St George's Healthcare NHS
NHS Trust

REPORT TO TRUST BOARD ***November 2014***

Paper Title:	Risk and Compliance report for Board incorporating: 1. Board Assurance Framework 2. Divisional self-declarations of compliance with CQC standards 3. External assurances including the CQC Intelligent Monitoring Draft Report 4. Risk Management Strategy
Sponsoring Director:	Peter Jenkinson, Director of Corporate Affairs
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Purpose:	To update the Board about compliance activity/risks and related developments occurring across the Trust and provide assurance about the management of risk.
Action required by the committee:	To note the report and approve the Risk Management Strategy
Document previously considered by:	Quality and Risk Committee Risk Management Strategy considered by the Organisational Risk Committee and EMT

Executive summary

Key Messages

Board Assurance Framework (BAF):

- All risks on the Board Assurance Framework are presented following review by Executive Sponsors.
- The risk scores for seven risks have reduced, following internal and external assurances received.
- There have been two new risks included in the BAF during the reporting period and no closed risks.

Divisional quarterly self-declarations of compliance with CQC Standards:

- The self- declarations of compliance with CQC standards are detailed in the report
- Action plans are in place to address issue of non-compliance.
- The Board is asked to note the divisional self-declarations and actions taken to ensure compliance with CQC standards.

External Assurances including the CQC Intelligent Monitoring Report:

- External assurances received during the period are detailed within the report , with no significant issues identified
- A summary of the new risks identified in the Care Quality Commission Intelligent Monitoring draft report, published in October 2014 are included. An assurance regarding each new risk is also included and the Trust awaits final publication in early December.
- The Trust Board is asked to note the risks identified in the CQC intelligent monitoring report

Risk Management Strategy:

- The Risk Management Strategy has been previously discussed and approved by the Organisational Risk Committee, Quality and Risk Committee and Executive Management Team.
- The Board is asked to approve the approach outlined in the strategy.

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 and the controls for all 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
3.2-05	The Trust does not deliver its cost reduction programme objectives	**5**	**5**	**25 ↑**
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**
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**
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**
3.7-06	Failure to meet the minimum requirements of the NTDA Accountability Framework: Quality Indicators/Access Metrics.	**4**	**4**	**16**
01-06	Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists	**5**	**3**	**15**

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.

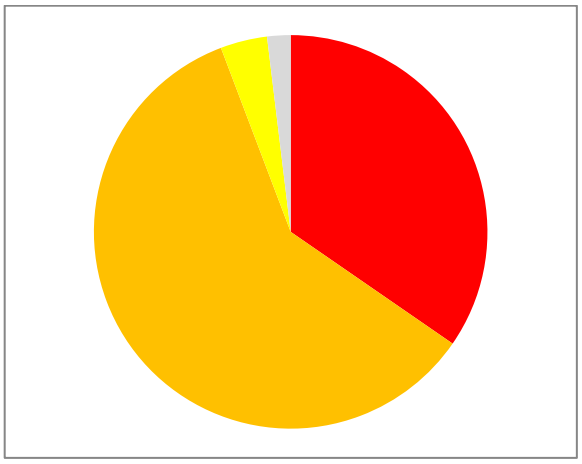
Table two: new risks

Ref	Description	Source	C	L	Rating	Exec
01-10	Risk to patients, staff and public health and safety in the event the Trust has failed to prepare adequately for an Ebola incident.	Discussion and report to EMT	**5**	**2**	**10**	**JH**
01-11	Risk that patients will potentially receive sub-standard care due to a number of factors impacting upon effectiveness of the service	Discussion at ORC and escalation from Div R/Register			**tbc**	**JH**

1.1 Summary of risks by score and domain

Figures one and two demonstrate there are 18 extreme risks on the BAF (score of 15 or above) which equates to 35%. Of these, 11 sit within the domains of Quality and Regulation and Compliance. Of the total risks on the BAF 37% relate to financial and operational risks.

Fig 1: BAF Risks by Score



15 and above (Extreme)	18
8-12 (High)	31
4-6 (Moderate)	2
0-3 (low)	0
TBC	1
Total	**52**

Fig 2: BAF Risks by Domain

						Total
1. Quality	8	8	0	0	1	17
2. Finance & Operations	3	16	0	0	0	19
3. Regulation & Compliance	7	1	1	0	0	9
4. Strategy Transformation & Development	0	3	0	0	0	3
5. Workforce	0	3	1	0	0	4
Total	**18**	**31**	**2**	**0**	**1**	**52**

1.2 Changes to risk scores

There have been seven changes to risk scores during the reporting period as detailed in table three. In addition, the current extreme risk relating to capacity: A602 'Pressures on internal capacity may result in the Trust being unable to meet demands from activity, negatively affecting quality, throughout the year' will be expanded to encompass the four separate aspects to the risk and associated controls.

Table three: Changes to risk scores

Ref	Description	C	L	Rating ↓↑
3.2-05	The Trust does not deliver its cost reduction programme objectives	**5**	**5**	**25 ↑**
3.7-06	Failure to meet the minimum requirements of the NTDA Accountability Framework: Quality and Governance Indicators/Access Metrics.	**4**	**4**	**16 ↑**
3.5-05	Cash-flow Risks – Forecast Cash balances will be depleted.	**3**	**4**	**12 ↑**
3.11 - 06	Poor environment in ICT department/on site data centre may lead to interruptions or failure of essential ICT services	**5**	**2**	**10 ↓**
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**	**3**	**9 ↓**

3.9-05	Minimise financial impact of Better Care Fund	**3**	**3**	**9 ↓**
2.3-05	Tariff Risk – CQUIN Premium	**4**	**2**	**8 ↓**

1.3 Closed risks

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

1.4 Summary of Extreme Risks at Divisional level:

There were ten new and one escalated divisional extreme risks presented to the Organisational Risk Committee on 5th November and a further four extreme risks have now been reduced or closed. An overview of the divisional extreme risks and rationale for changes can be found at Appendix 3. There were no extreme risks escalated at ORC for inclusion on the BAF.

1.5 Risk Management Strategy

The Trust knows, from external assurances received over the past two years, that we have a robust risk management framework in place. Assurances previously received as to our risk management framework include:

- CNST level 3
- NHSLA level 2
- 'Good' rating in CQC 'well-led' domain

However, we also know from our own divisional governance review completed in early 2014, and annual internal audits of risk management, and through feedback from Monitor that there are areas where we can strengthen that framework. We recognise that the maturity of the existing framework needs to continually develop to ensure that we have a framework in which all risks are appropriately identified, managed and escalated.

The aim of this strategy is to strengthen the existing risk management framework, 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.

The strategy has been previously discussed and approved by the Organisational Risk Committee, Quality and Risk Committee and the Executive Management team. The strategy is presented at Appendix 4. If approved by the Board, the next steps will include the development of a detailed implementation plan, in collaboration with the divisions, and confirmation of timescales for implementation.

2. Assurance Map

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

2.1 Care Quality Commission (CQC)

2.1.1 CQC Intelligent Monitoring Report – November 2014

The CQC published its most recent draft intelligent monitoring report in October 2014. The draft report shows a reduction in the overall number of risks as compared to the previous report, published in July 2014. The report highlights two elevated risks and three risks and the trust has responded to the CQC with assurances related to each risk identified in the report. In addition, the intelligent monitoring report also details a number of risks from previous reports which have now been closed. The final version of this intelligent monitoring report is due to be published on 3rd December 2014.

A summary of the risks and assurances provided is provided in table four below:

Table four: St. Georges CQC Intelligent Monitoring Report Risks: October 2014

Level of Risk	Indicator	Assurance/Actions on-going
Elevated Risk	Emergency readmissions with an overnight stay following an elective admission (01/04/2013 – 31/03/2014)	Using Dr Foster reported data: **Re-admissions Month Trend** - our re-admission profile by month from Aug-13 to May-14 shows our re-admission rate as having a high elevated risk from Oct-13 to Feb-14. Despite a steady decrease from Jan – March this has nonetheless contributed to the new risk rating in the CQC IM report. However, from March onwards this has reduced back to within expected range and for April and May our re-admissions are below that of the national average which is positive and should lead to the risk being re-evaluated. **Specialty trend** – This shows re-admissions by specialty of HRG. The report highlights key specialties where the observed number of re-admissions was greater than what was expected to and which currently are being investigated, these include: Neurosurgery, Cardiac surgery, colorectal surgery, transplantation surgery and General Medicine. This data is monitored via the performance team and any alert raising significant concern is escalated through performance reporting.
Elevated Risk	The proportion of cases assessed as achieving compliance with all nine standards of care measured within the National Hip Fracture data base (01/01/2013 – 31/12/2013)	Standards with which the Trust is not compliant in this most recent audit (Dec 2013): 1. Admission to Orthopaedic ward within 4 hours 2. Surgery on day of admission 3. Senior geriatric review within 72 hours of admission 4. Bone health medication assessment performed An action plan is in place to address each standard which is overseen by the Care Group Lead and General Manager and is monitored by the Care Group Governance Meeting. On the whole, significant improvement is expected against the above standards upon recruitment to ensure correct establishment to support practice. A second ortho-geriatrician is being appointed – this post will be filled in March. In addition a further there physicians' assistants post are in place from November. There has also been a lot of work on the pathways since the time of the audit, led by Service Improvement Hence it is anticipated the next audit will demonstrate some improvements prior to full recruitment.
Risk	Incidence of Methicillin-resistant Staphylococcus aureus (MRSA) (01-Aug-13 to 31-Jul-14)	The Trust has now reported 3 MRSA bacteraemia cases to the end of October. Focus is being placed on existing actions within the Trust i.e. hand hygiene compliance, antibiotic prescribing and prompt isolation. The profile will continue to be closely monitored and Divisions have been requested to closely review their performance and audit compliance within local clinical areas. Infection Control Training compliance rates are currently at 60% and still need to be increased. This is currently an extreme risk on the BAF: A513-01 and detailed assurance is provided to the Board through the Quality report.

Risk	In-hospital mortality – trauma and orthopaedic conditions (01/04/2012 – 18/06/2014).	The trust monitors mortality across all procedure and diagnosis groups and this routine internal benchmarking has identified a signal in the CCS diagnosis group 'crushing injury or internal injury'. This represents 8 deaths over a 12 month period (June 2013 – May 2014). Following discussion at the Mortality Monitoring Committee (MMC) on 17th September an investigation is currently underway which includes review of each case and examination of clinical coding. The outcome of this investigation will be reported to the MMC for discussion and identification of learning as appropriate. There are currently no other alerts related to either trauma or orthopaedics.
Risk	NHS Staff Survey - KF10. The proportion of staff receiving health and safety training in last 12 months (01-Sep-13 to 31-Dec-13)	As recorded on the Trust 'Wired' system: H&S compliance is currently 88% and the Trust standard is to achieve 85% compliance. It is possible this has been identified as a risk is due to the difficulty we have (in common with many other Trusts) that the Staff Survey question asks about annual training, whereas the requirement is to complete H&S training every 3 years.

2.1.2 Closed intelligent monitoring risks

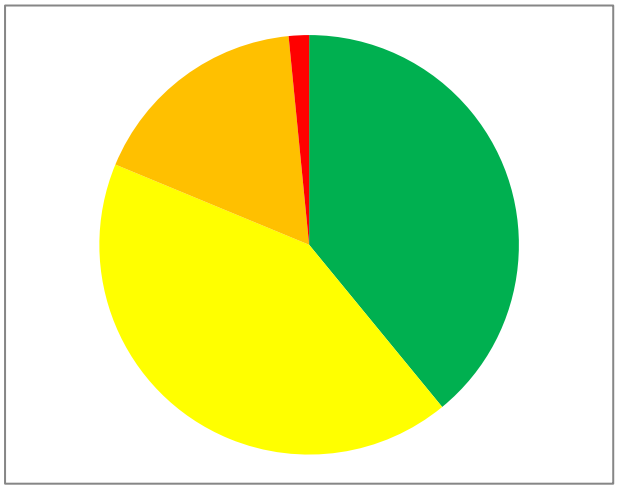
The intelligent monitoring report also highlighted several risks identified in previous reports, which have now been closed. These risks relate to:

- Occurrence of Never Events during the period 01/05/2013 – 30/04/2014;
- SSNAP Domain 2: overall team-centred rating score for key stroke unit;
- The proportion of patients whose operation was cancelled (01/01/2014 – 31/03/2014); and
- Data quality of trust returns to the Health and Social Care Information Centre (01/04/2013 – 28/02/2014).

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

Throughout quarter one each division undertook a divisional declaration of compliance with the CQC standards. These divisional self-declarations are undertaken against the current CQC outcomes and are informed through a variety of compliance and performance metrics. The divisional declarations were agreed at Divisional Governance Board meetings in November 2014 and are presented for challenge at divisional quarterly performance reviews. A summary of compliance is provided in fig 3 and table five below and highlights, by division, the number of outcomes that were green (fully compliant), yellow (compliant with minor actions), amber (partially compliant with further action required) and red (non-compliant), for each division during quarter 2 2014/15:

Fig 3 CQC Compliance by outcome Quarter 2 2014/15:



	No. of outcomes
Fully Compliant	25
Minor Non-compliances	27
Non-compliant & action plan in place	11
Red – non-compliant	1

Table five – Divisional compliance against CQC outcomes November 2014

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

The red non-compliant outcome in the Children & Women's and Diagnostics and Therapeutics Division is related to outcome 10 'safety and suitability of premises'. There have been improvements to this standard within the division since the previous report however some concerns still remain, particularly the leaking roof in Lanesborough wing and the general environment in outpatients. Actions to address these issues are part of a wider estates and facilities action plan, which is overseen by the Estates and Facilities team and monitored at monthly divisional governance and performance meetings.

There are also action plans in place to monitor progress of outcomes rated as 'Amber'. These action plans are monitored through monthly performance and governance meetings within each division and updates on these action plans will also be provided to the Corporate Risk team going forward. Further detail is provided at appendix 5 in each divisional self-assessment.

2.2 Summary of external assurance and third party inspections October-November 2014

2.2.1 ICNARC (Intensive Care National Audit and Research Centre

ICNARC audits are conducted across all hospitals in the UK providing critical care with the aim of fostering quality improvements in the provision of critical care. The Trust received its Quarter 2 2014/15 ICNARC audit reports during the reporting period for General ICU. No concerns were noted in these reports. The Trust is awaiting Quarter 2 2014/15 reports for Neuro ICU and Quarter 1 and Quarter 2 2014/15 reports for Cardiothoracic ICU.

2.2.2 Major Trauma Dashboard – Q2 2014/15

The Trust received its Quarter 2 2014/15 Major Trauma Centre dashboard draft report and no major concerns were noted. The report is being reviewed internally prior to finalisation. Any issues noted in the final report will be reported to a future Board meeting.

2.2.3 G4S Mock CQC Internal Audit – October 2014

G4S conducted an internal mock CQC compliance audit in late October 2014. The purpose of this internal audit was to ensure that internal systems are compliant with quality standards set out in the CQC framework. The results of this internal review are currently in the process of being collated and any issues identified will be presented to a future Board meeting, upon receipt from G4S.

2.2.4 South West London Pathology (SWLP) Services Accreditation

SWLP is a consortium providing pathology services consisting of Croydon Health Services NHS Trust, Kingston Hospital NHS Foundation Trust and St. Georges Healthcare NHS Trust. The service is hosted by St. Georges. Pathology services (Clinical Blood Sciences, Microbiology and Cellular Pathology) are required to meet standards set by the Clinical Pathology Accreditation (CPA). Laboratories are required to register each year with a full peer supported assessment every four years. In between each peer assessment there is also a review of each laboratories' quality management system, called a surveillance visit. This usually takes place every two years.

The service is currently working with the CPA to move towards a network inspection as opposed to single site inspections, which are currently being maintained throughout the transition process. The present position is that Kingston laboratories are within their current cycle of inspections and will be subject to a Clinical Blood Sciences surveillance visit (as service transition will not be completed before this inspection), which is likely to take place in April/May 2015.

St. Georges Clinical Blood Sciences were due to be assessed in September 2014 but this inspection was postponed and the trust is awaiting confirmation of a revised date for this assessment. St. Georges Microbiology and Cellular Pathology laboratories are within their cycle of inspections however the trust is awaiting confirmation of dates for these inspections. Croydon Clinical Blood Sciences were subject to an enhanced surveillance visit in September 2014 and a number of non-conformities were identified. The trust has an action place in place to address these issues and the CPA will be assessing progress of these actions in December 2014. Croydon Haematology and Blood Transfusion was subject to an enhanced surveillance visit in October 2014 and several non-conformities were identified which have all addressed. The CPA will be reviewing these non-conformities in January 2015.

2.3 Forthcoming Inspections – November 2014

2.3.1 London Fire and Emergency Planning Authority (LFEPA)

The LFEPA will be conducting monthly visits (commencing November 2014) 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. The potential consequence of a failure to comply with the regulations is also recorded as a risk on the BAF.

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	June 2014	Jul 2014	Aug 2014	Sept 2014	Oct 2014	Nov 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	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	16	→	
01-08 Risk to patient safety due to inconsistent	RGW		16	16	16	16	16	→	

processes and procedures for the follow up of diagnostic test results									
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	12	→	
01-10 Risk to patients, staff and public health and safety in the event the Trust has failed to prepare adequately for an Ebola incident.							10	**NEW**	
01-11 Risk that patients will potentially receive sub-standard care due to reduced availability of prison staff to support and inadequate healthcare response to clinical emergencies							tbc	**NEW**	

Strategic Objective/Principal Risk	**Lead**	**June 2014**	**Jul 2014**	**Aug 2014**	**Sept 2014**	**Oct 2014**	**Nov 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	12	→	

Domain: 2. Finance & Performance

Strategic Objective/Principal Risk	**Lead**	**June 2014**	**Jul 2014**	**Aug 2014**	**Sept 2014**	**Oct 2014**	**Nov 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	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	25	↑	Monitor review of CIP plans and process as part of FT application
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	8	↓	Reduced likelihood to 2: All CQUINs now finalised. NHSE CQUINs agreed.
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	SB	12	12	12	12	12	12	→	

- payment challenges									
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	12	↑	Increased likelihood score of 4
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	12	12	12	12	12	9	↓	Reduced likelihood to 3

Strategic Objective/Principal Risk	**Lead**	**June 2014**	**Jul 2014**	**Aug 2014**	**Sept 2014**	**Oct 2014**	**Nov 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	16	↑	Increased likelihood to 4
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	12	→	
3.10-06 Risk of failure to effectively manage exit from national Cerner programme	SB		10	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	12	↓	Likelihood reduced to 3 due to temporary solution and improved environment

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	9	↓	Likelihood reduced to 3 given immediate actions undertaken to address

Domain: 3. Regulation & compliance

Strategic Objective/Principal Risk	Lead	June 2014	Jul 2014	Aug 2014	Sept 2014	Oct 2014	Nov 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	→	
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	16	→	
03-03 Lack of decant space will result in delays in delivering the capital programme.	EM	16	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	16	→	
03-05 Trust wide risk to patient, public and staff safety of Legionella	EM				12	12	12	→	

Domain: 4. Strategy, transformation & development

Strategic Objective/Principal Risk	Lead	June 2014	Jul 2014	Aug 2014	Sept 2014	Oct 2014	Nov 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.	SM	12	12	12	12	12	12	→	
Strategic Objective/Principal Risk	**Lead**	**June 2014**	**Jul 2014**	**Aug 2014**	**Sept 2014**	**Oct 2014**	**Nov 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	SM	8	8	8	8	8	8	→	

Strategic Objective/Principal Risk	Lead	June 2014	Jul 2014	Aug 2014	Sept 2014	Oct 2014	Nov 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	June 2014	Jul 2014	Aug 2014	Sept 2014	Oct 2014	Nov 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	12	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	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	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 – Board Assurance Framework

Domain 1: Quality: 1.1 Patient Safety

<table>
<tr><td>Principal Risk</td><td colspan="5">A602.1-01 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
Unlimited demand on A&E which impacts on increase in emergency admissions & capacity for elective admissions affecting 28 day rebook timeframes.
Potential subsequent impact on patient pathways & patient safety. Delayed patient repatriation to host hospitals block beds for emergency/elective activity.
Winter pressures relate to Flu, d & v symptoms increase demand on side rooms and closure of beds.
Reduced numbers of discharges at weekends and on bank holidays causing capacity problems.
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>Updated Nov 14</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.

Operational Capacity Planner (OCP) developed to plan and</td><td>Assurance</td><td>Programme of applications for additional winter funding

Participation in Urgent Care Board

ECIST review (September 2013)

Negative assurance:
- ED performance
- RTT backlog of patients- cross ref BAF Risk 01-06
- Cancelled elective surgery during periods of significantly high activity i.e. Feb 2014</td></tr>
</table>

	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		
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 Nov 2014**	**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 26 c:diff (20 Nov 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 Agreed Clinical Pathway in place for the decontamination of nasoendoscopes , work to be concluded regarding the long term framework for the decontamination of this equipment
Gaps in controls	BAF risk 01-01 Informatics to support production of real time data Decontamination of nasendoscopes	**Gaps in assurance**	
Actions next period:	Continual revision of infection control action plan Increasing number of consultants champions for infection control. Pack for peripheral line insertion in place (to be considered for blood cultures also) Analysis and actions in relation to latest audit of line care – due May/June 2014 Trust wide environmental audit underway. Focus on areas where cleaning inspections demonstrated need to improve.		

Principal Risk	A411-01: Insufficient ICU capacity to handle an increasing workload				
Description	Insufficient capacity of ITU and HDU beds impacting on elective and emergency admissions requiring access to critical care. Increased cancellations. Increased financial costs on agency outlay				
Domain	**2. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Current**	**Updated Nov 14**	**Exec Sponsor**	Sofia Colas
Consequence	3	3	3	**Date opened**	30/05/2010
Likelihood	5	5	5	**Date closed**	
Score	15	15	15		
Controls & Mitigating Actions	2012/13 additional 1 bed in situ but gained additional L3 capacity for 2 beds. Where required - escalation to recovery area. Progress on Service improvement programme will be accelerated to fit into corporate programme for the review of Patient flows across the Trust-elective surgical pathway is on-going. Mitigation through opening of an escalation area in Recovery at additional cost Mitigating action is to cancel elective surgery to provide additional urgent capacity and to send activity to private sector.			**Assurance**	Due to bed pressures also elsewhere the trust took a decision to reduce the allocation of 6 critical care beds to 1 in total. However due to reconfiguration of HDU beds and although the net increase of beds is 1 there is an increase in L3 beds. Critical care bed management is a separate function and is well established and pro-actively managed. Critical Care Bleep holder attends bed escalation meetings to look into issues on a day to day basis. The risk is still live and currently at this point in the year is a rating of 15 is adequate. As we enter into the Q3 and 4 when the acuity and number of patients requiring ICU increases the risk will need to be updated to reflect the current situation. A meeting is taking place on 15 September 2014 to review the allocation of the CCU beds in order that capacity could be created at short notice.
Gaps in controls				**Gaps in assurance**	
Actions next period:	For 2014/15 a programme is underway to create 4 additional critical care beds on NICU. This programme is currently going through gateway 2 and will in the next 4 weeks go through the design and clinical sign off phase. Plan to open Q4 of 2014/15. Meeting is taking place on 15 September 2014 to review the allocation of the CCU beds in order that capacity could be created at short notice.				

Principal Risk	O1-01 A risk to patient safety of inappropriate antimicrobial prescribing due to conflicting and out of date guidance being available within the Trust.				
Description	Clinical guidelines produced by individual clinical departments containing antibiotic advice are unregulated and may contain antibiotic advice which is contrary to trust policy. Additionally old guidelines are not adequately deleted from the intranet and out of date antibiotic advice remain accessible. Risks are:-Not treating patients effectively-Causing adverse events due to toxicity and C.difficile. There is a financial/reputational risk to the Trust in its ability to meet HCAI targets and to its Foundation Trust application. Cross Ref BAF RiskA513-01				
Domain	**1.Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Current**	**Updated Nov 14**	**Exec Sponsor**	Jennie Hall
Consequence	3	3	3	**Date opened**	31/03/2013
Likelihood	4	4	4	**Date closed**	
Score	12	12	12		
Controls & Mitigating Actions	Email communication to Divisional Chairs, DDNGs, Governance Leads. Antimicrobial pharmacists and Antimicrobial Stewardship team promoting good antimicrobial prescribing practice. Fully discussed and monitored at the bi-monthly Antimicrobial Stewardship Committee. Grey book in place: editorial peer review of guidance from different clinical areas is updated regularly. CIU handbook, cardiology/radiology/gen surgery and part of haematology guidelines now harmonised. Guidelines containing antimicrobials must be approved by the Antimicrobial Stewardship Committee prior to being uploaded to the intranet - this has been written into the antimicrobial prescribing policy.			**Assurance**	The cardiology guidelines have all been updated. Obstetrics and Max-fax have named/assigned consultants to ensure guidelines are aligned. ENT have a registrar assigned to reviewing guidelines A meeting has been held to review the availability of 7 neutropenic sepsis policies. Five have been removed from the intranet and 2 will be amalgamated into a single policy (target date end of September) Revised Antimicrobial Prescribing Policy has been approved by PRG
Gaps in controls	No current process for regulation and control the production and dissemination of antimicrobial guidance which are not covered by the Grey book process.			**Gaps in assurance**	Renal, A&E & Thoracic guidelines remain outstanding
Actions next period:	Exercise to regulate and control the production and dissemination of antimicrobial guidance – using a method analogous to the policy review & ratification process Initial meeting set up to agree and plan strategy and work has commenced to scope and review the current breadth of guidance, to actively ascertain scope of the problem and to inform on-going solution Antimicrobial Stewardship Committee to update the Infection Control Committee by exception				

Principal Risk	01-02 Risk to patient safety arising from a lack of established or embedded process for use, provision, decontamination and maintenance of pressure relieving mattresses				
Description	Absence of a universal process for the provision, maintenance and decontamination of pressure relieving mattresses (PRMs): Inconsistent compliance with process for provision at ward level as a result. Lack of compliance with decontamination requirements: may result in infection control risk. Absence of programmed maintenance potentially results in faulty equipment. Potential factor in increased numbers of patients sustaining pressure ulcers and infection. (Cross Ref A513-O1)				
Domain	**1.Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Current**	**Updated Nov 2014**	**Exec Sponsor**	Jennie Hall
Consequence	3	3	3	**Date opened**	11/07/2013
Likelihood	4	3	3	**Date closed**	
Score	12	9	9		
Controls & Mitigating Actions	Additional initial resources approved at EMT. 32 new PRMs, 200 new top covers and band 3 post to cover 6 days per week. PRM are being cleaned following manufacturer's procedures between patients. Facilities for handling PRM are being upgraded, and procedures brought under BS13485 quality system. Out of hours delivery significantly improved by change to access for portering staff. **Mitigating Actions** Service improvements as part of an on-going process. Implementing electronic requesting of PRMs.			**Assurance**	Improved monitoring of availability and delivery times has been achieved. Data up to March 2014 shows the service achieving over 90 % delivery in under 2 hours within 0900-1700 weekdays.Availability improved out of hours due to altered access for porters, but there is no recording of delivery times. Mattresses are decontaminated and handled according to Trust policies (Clin 2.0 and 2.11), indeed to a higher standard than set by these policies since potentially contaminated mattresses are sent offsite to a specialist cleaning contractor.
Gaps in controls	The main gap is in information about the performance of the out of hours service, which has been improved by improved access for the porters to stock of PRM. There have been 11 DAtix reports of lack of availability in the 4 months from 1st April 2014, and only 2 of these are on weekdays, showing that weekend provision is weakest.			**Gaps in assurance**	Delivery records are collected on paper, and are entered into digital records and analysed by a Bioengineer. Due to a high workload completing trust wide equipment installation projects there has not been time to analyse this, so there is poor control of the KPI for the service, though management monitoring of the team issues leads us to believe that service levels are consistent with those up until March, which exceeded the required 90 % in 4 hours by achieving 90 % delivery in 2 hours. A trial of the computer ordering of PRM is underway, which will provide easily obtainable KPI.
Actions next period:	Continue to monitor availability and delivery times, and to produce performance figures from April 2014and continue with service improvement programme, with the main development in progress being the online ordering of PRM which improves the efficiency of the delivery team and gives easily accessible KPI. Long term planning being deal with within the business case being prepared, for submission to BCAG December 2014. The PRM and beds team working space in the 2nd floor Lanesborough plant wing is the subject of planning with Estates for improvement to give the trust a bed				

	store and improved area for PRM cleaning and maintenance.

Principal Risk	01-03 Risk to patient safety arising from a lack of embedded process for use, provision and maintenance of bed rails (cot sides)				
Description	Absence of a universal process for the provision and maintenance of bed rails. Inconsistent compliance with process for provision at ward level as a result. Not always available, not always fit for purpose and not always correctly applied. Lack of compliance with decontamination requirements: may result in falls risk. Absence of programmed maintenance potentially results in faulty equipment. Potential factor in increased numbers of patients sustaining falls.				
Domain	**1.Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Current**	**Updated Nov 2014**	**Exec Sponsor**	Jennie Hall
Consequence	3	3	3	**Date opened**	1.1.2014
Likelihood	4	4	4	**Date closed**	
Score	12	12	12		
Controls & Mitigating Actions	Has been included into work reviewing beds and mattresses as part of a business case being prepared. Additional rails have been purchased. Also a technician and a bleep provided to deal with delivery and maintenance requirements. **Mitigating Actions** Review of training and risk assessment tool underway by falls Lead, Consultant Physio. Review meeting lead by Falls lead planned for November.			**Assurance**	One SI recently (2013) and lack of bed rails was a root cause. A patient fell from bed at QMH recently (2013) due to lack of rails, and more rails have been provided to QMH, some more have been provided so that all beds have rails available at QMH.
Gaps in controls	Currently no robust process of managing and maintaining equipment. Training of staff in the correct fitting needed. November meeting with Trust Falls lead to review this.			**Gaps in assurance**	Business case is being finalised by Medical Physics and planned to go to BCAG & EMT but approved in principal at previous meeting as risks discussed.
Actions next period:	Continue to monitor availability and Datix reporting. Business case in preparation. Some additional sets purchased. Policy and risk assessment reviewed and information sent out to staff on how to access. Now being supported by General Manager Corporate Outpatients, Diagnostics and pathology.				

Principal Risk	01-04 There is a potential risk to patient safety should the organisation fail to meet its statutory duties under Section 11 in respect of number and levels of staff trained in safeguarding children.				
Description	Risk of staff not having required knowledge to safeguard children due to the required safeguarding children training not consistently being undertaken. Staff may not recognise a potential safeguarding issue, putting a vulnerable child at risk of harm.				
Domain	**3. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Current**	**Updated Nov 2014**	**Exec Sponsor**	Jennie Hall
Consequence	4	4	4	**Date opened**	1.1.14
Likelihood	3	3	3	**Date closed**	
Score	12	12	12		
Controls & Mitigating Actions	Training sessions in safeguarding children at all levels are held on a regular basis. Sessions are advertised in advance and training at a basic level is included the annual MAST update. Funding has been provided from NMET monies to provide extra training, using an outside trainer, at Level 3 in Safeguarding Children. A peer review of the SGC resource across the trust including benchmarking with similar size organisations has been completed early January 2014 and the report has been received. All managers have been contacted by the Safeguarding Nurse and the DDNG for CWDT&CC reminding them of their obligations under Section 11. Divisional training performance is reported at the quarterly performance reviews.			**Assurance**	Levels of Child Safeguarding training not meeting Trust standard, current position: Level 1 the target is 80%. Current score: 89.36 % (- 0.01%) Level 2 the target is 80%. Current score: 79.40% (- 0.67%) Level 3 the target is 80%. Current score: 57.98% (+ 3.2%) The numbers of staff trained at Level 2 and 3 are increasing steadily as a result of additional training sessions and further attention being paid to the data entry. Some refining of the Matrix for the WIRED system is in progress. The findings from the safeguarding review are about to be debated – as yet it is not clear what the implications from this will be in respect of training.
Gaps in controls				**Gaps in assurance**	
Actions next period:	The safeguarding children training analysis compliance action plan is being implemented and regularly up-dated and reviewed at trust-wide Strategic SGC committee. Continue to target level 3 and have additional sessions at level 3 funded by T&E as well as the regular programmed sessions. As a result of the peer review a decision has been made to bring together the community and acute safeguarding children team and to be line managed within the corporate nursing directorate.				

Principal Risk	01-05 Risk to patient safety arising from a lack of standardised and centralised decontamination practice across several areas of the Trust				
Description	Risk escalated from Surgical divisional risk register: A number of services continue to decontaminate equipment locally:- • ENT- Nasendoscopes • Gen Surg- Anal probes • Cardiac- TOE probes • ITU - Bronchoscopes The practice is no longer compliant with new guidance. The risks relate to the environment, process and tracking of equipment, which currently place staff and patients at potential risk of chemical toxicity and cross contamination.				
Domain	**4. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Current**	**Updated Nov 2014**	**Exec Sponsor**	Jennie Hall
Consequence	4	4	4	**Date opened**	31.5.2014
Likelihood	3	3	3	**Date closed**	
Score	12	12	12		
Controls & Mitigating Actions	The Decontamination Committee oversee maintenance of relevant standards/guidance in line with local departmental experts. Drying cabinets have been locked and a new escalation policy is in place to prevent further instruments from being quarantined due to poor /no tracking**.** Cardiac to comply with centralised decontamination for TOE probes: a new re-processor has been leased and was recently installed, although not yet operational & awaiting an estates update on plan to achieve this. Interim solution to use of Tristal wipes system Reduced capacity in SSD secondary to the DSU machines being out of action since Jan '14- reliant upon this capacity being back in place to enable the replacement of the St James wing machines which are now in the country as well permenant repairs to the leak in the SSD packing room. Tristal wipe system now in place for nasendoscopes and training on this and tracking fully rolled out. Increased staff support for busy OPD clinics in place to facilitate this process and work completed to separate clean and dirty clinical areas. Endoscopy have been describing mechanical issues with			**Assurance**	Nasendoscope audit & effectiveness of Tristal wipes system recently completed and fed back to ENT – May 2014. Practice requires improvement and regular auditing. Positive assurance: There have been no incidents of cross contamination Health edge electronic tracking system now in place and training rolled out to all areas. Compliance is consistent although relies upon nursing to police - there have been no further incidents of instruments being quarantined. Cardiac compliant with Tristal wipe system until such a time that the new reprocesser is operational and the service move to full centralisation On-going issues requiring estates input escalated via Trust Decontamination meetings, organisational risk and decon reports and indivudal communication with the estates department- awaiting a timeline and plan of works An increased number of nasendoscopes already operational and more being business planned for. ENT to present a timeline and proposal for full centralisation of nasendoscopes at October ICC. This paper will also include assurance in relation to the current interim Tristal wipe system.

	their drying cabinets, which are over ten yrs old and the decon committee await a full description of the risks and proposed options for a solution. This paper has been outstanding for 6 months and therefore we remain unclear around the scale of the problem- although no apparent impact on operational service.		
Gaps in controls		**Gaps in assurance**	
Actions next period:	ITU will tighten up their practice in relation to Bronchoscopes: a written process to be put in place. The rationale of the indicative cost pressure of the funding to lease an additional washer processor (1K per month) to enable decontamination to be carried out centrally has been drafted and to be signed off by each division. Explore long term solution to provide alternative centralised decontamination services which will entail a full business case and capital build (likely 2015-16)		

Principal Risk	01-06 Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists				
Description	Risk to patient safety and patient experience as patients waiting greater than 18 weeks on elective waiting lists. Possible impact that patient's condition deteriorates. Specific issues regarding cardiothoracic surgery waiting lists in particular.				
Domain	**5. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Current**	**Updated Nov 2014**	**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			**Assurance**	Negative assurance – two SIs have occurred where patients on cardiothoracic waiting list died suddenly without being offered a date for surgery/diagnostic test.

	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 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	**6. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Current**	**Updated Nov 2014**	**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: 7. Emergency department actions 8. Whole hospital actions 9. Wider system actions Progress in delivering action plan regularly reviewed: • 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			**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
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**	**Updated Nov 2014**	**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 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.			**Assurance**	Negative assurance: a number of recent serious incidents have occurred where patients have sustained harm as a result of a failure to appropriately follow up test results Commissioners have expressed concern and a requirement for assurance regarding processes and fail safes in place to prevent recurrence
Gaps in controls	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	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				
Description	Competence in the use of Medical Equipment is a personal responsibility of professional staff, many of whom are professionally registered and presentation of evidence of their maintenance of competency is part of the registration renewal process. The Trust has a responsibility to ensure that it has processes for identifying staff authorised to use equipment, and for identifying the training needs of staff related to Medical Equipment. This may be being carried out by local supervisors and managers, but the Trust needs assurance through having visibility of the training needs and the degree to which those needs have been met. There is currently no system to identify and report Trust wide medical equipment training needs, and to report the degree of compliance with those needs. This has the risk that the Trust cannot show that it has good management of staff with proper consideration of their competence and training needs relating to Medical Equipment. This was the subject of an audit in 2013.				
Domain	**1. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Current**	**Updated Nov 2014**	**Exec Sponsor**	Jennie Hall
Consequence	3	3	3	**Date opened**	1-10-2014
Likelihood	4	4	4	**Date closed**	
Score	12	12	12		
Controls & Mitigating Actions	Many areas, particularly high acuity areas, have training and some records, but generally records are incomplete. For some equipment there is well controlled training linked to authorisation (eg glucometers, blood gas meters). The Trust has a policy of equipment standardisation where possible, and this is linked to organised training on implementation (eg Smart pumps, glucometers, defibrillators, anaesthetic machines, patient monitors etc). The training requirements are also considered during the preparation for capital equipment purchases.			**Assurance**	Centralised records for glucometer training, and records of training for major standardisation projects. Records for some areas can be inspected (eg GICU), anaesthetics, but we know that record keeping is incomplete in many areas. Professional staff work under responsibility to maintain their professional competence, and to work within that competence, with many groups submitting evidence to satisfy continuing professional development requirements and within this many should be prompted to consider their competence with medical equipment that they use. This means that the extent of competence will be wider than the availability of records, and this gives some assurance of safety, though positive records are what are needed.
Gaps in controls	The majority of areas cannot show records for all staff for all equipment training needs			**Gaps in assurance**	Clear lack of complete records

Actions next period:	The training record software has recently been updated and is now being trialled with nursing in PICU through the practice nurse educators, and with a Dr in anaesthetics, and within Medical Physics. The trial is to see if the record entry system is workable, and to enable us to investigate the issues raised (eg unique identification of staff, identification of staff/manager pairs for authorisation, self-reporting and authorisation issues, speed etc). The experience will form the basis of an assessment of whether the system is workable, and the resources needed to implement this across the Trust. A business plan to support this is planned for the end of November. The Medical Devices Training Policy is also being written to include the responsibilities and procedures relating to record keeping and competence declaration.

Principal Risk	01-10 Risk to patients, staff and public health and safety in the event the Trust has failed to prepare adequately for an Ebola incident.				
Description	There is a risk to staff safety (and subsequently patient and public) if the Trust does not ensure adequate training policies, procedures and personal protective equipment (PPE) are in place, which may result in exposure and infection with the Ebola virus. This risk also encompasses the potential for inadequate clinical care care being provided to patients with suspected Ebola, whilst testing is undertaken as this requires a 15 hour turnaround time.				
Domain				**Strategic Objective**	
	Original	**Current**	**Update**	**Exec Sponsor**	Jennie Hall
Consequence	5			**Date opened**	14.11.2014
Likelihood	2			**Date closed**	
Score	10				
Controls & Mitigating Actions	• Viral Haemorrhagic Fever Policy (VHF) in place • Staff awareness programme on-going with a specific communications policy for VHF • Specific escalation policy developed and in place where a case is suspected • Laboratory policy in place • Training is underway for all appropriate staff – primarily in relation to the use of PPE • All A&E staff trained and agreement in place that patients will be assessed in line with normal protocols			**Assurance**	All controls in place meet the requirements of the DoH/HSE and advisory Committee on Dangerous Pathogens guidance for NHS Trusts in full and local implementation of precautionary measures extends beyond these requirements. There have been four suspected cases to date, the latter two following the full implementation of policies and procedures. These cases fully tested the system in place from which only minor issues arose which have been addressed.
Gaps in controls	'Fit testing' of masks has not been undertaken for doctors and a risk based approach to the decision not to do so. Length of time tests take to return to the trust could impact on patient care. (tests not processed locally) Uncertainty around patients requiring ITU care/ ventilation can be transferred to the Royal Free. The Trust has agreed that if a patient requires ITU they will be discussed on a case by case basis and if			**Gaps in assurance**	None identified at present

	appropriate cared for by the ITU team on McEntee ward.		
Actions next period:	Write to Public health England to challenge the central processing and built in time delays of tests (15 hours) Continue with specific staff training and more general awareness programme.		

Principal Risk	01-11 Risk that patients will potentially receive sub-standard care due to a number of factors impacting upon effectiveness of the service				
Description	Aggregated risk, escalated by ORC : Need to ensure robust and consistent leadership Need to ensure appropriate staffing profile Patients may not receive timely treatment due to reduced access to healthcare due to prison workforce benchmarking which has reduced the availability of prison staff to support healthcare Lack of clinical skills and healthcare response to clinical emergencies.				
Domain				**Strategic Objective**	
	Original	**Current**	**Update**	**Exec Sponsor**	Jennie Hall
Consequence				**Date opened**	1.11.14
Likelihood				**Date closed**	
Score	tbc				
Controls & Mitigating Actions	Prioritisation of access via triage process introduced. GP risk assessing and prioritising patients who need hospital treatment. All appointments logged and monitored. Competency assessment of OHC staff on life support/ resuscitation. On site scenario training - commence and on-going. identify staff who ILS training is out of date and secure training session. Spot check and on-going checks of emergency bags.			**Assurance**	Numbers of Do not attend appointments reducing. A number of Serious Incidents relating to Deaths in custody have highlighted shortcomings in some aspects of healthcare provision. Following initial Serious incidents where response was found to be sub-optimal, response to more recent emergency situations including resuscitation was found to have been managed more competently showing actions taken have been effective.
Gaps in controls	No agreed and documented triage process.			**Gaps in assurance**	
Actions next period:	Clinic decision triage system to be agreed with HMPW and clinical management risk sharing agreement. Strategic meeting with the Prison. Guidelines for checking emergency bags will be amended and re issued.				

	Further support with oxygen cylinders will be provided from Pharmacy. Review of Death in Custodies to commence Jan 2015 (Lead by SLaM).

Domain 1: Quality: 1.1 Patient Experience

Principal Risk	A410-O2: Failure to sustain the Trust response rate to complaints				
Description	Not always prioritised to same degree as other Trust objectives Responding inadequately and in an untimely way can seriously impact on the patient experience and limit the Trust's opportunity for learning. Negative impact on the Trust's reputation and loss of patient and public confidence				
Domain	**1.Quality**			**Strategic Objective**	**1.2 Patient Experience**
	Original	**Current**	**Update Nov 2014**	**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. Complaints action Plan in place from November 2014 focussing on 5 key areas to ensure improved turnaround of complaints but also to strengthen learning and organisation capacity to deal with complaints.			**Assurance**	Annual report presented to PEC (Aug) and QRC and TB (Sept). Medicine/cardiovascular division 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 Performance against 25 day timescale is currently significantly below 85% - internal Trust standard, internal trajectory to deliver performance against internal standards Quarterly performance review with Divisions and monthly performance review from October 2014 undertaken by the Chief Nurse with the DDNGs . Trust performance reviewed by PEC every 2 months Reported to TB monthly
Gaps in controls				**Gaps in assurance**	Detailed thematic analysis at care group level to ensure causes of complaints are well understood has been provided to divisions. Focus is on actions being put in place that lead to improvements (and therefore a reduction in complaints).
Actions next	Divisions with high volume of complaints, i.e. STNC, CWDT and Medcard have weekly meeting with care groups, with the expectation of developing				

period:	clear plans for T&O and general surgery All divisions requested to present improvement plan (with trajectory) to improve response rate

Principal Risk	02-01 Risk 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**	**Updated Oct 2014**	**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. Divisions make a self-declaration upon management of schemes not presented to 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 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	02-02 Risk of poor patient experience due to long delays when trying to contact central booking service				
Description	Recent increased call volumes and turnover of agency staff have contributed to a lack of capacity to deal with demand within the call centre. The trust previously had two OP scheduling call centres, which were merged as of 1/6/14. This was in response to feedback from patients, staff and specialty colleagues and was a decision that was made some time ago. • Following the merger, an anticipated reduction in calls was not realised. Concurrently, agency staff left the CBS at short notice and the CBS experienced periods of disruption to the Cerner system and process challenges following the recent upgrade. • There has been a trend of increased referrals, many of which will lead to inbound phone calls in the last quarter. • In June, the call centre received over 35,000 calls, with a mean response time of 11:42mins (range 30 seconds – 40 minutes), average before merge of 30,000 calls. • Currently there is no intelligence about the queues and calls.				
Domain				**Strategic Objective**	
	Original	**Current**	**Updated Nov 2014**	**Exec Sponsor**	Martin Wilson
Consequence	3	3	3	**Date opened**	1-10-2014
Likelihood	5	4	4	**Date closed**	
Score	15	12	12		
Controls & Mitigating Actions	Introduction of queue management software with external provider to assist with managing demand more efficiently and effectively. Due beginning August. • Embed a virtual platform and set up a divert system based on call requirement which will spread volume to the right agent by grading the complexity of the call. e.g. change apt, cancel apt, divert to switch if nothing to do with COS • Plan to implement a 'queue buster' system – caller is called back			**Assurance**	Call centre dashboard Weekly reporting to the board Monthly reporting DGB, DMB Complaints & PALS improvements

	when they get to the front of the queue rather than waiting on the phone. • Provide intelligence on call subjects and call volume peaks/ troughs Aim: • reduction to call response times •75% of calls answered within 30 seconds by the end of August.		
Gaps in controls	No physical capacity to increase number of staff answering calls. No control over demand of referrals for outpatient care. 60% of which result in an inbound call.	**Gaps in assurance**	
Actions next period:	In process of converting agency posts to substantive Working with Estates & Facilities to identify additional/alternative space Reviewing newly collected queue intelligence data in order to shorten our training programme On-going outpatient improvement programme to improve matching capacity to demand which will increase the number of first call resolutions.		

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

Principal Risk	2.2-O5 Tariff Risk – Emergency Threshold Tariff. The Trust's income and service contribution is reduced due to application of 30% tariff to emergency activity exceeding the contract thresholds				
Description	Emergency activity volumes and income exceed contract thresholds resulting in payment at a reduced 30% tariff due to generic growth in emergency activity: ▪ Changes in emergency pathway e.g. Trauma activity ▪ Failure of Commissioner QIPP schemes ▪ Failure to reduce rate of consequent admissions ▪ Consultation on emergency tariffs with potential long term reduction in income for emergency procedures.				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.1 Meet all financial targets**
	Original	**Current**	**Update November**	**Exec Sponsor**	Steve Bolam
Consequence	3	3	3	**Date opened**	01/12/2012
Likelihood	4	3	3	**Date closed**	
Score	12	9	9		
Controls & Mitigating Actions	**Controls** The expected impact of reduced emergency tariff on financial performance is considered as part of the Trust's business planning process, which is overseen by Business Planning Implementation Group and reported to EMT.			**Assurance**	▪ Role on System Resilience Working Group to positively influence how emergency care is managed in the local health economy and how retained funds are spent

	Actions taken include: ▪ NETA rebasing exercise undertaken by St. George's. Negotiations with CCG's on-going re uprating of threshold, concluded at £10.2m Threshold impact reduced to c£3.5m for 14/15 ▪ Divisions ensure correct coding of method of entry to trust, either as emergency or as inter-hospital transfer for example ▪ Continued investment in facilities to reduce level of emergency admissions, e.g. Consultant led A&E, AMU. ▪ Support commissioners to develop realistic, deliverable and measurable QIPP plans to manage demand for emergency services ▪ Identification of changes in emergency pathways ▪ Proactive identification of changes to patient pathways leading to expected increase in emergency admissions, and notification and negotiation with commissioners regarding appropriate operating of activity targets to reflect the changed patient pathway CCG's own the entirety of the financial risk on QIPP plans that fail to manage or reduce activity coming to St. George's. Mitigating actions: ▪ Central role played on System Resilience Working Group will allow St. George's to influence how the retained 70% of emergency tariffs are allocated. ▪ Bid for proportion of CCG retained 70% of tariff, to develop local projects to assist in demand management. ▪ Development of admissions avoidance projects in-year which reduce the overall number of patients being admitted to the trust		▪ Reported value of emergency threshold tariff loss
Gaps in controls	Ensure Commissioner 70% saving on tariff is reinvested appropriately.	**Gaps in assurance**	Access to representation on System Resilience Working Groups outside of Wandsworth/ Merton/Lambeth where significant level of STG funding sits
Actions next period:	Continue to engage with CCGs to maximise potential benefit of Better Care Fund in reducing emergency admissions The 2015/16 SLA negotiations have the potential to increase this risk given the financial challenge within the health economy. Need to ensure that the SLA position is robust and evidence based		

	Understanding and influencing decisions on other System resilience working groups

Principal Risk	2.1-O5 Tariff Risk - The tariffs applicable to Trust clinical services are adversely changed as a result of: •National Tariff changes •Local Tariff changes •Specialist Commissioning changes • Transfer of tariff responsibilities to Monitor				
Description	There is a risk that future tariff changes will be more challenging:- ▪ Local Tariff changes e.g. proposed reductions in charges for Sexual Health services & Community Cost & Volume tariffs for services, for example, delivered from Queen Mary's Hospital Roehampton. ▪ Changes in Commissioning arrangements for Specialist Services will lead to standardisation of local tariff agreements which may adversely affect current income levels – Fetal Medicine Unit potential loss of income for example ▪ Monitor is consulting on its policy on tariff and the future proposals may adversely affect Trust income ▪ The major trauma service fails to achieve best practice tariff ▪ Risks of CCGs not paying for increased income assumption based on improved coding e.g. for obstetrics				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.1 Meet all financial targets**
	Original	**Current**	**Update November**	**Exec Sponsor**	Steve Bolam
Consequence	3	3	3	**Date opened**	01/12/2012
Likelihood	4	4	4	**Date closed**	
Score	12	12	12		
Controls & Mitigating Actions	**Controls** ▪ Influence the development of future tariffs and related service specifications ▪ Active membership of Project Diamond provides the Trust with a London wide voice to reflect Tertiary Hospital views in the development of the tariff. ▪ Active membership of FT Network. ▪ Negotiation with commissioners. ▪ Agreement to phased introduction of change through SLA negotiation process will mitigate impact. Where local tariffs are reduced, trust to negotiate for			**Assurance**	External reviews:- E&Y report on the impact of the current tariff structure for members of Project Diamond has been acknowledged by D Flory and has resulted in explicit tariff subsidies for major London Trusts National tariff & rules published for 2014/15 with limited changes

	compensatory changes in other, less favourable tariffs where commissioners currently benefit, seeking to ensure a reduced overall impact Opportunities to offset loss e.g. through bidding for whole pathway tariffs, or through reviewing structure of service, are identified **Mitigating actions:** Divisions, services where tariff loses impact on overall service financial baseline to develop plans to review productivity opportunities, remove costs, and identify opportunities to grow activity at marginal cost. Where local tariffs are reduced to such an extent that the service becomes recurrently loss making, to review overall service viability and make decisions around longer term service structure Participation in Monitor 2013/14 PLICs voluntary data collection		
Gaps in controls	▪ Pathway based service costing. ▪ Benchmarking of Local Tariff Services - Identifying those services which currently attract a relatively high local tariff will enable the Trust to examine opportunities to address future risk.	**Gaps in assurance**	
Actions next period:	▪ Negotiations with commissioners managed by Director of Finance with regular reporting to Trust Board ▪ Engagement with Project Diamond group to develop a response to DOH/NHSE tariff proposals over MFF ▪ Development of database solution to ensure long term capture of major trauma activity – for completion by end 2014/15		

Principal Risk	**1.2-O5 Volume Risk – Decommissioning of Services**. Activity and associated income/contribution will be lost from services decommissioned due to: ▪ risks to the safe delivery of care ▪ changing national guidance ▪ centralisation plans
Description	Services are lost, along with the associated income and contribution to trust overheads, due to ▪ Risks to safe delivery of care due to low volumes not meeting national minimum activity thresholds e.g. gynaecological cancer and BMTs, or where the clinical or service quality of a service provided falls significantly below national minimum standards. ▪ Risks associated with failure of services to meet the new NHSE Service Specifications or other changes in national guidance. The new service

<table>
<tr><td></td><td colspan="5">specification for bariatric surgery presents risks to St. George's due to current level of service.
▪ Commissioner plans to centralise services</td></tr>
<tr><td>Domain</td><td colspan="3">2. Finance & Operations</td><td>Strategic Objective</td><td>2.1 Meet all financial targets</td></tr>
<tr><td></td><td>Original</td><td>Current</td><td>Update November</td><td>Exec Sponsor</td><td>Steve Bolam</td></tr>
<tr><td>Consequence</td><td>3</td><td>3</td><td>3</td><td>Date opened</td><td>01/12/2012</td></tr>
<tr><td>Likelihood</td><td>3</td><td>3</td><td>3</td><td>Date closed</td><td></td></tr>
<tr><td>Score</td><td>9</td><td>9</td><td>9</td><td colspan="2"></td></tr>
<tr><td>Controls & Mitigating Actions</td><td colspan="3">Controls - Specific
▪ For Bariatric Surgery, increasing the capacity in obesity clinics to improve compliance with tier 3 specification, with weekly meetings to monitor patient scheduling and on-going debate with NHSE about service spec.
▪ Alliance with Royal Marsden to provide BMT and Paediatric Oncology services
▪ Controls - Generic
▪ Divisional annual business plans to identify threats in the market, and how the service will respond to those issues
▪ Development of service specific marketing plans to identify options for maintaining services at SGH
▪ Cost / benefit analysis of investment into services to meet any deficiencies against new national service specifications for tertiary services, and subject to that analysis, implementation of investment to ensure trust meets required standards and will not therefore be de-commissioned
▪ Work through Urgent Care and System Improvement Board to influence local commissioner decisions regarding any plans to change the configuration of services or centralise services away from St. George's:

Mitigating actions:
1. Development of long term exit strategy for services without a viable long term market position
2. For any service that is de-commissioned, the trust will remove the costs (pay, non-pay, other) associated with</td><td>Assurance</td><td>Annual business plans and business planning process though to Finance & Performance Committee and Trust Board</td></tr>
</table>

	the service, assuming that substitute activity cannot be grown.		
Gaps in controls	Improvements needed in process for identification of 'at risk' services.	**Gaps in assurance**	None currently identified
Actions next period:	▪ Business planning for 2015/16 has started. Care Groups will be expected to identify any services at risk of decommissioning as part of this process		

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 on-going 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 November**	**Exec Sponsor**	Steve Bolam
Consequence	4	4	4	**Date opened**	01/12/2012
Likelihood	4	4	4	**Date closed**	
Score	16	16	16		
Controls & Mitigating Actions	Controls ▪ The expected impact of cost pressures on financial performance is considered as part of the Trust's business planning process. Robust provisions are made for future increases in cost in line with high level Guidance from Monitor. ▪ Adequate Contingency Reserves are set aside in line with NHS Guidance at 1% of Turnover ▪ The business planning process is overseen by Business Planning Steering Group which reports to EMT. ▪ Cost pressures are monitored in-year through the			**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

	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 2015/16 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. 2015/16 Business Planning process has started. The process will identify 2015/16 and 2016/17 cost pressures and CIP programmes and efficiency gains to offset these additional costs		

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 November	Exec Sponsor	Steve Bolam
Consequence	5	5	5	**Date opened**	01/12/2012
Likelihood	4	4	5	**Date closed**	
Score	20	20	25		

Controls & Mitigating Actions	Controls 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 leads. ▪ The trust is engaging with outside expertise to develop further robust CIP savings schemes for future years. Mitigating Actions	**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 Monitor review of CIP plans and process as part of FT application

	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**	Review of capacity planning and service improvement benefits expected indicates material gaps in 15/16 plans have opened up and need to be filled with alternative schemes
Actions next period:	Continued review and development of schemes supporting the programme Full review of 15/16 plans underway Develop and in-house process and methodology to identify 2016/17 CIP programme. Process to be overseen by the Business Planning Steering Group		

Principal Risk	2.3-O5 Tariff Risk – CQUIN Premium. Trust income is not maximised due to failure to deliver required performance against CQUIN quality standards.				
Description	CQUINs are not met at the level that the trust has assumed in its financial plans - in 2015/16 Maternity will no longer receive CQUIN funding with this being replaced by a CCG local tariff. Value circa £1.8M in 2015/16 - Future requirements not adequately identified. -Insufficient investment made in delivery				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.1 Meet all financial targets**
	Original	**Current**	**Update November**	**Exec Sponsor**	Steve Bolam
Consequence	4	4	4	**Date opened**	01/12/2012
Likelihood	4	3	2	**Date closed**	
Score	16	12	8		
Controls & Mitigating Actions	Controls Governance Arrangements ▪ Build expected level of CQUIN non-achievement, 15%, into financial baseline for the trust. Trust met 87% of CQUIN target in 2013/14 so surpassing internal target by 2%. ▪ Leads identified for each CQUIN			**Assurance**	Internal Audit in 2011 highlighted CQUIN performance insufficiently resourced. Two additional central posts (one nursing, one admin) appointed to assist in the delivery of CQUINs on the wards Commissioners agreed 95% CQUIN achievement as part of year end statement

	▪ CQUIN leads share reports on trust wide CQUINs with DDNGs to feed into divisional meetings. Assessment of risks related to each CQUIN shared with DDOs who are asked to develop mitigating action plans. ▪ Performance monitoring of CQUIN performance to ensure early identification of any variance from plan and identify and implement remedial actions. ▪ CQUIN achievement considered at quarterly divisional performance reviews. ▪ Investment in Delivery e.g. TB nurse recruitment ▪ Appropriate requirements are identified by divisions in Business Planning process – overseen by Business Planning Implementation Group and reported to EMT. ▪ For maternity – on-going discussions with CCGs to ensure that non-recurrent expenditure is met from recurrent CCG funding, minimising any overall loss to the trust. Mitigating actions: 1.Invest resources in – year to improve CQUIN performance, based on a cost-benefit analysis of undertaking that investment 3.Year End Settlement discussions – the level of risk relating to CQUINs is mitigated by agreement with commissioners to a year-end settlement, managed through the SLA negotiation process		
Gaps in controls	CQUIN performance is insufficiently embedded in Divisional Governance structures. Accountability and performance management arrangements need to be improved and adequately resourced.	**Gaps in assurance**	
Actions next period:	▪ Confirm that all CQUINs now finalised. . NHSE CQUINs agreed ▪ Finance & Performance Committee now receives quarterly CQUIN Performance Report to give Board sub-committee oversight. ▪ Next step is to develop CQUIN performance dashboard/oversight process at Divisional level		

Principal Risk	**1.3-O5 Volume Risk** – Tendering of services. Activity and associated income/contribution will be lost due to: • Service Line Tenders • Competition from Any Qualified Providers This risk is particularly related to the delivery of community services.				
Description	The Trust may lose contracts for a range of services resulting in associated lost income and lost contribution to overheads, due to Commissioner intentions. These include: An increased role for the Local Authority to commission services, leading to new and less predictable patterns of service commissioning – in 2015/16 Health visiting due for tendering by Local Authority with current value of £6.25M and Sexual health services worth £6.4M An increased introduction of service line tenders e.g. School nursing (value circa £1.35M for 2015/16) Potential for WCCG to tender all adult community health services under CAHS programme in 2015/16 Growth of AQPs across a range of services				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.1 Meet all financial targets**
	Original	**Current**	**Update November**	**Exec Sponsor**	Steve Bolam
Consequence	3	3	3	**Date opened**	01/12/2012
Likelihood	4	3	3	**Date closed**	
Score	12	9	9		
Controls & Mitigating Actions	**Controls** 1. To ensure that the trust delivers services in line with commissioner requirements, in advance of any service line tenders or wider commissioning decisions. This will ensure the trust is well placed to win any tender, or to offer a service that commissioners no longer feel the need to tender for e.g. Commissioning Adult Health Services (CAHS) as currently being developed by WCCG. 2. Annual business plan by clinical service to identify threats and opportunities in the market place, and how the service will respond to those issues 3. Ensure, through DMB, annual business plan in CSD and other divisions clearly programmes tender work and business development associated with these tenders into its work programme 4. Early identification of services affected. Potential areas currently identified are: - Sexual Health Services potential to be tendered in 2015/16 - School nursing 2015/16 - Health visiting in 2015/16 5. Decision to enter tender process for each invitation received, based on current strategic and service fit and financial contribution/profitability.			**Assurance**	Escalating process of assurance through annual business plans and business planning process though to Finance & Performance Committee and Trust Board Trust has won the Nelson Tender. This follows on from the winning of the Prison Tender. Winning both these illustrate and demonstrate that the trust has a track record on winning tenders, and has confidence that it can produce robust and innovative responses to any future tender of services

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

Principal Risk	**1.1-05 Volume Risk –** Competition with other providers. Activity and associated income/contribution will be lost due to competition from other service providers resulting in reductions in market share				
Description	The Trust's competitor and market share analyses indicate that there is a risk that some activity may be referred to alternative providers, particularly tertiary activity, resulting in associated lost income and lost contribution to overheads. For example, Cardiology going to GSTT from SWL and Surrey, or Neuroscience activity going to inner London providers. Risk identified in 2014/15 around loss of maternity and gynaecology market share				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.1 Meet all financial targets**
	Original	**Current**	**Update November**	**Exec Sponsor**	Steve Bolam

Consequence	4	3	3	**Date opened**	01/12/2012
Likelihood	3	3	3	**Date closed**	
Score	12	9	9		

Controls & Mitigating Actions	**Controls** 1.Quarterly market share and competitor analysis reported to divisional management and Commercial Board 2. Marketing information informs the development of divisional Business Plans, which is overseen by Business Planning Steering Group and reported to EMT. 3. Pro-active monthly monitoring of actual activity and referral source as recorded in SLAM for early identification of market share changes. 4. Development of service specific marketing plans to maintain and grow market share – Cardiac, Neuro and Paediatrics completed for 2013/14, and will be extended to other services, and further enhanced and developed during 2014/15 5. Development of marketing plan for maternity and genecology, with proposal for 1000 additional births in 2015/16. Business case in development 6. Proactive relationship management with key commissioners and referrers to help ensure that St. George's remains referral unit of choice in south west London and beyond, depending on clinical service. Active leadership role on Urgent Care and System Improvement Board to influence and lead sector wide debate. 7.Benchmark for quality and performance to understand how the St. George's service compares to competitors 8. Continued development of local clinical networks and strategic partnerships to maintain market position will help control impact. 9. On-going improvement in service quality, to maintain market share and encourage patients to actively choose St. George's. 10. Continued development and enhancement of clinical networks e.g. Urology network or Kingston/George's Cardiology partnership working, to strengthen St. George's market position. 11. Win new tenders e.g. Nelson Local Care Centre, to maintain and expand market share Mitigating Actions: ▪ Divisional management teams will undertake a range of actions to	**Assurance**	**Positive** ▪ On-going market share monitoring via SLAM and Dr. Foster data. ▪ Business planning processes to identify risks and market strategy

	mitigate this risk including: Develop deliverable and measurable action plans in response to any significant loss of market share, focusing on reclaiming lost referrals. Plans would need to clearly address issues identified by commissioner or service weaknesses, identified following internal review ▪ To develop action plan to develop new markets, focussing on Surrey referrals and south west London activity currently going out of sector. For each service to identify where potential substitution activity can be taken from, including: geographical area; rationale for growth; target volume; barriers to possible growth; commissioner position ▪ Trust internal substitution of activity from other departments, where demand outstripping capacity, to ensure estate and facilities are utilised ▪ Cost removal – assuming that substitute activity cannot be grown to detail where cost will be taken out: Staff, Non-pay, etc., and the value, timeframes for delivery and impact on financial performance of trust. Quality and other indicator impact to be quantified. These actions will be incorporated into divisional business plans, the development of which is overseen by the Business Planning Implementation Group and reported to EMT.		
Gaps in controls	Not all services have marketing plans	**Gaps in assurance**	None
Actions next period:	▪ On-going review at Commercial Board. ▪ Identify market share threats and opportunities through the business planning process for 2015/16 and develop appropriate response ▪ Utilise incoming marketing expertise and new Director of Strategy to develop trust marketing plans for 2015/16		

Principal Risk	2.4-O5 Tariff Risk – Performance Penalties & Payment Challenges. Trust income is reduced by contractual penalties due to poor performance against quality standards and KPIs- payment challenges				
Description	Targets or KPIs within the contract are not met and the level of financial penalties is higher than anticipated. Main KPIs are:-1st to FU ratios-Re-admission rates. In 2014/15 risk around Cardiac activity related to non-achievement of 18 week standard. The level of payment challenges due to data quality issues is higher than anticipated. Main data issues are:--Multiple 1st OP appointments-Ensuring correct recording of Emergency and Other Non-Elective method of admission. Risk in 2014/15 around payment challenges associated with major trauma service and not achieving best practice tariff				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.1 Meet all financial targets**
	Original	**Current**	**Update November**	**Exec Sponsor**	Steve Bolam

Consequence	5	4	4	**Date opened**	01/12/2012
Likelihood	3	3	3	**Date closed**	
Score	15	12	12		

Controls & Mitigating Actions	Controls Governance Arrangements: ▪ Good clinical engagement in local KPI target setting e.g. 1st to Follow up OP ratios, consultants are signed up to the levels in the contract. Much clinical engagement in the joint readmissions audit, to set the threshold appropriately. The budget for the level of challenges is based on challenges levied in prior years. Divisions are sighted on their level of budgeted challenges and the actions they must take to prevent challenges or to mitigate them. ▪ Negotiation of appropriate and realistic thresholds and targets with local CCG's to minimise trust exposure to challenges. ▪ Training of staff & data validation routines ▪ Ensure that data is recorded and charged for appropriately and that PbR Guidance is followed e.g. that OP appointments are appropriately recorded as First or Follow Up and that the correct method of admission is recorded for non-elective patients ▪ For Major trauma tariff new admin team recruited to ensure that activity accurately captured and coded. Mitigating Actions: ▪ Utilise clinical expertise to explain changes and challenge penalties imposed by CCG's. ▪ Year End Settlement discussions – the risk of income losses relating to further in-year challenges is mitigated by agreement with commissioners to a year-end settlement through the SLA negotiation process.	**Assurance**	In year performance monitoring of level of both accepted and rejected challenges, Current performance is within the budgeted levels.
Gaps in controls	The Trust needs to more pro-actively identify specific areas of risk ahead of challenges e.g. Chemotherapy charges	**Gaps in assurance**	
Actions next period:	▪ Good clinical engagement in local KPI target setting E.g. 1st to Follow up OP ratios, consultants are signed up to the levels in the contract. Much clinical engagement in the joint readmissions audit, to set the threshold appropriately.		

	▪ The budget for the level of challenges is based on challenges levied in prior years. ▪ Divisions are sighted on their level of budgeted challenges and the actions they must take to prevent challenges or to mitigate them. ▪ Cardiac review of skill mix, capacity and referral patterns to address 18 week underperformance ▪ New database solution agreed for Major trauma activity – to be in place by end 2014.

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

	new developments, minimising the risk of cost pressures developing as a result of new service developments		
Gaps in controls	Divisional use of PLICS and SLR data not as complete as required.	**Gaps in assurance**	Insufficient understanding of where steps in fixed costs are incurred
Actions next period:	Document PLICS strategy Implement agreed implementation plan for PLICS		

Principal Risk	3.5-05 Cash-flow Risks – Operational Finance: Forecast Cash balances will be depleted due to delays in receipt of:- ▪ Major Charitable donations towards the C&W development. ▪ Land Sales receipts ▪ Loan Finance				
Description	The Trust's cash balances may be significantly depleted due to the delay in receipt of significant one off charitable donations, land sale receipts or loan finance				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.1 Meet all financial targets**
	Original	**Current**	**Update November**	**Exec Sponsor**	Steve Bolam
Consequence	3	3	3	**Date opened**	01/06/2012
Likelihood	3	3	4	**Date closed**	
Score	9	9	12		
Controls & Mitigating Actions	Controls:-Capital Expenditure Management 1. Capital Programme Group (CPG) oversees the planning and monitoring of the annual and five year capital programme, which reports to Executive Management Team 2. Monthly capital finance reports on funding and expenditure are submitted to the CPG for review and forecasts updated. The Finance and Performance Committee and Trust Board receives a summary financial report on the capital programme as part of the finance report and significant variances and changes to plan explained. 3. Maintain reasonable and prudent capital cash flow projections based on detailed returns from capital budget holders commensurate with agreed funding and ensuring they are updated regularly to reflect changes in project timescales and in the receipt of external funding. 4. Secure agreement from donors to provide funds in accordance			**Assurance**	Previous track record in delivering major land sales projects e.g. Wolfson, Bolingbroke & The Grove

	with timing of investment requirements • Action Plan – written undertakings of commitment to transfer funds at agreed milestones e.g. Helipad. 5. Project plans to deliver land sales • Action Plan – business case setting out timelines and risk management in event of slippage. 6. Project Plan to secure loan finance • Action Plan – equipment items subject to leasing will be procured only when lease agreement completed. Other loan finance will be scheduled on prudent cash flow projections of related investment. Mitigations:- Delay capital investments in line with reduced funding 7. Manage working capital 8. Identify alternative sources of finance e.g. extend scope of leasing – subject to VFM and affordability tests.		
Gaps in controls	None identified	**Gaps in assurance**	
Actions next period:	Review of cash position under best, most likely and worst case I&E scenarios to November F&P Cttee Agree loan draw down with DH to ensure no cashflow risks from major loan funded projects		

Principal Risk	3.6-05 Cash-flow Risks – Operational Finance: Forecast Cash balances will be depleted due to:- •Adverse Income & Expenditure performance •Delays in receipt of SLA funding from Commissioners				
Description	The Trust's cash balances will be significantly depleted due to an adverse I&E position or delays in receipt of commissioner funding. Risk is currently greater due to change in Commissioner landscape.				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.1 Meet all financial targets**
	Original	**Current**	**Update November**	**Exec Sponsor**	Steve Bolam
Consequence	3	3	4	**Date opened**	01/06/2013
Likelihood	3	4	4	**Date closed**	
Score	9	12	16		

Controls & Mitigating Actions	Established SLA negotiation process: •SLA negotiation issues are escalated to FD/CE and reported to Finance and Performance Committee. •Locally agreed estimated values for contracts to allow appropriate levels of funding to be made ahead of final contract signature. •SLAs include special clause for interim invoicing of over-performance in advance of freeze date - enhances cash flow. Established Financial Management regime: •Adverse Income and Expenditure results are monitored in-year through the financial reporting regime. •New pressures are identified as early as possible and the financial impact is reported to the Finance and Performance committee. •Trust has set month-end cash balance target against which cash performance is measured: 10 days of operating expenses (in 2013/14 this is approx. £18m). .Working Capital Management •The Trust Cash Position is reported to the Board each month as part of the finance report, including detailed cash flow statements and 2-3 year cash projections. •Changes in debtors, stock and creditors reported and explained within finance report to Finance and Performance Committee and Board. •SLA interim invoicing – as above. Mitigating actions Manage Working Capital • Improve Debt Collection • Delay payment of creditors / manage balances with major creditors e.g. SGUL • Reduce stock levels e.g. extend scope of consignment stock to deliver one-off improvement in liquidity – subject to VFM and affordability tests (i.e. higher unit costs). Delay capital investments in line with reduced funding due to reduction in Trust surpluses Extend scope of leasing to finance capital programme subject to VFM and affordability tests. Explore opportunities for sale and leaseback arrangements LEEF loan agreed to be drawn down early at no additional expense / risk to	**Assurance**	Detailed monitoring and forecasting of cash flow and agreed debt through Finance and Performance Committee. HDD1 and HDD2 working capital reviews

	Trust		
Gaps in controls	Contract with NHSE likely to include unidentified QIPP leading to over performance on contract maybe c£1m per month & cash flow problems	**Gaps in assurance**	
Actions next period:	Seek to agree payment for over-performance in the contract with NHSE Further review of timing of CAPEX to ensure phased towards 2nd 6 months 14/15 and examine profile going forwards Review of cash position under best, most likely and worst case I&E scenarios to November F&P Cttee Agree loan draw down with DH to ensure no cashflow risks from major loan funded projects		

Principal Risk	3.9-05 Impact of Better Care Fund on Financial position of the trust. Funding of circa £2M rising up to £20M recurrently removed from the trust income position. With potential impact on financial performance, operational delivery and quality of services as well as the Trust's FT application				
Description	The Better Care Fund (BCF) is a new pooled health and social budget due to be implemented from 2014/15 and rising significantly in value in 2015/16. CCGs will be required to contribute significant health funds to the BCF locally. After initial concerns that BCF would impact by £20M from 2015/16, new figures from CCG's indicate that the impact of the BCF should be significantly lower than initially expected. Method of implementing BCF still being developed and expected to be a mix of predominantly QIPP type activity reductions and to a lesser extent tariff reductions. If income is reduced without a concomitant reduction in the trust's activity and cost base, the financial impact will severely impact the trust's financial performance and through that, have potential impacts on operational, quality and other elements of trust business.				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.1 Meet all financial targets**
	Original	**Current**	**Update November**	**Exec Sponsor**	Steve Bolam
Consequence	5	3	3	**Date opened**	31 January 2014
Likelihood	3	4	3	**Date closed**	
Score	15	12	9		
Controls & Mitigating Actions	**Controls** Engagement with CCG and local authority partners in south west London to understand and co-operatively plan for the management of the BCF 1. Trust is required to be a party to the Better Care Fund submission and plans that are made.			**Assurance**	Negative Guidance and understanding and local interpretation of guidance, and impact finically on local CCG's is unclear Structures to manage and oversee BCF are relatively new and untested

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

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

Principal Risk	3.7-06 Failure to meet the minimum of the NTDA Accountability Framework Quality and Governance Indicators results in reputational damage, delays to the FT application or the quality of care is compromised in order to meet the access targets (specifically 18 weeks, A&E waits, cancer waits)				
Description	There is a risk to the Trust FT application should it fail to perform against the Access Metrics set out by the NTDA Accountability Framework particularly in relation to:- 18 weeks- A&E Waits (4 hours)- Cancer waits (TWR, 31 & 62 day targets).Individual risks, controls and actions to mitigate are set out in Divisional risk registers				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.2 Meet all performance targets**
	Original	**Current**	**Update Nov 2014**	**Exec Sponsor**	Steve Bolam
Consequence	4	4	4	**Date opened**	30/05/2013
Likelihood	4	3	4	**Date closed**	
Score	16	12	16		

Controls & Mitigating Actions	Management framework in place which measures performance across key domains including operational performance. Divisions are held to account through formal quarterly performance reviews, monthly reporting and monitoring and escalation where required through the DoFPI The Trust has a performance management framework A&E performance meeting is held routinely within the Med/Card division to scrutinise and review ED performance Finance & Performance Committee meets monthly to review in detail the performance report including all areas of the TDA accountability framework Reporting to F&P includes description of key actions and sharing of recovery plans where necessary e.g. cancer recovery plan 12/13 Q4 Reporting continues to be improved and developments including desktop access to scorecards for Divisions and the introduction of risk forecasting are in train External scrutiny: Performance is reviewed by the TDA as part of the Accountability Framework and the Trust is held to account at a monthly meeting of senior teams Clinical Quality Review meeting and contract performance meetings are held monthly with commissioners where performance and remedial action is further scrutinised **Mitigating Actions** •Additional capacity is being introduced to support the Divisions and the performance framework in the shape of a Head of Performance and 2 x Divisional Performance leads •Reporting continues to be improved and developments including desktop access to scorecards for Divisions and the introduction of risk forecasting	**Assurance**	Positive assurance •HDD, BGAF and QGAF assessments •Internal audit

	are in train •Developmental work in place to introduce formal monthly scoring system for Divisions within the performance framework to improve visibility over performance risks and the effectiveness of remedial action •Additional capacity is being introduced to support the Divisions and the performance framework in the shape of a Head of Performance and 2 x Divisional Performance leads		
Gaps in controls	Absence of risk forecasting which is in development	**Gaps in assurance**	
Actions next period:	Recruit to staff new capacity		

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

Actions next period:	Development of process for transition of clinical information projects into business as usual via the ICT Service Improvement Programme.

Principal Risk	3.9-06- Risk of inappropriate deployment of e-prescribing and electronic clinical documentation				
Description	There is a risk that if e-prescribing and electronic documentation is inappropriately deployed this will have an adverse impact on patient care and clinical continuity.				
Domain	**2. Finance & Performance**			**Strategic Objective**	
	Original	**Current**	**Updated Nov 2014Nov 2014**	**Exec Sponsor**	Steve Bolam
Consequence	4	4	4	**Date opened**	1.7.14
Likelihood	3	3	3	**Date closed**	
Score	12	12	12		
Controls & Mitigating Actions	Deployment project being managed with PRINCE 2 methodology Clinical lead in place to ensure clinical input on programme board Gateway thresholds established for technical readiness and staff readiness Each clinical area has a task group with a clinical lead who has power to sign off to roll out in their area Overall deployment is subject to regular gateway reviews.			**Assurance**	Reporting on progress of project to Clinical Information Systems Programme Board On-going modification of deployment plan in response to lessons learned from early adoption means project is flexible and responsive to ensure success.
Gaps in controls				**Gaps in assurance**	None identified
Actions next period:	Continue to react to feedback On-going changes to project and implementation as a result of lessons learned.				

Principal Risk	3.10-06 – Risk of failure to effectively manage exit from national Cerner programme				
Description	Failure to put in place alternative arrangements to progress provision of clinical systems for acute and community services would lead to significant business continuity issues for the Trust.				
Domain	**2. Finance & Performance**			**Strategic Objective**	
	Original	**Current**	**Updated Nov 2014**	**Exec Sponsor**	Steve Bolam
Consequence	5	5	5	**Date opened**	1.7.14
Likelihood	2	2	2	**Date closed**	
Score	10	10	10		
Controls & Mitigating Actions	SGH are members of two procurement consortia to evaluate preferred suppliers. Membership enables control over the preferred suppliers to provide services in place of national programme for IT. Preferred providers selected. Initial exit slots agreed with Dept of health Funding to support transition and on-going running costs identified and agreed as part of business process.			**Assurance**	Full business case approved by the NTDA Contracts signed with preferred service providers
Gaps in controls	None yet identified			**Gaps in assurance**	None yet identified
Actions next period:	Confirm exit timetable with Dept of Health Establish programme team and associated governance structure				

Principal Risk	3.11-06- Poor environment in ICT department/on site data centre may lead to interruptions or failure of essential ICT services				
Description	Current issues negatively affecting the correct functioning of ICT equipment include poor air-conditioning and temperature control and a lack of Capacity and control of additional power provision. A failure to effectively manage the environment may lead to interruptions and failure to provide essential ICT services				
Domain	**2. Finance and performance**			**Strategic Objective**	
	Original	**Current**	**Updated Nov 2014**	**Exec Sponsor**	Steve Bolam
Consequence	4	4	4	**Date opened**	1.7.14
Likelihood	4	4	3	**Date closed**	
Score	16	16	12		
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			**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.

	Estates response to environment alarms reviewed		Estates have a plan for permanent fix but have not yet confirmed funding or scheduled date. Agree this could be downgraded/closed once work is completed.
Gaps in controls		**Gaps in assurance**	
Actions next period:	Additional air cooling to be procured and commissioned Estates and ICT have surveyed and identified required upgrade to air conditioning. This work will be commissioned by Estates in Autumn. Once work completed , risk will be downgraded.		

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	**3. Regulation & Compliance**			**Strategic Objective**	**3.1 Maintain compliance with all statutory and regulatory requirements**
	Original	**Update**	**Updated Nov 14**	**Exec Sponsor**	Steve Bolam
Consequence	3	3	3	**Date opened**	September 2014
Likelihood	5	3	3	**Date closed**	
Score	15	9	9		
Controls & Mitigating Actions	**Controls:** 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.			**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.

	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.		
Gaps in controls		**Gaps in assurance**	
Actions next period:	Task and finish group to meet, identify necessary remedial actions and ensure they are undertaken.		

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

Principal Risk	A534-07:Failure to demonstrate full compliance with the CQC Essential Standards of Quality and Safety				
Description	Lack of a sufficiently robust approach to self-assessment and subsequent actions to ensure compliance may lead to a CQC inspection finding of non-compliance. Improvement and/or enforcement action imposed by the CQC with associated reputational risk and risk to the FT application Ref BAF Risk A509. Ultimate risk of loss of licence to operate certain services.				
Domain	**3. Regulation & Compliance**			**Strategic Objective**	**3.1 Maintain compliance with all statutory and regulatory requirements**
	Original	**Update**	**Update Nov 14**	**Exec Sponsor**	Peter Jenkinson
Consequence	5	5	5	**Date opened**	31/10/2010
Likelihood	1	1	1	**Date closed**	
Score	5	5	5		
Controls & Mitigating Actions	**Controls:** Quality inspections launched October 2013 with reporting via divisional management and EMT. Corporate and Divisional action plans completed with on-going monitoring through divisional governance boards, Patient Safety Committee and QRC. Action plan in response to Compliance Actions and other recommendations from CIH inspection approved by Board and submitted to CQC May 2014. Trust wide action plan in response to recommendations approved by OMT June 2014. Compliance by September 2014. Quality surveillance data monitored and appropriate action taken in response - reported as part of overall CQC compliance monitoring update to Trust Board via Risk and Compliance Report.			**Assurance**	**Negative**: CQC unannounced inspection Jan 2013: 6 out of 8 standards non-compliant with three standards deemed to have moderate impact upon people who use services and three minor. Internal audit report identified gaps in the current evidence collation at divisional level. **Positive**: Final report from August inspection shows significant improvement from January inspection – compliance in 5 out of 8 standards and minor impact in other three standards. Publication of CQC assessment of trusts into risk 'bands' (October 2013), based on quality surveillance data puts trust into band 6 (lowest risk). Chief Inspector of Hospitals inspection report published 24th April 2014, with overall rating of 'Good'. Two compliance actions identified. Good progress against compliance Action plan - full update provided to CQC inspector August 2014

	Compliance framework published, Divisions now required to sign off quarterly self-certification statements re compliance with CQC standards. **Mitigation:** Internal and external stakeholder management to highlight excellence in patient safety and clinical effectiveness, and compliance with other regulatory / quality standards.		NTDA, Commissioners and CQC confirmed they were assured by progress against Compliance actions and improvement actions at Oct 2014 monitoring meeting.
Gaps in controls	Complete implementation of CIH action plan	**Gaps in assurance**	
Actions next period:	Continue to implement action plan following CIH inspection Second meeting with CCG whose role it is to scrutinise action plan on behalf of NTDA – scheduled mid-January.		

Principal Risk	A509-08: Trust unable to achieve readiness for FT status by planned authorisation date as per agreed NTDA Accountability Framework				
Description	External economic environment. Failure to achieve performance targets. Inability to demonstrate implementation of robust quality governance processes in particular CQC compliance. Lack of commissioner support.. Trust's reputation is adversely impacted. Future status of Trust in doubt if FT status is not achieved				
Domain	**3. Regulation & Compliance**			**Strategic Objective**	**3.1 Maintain compliance with all statutory and regulatory requirements**
	Original	**Current**	**Update Nov 14**	**Exec Sponsor**	Peter Jenkinson
Consequence	5	5	5	**Date opened**	31/10/2010
Likelihood	3	3	3	**Date closed**	
Score	15	15	15		
Controls & Mitigating Actions	Programme management resource and governance structures in place to oversee programme. Close monitoring of external economic environment and adaptation of strategy/approach accordingly. CIP/Finance controls as per finance risks. Clear action plan and performance management milestones in achieving Foundation Trust Status & risks managed at programme level. Controls for performance risks detailed in other risks.			**Assurance**	Monthly oversight meeting with TDA covering performance and FT readiness. Reported to Board via CEO report. QGAF assessment score 3.5 confirmed by Deloitte April 2013. CQC CIH inspection – overall 'Good' rating. Exec to Exec meeting with TDA completed 28-Jan-14, with positive feedback. Board to Board with TDA completed March 2014. TDA Board approval for entry into Monitor assessment phase April 2014. Monitor kick-off meeting held 4th June. Board to Board with Monitor 25 September and feedback received.
Gaps in controls				**Gaps in assurance**	Monitor assessment on-going – Monitor Board decision due 26 Nov 2014 2014.
Actions next period:	Await outcome of Monitor Board consideration of application.				

Principal Risk	A537-06:Confidential data reaching unintended audiences				
Description	Inability to control all electronic methods of data transfer (USB sticks, laptops, e mails etc) Also paper records vulnerable to loss. Data loss can result in data reaching unintended audiences (e.g. public), loss of reputation, SUIs and restrictions from information commissioner including financial fines.				
Domain	**3. Regulation & compliance**			**Strategic Objective**	**3.1 Maintain compliance with all statutory and regulatory requirements**
	Original	**Current**	**Updated Nov 2014**	**Exec Sponsor**	Ros Given Wilson
Consequence	5	5	5	**Date opened**	31/10/2010
Likelihood	3	3	3	**Date closed**	
Score	15	15	15		

Controls & Mitigating Actions	Policies on data protection, information security, medical records and corporate email reviewed and disseminated through IG training, MAST, Trust Induction and Trust Intranet. Technical controls - All Trust laptops encrypted. USB port blocking implemented. Trust known devices whitelisted. Encrypted USB sticks distributed and available to Trust. Non encrypted USB sticks read only. Encrypted external drives available. Roll out of Virtual Desktop Infrastructure and single sign on in progress. Remote access 2 factor authentication complete. Electronic data management project in progress [paper light environment, RFID tracking]. Reviewed medical storage – updated guidance and auditing practice. On-going communication to staff on IG matters through eG IG Manager has now commenced and will continue monitoring “High” alerts in the external email monitoring software prompting email notices to members of staff Monitoring of sensitive data being sent from non-secure commercial email accounts – in progress. Letters to those staff who repeatedly deviate from guidance and Trust policy are being sent.	**Assurance**	Reduction in recent incidents involving data loss. On-going monitoring of any new removable storage devices with a view to blocking all such devices when greater assurance obtained that there is no clinical risk. CQC finding of non-compliance with Outcome 21 Records in relation to the insecure storage of patient records. CQC report provides assurance of compliance on inspected wards in relation to secure storage of patient records. RFID case-note tracking. (First phase complete)
Gaps in controls	No method of control of stopping paper records being removed.	**Gaps in assurance**	
Actions next period:	Investigate and leverage monitoring and blocking capabilities of Trust’s web filtering solution. Web based email (e.g. gmail, Hotmail) traffic is being monitored – “high risk” flagged email is being further investigated for potential policy breaches.		

Principal Risk	A610-06: The Trust will not attain the nationally mandated target of 95% of all staff receiving annual information governance training				
Description	Failure to reach the target will result in an 'unsatisfactory' score for the IG toolkit submission for the Trust.				
Domain	**3. Regulation & compliance**			**Strategic Objective**	**3.1 Maintain compliance with all statutory and regulatory requirements**
	Original	**Current**	**Updated Nov 2014**	**Exec Sponsor**	Ros Given Wilson
Consequence	3	3	3	**Date opened**	31/10/2011
Likelihood	5	5	5	**Date closed**	
Score	15	15	15		
Controls & Mitigating Actions	Information governance is a mandatory module in Trust induction training, MAST training and Cerner Training. E-Learning platform for MAST. Review of attendance at HR and Workforce and IG Committee. Management procedures to follow up of non-attendance in place. New e-learning and e- assessment modules have gone live and continues to roll out. IG Manager continuously monitoring IG training compliance.			**Assurance**	Increase in uptake of training completed with MAST. Negative - still at 80% completed training. Statistic from WIRED: Increase in IG training compliance to 74% as of May end.– caution required around the accuracy of the WIRED statistics due to the "newness" of the system. Nationally mandated target of 95% was not met for 2013/14. MAST training committee established
Gaps in controls				**Gaps in assurance**	Trust wide IG Training compliance at 74.11% October 2014.
Actions next period:	MAST training is being strongly promoted over the coming year. The 2014-15 target for MAST compliance across the Trust is 95%. Comms to all Trust in eG mandating IG MAST.				

Principal Risk	03- 01 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	**Update**	**Updated Nov 2014**	**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 in 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**	**Updated Nov 2014**	**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			**Assurance**	Estates compliance records being assembled. Action plan being monitored and progress updates to the Operational Management Team.

	monitored. An audit on the gaps in compliance has been completed. There is a planned programme in place to close the gaps in compliance.		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	03-03 Lack of decant space will result in delays in delivering the capital programme.				
Description	Lack of decant space for capital schemes delays the ability to deliver large capital schemes.				
Domain	**3.Regulation & Compliance**			**Strategic Objective**	**3.1 Maintain compliance with all statutory & regulatory requirements**
	Original	**Current**	**Updated Nov 2014**	**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. Space surveys are undertaken on an annual basis to provide room usage data to enable the project manager to work out a plan. Monitored through the Capital Programme Board & Project Programme Board			**Assurance**	Documented risk assessments Capital project delivery is reviewed through Capital Programme Board & Project Programme Boards.
Gaps in controls	Short term planning brings forward new priorities that unbalance existing plans.			**Gaps in assurance**	
Actions next period:	The list of space requests are being collated to assess the requirements. This will form the basis to find and agree the location of a decant space. There is work underway to deliver a portakabin to move transactional staff out of clinical areas and release space for redevelopment.				

Principal Risk	03-04 Delay to the ability to deliver the capital programme and maintenance activity due to clinical and capacity demands preventing access for estates and projects works.				
Description	Delay to the ability to deliver the capital programme and maintenance activity as a result of spaces not being handed over to projects and maintenance as a result of capacity issues.				
Domain	**3.Regulation & Compliance**			**Strategic Objective**	**3.1 Maintain compliance with all statutory & regulatory requirements**
	Original	**Current**	**Updated Nov 2014**	**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.				

Principal Risk	03-05 Risk to patient safety as a result of legionella infection.				
Description	There is a risk to patient safety from legionella infection. This risk has been increased as a result of legionella being found in isolated areas in the St George's Hospital site.				
Domain	**3.Regulation & Compliance**			**Strategic Objective**	**3.1 Maintain compliance with all statutory & regulatory requirements**
	Original	**Current**	**Updated Nov 2014**	**Exec Sponsor**	Eric Munro
Likelihood	3	3	3	**Date opened**	14 May 2014
Consequence	4	4	4	**Date closed**	
Score	12	12	12		
Controls &	Testing regime in place as part of the planned preventative maintenance programme to check the chemical levels are			**Assurance**	Detailed action plan in place being led by the Head of Estates.

Mitigating Actions	correct. If high counts of legionella are found it is chemically treated. Monitoring of the daily testing regime for cleaning chemicals in place. Testing regime and results kept in the evidence log book. A specialist engineer is carrying out a site wide water management risk assessment.		
Gaps in controls		**Gaps in assurance**	Unable to demonstrate full compliance with Approved Code of Practice Legionnaires' disease. The control of legionella bacteria in water systems. (HSG274).
Actions next period:	Monitor the testing regime and results.		

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

Principal Risk	01-08 Increased strategic uncertainty in SW London				
Description	The longer it takes to develop proposals for service reconfiguration in SW London the more likely the health economy will face rapid and unplanned change because of system unsustainability.				
Domain	**4. Strategy, Transformation & Development**			**Strategic Objective**	**4.1 Redesign pathways to keep more people out of hospital**
Score	**Original**	**Current**	**Updated Nov 2014**	**Exec Sponsor**	Suzanne Marsello
Likelihood	4	4		**Date opened**	01/01/2013
Consequence	3	3		**Date closed**	
Score	12	12			
Controls & Mitigating Actions	• Continue to work with commissioners and partners, and provide leadership for necessary changes in SW London service re-configuration • Our LTFM does not include reconfiguration in the base case, so our FT application is not dependent on this. We must ensure that we have rigorously assessed potential upside and downside cases in a range of scenarios in SW London, and keep commissioners and NHSL/NTDA/Monitor involved in this thinking.			**Assurance**	• Our LTFM does not include reconfiguration in the base case, so our FT application is not dependent on this. • We are and will remain a fixed point as a major acute provider in SW London • Continue to ensure that quality standards are sustainably met at SGH • An acute trusts CEO group has been established to work alongside commissioners re: SWL CC
Gaps in controls	St. George's Healthcare NHS Trust has limited control over decision making processes in the CCGs, NHS England and			**Gaps in assurance**	

	the NTDA/Monitor.		
Actions next period:	Continue to support CCG and partner providers in developing proposals for sustainable health services in SW London. Continue to implement the trust strategy as per the 14/15 plan		

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

Principal Risk	A533-08: Reconfiguration of healthcare services in SWL result in unfavourable changes to SGHT services and finances				
Description	Likely future reconfiguration of acute services in SWL as current reconfiguration not affordable. Risk of reduced range of services or downsizing of services leading to loss of income and financial margin. Possible adverse effects on the delivery of patient care. Even small shifts of activity are likely to reduce financial margin on outpatient activity. As a result of uncertainty the Trust is unable to define activity, capacity and business plans. Risk that patient flows may either exceed expected numbers, impacting on capacity, performance and the quality of care or elective throughput. Opposite risk that predicted activity does not materialise as anticipated, leaving the trust with under-utilised assets				
Domain	**4. Strategy, Transformation & Development**			**Strategic Objective**	**4.2 redesign and configure our local hospital services to provide higher quality care**
Score	**Original**	**Current**	**Updated Nov 2014**	**Exec Sponsor**	Suzanne Marsello
Likelihood	5	4		**Date opened**	30/09/2010
Consequence	5	2		**Date closed**	
Score	25	8			
Controls & Mitigating Actions	Strategy team analyse the financial impacts of both the shifting of care away from the acute site and also the impact of predicated additional activity following acute reconfiguration as part of the business planning process. This includes sensitivity analyses on both activity and finance. The Trust playing leadership role in reconfiguration, planning and modelling for SW London in collaboration with commissioners and providers Development of relationships with new CCGs to work together on realistic QIPP and demand management plans through individual and SW London-wide out of hospital and integration programmes, including the Better Care Fund plans.			**Assurance**	LTFM base case does not assume upside of reconfiguration. Estimated the activity capacity and capital implications of a range of possible reconfiguration options
Gaps in controls	None identified			**Gaps in assurance**	
Actions next period:	Continue to support CCG and partner providers in developing proposals for sustainable health services in SW London. Continue to implement the trust strategy as per the 14/15 plan				

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

Principal Risk	05-05 Research does not form a key part of St. George's future activity which may result in the loss of funding and an inability to recruit and retain staff.				
Description	Although SGH has a Research Strategy, this is not embedded as a driver for research across the Trust. It is a high level document that does not set out how research will be embedded. •Track record in research relatively weak •St. George's brand is not strong in research. •Service demands restrict the ability to develop research at St George's (Historical differences in approach) •Loss of opportunities for research and development. •Inability to sustain research infra-structure and governance.				
Domain	**4. Strategy Transformation & Development**			**Strategic Objective**	**4.5 Drive research and innovation through our clinical services.**
	Original	**Current**	**Updated Nov 2014**	**Exec Sponsor**	Ros Given Wilson
Consequence	4	4	4	**Date opened**	28/02/2013
Likelihood	3	2	2	**Date closed**	
Score	12	8	8		

Controls & Mitigating Actions	• AMD for Research working with the Dean of Research and Enterprise. Regular joint meetings between SGUL and SGHT execs. • Research strategy implemented • CLRN Funded PAs for research active consultants within Divisions • Four Research sabbaticals awarded • Annual Plan for research strategy in place& monitored by research committee • Working with Information team, to integrate research data • Agreement of Divisional Scorecards – and introduction onto DMB or similar agenda • Implementing the Research Board	**Assurance**	Positive Assurance: • Agreed Trust KPIs for research. • Increased levels of recruitment to NHR trials - both on raw and weighted figures. We have had a 40% increase in weighted recruitment • Research KPIs reviewed at TB and EMT • MHRA has signed off compliance with clinical trials • Increase in number of studies approved Negative assurance: • Governance approval times are variable quarter by quarter but are improving when benchmarked with main competitors • Additionally, CRN have reduced the target approval timeline by 50% • Not all studies approved contribute to NIHR targets. • Issues with CRF staffing is improving
Gaps in controls	• Joint working between SGUL Institutes and SGH NHS • No system or guidance for prioritisation towards studies that contribute to NIHR recruitment (high-	**Gaps in assurance**	

	impact studies.) • There are capacity gaps for the JREO to in support developing research-interested consultants to initiate getting studies up and running • Lack of integration of research data in Trust information systems		
Actions next period:	Get remaining two research sabbaticals active by October 2014. Initiate round two of sabbatical investment Reorganisation of clinical research facility – ONGOING Follow up CRN re-structure and budget impact – September 2014		

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

Principal Risk	A516-04: Possible reductions in the overall number of junior doctors available with a possible impact on particular speciality areas				
Description	Inability to recruit and retain the appropriately skilled workforce to deliver our strategy				
Domain	**5. Workforce**			**Strategic Objective**	**5.1 Develop a highly skilled & engaged workforce championing our values**
	Original	**Current**	**Updated Nov 2014**	**Exec Sponsor**	Wendy Brewer
Consequence	4	4	4	**Date opened**	30/11/2012
Likelihood	4	1	1	**Date closed**	
Score	16	4	4		
Controls & Mitigating Actions	Workforce Utilisation Plan reviewed monthly by the Trust Board. The surgical 24/7 group continues to meet regularly to review progress. ANP and PA posts have been established in most divisions to replace the work previously done by junior doctors. A training and education plan is under development for the PAs and ANPs. Able to appoint to these posts and see them as part of the staffing establishment in the future			**Assurance**	Positive assurance received via regular review within divisions. No real reduction in numbers to date. Known and anticipated reductions in junior doctor numbers will be included in business planning guidance and information for 14/15 business planning round.
Gaps in controls	None identified			**Gaps in assurance**	
Actions next period:	Each of the divisions will consider workforce implications as part of the business planning round. Any particular difficulties in recruiting to vacancies will be identified and action plans produced.				

Principal Risk	A518-04:Failure to reduce the unacceptable levels of bullying & harassment reported by staff in the annual staff survey

Description	Expectations placed on staff continue to rise in the light of increased clinical activity and tougher standards. Pressure felt by managers and staff often results in inappropriate behaviours. Quality of patient care negatively affected				
Domain	**5. Workforce**			**Strategic Objective**	**5.1 Develop a highly skilled & engaged workforce championing our values**
	Original	**Current**	**Updated Nov 2014**	**Exec Sponsor**	Wendy Brewer
Consequence	4	4	4	**Date opened**	31/05/2010
Likelihood	4	3	3	**Date closed**	
Score	16	12	12		

Controls & Mitigating Actions	Staff are knowledgeable about the Stress Management policy & Dignity at Work: Bullying & Harassment policy. We have a H&B helpline that staff can use supplemented by access to the Staff Support and mediation service. Support is offered to managers on how to develop inter-personal skills through Leadership Development Programmes. Conflict resolution training is offered as part of induction. Regular contact with Staff side reps who raise issues on concern. Annual reports to the Organisational Risk Committee. The Friends and Family test for staff has been launched on a trial basis which will allow us to be aware of areas where there is an increase in pressure. Unconscious bias training for senior managers will be run for managers over the next 6 months.	**Assurance**	Divisional action plans are being revised in light of the 2013 staff survey results. The Listening into Action programme alongside work on the Trust's values will focus on action around harassment and bullying. December 2013: voluntary turnover rate has increased and is 11.1% (target 12%) and vacancy rate is 10.5% (target 11%). Listening into Action continues to be rolled out. Three high profile investigations on-going into allegations of bullying and harassment Report outlining further work to be undertaken presented to Executive Management Team and Overview and Scrutiny Committee in July 2014
Gaps in controls	None identified	**Gaps in assurance**	
Actions next period:	Action plans are being developed in response to 2014 staff survey results. The Listening into Action programme alongside work on the Trust's values will focus on action around harassment and bullying. Director of HR is developing an Embedding our Values programme for use across the organisation. A new set of poster on harassment and bullying will be publicised across the organisation to raise awareness		

Principal Risk	A520-04: Failure to maintain required levels of attendance at core mandatory and statutory training (MAST)				
Description	Loss of momentum caused by inability to release staff for training. Managers unable to ensure staff attending or undertaking eMast				
Domain	**5. Workforce**			**Strategic Objective**	**5.1 Develop a highly skilled & engaged workforce championing our values**
	Original	**Current**	**Updated**	**Exec Sponsor**	Wendy Brewer

			Nov 2014		
Consequence	4	2	3	**Date opened**	31/05/2010
Likelihood	3	1	4	**Date closed**	
Score	12	2	12		

Controls & Mitigating Actions	1. eMAST in place across the Trust. All managers are currently engaged in achieving compliance with target (all managers receive monthly reports on Core MAST take up and take action accordingly). New e-learning package being implemented and a new system for recording MAST will help ensure that all compliance activity is recorded. 2. eMAST training in place	**Assurance**	1. MAST policy Regular reports to ORC. Mandatory training rates to be reported on an individual subject basis in line with National Framework recommendations. 2. Fully compliant with CQC Outcome 14: Supporting Workers 3. Uptake of eMAST training reports presented to ORC. 4. A report regarding the transition to the national framework has been presented to the Workforce Committee. 5. New subjects have been added to the requirements, which has had an impact on overall numbers but provides assurance that all nationally recognised mandatory items are now included in St George's mandatory training.
Gaps in controls	Lack of capacity to deliver identified training – in particular face to face sessions e.g. Manual handling, Resus and Child safeguarding Level 3	**Gaps in assurance**	
Actions next period:	Implementation of new e-learning package and reporting systems. New systems fully functional although subject to some snagging problems. Work commencing to focus staff attention on individual subjects. Review of capacity to deliver versus training commenced ad to be completed New MAST Steering Group set up as task force to address continued risk to non- compliance with target		

Principal Risk	5.1-01 Failure to recruit and retain sufficient staff to manage turnover rates and support future increases in capacity				
Description	NHS Trusts in London have traditionally had high turnover rates for some staff groups (mainly nursing) and most recently this has been increasing at St. George's. We are also increasing capacity in the Trust, often to areas where we have identified staffing as hard to recruit to, and the combination of these factors has meant that supply has outstripped demand, resulting in a heavier reliance on temporary staff. We are reporting staffing fill of 90%~+ in Safe Staffing reports but the difficulties in staffing create pressures in terms of being able to deliver their services.				
Domain	**1.**			**Strategic Objective**	**1.1**
	Original	**Current**	**Updated Nov 2014**	**Exec Sponsor**	Wendy Brewer
Consequence	4	4	4	**Date opened**	1.9.14
Likelihood	3	3	3	**Date closed**	
Score	12	12	12		
Controls & Mitigating Actions	A monthly Workforce Report identifies staff in post, turnover and vacancy rates A monthly Safe Staffing report identifies the fill rate for shifts by substantive and temporary staff. Monthly nurse assessment days are held and where necessary additional days are held to deal with recruitment requirements. The corporate nursing team is identifying the cross Trust requirement for recruiting to nursing vacancies which will form part of a recruitment plan (domestic and overseas). Retention strategies are being developed to encourage staff to stay in the organisation. Exit questionnaires are sent to all leavers to complete. In some particular areas where particularly acute problems have been identified			**Assurance**	We have a proven track record of being able to recruit to normal turnover posts. Plans are already underway in some specialities to recruit to all their vacant and new posts.
Gaps in controls	Plans to recruit from overseas need to be finalised in the next few months if we are to recruit sufficient numbers of staff in time.			**Gaps in assurance**	
Actions next period:	Proposals around recruitment to be finalised by the DDNGs/Chief Nurse in September and October. Detailed action plan for next 12 months to be agreed.				

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	12	↓	after commencement of work on the 5th floor Lanesborough wing once Duke Elder ward and theatre space moves
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	→	
CW0073 & CW0072	Ineffective Temperature control on Delivery Suite during summer months affects women in labour and the unborn fetus.			Combined and reworded to cover the whole of Lanesborough Wing (CW0081)
CW0081	Temperature during the summer months in Lanesborough Wing	16	**New**	Combined risk as above
CW082	Manual Handling of deceased patients into Mortuary fridges	16	**New**	
CW084	Insufficient capacity in the mortuary resulting in closure of the mortuary	16	**New**	
	M&C		**Change**	
Risk Ref.	**Risk**	**Score**	**↑↓**	

MC30-D5	Risk to patient safety due to a lack of capacity to transfer patients to SGH for their cardiovascular procedures within 24hrs of referral. This risk may also impact on finances and business if it results in loss of referral pathway.	**15**	→	
MC31-D5	Risk to patient safety as patients waiting greater than 18 weeks on elective waiting list for cardiothoracic surgery.	**15**	→	
MC32-D1	The division is at risk of not delivering a balanced budget if robust CIP schemes are not found. Not all schemes identified in 13/14 have delivered and therefore knock on effect for schemes in 14/15.	**15**	→	
MC35-D1	Risk to patient and staff safety due to aggressive and violent behaviour of haemodialysis patient.	**15**	→	
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**	→	
MC55-D2	Financial – Volume. Lack of theatre capacity for cardiac surgery impacts on income	**20**	→	
MC57-D3	Fire risk in Knightsbridge Wing	**12**	↓	Control measures strengthened, bespoke fire training in place for all staff
MC58-D1	Patient safety risk arising from roll-out of electronic records	**16**	**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**	→	
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	**12**	↓	Improved position
C11	Failure to prescribe essential medication for patients having elective surgery	**16**	→	
C04	Financial risk – cost. Neurosciences, pharmacy and finance unable	**15**	→	

	to address under recording of high cost drugs of recharge to commissioners			
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**	
NEW tbc	Failure of OAE equipment leading to incompletion of OAE testing (objective hearing test) as equipment is extremely old	**16**	**New**	
NEW tbc	Incompletion of Aurical hearing aid fitting and tuning appointments due to programming equipment intermittently working in room	**16**	**New**	
NEW tbc	GPs in some regions (Surrey, Croydon) not prescribing Antiepileptic drugs (AEDs) recommend by consultant neurologists	**15**	**New**	
NEW tbc	Lack of trained fire wardens	**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**	→	
EF202	There is a risk of absconding patients getting onto the helipad as access is via a fire escape route	**16**	**NEW**	
	IM&T		**Change**	
Risk No.	**Risk**	**Score**	**↑↓**	
IT016	Reduction in capacity to deliver new infrastructure, systems and change programs	**16**	→	
IT018	Community staff experiencing access difficulties and slow response	**16**	→	

	to RIO			
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.	**12**	↓	Reduced likelihood from 5 to 4 due to on-going estates works
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**	**↑↓**	
CSW1023-COM-D5	Cost Improvement Programme not achieving target.	**16**	↑	Negative assurance from financial monthly meetings and budget reviews. (previously 12)

Appendix 5a – Divisional Self-Declaration against CQC outcomes Quarter 2 2014

Community Services

Compliance with CQC Essential Standards

CQC Essential Standard/ Outcome	Level of compliance (RAYG Rating)	Reasons for non-compliance where compliance is rated as Amber or Red &summary actions to address *<<report by exception only >>*
Outcome 1: Respecting and Involving People who use services		
Outcome 2: Consent to care and treatment		
Outcome 4: Care and Welfare of people who use services		OHC: EWS- no evidence of effective implementation as no audit completed. No evidence of holistic care plans for offender with co morbidities. HON leading on implementation.
Outcome 5: Meeting nutritional needs		
Outcome 6: Cooperating with other providers		
Outcome 7: Safeguarding people who use services from abuse		
Outcome 8: Cleanliness and infection control		OHC. Cleaning contract awarded to Sodexo . Staff waiting prison clearance to start. Cleaning of clinical area's being undertaken by healthcare staff in interim. Trust's Internal Auditors report provides positive assurance of outcomes of 'Contracted out cleaning contracts'. (Sept 14). On Risk register.
Outcome 9: Management of medicines		OHC: 52 med incidents reported in Q2 for CSD of which 24 coded to OHC none were moderate or above severity.
Outcome 10: Safety and suitability of premises		
Outcome 11: Safety, availability and suitability of equipment		
Outcome 12: Requirements relating to workers		
Outcome 13: Staffing		OHC, ICT (night) and Comm nursing –vacancy factor over 20%. Staff staffing monitoring in place and alerts reviewed. Bank and agency staff used to cover vacancies and 'fill factor' monitored. Active recruitment campaign commenced. Risks on risk register.
Outcome 14: Supporting workers		
Outcome 16: Assessing and monitoring quality of service provision		
Outcome 17: Complaints		18 new complaints in Q2. Closed in time 8 + 1 ext. Breached 4.Open 5. Trajectory– not achieved. Compared to other Divisions low number – but not achieving target. Action plan in place and gap closing.
Outcome 21: Records		

Divisions must confirm their compliance of all their services in relation to the CQC Essential standards. The information should be discussed and agreed by the Divisional Governance Board, where compliance will/will not be agreed.

Where Divisions are assessing themselves as either Amber (partial compliance) or Red (non-compliance) action plans should be in place for each Outcome assessed as Amber of Red. This action plan must detail the actions to be taken by the Divisions to ensure the next quarterly self-assessment reflects improved compliance with these outcomes.

Declaration 2

For one or more of the 16 outcomes the Division cannot make Declaration 1 and has provided relevant details upon the reason for non-compliance resulting in an Amber of Red rating. The Division confirms that all other outcomes have been met and sufficient plans are in place to ensure on-going compliance.

Discussed and agreed at the Divisional Integrated Performance and Governance Board on 3 Nov 2014

Divisional Chair

Paul Alford

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Divisional Director of Nursing & Governance

Alison Ludlam

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Appendix 5b – Divisional Self-Declaration against CQC outcomes Quarter 2 2014

Children, Women's, Diagnostic and Therapeutics

		Q2 (July/August/September) 2014/15 RAG Rating	
Outcome Number	**Outcome Title**	**Level of Compliance (RAG Rating)**	**Reasons for non-compliance where compliance is rated as Amber or Red &summary actions to address** *<<report by exception only >>*
1	Respecting and involving people who use services		Concerns remain in OPD, programme of works identified and progressing. Critical Care follow- up clinics. Improvements made to paediatric phlebotomy following feedback. Critical Care follow - up clinics now in place. FFT now being captured in OPD.
2	Consent to care and treatment		
4	Care and welfare of people who use services		On-going internal mock CQC inspections indicate general involvement of service users in care
5	Meeting nutritional needs		Some concerns raised regarding the quality the amount and the temperature of food across different areas. This is reflected in both the local CQC inspections and the corporate inspections
6	Cooperating with other providers		Critical care, NNU and Maternity involvement in associated networks
7	Safeguarding people who use services from abuse		Level 3 training currently stands at 55.19%, Level 2 stands at 86.19% and Level 1 is at 87.60%. 95% is the compliance target for all levels of training.
8	Cleanliness and infection control		Sporadic infections noted in paediatrics but no outbreaks. Several cases of CDT reported in CTICU, these are not however of the same strain. Hand hygiene compliance challenged in some areas
9	Management of medicines		Significant concerns raised and increase in medicine incidents following implantation of e- prescribing. 3 moderate harms as a result of medication errors in Q2, all in different areas of the division
10	Safety and suitability of premises		A number of issues from Q1 have been resolved such as the leak in lanesborough 5th floor theatres. However the following areas remain a concern: Lack of suitable side rooms in critical care, concerns regarding environment in OPD areas, leaking roof in Lanesborough level 5 offices, restricted space between cots in NNU
11	Safety, availability and suitability of equipment		No maintenance log of equipment No replacement strategy for equipment
12	Requirements related to workers		Appraisal rate for the division stands at 80.97% for non - medical appraisal at September 2014, this is an improvement from Q1. 83.46 6% medical appraisal September 2014, which is slight reduction on the previous quarter.
13	Staffing		Concerns regarding staffing levels in paediatrics and NNU continued during this period. 5 safe staffing alerts noted all within paediatrics. Position starting to improve in September 2014 with new recruits starting.
14	Supporting workers		Appraisal rate for the division stands at 80.97% for non - medical appraisal at September 2014, this is an improvement

			from Q1. 83.46 6% medical appraisal September 2014, which is slight reduction on the previous quarter.
16	Assessing and monitoring the quality of service provision		Internal mock CQC inspections in place, providing good feedback regarding services.
17	Complaints		Increased volume of complaints in COS – however significant action taken to address issues relating the CBS service. Numbers starting to decline towards latter part of Q2. Overall slight improvement of approximately 11% against targets for Q2.
21	Records		Increased compliance in regard to documentation audit across the divisions and improved availability of notes to clinics.

Summary

The division is reporting compliance against several of the CQC standards as listed. A number of areas, such as outcomes 17 – complaints and outcome 21 – records have improved in Q2. However there has been deterioration in outcome 9 – management of medicines; this relates primarily to the introduction of e - prescribing and some of the challenges associated with this.

Staffing within paediatric nursing remains a concern and has resulted in some bed closures in order to maintain safety; it is anticipated that these beds will start to open incrementally in Q3 with additional new starters commencing employment. As part of the establishment review the division has prioritised paediatrics for the additional available resource. Paediatrics is also to follow the Critical Care model and second a dedicated recruitment nurse to try and improve both recruitment and retention across the directorate.

The division has improved by 11% for both the required 85% target response rate of 25 days and 100% for extensions for complaints. New processes have been implemented in Women's and COS which will assist in improving performance. It is recognised that the division did not achieve the targets as indicated at the end of Q2, but is committed to continual improvement and aims to achieve full compliance by the end of Q4.

The division continues to work with the estates department to improve the environment and support expansion plans across the division.

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

Divisions must confirm their compliance of all their services in relation to the CQC Essential standards. The information should be discussed and agreed by the Divisional Governance Board, where compliance will/will not be agreed.

Where Divisions are assessing themselves as either Amber (partial compliance) or Red (non-compliance) action plans should be in place for each Outcome assessed as Amber of Red. This action plan must detail the actions to be taken by the Divisions to ensure the next quarterly self-assessment reflects improved compliance with these outcomes.

Declaration 2

For one or more of the 16 outcomes the Division cannot make Declaration 1 and has provided relevant details upon the reason for non-compliance resulting in an Amber of Red rating. The Division confirms that all other outcomes have been met and sufficient plans are in place to ensure on-going compliance.

Discussed and agreed at the Divisional Governance Board on date (please state) _____

Divisional Chair/Divisional Director of Nursing & Governance:

Andy Rhodes Jo Haworth

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Appendix 5c – Divisional Self-Declaration against CQC outcomes Quarter 2 2014

Medicine and Cardiovascular

		Q2 (Jul/Aug/Sept) 2014/15 RAG Rating	
Outcome Number	**Outcome Title**	**RAG Rating**	**Issues/Action/Comment**
1	Respecting and involving people who use services	Green	
2	Consent to care and treatment	Green	
4	Care and welfare of people who use services	Green	
5	Meeting nutritional needs	Green	
6	Cooperating with other providers	Green	
7	Safeguarding people who use services from abuse	Green	
8	Cleanliness and infection control	Amber	0 MRSA bacteraemia. , 6 C-diff (4 in last Q), higher than average SSIs in cardiothoracics. **Actions**: Improved compliance with antibiotic stewardship – to continue. DC / DDO attending SSI task group to strengthen leadership & help achieve objectives. Nursing continue to ensure staff attended ICT related training. Role out of ANTT at end of year.
9	Management of medicines	Green	
10	Safety and suitability of premises	Yellow	**THDCU** – actions taken to improve the environment within current physical constraints. BC written to increase day care capacity and improve patient environment. **Knightsbridge wing** – work continues to address identified fire risks. Steering group progressing well with plans for new renal unit.
11	Safety, availability and suitability of equipment	Green	
12	Requirements related to workers	Yellow	Above target in medical & non medical IPRs at 87%. Further work required to ensure all staff have completed MAST. Overall 68% compliant.
13	Staffing	Yellow	Establishment review shows requirement for 2.5million investment. Funding in budgets for 36 of 75wte needed. Patient safety protected by use of B&A. Only 1 safe staffing alert in Q2. Divisional sickness – Sept 2.94% Turnover – 16.8% Vacancy - 10.7%
14	Supporting workers	Green	Division actively addressing issues such as bullying and managing individual cases to improve the working environment for staff. Good attendance at "Unconscious bias" training for managers and senior clinicians.
16	Assessing and monitoring the quality of service provision	Green	
17	Complaints	Yellow	Data for Q2 so far shows 66% responded to in 25 days and 87% within agreed timescales. Trajectory set for achieving compliance by end of Q4. Need for tighter management and less reliance on extensions. Total number of complaints received has decreased.
21	Records	Yellow	Q2 has seen renal and CVT move to electronic records. Some concerns raised and

			escalated regarding accessing records by staff in areas not yet gone live. Actions in place. Small element of risk still exists around immediate availability of ED cards. Scanning process now in place that ensures all records are scanned real time. Backlog of records have been sent off site and will be scanned and available within the week. System in place to ensure no backlog of greater than 10 days.

Summary
Assessment of compliance against the CQC outcomes has been reached by reviewing various forms of evidence and triangulating the information to provide a RAG rating. The sources of information has included quality inspections, directorates assessing each other's clinical areas, audit results, complaints, professional judgement and other forms of feedback. The division is compliant in 10 outcomes, mostly meets the standards in 5 outcomes and has further work to do to become compliant in 1 of the outcomes. Progress against actions is reviewed in business meetings and at DMB and DGB.

Divisions must confirm their compliance of all their services in relation to the CQC Essential standards. The information should be discussed and agreed by the Divisional Governance Board, where compliance will/will not be agreed.

Where Divisions are assessing themselves as either Amber (partial compliance) or Red (non-compliance) action plans should be in place for each Outcome assessed as Amber of Red. This action plan must detail the actions to be taken by the Divisions to ensure the next quarterly self-assessment reflects improved compliance with these outcomes.

Declaration 2

For one or more of the 16 outcomes the Division cannot make Declaration 1 and has provided relevant details upon the reason for non-compliance resulting in an Amber of Red rating. The Division confirms that all other outcomes have been met and sufficient plans are in place to ensure on-going compliance.

Discussed and agreed at the Divisional Governance Board on date (please state) _____

Divisional Chair/Divisional Director of Nursing & Governance:

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Signed Alison Hughes DDNG Date: 11th November 2014

Eric Chemla DC

Fiona Ashworth DDO

Appendix 5d – Divisional Self-Declaration against CQC outcomes Quarter 2 2014

Surgery, Theatres, Neurosciences and Cancer

Division of Surgery, Theatres, Neurosciences & Cancer		Q2 (July/August/Sept) 2014/15 RAG Rating	
Outcome Number	**Outcome Title**	**Level of Compliance (RAG Rating)**	**Reasons for non-compliance where compliance is rated as Amber or Red &summary actions to address** *<<report by exception only >>*
1	Respecting and involving people who use services	Y	Pt information leaflets/discussions re procedures/risk, In patient & cancer survey results/ CNS availability
2	Consent to care and treatment	A	Compliance with consent policy/audit results/ WHO- neurosurgery, DSU & AET/ Associated SI's/MCA awareness at QMH & records of training generally
4	Care and welfare of people who use services	Y	Improve AI/SI/Complaint learning and feedback/Theatre capacity and recovery backlogs/documentation and use of care plans could improve/ dissemination of pt info leaflets
5	Meeting nutritional needs	Y	MUST assessment/weight/inconsistent care/documentation/associated complaints/intentional rounding
6	Cooperating with other providers	Y	Discharge planning/patient involvement/discharge summary quality, completion of and associated impact
7	Safeguarding people who use services from abuse	Y	Staff knowledge of MCA/safeguarding
8	Cleanliness and infection control	Y	Hand hygiene consistency/uniform policy adherence/use of green tape/dusty equipment/CDT/MRSA
9	Management of medicines	A	Timely prescribing of drug charts/safe storage/legibility of drug charts/antibiotic stewardship
10	Safety and suitability of premises	A	SSD plant/theatre environment/ventilation/chillers DSU/lift DSU/availability of fire wardens
11	Safety, availability and suitability of equipment	Y	Surgical instrument availability & age/nasendoscopes-decon process/bariatric equipment/mattress & cot side availability
12	Requirements related to workers	G	
13	Staffing	Y	Nursing scorecard being developed/Robust PDP's required/safe staffing process in place/vacancy factor risks identified
14	Supporting workers	Y	Overall IPR rate
16	Assessing and monitoring the quality of service provision	Corporate risk	
17	Complaints	Y	Significant improvements/ on-going work on volumes, performance and shared learning
21	Records	A	Missing notes/general quality of records/legibility/audit results/ICP completion

Summary
Quarterly CQC assessments take place within the division in all clinical areas- cross directorate audit is carried out to improve objectivity

Each directorate then self-assesses against the 16 outcomes and develops an associated action plan.

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

Divisions must confirm their compliance of all their services in relation to the CQC Essential standards. The information should be discussed and agreed by the Divisional Governance Board, where compliance will/will not be agreed.

Where Divisions are assessing themselves as either Amber (partial compliance) or Red (non-compliance) action plans should be in place for each Outcome assessed as Amber of Red. This action plan must detail the actions to be taken by the Divisions to ensure the next quarterly self-assessment reflects improved compliance with these outcomes.

Declaration 2

For one or more of the 16 outcomes the Division cannot make Declaration 1 and has provided relevant details upon the reason for non-compliance resulting in an Amber of Red rating. The Division confirms that all other outcomes have been met and sufficient plans are in place to ensure on-going compliance.

Discussed and agreed at the Divisional Governance Board on date (please state) _____

Divisional Chair/Divisional Director of Nursing & Governance:

Andrew Fleming Helene Anderson

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