St George's Healthcare NHS
NHS Trust

REPORT TO TRUST BOARD ***September 2014***

Paper Title:	Risk and Compliance report for Board incorporating: 1. Board Assurance Framework 2. Assurance Map
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.
- External assurances received during the period.

Recommendation:

The Trust Board is asked to note the report.

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**
3.12-06	Risk to patient safety due to data quality issues with Patient Administration System (PAS), Cerner, inhibiting ability to be able to monitor patient pathways and manage 18 week performance.	**3**	**5**	**15**

1.1 Changes to risk scores:

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

1.2 New and closed risks

There are no risks proposed for closure and no new risks identified for potential inclusion during the reporting period.

1.3 Summary of Extreme Risks at Divisional level:

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 Summary of external assurance and third party inspections August-September 2014

2.1.1 Major Trauma Dashboard

The Trust received its Quarter 1 2014/15 Major Trauma Centre dashboard. The report highlighted the general strong performance of St. Georges as an MTC, there were however three metrics where the Trust was performing below the national mean: 'transfer into the MTC within two days of referral', 'Proportion of patients with GCS <9 with definitive airway management within 30 minutes of arrival in ED' and 'definitive cover of open fractures within BOAST guidelines'. These matrices have been subject to internal review and no assurance and governance issues have been identified.

2.1.2 BSI Medical Physics and Clinical Engineering Audit

The medical physics and clinical engineering department were assessed by the BSI in August 2014 and no issues or concerns were noted. The trust was informed that the medical physics and clinical engineering team would be subject to a further review in February 2015.

2.1.3 South Thames Paediatric (ST1-5) Specialty Training Committee – Visit report

The draft report from the STC liaison visits are routine 3 yearly visits to hospitals within the South London Region has been received. The visits look at the (ST1-5) Paediatric training programme. They are led by a visiting faculty which include a visit lead, training programme director, college tutor/educational supervisor and a trainee representative.

In summary, a number of minor recommendations were made, some of which were to ensure sharing of the excellent models of training at SGH across other Trusts. SGH were commended on their exemplary communication, training and rota management, which have had a direct impact on patient safety. The trainees were unanimously happy with the training programme, expressing appreciation for strong educational leaders, brilliant rota management and a safe working environment. The Safeguarding training, which is unique to SGH was also commended, giving trainees the opportunity to share concerns.

2.2 Update on Action Plans – August-September 2014

2.2.1 South West London Regional GMC Visit

The trust was visited by the GMC in October 2012. During this visit, several areas of concern were noted and the GMC issued St. Georges with an action plan of criteria to address. The actions relating to this particular GMVC visit have now been addressed and closed.

2.3 Forthcoming Inspections – October 2014

2.3.1 National Cancer Peer Review

The trust has received notification that validated self-assessments will be conducted on the following disciplines in late 2014: Lung; Chemotherapy; Teenage and Young Adults; Haematology; Colorectal; Brain and CNS and Gynae-oncology. These assessments have been re-scheduled from earlier in the year.

3. CQC Quality Monitoring

3.1 CQC Mortality Outlier Alert – September 2014

The Trust received a CQC Mortality Outlier alert from Imperial College Dr. Foster (Imperial College Healthcare Trust) in September 2014. The alert indicated higher than average mortality rates for patients undergoing 'CAGB (Coronary artery bypass graft) other procedures' at St. Georges Healthcare NHS Trust. Dr. Foster has shared this information with the CQC who have requested that the trust provide them with an analysis of cardiothoracic clinical audit data by 09/10/2014 in order that they can assess the significance of this alert. The trust is currently compiling this information and the outcome of this investigation will be reported to the Board in due course.

3.2 Intelligent Monitoring Report (IMR)

The Trust has received a routine request from the CQC for assurance (by 26/9/2014) around how it is managing the current risks detailed in the July Intelligent Monitoring Report.

Previously, based on the IMR 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. The current risk profile however, would theoretically present an adjustment in the Trust Risk banding from band 6 to 5.

The Trust provided early assurance to the CQC in July in response to the draft IMR report, in particular with relation to the *Risk: Composite indicator – in hospital mortality – trauma and orthopaedic conditions and procedures (01.04.2012-18.06.2014).* The CQC acknowledged that the Trust had taken appropriate action to review and confirmed they did not consider there to be any notable care issues for these patients. However the advised that they do not have a process in place to follow up with trusts when there is a trigger for the aggregate in-hospital mortality indicator, or to incorporate feedback from trusts that may explain the raised mortality, therefore the 'Risk' would remain in the final publication of the July Intelligent Monitoring report.

The total risks are summarised below along with assurance previously provided to the Trust Board in July:

Table 2 – 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	Three never events (current financial year) relate to retained swabs. An overarching panel to review practice across all areas is shortly to commence. All never events are scrutinised externally by Commissioners.
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	Further detail provided below.

				indicator (01-Oct-13 to 31-Dec-13)	
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)	This is a sampling issue: Trust mandatory and Statutory training data for all staff groups confirmed that the proportion of staff having 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. A full report is 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.

Appendix 1: Executive Overview of Board Assurance Framework

Strategic Objective/Principal Risk	Lead	Mar 2014	May 2014	June 2014	Jul 2014	Aug 2014	Sept 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.	MW	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	12	→	
01-06 Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists	MW			15	15	15	15	→	
01-07 Risk to patient safety and experience as a result of potential Trist failure to meet 95% Emergency Access Standard	MW			16	16	16	16	→	

Domain: 1. Quality

Strategic Objective/Principal Risk	Lead	Mar 2014	May 2014	June 2014	Jul 2014	Aug 2014	Sept 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.	MW	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	12	→	
01-06 Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists	MW			15	15	15	15	→	
01-07 Risk to patient safety and experience as a result of potential Trist failure to meet 95% Emergency Access Standard	MW			16	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	16	→	

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

Domain: 2. Finance & Performance

Strategic Objective/Principal Risk	Lead	Mar 2014	May 2014	June 2014	Jul 2014	Aug 2014	Sept 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	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	16	16	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	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	SB	20	20	12	12	12	12	→	

Strategic Objective/Principal Risk	Lead	Mar 2014	May 2014	June 2014	Jul 2014	Aug 2014	Sept 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	12	→	
3.10-06 Risk of failure to effectively manage exit from national Cerner programme	SB				10	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	16	→	
3.12-06 Risk to patient safety due to data quality issues with Patient Administration System (PAS), Cerner, inhibiting ability to be able to monitor patient pathways and manage 18 week performance.	SB						15	→	

Domain: 3. Regulation & compliance

Strategic Objective/Principal Risk	Lead	Mar 2014	May 2014	June 2014	Jul 2014	Aug 2014	Sept 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	5	5	5	5	5	→	
A509-O8: Trust unable to achieve readiness for FT status by planned authorisation date as per agreed TFA	PJ	20	15	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	16	16	16	16	16	→	
03-02 Failure to demonstrate full Estates compliance	EM			16	16	16	16	→	
03-03 Lack of decant space will result in delays in delivering the capital programme.	EM			16	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.	EM				16	16	16	→	
03-05 Trust wide risk to patient, public and staff safety of Legionella	EM						12	→	

Domain: 4. Strategy, transformation & development

Strategic Objective/Principal Risk	**Lead**	**Mar 2014**	**May 2014**	**June 2014**	**Jul 2014**	**Aug 2014**	**Sept 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**	**Mar 2014**	**May 2014**	**June 2014**	**Jul 2014**	**Aug 2014**	**Sept 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**	**Mar 2014**	**May 2014**	**June 2014**	**Jul 2014**	**Aug 2014**	**Sept 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	Mar 2014	May 2014	June 2014	Jul 2014	Aug 2014	Sept 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	12	12	12	→	
5.1-01 Staffing levels across the Trust (following review of nursing establishment and subsequent medical staffing review to take place) also in light of staff concerns and various risks captured in divisional risk registers in relation to staffing.	WB						12	→	

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	MW	Martin Wilson	Director of Delivery & Performance

Appendix 2 – Detailed Board Assurance Framework Significant Risks

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**	Martin Wilson
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 diminish and performance and CIP targets can be met.			**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

	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**	C.diff - Currently above trajectory (20 reported against threshold 40: Sept. 10th 2014). All RCAs discussed at HCAI taskforce. CQC Compliance with Outcome 8: Infection Control (Feb 2014) Best practice visit to Southampton, Royal Free and west Hertfordshire MRSA – 3 cases, all investigated via RCA –and discussed at HCAI taskforce 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	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**	Martin Wilson
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	**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.

	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 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**	Martin Wilson
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:			**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)

	- Co-ordination control and leadership. - 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			**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

	Cerner order comms system has ability to undertake and 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 email detailing trust 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 was presented to PEC (Aug) and TB (Sept). Negative: Performance against 25 day timescale is currently significantly below 85% - internal Trust standard Performance did not improve for complaints received in month of July

Gaps in controls	All divisions requested to present improvement plan (with trajectory) to improve response rate: Plans were presented but improvement was not realised in Q1 or Q2 so far (complaints received in month of July)	**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	<u>Controls</u> Benchmarking St. George's services to ensure that opportunities ▪ Over-programming -Additional Schemes to be developed above annual requirement as a contingency against under-delivery ▪ Benchmarking St. George's services to ensure that opportunities are found ▪ Role of PMO in managing CIP programme. ▪ Rigorous PID development to support projects to be delivered ▪ Divisional Management Board 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 from productivity based Service Improvement Programme ▪ Development of in-house expertise to support development of service improvement culture ▪ Weekly meetings between directorates, divisions and the PMO to monitor scheme performance. All projects across the trust have clear directorate and divisional			**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 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

	leads. ▪ The trust is engaging with outside expertise to develop further robust CIP savings schemes for future years. <u>Mitigating Actions</u> 1.To develop further in-year non-recurrent CIP schemes 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. 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:	Continued review and development of schemes supporting the programme Start taking initial outputs of work of AT Kearney on 17/18 and 18/19 programme development		

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.				

Principal Risk	3.12-06 Risk to patient safety due to data quality issues with Patient Administration System (PAS), Cerner, inhibiting ability to be able to monitor patient pathways and manage 18 week performance.		
Description	There have been unintended consequences of recent upgrades to our main Patient Administration System (PAS), Cerner, inhibiting our ability to be able to monitor patient pathways and manage 18 week performance. This has created some clinical risk with a small number of patients having future appointments inappropriately cancelled. It also increased the likelihood of missing the 18w target, with potential financial penalties and reputational impact.		
Domain	**1.**	**Strategic Objective**	**1.1**

	Original	Current	Update	Exec Sponsor	Steve Bolam
Consequence	3			**Date opened**	Sep 2014
Likelihood	5			**Date closed**	
Score	15				

Controls & Mitigating Actions	The issues were picked up by existing 18w validation processes. A task and finish group has been formed, chaired by Steve Bolam (Director of Finance & Performance) with senior representation from the Services, IT, Contracts and Information. This group will meet fortnightly to ensure remaining issues are addressed and processes are put in place to mitigate future risks. The newly formed Clinical Systems Programme Board has established an approval process for proposed new systems and significant changes to systems. Approval is contingent on adequate data quality assurance. The Cerner Project Board membership, which is accountable to the Clinical Systems Programme Board, is being renewed to ensure senior clinical, operational and technical executive representation to oversee next phases of Cerner deployment.	**Assurance**	An investigation into the inappropriately cancelled patients, led by Fiona Ashworth (DDO), found no patient had suffered harm as a consequence. Patients who required it have been re-booked.
Gaps in controls		**Gaps in assurance**	
Actions next period:	Task and finish group to meet, identify necessary remedial actions and ensure they are undertaken.		

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	→	
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	→	
CW060	Delays to patients receiving chemotherapy of Trevor Howell day Unit	15	→	
B205	Loss of data due to clinical database no longer being supported	16	→	
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	→	
CW0070	Financial risk – cost. The division fails to achieve its CIP programme	15	→	
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	→	
CW0072	Ineffective Temperature control on Delivery Suite during summer months affects women in labour and the unborn fetus.	16	→	
CW0076	Long delays for patients when trying to contact central booking service	15	→	
	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	**15**	→	

	pressures			
	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			