where entered more than 24hours after the admission actually happened - this will have a significant impact on systems such as eDischarge and ePrescribing and should be done real-time to ensure patient Safety (wristband). 2011/12 plan includes cost pressures; VAT and pay awards.

The Royal Wolverhamtpon Hospitals NHS Trust

Board Assurance Framework

June-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/Control	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	O7 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 increased Complaints	Review of complaint policy to cover safeguarding adult process. CQC action plan. CQC Action Plan. Review of safegurading policy to reflect post TCS and strengthen controls.	Sep-11 Aug-11	D3 YELLOW	Jun-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	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 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)		QSC and BAC to review bimonthly action progress for Francis report - ongoing	E2 GREEN	Jun-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 Planning and Contracting	O6 2731	* Harm to vulnerable patients during a heatwave. A heatwave will affect the high risk groups i.e. older age individuals, individuals suffering from chronic and severe illness and such patients on chemotherapy with dehydration problems. * Staff shortages to support service delivery during a heatwave if it lasts more than a few days. * Laboratories, pharmaceutical storage and food storage areas may be adversely affected by increasing temperatures during heatwaves. * IT servers overheating and disruption to e-mail communications may occur during heatwaves which will affect service / business delivery. *Date of next review 1/6/2012*	C4 AMBER				Implementation of the Heatwave plan during 1st June -15th September to give assurance that the actions within the plan are complied with. Ensure the enactment of business continuity plans.	Sep-11	C2 YELLOW	Jun-11	
Trust Objective:		**To achieve a balance between demand & capacity of services**									
Director of Planning and Contracting	O6 2699	Not realising the benefits with the integration of the two organisations. Impact of movement to GP Consortia Commissioning - included in Risk 2508.	C4 AMBER	Development of a Benefits Realisation Plan. Action Plan. Benefits Realisation Sub Group established. TCS Steering Committee being set up. Exec lead identified			Development of a combined performance assurance framework for RWHT and WCPCT provider services To be developed - KPIs and benefits realisation monitoring tool Development of a combined performance assurance framework for RWHT and WCPCT provider services. To be developed - KPIs progress reports. Action Plan.	Sep-11 Aug-11	D3 YELLOW	Jun-11	

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	O16 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. Need to make clearer links between activity and expenditure.	Month 5/6 information to be distributed before December 24. Continue to develop relationships between activity and key expenditure variables	Dec-10	C2 YELLOW	Jun-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	Jun-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	O16 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	Jun-11	
Chief Operating Officer	O6 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	Jun-11	

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Director	Cross Ref	What is the Risk?	Level of Risk	How are we managing the risk?	Evidence that it is working.	Any Evidence that it is not working.	What else can we do?	Risk after actions	Date Last Reviewed	TB Accept Risk?
Trust Objective:		**To achieve Foundation Trust status**								
Chief Executive Officer	O16 1501	The Trust does not meet the DH / Monitor requirements to become a foundation trust. 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		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	Jun-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	O1 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	Jun-11	Yes
Trust Objective:	**To be in the national NHS top quartile of benchmarks**										
Director of Nursing & Midwifery	O16 1717	Failure to achieve re-registration by the CQC periodic review.	C2 YELLOW	Undertake quarterly Divisional Reviews Participation in PCT led projects to improve discharge. 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 on target due to PCR testing DNA & New to Review rates above target. Delays in Transfer of Care above internal target periodically. Length of Stay is above target	Undertake 4 service reviews during 2010/11 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 - modelling implementation commenced Service Improvement initiatives - Productive Theatre - ongoing	Mar-11 Jul-11 Aug-11	C2 YELLOW	Jun-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	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	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		Produce Quarterly Market Share analysis report 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	Jul-11	D2 GREEN	Jun-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
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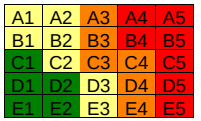
The Royal Wolverhamtpon Hospitals NHS Trust

Trust Risk Register

June-2011



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; Outcom
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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	O8 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 has increased the numbers of C-Diff due to more accurate testing (sensitivity).	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	Jun-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	O4 1320	There is no Trust process for the routine reporting of play X-ray films. The reporting of these films rely on a system of referrer evaluation and request. This has resulted in incidents and complaints.	B5 RED	PACS system implemented. Medical Physiscs inviolved in the new PACS system to ensure compliance with the IR(ME)R 2000 Regulations. 3 radiographers now trained to review chest x-rays. 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 Protocol developed clarifying referrer responsibilities in relation to requested reports Testing is still ongoing based on feedback and changes requested by Clinicians Images assessed by referrers; referrer evaluation form completed if Radiologist report required. NPSA alert local measures implemented across all directorates.	62% of chest x-rays now reported, anticipate reporting will reach 90% by April 11. Monitoring of incidents. Local policy for communication of critical or unexpected findings to reffering doctor. Referrer evaluation system Consultant alert system and review of images Recruit to approved additional Radiographer posts. Two appointed.	40,000 x-rays not viewed in a given year. Approximately a third need reporting on. An IT based 'alert' system is being developed to ensure that consultants are made aware of diagnostic that have not been reviewed. A project group has been established and the IT program is being written. Audits have shown that referring clinicians do not always record their evaluation in the medical records.	Implement programme of training for Radiographers - 2 chest reporters due to complete in September. Abdomen reporting course has been postponed by University due to staffing issues. Develop Chest reporting co-ordinator role to achieve target of reporting of all chest films. Redcruit 3rd Inter. Radiol: 1 plain film report session in job plan - ongoing. Implement the audit trail function within PACS system	Sep-11 Sep-11 Jun-11	D2 GREEN	Jun-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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				The Trust has a policy that referring clinicians should review diagnostic results and enter their evaluation into medical record.							
Director of Estates Development	O16 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	Jun-11	
Director of Nursing & Midwifery	O7 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	Safeguarding referrals % 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 - in progress		D3 YELLOW	Jun-11	
Director of Finance & Information	O6 2570	Inadequate estates as part of the Transfer of Community Services - WCPCT provider Services with effect from 1 April 2011. Legal consequences of a potential estates transfer ie property arrangements in line with White Paper with PCT being abolished by April 2013.	C4 AMBER	Engagement of Solicitor support External Support is being employed to review the condition of the Estates where Services from WCPCT are undertaken.	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	Jun-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 be the employer of choice.**										
Chief Operating Officer	O12 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.	High agency medical 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 Action Plan to address the issues.	Sep-11 Jul-11 Jul-11	C2 YELLOW	Jun-11	Yes
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 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. Staff survey results presented at Trust Board, TMT and senior managers briefings.	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. Turnover below National average and within Trust target.	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.	Analysis to be carried out during 2011 (pre next survey) to identify ways of incentivising staff to complete survey. To be discussed at Hr Sub and JNC. Exploring with survey contract provider options of reporting results at speciality level. Proposed Action Plan reviewed and developed for consultation of future Chat Back Sessions - Roll out chatback July 2011 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 2011 survey will be presented at TMT, Trust Board, HR Sub Committe and Senior Managers Briefing	Aug-11 Sep-11 Jul-11 Sep-11 Jun-12	D3 YELLOW	Jun-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 achieve a balance between demand & capacity of services**									
Chief Operating Officer	O6 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	Jun-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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Chief Operating Officer	O16 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	Some KPIs above target i.e. delayed discharges.	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	Jun-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?
				Capacity management team in place to facilitate timely admissions and discharges.							
Chief Operating Officer	O6 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.		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	Jun-11	
Director of Finance & Information	O19 2719	PAS Admissions are often updated on to PAS retrospectively - 13% of admissions Jul-Oct 2010 where entered more than 24hours after the admission actually happened - this will have a significant impact on systems such as eDischarge and ePrescribing and should be done real-time to ensure patient Safety (wristband).	A3 AMBER				Raise Awareness of issue Set Up initiative to resolve	May-11 May-11	D2 GREEN	Jun-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	O16 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	A&E targets monitored daily and reported tp TMT & Trust Board monthly 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. A&E targets achieved Earning warning of potential to fail Ratings Sustained performance On an ongoing basis and daily monitoring of hot spot areas	Two A&E KPI's are above target	A&E KPI's monitored daily. Working group set up to ensure all compliance aspects are covered. Targets monitored and managed weekly where possible, otherwise monthly or (some) quarterly - ongoing.	D3 YELLOW	Jun-11	Yes
Trust Objective:	**Deliver services within financial allocations**									
Director of Finance & Information	O16 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	Jun-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	O16 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.		Timescales and priorities to be determined when 1st phase report considered. Need to develop better appointment bases for some direct and indirect costs.	Briefing to Board	Dec-10	C3 AMBER	Jun-11	Yes
Director of Finance & Information	O16 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	Jun-11	
Director of Finance & Information	O6 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	Jun-11	
Chief Operating Officer	O16 2720	Loss of best practice tariff monies due to approx 38% of haemodialysis patients dialysing with a line instead of a fistula.	A4 RED	Close liaison with vascular surgeons to accommodate patients for fistula formation. Vascular access coordinator post in place Plan for patients to have working, mature fistula well in advance of haemodialysis commencing. Revision of vascular access pathway 2010, agreed by vascular surgeons early 2011.		A cohort of clinically unsuitable patients will always exist so a loss of income for these patients cannot be avoided. Tariff rules came into place April 11 from which point the directorate's income for haemodialysis is reduced.	Education of all new patients Use of clinical pyschologist Target suitable patients Reduce risk of fistula breakdown	 Sep-11	A3 AMBER	Jun-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?
Trust Objective:	**To be a high quality educator**										
Medical Director	O12 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. The IG training tool materials are being used in induction for new starters from November 2010 - not possible with a 20 minute slot. Paper assessments need to be filled out. New starters must also do mandatory training. Materials included in junior docs and quick induction.	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	Jun-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;