BAF Risk 1 is at draft stage – it is being reviewed with the Assistant Director of Operations

<table>
<tr><td>RISK I.D</td><td>1</td><td>Executive Lead</td><td>Managing Director</td><td>Risk Manager</td><td>Assistant Director of Operations</td></tr>
<tr><td>CQC Reference(s)</td><td colspan="5">Regulation 12 Safe care and treatment, Regulation 17 Good governance</td></tr>
<tr><td>Risk Title</td><td colspan="5">Failure to provide adequate patient safety , quality of care and patient experience due to capacity, demand and external agency stakeholder engagement</td></tr>
<tr><td>Risk Description</td><td colspan="5">A failure to manage patient flow and capacity, to develop new pathways and a lack of delivery from external partners may lead to poor patient outcomes; increased patient harm; poor patient experience; and poor staff morale.</td></tr>
<tr><td>Strategic Objective</td><td colspan="2">Excellent patient outcomes
Excellent patient experience</td><td>Risk Domains</td><td colspan="2">Safe; Effective; Caring; Responsive; Well Led</td></tr>
<tr><td>Date Identified</td><td>15/05/2017</td><td>Date Last Reviewed</td><td>CGG 13/07/2017
QAC 16/08/2017
Board 02/05/2017</td><td>Target Date</td><td>31/03/2018</td></tr>
</table>

<table>
<tr><td colspan="3">Risk Rating (Likelihood x Impact)</td><td>Relevant Key Performance Indicators</td></tr>
<tr><td>Initial Risk Score</td><td>20 (4x5)</td><td rowspan="5">Risk score — Target
25, 20, 15, 10, 5, 0
Jun-17, Jul-17, Aug-17, Sep-17</td><td rowspan="5">ED 4 hour
RTT
Cancer 62 day
Ambulance waiting times
Cancelled electives
Delayed discharges</td></tr>
<tr><td>Current Risk Score</td><td>20 (4x5)</td></tr>
<tr><td>Target Risk Score</td><td>15 (3x5)</td></tr>
<tr><td>Risk Appetite</td><td></td></tr>
<tr><td>Direction of travel</td><td>↔</td></tr>
</table>

Controls: (What are we currently doing to reduce the impact or likelihood of the risk occurring?)	**Gaps in Controls:**
1. A&E Delivery Board chaired by the Acute Managing Director with senior director engagement from the external bodies	1. Successful introduction of outsourcing
2. System escalation calls, standard and critical	2. None
3. CCG QIPP scheme focused on reducing demand	3. None
4. Ambulance tripartite document for the management of ambulance delays	4. None
5. Critical incident SOP for attending clinicians	5. None
6. Individual risk assessments undertaken for cancelled surgery	6. None
7. Risk assessments for direct admissions	7. None
8. ‘Buddy’ ward system	8. None

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9. Introduction of 'Red to Green' days and 'SAFER' 10. Outsourcing agreement re ophthalmology 11. Full capacity protocol 12. Five bed meetings daily 13. Safe at Southend meetings 14. Monitoring of staffing levels 15. Monitoring of the medical rota	9. None 10. None 11. None 12. None 13. None 14. Sufficient workforce recruitment gaps and impact assessments 15. Overview of actual workforce in relation to workforce, maternity leave and long term sickness Impact assessment of junior doctor contracts

Mitigating Actions: (What more do we need to do to fill the gaps)	Lead	Target Date
1. E-rostering for medical staff	E-rostering manager	30/12/2017
2. Review of the actual workforce	Head of HR	TBC
3. RTT Backlog clearance programme with the CCG and NHSI	Dept. Head of Operation	31/03/2018
4. Cancer pathways review	Dept. Head of Operation	TBC

Assurances: (How will we know that what we are doing is having an impact?)

Positive Assurances: (evidence that shows the controls are effective (for example metrics, inspections etc))	Negative Assurances: (evidence we won't find if the controls are effective (for example incidents, complaints etc))
Achievement of KPIs	Regulator or commissioners action

Related Risks

Risk Ref:	Description	Score
2455	The Trust not meeting the 62 day cancer treatment target	**20**
2450	Failure to meet the Trust 4hr ED standard due to bed capacity and increased activity	**16**
2744	Failure to ensure capacity alignment may lead to patient harm	**16**
2822	Patients may suffer harm as a result of capacity issues in the Ophthalmology service	**16**
2655	Diabetes and Endocrinology Backlog for follow-up patients	**16**
2581	Risk to patient safety due to temporary opening of extra	**12**

Risks scoring <4 | Risks scoring 4-6 | Risks scoring 8-12 | Risks scoring 15+

	Jun-17	Jul-17	Aug-17	Sep-17
Risks scoring 15+	9	5		
Risks scoring 8-12	9	8		
Risks scoring 4-6	3	6		
Risks scoring <4	0	0		

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	beds to increase capacity due to emergency admission demand		
2656	Cardiology and Respiratory Backlog for follow-up appointments	**12**	
2617	Patients planned for orthopaedic surgery on escalating waiting list breaching the 18weeks	**12**	
1837	Critical Care at maximum capacity impacting on admission, discharges, elective surgery income, waiting time & patient experience	**9**	
2712	Routine Gynaecology operations cancelled may lead to patient harm	**9**	
2821	Risk to patient safety due to lack of pre-assessment capacity	**9**	
2694	Inappropriate two week wait cancer referrals (Gynae)	**8**	
2120	Lack of theatre availability for gynaecological brachytherapy patients	**8**	
26	Risk to exacerbation of patients health due to non-clinical cancellation/delays to patients	**6**	
2726	Activation of the full capacity protocol may result in reduced quality of care and experience	**6**	
2153	Delay to Head and Neck and upper GI Cancer Pathway	**6**	
2292	Chemotherapy Capacity- Inability to meet the demand for chemotherapy in CTU; causing patient access delay.	**6**	
2147	Bed pressures impact on Surgical Directorate and lead to cancellation of Elective Admissions	**4**	
2156	Risk of harm to patients when Referral to Treatment (RTT) waits going on longer than 52 weeks.	4	

Risk Review Comments:	
08/08/2017	RTT: Backlog clearance programme with the CCG and NHSI under development to implement and deliver an action plan. Cancer: Pathways are being reviewed, structured and disciplined PPL in place to ensure patients are being treated against national standards. Capacity and demand work in progress

RISK I.D	2	Executive Lead	Yvonne Blucher	Risk Manager	Michael Catling

CQC Reference(s)	Regulation 12 Safe care and treatment, Regulation 17 Good governance
Risk Title	**Failure to meet constitutional and national performance targets**
Risk Description	A failure to meet constitutional and national performance targets, e.g. ED waiting times, Cancer referrals and Referral To Treatment (RTT), may lead to sub-optimal patient care and experience; a negative impact on quality indicators; financial penalties due to regulatory action being taken against the Trust; and reputational damage.

Strategic Objective	Excellent patient outcomes Excellent patient experience Financial and operational sustainability	**Risk Domains**	Regulatory / Legal

Date Identified	15/05/2017	**Date Last Reviewed**	CGG 13/07/2017 Audit Committee 26/07/2017 Board 02/05/2017	**Target Date**	31/03/2018

Risk Rating (Likelihood x Impact)	
Initial Risk Score	25
Current Risk Score	25
Target Risk Score	12
Risk Appetite	
Direction of travel	

Risk score — Target

25, 20, 15, 10, 5, 0

Jun-17, Jul-17, Aug-17, Sep-17

Relevant Key Performance Indicators
ED 4 hour
RTT
Cancer 62 day

Controls: (What are we currently doing to reduce the impact or likelihood of the risk occurring?)	**Gaps in Controls:**
1. Cancer Board	1. Lack of planned elective care pathway
2. ESR Cancer Director to manage the process and patient flow	2. No gaps
3. Live cancer patient tracking	3. Lack of HDU
4. Urgent Care Board	4. Clinical Decisions Unit
5. Theatre Utilisation Board	5. Lack of shared database across ESR sites to prevent late referrals
6. ED Operational Improvement Group – ECIP recommended weekly PTL reviews for cancer and RTT	6. RTT / Cancer Standards dependent on capacity at sub speciality level.
7. Live ED breech tracking reviewed at the bed meetings	7. Greater focus on capacity at stages of treatment at speciality

8. Trust/Clinical Directorate level Balance scorecards and performance management with framework with monthly Clinical Directorate performance meetings 9. Fortnightly Exec / CD meeting and weekly AD meetings 10. Live dashboard that provides up to date information for the 3 key standards	level to improve efficiency / utilisation. 8. Focus on interactions with other providers to ensure timely referral pathways

Mitigating Actions: (What more do we need to do to fill the gaps)	Lead	Target Date
1. Opening of High Dependence Unit	TBC	31/12/2017
2. Access to the Somerset cancer database	Director of Cancer	31/12/2017
3. Opening of Clinical Decisions Unit	TBC	31/12/2017

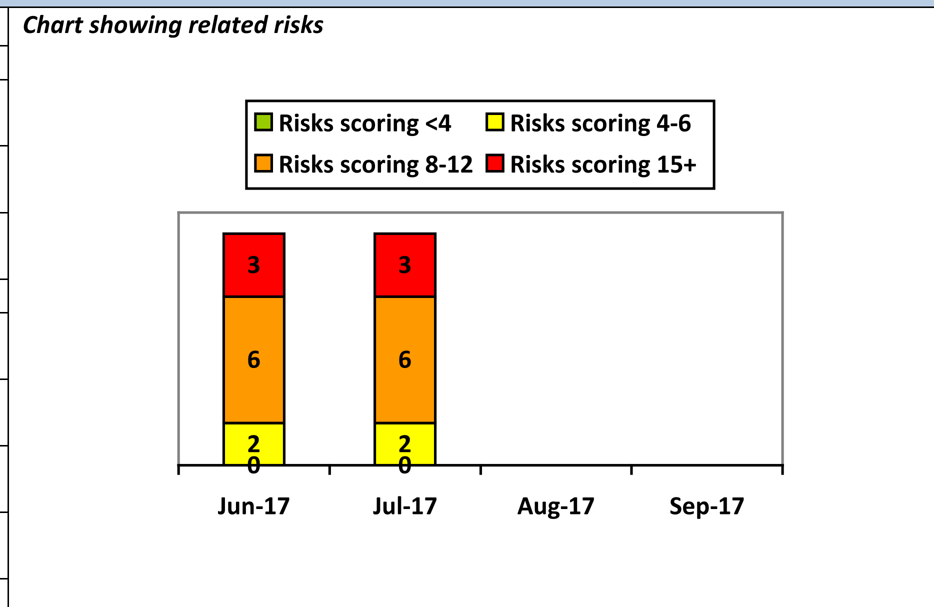
Assurances: (How will we know that what we are doing is having an impact?)

Positive Assurances: (evidence that shows the controls are effective (for example metrics, inspections etc))	Negative Assurances: (evidence we won't find if the controls are effective (for example incidents, complaints etc))
• *IST review and recommendations* • *Positive internal audits*	Regulator and commissioners notice

Related Risks

Risk Ref:	Description	Score
2455	The Trust not meeting the 62 day cancer treatment target	20
2152	The trusts failure to meet 18 week access target risking financial penalties	20
2450	Failure to meet the Trust 4hr ED standard due to bed capacity and increased activity	16
2151	Medical staffing issues could affect the Trust not meeting the 62 day cancer target	12
2655	Diabetes and Endocrinology Backlog for follow-up patients	12
1803	Failure to stay within DoH ceiling for C.Difficile- ceiling of 30 may lead to reputational damage and financial penalties	12
1823	Failure to stay within Department of Health targets for MRSA Bacteraemia	12
2715	Failure to meet 52 week target for interventional radiology procedures in Urology	12
2673	Failure to investigate serious incidents in a timely manner may lead to delayed learning and patient harm	9
2690	RTT admitted backlog	6

Chart showing related risks



2156	Risk of harm to patients when Referral to Treatment (RTT) waits going on longer than 52 weeks.	4	
Risk Review Comments:			

RISK I.D	3	Executive Lead	Adrian Buggle	Risk Manager	Marie Miller
CQC Reference(s)					
Risk Title	Trust not being financially sustainable				
Risk Description	A failure to maintain financial sustainability may result in external action being taken; damage to the Trust's reputation and the Trust's continuing abilities to function; and the imposition of regulatory controls leading to the loss of local control.				
Strategic Objective	Financial and operational sustainability	Risk Domains			
Date Identified	15/05/2017	Date Last Reviewed	CGG 13/07/2017 FRC 5/07/2017 Board 2/05/17	Target Date	31/03/2018

Risk Rating (Likelihood x Impact)			Relevant Key Performance Indicators
Initial Risk Score	25 (5 x 5)	(chart)	• Performance against the Income & Expenditure plan including the likely year-end forecast • A cost-improvement programme that is fully identified and is delivering savings according to the plan • The cash plan being on track and the value and timing of external borrowings being in accordance with the agreed plan. • Performance against the capital programme including the year-end forecast • Satisfactory audit reports on issues of value for money or efficiency
Current Risk Score	20 (4 x 5)		
Target Risk Score	15 (3 x 5)		
Risk Appetite	Level 2 'Cautious'		
Direction of travel	⟺		

Controls: (What are we currently doing to reduce the impact or likelihood of the risk occurring?)	Gaps in Controls:
1. (2287) The agreement of budgets which balance within the Control Total and the management of these at the directorate performance reviews. This also includes the development of the Financial Improvement Plan supported by a Turnaround Director and PMO. This work is overseen by the Site Leadership Team and the Efficiency Sub-Committee.	1a. Unindentified cost improvement balance of £0.1m 1b. Although the Trust has already contributed towards the running costs of the JEG and the project teams involved with developing the reconfiguration plans, there is still uncertainty and a possibility that the three acute Trusts will be required to contribute more.
2. Monthly reporting of financial performance at Board level & scrutiny at quarterly Finance & Resources Committee.	None
3. The Site Leadership Team undertakes a weekly review of financial issues and significant business cases followed by a monthly review of the directorate's financial performance	3. Cost-improvements (which were approved in the annual plan) have slipped by £0.2m for the period ending May 2017

4. Minor business cases and requests to change staffing establishments are brought to the Vacancy & Revenue Panel on a weekly basis.	None
5. Weekly cash forecasts and close monitoring of creditors and debtors with rapid escalation of difficulties where debts are not being settled.	None
6. (2003) Close management of investment / capital bids and regular review of the capital programme by the Investment Approval Committee which meets monthly. Alternative funding sources are reviewed including the use of charitable monies and the sale of property where appropriate.	None
7. Exploration of all funding sources including leases and loans	None
8. The Trust has assessed the need for further cash support in 2017/18 and has arranged an uncommitted revenue support loan to address this.	None
9. (1458) To ensure the accuracy and integrity of clinical coding, staff are provided with mandatory foundation Course (for trainees) and two year refresher courses (for qualified coders). Annual mandatory audit is carried out by an external clinical coding audit company and the internal use of a software auditing tool (3M Integrity Plus) helps ensure accuracy.	None
10. (2621) To ensure full reimbursement by the Commissioner for activity, detailed planning and discussion with directorates takes place in order to have a thorough understanding of the expected activity levels for the next year. There is effective negotiation with the Commissioners and robust challenge of any disinvestment plans that they may want to incorporate into the block contract. Accurate and timely monitoring of actual performance against the plan in order that adverse variances are identified and remedial action can be taken swiftly.	None
11. (2620) Where Trust staff are providing dedicated support to the Success Regime, a clear agreement of reimbursement is obtained along with timescales and if necessary roles are backfilled.	None

Mitigating Actions: (What more do we need to do to fill the gaps)	**Lead**	**Target Date**
1a. Further schemes to meet the remaining £0.1m balance are being developed and the gap is expected to be met by Month 04.	AB	July 2017
1b. The Trust will monitor events closely and quickly identify any potential for the costs of ESR to grow.	AB	Ongoing
3. The Trust is reviewing the cost improvements that have slipped and a reassessment of these will be made.	AB	July 2017

Assurances: (How will we know that what we are doing is having an impact?)	
Positive Assurances: (evidence that shows the controls are effective (for example metrics, inspections etc))	**Negative Assurances: (evidence we won't find if the controls are effective (for example incidents, complaints etc))**
1. Site Leadership Team agenda and minutes, efficiency sub-committee action log, the Lord Carter review of 2014/15 shows the Trust to be in the lower range of costs for acute providers.	1. The regular meetings with NHSI have not highlighted any significant specific action that the Trust is not already taking.
2. Board & FRC agenda and minutes, The Trust's financial position for 2016/17 achieved the plan	2. n/a
3. Directorate PRM action logs	3. n/a
4. The notes of the weekly Finance Management Group showing that the current cash position is being discussed. Case for Change document produced in conjunction with Grant Thornton.	4. n/a
5. Progress made in selling Fossets Farm and Board minutes.	5. Absence of late payment charges (from suppliers) during 2016/17
6. Investment Approval Committee and Revenues Approval Committee minutes / notes.	6. n/a
7. Agreement with leaseguard and the increase in the volume of leases as evidenced made by the payment made under the general ledger.	7. n/a
8. Agreement of the loan with NHSI. Compliance with the Section 42 conditions which are a requirement of the loan.	8. n/a
9. Training certificates and training records.	9. n/a
10. Budget sign-off documents by Clinical Directors, and Associate Directors and the Executives.	10. n/a
11. Existence of an agreed plan to cover the work in the absence of the individual concerned	11. n/a

Related Risks			
Risk Ref:	**Description**	**Score**	***Chart showing related risks***
2287	Trust fails to meet its financial targets. Closer scrutiny by Monitor and possible enforcement action	15	Risks scoring <4; Risks scoring 4-6
2003	In-year demands on the capital programme exceed the funding available	25	Jun-17: 3, 2
1458	Incorrect coding or delay in coding may lead to financial loss for the Trust	16	Jul-17: 3, 2
2621	The value of the block contract for clinical income may not be sufficient to reimburse the Trust for the costs of activity	12	Aug-17
2620	The implementation of the Success Regime disrupts the Trust's own financial plans	9	Sep-17

Risk Review Comments:	

RISK I.D	4	Executive Lead	Cathy O'Driscoll	Risk Manager	Sue Bridge
CQC Reference(s)	Regulation 5 – Fit and proper persons – Directors; Regulation 18 – Staffing; Regulation 19 – Fit and proper persons employed				
Risk Title	Inability to recruit and retain staff				
Risk Description	An inability to recruit and retain an appropriate workforce to meet the needs of the current and future patient base may lead to the Trust breaching licensing conditions; regulatory action being taken against the Trust; poorer patient outcomes and increased harm; and adverse publicity and/or reputational damage. Furthermore this may lead to the financial unsustainability of some services.				
Strategic Objective	1, 2, 3 & 4	Risk Domains	Human Resources/ OD/ Staffing Competence		
Date Identified	15/05/2017	Date Last Reviewed	CGG 13/07/2017 FRC 05/07/2017 Board 02/05/2017	Target Date	31/03/2018

Risk Rating (Likelihood x Impact)

Initial Risk Score	25
Current Risk Score	20
Target Risk Score	15
Risk Appetite	2
Direction of travel	⟷

Relevant Key Performance Indicators

KPI	Target	April 17	May 17	June 17
Qtr1 17/18				
Vacancy Rate	4%	12.72%	12.21%	
Vacancy Rate (nurses)	4%	15.59%	12.70%	
Vacancy Rate (consultants)	4%	11.21%	10.79%	
Agency (% of pay bill)	4%	9.31%	9.12%	
Turnover Rate	9.7%	12.55%	12.78%	
Appraisal	85%	65.78%	70.2%	

Controls: (What are we currently doing to reduce the impact or likelihood of the risk occurring?)	Gaps in Controls:
1. Key performance indicators for establishment, vacancies and turnover in place and reviewed by Directorates Boards and Executive Performance Boards monthly.	1. Vacancy rate needs to be further reconciled between HR, Finance and Directorates.
2. Speciality Review meetings held for specialities with highest vacancy/ agency spend.	2. Inability to attract to specialist positions e.g. Paediatrics and Respiratory
3. Recruitment Officer and Directorate Managers meetings to ensure recruitment plans are in place for every vacancy.	3. Not all vacancies are reflected on TRAC (therefore not recruited to). Delays in authorising and shortlisting candidates.

4. HR Organisational Development Strategy in place	4. Strategy not fully effective in addressing staff retention and recruiting hard to fill posts. Staff exit feedback indicates that staff are leaving due to work-life balance, relocation, promotion and training.
5. International and national recruitment campaigns are in place	5. Recruitment pipeline from overseas nursing is not delivering the expected numbers.
6. Directorate and corporate staff surveys and action plans in place	6. Action plans not delivering at pace needed to have significant impact on retention.
7. Corporate induction programme and on-boarding process in place	7. Inconsistency of local induction
8. Leaver/ exit interview process in place	8. Leaver process not linking to TRAC (does not initiate recruitment process)
9. Annual appraisal and PDP process in place for staff	9. Compliance rates 70% versus target of 85%
10. Safer Nursing Care Tool used to review nursing levels (2808)	10. No gaps identified
11. Trust bank staff in place to cover vacancies where possible (2451)	11. Bank unable to cover all vacancies, which impacts then on agency usage.
12. Dedicated medical and non-medical recruitment officers in place	12. Directorate difficulties using TRAC for medical staff due to administration support required
13. Daily staffing level and risk assessment by Matrons (70)	13. No gaps identified
14. Daily bed meetings and Safe@Southend meetings (70)	14. No gaps identified

Mitigating Actions: (What more do we need to do to fill the gaps)	**Lead**	**Target Date**
1. Production of business case to increase administration resources within Directorates to reconcile vacancy rates and maintain accurate staffing records on an on-going basis.	NB and JF	31st July 2017
2. Analyse workforce and service requirements for opportunities to adopt different workforce models.	JF and NB	On-going
3. Reconcile established vacancies with actions taken to recruit.	NB	31st July 2017
4. Develop retention initiatives and strategy in line with the National nursing retention campaign launched by NHSI and NHS employers.	SB and DT	31st July 2017
5. Reduce reliance on overseas nurse recruitment by using apprenticeship levy to up-skill HCA's to nurses.	SB and DT	On-going
6. See point 4 above		
7. Template induction plans and guidance in place for all staff groups.	DT, NR and EF	15th August 2017
8. Implement electronic leaver form, which notifies TRAC to initiate recruitment	NB	31st July 2017
9. Escalate via performance review meetings and continue to promote the benefits	SB and Site leads	On-going

<table>
<tr><td colspan="2">10. N/A
11. Increase the size of the bank pool, especially HCA and nurses via a review of the incentives for substantive to undertake dual work.
12. See above – action 1
13. N/A
14. N/A</td><td>NB and DT</td><td>31st July 2017</td></tr>
<tr><td colspan="4">Assurances: (How will we know that what we are doing is having an impact?)</td></tr>
<tr><td>Positive Assurances: (evidence that shows the controls are effective (for example metrics, inspections etc))</td><td colspan="3">Negative Assurances: (evidence we won’t find if the controls are effective (for example incidents, complaints etc))</td></tr>
<tr><td>1. Business case approval and Directorate administration posts recruited to. Establishment and vacancy rates are accurate and vacancy rate (KPI) reduces.
2. Speciality Review meeting minutes and actions, changes in posts in establishment (to reflect new posts), reduction in vacancy KPI. Exit interviews reflect ‘pull’ not ‘push’ factors.
3. Audit results demonstrate that all vacant post are being advertised on TRAC
4. Evidence of retention strategy in place, with monitored implementation plan, reduction in turnover KPI. Improved staff survey engagement results.
5. Trajectory for HCA apprenticeship training and recruitment in place and implementation plan monitored and tracked. Numbers of HCA’s trained and recruited meet the trajectories and nursing vacancy KPI reduction.
6. see point 4 above.
7. Evidence of template and guidance in place. Feedback from new starters through targeted survey and national staff survey indicate a positive experience/ score improvement. Improvement in retention of new starters measured through retention KPI.
8. Vacancy rate and TRAC timescales KPI improvement
9. Improvement in appraisal KPI, quality and ratios. Directorate PRM minutes/ actions
10. N/A
11. Increase in active bank numbers for HCA and nurses
12. See point 1 above</td><td colspan="3">1. Increase in recruitment timeline - TRAC KPI’s not met
2. Speciality action plans not delivering specific recruitment targets.
3. Recruitment not taking place for establishment vacancies, increase in recruitment timeline
4. Increasing turnover rates
5. Implementation plan not delivering HCA apprenticeship targets
6. See point 4 above
7. Directorates with no local induction guidance and templates and increasing turnover rates. Poor staff survey response rate.
8. Timescale from resignation to advertising on TRAC increases
9. Low appraisal numbers taking place
10. N/A
11. Increase in agency booking/ spend for HCA and nurses
12. Increase in recruitment timeline – TRAC KPI’s not met</td></tr>
</table>

13. N/A 14. N/A			13. N/A 14. N/A
Related Risks			
Risk Ref:	**Description**	**Score**	***Chart showing related risks***
2808	Staffing shortages may lead to compromised patient care or experience and failure to meet Safer Staffing requirements	20	
2451	Inability to recruit staff which will lead to a failure to meet expenditure targets.	20	
1949	Risk to patient safety due to shortage of medical staff across the Medicine Directorate	20	
70	Increased use of nursing agency staff with varying skills and experience	20	
2730	Implementation of the Success Regime may lead to poor staff engagement and morale	16	
2680	Incorrect diagnoses and treatment of patients due to Pathology First contract failings	12	
2462	Risk to patient safety due to medical staff vacancies at consultant and middle grade level	8	
2146	Compromise of patient care and safety due to staffing levels	8	
2205	Lack of paediatric junior medical staff	6	
Risk Review Comments:			

Risks scoring <4
Risks scoring 4-6
Risks scoring 8-12
Risks scoring 15+
5
3
1
5
3
1
Jun-17
Jul-17
Aug-17
Sep-17

RISK I.D	5	Executive Lead	John Henry	Risk Manager	John Henry
CQC Reference(s)	Premises and Equipment				
Risk Title	**Current and future estates, infrastructure and equipment does not comply with national specifications, meet service needs and/or service user needs**				
Risk Description	The ageing buildings, physical environment, associated infrastructure and inadequate backlog resources present a risk of services failing and impacting on the delivery of patient services. There is a risk of the Trust breaching its licensing conditions; regulatory action being taken against the Trust; poorer patient outcomes and/or patient harm; and adverse publicity and reputational damage.				
Strategic Objective	Excellent patient outcomes Excellent patient experience Engaged and Valued Staff Financial and Operational Sustainability	Risk Domains			

Date Identified	15/05/2017	Date Last Reviewed	CGG 13/07/2017 QAC 16/08/2017 Board 02/05/2017	Target Date	31 March 2018

Risk Rating (Likelihood x Impact)			Relevant Key Performance Indicators
Initial Risk Score	20	Risk score / Target 20, 15, 10, 5, 0 Jun-17, Jul-17, Aug-17, Sep-17	○ Cleaning performance Very High 98%, High 95%, Sig 85%, Low 75% ○ Catering performance Very High 98%, High 95%, Sig 85%, Low 75% ○ Laundry and linen quality target 97% ○ Telephony answer times P1 95% in 5s, GP 95% in 20s, Ext 95% in 40s, int 85% in 50s ○ EFM helpdesk answer times 95% in 50s ○ MEMS Turnaround 85%, Response 85%, PPM 78% ○ Estates Services (Response Time, PPM targets) P1 95%, P2 75%, P3 65%, P4 80%, P5 90%, PPM 75%, stat 100%
Current Risk Score	12		
Target Risk Score	9		
Risk Appetite	Level 2 'Cautious'		
Direction of travels	⟷		

Controls: (What are we currently doing to reduce the impact or likelihood of the risk occurring?)	Gaps in Controls:
1. All EFM Services policies and procedures linked to statutory requirements are in place.	Completion of PAM
2. EFM Training to ensure the workforce has the skills required to maintain the estate and to support the appointment of Authorised Persons and or Competent persons.	None
3. Hard Services – Statutory Compliance Processes Asset register, annual Planned	None

Preventative Maintenance (PPM) programme in place. Internal and external audit by Authorising Engineer (AE). Six Facet Condition Survey / Backlog Capital Programme / Incident reporting system.	
4. Soft Services – Cleaning Standards Standard operating procedures monitored by domestic supervisors Internal QA uses C4C to monitor cleaning standards for domestic and nursing staff.	None
5. Contract Monitoring	None
6. Business Continuity Plans	As yet incomplete.
7. All assets are risk assessed and managed via the capital replacement programme	Failure to secure all capital required for identified schemes
8. Medical Equipment – policy in accordance with MHRA guidance. ISO 9001 registered. Asset register, risk assessed PPM programme. Control over purchase and disposal of equipment. Evidenced user training programme. Equipment condition/fitness for purpose annually risk assessed for inclusion in capital programme. Equipment related incidents investigated.	None
9. (2672)Equipment has failed, additional scopes procured and washed through SSD	None
10. (2701) Upgrades phased through capital programme, works planned for 17/18	None
11. (2700) Regular cleaning regime undertaken as well as reactive maintenance. Equipment PPM's in place. Competent Management assigned to clinical roles. Temporary A/C units	No capital to complete works
12. (2702) Design development progressing. Phased programme drafted to avoid reduction in mortuary capacity during peak winter demand period. Capital expenditure required.	No capital to complete works
13. (2504) Survey carried out to identify location of Fire Dampers not linked into BMS and unable to be remotely tested. Phase 1 of works completed. Further works to complete all dampers to be carried out from Capital Funding 2017/18 within financial year.	None
14. (2485) Continued surveillance of the low temperature hot water system and tightening of teekay joints.	This is a temporary solution pending replacement of the system part.
15. (2477) Capital investment plan over two years, Phase 1 fire door replacement completed, Phase 2 fire door replacement currently underway.	None
16. (2445) Regular planned inspections.	Secondary transformer awaiting commissioning

Mitigating Actions: (What more do we need to do to fill the gaps)	**Lead**	**Target Date**
1. Estates and its related services are integral to the delivery of high quality, safe, effective and efficient clinical care. The 2016 NHS Premises Assurance Model (PAM) has been updated to reflect changes in policy, strategy, regulation, technology and supports the NHS Constitutional right:	JH	June 2017

'You have the right to be cared for in a clean, safe secure and suitable environment'. Summary Self-Assessment Question (SAQ) Domain Summary Update: • Hard & Soft Facilities Services: 66% Assurance reports complete and awaiting approval. Initial findings indicate good overall compliance with policy, maintenance, monitoring and review of systems in place. Some improvement identified regarding production and management of local risk assessment, allocation and training for appointed person/supervisor to comply with latest HTM guidance. Major resource allocations are associated with on-going capital improvement programme. • Patient Experience: Assessment complete: Overall good assurance compliance regarding Trust management arrangements in place for staff & patient: Engagement and involvement on estates and facilities services, perception of property condition, cleanliness and provision of adequate nutrition. • Efficiency: Assessment initiated requires input for finalisation and presentation for endorsement at Health and safety Committee • Effectiveness: Assessment complete: In summary shows good overall compliance with Estates arrangements in place regarding: Clear vision and strategy, well managed and robust approach to town planning, management of land and property and sustainable development • Governance: Assessment complete: Good overall compliance for Estates arrangements in place		
6. Business Continuity plans to be finalised.	JH	1 October 2017
7. Statutory high risk items and committed schemes approved, issues relating to non-funded items to be highlighted to investment and Approval Committee as they become apparent.	JH	1 April 2018
11. (2700) Capital funding to sought from 18/19 allocation.	JH	1 April 2018
12 (2702) Capital funding sought from Essex County Council	JH	1 July 2018
14 (2485) Legal action underway against designers and installers of the system	JH	1 April 2018
16 (2445) Commission transformer	JH	1 October 2017

Assurances: (How will we know that what we are doing is having an impact?)	
Positive Assurances: (evidence that shows the controls are effective (for example metrics, inspections etc))	**Negative Assurances: (evidence we won't find if the controls are effective (for example incidents, complaints etc))**
1. Policies updated within required timescales, annual audits to confirm implementation and action plans where required. Evidence available for HSE and CQC inspections. Premises Assurance Model completed with identified action plan.	Gaps in Premises assurance model outcomes
2. Training skills register demonstrates compliance	None

Authorised person appointed	
3. CAFM holds Asset register and annual programme of PPM, KPI audit reports submitted to the Trust Board. Estates Risk Assessed Capital Programme prioritises investment to remove high risk statutory items. Action plans available linked to incident reporting. Internet Access to Hard Services Tasks / response times and performance now available for staff / managers to monitor progress (4)	None
4. C4C Audit reports are sent to the services and action plans developed / implemented Repeat unannounced audits undertaken to ensure actions are completed KPI reports to QAC/ H+S and the Trust Board	Failures in cleaning standards identified up in CQC reports
5. KPI clearly identified in contract specification and reviewed at monitoring meetings	Limited assurance from QAC
6. Business Continuity plans are in place.	Failure to deal with significant incident or loss of utilities.
7. Risk assessed capital programme in place	Plant failure that has not been identified as end of life.
8. Monthly performance KPI's reported to board, Internal audit schedule, External (BSI) audit schedule, Quarterly medical devices safety report, Risk assessed capital programme	Major failure of equipment impacting patient care Instances of equipment impacting patient care being unavailable Incidents involving medical devices
9. Equipment is available to meet the requirements of the Endoscopy service.	Cancelled Endoscopy lists.
10. Full provision of Medical gas services	Failure of medical gas provision.
11. Positive CQC inspection reports	Requirement for improvement following CQC inspection.
12. Mortuary Service that is fit for purpose	Requirement to close mortuary due to regulatory requirement.
13. Fire spread managed and contained	Uncontained fire spread
14. Water leak that disables heating and hot water to the hospital	Cancelled theatre lists and ward closures.
15. Fire spread managed and contained	Uncontained fire spread
16. Power sustained to the hospital	Loss of power to the hospital

Related Risks

Risk Ref:	Description	Score	*Chart showing related risks*
2672	Risk of failure of the AER (automatic endoscopic reprocessor) machines	9	

2701	Medical Gases improvement works (Trust deferred capital improvements project)	12	Risks scoring <4 Risks scoring 4-6 Risks scoring 8-12 Risks scoring 15+ Jun-17: 8 Jul-17: 8 Aug-17 Sep-17
2700	CQC Planned works (Trust deferred Project) Drug room air conditioning Sanitary Ware replacement	12	
2702	Mortuary - Capital Improvement Project (deferred 2017/18)	9	
2504	Testing of fire & smoke dampers & ensuring fire stopping integrity (Trust deferred Capital improvement project)	12	
2485	Leakage/ failure risk - Failure to improve repair cold water mains pipework resulting from failed teekay joints.	8	
2477	Fire compartmentation review highlighted presence of fire doors that required replacement (Trust deferred Estates Project)	12	
2445	Failure to maintain integrity of electrical utilities to hospital areas fed from electrical sub-station 3	8	
Risk Review Comments:			
16/08/17	• Risk description has been altered slightly to align with strategic objective. KPI's need to be refined. • Environmental H&S audits are in place with associated action plans, trend analysis of tasks, completed by directorate are now being used to demonstrate actions are being closed, these have been introduced into Clinical Directorates performance reviews to agree actions to address the problem. • To enhance customer satisfaction and assurance reporting the use of intranet reporting on maintenance works has been introduced and is showing a month on month increase in usage. • Business continuity plans are in development with the Emergency Planning officer working with Basildon Hospital who have technical expertise in this subject matter. • Medical Equipment Management needs to ensure: assets are maintained in a timely fashion, replaced as and when the risk can no longer be managed and staff are trained to use the equipment as per manufacturer requirements. • The Premises Assurance model is being completed.		

RISK I.D	6	Executive Lead	Site Director of Finance	Risk Manager	Head of IT
CQC Reference(s)	Regulation 17 – Good Governance				
Risk Title	**Lack of robust IT infrastructures and digital defences against cyber security**				
Risk Description	Unable to deliver excellent patient outcomes and maintain financial and operation sustainability due to a failure to develop and embed a robust Clinical IT Strategy which may lead to inefficiencies financially and technically, causing further financial pressure on the Trust and the potential for patient harm. A failure to ensure appropriate investment in and application of digital defences to deter cyber-attacks may lead to patient harm; financial loss; and disruption and/or damage to the reputation of the Trust from the failure of information technology systems.				
Strategic Objective	Excellent Patient Outcomes, Excellent Patient Experience and financial and operational sustainability	Risk Domains	Infrastructure, technical, patient safety		
Date Identified	15/05/2017	Date Last Reviewed	CGG 13/07/2017 FRC 05/07/2017 Board 02/05/2017	Target Date	31/03/2018

Risk Rating (Likelihood x Impact)

Initial Risk Score	20 (4x5)
Current Risk Score	12 (3x4)
Target Risk Score	6 (3x2)
Risk Appetite	
Direction of travel	⟺

Risk score — Target

25
20
15
10
5
0
Jun-17 Jul-17 Aug-17 Sep-17

Relevant Key Performance Indicators

KPI	BTUH			SUHFT			MEHT			Target
Qtr117/18	A	M	J	A	M	J	A	M	J	
All relevant patches tested and implemented										
Unplanned downtime										

Controls: (What are we currently doing to reduce the impact or likelihood of the risk occurring?)	Gaps in Controls:
1. Datacentre has maintained power supply / UPS, air con is monitored via facilities BMS, fire detection system in place and suppression and water detection system (1609)	1. Don't currently have a resilient data centre room

2. Across 3 IT departments there is a cyber-security action plan in place which is reviewed on a weekly basis. 3. Limited scope on call service (2435)	2. No gaps identified 3. In-house resources do not support required hours 24/7, 365 days

Mitigating Actions: (What more do we need to do to fill the gaps)	**Lead**	**Target Date**
1. Second main network hub room at west end of site	**SLB**	**27/03/18**
2. Recruit dedicated cyber security officer across ESR	**AT**	

Assurances: (How will we know that what we are doing is having an impact?)	
Positive Assurances: (evidence that shows the controls are effective (for example metrics, inspections etc))	**Negative Assurances: (evidence we won't find if the controls are effective (for example incidents, complaints etc))**
Report on cyber threats and response to them Annual penetration test report and certificate	Unplanned downtime IT incidents

Related Risks			
Risk Ref:	**Description**	**Score**	***Chart showing related risks***
1609	Loss of Datacentre	15	
2669 – not yet approved	Lack of server operating system patching process	12	
2435	IT system support provision does not reflect criticality of system or hours of usage	12	
2719 – not yet approved	Antivirus support ending for windows XP and server 2003	8	
2425	Risk of disruption and / or damage to IT systems from cyber threats	8	
2727 – not yet approved	Risk of virus attacks against IT systems running old operating systems	8	

Risks scoring <4
Risks scoring 4-6
Risks scoring 8-12
Risks scoring 15+
Jun-17: 1, 5, 0
Jul-17: 1, 5, 0
Aug-17: 1, 5, 0
Sep-17

Risk Review Comments:	
22/08/17	**Risk reviewed and risk score maintained at 12 as actions remain unchanged. Controls and gaps reviewed to be more strategic in approach**

RISK I.D	7	Executive Lead	Medical Director	Risk Manager	AD Diagnostics and Therapies
CQC Reference(s)	Regulation 12 Safe care and treatment, Regulation 17 Good governance				
Risk Title	Failure to provide effective and reliable clinical support services				
Risk Description	A failure to provide excellent patient outcomes and achieve financial and operational stability through the lack of robust and reliable clinical support services, e.g. pathology and radiology, which may result in patient harm and reputational damage due to incorrect results, lack of services and significant delays.				
Strategic Objective	Excellent Patient Outcomes, Financial and Operational Sustainability	Risk Domains	Patient Safety, infrastructure, staffing		
Date Identified	15/05/2017	Date Last Reviewed	CGG 13/07/2017 QAC 16/08/2017 Board 02/05/2017	Target Date	31/03/2018

Risk Rating (Likelihood x Impact)

Initial Risk Score	25 (5x5)
Current Risk Score	16 (4x4)
Target Risk Score	6 (2x3)
Risk Appetite	
Direction of travel	⟺

Relevant Key Performance Indicators

	Jun17	Jul 17	Aug 17	Sept 17
Incidents	82	39		
SIs	0	1		
IRMER reports	0	1 (potential)		

Controls: (What are we currently doing to reduce the impact or likelihood of the risk occurring?)

1. Comprehensive maintenance contracts in place for radiology equipment
2. Concerns and issues raised to in-house facilities / estates team and escalated to senior management where appropriate
3. Recruitment strategy in place for AHPs / medical staff
4. Processes and software in place to ensure accurate radiology reports
5. Formal meetings / teleconferences / contract meetings occur with the senior managers of IPP and Trusts

Gaps in Controls:

1. Weekend cover not included
2. Timeliness of response / resolution
3. National shortage of these professions
4. Human error
5. Contract was due to be reviewed in December 2016 but did not take place. This is now due for December 2017. KPIS are not sufficient to monitor the current issues with incorrect pathology results and delays. Service is currently running on high number of locums and staff with limited

	experience

Mitigating Actions: (What more do we need to do to fill the gaps)	Lead	Target Date
2. E&F are building a case for a back-up chiller to address the issue of the scanner going down due to overheating	John Henry	30/09/17
4. Radiographers / Sonographers are currently being recruited	Darren Taylor	31/12/17
9. Case to be presented to Vacancy Control Panel for fixed term locum to cover the gaps	Darren Taylor	31/08/17

Assurances: (How will we know that what we are doing is having an impact?)

Positive Assurances: (evidence that shows the controls are effective (for example metrics, inspections etc))	Negative Assurances: (evidence we won't find if the controls are effective (for example incidents, complaints etc))
Vacancies will be filled KPIs will be achieved	Serious incidents Delays in turnaround times for pathology specimens and radiology reports IRMER reports Incorrect, inaccurate or missing pathology results Equipment breakdown / failure

Related Risks

Risk Ref:	Description	Score
2809	US room 2 overheating causing US scanner to shutdown resulting in loss of time on lists	12
2044	Effect on patient care due to failure of MRI equipment	12
2625	The potential for transcription error(s) in radiological reports	12
2512	Shortage of radiographers results in risk of harm to patients due to delay in diagnosis that is dependent in imaging	12
2423	Shortage of radiologists results in risk of harm to patients due to delay in diagnosis that is dependent on imaging	12
2357	Failure of radiology reports to cascade to other clinical systems	8
2680	Incorrect diagnoses and treatment of patients due to Pathology First contract failings	12

Chart showing related risks

2222	Lack of Histopathology Consultant could compromise turnaround times and lead to patient breaches	9	
2684	Delays in diagnosis or treatment due to reduced pathology service	8	
2698	Failure to recruit a substantive Consultant Microbiologist may have an impact on quality service delivery	8	
2835	Patients could be diagnosed or treated incorrectly due to inappropriate release of results from hub lab biochemistry	8	
2831	Patients incorrectly treated with B12 injection based upon false low B12 results	8	
2830	Potential failure to analyse all biochemistry assays in a timely manner due to moving samples to the Basildon ESL for calcium assays	5	
2825	Failure to provide test results on patients from labile samples	5	
2828	Reduced back up service for the hs troponin T assay	6	
2826	Patient care based upon results on ICE prior to clinical authorisation	6	
2834	Delay reporting of immunology results and potential patient treatment due to staff shortages in immunology department	8	
Risk Review Comments:			
08/08/17	The overall risk rating remains unchanged as the actions are still outstanding. The related risks have been updated; 3 risks have been removed from the risk register but an additional 7 new risks have been added. One risk (2809) has been reduced from 15 to 12. The level of incident reporting relating to pathology incidents has reduced in July 17.		

RISK I.D	8	Executive Lead	Managing Director	Risk Manager	Site DoN / Head of Governance
CQC Reference(s)	Regulation 18 – Staffing, Regulation 15 – premises and equipment, Regulation 17 – Good governance, Regulation 20 – Duty of candour				
Risk Title	Failing to meet CQC Health & Social Care regulations				
Risk Description	Failure to achieve Trust strategic objectives due to failing to consistently meet the requirements of the CQC Health & Social Care regulations or other national standards may lead to regulatory action being taken against the Trust, compromising patient care and reputational damage. The Trust currently has 5 requirement notices from the CQC relating to fundamental standards that are not being met				
Strategic Objective	Excellent patient outcomes, Excellent patient experience Engaged and valued staff, Financial and operational sustainability	Risk Domains	Regulatory / legal, reputation, patient safety, staffing		
Date Identified	15/05/2017	Date Last Reviewed	CGG 13/07/2017 QAC 16/08/2017 Board 02/05/2017	Target Date	31/03/2018

Risk Rating (Likelihood x Impact)

Initial Risk Score	25 (5 x 5)
Current Risk Score	15 (3 x 5)
Target Risk Score	5 (1 x5)
Risk Appetite	
Direction of travel	⟷

Risk score — Target

	Jun-17	Jul-17	Aug-17	Sep-17
Risk score	15	15		
Target	5	5	5	5

Relevant Key Performance Indicators

	Jun 17	Jul 17	Aug 17	Sept 17
Incidents	1041	1087		
SIs	9	16		
CQC – overdue actions	1	2		
Open requirement notices	5	5		
CQC rating	RI	RI		

Controls: (What are we currently doing to reduce the impact or likelihood of the risk occurring?)

1. Mock CQC inspections and quality visits are conducted to assess current compliance with HSC regulations. Action plans are developed in response to these inspections to address areas of concern or non-compliance.
2. Formal CQC action plan is reviewed weekly and updates provided to the site leadership team. Issues of concern are escalated via the quality and safety committee. Assurance is sought via clinical audit and CQC areas are included within the annual audit plan
3. CQC leads at Mid Essex, Basildon and Southend are now meeting regularly to review the approach to achieving and maintaining compliance with the HSC regulations. The group are

Gaps in Controls:

1. Mock CQC action plan is not always updated in a timely manner and some actions are overdue
2. Two actions are red on the formal CQC action plan
3. No gaps identified

focusing on the well led domain as a priority. 4. Peer reviews are carried out by various organisations on compliance to standards and regulations such as NHS Improvement and the Clinical Commission Group (CCG) via quality visits 5. A provider information request is now requested by the CQC annually which enable the Trust to review compliance against the Health and Social Care Act 2008 Regulations 2014	4. Recent NHSI and CCG reviews have identified concern with compliance against regulation 12 (2)h Safe care and treatment with regards to prevention and control of infection

Mitigating Actions: (What more do we need to do to fill the gaps)	**Lead**	**Target Date**
1. Undertake assessment of well led KLOEs to identify gaps	Tracy Turner	31/10/2017
2. Complete actions against requirement notices	Yvonne Blucher	31/10/2017
a. Approval of business case to redevelop mortuary	Dominic Hall	01/10/2016
b. Develop annexe and provide discreet access	Dominic Hall	28/10/2016
c. Resourcing of phase 2 pharmacist posts	Simon Worrall	31/10/2017
d. Review DNACPR forms following audit results	Resuscitation Lead	31/08/2017
e. Review systems to determine any further actions to meet verbal DoC	Sharon Murrell	31/08/2017
3. Close off must do action on CQC action plan – medication fridge temperature monitoring and record keeping – present findings to senior nurses and agree action	Yvonne Brierley	30/09/2017
4. Complete actions following NHSI infection prevention and control review	Denise Townsend	30/09/2017
5. Submit CQC provider information request	Tracy Turner	07/09/2017

Assurances: (How will we know that what we are doing is having an impact?)

Positive Assurances: (evidence that shows the controls are effective (for example metrics, inspections etc))	**Negative Assurances: (evidence we won't find if the controls are effective (for example incidents, complaints etc))**
1. Self- assessment reports against KLOE	1. Gaps in evidence required against KLOE
2. Provider information request returns	2. Gaps in available evidence required or out of date evidence
3. Mock CQC inspection reports and action plan reports	3. Overdue action plans
4. Formal CQC action plan reports and clinical audit reports	4. CQC requirement notices

Related Risks

Risk Ref:	**Description**	**Score**	***Chart showing related risks***
70	Increased use of nursing agency staff with varying skills and experience	20	
2359	Mortuary services ensure the deceased are managed with dignity and respect (capacity)	16	

2581	Risk to patient safety due to temporary opening of extra beds to increase capacity due to emergency admission demand	12
2365	Risk to patient safety due to nursing vacancies in the medical wards	16
2303	Clinical Pharmacy service to wards is under resourced	12
2700	E&F CQC planned works – trust deferred project	12
2702	Mortuary – capital improvement project deferred 2017/18	9
2366	Meeting the statutory duty of candour	9
2143	Serious security breach in mortuary	6
1499	Unauthorised use of mortuary service tunnel may lead to injury	6
336	Deviation from standard security procedures may lead to uncontrolled departure of child attending ED	4

Risks scoring <4
Risks scoring 4-6
Risks scoring 8-12
Risks scoring 15+

Jun-17: 0, 3, 3, 5
Jul-17: 0, 3, 5, 3
Aug-17
Sep-17

Risk Review Comments:	
04/08/17	Associated risks reviewed in line with new grading matrix. Risk score has reduced for risks 2518 (from 16 to 12) and 2303 (from 15 to 12), however the overall risk remains the same as there are 5 requirement notices still outstanding, unresolved actions on the CQC action plan and new guidance regarding the 'well led' domain has been published for which compliance has not yet been assessed.