St George's Healthcare NHS
NHS Trust

REPORT TO TRUST BOARD *August 2014*

Paper Title:	Risk and Compliance report for Board incorporating: 1. Board Assurance Framework 2. Assurance Map 3. Divisional quarterly self- declarations of compliance with CQC standards
Sponsoring Director:	Peter Jenkinson, Director of Corporate Affairs
Author:	Gurbachan Johal, Assurance Manager Sal Maughan, Head of Risk Management
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.
- Divisional quarterly self- declarations of compliance with CQC standards are detailed and action plans are in place to address issue of non-compliance
- External assurances received during the period.

Recommendation:

The Trust Board is asked to note:
- The Divisional self-declarations of compliance.

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 and on each of the Clinical Divisional and Corporate Directorate Risk Registers. Table 1 details the highest rated risks on the BAF. An executive overview of the BAF is included at Appendix 1. The rating is prior to controls being applied to the risk. Controls for the highest rated risks are detailed in Appendix 2. Risks are reduced once there is 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	Ability to deliver capital programme and maintenance activity within required timeframes	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
01-08	Risk to patient safety due to inconsistent processes and procedures for the follow up of diagnostic test results	4	4	16

1.1 Changes to risk scores:

There have been no changes to risk scores during the reporting period.

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.

At the time of the previous report two potential risks were to undergo a risk assessment to ascertain if it would be appropriate to include these on the BAF:

- Impact upon patient care and experience due to a potential lack of capacity to process the significantly increased volume of calls to call centre: this risk is now included on the Children's and Women's, Diagnostics and Therapeutics Divisional Risk Register and robust controls are in place to manage the risk – currently it is being managed at Divisional level and following risk assessment, inclusion on the BAF is not required. This will remain under review.

- Risk of failure to provide adequate training and provision of Medical Equipment - risk assessment to understand full scope of risk and work on-going is underway.

1.4 Summary of Extreme Risks at Divisional level:

- Children's and Women's, Diagnostics and Therapeutics (CW&DT) has closed one extreme risk during the reporting period: CW050 Computerised CTGs no longer performed for high risks antenatal pregnant women in DAU – technological solution is now operational.

A full summary of extreme divisional risks can be found at Appendix 3

2. Assurance Map

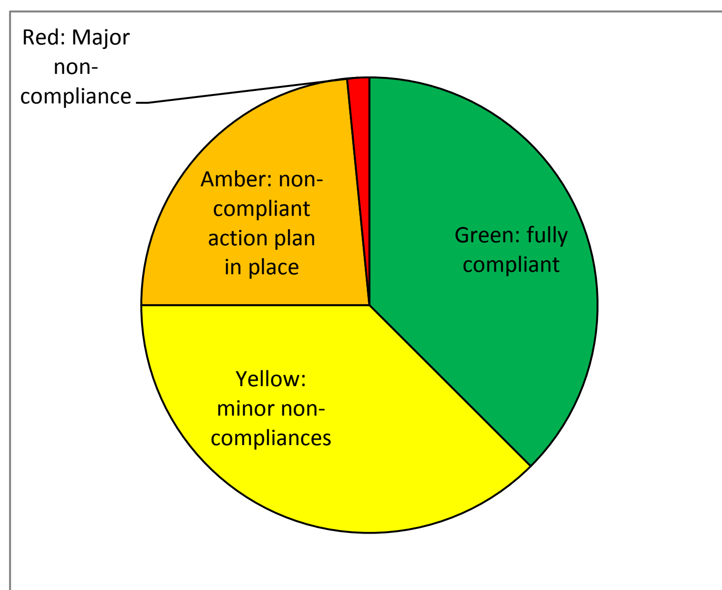
The Trust Assurance Map is a schedule of all external visits, inspections and reporting which captures on-going actions in response to external reviews and those underway to prepare for forthcoming visits. The assurances received from these external inspections help inform the board as to continued compliance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

2.1 Care Quality Commission (CQC)

2.1.1 Divisional Self-Declaration of Compliance against CQC Standards/Outcomes

Throughout quarter one divisions undertook a divisional declaration of compliance with the CQC standards. These divisional self-declarations are undertaken against the current CQC outcomes and are informed through a variety of compliance and performance metrics. The divisional declarations were agreed at Divisional Governance Board meetings in July/August 2014.

Fig 1.1 *CQC Compliance by outcome*



A summary of compliance is provided in fig 1.1 and table 2.1.1 below and highlights, by division, the number of outcomes that were green (fully compliant), yellow (compliant with minor actions), amber (partially compliant with further action required) and red (non-compliant), for each division during quarter 1 2014/15.

Status	No. of outcomes
Green	24
Yellow	24
Amber	15
Red	1

Table 2.1.1 – *Divisional compliance against CQC outcomes August 2014*

Division	OUTCOME 01 Respecting & involving	OUTCOME 02 Consent to care and	OUTCOME 04 Care and welfare of	OUTCOME 05 Meeting nutritional	OUTCOME 06 Co-operating with	OUTCOME 07 Safeguarding people	OUTCOME 08 Infection control	OUTCOME 09 Medicines	OUTCOME 10 Safety and suitability	OUTCOME 11 Safety and suitability	OUTCOME 12 Requirements relating	OUTCOME 13 Staffing	OUTCOME 14 Supporting workers	OUTCOME 16 Assessing and	OUTCOME 17 Complaints	OUTCOME 21 Records
CWD T	A	G	Y	G	G	Y	Y	G	R	A	Y	A	Y	G	A	A
C S	G	G	Y	G	G	G	Y	Y	G	G	G	A	G	G	A	Y
MCV	G	G	Y	G	Y	G	A	G	A	G	G	Y	Y	G	Y	A
STNC	Y	A	Y	Y	Y	Y	Y	A	A	Y	G	Y	Y	A	Y	A

The red non-compliant outcome in the Children & Women's and Diagnostics and Therapeutics Division is related to outcome 10 'safety and suitability of premises'. There are several estates and environmental concerns within the division, particularly in Lanesborough wing theatres, NNU and outpatients. Actions to address this issue are part of a wider estates and facilities action plan, which is overseen by the Estates and Facilities team and monitored at monthly divisional governance and performance meetings.

There are also action plans in place to monitor progress of outcomes rated as 'Amber'. These action plans are monitored through monthly performance and governance meetings within each division and updates on these action plans will also be provided to the Corporate Risk team going forward. Further detail is provided at appendix 4 in each divisional self-assessment.

The CQC is in the process of formalising revised standards, which are currently under public consultation. It is anticipated that the standards will be in place by April 2015. The divisional self-declaration will be revised to reflect the updated standards.

2.2 Summary of external assurance and third party inspections July-August 2014

2.2.1 ICNARC (Intensive Care National Audit and Research Centre)

ICNARC audits are conducted across all hospitals in the UK providing critical care with the aim of fostering quality improvements in the provision of critical care. The Trust received its Quarter 4 2013/14 ICNARC audit reports during the reporting period for Neuro ICU, Cardiothoracic ICU and General ICU. No concerns were noted in these reports.

2.2.2 TARN (Trauma and Audit Research Network)

The trauma and audit research network conducts audits of hospitals' trauma services as well as providing a performance comparison amongst hospitals with the explicit goal of improving trauma survival rates in young adults and children in the UK through improving performance. The trust received its TARN report for August 2014 and no issues were highlighted.

2.3 Update on Action Plans – July-August 2014

2.3.1 London Fire and Emergency Planning Authority

The trust was visited by the London Fire and Emergency Planning Authority (LFEPA) in January 2013. During this visit, several areas of concern were noted and the LFEPA issued St. Georges

with enforcement orders. There is a detailed action plan in place to address the concerns highlighted in these enforcement orders which is on-going; with the majority of cautions due to be addressed by the end of August 2014. The fire team is currently in the process of conducting a further trust-wide assessment in order that outstanding actions can be prioritised to ensure that the remaining enforcement orders can be lifted.

2.4 Pending Inspections – August 2014

2.4.1 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.

Conclusion

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

Appendix 1: Executive Overview of Board Assurance Framework

Strategic Objective/Principal Risk	Lead	Dec 2013	Mar 2014	May 2014	June 2014	Jul 2014	Aug 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	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	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	12	→	
01-06 Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists	BB				15	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	16	→	

Domain: 1. Quality

Strategic Objective/Principal Risk	Lead	Dec 2013	Mar 2014	May 2014	June 2014	Jul 2014	Aug 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	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	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	12	→	
01-06 Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists	BB				15	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	16	→	
01-08 Risk to patient safety due to inconsistent processes and procedures for the follow up of diagnostic test results	RGW					16	16	→	
01-09 Risk to patient safety and experience of reduced	JH							**New**	

staffing levels across Trust									

Strategic Objective/Principal Risk	Lead	Dec 2013	Mar 2014	May 2014	June 2014	Jul 2014	Aug 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	12	16	16	16	16	→	

Domain: 2. Finance & Performance

Strategic Objective/Principal Risk	Lead	Dec 2013	Mar 2014	May 2014	June 2014	Jul 2014	Aug 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	12	9	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	16	16	16	16	→	

3.2-O5 Cost Reduction slippage* The Trust does not deliver its cost reduction programme objectives:- •Objective 3: to detail savings plans for the next two years	SB	20	20	20	20	20	20	→	
2.3-O5 Tariff Risk – CQUIN Premium 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	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	12	→	
3.9-05 Minimise financial impact of Better Care Fund		15	20	20	12	12	12	→	

Strategic Objective/Principal Risk	Lead	Dec 2013	Mar 2014	May 2014	Jun 2014	Jul 2014	Aug 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	12	→	
3.10-06 Risk of failure to effectively manage exit from national Cerner programme	SB					10	10	→	
3.11 - 06 Poor environment in ICT department/on site data centre may lead to interruptions or failure of essential ICT services	SB					16	16	→	
3.12-06 Inability to centrally collate and provide robust quality data to services							Tbc	**New**	

Domain: 3. Regulation & compliance

Strategic Objective/Principal Risk	Lead	Dec 2013	Mar 2014	May 2014	Jun 2014	Jul 2014	Aug 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	15	15	5	5	5	5	→	
A509-O8: Trust unable to achieve readiness for FT status by planned authorisation date as per agreed TFA	PJ	20	20	15	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	9	9	16	16	16	16	→	
03-02 Failure to demonstrate full Estates compliance	EM				16	16	16	→	
03-03 Lack of decant space will result in delays in delivering the capital programme.	EM				16	16	16	→	
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	16	→	As above
03-05 Trust wide risk to patient, public and staff safety of Legionella							Tbc	**New**	

Domain: 4. Strategy, transformation & development

Strategic Objective/Principal Risk	Lead	Dec 2013	Mar 2014	May 2014	Jun 2014	Jul 2014	Aug 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**	**Dec 2013**	**Mar 2014**	**May 2014**	**Jun 2014**	**Jul 2014**	**Aug 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	Dec 2013	Mar 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	In month change	Change/progress

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

Domain: 5. Workforce

Strategic Objective/Principal Risk	Lead	Dec 2013	Mar 2014	May 2014	Jun 2014	Jul 2014	Aug 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	12	12	→	
5.1-01 Risk of low staff morale versus requirements to continue to increase efficiency	WB						Tbc	**New**	

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 Significant Risks

<table>
<tr><td>Principal Risk</td><td colspan="6">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.</td></tr>
<tr><td>Description</td><td colspan="6">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</td></tr>
<tr><td>Domain</td><td colspan="3">1. Quality</td><td colspan="2">Strategic Objective</td><td>1.1 Patient Safety</td></tr>
<tr><td></td><td>Original</td><td>Current</td><td>Update</td><td colspan="2">Exec Sponsor</td><td>Bernie Bluhm</td></tr>
<tr><td>Consequence</td><td>5</td><td>5</td><td>5</td><td colspan="2">Date opened</td><td>01/11/2012</td></tr>
<tr><td>Likelihood</td><td>4</td><td>4</td><td>4</td><td colspan="2">Date closed</td><td></td></tr>
<tr><td>Score</td><td>20</td><td>20</td><td>20</td><td colspan="3"></td></tr>
<tr><td>Controls
&
Mitigating Actions</td><td colspan="4">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 diminish and performance and CIP targets can be met.</td><td>Assurance</td><td>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</td></tr>
</table>

	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

<table>
<tr><td>Description</td><td colspan="6">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</td></tr>
<tr><td>Domain</td><td colspan="3">1.Quality</td><td colspan="2">Strategic Objective</td><td>1.1 Patient Safety</td></tr>
<tr><td></td><td>Original</td><td>Current</td><td>Update</td><td colspan="2">Exec Sponsor</td><td>Jennie Hall</td></tr>
<tr><td>Consequence</td><td>4</td><td>4</td><td>4</td><td colspan="2">Date opened</td><td>31/05/2010</td></tr>
<tr><td>Likelihood</td><td>4</td><td>4</td><td>4</td><td colspan="2">Date closed</td><td></td></tr>
<tr><td>Score</td><td>16</td><td>16</td><td>16</td><td colspan="3"></td></tr>
<tr><td>Controls
&
Mitigating
Actions</td><td colspan="4">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</td><td>Assurance</td><td>Overall trajectory below trajectory – 3 MRSA and 14 c:diff as at July 2014.

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</td></tr>
<tr><td>Gaps in controls</td><td colspan="4">BAF risk 01-01 Informatics to support production of real time data
Decontamination of nasendoscopes</td><td>Gaps in assurance</td><td></td></tr>
<tr><td>Actions next period:</td><td colspan="6">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</td></tr>
</table>

	Trust wide environmental audit underway. Focus on areas where cleaning inspections demonstrated need to improve.

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	**2. 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.	**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.

	During 2014-15 there will be formal quarterly resets of the plan to ensure that capacity constraint/availability are kept 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	**3. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Current**	**Update**	**Exec Sponsor**	Bernie Bluhm
Consequence	4	4	4	**Date opened**	1/6/2014
Likelihood	4	4	4	**Date closed**	
Score	16	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.	**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)

	- Expansion of R.A.T model - Ambulatory streaming from ED. - 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	4		**Date opened**	16.7.14
Likelihood	4	4		**Date closed**	
Score	16	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	**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

	record result endorsement for tests organised via order comms.		
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.		

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.	**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

	CGG is dynamic. CGG reports exceptional risks to QRC. 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		received nursing/clinical sign-off.
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		

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.	**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

	▪ 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 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.		going forward
Gaps in controls	None identified	**Gaps in assurance**	
Actions next period:	New pressures are identified as early as possible and the financial impact is reported to the Finance and Performance committee.		

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	Controls 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 ▪ 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	**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 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

<table>
<tr><td></td><td>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
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</td><td></td><td></td></tr>
<tr><td>Gaps in controls</td><td>Over-programming yet to be achieved Lack of consistent pipeline of future projects</td><td>Gaps in assurance</td><td></td></tr>
<tr><td>Actions next period:</td><td colspan="3">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</td></tr>
</table>

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	4		**Date opened**	1.7.14
Likelihood	4	4		**Date closed**	
Score	16	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				

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			**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

	actions. Planned and reactive monitoring of fire safety. Fire risks assessments		
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	03-04 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	4		**Date opened**		May 2014
Consequence	4	4		**Date closed**		
Score	16	16				
Controls & Mitigating Actions	Risk assessments undertaken for each project. Monitored through the Capital Programme Board & Project Programme Board. Engage with the department early in the capital scheme and jointly agree how this can be managed.				**Assurance**	Monitoring of project and maintenance activity through project/programme boards and Divisional Governance Boards.
Gaps in controls					**Gaps in assurance**	Not monitored robustly through all Divisional Governance Boards.
Actions next period:	To improve robust monitoring of project and maintenance activity.					

Appendix 3: Extreme Divisional Risks

Risk Ref.	CW&DT Risk	Score	August 14 Change ↑↓	Rationale for 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	**Closed**		Removed as now operational.
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**	
B205	Loss of data due to clinical database no longer being supported	**16 (prev 12)**	↑	Recent SI case and other risk incidents have highlighted the fragility of the system. Can only be resolved with migration to latest E3 version Agreed Euroking upgrade by IT. Business case completed. Waiting for financial approval. No progress on implementation
CW0068	Financial risk – CQUIN From 15/16 Maternity will no longer get CQUIN funding and instead CCG will develop a local tariff for 2015/16. Estimated value of risk in 14/15 = £2.5m	**16**	**new**	
CW0070	Financial risk – cost. The division fails to achieve its CIP programme	**15**	**new**	
CW0071	CW0071 - Financial risk – cost. The division does not receive funding for identified cost pressures. Estimated value of risk in 14/15 = c. £1.1m	**16**	**new**	
CW0072	Ineffective Temperature control on Delivery Suite during summer months affects women in labour and the unborn fetus.	**16**	**new**	
CW0076	Long delays for patients when trying to contact central booking service	**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	→	
MC46-D2	Financial Risk – cost pressures within division are not funded	16	→	
MC48-D2	Financial Risk Volume – decommissioning of cardiology services	15	→	
MC50-D2	Financial Risk – Tariff. Emergency threshold tariff	15	→	
MC40-D1	Risk to patient outcomes as palliative care team establishment is not sufficient to meet increasing demands	15	→	
MC55-D2	Financial – Volume. Lack of theatre capacity for cardiac surgery impacts on income	20	→	
	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	→	

C11	Failure to prescribe essential medication for patients having elective surgery	16	→	
C04	Financial risk – cost. Neurosciences, pharmacy and finance unable to address under recording of high cost drugs of recharge to commissioners	15	→	
C05	Financial Risk – cost. Failure to deliver CIP programme	15	→	
C06	Financial Risk – cost. Failure to receive divisional funding for cost pressures	15	→	
	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	→	
	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			

Appendix 4a – Divisional Self-Declaration against CQC outcomes July-August 2014

Medicine & Cardiovascular

		Q1 (Apr/May/Jun) 2014/15 RAG Rating	
Outcome Number	**Outcome Title**	**RAG Rating**	**Issues/Action/Comment**
1	Respecting and involving people who use services	Green	
2	Consent to care and treatment	Green	
4	Care and welfare of people who use services	Yellow	Complaints show care pathways not always meeting needs of patients. Missed / delayed diagnosis from patients attending ED. Delay in accessing services in cardiac **Actions**: Findings from complaint investigations shared at governance / team meetings. Specific actions taken with individuals where needed. CVT improvement plan in place.
5	Meeting nutritional needs	Green	
6	Cooperating with other providers	Yellow	Work continues on improving quality of information on discharge summaries and communication with community health and social care teams to improve discharge experiences.
7	Safeguarding people who use services from abuse	Green	
8	Cleanliness and infection control	Amber	1MRSA bacteraemia, 3 C-diff, higher than average SSIs in cardiothoracics. **Actions**: Improved compliance with antibiotic stewardship – to continue. DC / DDO attending SSI task group to strengthen leadership & help achieve objectives. Nursing continue to ensure staff attended ICT related training. Role out of ANTT at end of year.
9	Management of medicines	Green	
10	Safety and suitability of premises	Amber	**THDCU** – short term actions taken to improve the environment. BC written to increase day care capacity at same time as works to increase oncology bed capacity. **Knightsbridge wing** – works needed to take place to reduce identified fire risk. Steering group meeting regularly to progress plans for renal re build.
11	Safety, availability and suitability of equipment	Green	
12	Requirements related to workers	Green	
13	Staffing	Yellow	Establishment review shows requirement for 2.5million investment. Division have prioritised areas for investment. Patient safety protected by use of B&A or staff in post as cost pressure. Action plan being followed through and reported to project board. Staff reporting on safe staffing levels daily
14	Supporting workers	Yellow	The division has two formal investigations into staff behaviour that have neared completion. These are in two directorates. Recommendations will then be followed through.
16	Assessing and monitoring the quality of service provision	Green	
17	Complaints	Yellow	Data for Q1 so far 66% responded in 25 days

			and 84% within agreed timescales. **Actions:** Division review the 6 complaints that breached to understand reasons why and steps to take to improve performance.
21	Records	Amber	Some improvement in health records audit results in Q1. Work continues. Concern still around back log of ED cards waiting to be scanned. A number of ED cards still go missing. **Actions:** Additional resource has been put in place and ED working with IT to address scanning issues. Directorate are working on a recovery plan to resolve the situation to be presented at DGB.

Summary

Assessment of compliance against the CQC outcomes has been reached by reviewing various forms of evidence and triangulating the information to provide a RAG rating. The sources of information has included quality inspections, directorates assessing each other's clinical areas, audit results, complaints, professional judgement and other forms of feedback.

The division is compliant in 8 outcomes, mostly meets the standards in 5 outcomes and has further work to do to become compliant in 3 of the outcomes.

Progress against actions is reviewed in business meetings and at DMB and DGB.

Signed: Alison Hughes DDNG M&C

Date: 4th August 2014

Appendix 4b – Divisional Self-Declaration against CQC outcomes July-August 2014

Children, Women's, Diagnostic and Therapeutics

		Q1 (Apr/May/Jun) 2014/15 RAG Rating	
Outcome Number	**Outcome Title**	**Level of Compliance (RAG Rating)**	**Reasons for non-compliance where compliance is rated as Amber or Red &summary actions to address** *<<report by exception only >>*
1	Respecting and involving people who use services		Improvements made in EPU / AGU following implementation of privacy and dignity tool. Concerns remain in OPD, programme of works identified and progressing
2	Consent to care and treatment		
4	Care and welfare of people who use services		Concerns raised on mock CQC inspection on Frederick Hewitt – action plan in place to address concerns
5	Meeting nutritional needs		Previous concerns noted on FH ward, issues now resolved , hostess now in situ, use of red trays and nutrition group established
6	Cooperating with other providers		Nominated host for critical care network and involvement in other networks related to NNU, Maternity
7	Safeguarding people who use services from abuse		Level 3 training currently stands at 57.4%, needs to reach 95%
8	Cleanliness and infection control		Sporadic infections noted in paediatrics but no outbreaks. Hand hygiene compliance challenged in some areas
9	Management of medicines		
10	Safety and suitability of premises		Lack of suitable side rooms in critical care, concerns regarding environment in OPD areas, Sewage leak noted in 5th floor Lanesborough theatre, concerns regarding delivery suite, leaking in roof in Lanesborough level, restricted space between cots in NNU. Plans in place to address issues listed.
11	Safety, availability and suitability of equipment		No maintenance log of equipment No replacement strategy for equipment
12	Requirements related to workers		Appraisal rate for the division remains at 76.06 % for non - medical appraisal July 2014 84.96% medical appraisal July 2014
13	Staffing		Concerns regarding staffing levels in paediatrics and NNU remain. Position will improve in September 2014 when new recruits start. Recruitment strategy being developed
14	Supporting workers		Appraisal rate for the division remains at 76.06 % for non - medical appraisal July 2014 84.96% medical appraisal July 2014
16	Assessing and monitoring the quality of service provision		
17	Complaints		Increased volume of complaints on COS – plan in place to address key themes. Women's directorate not currently meeting targets
21	Records		Issues with access to notes identified in COS, several care groups have not yet submitted audit data for documentation review

Summary

The division is reporting compliance against several of the CQC standards as listed. In contrast however there are a number of areas that are non – compliant. Notably the division is reporting a red RAG rating for 'Safety and suitability of premises'. This relates to a number of different areas within the division that have significant challenges with the fabric of the building and general environment. Services are working with the estates department on a programme of works to address these issues. Some of the estates concerns have required immediate attention, such as the 'birthing pools' in maternity which are being addressed to ensure services are resumed.

Staffing within paediatric nursing remains a concern and has resulted in some bed closures as in order to maintain safety. There has been a significant effort to recruit into vacant posts and a large cohort of new staff will start in post in September 2014. Further work is required to ensure that recruitment is managed proactively and efforts are made to increase retention across this area.

The division is currently not achieving the required 85% target response rate of 25 days and 100% for extensions for complaints; directorates that are persistently failing have been asked to focus on recovery. The division is committed to achieving the targets by the end of Q2.

The lack of notes in COS is being addressed through an overall improvement plan in COS. In addition a focused piece of work during the 'perfect week' has seen an improvement in the tracking of notes and the subsequent availability of notes in clinics.

The Division is committed to sustaining performance in the areas of compliance, and working through actions plans to achieve compliance in the areas that are not currently being met.

Andy Rhodes Jo Haworth

Signed August 2014

Appendix 4c – Divisional Self-Declaration against CQC outcomes July-August 2014

Community Services

		Q1 (Apr/May/Jun) 2014/15 RAG Rating	
Outcome Number	**Outcome Title**	**RAG Rating**	**Issues/Action/Comment**
1	Respecting and involving people who use services		
2	Consent to care and treatment		April consent audit results- action plan in place.
4	Care and welfare of people who use services		OHC: EWS- no evidence of effective implementation as no audit completed. No evidence of holistic care plans for offender with co morbidities.
5	Meeting nutritional needs		
6	Cooperating with other providers		
7	Safeguarding people who use services from abuse		MCA , CQC compliance action following Feb 2014 inspection. Mitigation is MCA training plan in place. Mast: Safeguarding Adult: 91% Children (level 1) 92%
8	Cleanliness and infection control		OHC. Sodhexo cleaning contract not yet started. Other sites: cleaning and environmental compliance need further monitoring follow drop in audit results.
9	Management of medicines		OHC. No reduction in medication incidents /timely reviews at prison. Move to full e- medication not fully achieved and systm1 support compromised.
10	Safety and suitability of premises		
11	Safety, availability and suitability of equipment		
12	Requirements related to workers		
13	Staffing		OHC. Review of vacancy factor 28% in Feb 2014. ICT (night) and Comm nursing – new risks onto risk reg.
14	Supporting workers		
16	Assessing and monitoring the quality of service provision		
17	Complaints		17 new complaints in Q1 of these 5 Breached Q1 target. (10 closed in time , 2 open). Trajectory set.
21	Records		Project complete but no confirmation of correct storage of records at OHC. Connectivity with RIO problematic.
Summary			
Green 10 Yellow 4 Amber 2 (Focused actions in place). Red 0			

Alison Ludlam July 2014

Signed……………………………………………….......... Date……………………………………………….

Appendix 4d – Divisional Self-Declaration against CQC outcomes July-August 2014

<u>Surgery, Theatres, Neurosciences and Cancer</u>

		Q1 (Apr/May/Jun) 2014/15 RAG Rating	
Outcome Number	**Outcome Title**	**Level of Compliance (RAG Rating)**	**Reasons for non-compliance where compliance is rated as <u>Amber or Red</u> &summary actions to address** *<<report by exception only >>*
1	Respecting and involving people who use services	Y	Pt information leaflets/discussions re procedures/risk, In patient & cancer survey results/ CNS availability
2	Consent to care and treatment	A	Compliance with consent policy/audit results/ WHO- neurosurgery, DSU & AET/ Associated SI's/MCA awareness at QMH & records of training generally
4	Care and welfare of people who use services	Y	Improve AI/SI/Complaint learning and feedback/Theatre capacity and recovery backlogs/documentation and use of care plans could improve/ dissemination of pt info leaflets
5	Meeting nutritional needs	Y	MUST assessment/weight/inconsistent care/documentation/associated complaints/intentional rounding
6	Cooperating with other providers	Y	Discharge planning/patient involvement/discharge summary quality, completion of and associated impact
7	Safeguarding people who use services from abuse	Y	Staff knowledge of MCA/safeguarding
8	Cleanliness and infection control	Y	Hand hygiene consistency/uniform policy adherence/use of green tape/dusty equipment/CDT/MRSA
9	Management of medicines	A	Timely prescribing of drug charts/safe storage/legibility of drug charts/antibiotic stewardship
10	Safety and suitability of premises	A	SSD plant/theatre environment/ventilation/chillers DSU/lift DSU/availability of fire wardens
11	Safety, availability and suitability of equipment	Y	Surgical instrument availability & age/nasendoscopes-decon process/bariatric equipment/mattress & cot side availability
12	Requirements related to workers	G	
13	Staffing	Y	Nursing scorecard being developed/Robust PDP's required/safe staffing process in place/vacancy factor risks identified
14	Supporting workers	Y	Overall IPR rate
16	Assessing and monitoring the quality of service provision	A	Results of quality inspections.
17	Complaints	Y	Significant improvements/ on-going work on volumes, performance and shared learning
21	Records	A	Missing notes/general quality of records/legibility/audit results/ICP completion

Summary
Quarterly CQC assessments take place within the division in all clinical areas- cross directorate audit is carried out to improve objectivity Each directorate then self-assesses against the 16 outcomes and develops an associated

action plan.

Results have been summarised on a divisional wide basis to give the overall compliance rating shown above.

Helene Anderson 15/08/2014

Signed Print