St George's Healthcare NHS
NHS Trust

REPORT TO TRUST BOARD *July 2014*

Paper Title:	Risk and Compliance report for Board incorporating: 1. Board Assurance Framework 2. Assurance Map 3. Update on Quality Inspection programme 4. CQC Intelligent Monitoring Report
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Purpose:	To update the Board about compliance activity/risks and related developments occurring across the Trust and provide assurance about the management of risk.
Action required by the committee:	To note the report
Document previously considered by:	Quality and Risk Committee

Executive summary

Key Messages:
The paper presents:

- The significant risks on the Board Assurance Framework are presented following review at Executive Management Committee and Quality and Risk Committee.
- Progress on the actions arising out of previous external inspection and results of external assessments and inspections that have been recently concluded.
- Risks highlighted in the CQC Intelligent Monitoring report published on 21 July 2014.
- External assurances received during the period.

Recommendation:

The Trust Board is asked to note:

- The potential risks for consideration and inclusion in the BAF.
- The updated Assurance Map.
- The risks noted in the CQC intelligent monitoring draft report and trust assurances surrounding these risks.

Risks
The most significant risks on the Board Assurance Framework are detailed within the report.

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	All
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	All 16 core Essential Standards of Quality and Safety

Equality Impact Assessment (EIA): Has an EIA been carried out? Yes
If yes, please provide a summary of the key findings

1. Risks - Board Assurance Framework (BAF):

This report identifies the extreme risks on the BAF, new and closed risks during the reporting period and significant changes made following regular review at Executive Management Team. Table 1 details the highest rated risks on the BAF. An executive overview of the BAF and the detail of each individual risk are included at Appendix 1& 2 (pages 9 & 16). The rating is prior to controls being applied to the risk. Controls are detailed in Appendix 2. Risks are reduced once evidence that controls are effective.

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**
01-07	Risk to patient safety and experience as a result of potential Trist failure to meet 95% Emergency Access Standard	**4**	**4**	**16**
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	**5**	**3**	**15**
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**
3.11 - 06	Poor environment in ICT department/on site data centre may lead to interruptions or failure of essential ICT services	**4**	**4**	**16 (new)**
01-08	Risk to patient safety due to inconsistent processes and procedures for the follow up of diagnostic test results	**4**	**4**	**16 (new)**

1.1 Changes to risk scores:

At the time of reporting, there has been an increase in one risk score due to the emerging concerns around a lack of capacity to deliver all required MAST training: in particular face to face training such as Manual Handling/Resus and Safeguarding:

Ref	Description	C (prev)	L	Rating
A520-04	Failure to maintain required levels of attendance at core and mandatory and statutory training (MAST)	**3 (2)**	**4 (1)**	**12 (2)**

1.2 Closed risks

There are no risks proposed for closure.

1.3 New Risks proposed for inclusion:

The risks on the Board Assurance Framework are reviewed on a rolling basis and are subject to formal review by the Executive Management team prior to Trust Board. As part of the review, the range and severity of risks are considered, and potential and new risks are proposed for consideration and inclusion on the BAF. In addition, throughout July there has been a process undertaken to risk assess achievement of corporate objectives.

There are four new risks proposed for inclusion on the BAF:

- Potential risk to patient safety and continuity of care by poor Implementation of e-prescribing (identified following review of corporate objectives – Improve productivity)
- Potential risk to patient safety and continuity of care by poor preparation and procurement of programmed transition to Cerner (STG) from the national programme (identified following review of BAF risks by Executive Director)
- ICT Department environment: Impact upon business continuity of potential failures in air-conditioning and electrical supply. (Identified following review of ICT risk register at ORC)
- Diagnostics and screening procedures and gaps in fail safes to ensure appropriate follow up of results (identified via review of Serious Incidents and concerns raised by Clinical Commissioning Group – July 2014)

In addition, and following review at ORC, the following risk, escalated from the Estates and Facilities Directorate Risk Register in June, has been separated to reflect two separate risks (03-03 & 03-04):

- 03-03 Delay to the ability to deliver the capital programme and maintenance activity

1.4 New Risks identified during process of review and currently undergoing a full risk assessment (not yet on the BAF but will be included by next meeting):

- Risk to patient safety and experience of reduced staffing levels across Trust, potentially constituting two separate risks: nursing and overall staffing levels (identified following review of corporate objectives in conjunction with the findings of a detailed establishment review and review of several divisional risks as discussed at ORC)
- Risk of low staff morale versus requirements to continue to increase efficiency (identified via review of Corporate Objectives – Developing our Workforce).
- Risk of failure to provide adequate training and provision of Medical Equipment (identified through review of Divisional risk register, where existing risk was escalated at ORC)
- Trust wide risk to patient, public and staff safety of Legionella (identified through review of Divisional risk register where existing risk was escalated at ORC)
- Impact upon patient care and experience due to a potential lack of capacity to process the significantly increased volume of calls to call centre (identified by Division and reviewed at Executive Management Team)
- Issues around data quality collation and provision across the Trust (identified through on-going review of data quality and reports through various Trust committees including the Quality and Risk Committee)

1.5 Summary of Extreme Risks at Divisional level:

- Children's and Women's, Diagnostics and Therapeutics (CW&DT) have identified two new extreme risks. (Cancer treatment in Trevor Howell and loss of theatre time for women).

- Medicine and Cardiovascular (M&C) have identified six new extreme risks, four of which relate to finance and are as a result of aligning the divisional risk register with the Financial Risks on the BAF
- Surgery (STNC) have downgraded one extreme risk (C-01) due to improved scheduling of operations to ensure availability of stealth operating machine and have identified four new extreme risks, three of which are finance risks.
- Estates and Facilities (E&F) have downgraded two extreme risks (EF131 & EF118), and have identified one new extreme risk.
- IM&T have downgraded two extreme risks to high (IT004 & IT011) and have increased one high risk to extreme (IT016)

A full summary of extreme divisional risks can be found at Appendix 3 (p68).

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 Summary of external assurance and third party inspections June-July 2014

2.1.1 London Fire Brigade Notice of Deficiency

The Trust has been served with a Notice of Deficiency in relation to Knightsbridge Wing by the LFB following an incident in February. The Director of Estates and Facilities has followed this up with the Assistant Commissioner at LFB. We have until 11 September to address a schedule of six actions relating to assessment, prevention, training, maintenance, physical separation of a boiler room and means of raising an alarm. The LFB will inspect the premises sometime during September to review progress. The risk of fire safety compliance is an extreme risk on the board assurance framework.

2.1.2 London Stroke Commissioning (HASU) Review

The Trust was assessed by the London Stroke Commissioning Review in June 2014. The trust is yet to receive a formal report detailing the findings of the review; however it was very positive in general with lots of encouraging feedback from the commissioners. The main concern raised in the review was the number (percentage of patients) that do not go to the HASU when referred as a stroke. The trust has responded to commissioners regarding this concern and will develop any action plan to address any formal recommendations upon receipt of the report.

2.1.3 Radiological Protection Centre – BSI 9001

The radiological protection centre BSI 9001 quality audit identified three non-conformities in its March 2014 of St. Georges. The Trust received confirmation in June 2014 that all necessary actions had been sufficiently completed and that all non-conformities had been closed.

2.1.4 MHRA Accreditation – Blood Safety and Quality Regulations

The Trust submitted its blood safety and quality MHRA accreditation compliance report in June 2014. No concerns and non-conformities were identified.

2.2 Pending External Inspections – July 2014

2.2.1 BSI Medical Physics Accreditation

The trust is due to be audited by the BSI quality institute in August 2014. The medical physics department are fully prepared for the review. The medical physics department is also due to be audited by the United Kingdom Accreditation Service (UKAS) in late summer.

2.2.2 National Cancer Peer Review

The trust has received notification that validated self-assessments will be conducted on the following disciplines in late July 2014: Lung; Chemotherapy; Teenage and Young Adults; Haematology; Colorectal; Brain and CNS and Gynae-oncology.

2.3 External Assurance - conclusion

The key risk to report from external assurances is the compliance with fire safety. A comprehensive action plan in place and this has been recorded as an extreme risk on the BAF. The Trust continues to progress with the monitoring and compliance of action plans in place to address the recommendations arising out of external inspections.

3. Trust Quality Inspection Programme

The quality inspection programme is the key driver in ensuring that the trust achieves and maintains compliance with regulatory standards and requirements. The programme has been developed using the CQC framework for inspections and wards and clinical areas are inspected under five broad domains as follows:

- Are the trusts services *Safe;*
- Are the trusts services *Effective;*
- Are the trusts services *Caring;*
- Are the trusts services *Responsive* to people's needs; and
- Are the trusts services *Well-led?*

Inspections are conducted by a team of three consisting of a trust lead (senior non-clinical manager), a clinical lead (a trust based clinician) and a volunteer patient representative. Staff and patients are interviewed and the inspection team conducts a review of patient documentation as well as the general environment of each area inspected. Inspection reports detailing the key findings and observations are shared with the ward/area as well as senior divisional management and the final reports are reviewed by the Executive Management team.

Going forward, and in order to provide assurance around the themes and learning derived from the Quality Inspections, a summary of findings and outcomes of quality inspections will also be reported quarterly to the Trust board meeting. In the interim however, a thematic analysis of June inspections is provided below.

3.1 Quality Inspection Update – June 2014

Six wards and one outpatient clinic were reviewed during June 2014: three in Medicine and Cardiovascular division; two in Surgery, Theatres, Neurosciences and Cancer Services division and two in Children and Women's and Diagnostics and Therapeutics division.

Are the Trusts Services Safe

Inspection teams noted that staff were generally compliant with the trust uniform policy and were always bare below the elbows. Patients noted that staff adhered to a strong infection prevention regime and were vigilant in washing hands and using alcohol hand rub. In general it was noted that the wards and outpatient area inspected during the month were generally clean, however inspection teams commented that there were occasions where commodes were dirty and incorrectly labelled. One patient complained about the cleanliness of the ward in general but specifically the bathroom on Frederick Hewitt (Paediatric) ward being unclean.

The standard of patient records and documentation on wards varied considerably. It was noted that the standard of record keeping on Gunning (Surgery) and Nicholls (Paediatric) wards were particularly high, whilst there were more issues prevalent to patient records on Frederick Hewitt

and Gray (Surgery) wards. The main issues that inspection teams noted with regards to patient records were charts and observations not being correctly completed, loose documentation in patient files and poor legibility of documentation.

Patients felt that staff had generally been very respectful and sought to protect patient privacy and dignity. The inspection team on Frederick Hewitt ward were informed of one instance were a parent had overheard clinical staff discussing a patient's condition in a public area on the ward and felt that this was inappropriate.

Are the Trusts Services Effective
Patients were generally complimentary of the food provided at St. Georges. Patients on most wards felt that the food was palatable, hot and plentiful. The only exceptions to this occurred on Frederick Hewitt and Nicholls wards where parents commented that the food did not look particularly appetising and was not child friendly. Inspection teams noted that there were several instances where patients had missed meals due to procedures being undertaken away from their ward or clinical area, generally patients were always offered a meal upon returning to the ward/area.

Patients on all wards/clinical areas inspected felt that staff at St. Georges where very competent, frequently noting that staff are 'excellent' and 'friendly'.

Are the Trusts Services Caring
All patients spoken to during the inspections felt content with their care at St. Georges overall. Patients felt that they had been involved in their care and treatments and procedures had generally been explained to them clearly. Patients on Gunning ward commented that staff always do their best but that the quality of service provided could potentially be compromised because staff on the ward appear to always be rushed. Patients generally felt that staff had always provided assistance as required, however on occasions this took too long. This was particularly noted on Nicholls and Frederick Hewitt.

Staff competencies were generally mixed on all wards inspected during the month. There were frequent occasions where staff were unaware who the trust safeguarding lead is. There were also occasions where staff were unaware of how to report an incident, access an interpreter and displayed limited knowledge around protecting patient confidentiality.

Are the Trusts Services Responsive to People's Needs
Patients on all wards commented that they felt confident in being able to raise a concern with staff and that were a concern had been raised, it had been resolved amicably. Patients on Gunning ward reported that patient's privacy and dignity *could* be compromised given that staff 'were always so rushed', but despite this, staff were personable and caring.

Inspection teams noted that information provided on each ward/clinic inspected was generally concise and displayed clearly. The only exception to this was on Frederick Hewitt ward where the inspection team noted that noticeboards contained too much information which was overwhelming.

Are the Trusts Services Well-Led
All staff interviewed had received an appraisal within the last year and had also completed a local induction. Staff where generally up to date with mandatory and statutory (MAST) training. There was an exception to this on Gunning ward were one staff member had not completed all elements of MAST training. All staff were aware of how to locate trust policy and raise concerns.

Inspection teams conducted reviews of resuscitation trolley checks, controlled drugs checks and safety checks on wards and no issues were reported. It was noted on Frederick Hewitt ward at the time of inspection that the ward was down three nurses on the shift potentially breaching safe staffing levels. The matron on the ward expressed concern at this.

In conclusion the main themes from the inspections carried out throughout June were that documentation continues to be an issue across all areas, a number of initiatives continue to focus upon this area of practice. Environmental and cleaning standards also require continued focus to ensure appropriate standards are maintained. The inspection of Freddie Hewitt ward identified that there is cause for concern across all CQC domains.

4. CQC Intelligent Monitoring Report July 2014

The CQC published its most recent iteration of the intelligent monitoring report on 21 July 2014. The report highlights St. Georges as having six 'risks' and no 'elevated' risks. A summary of the risks is provided in table 4.1 below:

Table 4.1 – St. Georges CQC Intelligent Monitoring Report Risks

Level of Risk	**Indicator**	**Observed**	**Expected**	**Description of data & source**	**Assurance**
Risk	**Never Events**	6	0	Occurrence of Never Events during the period 01/05/2013-30/04/2014. Data Source STEIS	All never events are investigated in line with national requirements and are presented to the Quality and Risk Committee. These are also subject to overview and scrutiny by the CCG.
Risk	**Composite Indicator – In-Hospital mortality**	-	-	In-hospital mortality – trauma and orthopaedic conditions (01/04/2012 – 18/06/2014).	Further detail provided below.
Risk	**SSNAP Domain 2**	Level D	-	SSNAP Domain 2: overall team-centred rating score for key stroke unit indicator (01-Oct-13 to 31-Dec-13)	Further detail provided below.
Risk	**Access Measures – Patient Operation Cancellations**	0.019	0.009	The proportion of patients whose operation was cancelled (01/01/14 to 31-Mar-14)	Improving trajectory – see further detail provided below.
Risk	**Reporting Culture – Data Quality**	-	-	Data quality of trust returns to the HSCIC (01-Apr-13 to 28-Feb-14)	All returns to the HSCIC are quality checked as a matter of course.
Risk	**NHS Staff Survey – Health and Safety Training**	0.64	0.75	NHS Staff Survey - KF10. The proportion of staff receiving health and safety training in last 12 months (01-Sep-13 to 31-Dec-13)	Analysis of Trust mandatory and Statutory training data confirmed that the proportion of staff that had completed health and safety training was 90% during the time-frame in question.

Composite Indicator: In-hospital mortality – trauma and orthopaedic conditions (April 2012 to June 2014)

On a monthly basis the trust benchmarks mortality against the national average across procedure and diagnosis groups using the Dr Foster system. In January 2014 we identified a signal for higher than expected mortality in 'Other fractures' for the period Nov 12 to Oct 13, where there were 23 deaths observed against an expected 13.2 (relative risk 173.9). A review was instigated which involved the Care Group lead and the Associate Medical Director in examining a sample of cases (all deaths in the most recent quarter i.e. August to October 2013). The review found approximately

half of the patients had suffered multiple traumas as a result of road traffic accidents, and the remaining cases were elderly patients with multiple comorbidities that had fallen and suffered a fracture and were not cared for under Orthopaedics. There were no systematic care issues identified and the Mortality Monitoring Committee signed off the review as complete in June 2014. No other T&O related signals have been identified. The clinical audit team will investigate the methodology used to derive this indicator in the Intelligent Monitoring report and will report to the MMC in due course.

SSNAP Domain 2: overall team-centred rating score for key stroke unit indicator (01 Oct 13 to 31 Dec 13)

The SSNAP audit now reports quarterly and showed mixed results for St George's, with very good performance in some areas such as scanning and scope for improvement in others, for example specialist assessment. These scores incorporate adjustment for case ascertainment and audit compliance, therefore a high volume and quality of submissions is central to obtaining accurate audit results.

A trust based stroke physicians has a leading role in the national audit and has been able to provide insight regarding the development of SSNAP reporting and also the learning curve for entering data into this new national audit programme. This specialist knowledge has been very useful when interpreting the trusts results and deciding on local actions, as summarised below:

- Assurance from the team that data entered is of high number and adjustment of our HES denominator for case ascertainment.
- A revised clerking pro-forma been introduced as a data collection tool to improve data quality.
- Monthly meeting to discuss performance issues
-

It is anticipated that there will be an improvement in the trusts audit outcomes in subsequent reports through improved data recording. However, the service acknowledges that there are also service improvements required and these are being addressed on an on-going basis. More accurate audit results overtime will help to focus actions and measure such improvements. It has been agreed that it would be beneficial to pull together a full annual report in the autumn, with a summary submitted to the Board in the Quality report.

Access Measures – Patient Operation Cancellations

The national standard is for no more than 0.8% of patients should have their operations cancelled for non-clinical reason. The Trust's performance at the end of Quarter 4 was 2% (212 cancellations out of 10,376 elective admissions) were cancelled for non-clinical reasons. In Quarter 1 2014/15, this position improved to 1.5%, with a fall in the number of cancellations to 179 against an increase in elective admissions to 11,613.

The Trust is pro-actively monitoring its elective programme which includes all cancelled operations, and prioritising them for re-booking. These are also being reviewed with commissioners on a monthly basis.

Risk Banding

Previously the Trust was placed in risk Banding 6 (the lowest risk banding). However, the Trust is now within the cohort of Trusts which have recently undergone an inspection and which do not have a risk banding, as the CQC have made a judgment upon the quality of care for the Trust which was an overall rating of 'Good'.

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. The quality inspection programme further identifies concerns and issues arising out of these inspections are monitored through the relevant Divisional Governance Board.

Appendix 1: Executive Overview of Board Assurance Framework

Strategic Objective/Principal Risk	Lead	Oct 2013	Dec 2013	Mar 2014	May 2014	June 2014	Jul 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.	BB	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	SC	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.	JH	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	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	12	→	
01-05 Risk to patient safety arising from a lack of standardised and centralised decontamination practice across several areas of the Trust.	JH			12	12	12	12	→	
01-06 Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists	BB					15	15	→	
01-07 Risk to patient safety and experience as a result of potential Trist failure to meet 95% Emergency Access Standard	BB					16	16	→	

Domain: 1. Quality

Strategic Objective/Principal Risk	Lead	Oct 2013	Dec 2013	Mar 2014	May 2014	June 2014	Jul 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.	BB	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	SC	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.	JH	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	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	12	→	
01-05 Risk to patient safety arising from a lack of standardised and centralised decontamination practice across several areas of the Trust.	JH			12	12	12	12	→	
01-06 Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists	BB					15	15	→	
01-07 Risk to patient safety and experience as a result of potential Trist failure to meet 95% Emergency Access Standard	BB					16	16	→	
01-08 Risk to patient safety due to inconsistent processes and procedures for the follow up of diagnostic test results	RGW						16	**NEW**	

Strategic Objective/Principal Risk	Lead	Oct 2013	Dec 2013	Mar 2014	May 2014	June 2014	Jul 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)	JH	15	15	12	16	16	16	→	

Domain: 2. Finance & Performance

Strategic Objective/Principal Risk	Lead	Oct 2013	Dec 2013	Mar 2014	May 2014	June 2014	Jul 2014	In month change	Change/progress
2.1 Meet all financial targets									
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	SB	9	12	9	9	9	9	→	
2.1-O5 Tariff Risk - The tariffs applicable to Trust clinical services are adversely changed as a result of:- •National Tariff changes •Local Tariff changes •Specialist Commissioning changes • Transfer of tariff responsibilities to Monitor	SB	12	12	12	12	12	12	→	
1.2-O5 Volume Risk – Decommissioning of Services Activity and associated income/contribution will be lost from services decommissioned due to:- • risks to the safe delivery of care • changing national guidance • centralisation plans	SB	9	9	9	9	9	9	→	
3.3-O5 Cost Pressures * The Trust faces higher than expected costs due to:- •unforeseen service pressures •higher than expected inflation	SB	12	12	12	16	16	16	→	
3.2-O5 Cost Reduction slippage* The Trust does not deliver its cost reduction programme objectives:-	SB	20	20	20	20	20	20	→	

•Objective 3: to detail savings plans for the next two years									
2.3-O5 Tariff Risk – CQUIN Premium 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 Activity and associated income/contribution will be lost due to:- • Competition from Any Qualified Providers • Service Line Tenders	SB	9	9	9	9	9	9	→	
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 *	SB	9	9	9	9	9	9	→	
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	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	→	
3.5-05 - Cashflow Risks – Forecast Cash balances will be depleted due to delays in receipt of:- Major Charitable donations towards the C&W development. Land Sales receipts Loan Finance	SB		9	9	9	9	9	→	
3.6-05 - Cashflow Risks – Operational Finance Forecast Cash balances will be depleted due to:- Adverse Income & Expenditure performance Delays in receipt of SLA funding from Commissioners	SB		9	9	12	12	12	→	
3.9-05 Minimise financial impact of Better Care Fund			15	20	20	12	12	→	

Strategic Objective/Principal Risk	Lead	Oct 2013	Dec 2013	Mar 2014	May 2014	Jun 2014	Jul 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	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	12	→	
3.9 – 06 Risk of inappropriate deployment of e-prescribing and electronic clinical documentation	SB						12	**NEW**	
3.10-06 Risk of failure to effectively manage exit from national Cerner programme	SB						10	**NEW**	
3.11 - 06 Poor environment in ICT department/on site data centre may lead to interruptions or failure of essential ICT services	SB						16	**NEW**	

Domain: 3. Regulation & compliance

Strategic Objective/Principal Risk	Lead	Oct 2013	Dec 2013	Mar 2014	May 2014	Jun 2014	Jul 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 and Safety	PJ	20	15	15	5	5	5	→	
A509-O8: Trust unable to achieve readiness for FT status by planned authorisation date as per agreed TFA	PJ	20	20	20	15	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)	EM	15	9	9	16	16	16	→	
03-02 Failure to demonstrate full Estates compliance	EM					16	16	→	
03-03 Lack of decant space will result in delays in delivering the capital programme.	EM					16	16	→	Reworded to reflect this risk has been separated into two new risks
03-04 Delay to the ability to deliver the capital programme and maintenance activity due to clinical and capacity demands preventing access for estates and projects works.							16	**New**	As above

Domain: 4. Strategy, transformation & development

Strategic Objective/Principal Risk	**Lead**	**Oct 2013**	**Dec 2013**	**Mar 2014**	**May 2014**	**Jun 2014**	**Jul 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**	**Oct 2013**	**Dec 2013**	**Mar 2014**	**May 2014**	**Jun 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**	**Oct 2013**	**Dec 2013**	**Mar 2014**	**May 2014**	**Jun 2014**	**Jul 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	8	8	8	8	8	→	

Domain: 5. Workforce

Strategic Objective/Principal Risk	Lead	Oct 2013	Dec 2013	Mar 2014	May 2014	Jun 2014	Jul 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	12	↑	There is not capacity to deliver all required MAST training: in particular Manual Handling/ Resus and Safeguarding

JH	Jennie Hall	Chief Nurse	PJ	Ros Given-Wilson	Medical Director
SC	Sofia Colas	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	Eric Munro	Director of Estates & Facilities	BB	Bernie Bluhm	Interim Director of Delivery & Performance

Appendix 2 – Detailed Board Assurance Framework Risks

Domain 1: Quality: 1.1 Patient Safety

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. Potential for commissioner challenges and financial penalties There is an unlimited demand on A&E which will may impact on increase in emergency admissions A rise in emergency admissions impacts on capacity for elective admissions, time that theatres are not in use and 28 day rebook timeframes. Variable demand may impact on patient pathways and negatively affect patient safety. Delayed transfer of care and repatriation patient delays to host hospitals block beds for emergency/elective activity. Winter pressures relating to Flu, diarrhoea & vomiting symptoms increase demand on side rooms and closure of beds. There are reduced numbers of discharges at weekends and on bank holidays causing capacity problems on the next working day/s Pressure on bed capacity and failure to meet operational targets both emergency and elective Use of bank/agency staff to staff escalation areas Loss of Trust income due to elective cancellations Adverse reputation				
Domain	**1. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Current**	**Update**	**Exec Sponsor**	Bernie Bluhm
Consequence	5	5	5	**Date opened**	01/11/2012
Likelihood	4	4	4	**Date closed**	
Score	20	20	20		
Controls & Mitigating Actions	**Controls:** 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. This includes development of additional physical capacity in Q3 and Q4, and gains in patient flow from the Improvement Programme. Equivalent total bed capacity realisable by year end - 169 beds. 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. If delivered as planned, capacity pressures will substantially			**Assurance**	Programme of applications for additional winter funding Participation in Urgent Care Board ECIST review (September 2013) Negative assurance: - ED performance - RTT backlog of patients- cross ref BAF Risk 01-06 - Cancelled elective surgery during periods of significantly high activity i.e. Feb 2014

	diminish and performance and CIP targets can be met. There are however risks with respect to the timing and delivery of both aspects of the plan. To control these risks, we have: Ensured that maximum possible resource is deployed towards the improving patient flow programme so that optimal delivery can be achieved A structured approach to appraising the options for creating further physical capacity for 2015-16 and beyond. This work is underway. Increased capital project management capability **Mitigations:** • Seek additional external capacity • 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. 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 2014/15 The Trust's reputation is adversely affected Foundation Trust application affected Loss of patient & public confidence in the Trust 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 Regular reports to the Patient Safety Committee, EMT & Trust Board Infection Control score card used to monitor monthly progress Regular communications sent to support practice and raise awareness to ensure staff adhere strictly to diarrhoea protocol Divisional action plans presented to the taskforce as required Zero Tolerance statement on the Trust intranet Bi-monthly antimicrobial steering group chaired by Medical Director Consultant level information circulated on a regular basis RCA carried out for each infection (MRSA, MSSA & Cdiff) Infection Control Policy in place Weekly line care rounds & C:diff rounds on-going Competence assessment document for taking blood cultures approved			**Assurance**	Overall trajectory below trajectory – 2 MRSA and 11 c:diff CQC Compliance with Outcome 8: Infection Control (Feb 2014) Best practice visit to Southampton, Royal Free and west Hertfordshire Infection control action plans subject to review by internal audit – reasonable insurance. 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 Decontamination of nasendoscopes			**Gaps in assurance**	
Actions next period:	Continual revision of infection control action plan Increasing number of consultants champions for infection control. Pack for peripheral line insertion in place (to be considered for blood cultures also)				

	Analysis and actions in relation to latest audit of line care – due May/June 2014 Trust wide environmental audit underway. Focus on areas where cleaning inspections demonstrated need to improve.

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**	Sofia Colas
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. 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. Mitigation through opening of an escalation area in Recovery at additional cost 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. 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. Risks are:-Not treating patients effectively-Causing adverse events due to toxicity and C.difficile. There is a financial/reputational risk to the Trust in its ability to meet HCAI targets and to its Foundation Trust application. Cross Ref BAF RiskA513-01				
Domain	**1.Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Current**	**Update 8/5**	**Exec Sponsor**	Jennie Hall
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. Antimicrobial pharmacists and Antimicrobial Stewardship team promoting good antimicrobial prescribing practice. Fully discussed and monitored at the bi-monthly Antimicrobial Stewardship Committee. Grey book in place: editorial peer review of guidance from different clinical areas is updated regularly. 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.			**Assurance**	The cardiology guidelines have all been updated. Obstetrics and Max-fax have named/assigned consultants to ensure guidelines are aligned.
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 Antimicrobial Stewardship Committee to update the Infection Control Committee by exception				

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				
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. Lack of compliance with decontamination requirements: may result in infection control risk. Absence of programmed maintenance potentially results in faulty equipment. 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 decontamination costs per mattress. **Mitigating Actions** 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.			**Assurance**	Improved monitoring of availability and delivery times. Most recent data showing improved delivery times. Still some delays with availability and collection especially out of hours and at weekends. 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. 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. Discussions continue around process for de-contamination of mattresses between Med Physics & DIPC/Dep Chief Nurse 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)				
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. Lack of compliance with decontamination requirements: may result in falls risk. Absence of programmed maintenance potentially results in faulty equipment. 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		
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. **Mitigating Actions** 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. A patient fell from bed at QMH recently due to lack of rails.
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.				

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. Funding has been provided from NMET monies to provide extra training, using an outside trainer, at Level 3 in Safeguarding Children. 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. 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: Level 1 the target is 80%. Current score: 89.37 % (- 1.05%) Level 2 the target is 80%. Current score: 80.07% (+ .18%) Level 3 the target is 80%. Current score: 54.78% (+ 5.76%) 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.
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. Continue to target level 3 and have additional sessions at level 3 funded by T&E as well as the regular programmed sessions. Await peer review report.				

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:- • ENT- Nasendoscopes • Gen Surg- Anal probes • Cardiac- TOE probes • ITU - Bronchoscopes 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**	Jennie Hall
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. 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**.** Cardiac to comply with centralised decontamination for TOE probes: a new re-processor has been leased and was recently installed. 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. 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. 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. Explore long term solution to provide alternative centralised decontamination services which will entail a full business case and capital build (likely 2015-16)				

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

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. Governance arrangements are: 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 Sub groups for admitted and non- admitted pathways which involve service managers and the 18 weeks team. RTT performance is reported to the FPI Committee on a monthly basis and the issues concerning any particularly challenged specialty are discussed in detail. 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. 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. During 2014-15 there will be formal quarterly resets of the plan to ensure that capacity constraint/availability are kept	**Assurance**	Negative assurance – two SIs have occurred where patients on cardiothoracic waiting list died suddenly without being offered a date for surgery/diagnostic test. Process of re-validation and management of waiting lists reported by all divisions to June Patient Safety Committee 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.

	pace with and the plan is as up to date as possible. 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		

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: - Patient experience whereby patients would not be treated or transferred within four hours - Patient safety – delays in patients receiving ED or specialist senior clinical input - Risk of regulatory action including from commissioners and regulators - 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 Divisional escalation bleep holder to ensure prompt escalation and response 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. This plan is reviewed with the CEO, Director of Finance and Director of Delivery and Improvement on a fortnightly basis. - ED internal improvement plan with focus on: - Co-ordination control and leadership. - Expansion of R.A.T model - Ambulatory streaming from ED.			**Assurance**	+ve = No clinical incidents arising from long ED waits +ve = Q1 performance standard has been met Delivery trajectory for Q2 remains possible but carries significant risk. Contract query notice served by commissioners (June 2014)

	- Specialty escalation and admitting pathway from ED. Provision of Surgical Assessment Unit and hot clinic model. Introduction of new frailty model (older people). Expansion of ambulatory capacity to facilitate increase in ambulatory pathways. Discharge planning and process work stream to include provision of a discharge lounge and partnership working arrangements. 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 Continue to implement improvement plan.		

Principal Risk	01-08 Risk to patient safety due to inconsistent processes and procedures for the follow up of diagnostic test results				
Description	Should the Trust fail to ensure robust mechanisms for the timely and appropriate follow up of all diagnostics tests undertaken and critical test results eg blood tests , cell path and radiology this may result in adverse impact upon patient care in terms of delays in treatment				
Domain	**1. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Current**	**Update**	**Exec Sponsor**	Ros Given Wilson
Consequence	4			**Date opened**	16.7.14
Likelihood	4			**Date closed**	
Score	16				
Controls & Mitigating Actions	Gap analysis of systems for reviewing diagnostic test results across all areas which carry out diagnostic tests underway. Systems in place for many areas. Areas without systems are required to develop them. Failsafe systems for critical test results in laboratories and radiology. Radiology are strengthening their failsafe safety net system which has failed on a number of occasions recently. This now includes e mail to MDT for unexpected cancer (cancer MDTs are working through their responses to these alerts Cerner order comms system has ability to undertake and record result endorsement for tests organised via order comms.			**Assurance**	Negative assurance: a number of recent serious incidents have occurred where patients have sustained harm as a result of a failure to appropriately follow up test results Commissioners have expressed concern and a requirement for assurance regarding processes and fail safes in place to prevent recurrence

Gaps in controls	No defined process for each diagnostic test in every care group. There are a number of issues with ability to use IT to ensure test endorsement at present which include: Not all tests on Cerner, consultant attribution often incorrect, large backlogs of unendorsed results, delays getting results to cerner with some provisional results appearing earlier on EPR, ease and familiarity of EPR vs Cerner use, presence of historical data on EPR but not Cerner	**Gaps in assurance**	Scope of instances where failure to follow up test results has occurred is wide.
Actions next period:	RGW will reiterate a message to all doctors that it their legal responsibility to ensure that there is a robust system to review and act on diagnostic tests. RGW and Div chairs to ensure completion of the gap analysis checking whether each area has a system Divisions to report back to PSC on work to close identified gaps. Project group to be set up including IT, operations and service improvement to improve process of results endorsement on Cerner and roll it's use out in Trust.		

Domain 1: Quality: 1.1 Patient Experience

Principal Risk	A410-O2: Failure to sustain the Trust response rate to complaints				
Description	Not always prioritised to same degree as other Trust objectives Responding inadequately and in an untimely way can seriously impact on the patient experience and limit the Trust's opportunity for learning. 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**	Jennie Hall
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. Included as a measure within the divisional performance scorecard. LEAN review of complaints process. Greater oversight of complaints by DDNGs Regular reporting via PEC,QRC & Trust Board. Implemented a risk rating system to identify high risk complaints.			**Assurance**	Positive; Annual report to be presented to PEC (Aug)and QRC and TB (Sept). Medicine/cardiovascular division has improved performance. Results of the recent survey of complainants which seeks feedback of their experience of our process reported to PSC and QRC Dec 14 Negative: Performance against 25 day timescale is currently significantly below 85% - internal Trust standard

Gaps in controls		**Gaps in assurance**	Overall Trust response rate remains low and continues to deteriorate 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 • Improve reporting of feedback received from NHS Choices, care Connect etc on-going • 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)				
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	4	4	**Date closed**	
Score	16	16	16		
Controls & Mitigating Actions	All combined schemes (divisional improvement programmes, run rates) must have a Quality Impact Assessment covering 5 dimensions (5x5 risk scoring): - Patient Safety - Patient Outcome - Patient Experience - Staff welfare - Financial impact 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. CGG chaired by Medical Director – all schemes with risk score over 12 also referred for consideration for approval by CGG. CGG is dynamic. CGG reports exceptional risks to QRC.			**Assurance**	Positive assurance: External scrutiny of process by Trust Board, commissioners and NTDA. Each scheme has KPIs related to their risk registers which are regularly reviewed. High level governance structure robust Clinical Procurement management Committee now reports to CGG Negative assurance: 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.

	Process of assurance feeds up from DGBs not just Risk Registers Divisions encouraged to bring run-rate schemes. Divisions make a self-declaration upon management of schemes not presented to CGG		
Gaps in controls	Potential that not all risks are recognised and that 5x5 risk scoring application is inconsistent across divisions. Reliance upon divisions recognising clinical risks Insufficient mitigations & increased pressure to deliver CIPs may result in less rigorous application of QIA process. Not picking up coss Trust schemes adequately – these to commence coming to CGG i.e. capacity	**Gaps in assurance**	
Actions next period:	Continued oversight by CGG and refinement of CGG process Trust wide scheme to come to CGG		

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

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: ▪ Changes in emergency pathway e.g. Trauma activity ▪ Failure of Commissioner QIPP schemes ▪ Failure to reduce rate of consequent admissions ▪ Consultation on emergency tariffs with potential long term reduction in income for emergency procedures.				
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** 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.			**Assurance**	▪ Role on System Resilience Working Group to positively influence how emergency care is managed in the local health economy and how retained funds are spent

	Actions taken include: ▪ NETA rebasing exercise undertaken by St. George's. Negotiations with CCG's on-going re uprating of threshold, concluded at £10.2m Threshold impact reduced to c£3.5m for 14/15 ▪ Divisions ensure correct coding of method of entry to trust, either as emergency or as inter-hospital transfer for example ▪ Continued investment in facilities to reduce level of emergency admissions, e.g. Consultant led A&E, AMU. ▪ Support commissioners to develop realistic, deliverable and measurable QIPP plans to manage demand for emergency services ▪ Identification of changes in emergency pathways ▪ 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. Mitigating actions: ▪ Central role played on System Resilience Working Group will allow St. George's to influence how the retained 70% of emergency tariffs are allocated. ▪ Bid for proportion of CCG retained 70% of tariff, to develop local projects to assist in demand management. ▪ Development of admissions avoidance projects in-year which reduce the overall number of patients being admitted to the trust		▪ Reported value of emergency threshold tariff loss
Gaps in controls	Ensure Commissioner 70% saving on tariff is reinvested appropriately.	**Gaps in assurance**	Access to representation on System Resilience Working Groups outside of Wandsworth/ Merton/Lambeth where significant level of STG funding sits
Actions next period:	Engage with CCGs to maximise potential benefit of Better Care Fund in reducing emergency admissions Understanding and influencing decisions on other System resilience working groups Establish routine QIPP meetings with Merton CCG		

Principal Risk	2.1-O5 Tariff Risk - The tariffs applicable to Trust clinical services are adversely changed as a result of: •National Tariff changes •Local Tariff changes •Specialist Commissioning changes • 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 for services, for example, delivered from Queen Mary's Hospital Roehampton. ▪ Changes in Commissioning arrangements for Specialist Services will lead to standardisation of local tariff agreements which may adversely affect current income levels – Fetal Medicine Unit potential loss of income £1.3M for example ▪ Monitor is consulting on its policy on tariff and the future proposals may adversely affect Trust income ▪ The major trauma service fails to achieve best practice tariff ▪ Risks of CCGs not paying for increased income assumption based on improved coding e.g. for obstetrics				
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		
Controls & Mitigating Actions	**Controls** ▪ Influence the development of future tariffs and related service specifications ▪ Active membership of Project Diamond provides the Trust with a London wide voice to reflect Tertiary Hospital views in the development of the tariff. ▪ Active membership of FT Network. ▪ Negotiation with commissioners. ▪ 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			**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 National tariff & rules published for 2014/15 with limited changes

	Mitigating actions: 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 structure Participation in Monitor 2013/14 PLICs voluntary data collection		
Gaps in controls	▪ Pathway based service costing. ▪ 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 ▪ Engagement with Project Diamond group to develop a response to DOH/NHSE tariff proposals over MFF ▪ Development of database solution to ensure long term capture of major trauma activity – for completion by end 2014/15 ▪ Negotiation with commissioners to mitigate impact of proposed change to fetal medicine tariffs		

Principal Risk	**1.2-O5 Volume Risk – Decommissioning of Services**. Activity and associated income/contribution will be lost from services decommissioned due to: ▪ risks to the safe delivery of care ▪ changing national guidance ▪ centralisation plans				
Description	Services are lost, along with the associated income and contribution to trust overheads, due to ▪ Risks to safe delivery of care due to low volumes not meeting national minimum activity thresholds e.g. gynaecological cancer and BMTs, or where the clinical or service quality of a service provided falls significantly below national minimum standards. ▪ Risks associated with failure of services to meet the new NHSE Service Specifications or other changes in national guidance. The new service specification for bariatric surgery presents risks to St. George's due to current level of service. ▪ 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** 1. For Bariatric Surgery, increasing the capacity in obesity clinics to improve compliance with tier 3 specification, with weekly meetings to monitor patient scheduling and ongoing debate with NHSE about service spec. 2. Alliance with Royal Marsden to provide BMT and Paediatric Oncology services **Controls - Generic** 3. Divisional annual business plans to identify threats in the market, and how the service will respond to those issues 4. Development of service specific marketing plans to identify options for maintaining services at SGH 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 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: Mitigating actions: 7. Development of long term exit strategy for services without a viable long term market position 8. 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.	**Assurance**	Annual business plans and business planning process though to Finance & Performance Committee and Trust Board
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. NHSE have visited and received assurance on neurosciences services – the only outstanding action is the move of the neuro-rehab service to QMH, scheduled for later in 2014. • Business planning 2014/15 completed. Begin process of developing business planning model and timeline for 2015/16		

Principal Risk	3.3-O5 Cost Pressures - The Trust faces higher than expected costs due to:- •unforeseen service pressures •higher than expected inflation				
Description	The Trust has to meet costs of unforeseen changes in service requirements for example the ongoing and evolving understanding of meeting requirements associated with Francis Report outcomes or other compliance 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. In addition, costs incurred from the usage of private sector capacity to deliver waiting time targets or services out of hours, will increase marginal costs and decrease contribution from individual services e.g. Cardiology and Cardiac Surgery				
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	4	4	**Date closed**	
Score	16	16	16		

Controls & Mitigating Actions	Controls ▪ 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. ▪ Adequate Contingency Reserves are set aside in line with NHS Guidance at 1% of Turnover ▪ The business planning process is overseen by Business Planning Implementation Group which reports to EMT. ▪ 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. ▪ 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 ▪ Reduced use external capacity by better capacity planning and management of internal resources	**Assurance**	The Trust has a good track record of delivering its financial targets in recent years. 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

	Mitigating actions 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.		
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.		

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 ▪ Opportunities to save are not sufficiently developed to deliver the value required ▪ Savings identified within schemes are overoptimistic / savings are double counted ▪ Savings are redeployed ▪ Savings schemes are not delivered as planned or are delivered late ▪ Capacity constraints prevent delivery of activity plans ▪ 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		
Controls & Mitigating Actions	<u>Controls</u> Benchmarking St. George's services to ensure that opportunities for CIP savings are identified through avenues such as: ▪ SAFE analysis of productivity opportunities ▪ Albatross HRG reference cost comparison			**Assurance**	Audit Reports Internal review of PMO processes by Governance Team Benchmarked controls against Monitor's guide on "Delivering Sustainable Cost Improvement Programmes" (19-01-2012). Audit Reports Internal review of PMO processes by Governance Team

	▪ Civil eyes Consultant performance comparison ▪ Service Line Management Over-programming ▪ Additional Schemes to be developed above annual requirement as a contingency against under-delivery Programme Management Office (PMO) ▪ Role of PMO in managing CRP programme. ▪ Rigorous PID and POD development to support CRP projects. ▪ Director oversight, review and sign-off of projects to ensure that only projects that have a realistic chance of delivery are agreed and implemented. ▪ 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. ▪ Future CIP strategy to identify pipeline of future projects Service Improvement Team GE Organisational change/ Lean (See Programme Plan for Exemplar site) ▪ Development of in-house expertise Development of savings culture ▪ Weekly meetings between directorates, divisions and the PMO to monitor scheme performance. All projects across the trust have clear directorate and divisional leads. ▪ The trust is engaging with outside expertise to develop further robust CIP savings schemes for future years. Mitigating Actions 1.To develop further in-year non-recurrent CIP projects to offset the non-delivery of the full CIP programme. These would include: ▪ Vacancy freezes ▪ Reductions in procurement spend ▪ Slowing of in-year capital programme		Audit Reports Internal review of PMO processes by Governance Team TDA review of Trust CIP governance NTDA review and approval of 2 year CIP programme as presented in preparation for NTDA approval of FT application

	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 TDA CIP review group. 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 Develop 'fighting fund' for additional contingency Start taking initial outputs of work of AT Kearney on 17/18 and 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.				
Description	CQUINs are not met at the level that the trust has assumed in its financial plans - in 2015/16 Maternity will no longer receive CQUIN funding with this being replaced by a CCG local tariff. Value circa £1.8M in 2015/16 - Future requirements not adequately identified. -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**	
Score	16	12	12		
Controls & Mitigating Actions	Controls Governance Arrangements ▪ Build expected level of CQUIN non-achievement, 15%, into financial baseline for the trust. Trust met 87% of CQUIN target in 2013/14 so surpassing internal target by 2%. ▪ Leads identified for each CQUIN ▪ 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.			**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 Commissioners agreed 95% CQUIN achievement as part of year end statement

	▪ Performance monitoring of CQUIN performance to ensure early identification of any variance from plan and identify and implement remedial actions. ▪ CQUIN achievement considered at quarterly divisional performance reviews. ▪ Investment in Delivery e.g. TB nurse recruitment ▪ Appropriate requirements are identified by divisions in Business Planning process – overseen by Business Planning Implementation Group and reported to EMT. ▪ For maternity – ongoing discussions with CCGs to ensure that non-recurrent expenditure is met from recurrent CCG funding, minimising any overall loss to the trust. Mitigating actions: 1.Invest resources in – year to improve CQUIN performance, based on a cost-benefit analysis of undertaking that investment 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		
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 only 2 outstanding with CCG's, including Maternity. NHSE CQUINs agreed, subject to final sign-off. ▪ Finalise CQUIN reporting to Divisions and Trust Board		

Principal Risk	**1.3-O5 Volume Risk** – Tendering of services. Activity and associated income/contribution will be lost due to: ▪ Service Line Tenders ▪ Competition from Any Qualified Providers 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: An increased role for the Local Authority to commission services, leading to new and less predictable patterns of service commissioning – in 2015/16 Health visiting due for tendering by Local Authority with current value of £6.25M and Sexual health services worth £6.4M An increased introduction of service line tenders e.g. School nursing (value circa £1.35M for 2015/16) Potential for WCCG to tender all adult community health services under CAHS programme in 2015/16 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** 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. Commissioning Adult Health Services (CAHS) as currently being developed by WCCG. 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 3. Ensure, through DMB, annual business plan in CSD and other divisions clearly programmes tender work and business development associated with these tenders into its work programme 4. Early identification of services affected. Potential areas currently identified are: - Sexual Health Services potential to be tendered in 2015/16 - School nursing 2015/16 - Health visiting in 2015/16 5. Decision to enter tender process for each invitation received, based on			**Assurance**	Escalating process of assurance through annual business plans and business planning process though to Finance & Performance Committee and Trust Board

	current strategic and service fit and financial contribution/profitability. 6. 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 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. **Mitigating actions:** Divisional management teams will undertake a range of actions to mitigate this risk including: 1.That St. George's wins any tenders that it chooses to bid for, negating the need for other mitigating actions 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 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. ▪ Undertake review of competitive position of local authority commissioned services (joint action with contracts/strategy team) ▪ Review timing of tenders and document and refresh at divisional level - agreed with Director of Strategy ▪ Bid for Nelson Local Care Centre Tender for provision for outpatient, diagnostic and other services.		

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				
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. Risk identified in 2014/15 around loss of maternity and gynaecology market share				
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		

Controls & Mitigating Actions	**Controls** 1.Quarterly market share and competitor analysis reported to divisional management and Commercial Board 2. Marketing information informs the development of divisional Business Plans, which is overseen by Business Planning Implementation Group and reported to EMT. 3. Pro-active monthly monitoring of actual activity and referral source as recorded in SLAM for early identification of market share changes. 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 during 2014/15 5. Development of marketing plan for maternity and genecology, with proposal for 1000 additional births in 2015/16. Business case in development 6. 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. 7.Benchmark for quality and performance to understand how the St. George's service compares to competitors 8. Continued development of local clinical networks and strategic partnerships to maintain market position will help control impact. 9. Ongoing improvement in service quality, to maintain market share and encourage patients to actively choose St. George's. 10. Continued development and enhancement of clinical networks e.g.	**Assurance**	**Positive** ▪ On-going market share monitoring via SLAM and Dr. Foster data. ▪ Business planning processes to identify risks and market strategy

	Urology network or Kingston/George's Cardiology partnership working, to strengthen St. George's market position. 11. Win new tenders e.g. Nelson Local Care Centre, to maintain and expand market share Mitigating Actions: ▪ 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 ▪ 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 taken from, including: geographical area; rationale for growth; target volume; barriers to possible growth; commissioner position ▪ Trust internal substitution of activity from other departments, where demand outstripping capacity, to ensure estate and facilities are utilised ▪ 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. ▪ Tender for Nelson Local Care Centre		

	▪ Develop Maternity and Gynaecology Marketing plan and sign off ▪ Further develop Neuro, Cardiac and Paed marketing plans to consolidate position

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. In 2014/15 risk around Cardiac activity related to non-achievement of 18 week standard. 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. Risk in 2014/15 around payment challenges associated with major trauma service and not achieving best practice tariff				
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		

Controls & Mitigating Actions	Controls Governance Arrangements: ▪ 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. ▪ Negotiation of appropriate and realistic thresholds and targets with local CCG's to minimise trust exposure to challenges. ▪ Training of staff & data validation routines ▪ 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 ▪ For Major trauma tariff new admin team recruited to ensure that activity accurately captured and coded. Mitigating Actions:	**Assurance**	In year performance monitoring of level of both accepted and rejected challenges, Current performance is within the budgeted levels.

	▪ Utilise clinical expertise to explain changes and challenge penalties imposed by CCG's. ▪ Year End Settlement discussions – the risk of income 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. ▪ 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. ▪ Cardiac review of skill mix, capacity and referral patterns to address 18 week underperformance ▪ New database solution agreed for Major trauma activity – to be in place by end 2014.		

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.				
Description	The additional costs of delivering increased activity are higher than expected due to: •Poor cost estimates •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 ▪ 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. ▪ Costs are based on data from robust historical costing systems including PLICS and Reference Costs which have been calculated in line with national guidance. ▪ Capacity requirements of additional activity are identified through the Capacity Management element			**Assurance**	.

	of the Business Planning process, overseen by the Business Planning Steering Group and reported to EMT Short term funding for premium costs of temporary 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:	Agree a development plan for improvements to PLICs.		

Principal Risk	3.5-05 Cash-flow Risks – Operational Finance: Forecast Cash balances will be depleted due to delays in receipt of:- ▪ Major Charitable donations towards the C&W development. ▪ Land Sales receipts ▪ 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 1. Capital Programme Group (CPG) oversees the planning and monitoring of the annual and five year capital programme, which reports to Executive Management Team 2. Monthly capital finance reports on funding and expenditure are submitted to the CPG for review and forecasts updated. The			**Assurance**	Previous track record in delivering major land sales projects e.g. Wolfson, Bolingbroke & The Grove

	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 explained. 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. 4. Secure agreement from donors to provide funds in accordance with timing of investment requirements • Action Plan – written undertakings of commitment to transfer funds at agreed milestones e.g. Helipad. 5. Project plans to deliver land sales • Action Plan – business case setting out timelines and risk management in event of slippage. 6. Project Plan to secure loan finance • 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. Mitigations:- Delay capital investments in line with reduced funding 7. Manage working capital 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:			

Principal Risk	3.6-05 Cash-flow Risks – Operational Finance: Forecast Cash balances will be depleted due to:- •Adverse Income & Expenditure performance •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**
	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: •SLA negotiation issues are escalated to FD/CE and reported to Finance and Performance Committee. •Locally agreed estimated values for contracts to allow appropriate levels of funding to be made ahead of final contract signature. •SLAs include special clause for interim invoicing of over-performance in advance of freeze date - enhances cash flow. Established Financial Management regime: •Adverse Income and Expenditure results 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. •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). .Working Capital Management •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. •Changes in debtors, stock and creditors reported and explained within finance report to Finance and Performance Committee and Board. •SLA interim invoicing – as above. Mitigating actions Manage Working Capital • Improve Debt Collection • Delay payment of creditors / manage balances with major creditors e.g.			**Assurance**	Detailed monitoring and forecasting of cash flow and agreed debt through Finance and Performance Committee. HDD1 and HDD2 working capital reviews

	SGUL • 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). Delay capital investments in line with reduced funding due to reduction in Trust surpluses Extend scope of leasing to finance capital programme subject to VFM and affordability tests. 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 Further review of timing of CAPEX to ensure phased towards 2nd 6 months 14/15 and examine profile going forwards		

Principal Risk	3.9-05 Impact of Better Care Fund on Financial position of the trust. 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. After initial concerns that BCF would impact by £20M from 2015/16, new figures from CCG's indicate that the impact of the BCF should be significantly lower than initially expected. 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. 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.				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.1 Meet all financial targets**
	Original	**Current**	**Update**	**Exec Sponsor**	Steve Bolam
Consequence	5	3	3	**Date opened**	31 January 2014
Likelihood	3	4	4	**Date closed**	
Score	15	12	12		
Controls & Mitigating	**Controls** Engagement with CCG and local authority partners in south west London to understand and co-operatively plan for the			**Assurance**	Negative Guidance and understanding and local interpretation of guidance, and impact finically on local CCG's is unclear

Actions	management of the BCF 1. Trust is required to be a party to the Better Care Fund submission and plans that are made. 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. **Mitigations** 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. 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% 3. Substitution of clinical activity lost to BCF related projects from other trusts locally 4. That the trust will benefit through the potential expansion of community delivered services, funded through the BCF. 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		Structures to manage and oversee BCF are relatively new and untested +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. ▪ 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

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. Divisions are held to account through formal quarterly performance reviews, monthly reporting and monitoring and escalation where required through the DoFPI The Trust has a performance management framework A&E performance meeting is held routinely within the Med/Card division to scrutinise and review ED performance Finance & Performance Committee meets monthly to review in detail the performance report including all areas of the TDA accountability framework Reporting to F&P includes description of key actions and sharing of recovery plans where necessary e.g. cancer recovery plan 12/13 Q4 Reporting continues to be improved and developments including desktop access to scorecards for Divisions and the introduction of risk forecasting are in train External scrutiny: 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 Clinical Quality Review meeting and contract performance meetings are held monthly with commissioners where performance and remedial action is further scrutinised **Mitigating Actions** •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 •Reporting continues to be improved and developments including desktop access to scorecards for Divisions and the introduction of risk forecasting are in train			**Assurance**	Positive assurance •HDD, BGAF and QGAF assessments •Internal audit

	•Developmental work in place to introduce formal monthly scoring system for Divisions within the performance framework to improve visibility over performance risks and the effectiveness of remedial action •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		

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 Director of FPI is SRO and sits on programme board. Regular programme board reports to Executive Management team Programme board highlight reports to EMT include RAG status and provides assurance project on track – this reporting mechanism promotes transparency and challenge Chief Clinical Information Officer in post 18 Champion Users seconded to support deployment 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**	Programme Board highlights reports to EMT to include RAG status and provides assurance project on track. Chief Information Officer in post 18 Champion users seconded to support development Now over-arching clinical governance in place, including clinically led gateway review of ICT clinical programme
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 period:	Development of process for transition of clinical information projects into business as usual via the ICT Service Improvement Programme.				

Principal Risk	3.9-06- Risk of inappropriate deployment of e-prescribing and electronic clinical documentation				
Description	There is a risk that if e-prescribing and electronic documentation is inappropriately deployed this will have an adverse impact on patient care and clinical continuity.				
Domain	**2. Finance & Performance**			**Strategic Objective**	
	Original	**Current**	**Update**	**Exec Sponsor**	Steve Bolam
Consequence	4			**Date opened**	1.7.14
Likelihood	3			**Date closed**	
Score	12				
Controls & Mitigating Actions	Deployment project being managed with PRINCE 2 methodology Clinical lead in place to ensure clinical input on programme board Gateway thresholds established for technical readiness and staff readiness Each clinical area has a task group with a clinical lead who has power to sign off to roll out in their area Overall deployment is subject to regular gateway reviews.			**Assurance**	Reporting on progress of project to Clinical Information Systems Programme Board On-going modification of deployment plan in response to lessons learned from early adoption means project is flexible and responsive to ensure success
Gaps in controls				**Gaps in assurance**	None identified
Actions next period:	Continue to react to feedback On-going changes to project and implementation as a result of lessons learned				

Principal Risk	3.10-06 – Risk of failure to effectively manage exit from national Cerner programme				
Description	Failure to put in place alternative arrangements to progress provision of clinical systems for acute and community services would lead to significant business continuity issues for the Trust.				
Domain	**2. Finance & Performance**			**Strategic Objective**	
	Original	**Current**	**Update**	**Exec Sponsor**	Steve Bolam
Consequence	5			**Date opened**	1.7.14
Likelihood	2			**Date closed**	
Score	10				
Controls & Mitigating	SGH are members of two procurement consortia to evaluate preferred suppliers. Membership enables control over the preferred suppliers			**Assurance**	Full business case approved by the NTDA Contracts signed with preferred service providers

Actions	to provide services in place of national programme for IT. Preferred providers selected. Initial exit slots agreed with Dept of health Funding to support transition and on-going running costs identified and agreed as part of business process.		
Gaps in controls	None yet identified	**Gaps in assurance**	None yet identified
Actions next period:	Confirm exit timetable with Dept of Health Establish programme team and associated governance structure		

Principal Risk	3.11-06- Poor environment in ICT department/on site data centre may lead to interruptions or failure of essential ICT services				
Description	Current issues negatively affecting the correct functioning of ICT equipment include poor air-conditioning and temperature control and a lack of Capacity and control of additional power provision. A failure to effectively manage the environment may lead to interruptions and failure to provide essential ICT services				
Domain	**2. Finance and performance**			**Strategic Objective**	
	Original	**Current**	**Update**	**Exec Sponsor**	Steve Bolam
Consequence	4			**Date opened**	1.7.14
Likelihood	4			**Date closed**	
Score	16				
Controls & Mitigating Actions	Review of environmental controls conducted with Estates Additional air cooling requirements identified Short term – additional portable air coolers hired to provide additional cooling during hot weather Estates response to environment alarms reviewed			**Assurance**	Temperatures being monitored via environmental controls and daily physical checks. Temporary additional air cooling has been provided in data centre and adjacent plant room area
Gaps in controls				**Gaps in assurance**	
Actions next period:	Additional air cooling to be procured and commissioned				

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

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	**Update**	**Update**	**Exec Sponsor**	Peter Jenkinson
Consequence	5	5	5	**Date opened**	31/10/2010
Likelihood	3	1	1	**Date closed**	
Score	15	5	5		
Controls & Mitigating Actions	**Controls:** 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. 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. Compliance by September 2014. Quality surveillance data monitored and appropriate action taken in response - reported as part of overall CQC compliance monitoring update to Trust Board via Risk and Compliance Report. Compliance framework published, Divisions now required to sign off quarterly self-certification statements re compliance with CQC standards. **Mitigation:** Internal and external stakeholder management to highlight excellence in patient safety and clinical effectiveness, and compliance with other regulatory / quality standards.			**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. **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. Publication of CQC assessment of trusts into risk 'bands' (October 2013), based on quality surveillance data puts trust into band 6 (lowest risk). Chief Inspector of Hospitals inspection report published 24th April 2014, with overall rating of 'Good'. Two compliance actions identified.
Gaps in controls	Complete implementation of CIH action plan			**Gaps in assurance**	
Actions next period:	Implement action plan following CIH inspection				

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. Failure to achieve performance targets. Inability to demonstrate implementation of robust quality governance processes in particular CQC compliance. 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	3	3	**Date closed**	
Score	15	15	15		

Controls & Mitigating Actions	Programme management resource and governance structures in place to oversee programme. Close monitoring of external economic environment and adaptation of strategy/approach accordingly. CIP/Finance controls as per finance risks. Clear action plan and performance management milestones in achieving Foundation Trust Status & risks managed at programme level. Succession planning for key exec roles in place, full Board complement expected June 2014. Controls for performance risks detailed in other risks.	**Assurance**	Monthly oversight meeting with TDA covering performance and FT readiness. Reported to Board via CEO report. QGAF assessment score 3.5 confirmed by Deloitte April 2013. CQC CIH inspection – overall 'Good' rating. Exec to Exec meeting with TDA completed 28-Jan-14, with positive feedback. Board to Board with TDA completed March 2014. TDA Board approval for entry into Monitor assessment phase April 2014. Monitor kick-off meeting held 4th June.
Gaps in controls		**Gaps in assurance**	Monitor assessment on-going – feedback from interviews, board observations and document review expected September 2014. Board to Board meeting with Monitor currently planned for 25 September 2014. Monitor authorisation – currently expected November 2014.
Actions next period:	Completion of Monitor assessment process and feedback.		

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		

Controls & Mitigating Actions	Policies on data protection, information security, medical records and corporate email reviewed and disseminated through IG training, MAST, Trust Induction and Trust Intranet. Technical controls - All Trust laptops encrypted. USB port blocking implemented. 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. Remote access 2 factor authentication complete. Electronic data management project in progress [paper light environment, RFID tracking]. Reviewed medical storage – updated guidance and auditing practice. On-going communication to staff on IG matters through eG IG Manager has now commenced and will continue monitoring "High" alerts in the external email monitoring software prompting email notices to members of staff Monitoring of sensitive data being sent from non-secure commercial email accounts – in progress.	**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. CQC finding of non-compliance with Outcome 21 Records in relation to the insecure storage of patient records. CQC report provides assurance of compliance on inspected wards in relation to secure storage of patient records. RFID case-note tracking. (First phase complete)
Gaps in controls	No method of control of stopping paper records being removed.	**Gaps in assurance**	
Actions next period:	Investigate and leverage monitoring and blocking capabilities of Trust's web filtering solution.		

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		
Controls & Mitigating	Information governance is a mandatory module in Trust induction training, MAST training and Cerner Training. E-Learning platform for MAST.			**Assurance**	Increase in uptake of training completed with MAST. Negative - still at 80% completed training.

Actions	Review of attendance at HR and Workforce and IG Committee. Management procedures to follow up of non-attendance in place. New e-learning and e- assessment modules have gone live and continues to roll out. IG Manager continuously monitoring IG training compliance.		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. Nationally mandated target of 95% was not met for 2013/14. MAST training committee established
Gaps in controls		**Gaps in assurance**	
Actions next period:	MAST training is being strongly promoted over the coming year. The 2014-15 target for MAST compliance across the Trust is 95%. Comms to all Trust in eG mandating IG MAST.		

Principal Risk	O3- O1 Risk of prosecution and fines as a result of non-compliance with fire regulation. Currently the Trust has been served an improvement notice and cannot fully 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	**Update**	**Update**	**Exec Sponsor**	Eric Munro
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. Regular meetings/communication with Fire Brigade to check progress. Specialist fire safety resource in place to lead on the actions. Planned and reactive monitoring of fire safety. Fire risks assessments			**Assurance**	Reporting on fire risk assessments to Health, Safety and Fire Committee and escalate any issues to the Organisational Risk Committee. Staff appropriately trained to increase compliance
Gaps in controls	Comprehensive surveys and assessments of compartmentation.			**Gaps in assurance**	Fire risk assessments not in place for all areas. Not all staff appropriately trained to increase rate of compliance.

Actions next period:	Implement action plan in period. (Fire risk assessments, training, infrastructure, governance). Monitor progress through Health, Safety & Fire Committee and via Organisational Risk Committee.

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**	Eric Munro
Likelihood	4	4	4	**Date opened**	October 2012
Consequence	4	4	4	**Date closed**	
Score	16	16	16		
Controls & Mitigating Actions	Revised estates permanent management structure is in place this includes a compliance manager. Planet FM system (the estates helpdesk and job request system) is being upgraded to allow compliance to be monitored. An audit on the gaps in compliance has been completed. There is a planned programme in place to close the gaps in compliance. This risk is monitored via the Health, Safety & Fire Committee and overseen by the Organisational Risk Committee.			**Assurance**	Estates compliance records being assembled. Action plan being monitored and progress updates to the Operational 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. To ensure that regular updates are provided to the committees monitoring this risk. There is an external expert review of compliance scheduled for August 2014				

Principal Risk	03-03 Lack of decant space will result in delays in delivering the capital programme.				
Description	Lack of decant space for capital schemes delays the ability to deliver large capital schemes.				
Domain	**3.Regulation & Compliance**			**Strategic Objective**	**3.1 Maintain compliance with all statutory & regulatory requirements**
	Original	**Current**	**Update**	**Exec Sponsor**	Eric Munro
Likelihood	4			**Date opened**	May 2014
Consequence	4			**Date closed**	
Score	16				
Controls & Mitigating Actions	Risk assessments undertaken for each project. Space surveys are undertaken on an annual basis to provide room usage data to enable the project manager to work out a plan. Monitored through the Capital Programme Board & Project Programme Board			**Assurance**	Documented risk assessments Capital project delivery is reviewed through Capital Programme Board & Project Programme Boards.
Gaps in controls	Short term planning brings forward new priorities that unbalance existing plans.			**Gaps in assurance**	
Actions next period:	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 deliver a portakabin to move transactional staff out of clinical areas and release space for redevelopment.				

Principal Risk	03-04 Delay 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**	Eric Munro
Likelihood	4			**Date opened**	May 2014
Consequence	4			**Date closed**	
Score	16				
Controls & Mitigating	Risk assessments undertaken for each project. Monitored through the Capital Programme Board & Project			**Assurance**	Monitoring of project and maintenance activity through project/programme boards and Divisional Governance Boards.

Actions	Programme Board. Engage with the department early in the capital scheme and jointly agree how this can be managed.		
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.		

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

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 • 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 upside and downside cases in a range of scenarios in SW London, and keep commissioners and NHSL/NTDA/Monitor involved in this thinking.			**Assurance**	• Our LTFM does not include reconfiguration in the base case, so our FT application is not dependent on this. • We are and will remain a fixed point as a major acute provider in SW London • Continue to ensure that quality standards are sustainably met at SGH
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. 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

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. STG playing leadership role in reconfiguration, planning and modelling for SW London in collaboration with commissioners and providers 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.			**Assurance**	LTFM base case does not assume upside of reconfiguration. Estimated the activity capacity and capital implications of a range of possible reconfiguration options
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. 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 services

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. •Track record in research relatively weak •St. George's brand is not strong in research. •Service demands restrict the ability to develop research at St George's (Historical differences in approach) •Loss of opportunities for research and development. •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	• AMD for Research working with the Dean of Research and Enterprise. Regular joint meetings between SGUL and SGHT execs. • Research strategy implemented • CLRN Funded PAs for research active consultants within Divisions • Four Research sabbaticals awarded • Annual Plan for research strategy in place& monitored by research committee • Working with Information team, to integrate research data • Agreement of Divisional Scorecards – and introduction onto DMB or similar agenda • Implementing the Research Board	**Assurance**	Positive Assurance: • Agreed Trust KPIs for research. • Increased levels of recruitment to NHR trials - both on raw and weighted figures. We have had a 40% increase in weighted recruitment • Research KPIs reviewed at TB and EMT • MHRA has signed off compliance with clinical trials • Increase in number of studies approved Negative assurance: • Governance approval times are variable quarter by quarter but are improving when benchmarked with main competitors • Additionally, CRN have reduced the target approval timeline by 50% • Not all studies approved contribute to NIHR targets. • Issues with CRF staffing is improving
Gaps in controls	• Joint working between SGUL Institutes and SGH NHS • No system or guidance for prioritisation towards studies that contribute to NIHR recruitment (high-impact studies.) • There are capacity gaps for the JREO to in support developing research-interested consultants to initiate getting studies up and running • Lack of integration of research data in Trust	**Gaps in assurance**	

	information systems		
Actions next period:	Get remaining two research sabbaticals active by October 2014. Initiate round two of sabbatical investment Reorganisation of clinical research facility – ONGOING Follow up CRN re-structure and budget impact – September 2014		

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

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		
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. Pressure felt by managers and staff often results in inappropriate behaviours. 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. 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. Unconscious bias training for senior managers will be run for managers over the next 6 months.	**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. Three high profile investigations on-going into allegations of bullying and harassment Report outlining further work to be undertaken presented to Executive Management Team and Overview and Scrutiny Committee in July 2014
Gaps in controls	None identified	**Gaps in assurance**	
Actions next period:	Action plans are being developed in response to 2014 staff survey results. The Listening into Action programme alongside work on the Trust's values will focus on action around harassment and bullying. Director of HR is developing an Embedding our Values programme for use across the organisation. A new set of poster on harassment and bullying will be publicised across the organisation to raise awareness		

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. 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	3	**Date opened**	31/05/2010
Likelihood	3	1	4	**Date closed**	
Score	12	2	12		
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.			**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. 2. Fully compliant with CQC Outcome 14: Supporting Workers 3. Uptake of eMAST training reports presented to ORC. 4. A report regarding the transition to the national framework has been presented to the Workforce Committee.

	2. eMAST training in place		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	Lack of capacity to deliver identified training – in particular face to face sessions e.g. Manual handling, Resus and Child safeguarding Level 3	**Gaps in assurance**	
Actions next period:	Implementation of new e-learning package and reporting systems. New systems fully functional although subject to some snagging problems. Work commencing to focus staff attention on individual subjects. Review of capacity to deliver versus training commenced ad to be completed New MAST Steering Group set up as task force to address continued risk to non- compliance with target		

Appendix 3: Extreme Divisional Risks

	CW&DT		
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 £2.9m overspend at M10 due to a number of adverse movements	**25**	→
CW058	Loss of theatre time and space for women's services	**16**	**new**
CW060	Delays to patients receiving chemotherapy of Trevor Howell day Unit	**15**	**new**
	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**	→
MC41-D1	Risk to patient safety due to shortage of 13 nursing staff in the Endoscopy Unit & Bowel cancer screening unit	**16**	**new**
MC46-D2	Financial Risk – cost pressures within division are not funded	**16**	**new**
MC48-D2	Financial Risk Volume – decommissioning of cardiology services	**15**	**new**
MC50-D2	Financial Risk – Tariff. Emergency threshold tariff	**15**	**new**
MC40-D1	Risk to patient outcomes as palliative care team establishment is not sufficient to meet increasing demands	**15**	**new**
MC55-D2	Financial – Volume. Lack of theatre capacity for cardiac surgery impacts on income	**20**	**new**
	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**	→
B289	AMW Neuroradiology have no current access to CT imaging (DynaCT/InnovaCT/VasoCT) for patients undergoing angiography.	**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**	→
TBC	Failure to prescribe essential medication for patients having elective surgery	**16**	**new**
C04	Financial risk – cost. Neurosciences, pharmacy and finance unable to address under recording of high cost drugs of recharge to commissioners	**15**	**new**
C05	Financial Risk – cost. Failure to deliver CIP programme	**15**	**new**
C06	Financial Risk – cost. Failure to receive divisional funding for cost pressures	**15**	**new**
	E&F		**Change ↑↓**
Risk No.	**Risk**	**Score**	
EF176	Estates compliance – survey revealed gaps in compliance in statutory and mandatory items	**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**	→
EF200	Delay to ability to deliver the capital programme and maintenance activity due to clinical and capacity demands preventing access for works	**16**	**new**
	IM&T		**Change ↑↓**
Risk No.	**Risk**	**Score**	
IT004	Insufficient staffing levels in ICT support leading to increasing numbers of outstanding calls remaining unresolved.	**15**	→
IT016	Reduction in capacity to deliver new insfrastructure, systems and change programs	**16**	↑
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**	→
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**	→
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**	→
IT032	Increased risk to network availability due to inadequate electrical supply to key locations.	**15**	→
IT033	Increased clinical risk to patient safety resulting from lack of UPS protection for main Trust Switchboard.	**20**	→
	CSW		**Change ↑↓**
Risk No.	**Risk**	**Score**	
	No extreme risks		