St George's Healthcare NHS
NHS Trust

REPORT TO TRUST BOARD ***October 2014***

Paper Title:	Risk and Compliance report for Board incorporating: 1. Board Assurance Framework 2. Assurance Map 3. Quarterly thematic analysis of Quality Inspection findings
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.
- Update on the trust quality inspection programme.
- Risk and Compliance reporting schedule.

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
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 New risks proposed for inclusion

There have been two new risks included on the BAF during the reporting period; these are detailed in table two.

Table two: new risks

Ref	Description	Source	C	L	Rating	Exec
01-09	Risk to patient safety due to a lack of a Trust wide visible training needs analysis, and lack of a system for ensuring these have been met in relation to Medical Devices	Discussion at ORC	3	4	12	JH
02-03	Risk of poor patient experience due to long delays when trying to contact central booking service	Discussion at EMT & ORC and escalation from Div R/Register	3	4	12	MW

A further three are prosed for inclusion and are currently undergoing a risk assessment. These will be included in the BAF to be presented in full at Trust board in November:

- Offender healthcare – identified and escalated following discussion at ORC (Sept) of aggregated risks at Divisional level

- Operational readiness for Ebola incidence/outbreak – identified following briefing at EMT, steering group in place chaired by Chief Nurse and risk assessment currently completed at EMT
- Operational readiness for an Ebola outbreak/incidence – identified via briefing at EMT

1.2 Changes to risk scores

Whilst there have been no formal changes to risk scores during the reporting period there has been a change to risk descriptions of three risks, this aim is to more accurately articulate each risk:

Table three: changes to risk descriptions

Ref	Previous risk description	Revised risk description
O3-01	Ability of the Trust to demonstrate its compliance in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO)	Risk of premises closure, prosecution and fines as a result of non-compliance with fire regulations in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO)
03-02	Failure to demonstrate full Estates compliance	Risk of premises closure, prosecution and fines as a result of failure to demonstrate full compliance with Estates and Facilities legislation
5.1-01	Staffing levels across the Trust	Failure to recruit and retain sufficient staff to manage turnover rates and support future increases in capacity

There was discussion and agreement at Executive Management Team meeting (13th Oct) that the current BAF risk: A602 'Pressures on internal capacity may result in the Trust being unable to meet demands from activity, negatively affecting quality, throughout the year' should be separated into four new risks:

- Delivery of capacity developmental plan
- Theatre capacity plan
- Critical care planning
- Staffing to support capacity

This is underway and the new risks will be included in the full BAF report to Trust Board in November.

1.3 Closed risks

There are no risks proposed for closure during the reporting period.

1.4 Summary of Extreme Risks at Divisional level:

A full summary of extreme divisional risks can be found at Appendix 3. In total, seven extreme risks have been reduced to high risks during the reporting period following receipt of positive assurance that actions to manage the risk are effective. The reductions in risk ratings are made following consideration and agreement at each Divisional Governance Board.

1.5 Risk Management Strategy

The newly developed Risk management Strategy will be presented to Trust Board in November. The aim of this strategy is to strengthen the existing risk management framework, further embedding risk management at a local level, to achieve greater local level ownership of risk and ensuring appropriate escalation of risks through the organisation to the Board, supported by enhanced clarity regarding roles and responsibilities for risk management and strengthened governance arrangements to support the current framework, training and tools.

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 September-October 2014

2.1.1 Patient Led Assessments of the Care Environment (PLACE)

The Trust received its final scores following the PLACE assessment conducted earlier this year. The assessments are conducted by patients who review the general environment and score the trust on four separate elements: cleanliness; food; privacy, dignity and well-being and, condition, appearance and maintenance. The scores are detailed in table four below, highlighting trust performance against the national average:

Table four – Trust PLACE performance against national average

PLACE Criterion	Trust Score 2014	National Average 2014
Cleanliness	95.52%	97.25%
Food	86.78%	88.79%
Privacy, Dignity and Wellbeing	86.70%	87.73%
Condition, Appearance and Maintenance	91.82%	91.97%

The table above shows trust performance to be marginally below the national average for all elements of the assessment. There are actions in place to improve the trust's PLACE scores which are part of a wider estates and facilities action plan. This plan is subject to regular monitoring and updates regarding actions to improve PLACE scores will be reported to future meetings of the Board, as required.

2.1.2 London Fire & Emergency Planning Authority (LFEPA)

The LFEPA Enforcement Officer visited the trust during September in order to follow up an Enforcement Notice in place on Knightsbridge Wing. During this visit, the Enforcement Officer also inspected several other areas which had not previously been subjected to a LFEPA audit. Briefly, the units inspected included:

- New Build Offices (Old Pharmacy location);
- Old Chest and Breast Clinics;
- Occupational Health 1;
- Education Centre;
- Robert Lowe Sports Centre;
- Bence Jones; and
- Phoenix Centre.

The Enforcement Officer was satisfied that appropriate work had been planned and begun to address the Enforcement Notice in place on Knightsbridge Wing, however, he remained concerned regarding general housekeeping in these other units and noted several instances of non-compliance with fire safety regulations. The Enforcement Officer informed the trust Fire Officer that he will be returning to the trust on a monthly basis to re-visit the units inspected above, as well as other units that have not been previously inspected. The relating risk on the Board Assurance Framework remains at 16 (extreme).

2.2 Forthcoming Inspections – October-November 2014

2.2.1 South East London CSU Transitional Care and Neonatal Audit

The trust has received notification that the South East London CSU will be conducting an audit of transitional care and neonatal records in late October. The review will focus on transitional care pathways and the audit team will be reviewing appropriate wards and patient records. Findings will be reported to a future Board meeting.

2.2.2 London Fire and Emergency Planning Authority (LFEPA)

The LFEPA will be conducting monthly visit to the trust to audit units that have not previously been inspected. The LFEPA have also informed the trust that they will be undertaking a follow up visit in February 2015. The purpose of this visit is to re-inspect Grosvenor and Lanesborough wings' which were issued with Enforcement and Deficiency Notices in February 2013. There is a detailed action plan in place to address the issues highlighted in these notices. The plan is on target and is monitored by the Health, Safety and Fire Committee.

2.2.3 Major Trauma National Peer Review

The trust has received confirmation that it will reviewed during Quarter 4 2014/15. This peer review focuses on the quality of the trusts major trauma unit.

3. Trust Internal Quality Inspection Programme

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

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

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

3.1 Quality Inspection Update: 01 July – 30 September

3.1.1 Quality Inspection Programme

Twenty inspections have been conducted during the reporting period as follows: nine inspections conducted on wards in the Medicine and Cardiovascular Division; six inspections conducted on wards in the Surgery, Theatres, Neurosciences and Cancer Division; three inspections conducted on wards in the Children & Women's and Diagnostics and Therapeutics Division; One inspection conducted on a ward in the Community Services Division; and three inspections conducted in outpatient clinics.

3.1.2 Quality Inspection Findings

Are the Trusts Services Safe?

Inspection teams noted that staff were compliant with the trust uniform policy and were always bare below the elbows. Patients noted that staff adhered to a strong infection prevention regime and were vigilant in washing hands and using alcohol hand rub. A key general theme throughout the reporting periods was cleanliness of wards, particularly bathrooms on wards with patients commenting on several occasions that they felt the bathrooms were generally unclean and potentially hazardous in one instance (Gwillim ward).

The standard of patient records and documentation on wards varied considerably. It was noted that the standard of record keeping on Holdsworth and Florence Nightingale wards (Surgery) and the Neo-natal Unit (Children &Women's) were particularly high, whilst there were more issues prevalent to patient records on Mary Seacole ward (Community) and Gwillim (Children & Women's) wards. The main issues that inspection teams noted with regards to patient records were charts and observations not being correctly completed, loose documentation in patient files

and poor legibility of documentation. It was further noted on Mary Seacole ward that capacity documentation had not been completed as required in two instances reviewed. Further it was noted on Gwillim ward that medications that were given to patients, or omitted, were not recorded on the chart in any of the patient files reviewed.

Patients felt that staff had generally been very respectful and sought to protect patient privacy and dignity. Patients regularly described staff to be 'caring and helpful'.

Actions:
The estates and facilities team have also been proactive in addressing the many issues related to cleanliness identified throughout the current reporting period.

The quality of note-keeping on Mary Seacole ward was an issue highlighted by the CQC Inspection in February 2014. Currently there are senior reviews and documentation checks taking place daily for new patients and six 6 patient's records are reviewed daily by the Head of Nursing, An audit to check for improvements will be undertaken October 2014

Are the Trusts Services Effective?
Patient feedback regarding meals provided at St. Georges was mixed. Patients on most wards felt that the food was palatable, hot and plentiful. However, there were several instances where patients felt that the choice of food was limited, particularly for patients with religious dietary requirements (Rodney Smith Ward). Patients on Gwillim ward also felt that food portions were not sufficient for nursing mothers. The inspection team on Holdsworth ward noted one instance where a patient with a red tray was not receiving assistance; this was immediately escalated and rectified during the inspection.

Patients felt that staff were very generally personable and friendly; regularly describing staff to be 'caring' and 'helpful'.

Actions:
The estates and facilities team have been very proactive in escalating issues related to meal provision at St. Georges and have been quick to encompass further findings that have been identified throughout the current reporting period (such as religious dietary requirements, which were escalated and addressed in the immediate aftermath of the relevant inspection).

Are the Trusts Services Caring?
All patients spoken to during the inspections felt content with their care at St. Georges overall. Patients felt that they had been involved in their care and treatments and procedures had generally been explained to them clearly. Patients fed back to inspection teams on several occasions that they felt staff were 'too busy' and 'overworked'. Patients generally felt that staff had always provided assistance as required, however on occasions this took too long due to them being so busy. This was particularly noted on Mary Seacole, Gwillim and Thomas Young wards. Patients on Thomas Young ward felt that nurses were particularly busy at night time, which had resulted in delays to their requests for assistance.

Staff competencies showed significant improvement during the reporting period. Generally staff were aware of how to report an incident, access an interpreter and sound knowledge around protecting patient confidentiality. Staff were also able to describe how they would assist patients in understanding their condition, treatment or procedure and how they would deal with a patient concerns. There were several instances where inspection teams identified staff that were unsure of trust safeguarding requirements (Holdsworth, James Hope and Rodney Smith wards, Trevor Howell Day Unit and Neo-natal Unit). In each case, inspections teams informed the Matron, senior sister in charge to ensure that this was followed up.

Are the Trusts Services Responsive to People's Needs?
Patients on all wards commented that they felt confident in being able to raise a concern with staff and that were a concern had been raised, it had been resolved amicably. Inspection teams noted that although information was provided on wards and clinics, noticeboards were generally cramped and unclear. This was particular prevalent in all outpatient clinics. Inspection teams in outpatient clinics also noted that there were excessive waiting times and that patients were not provided with any information regarding potential waiting times. Further, there are chronic space issues in outpatient clinics in general which lead to a compromised patient experience. Patients in outpatient clinics felt that due to the lack of space and set up of clinics, privacy and dignity *could* be compromised as there were occasions where conversations between staff and patients could be overheard. Patients also felt that signage in outpatients in generally is poor and leaves patients feeling confused as to where they should actually be. There is an outpatient service improvement programme in place which will encompass these issues in service improvements

Actions:
There has also been progress with regard to the information on noticeboards in wards and clinics, whilst there is still room for improvement in this regards, wards and clinics have begun to review this to ensure that information is provided more clearly.

There is a detailed corporate outpatient's improvement programme in place which will address the many issues highlighted through inspections conducted during the reporting period.

Are the Trusts Services Well-Led?
All staff interviewed had completed a local induction and where generally up to date with mandatory and statutory (MAST) training. Inspection teams noted several instances where staff had not received and appraisal within a year, as required by trust policy (Ruth Myles unit, Holdsworth and Thomas Young wards). All staff where aware of how to locate trust policy and raise concerns. Inspection teams conducted reviews of resuscitation trolley checks, controlled drugs checks and safety checks on wards and no issues were reported.

Actions:
There has also been an improvement in engagement from wards, particularly with regard to acting on patient feedback identified through the quality inspection programme.

It was also previously noted on Frederick Hewitt ward that there were issues surrounding staffing levels, these issues have been escalated to the divisional risk register and a recruitment plan is in place. The issue of staffing across all paediatric units was also an area for improvement following the CQC inspection and progress of the plans in place to address paediatric staffing shortages is also being monitored through the CQC improvement action plan.

4. Risk and Compliance Reporting Schedule

The Board, through this risk and compliance report receives regular updates on the Board Assurance Framework (BAF) and Assurance Map, Quality Inspection Programme and Divisional CQC Self-Declarations of compliance. The reporting schedule for 2014/15 is set out in table five. Divisional CQC Self Declarations are presented to Board, once considered and agreed at the relevant Divisional Governance Board (DGB meeting) and at QRC.

Table five: TB reporting schedule

Board Reporting Element	Financial Year 2014/15 – 2015-16												
	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15
Full Board Assurance Framework (BAF)	✓		✓		✓		✓		✓		✓		✓
Divisional CQC Self-Declarations	✓			✓			✓			✓			✓
Quality Inspection Update			✓			✓			✓			✓	
Full Assurance Map		✓			✓			✓			✓		

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 and any issues identified through the internal quality inspection programme, as required.

Appendix 1: Executive Overview of Board Assurance Framework

Domain: 1. Quality

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

01-09 Risk to patient safety due to a lack of a Trust wide visible training needs analysis, and lack of a system for ensuring these have been met in relation to Medical Devices	JH						12	**New**	

Strategic Objective/Principal Risk	**Lead**	**May 2014**	**June 2014**	**Jul 2014**	**Aug 2014**	**Sept 2014**	**Oct 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	16	16	16	16	16	16	→	
02-03 Risk of poor patient experience due to long delays when trying to contact central booking service							12	**New**	

Domain: 2. Finance & Performance

Strategic Objective/Principal Risk	**Lead**	**May 2014**	**June 2014**	**Jul 2014**	**Aug 2014**	**Sept 2014**	**Oct 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	SB	9	9	9	9	9	9	→	

• centralisation plans									
3.3-O5 Cost Pressures * The Trust faces higher than expected costs due to:- •unforeseen service pressures •higher than expected inflation	SB	16	16	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	12	12	12	12	12	→	
3.9-05 Minimise financial impact of Better Care Fund	SB	20	12	12	12	12	12	→	

Strategic Objective/Principal Risk	Lead	May 2014	June 2014	Jul 2014	Aug 2014	Sept 2014	Oct 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	12	→	
3.10-06 Risk of failure to effectively manage exit from national Cerner programme	SB			10	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	16	→	
3.12-06 3.12- O6 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	15	→	

Domain: 3. Regulation & compliance

Strategic Objective/Principal Risk	Lead	May 2014	June 2014	Jul 2014	Aug 2014	Sept 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	5	5	5	5	5	5	→	
A509-O8: Trust unable to achieve readiness for FT status by planned authorisation date as per agreed TFA	PJ	15	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	→	
03-01Risk of premises closure, prosecution and fines as a result of non-compliance with fire regulations in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO)	EM	16	16	16	16	16	16	→	Change to wording
03-02 Risk of premises closure, prosecution and fines as a result of failure to demonstrate full compliance with Estates and Facilities legislation	EM		16	16	16	16	16	→	Change to wording
03-03 Lack of decant space will result in delays in delivering the capital programme.	EM		16	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	16	→	
03-05 Trust wide risk to patient, public and staff safety of Legionella	EM					12	12	→	

Domain: 4. Strategy, transformation & development

Strategic Objective/Principal Risk	**Lead**	**May 2014**	**June 2014**	**Jul 2014**	**Aug 2014**	**Sept 2014**	**Oct 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**	**May**	**June**	**Jul**	**Aug**	**Sept**	**Sept**	**In month**	**Change/progress**

		2014	2014	2014	2014	2014	2014	change	
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	May 2014	June 2014	Jul 2014	Aug 2014	Sept 2014	Oct 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	May 2014	June 2014	Jul 2014	Aug 2014	Sept 2014	Oct 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	12	12	12	12	→	
5.1-01 Failure to recruit and retain sufficient staff to manage turnover rates and support future increases in capacity	WB					12	12	→	Change to wording

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	SM	Suzanne Marsello	Interim 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

<table>
<tr><td>Principal Risk</td><td colspan="5">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="5">Requirement for high activity volumes in some specialities.
Potential for commissioner challenges and financial penalties
There is an unlimited demand on A&E which 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
- Delivery of capacity development plan
- Theatre capacity plan
- Critical care capacity plan
- Staffing to support capacity plan</td></tr>
<tr><td>Domain</td><td colspan="3">1. Quality</td><td>Strategic Objective</td><td>1.1 Patient Safety</td></tr>
<tr><td></td><td>Original</td><td>Current</td><td>Update</td><td>Exec Sponsor</td><td>Martin Wilson</td></tr>
<tr><td>Consequence</td><td>5</td><td>5</td><td>5</td><td>Date opened</td><td>01/11/2012</td></tr>
<tr><td>Likelihood</td><td>4</td><td>4</td><td>4</td><td>Date closed</td><td></td></tr>
<tr><td>Score</td><td>20</td><td>20</td><td>20</td><td colspan="2"></td></tr>
<tr><td>Controls & Mitigating Actions</td><td colspan="3">Controls:
Director of Delivery and Improvement appointed to lead organisation’s work on (in year and next year) capacity planning and delivery. Supported by full time Programme Manager dedicated to capacity.
Significant additional bed capacity being developed in 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.</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</td></tr>
</table>

	Operational Capacity Planner (OCP) developed to plan and track progress on all capacity creation and release schemes. Reviewed weekly at OMT and EMT. OCP managed by Programme Manager and includes 4 key areas: staffing, clinical pathway; physical capacity; and commercial / contracting arrangements. Business Planning for 2015/16 commenced with focus on aligning divisional activity and capacity plans. Specific theatre capacity analysis and plan developed linked to a longer term theatres strategy currently in development. If delivered as planned, capacity pressures will substantially diminish and performance and CIP targets can be met. There are however risks with respect to the timing and delivery of both aspects of the plan. To control these risks, we have: Ensured that maximum possible resource is deployed towards the improving patient flow programme so that optimal delivery can be achieved A structured approach to appraising the options for creating further physical capacity for 2015-16 and beyond. This work is underway. Increased capital project management capability **Mitigations:** • Seek additional external capacity • Cap demand for services		activity i.e. Feb 2014
Gaps in controls		**Gaps in assurance**	Lack of critical path currently identified for all forecast building schemes.
Actions next period:	Realisation of new physical bed capacity Development of critical path for all forecast building schemes, and embedding the holding to account of Senior Responsible Owners for delivery of agreed schemes. 2015/16 business planning accelerated		

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 and 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	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 Best practice visit to Southampton, Royal Free and west Hertfordshire	**Assurance**	Overall beyond trajectory – 3 MRSA and 22 c:diff (22 Oct 2014) CQC Compliance with Outcome 8: Infection Control (Feb 2014) 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 Bi-weekly taskforce meeting and bi-monthly Infection Control Committee meeting Regular reports to the Patient Safety Committee, EMT & Trust Board
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	5	**Date opened**	31.5.2014
Likelihood	3	3	3	**Date closed**	
Score	15	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. RTT performance delivery plan to ensure full chronological booking and achievement of RTT aggregate trust levels standards agreed with commissioners. As part of this plan the Trust is developing action plans by December 2014 in	**Assurance**	Negative assurance – two SIs have occurred where patients on cardiothoracic waiting list died suddenly without being offered a date for surgery/diagnostic test.

	three specialties with particular performance challenges to ensure specialty level compliance. Divisions have reviewed clinical review of waiting lists to ensure any clinical risks due to waiting are reviewed and managed. Approach reviewed by QRC and CQRM committees. RTT and Data Quality task and finish groups established to build more robust operational approach to management of RTT delivery day to day.		
Gaps in controls		**Gaps in assurance**	Current data quality for Patient Tracking Lists for incomplete pathways is too poor to enable prospective assurance of 18 week delivery for patients not on inpatient waiting list.
Actions next period:	Continue to implement RTT improvement plan with support of commissioners. RTT and Data Quality task and finish groups to continue and complete by end of December. Develop plan for three specialties not currently expected to deliver specialty level standards by March 2015.		

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	Emergency Access Operational Standard Action Plan developed covering capacity, pathway improvement and performance management in three areas: 4. Emergency department actions 5. Whole hospital actions 6. Wider system actions Progress in delivering action plan regularly reviewed:			**Assurance**	+ve = No clinical incidents arising from long ED waits +ve = Q2 performance standard has been met Daily reporting to Exec team Escalation meetings between division & CEO ECIST review of action plan

	• ED action plan via ED Senior team meeting weekly • Whole hospital actions via OMT fortnightly • Wider system actions via System Resilience Group performance meeting monthly • Overall the plan is reviewed with the CEO and Director of Delivery and Improvement on a fortnightly basis Continued close and pro-active working with ECIST		
Gaps in controls		**Gaps in assurance**	No metrics currently in place and reported for newly agreed hospital wide operational standards ED dashboard not yet finalised
Actions next period:	To implement improvement plan (particularly focussed on whole hospital and wider system actions) To develop hospital wider operational standards and flow dashboard that will help identify contributory factors to performance		

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	4	**Date opened**	16.7.14
Likelihood	4	4	4	**Date closed**	
Score	16	16	16		
Controls & Mitigating Actions	Gap analysis of systems for reviewing diagnostic test results across all areas which carry out diagnostic tests completed and SOPs being written for those without. Systems in place for many areas. Areas without systems are required to develop them by Dec 2014 Failsafe systems for critical test results in laboratories and radiology. Radiology are strengthening their failsafe safety net system which has failed on a number of occasions recently. This now includes e mail to MDT for unexpected cancer (cancer MDTs are working through their responses to these alerts Cerner order comms system has ability to undertake and record result endorsement for tests organised via order			**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

	comms. Project group set up including IT, operations and service improvement to improve process of results endorsement on Cerner and roll it's use out in Trust.		
Gaps in controls	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:	Divisions to report back to PSC on work to close identified gaps – Dec 2014		

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 Quarterly performance review with Divisions Trust performance reviewed by PEC every 2 months Reported to TB monthly

Gaps in controls		**Gaps in assurance**	Overall Trust response rate remains low and continues to deteriorate Need more detailed thematic analysis at care group level to ensure causes of complaints are well understood & that actions are put in place that lead to improvements (and therefore a reduction in complaints).
Actions next period:	Following review of complaints process following the publication of Hart/Clwyd report (post Francis) - presentation to QRC and work now underway to address recommendations Improve reporting of feedback received from NHS Choices, care Connect etc on-going Regular updates to be reported to newly established Operational Management Team, chaired by Director for Delivery and Performance		

Principal Risk	02-02Risk of diminished quality of patient care as a result of Cost Improvement Programmes (CIPs)				
Description	As Cost Improvement Programmes continue to be rolled out, there is a potential risk that inadequate identification, monitoring and mitigating actions will fail to ensure that quality of care is preserved.				
Domain	**1.Quality**			**Strategic Objective**	**1.2 Patient Experience**
	Original	**Current**	**Update**	**Exec Sponsor**	Ros Given Wilson
Consequence	4	4	4	**Date opened**	01/07/2013
Likelihood	4	4	4	**Date closed**	
Score	16	16	16		
Controls & Mitigating Actions	All combined schemes (divisional improvement programmes, run rates) must have a Quality Impact Assessment covering 5 dimensions (5x5 risk scoring): - Patient Safety - Patient Outcome - Patient Experience - Staff welfare - Financial impact Combined schemes are subject to local governance scrutiny and approval, at care group, directorate and divisional level; overseen by Divisional triumvirate including Divisional Chair, Divisional Director of Operations and Divisional Director of Nursing & Governance. CGG chaired by Medical Director – all schemes with risk score over 12 also referred for consideration for approval by CGG. CGG is dynamic. CGG reports exceptional risks to QRC. Process of assurance feeds up from DGBs not just Risk Registers Divisions encouraged to bring run-rate schemes.			**Assurance**	Positive assurance: External scrutiny of process by Trust Board, commissioners and NTDA. Each scheme has KPIs related to their risk registers which are regularly reviewed. High level governance structure robust Clinical Procurement management Committee now reports to CGG Negative assurance: Relies on robust divisional governance structure – recent divisional governance review identified that historically, not all CIPs which impact upon quality of care receive received nursing/clinical sign-off.

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

Principal Risk	3.3-O5 Cost Pressures - The Trust faces higher than expected costs due to:- •unforeseen service pressures •higher than expected inflation				
Description	The Trust has to meet costs of unforeseen changes in service requirements for example the ongoing and evolving understanding of meeting requirements associated with Francis Report outcomes or other compliance requirements. The cost of meeting new and existing service standards are higher than expected. Inflationary cost pressures are greater than expected e.g. changes in energy costs. In addition, costs incurred from the usage of private sector capacity to deliver waiting time targets or services out of hours, will increase marginal costs and decrease contribution from individual services e.g. Cardiology and Cardiac Surgery				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.1 Meet all financial targets**
	Original	**Current**	**Update**	**Exec Sponsor**	Steve Bolam
Consequence	4	4	4	**Date opened**	01/12/2012
Likelihood	4	4	4	**Date closed**	
Score	16	16	16		
Controls & Mitigating Actions	Controls ▪ The expected impact of cost pressures on financial performance is considered as part of the Trust's business planning process. Robust provisions are made for future increases in cost in line with high level Guidance from Monitor. ▪ Adequate Contingency Reserves are set aside in line with NHS Guidance at 1% of Turnover ▪ The business planning process is overseen by Business			**Assurance**	The Trust has a good track record of delivering its financial targets in recent years. Cost pressures in 14/15 are high as a result of further compliance, staffing and other imperatives. Choices have been made on which top priority pressures must be funded. This is expected to continue to be an issue going forward

	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.		
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	**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 Month 6: –ve slippage in achievement of CIP targets

	projects Service Improvement Team GE Organisational change/ Lean (See Programme Plan for Exemplar site) ▪ Development of in-house expertise Development of savings culture ▪ Weekly meetings between directorates, divisions and the PMO to monitor scheme performance. All projects across the trust have clear directorate and divisional leads. ▪ The trust is engaging with outside expertise to develop further robust CIP savings schemes for future years. Mitigating Actions 1.To develop further in-year non-recurrent CIP projects to offset the non-delivery of the full CIP programme. These would include: ▪ Vacancy freezes ▪ Reductions in procurement spend ▪ Slowing of in-year capital programme 2. Bring forward of future years schemes – with a two year programme of CIP projects in place, the trust will bring forward schemes from future years to offset under-performance in the CIP programme in year TDA CIP review group. 3. Review list of downside mitigations to see what can be actioned now		
Gaps in controls	Over-programming yet to be achieved Lack of consistent pipeline of future projects	**Gaps in assurance**	
Actions next period:	Update rolling 2 year CIP programme with detailed PIDs covering 14/15 and 15/16 Develop 'fighting fund' for additional contingency Start taking initial outputs of work of AT Kearney on 17/18 and 18/19 programme development		

Principal Risk	O3- O1 Risk of premises closure, prosecution and fines as a result of non-compliance with fire regulations in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO)				
Description	Ability of the Trust to demonstrate its compliance in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO)				
Domain	**3.Regulation & Compliance**			**Strategic Objective**	**3.1 Maintain compliance with all statutory & regulatory requirements**
	Original	**Current**	**Update**	**Exec Sponsor**	Eric Munro
Likelihood	5	4	4	**Date opened**	14/03/2013
Consequence	3	4	4	**Date closed**	
Score	15	16	16		

Controls & Mitigating Actions	Robust action plan in place being led by the fire safety team and monitored through the Health, Safety & Fire Committee. Regular meetings/communication with Fire Brigade to check progress. Specialist fire safety resource in place to lead on the actions. Planned and reactive monitoring of fire safety. Fire risks assessments (FRAs) prepared by Fire Safety Specialists and issued to space/premises managers	**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 LFEPA visit Sept 14
Gaps in controls	Comprehensive surveys and assessments of compartmentation. Responsible persons to be identified for all individual areas subject to FRAs.	**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 Risk of premises closure, prosecution and fines as a result of failure to demonstrate full compliance with Estates and Facilities legislation				
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.			**Assurance**	Estates compliance records being assembled. Action plan being monitored and progress updates to the Operational Management Team. Authorising engineers appointed across all main risk areas. This risk is monitored via the Health, Safety & Fire Committee and overseen by the Organisational Risk Committee.
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	4	**Date opened**	May 2014
Consequence	4	4	4	**Date closed**	
Score	16	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	Oct 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	→	
CW055	Planned Preventative Maintenance of the x3 SAL Medical Microbiology Autoclaves and Containment Level 3 Air Handling Unit.	20	→	
CW057	The Division is significantly overspent 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	→	
CW0067	Financial risk – growth. Risk of CCG not paying for increased income assumptions particularly in children services, radiology and women's	15	→	
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	12	↓	Downgraded from 15 to 12 – will be closed from this report
	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	**12**	↓	Risk reduced to 12 – on track with recruitment to be closed off this report
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	**12**	↓	Risk reduced to 12 – following further risk assessment to be closed off this report
MC55-D2	Financial – Volume. Lack of theatre capacity for cardiac surgery impacts on income	**20**	→	
MC57-D3	Fire risk in Knightsbridge Wing	**15**	**New**	
	STN&C		**Change**	
Risk Ref.	**Risk**	**Score**	**↑↓**	
B287	Four types of defibrillators in use with non-interchangeable electrodes - poses a significant patient safety risk in the event of the wrong electrodes being available during a cardiac arrest.	**20**	→	
B253	SSD risk upgraded in light of recent significant failures and down time of SJW equipment. On-going issues. Upgraded from 12 to 16	**16**	→	
B268	Sterilisation equipment requires replacing and breakdown may cause service failure potentially resulting in cancelled surgery.	**15**	→	
B289	AMW Neuroradiology have no current access to CT imaging (DynaCT/InnovaCT/VasoCT) for patients undergoing angiography.	**12**	↓	Downgraded from 15 to 12 – will be closed from this report
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	**15**	→	

	unavailability of records			
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**	→	
NEW tbc	Incompletion of hearing tests / patients becoming unwell due to high temperatures in 2 x adult sound-treated hearing test booths	**15**	**New**	
	E&F		**Change**	
Risk No.	**Risk**	**Score**	**↑↓**	
EF176	Estates compliance – survey revealed gaps in compliance in statutory and mandatory items	**16**	→	
EF189	Standby Generators within Lanesborough Wing are at the end of their useful life and have insufficient capacity to meet the needs of current healthcare demands and will not need the demand as the building is re-developed and refurbished to modern standards.	**16**	→	
EF195	Electrical upgrades/maintenance to UPS and IPS in AMW	**16**	→	
EF198	Risk of noncompliance with fire regulations as a result of the lack of fire risk assessments for some areas on the St George's Hospital site.	**15**	→	
EF200	Delay to ability to deliver the capital programme and maintenance activity due to clinical and capacity demands preventing access for works	**16**	→	
	IM&T		**Change**	
Risk No.	**Risk**	**Score**	**↑↓**	
IT004	Insufficient staffing levels in ICT support leading to increasing numbers of outstanding calls remaining unresolved.	**12**	↓	Likelihood reduced to 4 due to Extended finding - will be closed from this report
IT016	Reduction in capacity to deliver new infrastructure, 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.	**9**	↓	Likelihood reduced to 3 following positive assurance will be closed from

				this report
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**	**↑↓**	
CSW1029	Inadequate healthcare response to emergencies	**9**	↓	New risk in Sept entered at 15 downgraded due to training provision and further evidence of improved emergency response