The Royal Wolverhampton Hospitals NHS Trust

Trust Board Report

Meeting Date:	26th September 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

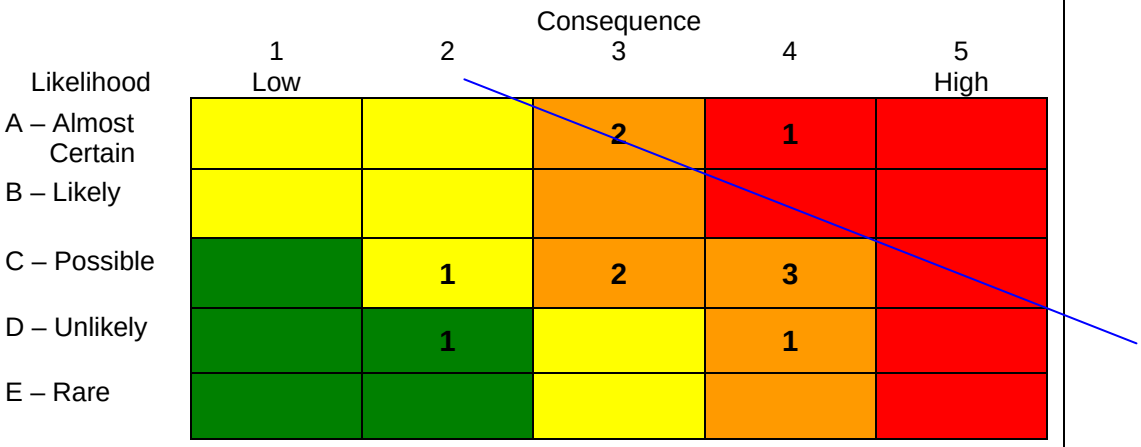
The Board Assurance Framework "provides organisations with a simple but comprehensive method for the effective and focused management of the principal risks that arise in meeting their objectives. It also provides a structure for the evidence to support the Statement on Internal Control" (Integrated 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	2

There are currently 11 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:

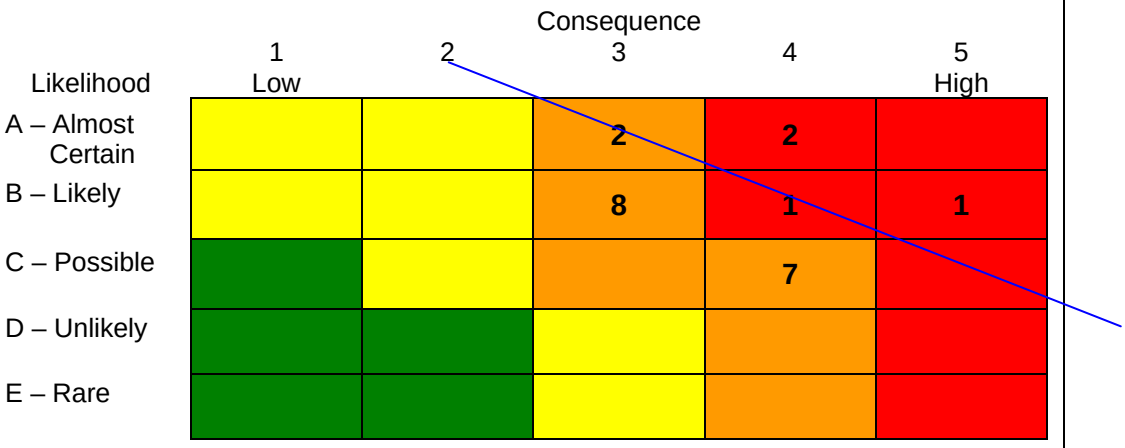
	ID	Risk Title	Lead
RED	2765	Capacity Issues - Health Visiting Service (Bilston)	COO

Trust Risk Register – Updates (Appendix B)

Following updates the split of the Trust Risk Register is:

Risks currently being managed (ongoing)	21
Risks managed to target level	0

There are currently 21 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
	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 (September 2011).

Lead Director	Risk	Risk Title	Update	Reasoning / Progress Against Actions
Director of Nursing and Midwifery	1717	Failure to achieve re-registration by CQC periodic review	Positive controls, positive assurances and action plan updated.	Staff awareness campaign started: e.g. leaflets, totem poles and desktop. CQC Reports – privacy, dignity and nutrition – responsive review. Action plans for CQC report Workforce review Develop Trust audit to test outcome compliance. Internal audit project to be undertaken
	2449	Inadequate and ineffective systems to Safeguard Vulnerable adults.	Positive controls and Action Plan updated.	Rapid Improvement project Falls. Introduced Discharge / transfer checklist for each patient - signed off by RN. Increase senior clinical nursing presence to supervise care. Band 7 presence out of hours. Rapid improvement projects for Falls and Tissue Viability. Decrease in safeguarding referrals since June / July 2011
	2482	Failure to learn from national / local organisations experience e.g. Francis report	Positive controls and action plan updated.	No red actions on plan outstanding. 3 recommendations closed. CQC action plans: - nutrition and dignity - Responsive review to Trust Board.
Director of Finance	1737	Inadequate activity and financial reporting leading to inappropriate decisions	***Risk closed***	All actions completed.
	2451	Imposed reduction in Capital Funding as a result of National Policy/Spending Cuts.	***Risk closed***	Closed as CRL now confirmed.
	2464	Effect of national debt.	***Risk closed***	Closed as contracts now agreed.
	2807	Delivery of the CRL for 2011/12 Capital Programme	***New risk***	Failure to deliver the agreed Capital Resource Limit (CRL) for 2011/12 Capital Programme due to delay in start on site date for Pathology Project.
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.	Positive controls updated.	Review DoH Any Qualified Provider proposals.
	2508	Commissioning responsibility changes - affects contracted income	**Transferred from COO's BAF** and Action Plan updated	Target GP Consortia as they develop and develop links with Clusters. Director level engagement with the PCT - meeting arranged for Sept 2011.
	2699	Integration with PCT	Positive controls and action plan updated.	Re-launch of process to generate ideas and capture work in progress Align process to that for CIP and other service redesign programmes to make the

				system easy to navigate Share success, ideas and tools through a microsite on the intranet
	2731	Heatwave planning	Positive assurance updated.	All actions are in place in readiness for a heatwave – heatwave period ends 15 Sept 2011. Regular weather reporting across the Trust has taken place since June 2011.

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

Lead Director	Risk	Risk Title	Update	Reasoning / Progress Against Actions
Chief Operating Officer	1714	Failure of other agencies to support discharge process.	Action Plan updated.	Integrated patient flow team through Reablement funding. Training and awareness sessions on services within Community Services.
	1716	Failure to achieve targets in accordance with the operating framework (waiting times, HCC, S4BH etc.).	Gaps in Assurance and action plan updated. Current grade changed from C4 Amber to B3 Amber.	Three A&E KPIs are above target. Excessive breaches in A&E standards. Review escalation process. Review staffing patterns in relation to peak time of activity.
	2492	Failure to ensure that inpatient, outpatient, day case and theatre capacity meets demand.	Action plan updated	Currently reviewing Length of Stay by HRG.
	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.	Develop full Performance Management Framework around the TCS integration projects and produce monthly updates.
	2761	Lack of LSMS support for TCS transferred community services	Action plan updated.	Implement permanent solution to provide professional support.
Medical Director	2572	Information Governance training risk	Gaps in Assurance updated. Downgraded to **A3 Amber**.	No clarification from IG Policy team at DoH on whether staff who completed training between April-June 2011 count for the financial year 11/12 .
Director of Finance	1739	Failure to develop Service Line Reporting across the Trust.	Action Plan updated. Residual Risk rating now D3 Yellow.	Briefing to Board took place in May 2011. Monthly figures now produced within 3 weeks of month end. Contribution targets to be set in August.
	2414	Failure to obtain approval of the Business Case for the Pathology project	Action Plan updated. Residual Risk rating now C4 Amber.	Business case submitted to SHA in June 2011. Ongoing negotiations with SHA's provider colleagues taking place.
	2570	Inadequate estates as part of the Transfer of Community Services.	Action Plan updated.	Site by site analysis underway as to condition of property occupied. Detailed individual / lease negotiations to take place Sept to Dec 2011 with legal support.
	2571	Failure to receive sufficient cash with the WCPCT transfer of Provider Services	***Risk closed***	No longer an issue.

		by April 2011.		
	2719	Timeliness of PAS Admission	Action Plan updated. Residual risk rating now B3 Amber.	Awareness has been raised. Detailed plan to resolve being formulated.
	2781	Contractual risks	***New risk***	Contractual risks due to tariff changes for emergency threshold.
	2782	Capital Resource Limit	***New risk***	Capital Resource limit achievement at risk.
Director of HR	1693	Equal Pay Claims - potential significant cost to the Trust	Upgraded to C4 Amber – moved from Directorate RR to Trust RR	
	1742	Failure to learn from staff survey.	Positive controls, positive assurances and action plans updated	ChatBack was completed in July/August 2011. Process underway to cascade results and to develop actions plans. This will enable us to monitor progress against key metrics from staff survey. ChatBack 2011 results show improvement in most areas. Closed action – exploring with survey contract provider options of reporting results at speciality level.
Director of Nursing and Midwifery	535	Infection Control	Positive controls updated.	Recruited new lead IPN.
	2448	Failure to have effective systems in place for patients with learning disabilities or requiring application of Mental Capacity Act.	Positive controls updated and action plan updated.	Training and implementation plan. Reviewed MCA guidance with PCT.

The Royal Wolverhampton Hospitals NHS Trust

Board Assurance Framework

September-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										

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 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 Introduced Discharge / transfer checklist for each patient - signed off by RN. Increased senior clinical nursing presence to supervise care. Rapid Improvement project Falls. 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 Ofsted report CQC report Decrease in safeguarding referrals since June / July 2011 Safeguarding database population	Internal audit review CQC Report Safeguarding referrals to local authority increased (summer 2011) Complaints	Review of complaint policy to cover safeguarding adult process. CQC action plan. Band 7 presence out of hours Rapid improvement projects for Tissue Viability Review of safegurading policy to reflect post TCS and strengthen controls to TMT Sept 11.	Oct-11 Oct-11 Dec-11 Sep-11	D3 YELLOW	Sep-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 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. No red actions on plan outstanding. 3 recommendations closed. 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)		CQC action plans: - nutrition and dignity - Responsive review to Trust Board QSC and BAC to review bimonthly action progress for Francis report - ongoing	Sep-11	E2 GREEN	Sep-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 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	Heatwave Plan update for 2011 including Community service provision. SHA monitoring implemented. Action plan in place with key lead identified for implementation in the event of a heatwave. Plans reviewed during level 2 notification to ensure robustness.	SHA Monitoring sheet for Level 2 enacted (26 June 2011). SHA Assurance template submitted 1 July 2011. All actions are in place in readiness for a heatwave - heatwave period ends 15 Sept 2011. Regular weather reporting across the Trust has taken place since June 2011.		Implementation of the Heatwave plan during 1st June -15th September to give assurance that the actions within the plan are complied with - now implemented Ensure the enactment of business continuity plans in the event of a heatwave occurring.	Sep-11	C2 YELLOW	Sep-11	Yes
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 established. Report to Trust Board in Jul 2011 to update on progress and outline projects. 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 Re-launch of process to generate ideas and capture work in progress Align process to that for CIP and other service redesign programmes to make the system easy to navigate Share success, ideas and tools through a microsite on the intranet	Sep-11 Aug-11	D3 YELLOW	Sep-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?
Chief Operating Officer	O16 2765	High levels of sickness and maternity leave affecting Health Visiting capacity within Bilston team.	A4 RED	Health Visitor on phased return to work will manage in coming post and assess records as capacity allows prior to transferring to school health. Accommodate teams within local Children's Centres Review & reconfiguration of caseloads to support vulnerable families. Phased return to work for 3wte planned 0.7wte interim support identified from other location Non- essential visits postponed IPM or Digital pens data to be inputted within 5 working days. Identify any outstanding training. Group supervision may be beneficial to team in addition to 1-1 supervision. Move from corporate caseloads into identified named caseloads. All children transferring into the area to be reviewed and actioned. All primaries will be managed city wide on a Rota basis. Health Visitor making primary contact will remain responsible for the child for 6-8 weeks.	Daily attendance with direct supervision and support from senior health visiting co-ordinator. The co-ordinator will make daily checks against the actions within the interim work plan and ensure that the named health visitors are fulfilling their responsibilities. Health visiting co-ordinators to escalate any concerns to the Children's senior management team. Weekly meeting between health visiting co-ordinator and Children's management team in place to monitor and assure. Interim work plan has been developed and agreed inclusively with the Bilston Health Visiting team.	Routine and universal work for this team is being supported city wide using the vacant caseload policy.	Interim work plan under regular review and will be extended until medium term plan is enacted. Establish additional 5 wte Health Visitors across the teams thus further reducing the risks within the Bilston Health Visitor team To continue to manage return to work processes aligned to the presentation of this risk.	Sep-11 Sep-11 Sep-11	C2 YELLOW	Sep-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?
				Due to continued capacity issues development checks will be managed as indicated on vacant caseload policy. Nursery Nurse will offer support to the team on Friday's to complete development checks. Resident Health visitors to manage their own and vacant caseload child protection and safeguarding children All general clinics being managed by additional Health Visitors from neighbouring team due to further short term sickness absence						
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.	C3 AMBER	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 Trend continues with considerably more positive (plus neutral) coverage than negative. 71% positive and neutral and 29% negative coverage 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	Sep-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:	**Deliver services within financial allocations**										
Director of Planning and Contracting	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.		Director level engagement with the PCT - meeting arranged for Sept 2011 Target GP Consortia as they develop and develop links with Clusters. Review current and future contract Portfolios. Include potentially new configured Trust services in all assessment/reviews. Revise Communication Strategy to reflect commissioning changes.	Sep-11	B2 YELLOW	Sep-11	Yes
Director of Finance & Information	2807	Failure to deliver the agreed Capital Resource Limit (CRL) for 2011/12 Capital Programme due to delay in start on site date for Pathology Project.	A3 AMBER		Capital Review Group	SHA approval to reduction/under-achievement in CRL	CRG and Trust Board approval for revised Capital Programme Seek agreement to reduction/under-achievement of the CRL with SHA Revise CRL Revise cash flow Inform Divisions of any released funds for 2012/13 bring-forward projects	Sep-11 Sep-11 Oct-11 Oct-11 Oct-11	D1 GREEN	Sep-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	O16 1501	The Trust does not meet the DH / Monitor requirements to become a foundation trust.	C3 AMBER	Continue to work with CQC and other bodies to understand the Trust's mortality figures 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 board memorandum / self certification process Review of Monitor's Compliance Framework against Trust performance report	Trust Management Team and Trust Board monthly update Completed HDD Membership recruitment above trajectory Delivery of Action Plan Milestones	Trust currently exceeds Monitor threshold for authorisation.	Board Development Sessions Action Learning From SHA FT Network Undertake further review of mortality outlier alerts Complete actions as identified in plans submitted to CQC in response to Responsive Review/ DANI review 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	C3 AMBER	Sep-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;

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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. Staff awareness campaign started: e.g. leaflets, totem poles and desktop 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 CQC Reports - Privacy, Dignity and Nutrition - Responsive Review DNA & New to Review rates above target. Delays in Transfer of Care above internal target periodically. Length of Stay is above target	Action Plans for CQC report - ongoing Workforce review Develop Trust audit to test outcome compliance Internal audit project to be undertaken 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	Nov-11 Oct-11 Mar-11 Aug-11	C2 YELLOW	Sep-11	Yes
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 Review DoH Any Qualified Provider proposals.	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	Sep-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 Wolverhampton Hospitals NHS Trust

Trust Risk Register

September-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

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Trust Objective: **To provide our patients & staff with a safe environment.**

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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	Medical Physics involved in the new PACS system to ensure compliance with the IR(ME)R 2000 Regulations. 3 radiographers now trained to review chest x-rays. Implement the audit trail function within PACS system - function is now active within PACS Redcruit 3rd Inter. Radiol: 1 plain film report session in job plan - Musculoskeletal radiologist now appionted 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.	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.	Radiographer posts have been filled from 1st August and all GP, A&E and appropriate outpatient films will be reported by 1st August. All appropriate inpatients will be reported by the end of September 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.	Sep-11 Sep-11 Sep-11	D2 GREEN	Sep-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?
				NPSA alert local measures implemented across all directorates. The Trust has a policy that referring clinicians should review diagnostic results and enter their evaluation into medical record.							
Director of Finance & Information	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		Business case submitted to SHA in June 2011. Ongoing negotiations with SHA's provider colleagues taking place.	Aug-11	C4 AMBER	Sep-11	Yes
Director of Finance & Information	O6 2570	Inadequate estates as part of the Transfer of Community Services - WCPCT provider Services with effect from 1 April 2011. Legal consequences of a potential estates transfer ie property arrangements in line with White Paper with PCT being abolished by April 2013.	C4 AMBER	Engagement of Solicitor support External Support is being employed to review the condition of the Estates where Services from WCPCT are undertaken.	Outcome of Due Diligence exercise		Site by site analysis underway as to condition of property occupied. Detailed individual / lease negotiations to take place Sept to Dec 2011 with legal support.	Dec-11	C3 AMBER	Sep-11	Yes
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 Reviewed MCA guidance with PCT 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	Division developing Business Case to make substantive post for L.D Nurse Training and implementation plan Patient identification system of learning disability patients - agreement from GP's - implementation plan being developed	Sep-11 Oct-11 Mar-12	D3 YELLOW	Sep-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 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. Recruited new Lead IPN 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	Sep-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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				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. Circulate letter regarding PCR testing from SHA Cross reference old vs new testing on sample						
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 Sep-11 Sep-11	C2 YELLOW	Sep-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	O14 1742	Failure to learn from staff survey.	B3 AMBER	Key Indicators in staff survey covered by Trust policies (eg appraisal, harassment and bullying, etc). Staff Governors in constitution have voice to influence direction of Trust Action plan to learn from past survey constructed Staff feedback has been incorporated into the Trust Board quality & safety dashboard thereby aligning staff engagement with patient safety agenda. Chatback was completed in July/August 2011. Process underway to cascade results and to develop action plans. This will enable us to monitor progress against key metrics from staff survey. 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. ChatBack 2011 results show improvement in most areas. 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.	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	Sep-11 Jun-12	D3 YELLOW	Sep-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 Human Resources	1693	Equal Pay Claims - potential significant cost to the Trust	C4 AMBER	Meeting in April to discuss	Regular analysis as part of audit process		Continue work with solicitors Meeting in April for discussion further meeting in September for discussion	D3 YELLOW	Sep-11	
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 Training and awareness sessions on services within Community Services Integrated patient flow team through Reablement funding Single Emergency Portal Project underway. 1st phase concentrating on pathway modelling A&E and EAU - ongoing LEAN Project Managing Complex Discharges - ongoing	D2 GREEN	Sep-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 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.	Currently reviewing Length of Stay by HRG Utilise the findings of the Capacity to deliver bed reductions/CIP plans.	Sep-11	D3 YELLOW	Sep-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?
				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 developed. Revised integrated management arrangements in place Commence harmonisation of policies Interim governance arrangements established to maintain service delivery BTA signed off 31 March 2011. First Phase of TCS completed TCS Integration Committee established. 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 completed. 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 Develop full Performance Management Framework around the TCS integration projects and produce monthly updates Maintain relationship with WCPCT - ongoing	Sep-11 Sep-11 Sep-11	C2 YELLOW	Sep-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	2761	Lack of LSMS support for TCS transferred community services. Lack of Senior Fire Safety Advisor support for TCS transferred community services.	C4 AMBER	Interim arrangement established with PCT to provide professional support Head of Governance and Head of Estates established interim proposal to utilise existing internal resource to reduce risks			All staff safety Datix reported incidents will be reviewed by the Community HG Manager Community Staff will be advised to contact HG Manager or PCT Professional leads if further security /safety advice needed Any reported security or fire incidents relating to community services will be referred back to relevant service manager for action /escalation Continued review of risk assessment Implement permanent solution to provide professional suport	Oct-11	E4 AMBER	Sep-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				Awareness has been raised. Detailed plan to resolve being formulated.	Sep-11	B3 AMBER	Sep-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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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.	B3 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	Four A&E KPI's are above target Excessive breaches in A&E standards	A&E KPI's monitored daily. Working group set up to ensure all compliance aspects are covered. Review staffing patterns in relation to peak time of activity Review escalation process Targets monitored and managed weekly where possible, otherwise monthly or (some) quarterly - ongoing.	D3 YELLOW	Sep-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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Trust Objective:	**Deliver services within financial allocations**										
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. Aug 11 update: now 27% of haemodialysis patients dialysing with a line instead of a fistula. Adverse impact of £374k	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.	For all new patients the pathway of choice is for them to have a Fistula	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	Nov-11 Nov-11 Nov-11 Sep-11	A3 AMBER	Sep-11	Yes
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		B3 AMBER	Sep-11	Yes
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 took place in May 2011. Monthly figures now produced within 3 weeks of month end. Contribution targets to be set in August.	Aug-11	D3 YELLOW	Sep-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 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	Sep-11	Yes
Director of Finance & Information	2781	Contractual risks due to tariff changes for emergency threshold.	B3 AMBER	System in place to alert when issues occur. Reserve set against risk.					C2 YELLOW	Sep-11	
Director of Finance & Information	2782	Capital Resource limit achievement at risk.	B3 AMBER						C2 YELLOW	Sep-11	
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.	A3 AMBER	IG training will change from being once only required to annual requirement in Trust policy OP41 from 2010. National Requirmeent of IGToolkit The IG training tool repleaced training on the KITE local education website Refresher module will be launched 2011/12 financial year. Materials need to be changed and relaunched to ensure staff complete correct training. Training options have been differentialted fo staff needs, E-learning, paper and face to face training avaliable	IG training materials being used in on Mandatory training days, Trust Induction, Junior doctors induction and Quick induction, KITE. Training compliance improved from 54% May 2011 to 98% June 2011 Training Database scrutinise staff training and inform mangers of non compliance TNA for IG training reviewed by IGSG Aug 2011 Training data from PCT regarding TCS staff training compliance recieved June 2011	No resourses for IG or IG training transfered through TCS. No training contingency if 1 IG officer is unavaliable No clarification from IG Policy team at DoH on whether staff who completed training between April-June 2011 count for the financial year 11/12 . Increased training need following TCS and increase in number of Trust staff	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.	Mar-11	B3 AMBER	Sep-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;