St George's Healthcare NHS
NHS Trust

**REPORT TO THE TRUST BOARD: JUNE 2014**

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| **Paper Title:** | **Risk and Compliance Report** |
| **Sponsoring Director:** | **Peter Jenkinson**<br>Director of Corporate Affairs |
| **Author:** | **Sal Maughan**<br>Corporate Risk and Assurance Manager |
| **Purpose:** | To update the Board on compliance related issues/risks and related developments occurring across the Trust and provide assurance about the management of risk. |
| **Action required by the board:** | For information and discussion as required |
| **Document previously considered by:** | N/A |

**Executive summary**

**Key messages**

- The full Board Assurance Framework (BAF) is presented; in total there are nine risks scored at 16 or above and four new risks included on the BAF. There have been no risks closed during the reporting period.
- An overview of the Divisional risk register extreme risks is included in the report
- The action plan developed to address the wider issues identified at the recent CIH inspection is included in the report with current position on progress. This is a dynamic document which continues to be developed and which, in tandem with the actions on-going to address issues of non-compliance, is monitored via the bi-weekly Organisation Management Team meetings. The action plan will also be monitored externally by Wandsworth CCG Clinical Quality Review group on behalf of the NTDA.
- Changes to the CQC intelligent monitoring (IM) process and report are summarised; to date the Trust remains in the lowest risk banding pending the next published IM report which is due in July 2014.

**Recommendation**

The Board is asked to:

- Note the report

**Risks**

*The most significant risks on the Board Assurance Framework are detailed in the report*

## 1. Risks - Board Assurance Framework (BAF):

This report details the highest rated extreme risks on the BAF, new and closed risks during the reporting period and significant changes made following regular review with each Executive owner. Table 1 details the highest rated risks on the BAF. The risk score for one risk has increased. An executive overview can be found at Appendix 1 and full details of each risk is included at Appendix 2:

**Table one: highest rated risks**

| Ref | Description | C | L | Rating |
|---|---|---|---|---|
| A602 | Pressures on internal capacity may result in the Trust being unable to meet demands from activity, negatively affecting quality, throughout the year. | **5** | **4** | **20** |
| 3.2-05 | The Trust does not deliver its cost reduction programme objectives | **5** | **4** | **20** |
| A513 | Failure to achieve the National HCAI targets | **4** | **4** | **16** |
| 02-02 | Risk of diminished quality of patient care as a result of Cost Improvement Programmes (CIPs) | **4** | **4** | **16** |
| 01-06 | Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists | **4** | **4** | **16** |
| A410-02 | Failure to sustain the Trust response rate to complaints | **4** | **4** | **16** |
| 3.3-05 | The Trust faces higher than expected costs | **4** | **4** | **16** |
| 03-01 | Ability to demonstrate compliance with Regulatory Reform (Fire Safety) Order 2005 | **4** | **4** | **16** |
| 03-02 | Failure to demonstrate full Estates compliance | **4** | **4** | **16** |
| 03-03 | Delay to the ability to deliver capital programme and maintenance activity | **4** | **4** | **16** |

**1.1 Summary of risks by Strategic Objective:**

| Domain | | Strategic Objective | Risks |
|---|---|---|---|
| **1.** | **Quality** | 1.1 Patient Safety | 10 |
| | | 1.2 Patient Experience | 2 |
| **2.** | **Finance & Performance** | 2.1 Meet all financial targets | 13 |
| | | 2.2 Meet all operational & performance targets | 2 |
| **3.** | **Regulation & compliance** | 3.1 Maintain compliance with all statutory & regulatory requirements | 7 |
| **4.** | **Strategy, transformation & development** | 4.1 Redesign pathways to keep more people out of hospital | 1 |
| | | 4.2 Redesign & configure our local hospital services to provide higher quality care | 1 |
| | | 4.5 Drive research & innovation through our clinical services | 1 |
| **5.** | **Workforce** | 5.1 Develop a highly skilled & engaged workforce championing our values | 3 |
| | **Total Risks** | | **40** |

### 1.2 Closed Risks

There have been no risks closed during the reporting period.

However, following detailed risk assessments the following risks previously proposed for inclusion on the BAF are now included on the Corporate Directorate risk register to be managed locally and therefore will not be included on the BAF:

- Risk of not achieving the planned Estates and Facilities directorate financial outcomes.
- Risk of legionella infection associated with the three cooling towers (cooling towers are high risk equipment)
- Inadequate electrical back up to Lanesborough Wing

In addition, due to the recovering trajectory the potential risks of failure to meet the 62 day cancer target has not been included but is encompassed with Risk 3.7-06

### 1.3 New Risks

The following new risks have been included on the BAF:

- Emergency Department performance
- Delay to the ability to deliver capital programme and maintenance activity (also encompassing the previously identified lack of decant space to support capital projects)
- Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists

In addition the following risks are currently undergoing a risks assessment:

- Implementation of e-prescribing in June 2014
- Preparation and securing of programmed transition to Cerner (STG) from the national programme
- Planning process for Private Patient Unit and car park

### 1.4 Potential new risks

During the period of review the following potential new risks were highlighted:

- Staffing levels across the Trust (nursing and medical)
- Data quality and availability

Following approval of the corporate annual objectives by Trust Board, the process new risks of delivery against the annual corporate objectives with the BAF are under review. These will be presented, with the BAF in its entirety to the Trust Board in July 2014.

### 1.5 Summary of divisional extreme risks

The Clinical Divisional and Corporate directorate risks registers are included at Appendix 3. The Community Services division currently has no extreme risks.

All divisional risks registers are presented in full to the Organisational Risk Committee (ORC) for review. Further work is underway to develop corporate risks registers to ensure oversight of all risk registers by September 2014.

## 2. Assurance Map

The Trust Assurance Map is a schedule of all external visits, inspections and reporting which captures on-going actions in response to external reviews and those underway to prepare for forthcoming visits. The assurances received from these external inspections help inform the board as to continued compliance with regulatory requirements including Care Quality Commission Essential Standards of Quality and Safety. The following section provides a summary of all external visits and inspections during the reporting period.

### 2.1 Care Quality Commission (CQC)

#### 2.1.1 CQC CIH Inspection February 2014 – Action Plan

The Trust submitted a compliance action plan to the CQC on 31st may following Trust board approval.

In addition a Trust wide action plan to address the wider issues identified at inspection is in place and is included at Appendix 4. The overall actions are monitored via the Organisational Management Meeting (OMT) and externally via the WCCG Clinical Quality Review Group meeting on behalf of the NTDA.

## 2.2 Summary of external assurance and third party inspections May-June 2014

### 2.2.1 MTC Trauma Dashboard

The Trust received its Quarter 4 2013/14 Major Trauma Centre dashboard. No concerns were noted and the report highlighted the Trust's consistent strong performance on delivering consultant led care to patients on arrival in ED.

### 2.2.2 PLACE

In April 2013 PEAT (Patient Environment Action Team) inspections where replaced by PLACE (Patient Led Assessments of the Care Environment). These assessments see local people come in to the hospital as part of teams to assess how the environment supports patients' privacy and dignity, food, cleanliness and general building maintenance. It focuses entirely on the care environment. The Trust was initially assessed in May 2013 and non-conformities were identified, the majority of which have been addressed through a detailed action plan. The Trust has been subject to a further PLACE review in May 2014 and results will be provided in September 2014. These reports will inform a new action plan which will include any outstanding actions from the previous assessment.

## 2.3 Pending Inspections – June 2014

### 2.3.1 G4S – UKAS Quality Management Certification (9001)

The United Kingdom Accreditation Service (UKAS) will be auditing G4S' capacity to deliver patient transport services that conform to nationally recognised standards and the Trust's own policy objectives. This inspection was scheduled to take place in March 2014 but has now been postponed with no further confirmed date for inspection. The G4S Quality Standards Manager has provided assurance that they are well-prepared for this accreditation.

## 2.4 External Assurance - conclusion

The Trust continues to progress with the monitoring and compliance of actions arising out of external inspections.

## 3 Intelligent Monitoring Report

The CQC introduced the intelligent monitoring report in October 2013 to replace the previous monthly Quality Risk Profile reports. As part of these new reports, each NHS Trust is allocated a banding based on the level of risk identified from the CQC's analysis of data. St. Georges was placed in band 6 (the lowest risk band possible) after release of the initial intelligent monitoring report in October 2013. The subsequent report in March 2014 highlighted that previous identified risks had been removed and two new risks were identified. These related to:

- **Never Events** – the CQC intelligent monitoring report identified that, at the end of the data collection period, the Trust had reported two serious incidents defined as Never Events (against a CQC benchmark of 0). The Trust declares and investigates all Never Events in line with national requirements, and the actions and learning from Never Events are also presented to the Quality and Risk Committee. These are also further reviewed and scrutinised by the Commissioners externally via the Clinical Quality Review Group.

- **Potential under reporting of staff health and safety training** – the previous intelligent monitoring report identified that 64% of staff had completed health and safety training (against a CQC benchmark of 75%). The CQC used results obtained from the staff survey to inform this indicator. It is important to note that the staff survey is a sub-set of all Trust staff. Analysis of Trust MAST data showed that 90% of staff had completed health and safety training in the reporting period under review.

The next intelligent monitoring report is due to be published on 24 July 2014 and will be provided to the Trust in draft format on 23 June 2014 and the Trust has until 4 July 2014 to respond with feedback or raise any queries.

The CQC have also made several key changes and updates to the intelligent monitoring report. Briefly, these include:

- Introduction of a new indicator assessing trusts' responses to Patient Safety Alerts (monitored through the Central Alerting System)
- Introduction of a new indicator using the results of the Patient Led Assessment of the Care Environment (PLACE).
- Inclusion of Monitor's Financial Risk Rating in addition to the Governance Risk Rating previously used.
- Changes to the indicator used from the Sentinel Stroke National Audit Programme following advice from the Royal College of Physicians' audit team.

**Conclusion**
In conclusion, the Trust continues to drive compliance with external assurance providers. There are detailed action plans in place to address any concerns identified through external inspections, as required.

## Appendix 1: Executive Overview of Board Assurance Framework

**Domain: 1. Quality**

| Strategic Objective/Principal Risk | Lead | Aug 2013 | Oct 2013 | Dec 2013 | Mar 2014 | May 2014 | June 2014 | In month change | Change/progress |
|---|---|---|---|---|---|---|---|---|---|
| **1.1 Patient Safety** | | | | | | | | ↓↑ | |
| A602.1-O1 Pressures on internal capacity may result in the Trust being unable to meet demands from activity, negatively affecting quality, throughout the year. | MS | 20 | 20 | 20 | 20 | 20 | 20 | → | |
| A513-O1: Failure to achieve the National HCAI targets for MRSA and C Diff | JH | 16 | 16 | 16 | 16 | 16 | 16 | → | |
| A411-O1: Insufficient ICU capacity to handle an increasing workload | AW | 15 | 15 | 15 | 15 | 15 | 15 | → | |
| O1-01 A risk to patient safety of inappropriate antimicrobial prescribing due to conflicting and out of date guidance being available within the Trust. | RGW | 12 | 12 | 12 | 12 | 12 | 12 | → | |
| 01-02: 01-02 Lack of established process for use, provision, decontamination and maintenance of pressure relieving mattresses | JH | 9 | 9 | 9 | 9 | 9 | 9 | → | |
| 01-03 Lack of embedded process for use, provision and maintenance of bed rails | JH | | | 12 | 12 | 12 | 12 | → | |
| 01-04 Risk to patient safety should the organisation fail to meet its statutory duties under Section 11 in respect of number and levels of staff trained in safeguarding children. | JH | | | 12 | 12 | 12 | 12 | → | |
| 01-05 Risk to patient safety arising from a lack of standardised and centralised decontamination practice across several areas of the Trust. | BB | | | | 12 | 12 | 12 | → | |
| 01-06 Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists | RGW | | | | | | 15 | → | Risk re-worded to reflect wider issues regarding RTT |
| 01-07 Risk to patient safety and experience as a result of potential Trist failure to meet 95% Emergency Access | | | | | | | 16 | **NEW** | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Standard | | | | | | | | | |

| Strategic Objective/Principal Risk | Lead | Aug 2013 | Oct 2013 | Dec 2013 | Mar 2014 | May 2014 | June 2014 | In month change | Change/progress |
|---|---|---|---|---|---|---|---|---|---|
| **1.2 Patient Experience** | | | | | | | | | |
| A410-O2: Failure to sustain the Trust response rate to complaints | JH | 16 | 16 | 16 | 16 | 16 | 16 | → | |
| 02-02 Risk of diminished quality of patient care as a result of Cost Improvement Programmes (CIPs) | RGW | 16 | 15 | 15 | 12 | 16 | 16 | → | |

**Domain: 2. Finance & Performance**

| Strategic Objective/Principal Risk | Lead | Aug 2013 | Oct 2013 | Dec 2013 | Mar 2014 | May 2014 | June 2014 | In month change | Change/progress |
|---|---|---|---|---|---|---|---|---|---|
| **2.1 Meet all financial targets** | | | | | | | | | |
| 2.2-O5 Tariff Risk – Emergency Threshold Tariff.<br>The Trust's income and service contribution is reduced due to application of 30% tariff to emergency activity exceeding the contract thresholds | SB | 9 | 9 | 12 | 9 | 9 | 9 | → | |
| 2.1-O5 Tariff Risk -<br>The tariffs applicable to Trust clinical services are adversely changed as a result of:-<br>•National Tariff changes<br>•Local Tariff changes<br>•Specialist Commissioning changes<br>• Transfer of tariff responsibilities to Monitor | SB | 12 | 12 | 12 | 12 | 12 | 12 | → | |
| 1.2-O5 Volume Risk – Decommissioning of Services<br>Activity and associated income/contribution will be lost from services decommissioned due to:-<br>• risks to the safe delivery of care | SB | 6 | 9 | 9 | 9 | 9 | 9 | → | |

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|---|---|---|---|---|---|---|---|---|---|
| • changing national guidance<br>• centralisation plans | | | | | | | | | |
| 3.3-O5 Cost Pressures *<br>The Trust faces higher than expected costs due to:-<br>•unforeseen service pressures<br>•higher than expected inflation | SB | 12 | 12 | 12 | 12 | 16 | 16 | ↑ | Cost pressures increased in 14/15 as a result of further compliance, staffing and other imperatives. |
| 3.2-O5 Cost Reduction slippage*<br>The Trust does not deliver its cost reduction programme objectives:-<br>•Objective 3: to detail savings plans for the next two years | SB | 20 | 20 | 20 | 20 | 20 | 20 | → | |
| 2.3-O5 Tariff Risk – CQUIN Premium<br>Trust income is not maximised due to failure to deliver required performance against CQUIN quality standards. | SB | 12 | 12 | 12 | 12 | 12 | 12 | → | |
| 1.3-O5 Volume Risk – Tendering of services<br>Activity and associated income/contribution will be lost due to:-<br>• Competition from Any Qualified Providers<br>• Service Line Tenders | SB | 9 | 9 | 9 | 9 | 9 | 9 | → | |
| 1.1-05 Volume Risk – Competition with other providers<br>Activity and associated income/contribution will be lost due to competition from other service providers resulting in reductions in market share * | SB | 9 | 9 | 9 | 9 | 9 | 9 | → | |
| 2.4-O5 Tariff Risk – Performance Penalties & Payment Challenges*<br>Trust income is reduced by:-<br>- contractual penalties due to poor performance against quality standards and KPIs<br>- payment challenges | SB | 12 | 12 | 12 | 12 | 12 | 12 | → | |
| 3.4-O5 The Trust faces higher than expected costs due to higher marginal costs - higher than expected investment required to deliver service increases. | SB | 9 | 9 | 9 | 9 | 9 | 9 | → | |

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|---|---|---|---|---|---|---|---|---|---|
| 3.5-05 - Cashflow Risks – Forecast Cash balances will be depleted due to delays in receipt of:-<br>Major Charitable donations towards the C&W development.<br>Land Sales receipts<br>Loan Finance | SB | | 9 | 9 | 9 | 9 | 9 | → | |
| 3.6-05 - Cashflow Risks – Operational Finance<br>Forecast Cash balances will be depleted due to:-<br>Adverse Income & Expenditure performance<br>Delays in receipt of SLA funding from Commissioners | SB | | 9 | 9 | 9 | 12 | 12 | → | |
| 3.9-05 Minimise financial impact of Better Care Fund | | | | 15 | 20 | 20 | 12 | ↓ | Likely financial impact to be £1.5m as opposed to £20m as previously thought. |

| Strategic Objective/Principal Risk | Lead | Aug 2013 | Oct 2013 | Dec 2013 | Mar 2014 | May 2014 | Jun 2014 | In month change | Change/progress |
|---|---|---|---|---|---|---|---|---|---|
| **2.2 Meet all operational & performance requirements** | | | | | | | | | |
| 3.7- 06 Failure to meet the minimum requirements of the NTDA Accountability Framework: Quality and Governance Indicators/Access Metrics. | SB | | 12 | 12 | 12 | 12 | 12 | → | |
| 3.8 – 06 Low compliance with new working practices introduced as part of new ICT enabled change programme | SB | | 12 | 12 | 12 | 12 | 12 | → | |

**Domain: 3. Regulation & compliance**

| Strategic Objective/Principal Risk | Lead | Aug 2013 | Oct 2013 | Dec 2013 | Mar 2014 | May 2014 | Jun 2014 | In month change | Change/progress |
|---|---|---|---|---|---|---|---|---|---|
| **3.1 Maintain compliance with all statutory & regulatory requirements** | | | | | | | | | |
| A534-O7:Failure to provide adequate supporting evidence for all the CQC Essential standards of Quality | PJ | 20 | 20 | 15 | 15 | 5 | 5 | → | |

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|---|---|---|---|---|---|---|---|---|---|
| and Safety | | | | | | | | | |
| A509-O8: Trust unable to achieve readiness for FT status by planned authorisation date as per agreed TFA | PJ | 15 | 20 | 20 | 20 | 15 | 15 | → | |
| A537-O6:Confidential data reaching unintended audiences | RGW | 15 | 15 | 15 | 15 | 15 | 15 | → | |
| A610-O6: The Trust will not attain the nationally mandated target of 95% of all staff receiving annual information governance training | RGW | 15 | 15 | 15 | 15 | 15 | 15 | → | |
| O3- O1 Ability of the Trust to demonstrate its compliance in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO) | DH | 15 | 15 | 9 | 9 | 16 | 16 | → | |
| 03-02 Failure to demonstrate full Estates compliance | | | | | | | 16 | **NEW** | |
| 03-03 Delay to the ability to deliver the capital programme and maintenance activity | | | | | | | 16 | **NEW** | |

**Domain: 4. Strategy, transformation & development**

| **Strategic Objective/Principal Risk** | **Lead** | **Aug 2013** | **Oct 2013** | **Dec 2013** | **Mar 2014** | **May 2014** | **Jun 2014** | **In month change** | **Change/progress** |
|---|---|---|---|---|---|---|---|---|---|
| **4.1 Redesign pathways to keep more people out of hospital** | | | | | | | | | |
| 01-O8 Prolonged strategic uncertainty in SW London. | TK | 12 | 12 | 12 | 12 | 12 | 12 | → | |
| **Strategic Objective/Principal Risk** | **Lead** | **Aug 2013** | **Oct 2013** | **Dec 2013** | **Mar 2014** | **May 2014** | **Jun 2014** | **In month change** | **Change/progress** |
| **4.2 Redesign & configure our local hospital services to provide higher quality care** | | | | | | | | | |
| A533-O8: Reconfiguration of healthcare services in SWL result in unfavourable changes to SGHT services and finances | TK | 8 | 8 | 8 | 8 | 8 | 8 | → | |

| Strategic Objective/Principal Risk | Lead | Aug 2013 | Oct 2013 | Dec 2013 | Mar 2014 | May 2014 | Jun 2014 | In month change | Change/progress |
|---|---|---|---|---|---|---|---|---|---|
| **4.5 Drive research & innovation through our clinical services** | | | | | | | | | |
| 05-05 Research does not form a key part of St. George's future activity which may result in the loss of funding and an inability to recruit and retain staff. | RGW | 12 | 12 | 8 | 8 | 8 | 8 | → | |

**Domain: 5. Workforce**

| Strategic Objective/Principal Risk | Lead | Aug 2013 | Oct 2013 | Dec 2013 | Mar 2014 | May 2014 | Jun 2014 | In month change | Change/progress |
|---|---|---|---|---|---|---|---|---|---|
| **5.1 Develop a highly skilled & engaged workforce championing our values** | | | | | | | | | |
| A518-O4:Failure to reduce the unacceptable levels of bullying & harassment reported by staff in the annual staff survey | WB | 12 | 12 | 12 | 12 | 12 | 12 | → | |
| A516-O4: Possible reductions in the overall number of junior doctors available with a possible impact on particular specialty areas | WB | 4 | 4 | 4 | 4 | 4 | 4 | → | |
| A520-O4: Failure to maintain required levels of attendance at core mandatory and statutory training (MAST) | WB | 2 | 2 | 2 | 2 | 2 | 2 | → | |

| | | | | | |
|---|---|---|---|---|---|
| JH | Jennie Hall | Chief Nurse | PJ | Ros Given-Wilson | Medical Director |
| AW | Anneliese Weichart | Divisional Director of Operations – CWS | RGW | Steve Bolam | Director of Finance Performance & Information |
| PJ | Peter Jenkinson | Director of Corporate Affairs | SB | Trudi Kemp | Director of Strategy |
| MS | Miles Scott | Chief Executive | TK | Wendy Brewer | Director of Human Resources |
| DH | David Hastings | Interim Director of Estates & Facilities | BB | Bernie Bluhm | Interim Director of Delivery & Performance |

**Domain 1: Quality: 1.1 Patient Safety**

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|---|---|---|---|---|---|
| **Principal Risk** | A602.1-O1 Pressures on internal capacity may result in the Trust being unable to meet demands from activity, negatively affecting quality, throughout the year. | | | | |
| **Description** | Requirement for high activity volumes in some specialities.<br>Potential for commissioner challenges and financial penalties<br>There is an unlimited demand on A&E which will may impact on increase in emergency admissions<br>A rise in emergency admissions impacts on capacity for elective admissions, time that theatres are not in use and 28 day rebook timeframes.<br>Variable demand may impact on patient pathways and negatively affect patient safety.<br>Delayed transfer of care and repatriation patient delays to host hospitals block beds for emergency/elective activity.<br>Winter pressures relating to Flu, diarrhoea & vomiting symptoms increase demand on side rooms and closure of beds.<br>There are reduced numbers of discharges at weekends and on bank holidays causing capacity problems on the next working day/s<br>Pressure on bed capacity and failure to meet operational targets both emergency and elective<br>Use of bank/agency staff to staff escalation areas<br>Loss of Trust income due to elective cancellations<br>Adverse reputation | | | | |
| **Domain** | **1. Quality** | | | **Strategic Objective** | **1.1 Patient Safety** |
| | **Original** | **Current** | **Update** | **Exec Sponsor** | Miles Scott |
| **Consequence** | 5 | 5 | 5 | **Date opened** | 01/11/2012 |
| **Likelihood** | 4 | 4 | 4 | **Date closed** | |
| **Score** | 20 | 20 | 20 | | |
| **Controls & Mitigating Actions** | **Controls:**<br>Capacity will be tight again in 2014-15 as demand continues to rise, and the acuity of the patients we are admitting continues to rise. Plans in place for controlling this risk through capacity planning for 2014-15 and 2015-16.<br>This includes development of additional physical capacity in Q3 and Q4, and gains in patient flow from the Improvement Programme.<br>Equivalent total bed capacity realisable by year end - 169 beds.<br>There is the potential for additional capacity in Q4 in the Improvement Programme as a result of developing a Surgical Admissions Unit and a Discharge Unit. Plans are currently being developed.<br>If delivered as planned, capacity pressures will substantially diminish and performance and CIP targets can be met. | | | **Assurance** | Programme of applications for additional winter funding<br><br>Participation in Urgent Care Board<br><br>ECIST review (September 2013)<br><br>Negative assurance:<br>- ED performance<br>- RTT backlog of patients- cross ref BAF Risk 01-06<br>- Cancelled elective surgery during periods of significantly high activity i.e. Feb 2014 |

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|---|---|---|---|
| | There are however risks with respect to the timing and delivery of both aspects of the plan. To control these risks, we have:<br>Ensured that maximum possible resource is deployed towards the improving patient flow programme so that optimal delivery can be achieved<br>A structured approach to appraising the options for creating further physical capacity for 2015-16 and beyond. This work is underway.<br>Increased capital project management capability<br><br>**Mitigations:**<br>• Seek additional external capacity<br>• Cap demand for services | | |
| **Gaps in controls** | The summer period saw a higher level of activity than predicted, and this resulted in bed pressures that exceeded those in the winter.<br>Revised the capacity modeling completed Sep 13 shows the trust is at risk of a difficult winter, even after the additional capacity we have planned has been put in place. | **Gaps in assurance** | |
| **Actions next period:** | • Initiating capacity planning for 14/15 | | |

| **Principal Risk** | A513-O1: Failure to achieve the National HCAI targets for MRSA and C Diff | | | | |
|---|---|---|---|---|---|
| **Description** | The target for MRSA is set at 0 cases (zero tolerance) and 40 case for C. Diff for year 2013/14<br>The Trust's reputation is adversely affected Foundation Trust application affected<br>Loss of patient & public confidence in the Trust<br>Risk of patient harm | | | | |
| **Domain** | **1.Quality** | | | **Strategic Objective** | **1.1 Patient Safety** |
| | **Original** | **Current** | **Update** | **Exec Sponsor** | Jennie Hall |
| **Consequence** | 4 | 4 | 4 | **Date opened** | 31/05/2010 |
| **Likelihood** | 4 | 4 | 4 | **Date closed** | |
| **Score** | 16 | 16 | 16 | | |

| | | | |
|---|---|---|---|
| **Controls & Mitigating Actions** | Bi-weekly taskforce meeting and bi-monthly Infection Control Committee meeting<br>Regular reports to the Patient Safety Committee, EMT & Trust Board<br>Infection Control score card used to monitor monthly progress<br>Regular communications sent to support practice and raise awareness to ensure staff adhere strictly to diarrhoea protocol<br>Divisional action plans presented to the taskforce as required<br>Zero Tolerance statement on the Trust intranet<br>Bi-monthly antimicrobial steering group chaired by Medical Director<br>Consultant level information circulated on a regular basis<br>RCA carried out for each infection (MRSA, MSSA & Cdiff)<br>Infection Control Policy in place<br>Weekly line care rounds & C:diff rounds on-going<br>Competence assessment document for taking blood cultures approved | **Assurance** | Overall trajectory has now recovered. (30 reported against threshold 45:end of Feb 2013). 3 c:diff ytd – below trajectory<br><br>CQC Compliance with Outcome 8: Infection Control (Feb 2014)<br><br>Best practice visit to Southampton, Royal Free and west Hertfordshire<br><br>MRSA – 6 cases, all investigated via RCA – last two bacteraemia showed poor compliance with line care.<br><br>Infection control action plans subject to review by internal audit – reasonable insurance.<br><br>Peer review of infection control nursing team (By Barts & the London Trust) final report agreed with recommendations |
| **Gaps in controls** | BAF risk 01-01 Informatics to support production of real time data<br>Decontamination of nasendoscopes | **Gaps in assurance** | |
| **Actions next period:** | Continual revision of infection control action plan<br>Increasing number of consultants champions for infection control.<br>Pack for peripheral line insertion in place (to be considered for blood cultures also)<br>Analysis and actions in relation to latest audit of line care – due May/June 2014<br>Trust wide environmental audit underway. Focus on areas where cleaning inspections demonstrated need to improve. | | |

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| **Principal Risk** | A411-O1: Insufficient ICU capacity to handle an increasing workload | | | | |
| **Description** | Insufficient capacity of ITU and HDU beds impacting on elective and emergency admissions requiring access to critical care. Increased cancellations. Increased financial costs on agency outlay | | | | |
| **Domain** | **2. Quality** | | | **Strategic Objective** | **1.1 Patient Safety** |
| | **Original** | **Current** | **Update** | **Exec Sponsor** | Anneliese Weichart |
| **Consequence** | 4 | 3 | 3 | **Date opened** | 30/05/2010 |

| | | | | | |
|---|---|---|---|---|---|
| **Likelihood** | 5 | 5 | 5 | **Date closed** | |
| **Score** | 20 | 15 | 15 | | |
| **Controls & Mitigating Actions** | 2012/13 additional 1 bed in situ but gained additional L3 capacity for 2 beds. Where required - escalation to recovery area.<br>Progress on Service improvement programme will be accelerated to fit into corporate programme for the review of Patient flows across the Trust-elective surgical pathway is on-going.<br>Mitigation through opening of an escalation area in Recovery at additional cost<br>Mitigating action is to cancel elective surgery to provide additional urgent capacity and to send activity to private sector. | | | **Assurance** | Due to bed pressures also elsewhere the trust took a decision to reduce the allocation of 6 critical care beds to 1 in total. However due to reconfiguration of HDU beds and although the net increase of beds is 1 there is an increase in L3 beds.<br><br>Critical care bed management is a separate function and is well established and pro-actively managed. Critical Care Bleep holder attends bed escalation meetings to look into issues on a day to day basis. |
| **Gaps in controls** | | | | **Gaps in assurance** | |
| **Actions next period:** | For 2014/15 a programme is underway to create 4 additional critical care beds on NICU. This programme is currently going through gateway 2 and will in the next 4 weeks go through the design and clinical sign off phase. Plan to open Q4 of 2014/15. | | | | |

| | | | | | |
|---|---|---|---|---|---|
| **Principal Risk** | O1-01 A risk to patient safety of inappropriate antimicrobial prescribing due to conflicting and out of date guidance being available within the Trust. | | | | |
| **Description** | Clinical guidelines produced by individual clinical departments containing antibiotic advice are unregulated and may contain antibiotic advice which is contrary to trust policy. Additionally old guidelines are not adequately deleted from the intranet and out of date antibiotic advice remain accessible.<br>Risks are:-Not treating patients effectively-Causing adverse events due to toxicity and C.difficile.<br>There is a financial/reputational risk to the Trust in its ability to meet HCAI targets and to its Foundation Trust application.<br>Cross Ref BAF RiskA513-01 | | | | |
| **Domain** | **1.Quality** | | | **Strategic Objective** | **1.1 Patient Safety** |
| | **Original** | **Current** | **Update 8/5** | **Exec Sponsor** | Ros Given Wilson |
| **Consequence** | 3 | 3 | 3 | **Date opened** | 31/03/2013 |
| **Likelihood** | 4 | 4 | 4 | **Date closed** | |
| **Score** | 12 | 12 | 12 | | |
| **Controls & Mitigating Actions** | Email communication to Divisional Chairs, DDNGs, Governance Leads.<br>Antimicrobial pharmacists and Antimicrobial Stewardship team promoting good antimicrobial prescribing practice.<br>Fully discussed and monitored at the bi-monthly | | | **Assurance** | The cardiology guidelines have all been updated.<br><br>Obstetrics and Max-fax have named/assigned consultants to ensure guidelines are aligned. |

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| | Antimicrobial Stewardship Committee.<br>Grey book in place: editorial peer review of guidance from different clinical areas is updated regularly.<br>CIU handbook, cardiology/radiology/gen surgery and part of haematology guidelines now harmonised. Guidelines containing antimicrobials must be approved by the Antimicrobial Stewardship Committee prior to being uploaded to the intranet - this has been written into the antimicrobial prescribing policy. | | |
| **Gaps in controls** | No current process for regulation and control the production and dissemination of antimicrobial guidance which are not covered by the Grey book process. | **Gaps in assurance** | Renal, Haematology - Oncology, A&E & Thoracic guidelines remain outstanding |
| **Actions next period:** | Exercise to regulate and control the production and dissemination of antimicrobial guidance – using a method analogous to the policy review & ratification process Initial meeting set up to agree and plan strategy and work has commenced to scope and review the current breadth of guidance, to actively ascertain scope of the problem and to inform on-going solution<br>Antimicrobial Stewardship Committee to update the Infection Control Committee by exception<br>Ensure antibiotic stewardship strategy is consistent with practice at QMR ( via liaison with Kingston microbiology) Meeting with QMH microbiology (scheduled for June 19th) | | |

| **Principal Risk** | 01-02 Risk to patient safety arising from a lack of established or embedded process for use, provision, decontamination and maintenance of pressure relieving mattresses | | | | |
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| **Description** | Absence of a universal process for the provision, maintenance and decontamination of pressure relieving mattresses (PRMs): Inconsistent compliance with process for provision at ward level as a result.<br>Lack of compliance with decontamination requirements: may result in infection control risk.<br>Absence of programmed maintenance potentially results in faulty equipment.<br>Potential factor in increased numbers of patients sustaining pressure ulcers and infection. (Cross Ref A513-O1) | | | | |
| **Domain** | **1.Quality** | | | **Strategic Objective** | **1.1 Patient Safety** |
| | **Original** | **Current** | **Update** | **Exec Sponsor** | Jennie Hall |
| **Consequence** | 3 | 3 | 3 | **Date opened** | 11/07/2013 |
| **Likelihood** | 4 | 3 | 3 | **Date closed** | |
| **Score** | 12 | 9 | 9 | | |
| **Controls & Mitigating Actions** | Additional initial resources approved at EMT. 32 new PRMs, 200 new top covers and band 3 post to cover 6 days per week. Also agreement for full decontamination in between each patient. More detail required for EMT re costs for this as will required more PRMs to replace and estimate of | | | **Assurance** | Improved monitoring of availability and delivery times. Most recent data showing improved delivery times.<br><br>Still some delays with availability and collection especially out of hours and at weekends. |

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| | decontamination costs per mattress.<br><br>**Mitigating Actions**<br>If demand exceeds supply additional mattresses will be rented or purchased urgently. Until substantive staff in post will attempt to cover with existing staff working extra paid hours. | | No agreed process yet for decontamination of mattresses. |
| **Gaps in controls** | Need to reduce amount delivered within 24 hours and increase amount delivered within 2/4 hours.<br>Not decontaminating PRMs in between every patient yet unless known infection. | **Gaps in assurance** | Still longer than desired delivery and collection times. Awaiting costs re decontamination from Medical Physics to go back to EMT but approved in principal at previous meeting as risks discussed. |
| **Actions next period:** | Continue to monitor availability and delivery times. Update paper to go to EMT with costs of decontamination for PRMs. Still need further discussion re long term plan and possible managed contract.<br>Discussions continue around process for de-contamination of mattresses between Med Physics & DIPC/Dep Chief Nurse<br>Business Case in draft form and specification also drafted. Now being supported by General Manager Corporate Outpatients, Diagnostics and pathology. | | |

| **Principal Risk** | 01-03 Risk to patient safety arising from a lack of embedded process for use, provision and maintenance of bed rails (cot sides) | | | | |
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| **Description** | Absence of a universal process for the provision and maintenance of bed rails. Inconsistent compliance with process for provision at ward level as a result. Not always available, not always fit for purpose and not always correctly applied.<br>Lack of compliance with decontamination requirements: may result in falls risk.<br>Absence of programmed maintenance potentially results in faulty equipment.<br>Potential factor in increased numbers of patients sustaining falls. | | | | |
| **Domain** | **1.Quality** | | | **Strategic Objective** | **1.1 Patient Safety** |
| | **Original** | **Current** | **Update** | **Exec Sponsor** | Jennie Hall |
| **Consequence** | 3 | 3 | 3 | **Date opened** | 1.1.2014 |
| **Likelihood** | 4 | 4 | 4 | **Date closed** | |
| **Score** | 12 | 12 | 12 | | |

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| **Controls & Mitigating Actions** | Has been included into work reviewing beds and mattresses. Likely additional resources required approved at EMT. More detail required for EMT re costs for this as need trust wide audit.<br>**Mitigating Actions**<br>If demand exceeds supply additional rails will be rented or purchased urgently. Review of training and risk assessment tool underway by falls Lead, Consultant Physio. | **Assurance** | One SI recently and lack of bed rails was a root cause.<br>A patient fell from bed at QMH recently due to lack of rails. |

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| **Gaps in controls** | Currently no robust process of managing and maintaining equipment. | **Gaps in assurance** | Awaiting costs from Medical Physics to go back to EMT but approved in principal at previous meeting as risks discussed. |
| **Actions next period:** | Continue to monitor availability and Datix reporting. Update paper to go to EMT from med Physics with costs. Still need further discussion re long term plan and possible managed contract as would have electric beds with integrated rails. Some additional sets purchased. Policy and risk assessment reviewed and information sent out to staff on how to access. Now being supported by General Manager Corporate Outpatients, Diagnostics and pathology. | | |

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| **Principal Risk** | 01-04 There is a potential risk to patient safety should the organisation fail to meet its statutory duties under Section 11 in respect of number and levels of staff trained in safeguarding children. | | | | |
| **Description** | Risk of staff not having required knowledge to safeguard children due to the required safeguarding children training not consistently being undertaken. Staff may not recognise a potential safeguarding issue, putting a vulnerable child at risk of harm. | | | | |
| **Domain** | **3. Quality** | | | **Strategic Objective** | **1.1 Patient Safety** |
| | **Original** | **Current** | **Update** | **Exec Sponsor** | Jennie Hall |
| **Consequence** | 4 | 4 | 4 | **Date opened** | 1.1.14 |
| **Likelihood** | 3 | 3 | 3 | **Date closed** | |
| **Score** | 12 | 12 | 12 | | |
| **Controls & Mitigating Actions** | Training sessions in safeguarding children at all levels are held on a regular basis. Sessions are advertised in advance and training at a basic level is included the annual MAST update.<br><br>Funding has been provided from NMET monies to provide extra training, using an outside trainer, at Level 3 in Safeguarding Children.<br><br>A peer review of the SGC resource across the trust including benchmarking with similar size organisations has been completed early January 2014 and the report is awaited.<br><br>All managers have been contacted by the Safeguarding Nurse and the DDNG for CWDT&CC reminding them of their obligations under Section 11. Divisional training performance is reported at the quarterly performance reviews. | | | **Assurance** | Levels of Child Safeguarding training not meeting Trust standard, current position:<br>Level 1 the target is 80%. Current score: 89.37 % (- 1.05%)<br>Level 2 the target is 80%. Current score: 80.07% (+ .18%)<br>Level 3 the target is 80%. Current score: 54.78% (+ 5.76%)<br><br>The numbers of staff trained at Level 2 and 3 are increasing steadily as a result of additional training sessions and further attention being paid to the data entry. Some refining of the Matrix for the WIRED system is in progress. The findings from the safeguarding review are about to be debated – as yet it is not clear what the implications from this will be in respect of training. |

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| **Gaps in controls** | | **Gaps in assurance** | |
| **Actions next period:** | The safeguarding children training analysis compliance action plan is being implemented and regularly up-dated and reviewed at trust-wide Strategic SGC committee.<br>Continue to target level 3 and have additional sessions at level 3 funded by T&E as well as the regular programmed sessions.<br>Await peer review report. | | |

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| **Principal Risk** | 01-05 Risk to patient safety arising from a lack of standardised and centralised decontamination practice across several areas of the Trust | | | | |
| **Description** | Risk escalated from Surgical divisional risk register: A number of services continue to decontaminate equipment locally:-<br>• ENT- Nasendoscopes<br>• Gen Surg- Anal probes<br>• Cardiac- TOE probes<br>• ITU - Bronchoscopes<br>The practice is no longer compliant with new guidance. The risks relate to the environment, process and tracking of equipment, which currently place staff and patients at potential risk of chemical toxicity and cross contamination. | | | | |
| **Domain** | **4. Quality** | | | **Strategic Objective** | **1.1 Patient Safety** |
| | **Original** | **Current** | **Update** | **Exec Sponsor** | Bernie Bluhm |
| **Consequence** | 4 | 4 | 4 | **Date opened** | 31.5.2014 |
| **Likelihood** | 3 | 3 | 3 | **Date closed** | |
| **Score** | 12 | 12 | 12 | | |
| **Controls & Mitigating Actions** | The Decontamination Committee oversee maintenance of relevant standards/guidance in line with local departmental experts.<br>Drying cabinets have been locked and a new escalation policy is in place to prevent further instruments from being quarantined due to poor /no tracking**.**<br>Cardiac to comply with centralised decontamination for TOE probes: a new re-processor has been leased and was recently installed.<br>Interim solution to use of Tristal wipes system | | | **Assurance** | Nasendoscope audit & effectiveness of Tristal wipes system recently completed and fed back to ENT – May 2014. Practice requires improvement and regular auditing.<br>Positive assurance: There have been no incidents of cross contamination |
| **Gaps in controls** | | | | **Gaps in assurance** | |
| **Actions next period:** | ITU will tighten up their practice in relation to Bronchoscopes: a written process to be put in place.<br>The rationale of the indicative cost pressure of the funding to lease an additional washer processor (1K per month) to enable decontamination to be carried out centrally has been drafted and to be signed off by each division.<br>Explore long term solution to provide alternative centralised decontamination services which will entail a full business case and capital build (likely | | | | |

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| **Principal Risk** | 01-06 Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists | | | | |
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| **Description** | Risk to patient safety and patient experience as patients waiting greater than 18 weeks on elective waiting lists.<br>Possible impact that patient's condition deteriorates.<br>Specific issues regarding cardiothoracic surgery waiting lists in particular. | | | | |
| **Domain** | **5. Quality** | | | **Strategic Objective** | **1.1 Patient Safety** |
| | **Original** | **Current** | **Update** | **Exec Sponsor** | tbc |
| **Consequence** | 5 | 5 | | **Date opened** | 31.5.2014 |
| **Likelihood** | 3 | 3 | | **Date closed** | |
| **Score** | 15 | 15 | | | |

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| **Controls & Mitigating Actions** | Management of the RTT 18 week standard is the responsibility of clinical divisions and their general management teams. They are supported in their work by the Information Team and the 18 Week Validation Team which reports into Deirdre Baker – Assistant Director of Finance.<br>Governance arrangements are:<br>Compliance Meeting chaired monthly by the Director of Finance, Performance & Informatics and attended by the Director of Delivery & Improvement, General Managers, Information Team and the 18 weeks team<br>Sub groups for admitted and non- admitted pathways which involve service managers and the 18 weeks team.<br>RTT performance is reported to the FPI Committee on a monthly basis and the issues concerning any particularly challenged specialty are discussed in detail.<br>Performance is also monitored by commissioners at the monthly commissioner/SGH meeting and any clinical quality issues discussed at the monthly commissioner/SGH Clinical Quality Review meetings.<br>The Trust has a well-established model for planning and setting a trajectory for the achievement of the 18 week standard and this is used by the general managers to set the operational standards for their teams.<br>During 2014-15 there will be formal quarterly resets of the | **Assurance** | Negative assurance – two SIs have occurred where patients on cardiothoracic waiting list died suddenly without being offered a date for surgery/diagnostic test.<br><br>Process of re-validation and management of waiting lists reported by all divisions to June Patient Safety Committee<br><br>Full note review of cardiothoracic waiting list to be carried out and GPs contacted to warn them of long waits and to contact Cons if concerns re individual patients. |

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| | plan to ensure that capacity constraint/availability are kept pace with and the plan is as up to date as possible.<br>Cardiology specific recovery plan in place. | | |
| **Gaps in controls** | No standardised process for regular review of patients on waiting lists. | **Gaps in assurance** | |
| **Actions next period:** | Continue to implement recommendations arising from each divisional review of waiting list management process and above recovery plan | | |

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| **Principal Risk** | 01-07 Risk to patient experience and safety as a result of potential Trust failure to meet 95% Emergency Access Standards | | | | |
| **Description** | Should the Trust recurrently fail to meet 95% Emergency Access Standards there would be a risk to:<br>- Patient experience whereby patients would not be treated or transferred within four hours<br>- Patient safety – delays in patients receiving ED or specialist senior clinical input<br>- Risk of regulatory action including from commissioners and regulators<br>- Trust reputational damage of failure to deliver the 95% clinical standard | | | | |
| **Domain** | **6. Quality** | | | **Strategic Objective** | **1.1 Patient Safety** |
| | **Original** | **Current** | **Update** | **Exec Sponsor** | Bernie Bluhm |
| **Consequence** | 4 | 4 | | **Date opened** | 1/6/2014 |
| **Likelihood** | 4 | 4 | | **Date closed** | |
| **Score** | 16 | 16 | | | |
| **Controls & Mitigating Actions** | Executive Director led daily performance review meetings<br>Divisional escalation bleep holder to ensure prompt escalation and response<br>A five point action plan has been agreed which includes focus on ED processes, ambulatory care, speciality pathways, including provision of a surgical assessment unit and discharge processes including a discharge lounge.<br>This plan is reviewed with the CEO, Director of Finance and Director of Delivery and Improvement on a fortnightly basis.<br>- ED internal improvement plan with focus on:<br>- Co-ordination control and leadership.<br>- Expansion of R.A.T model<br>- Ambulatory streaming from ED.<br>- Specialty escalation and admitting pathway from | | | **Assurance** | +ve = No clinical incidents arising from long ED waits<br>+ve = As at 18.6.14 five out of previous eight week 95% standard has been met<br>Delivery trajectory for end of Q1 remains possible but carried significant risk.<br>Contract query notice served by commissioners (June 2014) |

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| | ED.<br>Provision of Surgical Assessment Unit and hot clinic model.<br>Introduction of new frailty model (older people).<br>Expansion of ambulatory capacity to facilitate increase in ambulatory pathways.<br>Discharge planning and process work stream to include provision of a discharge lounge and partnership working arrangements.<br>Continued close and pro-active working with ECIST | | |
| **Gaps in controls** | | **Gaps in assurance** | |
| **Actions next period:** | To develop unscheduled care dashboard that will help identify contributory factors to performance<br>Continue to implement improvement plan. | | |

**Domain 1: Quality: 1.1 Patient Experience**

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| **Principal Risk** | A410-O2: Failure to sustain the Trust response rate to complaints | | | | |
| **Description** | Not always prioritised to same degree as other Trust objectives<br>Responding inadequately and in an untimely way can seriously impact on the patient experience and limit the Trust's opportunity for learning.<br>Negative impact on the Trust's reputation and loss of patient and public confidence | | | | |
| **Domain** | **1.Quality** | | | **Strategic Objective** | **1.2 Patient Experience** |
| | **Original** | **Current** | **Update 8/5** | **Exec Sponsor** | Alison Robertson |
| **Consequence** | 4 | 4 | 4 | **Date opened** | 30/04/2009 |
| **Likelihood** | 4 | 4 | 4 | **Date closed** | |
| **Score** | 16 | 16 | 16 | | |
| **Controls & Mitigating Actions** | Weekly spread-sheet detailing care group response times circulated.<br>Included as a measure within the divisional performance scorecard.<br>LEAN review of complaints process.<br>Greater oversight of complaints by DDNGs<br>Regular reporting via PEC,QRC & Trust Board. | | | **Assurance** | Positive;<br>Annual report to be presented to PEC (Aug)and QRC and TB (Sept).<br>Medicine/cardiovascular division has improved performance.<br>Results of the recent survey of complainants which seeks feedback of their experience of our process reported to PSC and QRC Dec 14<br>Negative:<br>Performance against 25 day timescale is currently significantly below 85% |

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| | Implemented a risk rating system to identify high risk complaints. | | - internal Trust standard |
| **Gaps in controls** | | **Gaps in assurance** | Overall Trust response rate remains low and continues to deteriorate<br>Need more detailed thematic analysis at care group level to ensure causes of complaints are well understood & that actions are put in place that lead to improvements (and therefore a reduction in complaints). |
| **Actions next period:** | • Following review of complaints process following the publication of Hart/Clwyd report (post Francis) - presentation to QRC and work now underway to address recommendations<br>• Improve reporting of feedback received from NHS Choices, care Connect etc on-going<br>• STNC meeting with care groups, with the expectation of developing clear plans for T&O and general surgery<br>• All divisions requested to present improvement plan (with trajectory) to improve response rate<br>• Regular updates to be reported to newly established Operational Management Team, chaired by Director for Delivery and Performance | | |

| **Principal Risk** | 02-02Risk of diminished quality of patient care as a result of Cost Improvement Programmes (CIPs) | | | | |
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| **Description** | As Cost Improvement Programmes continue to be rolled out, there is a potential risk that inadequate identification, monitoring and mitigating actions will fail to ensure that quality of care is preserved. | | | | |
| **Domain** | **1.Quality** | | | **Strategic Objective** | **1.2 Patient Experience** |
| | **Original** | **Current** | **Update** | **Exec Sponsor** | Ros Given Wilson |
| **Consequence** | 4 | 4 | 4 | **Date opened** | 01/07/2013 |
| **Likelihood** | 4 | 3 | 4 | **Date closed** | |
| **Score** | 16 | 12 | 16 | | |

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| **Controls & Mitigating Actions** | All combined schemes (divisional improvement programmes, run rates) must have a Quality Impact Assessment covering 5 dimensions (5x5 risk scoring):<br>- Patient Safety<br>- Patient Outcome<br>- Patient Experience<br>- Staff welfare<br>- Financial impact<br>Combined schemes are subject to local governance scrutiny and approval, at care group, directorate and divisional level; overseen by Divisional triumvirate including Divisional Chair, Divisional Director of Operations and Divisional Director of Nursing & Governance.<br>Local governance structures report monthly to Clinical Governance Group | **Assurance** | Positive assurance:<br>External scrutiny of process by Trust Board, commissioners and NTDA.<br>Each scheme has KPIs related to their risk registers which are regularly reviewed.<br>High level governance structure robust<br><br>Negative assurance:<br>Relies on robust divisional governance structure – recent divisional governance review identified that historically, not all CIPs which impact upon quality of care receive received nursing/clinical sign-off. |

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| | (CGG) which reviews and approves all PODS/PIDS (project outline and initiation documents). Risk Registers also reviewed.<br>CGG chaired by Medical Director – all schemes with risk score over 12 also referred for consideration for approval by CGG.<br>CGG is dynamic.<br>CGG reports exceptional risks to QRC.<br>Process of assurance feeds up from DGBs not just Risk Registers<br>Divisions encouraged to bring run-rate schemes. | | |
| **Gaps in controls** | Potential that not all risks are recognised and that 5x5 risk scoring application is inconsistent across divisions.<br>Reliance upon divisions recognising clinical risks<br>Insufficient mitigations & increased pressure to deliver CIPs may result in less rigorous application of QIA process. | **Gaps in assurance** | |
| **Actions next period:** | Continued oversight by CGG and refinement of CGG process | | |

**Domain 2. Finance & Performance: 2.1 Meet all financial targets**

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| **Principal Risk** | 2.2-O5 Tariff Risk – Emergency Threshold Tariff. The Trust's income and service contribution is reduced due to application of 30% tariff to emergency activity exceeding the contract thresholds | | | | |
| **Description** | Emergency activity volumes and income exceed contract thresholds resulting in payment at a reduced 30% tariff due to generic growth in emergency activity:<br>•Changes in emergency pathway e.g. Trauma activity<br>•Failure of Commissioner QIPP schemes<br>•Failure to reduce rate of consequent admissions | | | | |
| **Domain** | **2. Finance & Operations** | | | **Strategic Objective** | **2.1 Meet all financial targets** |
| | **Original** | **Current** | **Update** | **Exec Sponsor** | Steve Bolam |
| **Consequence** | 3 | 3 | 3 | **Date opened** | 01/12/2012 |
| **Likelihood** | 4 | 3 | 3 | **Date closed** | |
| **Score** | 12 | 9 | 9 | | |
| **Controls & Mitigating Actions** | **Controls**<br>The expected impact of reduced emergency tariff on financial performance is considered as part of the Trust's business planning process, which is overseen by Business Planning Implementation Group and reported to EMT.<br>Actions taken include:<br>▪ NETA rebasing exercise undertaken by St. George's. Negotiations with CCG's on-going re uprating of threshold, concluded at £10.2m Threshold impact | | | **Assurance** | Role on Urgent Care and System Improvement Board to positively influence how emergency care is managed in the local health economy and how retained funds are spent Reported value of emergency threshold tariff loss |

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| | reduced to c£3.5m for 14/15<br>▪ Continued investment in facilities to reduce level of emergency admissions, e.g. Consultant led A&E, AMU.<br>▪ Support commissioners to develop realistic, deliverable and measurable QIPP plans to manage demand for emergency services<br>▪ Identification of changes in emergency pathways<br>▪ Proactive identification of changes to patient pathways leading to expected increase in emergency admissions, and notification and negotiation with commissioners regarding appropriate operating of activity targets to reflect the changed patient pathway CCG's own the entirety of the financial risk on QIPP plans that fail to manage or reduce activity coming to St. George's.<br><br>Mitigating actions:<br>▪ Central role played on new Urgent Care and System Improvement Board will allow St. George's to influence how the retained 70% of emergency tariffs are allocated.<br>▪ Bid for proportion of CCG retained 70% of tariff, to develop local projects to assist in demand management.<br>▪ Development of admissions avoidance projects in-year which reduce the overall number of patients being admitted to the trust | | |
| **Gaps in controls** | Ensure Commissioner 70% saving on tariff is reinvested appropriately. | **Gaps in assurance** | Access to representation on urgent care boards (UCBs) outside of Wandsworth/ Merton/Lambeth where significant level of STG funding sits |
| **Actions next period:** | Understanding and influencing decisions on other UCB<br>Agreement with CCG's on uplift on NETA threshold. Principle agreed by CCG's, currently negotiating on value for 14/15.<br>Establish routine QIPP meetings with Merton CCG | | |

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| **Principal Risk** | 2.1-O5 Tariff Risk - The tariffs applicable to Trust clinical services are adversely changed as a result of: |

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| | •National Tariff changes<br>•Local Tariff changes<br>•Specialist Commissioning changes<br>• Transfer of tariff responsibilities to Monitor | | | | |
| **Description** | There is a risk that future tariff changes will be more challenging:-•Local Tariff changes e.g. proposed reductions in charges for Sexual Health services & Community Cost & Volume tariffs<br>•Changes in Commissioning arrangements for Specialist Services will lead to standardisation of local tariff agreements which may adversely affect current income levels<br>•Monitor is consulting on its policy on tariff and the future proposals may adversely affect Trust income | | | | |
| **Domain** | **2. Finance & Operations** | | | **Strategic Objective** | **2.1 Meet all financial targets** |
| | **Original** | **Current** | **Update** | **Exec Sponsor** | Steve Bolam |
| **Consequence** | 3 | 3 | 3 | **Date opened** | 01/12/2012 |
| **Likelihood** | 4 | 4 | 4 | **Date closed** | |
| **Score** | 12 | 12 | 12 | | |

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| **Controls & Mitigating Actions** | **Controls**<br>▪ Influence future tariff.<br>▪ Active membership of Project Diamond provides the Trust with a London wide voice to reflect Tertiary Hospital views in the development of the tariff.<br>▪ Active membership of FT Network.<br>▪ Negotiation with commissioners.<br>▪ Agreement to phased introduction of change through SLA negotiation process will mitigate impact. Where local tariffs are reduced, trust to negotiate for compensatory changes in other, less favourable tariffs where commissioners currently benefit, seeking to ensure a reduced overall impact Opportunities to offset loss e.g. through bidding for whole pathway tariffs, or through reviewing structure of service, are identified<br>**Mitigating actions:**<br>Divisions, services where tariff loses impact on overall service financial baseline to develop plans to review productivity opportunities, remove costs, and identify opportunities to grow activity at marginal cost. Where local tariffs are reduced to such an extent that the service becomes recurrently loss making, to review overall service viability and make decisions around longer term service | **Assurance** | External reviews:- E&Y report on the impact of the current tariff structure for members of Project Diamond has been acknowledged by D Flory and has resulted in explicit tariff subsidies for major London Trusts<br><br>National tariff & rules published for 2014/15 with limited changes |

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| | structure<br>Participation in Monitor 2013/14 PLICs voluntary data collection | | |
| **Gaps in controls** | ▪ Pathway based service costing.<br>▪ Benchmarking of Local Tariff Services - Identifying those services which currently attract a relatively high local tariff will enable the Trust to examine opportunities to address future risk. | **Gaps in assurance** | |
| **Actions next period:** | Negotiations with commissioners managed by Director of Finance with regular reporting to Trust Board<br><br>Engagement with Project Diamond group to develop a response to DOH/NHSE tariff proposals over MFF | | |

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| **Principal Risk** | **1.2-O5 Volume Risk – Decommissioning of Services**. Activity and associated income/contribution will be lost from services decommissioned due to:<br>• risks to the safe delivery of care<br>• changing national guidance<br>• centralisation plans | | | | |
| **Description** | Services are lost, along with the associated income and contribution to trust overheads, due to<br>•Risks to safe delivery of care due to low volumes not meeting national minimum activity thresholds e.g. complex gynaecology, gynaecological cancer, or where the clinical or service quality of a service provided falls significantly below national minimum standards.<br>•Risks associated with failure of services to meet the new NHSE Service Specifications or other changes in national guidance Currently St. George's has one service where the trust is not meeting NHSE Service Specifications and has scored a 4 – Neuro-Rehab (lack of level 1 beds)<br>•Commissioner plans to centralise services | | | | |
| **Domain** | **2. Finance & Operations** | | | **Strategic Objective** | **2.1 Meet all financial targets** |
| | **Original** | **Current** | **Update** | **Exec Sponsor** | Steve Bolam |
| **Consequence** | 3 | 3 | 3 | **Date opened** | 01/12/2012 |
| **Likelihood** | 3 | 3 | 3 | **Date closed** | |
| **Score** | 9 | 9 | 9 | | |
| **Controls & Mitigating Actions** | **Controls - Specific**<br>1. For Neuro-rehab, the centralisation of Neuro-rehab at QMH, and the appointment of 2 new consultants should remove this as a level 1 risk.<br>2. Alliance with Royal Marsden to provide BMT and Paediatric Oncology Services<br>**Controls - Generic**<br>3. Divisional annual business plans to identify threats in the market, and how the service will respond to those | | | **Assurance** | Annual business plans and business planning process though to Finance & Performance Committee and Trust Board |

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| | issues<br>4. Development of service specific marketing plans to identify options for maintaining services at SGH<br>5. Cost / benefit analysis of investment into services to meet any deficiencies against new national service specifications for tertiary services, and subject to that analysis, implementation of investment to ensure trust meets required standards and will not therefore be de-commissioned<br>6. Work through Urgent Care and System Improvement Board to influence local commissioner decisions regarding any plans to change the configuration of services or centralise services away from St. George's:<br><br>Mitigating actions:<br>▪ Development of long term exit strategy for services without a viable long term market position<br>▪ For any service that is de-commissioned, the trust will remove the costs (pay, non-pay, other) associated with the service, assuming that substitute activity cannot be grown. | | |
| **Gaps in controls** | Improvements needed in process for identification of 'at risk' services. | **Gaps in assurance** | None currently identified |
| **Actions next period:** | ▪ Await formal confirmation from NHSE as to compliance with each service specification. Once received Neuro-rehab position with NHSE, and put in place remedial actions.<br>▪ Business planning 2014/15 on-going | | |

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| **Principal Risk** | 3.3-O5 Cost Pressures - The Trust faces higher than expected costs due to:-<br>•unforeseen service pressures<br>•higher than expected inflation | | | | |
| **Description** | The Trust has to meet costs of unforeseen changes in service requirements. The cost of meeting new and existing service standards are higher than expected. Inflationary cost pressures are greater than expected e.g. changes in energy costs | | | | |
| **Domain** | **2. Finance & Operations** | | | **Strategic Objective** | **2.1 Meet all financial targets** |
| | **Original** | **Current** | **Update** | **Exec Sponsor** | Steve Bolam |
| **Consequence** | 4 | 4 | 4 | **Date opened** | 01/12/2012 |

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| **Likelihood** | 4 | 4 | 4 | **Date closed** | |
| **Score** | 16 | 16 | 16 | | |
| **Controls & Mitigating Actions** | Controls<br>▪ The expected impact of cost pressures on financial performance is considered as part of the Trust's business planning process. Robust provisions are made for future increases in cost in line with high level Guidance from Monitor.<br>▪ Adequate Contingency Reserves are set aside in line with NHS Guidance at 1% of Turnover<br>▪ The business planning process is overseen by Business Planning Implementation Group which reports to EMT.<br>▪ Cost pressures are monitored in-year through the financial reporting regime. New pressures are identified as early as possible and the financial impact is reported to the Finance and Performance committee.<br>▪ New Cost Pressure Review Group developed as part of 2014/15 Business Planning Process. Group reports to EMT and acts as key arbitrator on proposed new cost pressures,<br><br>Mitigating actions<br>Development of In Year Recovery Plans if required, recovery plans are formulated in response to monthly forecasts produced as part of financial reporting process. The Trust has a number of actions it can deploy to recover its financial position if it is adversely affected by cost pressures, e.g. vacancy freezes, controls on discretionary expenditure, etc. | | | **Assurance** | The Trust has a good track record of delivering its financial targets in recent years.<br><br>Cost pressures in 14/15 are high as a result of further compliance, staffing and other imperatives. Choices have been made on which top priority pressures must be funded. This is expected to continue to be an issue going forward |
| **Gaps in controls** | None identified | | | **Gaps in assurance** | |
| **Actions next period:** | New pressures are identified as early as possible and the financial impact is reported to the Finance and Performance committee. | | | | |

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| **Principal Risk** | 3.2-O5 Cost Improvement Programme slippage. The Trust does not deliver its cost improvement programme objectives | | | | |
| **Description** | •Opportunities for savings schemes are not identified<br>•Opportunities to save are not sufficiently developed to deliver the value required<br>•Savings identified within schemes are overoptimistic / savings are double counted<br>•Savings are redeployed<br>•Savings schemes are not delivered as planned<br>•Savings identified are only non-recurrent | | | | |
| **Domain** | **2. Finance & Operations** | | | **Strategic Objective** | **2.1 Meet all financial targets** |
| | **Original** | **Current** | **Update** | **Exec Sponsor** | Steve Bolam |
| **Consequence** | 5 | 5 | 5 | **Date opened** | 01/12/2012 |
| **Likelihood** | 4 | 4 | 4 | **Date closed** | |
| **Score** | 20 | 20 | 20 | | |

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| **Controls & Mitigating Actions** | <u>Controls</u><br>Benchmarking St. George's services to ensure that opportunities for CIP savings are identified through avenues such as:<br>▪ SAFE analysis of productivity opportunities<br>▪ Albatross HRG reference cost comparison<br>▪ Civil eyes Consultant performance comparison<br>▪ Service Line Management<br>Over-programming<br>▪ Additional Schemes to be developed above annual requirement as a contingency against under-delivery<br>Programme Management Office (PMO)<br>▪ Role of PMO in managing CRP programme.<br>▪ Rigorous PID and POD development to support CRP projects.<br>▪ Director oversight, review and sign-off of projects to ensure that only projects that have a realistic chance of delivery are agreed and implemented.<br>▪ Risk assessment of all schemes, challenge on the value of savings achievable and monitoring of scheme progress, with reporting back to F&P Committee and the Board.<br>▪ Appointment in 2013/14 of interim Divisional CIP leads.<br>▪ Future CIP strategy to identify pipeline of future projects Service Improvement Team GE Organisational | **Assurance** | Audit Reports Internal review of PMO processes by Governance Team<br><br>Benchmarked controls against Monitor's guide on "Delivering Sustainable Cost Improvement Programmes" (19-01-2012).<br><br>Audit Reports Internal review of PMO processes by Governance Team<br>Audit Reports Internal review of PMO processes by Governance Team<br><br>TDA review of Trust CIP governance<br><br>NTDA review and approval of 2 year CIP programme as presented in preparation for NTDA approval of FT application |

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| | change/ Lean (See Programme Plan for Exemplar site)<br>▪ Development of in-house expertise Development of savings culture<br><br>Mitigating Actions<br>1.To develop further in-year non-recurrent CIP projects to offset the non-delivery of the full CIP programme. These would include:<br>▪ Vacancy freezes<br>▪ Reductions in procurement spend<br>▪ Slowing of in-year capital programme<br>2. Bring forward of future years schemes – with a two year programme of CIP projects in place, the trust will bring forward schemes from future years to offset under-performance in the CIP programme in year<br>TDA CIP review group.<br>3. Review list of downside mitigations to see what can be actioned now | | |
| **Gaps in controls** | Over-programming yet to be achieved Lack of consistent pipeline of future projects | **Gaps in assurance** | |
| **Actions next period:** | Update rolling 2 year CIP programme with detailed PIDs covering 14/15 and 15/16<br><br>Develop 'fighting fund' for additional contingency<br>Confirm mitigation plans to June Finance, performance and Information Committee after agreeing with divisions.<br>Agree proposal for support on 16/17 to 18/19 programme development | | |

| **Principal Risk** | 2.3-O5 Tariff Risk – CQUIN Premium. Trust income is not maximised due to failure to deliver required performance against CQUIN quality standards. | | | | |
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| **Description** | CQUINs are not met at the level that the trust has assumed in its financial plans<br>- 2014/15 Maternity CQUIN brings with it significant financial risk, circa £2.5M The trust currently has significant recurrent expenditure linked to non-recurrent CQUIN funding, so any failure to deliver the CQUIN will potentially leave the trust with a significant financial challenge.<br>- Future requirements not adequately identified.<br>-Insufficient investment made in delivery | | | | |
| **Domain** | **2. Finance & Operations** | | | **Strategic Objective** | **2.1 Meet all financial targets** |
| | **Original** | **Current** | **Update** | **Exec Sponsor** | Steve Bolam |
| **Consequence** | 4 | 4 | 4 | **Date opened** | 01/12/2012 |
| **Likelihood** | 4 | 3 | 3 | **Date closed** | |

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| **Score** | 16 | 12 | 12 | | |
| **Controls & Mitigating Actions** | Controls<br>Governance Arrangements<br>▪ Build expected level of CQUIN non-achievement into financial baseline for the trust.<br>▪ Leads identified for each CQUIN<br>▪ CQUIN leads share reports on trust wide CQUINs with DDNGs to feed into divisional meetings. Assessment of risks related to each CQUIN shared with DDOs who are asked to develop mitigating action plans.<br>▪ Performance monitoring of CQUIN performance to ensure early identification of any variance from plan and identify and implement remedial actions.<br>▪ CQUIN achievement considered at quarterly divisional performance reviews.<br>▪ Investment in Delivery<br>▪ Appropriate requirements are identified by divisions in Business Planning process – overseen by Business Planning Implementation Group and reported to EMT.<br><br>Mitigating actions:<br>1.Invest resources in – year to improve CQUIN performance, based on a cost-benefit analysis of undertaking that investment<br>3.Year End Settlement discussions – the level of risk relating to CQUINs is mitigated by agreement with commissioners to a year-end settlement, managed through the SLA negotiation process | | | **Assurance** | Internal Audit in 2011 highlighted CQUIN performance insufficiently resourced. Two additional central posts (one nursing, one admin) appointed to assist in the delivery of CQUINs on the wards<br><br>Commissioners agreed 95% CQUIN achievement as part of year end statement |
| **Gaps in controls** | CQUIN performance is insufficiently embedded in Divisional Governance structures. Accountability and performance management arrangements need to be improved and adequately resourced. | | | **Gaps in assurance** | |
| **Actions next period:** | Finalise all CQUINs with commissioners<br><br>Finalise CQUIN reporting to Divisions and Trust Board<br><br>Confirm plans and investment requirements for 14/15 CQUINs as part of business planning | | | | |

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| **Principal Risk** | **1.3-O5 Volume Risk** – Tendering of services. Activity and associated income/contribution will be lost due to:<br>▪ Service Line Tenders<br>▪ Competition from Any Qualified Providers<br>This risk is particularly related to the delivery of community services. | | | | |
| **Description** | The Trust may lose contracts for a range of services resulting in associated lost income and lost contribution to overheads, due to Commissioner intentions. These include:<br>• An increased role for the Local Authority to commission services, leading to new and less predictable patterns of service commissioning<br>• An increased introduction of service line tenders e.g. School nursing (value circa £1.35M for 2015/16,) and HMP Wandsworth Prison Tender (value circa £5.8M in 2013/14) which St. George's won the tender for.<br>• Growth of AQPs across a range of services | | | | |
| **Domain** | **2. Finance & Operations** | | | **Strategic Objective** | **2.1 Meet all financial targets** |
| | **Original** | **Current** | **Update** | **Exec Sponsor** | Steve Bolam |
| **Consequence** | 3 | 3 | 3 | **Date opened** | 01/12/2012 |
| **Likelihood** | 4 | 3 | 3 | **Date closed** | |
| **Score** | 12 | 9 | 9 | | |
| **Controls & Mitigating Actions** | **Controls**<br>1. To ensure that the trust delivers services in line with commissioner requirements, in advance of any service line tenders or wider commissioning decisions. This will ensure the trust is well placed to win any tender, or to offer a service that commissioners no longer feel the need to tender for e.g. Commission Adult Health Services (CAHS) as currently being developed by WCCG.<br>2. Annual business plan by clinical service to identify threats and opportunities in the market place, and how the service will respond to those issues<br>3. Early identification of services affected. Potential areas currently identified are:<br>- Sexual Health Services potential to be tendered in 2015/16<br>- School nursing 2015-16<br>- Health visiting in 2014/15<br>4. Decision to enter tender process for each invitation received, based on current strategic and service fit and financial contribution/profitability.<br>5. Good, collaborative relationship with local CCG's. The trust will work with them in the new Urgent care and System Improvement Board which will have Work-streams looking at out of hospital care, help St. George's | | | **Assurance** | Escalating process of assurance through annual business plans and business planning process though to Finance & Performance Committee and Trust Board |

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| | retain strong position in local health market. Development of collaborative relationship with Local Authorities to deliver services reflective of LA needs and requirements, through both the Health & Wellbeing Board and other bi-lateral arrangements.<br><br>**Mitigating actions:**<br>Divisional management teams will undertake a range of actions to mitigate this risk including:<br>1.That St. George's wins any tenders that it chooses to bid for, negating the need for other mitigating actions<br>2. Lost service Line Tenders: TUPE of all staff involved. Identification of any potential substitution activity that retained assets – staff or facilities – can undertake service lines are lost in tender process. Close capacity where all activity mitigations exhausted. Reduce associated fixed costs<br>3.AQP - Registering for AQP services in other markets to offset potential losses. Seek to substitute activity with other AQP activity. Reduce staff costs to meet reduced demand | | |
| **Gaps in controls** | None currently identified | **Gaps in assurance** | Capacity to manage multiple tenders mainly in the Community Services Division |
| **Actions next period:** | ▪ Understanding from CCG and Local Authority of future intentions regarding services to be subject to tender through SLA negotiation and agreement. These actions will be incorporated into divisional business plans, the development of which is overseen by the Business Planning Implementation Group and reported to EMT.<br>▪ Undertake review of competitive position of local authority commissioned services (joint action with contracts/strategy team)<br>▪ Review timing of tenders and document and refresh at divisional level - agreed with Director of Strategy | | |

| **Principal Risk** | **1.1-05 Volume Risk** – Competition with other providers. Activity and associated income/contribution will be lost due to competition from other service providers resulting in reductions in market share | | | | |
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| **Description** | The Trust's competitor and market share analyses indicate that there is a risk that some activity may be referred to alternative providers, particularly tertiary activity, resulting in associated lost income and lost contribution to overheads. For example, Cardiology going to GSTT from SWL and Surrey, or Neuroscience activity going to inner London providers, | | | | |
| **Domain** | **2. Finance & Operations** | | | **Strategic Objective** | **2.1 Meet all financial targets** |
| | **Original** | **Current** | **Update** | **Exec Sponsor** | Steve Bolam |
| **Consequence** | 4 | 3 | 3 | **Date opened** | 01/12/2012 |
| **Likelihood** | 3 | 3 | 3 | **Date closed** | |
| **Score** | 12 | 9 | 9 | | |

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| **Controls & Mitigating Actions** | **Controls**<br>1.Quarterly market share and competitor analysis reported to divisional management and Commercial Board<br>2. Marketing information informs the development of divisional Business Plans, which is overseen by Business Planning Implementation Group and reported to EMT.<br>3. Pro-active monthly monitoring of actual activity and referral source as recorded in SLAM for early identification of market share changes.<br>4. Development of service specific marketing plans to maintain and grow market share – Cardiac, Neuro and Paediatrics completed for 2013/14, and will be extended to other services, and further enhanced and developed for 2014/15<br>5. Proactive relationship management with key commissioners and referrers to help ensure that St. George's remains referral unit of choice in south west London and beyond, depending on clinical service. Active leadership role on Urgent Care and System Improvement Board to influence and lead sector wide debate.<br>7.Benchmark for quality and performance to understand how the St. George's service compares to competitors<br>8. Continued development of local clinical networks and strategic partnerships to maintain market position will help control impact.<br>9. Ongoing improvement in service quality, to maintain market share and encourage patients to actively choose St. George's.<br>10. Continued development and enhancement of clinical networks e.g. Urology network or Kingston/George's Cardiology partnership working, to strengthen St. George's market position.<br><br>Mitigating Actions:<br>• Divisional management teams will undertake a range of actions to mitigate this risk including: Develop deliverable and measurable action plans in response to any significant loss of market share, focusing on reclaiming lost referrals. Plans would need to clearly address issues identified by commissioner or service weaknesses, identified following internal review<br>• To develop action plan to develop new markets, focussing on Surrey referrals and south west London activity currently going out of sector. For each service to identify where potential substitution activity can be | **Assurance** | **Positive**<br>▪ On-going market share monitoring via SLAM and Dr. Foster data.<br>▪ Business planning processes to identify risks and market strategy |

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| | taken from, including: geographical area; rationale for growth; target volume; barriers to possible growth; commissioner position<br>• Trust internal substitution of activity from other departments, where demand outstripping capacity, to ensure estate and facilities are utilised<br>• Cost removal – assuming that substitute activity cannot be grown to detail where cost will be taken out: Staff, Non-pay, etc., and the value, timeframes for delivery and impact on financial performance of trust. Quality and other indicator impact to be quantified. These actions will be incorporated into divisional business plans, the development of which is overseen by the Business Planning Implementation Group and reported to EMT. | | |
| **Gaps in controls** | Not all services have marketing plans | **Gaps in assurance** | None |
| **Actions next period:** | ▪ Ongoing review at Commercial Board.<br>▪ Business planning 2014/15 including refresh of divisional plans on-going | | |

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| **Principal Risk** | 2.4-O5 Tariff Risk – Performance Penalties & Payment Challenges. Trust income is reduced by contractual penalties due to poor performance against quality standards and KPIs- payment challenges | | | | |
| **Description** | Targets or KPIs within the contract are not met and the level of financial penalties is higher than anticipated. Main KPIs are:-1st to FU ratios-Re-admission rates.<br>The level of payment challenges due to data quality issues is higher than anticipated. Main data issues are:--Multiple 1st OP appointments-Ensuring correct recording of Emergency and Other Non-Elective method of admission | | | | |
| **Domain** | **2. Finance & Operations** | | | **Strategic Objective** | **2.1 Meet all financial targets** |
| | **Original** | **Current** | **Update** | **Exec Sponsor** | Steve Bolam |
| **Consequence** | 5 | 4 | 4 | **Date opened** | 01/12/2012 |
| **Likelihood** | 3 | 3 | 3 | **Date closed** | |
| **Score** | 15 | 12 | 12 | | |

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| **Controls & Mitigating Actions** | Controls<br>Governance Arrangements:<br>▪ Good clinical engagement in local KPI target setting e.g. 1st to Follow up OP ratios, consultants are signed up to the levels in the contract. Much clinical engagement in the joint readmissions audit, to set the threshold appropriately. The budget for the level of challenges is based on challenges levied in prior years. Divisions are sighted on their level of budgeted challenges and the actions they must take to prevent challenges or to mitigate them.<br>▪ Negotiation of appropriate and realistic thresholds and targets with local CCG's to minimise trust exposure to challenges.<br>▪ Training of staff & data validation routines<br>▪ Ensure that data is recorded and charged for appropriately and that PbR Guidance is followed e.g. that OP appointments are appropriately recorded as First or Follow Up and that the correct method of admission is recorded for non-elective patients<br><br>Mitigating Actions:<br>▪ Utilise clinical expertise to explain changes and challenge penalties imposed by CCG's.<br>▪ Year End Settlement discussions – the risk of income | **Assurance** | In year performance monitoring of level of both accepted and rejected challenges, Current performance is within the budgeted levels. |

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| | losses relating to further in-year challenges is mitigated by agreement with commissioners to a year-end settlement through the SLA negotiation process. | | |
| **Gaps in controls** | The Trust needs to more pro-actively identify specific areas of risk ahead of challenges e.g. Chemotherapy charges | **Gaps in assurance** | |
| **Actions next period:** | •Good clinical engagement in local KPI target setting E.g. 1st to Follow up OP ratios, consultants are signed up to the levels in the contract. Much clinical engagement in the joint readmissions audit, to set the threshold appropriately.<br>•The budget for the level of challenges is based on challenges levied in prior years.<br>•Divisions are sighted on their level of budgeted challenges and the actions they must take to prevent challenges or to mitigate them. | | |

| **Principal Risk** | 3.4-O5 The Trust faces higher than expected costs due to higher marginal costs - higher than expected investment required to deliver service increases. | | | | |
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| **Description** | The additional costs of delivering increased activity are higher than expected due to:<br>•Poor cost estimates<br>•Premium costs of securing increases in capacity outside normal hours or in the private sector | | | | |
| **Domain** | **2. Finance & Operations** | | | **Strategic Objective** | **2.1 Meet all financial targets** |
| | **Original** | **Current** | **Update** | **Exec Sponsor** | Steve Bolam |
| **Consequence** | 3 | 3 | 3 | **Date opened** | 01/12/2012 |
| **Likelihood** | 3 | 3 | 3 | **Date closed** | |
| **Score** | 9 | 9 | 9 | | |
| **Controls & Mitigating Actions** | Controls<br>▪ Marginal costs of additional activity are identified through the Business Planning process, which is overseen by the Business Planning Steering Group and reported to EMT. Prudent costing approach identifying only site and trust level infrastructure and management costs as fixed.<br>▪ Costs are based on data from robust historical costing systems including PLICS and Reference Costs which have been calculated in line with national guidance.<br>▪ Capacity requirements of additional activity are identified through the Capacity Management element of the Business Planning process, overseen by the Business Planning Steering Group and reported to EMT<br>Short term funding for premium costs of temporary | | | **Assurance** | . |

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| | increases in demand is negotiated with commissioners through SLA negotiation process. SLA negotiation is escalated to FD/CE and reported to Finance and Performance Committee. Business case approval process rigorously tests income and expenditure assumptions for new developments, minimising the risk of cost pressures developing as a result of new service developments | | |
| **Gaps in controls** | Divisional use of PLICS and SLR data not as complete as required. | **Gaps in assurance** | Insufficient understanding of where steps in fixed costs are incurred |
| **Actions next period:** | Confirm marginal cost model for use in 14/15 business planning.<br><br>Agree a development plan for improvements to PLICs. | | |

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| **Principal Risk** | 3.5-05 Cash-flow Risks – Operational Finance: Forecast Cash balances will be depleted due to delays in receipt of:-<br>• Major Charitable donations towards the C&W development.<br>• Land Sales receipts<br>• Loan Finance | | | | |
| **Description** | The Trust's cash balances may be significantly depleted due to the delay in receipt of significant one off charitable donations, land sale receipts or loan finance | | | | |
| **Domain** | **2. Finance & Operations** | | | **Strategic Objective** | **2.1 Meet all financial targets** |
| | **Original** | **Current** | **Update** | **Exec Sponsor** | Steve Bolam |
| **Consequence** | 3 | 3 | 3 | **Date opened** | 01/06/2012 |
| **Likelihood** | 3 | 3 | 3 | **Date closed** | |
| **Score** | 9 | 9 | 9 | | |
| **Controls & Mitigating Actions** | Controls:-Capital Expenditure Management<br>1. Capital Programme Group (CPG) oversees the planning and monitoring of the annual and five year capital programme, which reports to Executive Management Team<br>2. Monthly capital finance reports on funding and expenditure are submitted to the CPG for review and forecasts updated. The Finance and Performance Committee and Trust Board receives a summary financial report on the capital programme as part of the finance report and significant variances and changes to plan | | | **Assurance** | Previous track record in delivering major land sales projects e.g. Wolfson, Bolingbroke & The Grove |

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| | explained.<br>3. Maintain reasonable and prudent capital cash flow projections based on detailed returns from capital budget holders commensurate with agreed funding and ensuring they are updated regularly to reflect changes in project timescales and in the receipt of external funding.<br>4. Secure agreement from donors to provide funds in accordance with timing of investment requirements<br>• Action Plan – written undertakings of commitment to transfer funds at agreed milestones e.g. Helipad.<br>5. Project plans to deliver land sales<br>• Action Plan – business case setting out timelines and risk management in event of slippage.<br>6. Project Plan to secure loan finance<br>• Action Plan – equipment items subject to leasing will be procured only when lease agreement completed. Other loan finance will be scheduled on prudent cash flow projections of related investment.<br>Mitigations:-<br>Delay capital investments in line with reduced funding<br>7. Manage working capital<br>8. Identify alternative sources of finance e.g. extend scope of leasing – subject to VFM and affordability tests. | | |
| **Gaps in controls** | None identified | **Gaps in assurance** | |
| **Actions next period:** | | | |

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| **Principal Risk** | 3.6-05 Cash-flow Risks – Operational Finance: Forecast Cash balances will be depleted due to:-<br>•Adverse Income & Expenditure performance<br>•Delays in receipt of SLA funding from Commissioners |
| **Description** | The Trust's cash balances will be significantly depleted due to an adverse I&E position or delays in receipt of commissioner funding. Risk is currently greater due to change in Commissioner landscape. |

| Domain | 2. Finance & Operations | | | Strategic Objective | | 2.1 Meet all financial targets |
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| | Original | Current | Update | Exec Sponsor | | Steve Bolam |
| Consequence | 3 | 3 | 3 | Date opened | | 01/06/2013 |
| Likelihood | 3 | 4 | 4 | Date closed | | |
| Score | 9 | 12 | 12 | | | |
| Controls & Mitigating Actions | Established SLA negotiation process:<br>•SLA negotiation issues are escalated to FD/CE and reported to Finance and Performance Committee.<br>•Locally agreed estimated values for contracts to allow appropriate levels of funding to be made ahead of final contract signature.<br>•SLAs include special clause for interim invoicing of over-performance in advance of freeze date - enhances cash flow.<br>Established Financial Management regime:<br>•Adverse Income and Expenditure results are monitored in-year through the financial reporting regime.<br>•New pressures are identified as early as possible and the financial impact is reported to the Finance and Performance committee.<br>•Trust has set month-end cash balance target against which cash performance is measured: 10 days of operating expenses (in 2013/14 this is approx. £18m).<br>.Working Capital Management<br>•The Trust Cash Position is reported to the Board each month as part of the finance report, including detailed cash flow statements and 2-3 year cash projections.<br>•Changes in debtors, stock and creditors reported and explained within finance report to Finance and Performance Committee and Board.<br>•SLA interim invoicing – as above.<br><br>Mitigating actions<br>Manage Working Capital<br>• Improve Debt Collection<br>• Delay payment of creditors / manage balances with major creditors e.g. SGUL<br>• Reduce stock levels e.g. extend scope of consignment stock to deliver one-off improvement in liquidity – subject to VFM and affordability tests (i.e. higher unit costs). | | | | Assurance | Detailed monitoring and forecasting of cash flow and agreed debt through Finance and Performance Committee.<br><br>HDD1 and HDD2 working capital reviews |

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| | Delay capital investments in line with reduced funding due to reduction in Trust surpluses<br>Extend scope of leasing to finance capital programme subject to VFM and affordability tests.<br>Explore opportunities for sale and leaseback arrangements | | |
| **Gaps in controls** | Contract with NHSE likely to include unidentified QIPP leading to over performance on contract maybe c£1m per month & cash flow problems | **Gaps in assurance** | |
| **Actions next period:** | Seek to agree payment for over-performance in the contract with NHSE<br>Further review of timing of CAPEX to ensure phased towards 2nd 6 months 14/15 and examine profile going forwards | | |

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| **Principal Risk** | 3.9-05 Impact of Better Care Fund on Financial position of the trust.<br>Funding of circa £2M rising up to £20M recurrently removed from the trust income position. With potential impact on financial performance, operational delivery and quality of services as well as the Trust's FT application | | | | |
| **Description** | The Better Care Fund (BCF) is a new pooled health and social budget due to be implemented from 2014/15 and rising significantly in value in 2015/16. CCGs will be required to contribute significant health funds to the BCF locally. Initial estimates indicate a financial impact on St. George's of circa £2M in 2014/15 and circa £20M in 2015/16 and recurrently afterwards.<br>Method of implementing BCF still being developed and expected to be a mix of predominantly QIPP type activity reductions and to a lesser extent tariff reductions.<br>If income is reduced without a concomitant reduction in the trust's activity and cost base, the financial impact will severely impact the trust's financial performance and through that, have potential impacts on operational, quality and other elements of trust business.<br>If this risk is realised the BCF has the potential to undermine the trusts FT application, as it may make it impossible for the trust to deliver the required surpluses | | | | |
| **Domain** | **2. Finance & Operations** | | | **Strategic Objective** | **2.1 Meet all financial targets** |
| | **Original** | **Current** | **Update** | **Exec Sponsor** | Steve Bolam |
| **Consequence** | 5 | 5 | 3 | **Date opened** | 31 January 2014 |
| **Likelihood** | 3 | 4 | 4 | **Date closed** | |
| **Score** | 15 | 20 | 12 | | |
| **Controls &** | **Controls**<br>Engagement with CCG and local authority partners in south | | | **Assurance** | Negative<br>Guidance and understanding and local interpretation of guidance, and |

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| **Mitigating Actions** | west London to understand and co-operatively plan for the management of the BCF<br>1. Trust is required to be a party to the Better Care Fund submission and plans that are made.<br>2. That St. George's will work constructively with and through South West London Collaborative Commissioning to influence and mitigate the impact of the BCF on St. George's.<br>**Mitigations**<br>1. Bring forward of future years CIP plans or current central mitigations in the CIP programme to offset increased loss of income to the trust.<br>2. Where QIPP related projects do not deliver anticipated reduction in inpatient or other activity at St. George's, the trust would anticipate that it will be funded for this over-performance at 100%<br>3. Substitution of clinical activity lost to BCF related projects from other trusts locally<br>4. That the trust will benefit through the potential expansion of community delivered services, funded through the BCF.<br>5. BCF leads to a review of clinical service configuration in south west London which creates opportunities for additional activity to flow to St. George's | | impact finically on local CCG's is unclear<br><br>Structures to manage and oversee BCF are relatively new and untested<br><br>+ve assurance: SWL system receiving support from PWC as part of 5 year planning process to ensure plans are coherent, consistent and deliverable. |
| **Gaps in controls** | | **Gaps in assurance** | |
| **Actions next period:** | ▪ Work co-operatively with CCG and Local Authority partners to inform and develop BCF plans locally.<br>▪ Outcomes form 5 year planning process will be clearer and we will prepare revised LTFM | | |

**Domain 2. Finance & Performance: 2.2 Meet all operational & performance requirements**

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| **Principal Risk** | 3.7-06 Failure to meet the minimum of the NTDA Accountability Framework Quality and Governance Indicators results in reputational damage, delays to the FT application or the quality of care is compromised in order to meet the access targets (specifically 18 weeks, A&E waits, cancer waits) | | |
| **Description** | There is a risk to the Trust FT application should it fail to perform against the Access Metrics set out by the NTDA Accountability Framework particularly in relation to:- 18 weeks- A&E Waits (4 hours)- Cancer waits ( TWR, 31 & 62 day targets).Individual risks, controls and actions to mitigate are set out in Divisional risk registers | | |
| **Domain** | **2. Finance & Operations** | **Strategic Objective** | **2.2 Meet all performance targets** |

| | Original | Current | Update | Exec Sponsor | | Steve Bolam |
|---|---|---|---|---|---|---|
| **Consequence** | 4 | 4 | 4 | **Date opened** | | 30/05/2013 |
| **Likelihood** | 4 | 3 | 3 | **Date closed** | | |
| **Score** | 16 | 12 | 12 | | | |
| **Controls & Mitigating Actions** | Management framework in place which measures performance across key domains including operational performance.<br>Divisions are held to account through formal quarterly performance reviews, monthly reporting and monitoring and escalation where required through the DoFPI<br>The Trust has a performance management framework<br>A&E performance meeting is held routinely within the Med/Card division to scrutinise and review ED performance<br>Finance & Performance Committeemeets monthly to review in detail the performance report including all areas of the TDA accountability framework<br>Reporting to F&P includes description of key actions and sharing of recovery plans where necessary e.g. cancer recovery plan 12/13 Q4<br>Reporting continues to be improved and developments including desktop access to scorecards for Divisions and the introduction of risk forecasting are in train<br>External scrutiny:<br>Performance is reviewed by the TDA as part of the Accountability Framework and the Trust is held to account at a monthly meeting of senior teams<br>Clinical Quality Review meeting and contract performance meetings are held monthly with commissioners where performance and remedial action is further scrutinised<br>**Mitigating Actions**<br>•Additional capacity is being introduced to support the Divisions and the performance framework in the shape of a Head of Performance and 2 x Divisional Performance leads<br>•Reporting continues to be improved and developments including desktop access to scorecards for Divisions and the introduction of risk forecasting are in train<br>•Developmental work in place to introduce formal monthly scoring system for Divisions within the performance framework to improve visibility over performance risks and the | | **Assurance** | Positive assurance<br>•HDD, BGAF and QGAF assessments<br>•Internal audit | |

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| | effectiveness of remedial action<br>•Additional capacity is being introduced to support the Divisions and the performance framework in the shape of a Head of Performance and 2 x Divisional Performance leads | | |
| **Gaps in controls** | Absence of risk forecasting which is in development | **Gaps in assurance** | |
| **Actions next period:** | Recruit to new capacity | | |

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| **Principal Risk** | 3.8-06 Low compliance with new working practices introduced as part of new ICT enabled change programme | | | | |
| **Description** | Partial adoption of new working practices could lead to inconsistencies in management of patient care. Failure to conform to new operational procedures could lead to decrease in organisational efficiency. | | | | |
| **Domain** | **2. Finance & Operations** | | | **Strategic Objective** | **2.2 Meet all performance targets** |
| | **Original** | **Current** | **Update** | **Exec Sponsor** | Steve Bolam |
| **Consequence** | 4 | 4 | 4 | **Date opened** | 02/06/2013 |
| **Likelihood** | 3 | 3 | 3 | **Date closed** | |
| **Score** | 12 | 12 | 12 | | |
| **Controls & Mitigating Actions** | Each project within ICT programme is:- Managed using PRINCE methodology- Has a clinical lead- Reports to clinical systems programme board- Has individual risks and issues register managed on-going<br>Director of FPI is SRO and sits on programme board.<br>Regular programme board reports to Executive Management team<br>Programme board highlight reports to EMT include RAG status and provides assurance project on track – this reporting mechanism promotes transparency and challenge<br>Chief Clinical Information Officer in post<br>18 Champion Users seconded to support deployment<br><br>Mitigating actions centre upon phases of engagement:- Involve clinical staff/health care groups in system design- Healthcare groups involved in implementation- H/care groups involved in endorsement of new working practices | | | **Assurance** | |
| **Gaps in controls** | Ensuring full and representative health care professionals' input into key areas Some constraints of operating within national programme for IT framework | | | **Gaps in assurance** | |
| **Actions next** | Development of process for transition of clinical information projects into business as usual via the ICT Service Improvement Programme. | | | | |

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| **period:** | |

**Domain 3. Regulation & Compliance: 3.1 maintain compliance with all statutory & regulatory requirements**

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| **Principal Risk** | A534-O7:Failure to demonstrate full compliance with the CQC Essential Standards of Quality and Safety | | | | |
| **Description** | Lack of a sufficiently robust approach to self-assessment and subsequent actions to ensure compliance may lead to a CQC inspection finding of non-compliance. Improvement and/or enforcement action imposed by the CQC with associated reputational risk and risk to the FT application Ref BAF Risk A509. Ultimate risk of loss of licence to operate certain services. | | | | |
| **Domain** | **3. Regulation & Compliance** | | | **Strategic Objective** | **3.1 Maintain compliance with all statutory and regulatory requirements** |
| | **Original** | **Current** | **Update** | **Exec Sponsor** | Peter Jenkinson |
| **Consequence** | 5 | 5 | 5 | **Date opened** | 31/10/2010 |
| **Likelihood** | 3 | 3 | 1 | **Date closed** | |
| **Score** | 15 | 15 | 5 | | |

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| **Controls & Mitigating Actions** | **Controls:**<br>Quality inspections launched October 2013 with reporting via divisional management and EMT. Corporate and Divisional action plans completed with on-going monitoring through divisional governance boards, Patient Safety Committee and QRC.<br><br>Action plan in response to Compliance Actions and other recommendations from CIH inspection approved by Board and submitted to CQC May 2014. Trust wide action plan in response to recommendations approved by OMT June 2014.<br><br>Quality surveillance data monitored and appropriate action ensured in response - reported as part of overall CQC compliance monitoring update to Trust Board via Risk and Compliance Report.<br><br>**Divisions now required to sign off quarterly self-certification statements re compliance with CQC standards.**<br><br>**Mitigation:**<br>Internal and external stakeholder management to highlight | **Assurance** | **Negative**: CQC unannounced inspection Jan 2013: 6 out of 8 standards non-compliant with three standards deemed to have moderate impact upon people who use services and three minor. Internal audit report identified gaps in the current evidence collation at divisional level.<br><br>**Positive**: Final report from August inspection shows significant improvement from January inspection – compliance in 5 out of 8 standards and minor impact in other three standards.<br><br>Publication of CQC assessment of trusts into risk 'bands' (October 2013), based on quality surveillance data puts trust into band 6 (lowest risk).<br><br>Chief Inspector of Hospitals inspection report published 24th April 2014, with overall rating of 'Good'. Two compliance actions identified. |

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| | excellence in patient safety and clinical effectiveness – clinical outcomes. | | |
| **Gaps in controls** | Compliance framework to be published May 2014, to include process for divisional self-certification. | **Gaps in assurance** | |
| **Actions next period:** | Compliance framework to be finalised and published<br>Implement action plan following CIH inspection | | |

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| **Principal Risk** | A509-O8: Trust unable to achieve readiness for FT status by planned authorisation date as per agreed NTDA Accountability Framework | | | | |
| **Description** | External economic environment.<br>Failure to achieve performance targets.<br>Inability to demonstrate implementation of robust quality governance processes in particular CQC compliance.<br>Lack of commissioner support. Lack of support from NTDA for current timescale due to financial performance, including CIPs. Trust's reputation is adversely impacted. Future status of Trust in doubt if FT status is not achieved by 2014 | | | | |
| **Domain** | **3. Regulation & Compliance** | | | **Strategic Objective** | **3.1 Maintain compliance with all statutory and regulatory requirements** |
| | **Original** | **Current** | **Update** | **Exec Sponsor** | Peter Jenkinson |
| **Consequence** | 5 | 5 | 5 | **Date opened** | 31/10/2010 |
| **Likelihood** | 3 | 4 | 3 | **Date closed** | |
| **Score** | 15 | 20 | 15 | | |
| **Controls & Mitigating Actions** | Programme management resource and governance structures in place to oversee programme.<br>Close monitoring of external economic environment and adaptation of strategy/approach accordingly.<br>CIP/Finance controls as per finance risks.<br>Clear action plan and performance management milestones in achieving Foundation Trust Status & risks managed at programme level.<br>Succession planning for key exec roles in place, full Board complement expected June 2014. | | | **Assurance** | Monthly oversight meeting with TDA covering performance and FT readiness. Reported to Board via CEO report.<br>QGAF assessment score 3.5 confirmed by Deloitte April 2013.<br>CQC CIH inspection – overall 'Good' rating.<br>Exec to Exec meeting with TDA completed 28-Jan-14, with positive feedback.<br>Board to Board with TDA completed March 2014.<br>TDA Board approval for entry into Monitor assessment phase April 2014.<br>Monitor kick-off meeting held 4th June. |
| **Gaps in controls** | | | | **Gaps in assurance** | Monitor authorisation – expected October / November 2014. |

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| **Actions next period:** | Monitor assessment process, including interviews, document submission and observation of board / committees. |

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| **Principal Risk** | A537-O6:Confidential data reaching unintended audiences | | | | |
| **Description** | Inability to control all electronic methods of data transfer ( USB sticks, laptops, e mails etc) Also paper records vulnerable to loss. Data loss can result in data reaching unintended audiences ( e.g. public), loss of reputation, SUIs and restrictions from information commissioner including financial fines. | | | | |
| **Domain** | **3. Regulation & compliance** | | | **Strategic Objective** | **3.1 Maintain compliance with all statutory and regulatory requirements** |
| | **Original** | **Current** | **Update** | **Exec Sponsor** | Ros Given Wilson |
| **Consequence** | 5 | 5 | 5 | **Date opened** | 31/10/2010 |
| **Likelihood** | 3 | 3 | 3 | **Date closed** | |
| **Score** | 15 | 15 | 15 | | |

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| **Controls & Mitigating Actions** | Policies on data protection, information security, medical records and corporate email reviewed and disseminated through IG training,<br>MAST, Trust Induction and Trust Intranet.<br>Technical controls - All Trust laptops encrypted. USB port blocking implemented.<br>Trust known devices whitelisted. Encrypted USB sticks distributed and available to Trust. Non encrypted USB sticks read only. Encrypted external drives available. Roll out of Virtual Desktop Infrastructure and single sign on in progress.<br>Remote access 2 factor authentication complete. Electronic data management project in progress [paper light environment, RFID tracking].<br>Reviewed medical storage – updated guidance and auditing practice.<br>On-going communication to staff on IG matters through eG | **Assurance** | Reduction in recent incidents involving data loss. On-going monitoring of any new removable storage devices with a view to blocking all such devices when greater assurance obtained that there is no clinical risk.<br><br>CQC finding of non-compliance with Outcome 21 Records in relation to the insecure storage of patient records.<br><br>CQC report provides assurance of compliance on inspected wards in relation to secure storage of patient records. |
| **Gaps in controls** | No method of control of stopping paper records being removed. | **Gaps in assurance** | |

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| **Actions next period:** | Investigate and leverage monitoring and blocking capabilities of Trust's web filtering solution.<br>RFID case-note tracking. (First phase complete )<br>Monitoring of sensitive data being sent from non secure commercial email accounts – in progress.<br>IG Manager has now commenced and will continue monitoring "High" alerts in the external email monitoring software prompting email notices to members of staff (2 in May) |

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| **Principal Risk** | A610-O6: The Trust will not attain the nationally mandated target of 95% of all staff receiving annual information governance training | | | | |
| **Description** | Failure to reach the target will result in an 'unsatisfactory' score for the IG toolkit submission for the Trust. | | | | |
| **Domain** | **3. Regulation & compliance** | | | **Strategic Objective** | **3.1 Maintain compliance with all statutory and regulatory requirements** |
| | **Original** | **Current** | **Update** | **Exec Sponsor** | Ros Given Wilson |
| **Consequence** | 3 | 3 | 3 | **Date opened** | 31/10/2011 |
| **Likelihood** | 5 | 5 | 5 | **Date closed** | |
| **Score** | 15 | 15 | 15 | | |

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| **Controls & Mitigating Actions** | Information governance is a mandatory module in Trust induction training, MAST training and Cerner Training. E-Learning platform for MAST.<br>Review of attendance at HR and Workforce and IG Committee.<br>Management procedures to follow up of non-attendance in place. | **Assurance** | Increase in uptake of training completed with MAST. Negative - still at 80% completed training.<br><br>Statistic from WIRED: Increase in IG training compliance to 74% as of May end.– caution required around the accuracy of the WIRED statistics due to the "newness" of the system.<br><br>Nationally mandated target of 95% was not met for 2013/14. |
| **Gaps in controls** | | **Gaps in assurance** | |
| **Actions next period:** | New e-learning and e- assessment modules have gone live and continues to roll out. Completed full review of all IG module materials.<br>MAST training is being strongly promoted over the coming year.<br>The 2013 – 2014 target for MAST compliance across the Trust is 95%.<br>Comms to all Trust in eG mandating IG MAST. Comms from Medical Director to Divisions mandating IG MAST.<br>IG Manager continuously monitoring IG training compliance. | | |

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| **Principal Risk** | O3- O1 Ability of the Trust to demonstrate its compliance in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO) | | | | |
| **Description** | Ability of the Trust to demonstrate its compliance in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO) | | | | |
| **Domain** | **3.Regulation & Compliance** | | | **Strategic Objective** | **3.1 Maintain compliance with all statutory & regulatory requirements** |
| | **Original** | **Current** | **Update** | **Exec Sponsor** | David Hastings |

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| **Likelihood** | 5 | 4 | 4 | **Date opened** | 14/03/2013 |
| **Consequence** | 3 | 4 | 4 | **Date closed** | |
| **Score** | 15 | 16 | 16 | | |
| **Controls & Mitigating Actions** | Robust action plan in place being led by the fire safety team and monitored through the Health, Safety & Fire Committee.<br><br>Regular meetings/communication with Fire Brigade to check progress.<br><br>Specialist fire safety resource in place to lead on the actions. Planned and reactive monitoring of fire safety.<br><br>Regular Fire risks assessments | | | **Assurance** | Reporting on Fire Risk assessments to Health Safety and Fire Committee and escalate any issues to the Organisational Risk Committee<br><br>Staff appropriately trained to increase compliance<br><br>Internal audit finding of limited assurance |
| **Gaps in controls** | Comprehensive surveys and assessments of compartmentation.<br>Fire risk assessments not in place for all areas.<br>Not all staff appropriately trained to increase rate of compliance. | | | **Gaps in assurance** | Follow up Internal Audit - Sept 2014 |
| **Actions next period:** | Implement action plan in period. (Fire risk assessments, training, infrastructure, governance).<br>Monitor progress through Health, Safety & Fire Committee and via Organisational Risk Committee. | | | | |

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| **Principal Risk** | 03-02 Failure to demonstrate full Estates Compliance | | | | |
| **Description** | There are gaps in the mandatory and statutory estates compliance documentation. There is a lack of written evidence and historical data of compliance demonstrating that planned and reactive maintenance is being undertaken. | | | | |
| **Domain** | **3.Regulation & Compliance** | | | **Strategic Objective** | **3.1 Maintain compliance with all statutory & regulatory requirements** |
| | **Original** | **Current** | **Update** | **Exec Sponsor** | David Hastings |
| **Likelihood** | 4 | 4 | 4 | **Date opened** | October 2012 |
| **Consequence** | 4 | 4 | 4 | **Date closed** | |
| **Score** | 16 | 16 | 16 | | |
| **Controls & Mitigating** | Revised estates permanent management structure is in place this includes a compliance manager. | | | **Assurance** | Estates compliance records being assembled.<br><br>Action plan being monitored and progress updates to the Operational |

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| **Actions** | Planet FM system (the estates helpdesk and job request system) is being upgraded to allow compliance to be monitored.<br><br>An audit on the gaps in compliance has been completed.<br><br>There is a planned programme in place to close the gaps in compliance.<br><br>This risk is monitored via the Health, Safety & Fire Committee and overseen by the Organisational Risk Committee. | | Management Team. |
| **Gaps in controls** | The action plan will be further developed as higher risk items are closed. | **Gaps in assurance** | Full compliance reports not yet available. |
| **Actions next period:** | Complete the actions from arising from the internal audit.<br>To ensure that regular updates are provided to the committees monitoring this risk.<br>There is an external expert review of compliance scheduled for August 2014 | | |

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| **Principal Risk** | 03-03Delay to the ability to deliver the capital programme and maintenance activity due to clinical and capacity demands preventing access for estates and projects works. | | | | |
| **Description** | Delay to the ability to deliver the capital programme and maintenance activity as a result of spaces not being handed over to projects and maintenance as a result of capacity issues. | | | | |
| **Domain** | **3.Regulation & Compliance** | | | **Strategic Objective** | **3.1 Maintain compliance with all statutory & regulatory requirements** |
| | **Original** | **Current** | **Update** | **Exec Sponsor** | David Hastings |
| **Likelihood** | | 4 | | **Date opened** | May 2014 |
| **Consequence** | | 4 | | **Date closed** | |
| **Score** | | 16 | | | |
| **Controls & Mitigating Actions** | Risk assessments undertaken for each project.<br>Space surveys are undertaken on an annual basis to provide room usage data to enable the project manager to work out a plan. | | | **Assurance** | Monitoring of project and maintenance activity through project/programme boards and Divisional Governance Boards.<br><br>Capital project delivery is reviewed through Capital Programme Board & |

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| | Monitored through the Capital Programme Board & Project Programme Board<br>Engage with the department early in the capital scheme and jointly agree how this can be managed. | | Project Programme Boards. |
| **Gaps in controls** | | **Gaps in assurance** | Not monitored robustly through all Divisional Governance Boards. |
| **Actions next period:** | To improve robust monitoring of project and maintenance activity.<br><br>The list of space requests are being collated to assess the requirements. This will form the basis to find and agree the location of a decant space. There is work underway to find commercial office space to rent to move transactional staff off site and release space for redevelopment. | | |

**Domain 4. Strategy, transformation & development: 4.1 Redesign pathways to keep more people out of hospital**

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| **Principal Risk** | 01-O8 Increased strategic uncertainty in SW London | | | | |
| **Description** | The longer it takes to develop proposals for service reconfiguration in SW London the more likely the health economy will face rapid and unplanned change because of system unsustainability. | | | | |
| **Domain** | **4. Strategy, Transformation & Development** | | | **Strategic Objective** | **4.1 Redesign pathways to keep more people out of hospital** |
| **Score** | **Original** | **Current** | **Update** | **Exec Sponsor** | Trudi Kemp |
| **Likelihood** | 4 | 4 | 4 | **Date opened** | 01/01/2013 |
| **Consequence** | 3 | 3 | 3 | **Date closed** | |
| **Score** | 12 | 12 | 12 | | |
| **Controls & Mitigating Actions** | • Continue to work with commissioners and partners, and provide leadership for necessary changes in SW London service re-configuration<br>• Our LTFM does not include reconfiguration in the base case, so our FT application is not dependent on this. We must ensure that we have rigorously assessed potential | | | **Assurance** | • Our LTFM does not include reconfiguration in the base case, so our FT application is not dependent on this.<br>• We are and will remain a fixed point as a major acute provider in SW London<br>• Continue to ensure that quality standards are sustainably met at SGH |

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| | upside and downside cases in a range of scenarios in SW London, and keep commissioners and NHSL/NTDA/Monitor involved in this thinking. | | |
| **Gaps in controls** | St. George's Healthcare NHS Trust has limited control over decision making processes in the CCGs, NHS England and the NTDA/Monitor. | **Gaps in assurance** | |
| **Actions next period:** | Continue to support CCG and partner providers in developing proposals for sustainable health services in SW London.<br><br>Continue to implement the trust strategy as per the 14/15 plan | | |

**Domain 4. Strategy, transformation & development: 4.2 Redesign and reconfigure our local hospital services to provide higher quality care**

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| **Principal Risk** | A533-O8: Reconfiguration of healthcare services in SWL result in unfavourable changes to SGHT services and finances | | | | |
| **Description** | Likely future reconfiguration of acute services in SWL as current reconfiguration not affordable. Risk of reduced range of services or downsizing of services leading to loss of income and financial margin. Possible adverse effects on the delivery of patient care. Even small shifts of activity are likely to reduce financial margin on outpatient activity. As a result of uncertainty the Trust is unable to define activity, capacity and business plans. Risk that patient flows may either exceed expected numbers, impacting on capacity, performance and the quality of care or elective throughput. Opposite risk that predicted activity does not materialise as anticipated, leaving the trust with under utilised assets | | | | |
| **Domain** | **4. Strategy, Transformation & Development** | | | **Strategic Objective** | **4.2 redesign and configure our local hospital services to provide higher quality care** |
| **Score** | **Original** | **Current** | **Update** | **Exec Sponsor** | Trudi Kemp |
| **Likelihood** | 5 | 4 | 4 | **Date opened** | 30/09/2010 |
| **Consequence** | 5 | 2 | 2 | **Date closed** | |
| **Score** | 25 | 8 | 8 | | |
| **Controls & Mitigating Actions** | Strategy team regularly analysing the financial impacts of both the shifting of care away from the acute site and also the impact of predicated additional activity following acute reconfiguration. This includes sensitivity analyses on both activity and finance.<br>STG playing leadership role in reconfiguration, planning and modelling for SW London in collaboration with | | | **Assurance** | LTFM base case does not assume upside of reconfiguration.<br><br>Estimated the activity capacity and capital implications of a range of possible reconfiguration options |

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| | commissioners and providers<br>Development of relationships with new CCGs to work together on realistic QIPP and demand management plans through individual and SW London-wide out of hospital and integration programmes. | | |
| **Gaps in controls** | None identified | **Gaps in assurance** | |
| **Actions next period:** | Continue to support CCG and partner providers in developing proposals for sustainable health services in SW London.<br><br>Continue to implement the trust strategy as per the 14/15 plan | | |

**Domain 4. Strategy, transformation & development: 4.3 Drive research & innovation through our clinical servcies**

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| **Principal Risk** | 05-05 Research does not form a key part of St. George's future activity which may result in the loss of funding and an inability to recruit and retain staff. | | | | |
| **Description** | Although SGH has a Research Strategy, this is not embedded as a driver for research across the Trust. It is a high level document that does not set out how research will be embedded.<br>•Track record in research relatively weak<br>•St. George's brand is not strong in research.<br>•Service demands restrict the ability to develop research at St George's (Historical differences in approach)<br>•Loss of opportunities for research and development.<br>•Inability to sustain research infra-structure and governance. | | | | |
| **Domain** | **4. Strategy Transformation & Development** | | | **Strategic Objective** | **4.5 Drive research and innovation through our clinical services.** |
| | **Original** | **Current** | **Update** | **Exec Sponsor** | Ros Given Wilson |
| **Consequence** | 4 | 4 | 4 | **Date opened** | 28/02/2013 |
| **Likelihood** | 3 | 2 | 2 | **Date closed** | |
| **Score** | 12 | 8 | 8 | | |
| **Controls & Mitigating Actions** | • Joint Executive Group now established with appointed leads in JREO.<br>• AMD for Research working with the Dean of Research and Enterprise. Regular joint meetings between SGUL and SGHT execs.<br>• Research strategy signed off.<br>• CLRN Funded PAs for research active consultants within Divisions now agreed<br>• Four Research sabbaticals have been awarded, of | | | **Assurance** | Positive Assurance:<br>• Agreed Trust KPIs for research.<br>• Increased levels of recruitment to NHR trials - both on raw and weighted figures. We have had a 40% increase in weighted recruitment<br>• Research KPIs reviewed at TB.<br>• MHRA has signed off compliance with clinical trials<br>• Increase in number of studies approved |

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| | which two sabbaticals have started.<br>• Annual Plan for research strategy currently being drafted<br>• Working with Information team, to integrate research data | | Negative assurance:<br>• Governance approval times are variable quarter by quarter Additionally, CRN have reduced the target approval timeline by 50%<br>• Not all studies approved contribute to NIHR targets.<br>• Issues with CRF staffing is improving but two vacancies remain and are in recruitment. This could derail and delay studies from areas that rely on that help. |
| **Gaps in controls** | • Joint working between SGUL Institutes and SGH NHS<br>• No system or guidance for prioritisation towards studies that contribute to NIHR recruitment (high-impact studies.)<br>• There are capacity gaps for the JREO to in support developing research-interested consultants to initiate getting studies up and running<br>• Lack of integration of research data in Trust information systems | **Gaps in assurance** | |
| **Actions next period:** | Get remaining two research sabbaticals active by October 2014.<br>Initiate round two of sabbatical investment<br>Reorganisation of clinical research facility – ONGOING<br>Agreement of Divisional Scorecards – and introduction onto DMB or similar agenda – ONGOING<br>Implementing the Research Board – ONGOING<br>Follow up CRN re-structure and budget impact – September 2014 | | |

**Domain: 5. Workforce: 5.1 Develop a highly skilled & engaged workforce championing our values**

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| **Principal Risk** | A516-O4: Possible reductions in the overall number of junior doctors available with a possible impact on particular speciality areas | | | | |
| **Description** | Inability to recruit and retain the appropriately skilled workforce to deliver our strategy | | | | |
| **Domain** | **5. Workforce** | | | **Strategic Objective** | **5.1 Develop a highly skilled & engaged workforce championing our values** |
| | **Original** | **Current** | **Update** | **Exec Sponsor** | Wendy Brewer |
| **Consequence** | 4 | 4 | 4 | **Date opened** | 30/11/2012 |
| **Likelihood** | 4 | 1 | 1 | **Date closed** | |
| **Score** | 16 | 4 | 4 | | |

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| **Controls & Mitigating Actions** | Workforce Utilisation Plan reviewed monthly by the Trust Board. The surgical 24/7 group continues to meet regularly to review progress. ANP and PA posts have been established in most divisions to replace the work previously done by junior doctors. A training and education plan is under development for the PAs and ANPs. Able to appoint to these posts and see them as part of the staffing establishment in the future | | | **Assurance** | Positive assurance received via regular review within divisions. No real reduction in numbers to date. Known and anticipated reductions in junior doctor numbers will be included in business planning guidance and information for 14/15 business planning round. |
| **Gaps in controls** | None identified | | | **Gaps in assurance** | |
| **Actions next period:** | Each of the divisions will consider workforce implications as part of the business planning round. Any particular difficulties in recruiting to vacancies will be identified and action plans produced. | | | | |
| **Principal Risk** | A518-O4:Failure to reduce the unacceptable levels of bullying & harassment reported by staff in the annual staff survey | | | | |
| **Description** | Expectations placed on staff continue to rise in the light of increased clinical activity and tougher standards.<br>Pressure felt by managers and staff often results in inappropriate behaviours.<br>Quality of patient care negatively affected | | | | |
| **Domain** | **5. Workforce** | | | **Strategic Objective** | **5.1 Develop a highly skilled & engaged workforce championing our values** |
| | **Original** | **Current** | **Update** | **Exec Sponsor** | Wendy Brewer |
| **Consequence** | 4 | 4 | 4 | **Date opened** | 31/05/2010 |
| **Likelihood** | 4 | 3 | 3 | **Date closed** | |
| **Score** | 16 | 12 | 12 | | |
| **Controls & Mitigating Actions** | Staff are knowledgeable about the Stress Management policy & Dignity at Work: Bullying & Harassment policy. We have a H&B helpline that staff can use supplemented by access to the Staff Support and mediation service. Support is offered to managers on how to develop inter-personal skills through Leadership Development Programmes. Conflict resolution training is offered as part of induction. Regular contact with Staff side reps who raise issues on concern. Annual reports to the Organisational Risk Committee.<br>The Friends and Family test for staff has been launched on a trial basis which will allow us to be aware of areas where there is an increase in pressure. | | | **Assurance** | Divisional action plans are being revised in light of the 2013 staff survey results. The Listening into Action programme alongside work on the Trust's values will focus on action around harassment and bullying. December 2013: voluntary turnover rate has increased and is 11.1% (target 12%) and vacancy rate is 10.5% (target 11%). Listening into Action continues to be rolled out. |

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| **Gaps in controls** | None identified | **Gaps in assurance** | |
| **Actions next period:** | Action plans are being developed in response to 2014 staff survey results.<br>The Listening into Action programme alongside work on the Trust's values will focus on action around harassment and bullying.<br>Director of HR is developing an Embedding our Values programme for use across the organisation.<br>Unconscious bias training for senior managers will be run for managers over the next 6 months.<br>A new set of poster on harassment and bullying will be publicised across the organisation to raise awareness. | | |

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| **Principal Risk** | A520-O4: Failure to maintain required levels of attendance at core mandatory and statutory training (MAST) | | | | |
| **Description** | Loss of momentum caused by inability to release staff for training.<br>Managers unable to ensure staff attending or undertaking eMast | | | | |
| **Domain** | **5. Workforce** | | | **Strategic Objective** | **5.1 Develop a highly skilled & engaged workforce championing our values** |
| | **Original** | **Current** | **Update** | **Exec Sponsor** | Wendy Brewer |
| **Consequence** | 4 | 2 | 2 | **Date opened** | 31/05/2010 |
| **Likelihood** | 3 | 1 | 1 | **Date closed** | |
| **Score** | 12 | 2 | 2 | | |
| **Controls & Mitigating Actions** | 1. eMAST in place across the Trust. All managers are currently engaged in achieving compliance with target (all managers receive monthly reports on Core MAST take up and take action accordingly). New e-learning package being implemented and a new system for recording MAST will help ensure that all compliance activity is recorded.<br>2. eMAST training in place | | | **Assurance** | 1. MAST policy Regular reports to ORC. Mandatory training rates to be reported on an individual subject basis in line with National Framework recommendations.<br>2. Fully compliant with CQC Outcome 14: Supporting Workers<br>3. Uptake of eMAST training reports presented to ORC.<br>4. A report regarding the transition to the national framework has been presented to the Workforce Committee.<br>5. New subjects have been added to the requirements, which has had an impact on overall numbers but provides assurance that all nationally recognised mandatory items are now included in St George's mandatory training. |
| **Gaps in controls** | None identified | | | **Gaps in assurance** | |
| **Actions next period:** | Implementation of new e-learning package and reporting systems. | | | | |

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| | New systems fully functional although subject to some snagging problems. Work commencing to focus staff attention on individual subjects. |

Appendix 3

| | CW&DT | | |
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| **Risk Ref.** | **Risk** | **Score** | **Change ↑↓** |
| CW048 | Lack of awareness & resources for inpatients may mean patients who are victims of domestic violence are not identified | **16** | → |
| CW050 | Computerised CTGs no longer performed for high risks antenatal pregnant women no longer used in DAU | **15** | → |
| CW057 | The Division has a £1.5m overspend at M1 due to a number of adverse movements | **25** | → |
| | **M&C** | | **Change ↑↓** |
| **Risk Ref.** | **Risk** | **Score** | |
| MC30-D5 | Risk to patient safety due to a lack of capacity to transfer patients to SGH for their cardiovascular procedures within 24hrs of referral. This risk may also impact on finances and business if it results in loss of referral pathway. | **15** | → |
| MC31-D5 | Risk to patient safety as patients waiting greater than 18 weeks on elective waiting list for cardiothoracic surgery. | **15** | → |
| MC32-D1 | The division is at risk of not delivering a balanced budget if robust CIP schemes are not found. Not all schemes identified in 13/14 have delivered and therefore knock on effect for schemes in 14/15. | **15** | → |
| MC35-D1 | Risk to patient and staff safety due to aggressive and violent behaviour of haemodialysis patient. | **15** | → |
| MC36-D1 | Risk to patient safety as lack of comprehensive emergency call bell system in the Emergency Department. Temporary systems that had been put in place in some areas are no longer functional. | **15** | **new** |
| MC40-D1 | Risk to patient not being seen by the Palliative Care Team in the community. Increase inpatient staying due to increase waiting time between referral to Palliative Care Team and review by team in the community. | **15** | **new** |
| MC-MC37-D1 | Risk to patient as may not be effectively monitored through telemetry. | **15** | ↑ |
| | **STN&C** | | **Change ↑↓** |
| **Risk Ref.** | **Risk** | **Score** | |
| B287 | Four types of defibrillators in use with non-interchangeable electrodes - poses a significant patient safety risk in the event of the wrong electrodes being available during a cardiac arrest. | **20** | → |
| B253 | SSD risk upgraded in light of recent significant failures and down time of SJW equipment. On-going issues. Upgraded from 12 to 16 | **16** | → |
| B268 | Sterilisation equipment requires replacing and breakdown may cause service failure potentially resulting in cancelled surgery. | **15** | → |
| B294 | Faults with Primus anaesthetic machines may result in ventilator or power failure – due to age of machine (10 yrs+) | **15** | → |
| B295 | Patients being seen in clinic without full medical records due to unavailability of records | **15** | → |
| C04 | Under-recording of high cost drugs eligible for recharge to commissioners by the Neurosciences Directorate, Pharmacy and Finance Department. | **15** | **new** |

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| C05 | The Division fails to achieve its CIP programme due to late commencement of schemes, capacity constraints and failure to mitigate against the above | **15** | **new** |
| C06 | The division does not receive funding for identified cost pressures | **15** | **new** |
| EF200 | Delay to the ability to deliver the capital programme as a result of spaces not be handed over to projects as a result of capacity issues | **16** | ↑ |
| | **IM&T** | | |
| **Risk No.** | **Risk** | **Score** | **Change ↑↓** |
| IT004 | Insufficient staffing levels in ICT support leading to increasing numbers of outstanding calls remaining unresolved. | **15** | → |
| IT018 | Community staff experiencing access difficulties and slow response to RIO | **16** | → |
| IT011 | Computer hardware in the clinical areas and issues with VDI. | **16** | → |
| IT029 | There is a risk of onsite data centre (DC) failure due to inadequate provision and support of air conditioning cooling in the DC. | **20** | **new** |
| IT030 | There is a risk to the provision of existing and future ICT applications hosted in the onsite DC due to lack of capacity and control of additional power provision. | **15** | **new** |
| IT031 | There is a risk to the provision of existing and future ICT applications hosted in the onsite DC due to poor environmental monitoring [UPS, air conditioning, BMS push alerts] | **20** | **new** |
| IT032 | Increased risk to network availability due to inadequate electrical supply to key locations. | **15** | **new** |
| IT033 | Increased clinical risk to patient safety resulting from lack of UPS protection for main Trust Switchboard. | **20** | **new** |
| EF176 | Estates compliance – survey revealed gaps in compliance in statutory and mandatory items | **16** | → |
| EF131 | Cooling Towers on the roof of St James Wing - three wet cooling towers; statutory guidance consider these high risk because of legionella risk. The risk has increased following the opening of the helipad. | **16** | → |
| EF189 | Standby Generators within Lanesborough Wing are at the end of their useful life and have insufficient capacity to meet the needs of current healthcare demands and will not need the demand as the building is re-developed and refurbished to modern standards. | **16** | → |
| EF195 | Electrical upgrades/maintenance to UPS and IPS in AMW | **16** | → |
| EF198 | Risk of noncompliance with fire regulations as a result of the lack of fire risk assessments for some areas on the St George's Hospital site | **15** | → |
| EF199 | Lack of decant space for capital schemes delays the ability to deliver large capital schemes | **16** | **new** |
| EF200 | Delay to the ability to deliver the capital programme as a result of spaces not be handed over to projects as a result of capacity issues | **16** | ↑ |
| | **CSW** | | **Change ↑↓** |
| **Risk No.** | **Risk** | **Score** | |
| | No extreme risks | | |

Appendix 4

| CQC Outcome/ Domain | Identified issue | Area/Dept action relates to | Action already or to be taken | Measure or test of Effectiveness | Lead | Date for completion | Progress update (13.6.14) |
|---|---|---|---|---|---|---|---|
| Safe | Ensure risk registers reflect the risks in each department and ensure appropriate action is taken to address recommendations from national guidance. | Corporate action: | 1. Implement actions arising from Internal Audit (Mar 2014) within agreed timescales<br>2. Develop specific risk training for staff to support accurate and timely identification of risks on risk registers | Audit recommendations/ actions closed off training in place | Corp Risk and Assurance Mgr/Risk Mgrs | end of Sept 2014 | Not due: On track |
| | | Divisional action: | 1.Risk register reviewed at each DGB.<br>2.Clarify process for staff in identifying and adding new risks to the register.<br>3.Review terms of reference for divisional and local governance meetings.<br>4. Ensure risks identified at divisional performance reviews are included in risks registers | Risk Registers will reflect actual local risks identified. | DDNGs | monthly & on-going | DGB TOR reviewed for:<br>Comm Servs<br>CW&DT<br>Med & CV in progress<br>Surgery in progress<br>all other actions ongoing |
| Well Led | Ensure action is taken to address issues of bullying and harassment and support staff in raising concerns | Human Resources (concerns relate to Children's Services) | Review of specific concerns raised by CQC, to ensure that all areas where concerns have been listed, have a plan to bring the concerns to the attention of those identified and a specific plan to address the concerns.<br>To report back to EMT by 21/4/14. | Improved staff survey results | Director HR | 21/04/2014 | Complete: Report submitted to EMT on 14 April 14 and plan for handling individual concerns set out. Principles for dealing with general concerns agreed and progressing. To be presented to the Overview and Scrutiny Committee - July 2014. |

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| Well Led | Alleviate staff concerns about permanent staffing levels on the children and young people wards. | Corporate Nursing | 1.Robust review of establishments almost complete (May board)<br>2.Safe staffing policy and escalation revised<br>3.Implementation of acuity & dependency tool | Staff survey results<br>Staffing levels / numbers | Dep Chief Nurse | End May | An establishment review was undertaken and approved by the board on 29 May 2014. This review identified a need to uplift the paediatric ward and NNU establishments. In line with trust-wide plans the implementation of this review will be taken forward based on risk assessments and further financial evaluation. |
| | | CW&DT | Workforce plan developed for children's servicesProactive recruitment campaigns and assessment centres for nursing staff recruitment<br>• On-going recruitment of band 5 nurses at trust regular monthly assessment days<br>• Use of agencies for overseas recruitment<br>• Planned visit to Scotland for recruitment following attendance at recruitment fair in Glasgow<br>• Clinically based teacher to support students – and aid recruitment on qualification<br>• Part-time practice educator in place; full-time post advertised<br>• Plan for neurology trained CNS to be ward based to | Staff survey results<br>Staffing levels / numbers | DDNG/DDO | On-going | Assessment centres are on-going.<br>Visit to Romania has happened but with limited success |

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| | | | support staff<br>• Programme of culture change on-going to improve retention rate of current staff | | | | |
| Safe | Ensure appropriate cascade of information regarding staffing<br><br>Ensure lessons learnt from incidents across the hospital | Corporate | 1. Biannual establishment reviews in place from April 2014 and reported to Trust board.<br>2.Safe staffing policy and process embedded within divisions. Safe Staffing boards to be in place in each clinical area from Jun 2014<br>3.Implement tracking facility for actions arising from Adverse incidents onto Datix system | Daily email alert for safe staffing. Assurance to be provided to the Nursing Board on incidents and actions taken. Reduced number of incidents relating to staffing. | Dep Chief Nurse<br><br>Corporate Risk and Assurance Manager | quarterly<br><br>Sept 14 | Bi-annual establishment review done in May 2014. Safe staffing board in place in clinical areas (ward based areas).<br><br>Datix tracking system on track |
| | | Clinical and corporate divisions | Learning from SIs and adverse incidents shared at local and divisional governance meetings.<br><br>Ensure trend analysis and learning from adverse incidents is incorporated into regular governance reports | | DDNGs & Corp Divisional Leads | on-going | On going |
| Well Led | Clarify the management structures and the responsibilities of other team members to staff in the outpatient services | Children's & Women's Division | Structure to be reviewed and confirmed. | structure chart | DDNG/GM - OPD | Jun-14 | Complete - HON for OPD now in post and has reviewed nursing structures and regular staffing wit recommendations to be taken forwrad through normal business planning |

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| Care | Address issues of privacy, dignity and confidentiality as detailed in the report for this hospital | all divisions | 1. Ensure curtains fit around beds and work with Estates to ensure that curtains are providing coverage of beds and patients.<br>2. Staff to be mindful of noise at night.<br>3. Ensure staff document patient/family involvement in care.<br>4. Respond to findings of privacy and dignity audits.<br>5. Number of noise meters to raise staff awareness of issue now in place includinng Gray, Kent and Mc kissock wards. | Matron /HON quality ward checks.<br><br>Positive responses from FFT and Picker Inpatient survey. Fewer complaints relating to dignity. | HoNs | Oct-14 | Not due |
| Safe | Avoid the unnecessary overbooking of outpatient clinics | CW&DT | There is a workstream which encompasses this action as part of the overall COS improvement plan to establish clear rules around the overbooking of clinics | | GM/HON COS | on-going | On- going |
| Well Led | Ensure that all staff receive appraisals and supervision and that this is documented | All divisions & Corporate | Continue to monitor and manage appraisal rates through divisional structures/quarterly performance reviews | Trust target for appraisal rate achieved. | Divisional Triumvirates and Dept Heads | on-going | On- going |

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| Safe | Review the combining of cardiology and cardiothoracic patients on Caroline Ward | M&CV | A review of the cardiothoracic bed base is currently being carried out to enable the development of a heart failure unit.<br>This review will entail ensuring each specialty within the directorate has the appropriate number of beds.<br>However in order to achieve maximum efficiency, single sex accommodation and availability of beds for urgent admissions there needs to be some flexibility with the use of beds. An assessment of the patient's condition and nursing needs by senior nursing and medical staff would always inform the decision. | Monitoring of feedback from patients via FFT or complaints.<br>Monitoring of adverse incidents. | Clinical director / GM | Jul-14 | Review complete: Beds strategy for the directorate in progress with number of beds each specialty required identified. Business cases to support the development of additional beds have been drafted. Plan for additional 7 beds to be available Q4 2014/15 and additional 18 beds available Q2/3 2015/16. Heart failure unit phase 1 will be implemented Q2 2014/15 with phase 2 following the build of the additional 18 beds. |
| Safe | Ensure that there are adequate numbers of porters to cover the A&E department, particularly at peak times | Estates & Facilities | Additional porters are provided to A & E funded by winter pressures. Additional porters work from 12.00 hours until midnight and from 23.00 hours to 09.00 hours. As a result of increased demand for patient movements later in the evening a review is underway to see what extra resource is required. These will be provided as a cost pressure. | Feedback from A & E and diagnostics | GM-Facilities | 01-May-14 | Complete |

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| Safe | Prevent the breaching of single-sex bays | All divisions/corp nursing | Maintain compliance with Mixed Sex Accommodation policy. In HASU daily escalation and review takes place. Monthly RCA of any breaches. | Matron /HON quality ward checks | DDNGs/HONs | complete & on-going | On-going |
| Responsive | Ensure that patients are always transferred to the most appropriate ward | Corporate Nursing | Monitor compliance with trust transfer policy - consider audit cycle. | | Site team | ongoing | On-going |
| Effective | Ensure that all staff always adhere to fire safety regulations | all divisions/corporate | Review staff awareness of fire safety regulations. Monitor at divisional health and safety group. Ensure adequate levels of staff attending Fire Safety sessions. | agenda and minutes of divisional health and safety group. | DDNGs/Fire Safety Mgr | Jul-14 | Not due |
| Safe | Review the recording system for pain relief of patients in the children's emergency department so that it includes a space for staff to detail hourly checks | M&CV | Review children's ED cards with a view tomaking any required changes. | | ED Matron | Sep-14 | ED cards that have gone off to the publishers made adjustments for recording pain relief checks |
| Responsive | Review communication systems in the event of admission and discharge with community health providers | all divisions/corporate | Trust wide Discharge Planning improvement plan in place | | tbc | | |

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| OPD - responsive | Improvements to outpatient services for children | QMH | Review of all children OPD suites, include children and parents in review. | Patient satisfaction survey to DGB | AD Adult and Diagnostic services | Sep-14 | Not due |
| Safe | Ensure that patient documentation is complete | QMH (Mary Seacole) | Mary Seacole ward: Nursing documentation to be reviewed by ward manager daily | Ward meeting Care group meeting Matron quality rounds HON spot checks monthly | HoN Senior Health | Jul-14 | Not due |
| Safe | Ensure that staff receive appropriate training in using, moving and handling equipment | QMH/corp | Mary Seacole ward: Staff training needs to be reviewed and updated. | Training records to be kept and monitored | HoN Senior Health | Sep-14 | Not due |
| OPD - Responsive | Review the signposting in the orthotics department | Estates | Seek patients opinion as to signage satisfaction | Patient satisfaction survey to DGB | AD Adult and Diagnostic services | Sep-14 | Not due |
| Safe | Review confidentiality within the sexual health clinic waiting area | QMH | Seek patients' opinion as to confidentiality of sexual health clinic as part of service improvement evaluation | Confidentiality in clinics review report and recommendations supported by DGB | AD Adult and Diagnostic services | Sep-14 | Not due |
| Effective | Ensure that all staff are aware of the location of emergency equipment | QMH | Raise awareness of location of emergency equipment through staff briefings and how to respond to medical emergencies. | Staff are aware of how to manage medical emergencies. | AD Adult and Diagnostic services | Jul-14 | Not due |

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| Effective | Defibrillators and resuscitation equipment should be reviewed in all premises where coil fittings and implants are performed | St John's Therapy Centre | Review all clinics which have coil fittings and implants and identify appropriate equipment required | Appropriate equipment in place to support adverse reaction. | AD Adult and Diagnostic services | Jun-14 | Review completed and risk assessment undertaken and plan/controls to manage and reduce risk now on Risk Register. To be managed through normal Trust process. |
| Responsive | Information should be reviewed to address the needs of the local population | Corp | Communications to all staff around access to translation services and facilities to ensure leaflets in other languages can be provided as appropriate | Use of service | Dep Head of Comms | Jun-14 | Complete and to continue |
| Safe | All clinical staff should receive safeguarding supervision from a named professional, in line with best practice guidance | Comm servs | All staff receive child safeguarding supervision from either named nurse or identified practitioner with appropriate skills and training. | Benchmark of safeguarding supervision against best practice guidelines | Child safeguarding lead for CSD. | Sep-14 | Not due |
| Effective | The trust should review the integration of the IT system and ensure a prompt response to community IT issues | IT | Since taking full management of the community IT infrastructure in October 2013 options for closer integration of IT infrastructure has been commissioned. Domains will be brought together post migration of key clinical information services from national to local service provision. IT service desk performance is review and reported to the Trust ICT user group which includes both community and acute staff | Monitoring of Service Levels via ICT user group | Director of IT | Sep-15 | Not due - on track |

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| | | | representation | | | | |
| Well-led | Senior managers should be more visible in the community settings to enhance leadership | Comm Servs | Quarterly community road shows led by DC in place. Seek opinion from staff what would be helpful in meeting their needs. | Plan of visits from divisional and corporate team | Div Chair | Jul-14 | Complete - in place |
| | | Corp | Ensure Quality inspections undertaken by senior managers and Executives regularly encompasses Community locations | | Corporate Risk and Assurance Manager | on-going | current programme under review to identify regular inspections at QMH |
| Effective | The relevance of communication that is cascaded to community staff should be strengthened where appropriate | Communications team | put in place a dedicated member of the Communications team to link directly with Comm Servs to understand clearly objectives, priorities and type of support needed with communications to ensure relevant and appropriate | Effectiveness of communications | Head of Comms | Jul-14 | On track |
| Safe | Patients' allergy status should be recorded on the medication administration charts as well as | Corporate Outpatients (St John's Therapy Centre) | All medication charts to include allergy status. | | tbc | tbc | |

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| | on care records | | | | | | |
| Well Led | Complete review of findings of inspection and issues identified in order to provide an overarching response to the wider work ongoing to address these issues: | EoLC | End of Life Care Steering Group to develop, implement and monitor improvement plan to address overall findings of CQC in relation to EoLC | | Dep C/Nurse / Chief Nusre? | tbc | |