Board of Directors' Meeting Report – 5 December 2017

Agenda item 100/17

Title	Board Assurance Framework – Quarterly review
Sponsoring Director	Yvonne Blucher, Managing Director
Author(s)	Brinda Sittapah, Company Secretary
Purpose	To provide a quarterly review of the Board Assurance Framework to the Board
Executive Summary The Board Assurance Framework (BAF) has been reviewed over the course of the last few months to improve consistency with the JWB BAF. The BAF is reviewed on a monthly basis at the Corporate Governance Group as part of the Site Leadership Team. The various Board Sub-Committees also review the BAF risks allocated to them by the Board at all their meetings. As per the BAF methodology the BAF should be reviewed by the Board on a 6 monthly basis, however it has been suggested by the JEG that the BAF be reviewed on a quarterly basis to be consistent with the JWB reporting. BAF Risks 1, 5, 7, 8 were reviewed by the Quality Assurance Committee on 18 October. BAF Risk 2 was reviewed by the Audit Committee on 25 October. BAF Risk 3, 4 & 6 were reviewed by the Finance and Resources Committee on 31 October.	
Related Trust Objective	Excellent Patient Outcomes Excellent Patient Experience Engaged and Valued Staff Financial and Operational Sustainability – Financial, Operational, Estate
Related Risk	All BAF Risks
Legal implications / regulatory requirements	The Board Assurance Framework is an important part of the Trust's internal control framework.
Quality impact assessment	There are no quality implications arising directly from this report.
Equality impact assessment	As far as can be ascertained this paper has no detrimental impact for the 9 protected characteristics under the Equality Act 2010.
Recommendations: The Board is asked to review and approve the BAF.	

<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 05/10/2017
QAC 18/10/2017
Board 05/09/2017</td><td>Target Date</td><td>31/03/2018</td></tr>
<tr><td colspan="3">Risk Rating (Likelihood x Impact)</td><td colspan="3">Relevant Key Performance Indicators</td></tr>
<tr><td>Initial Risk Score</td><td>20 (4x5)</td><td rowspan="5">Risk score — Target
30 / 20 / 10 / 0
Jun-17 Jul-17 Aug-17 Sep-17 Oct-17</td><td colspan="3" 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>
<tr><td colspan="3">Controls: (What are we currently doing to reduce the impact or likelihood of the risk occurring?)</td><td colspan="3">Gaps in Controls:</td></tr>
<tr><td colspan="3">1. A&E Delivery Board chaired by the Acute Managing Director with senior director engagement from the external bodies
2. System escalation calls, standard and critical
3. CCG QIPP scheme focused on reducing demand
4. Ambulance tripartite document for the management of ambulance delays
5. Critical incident SOP for attending clinicians
6. Individual risk assessments undertaken for cancelled surgery
7. Risk assessments for direct admissions
8. ‘Buddy’ ward system
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</td><td colspan="3">1. Successful introduction of outsourcing
2. None
3. None
4. None
5. None
6. None
7. None
8. None
9. None
10. None
11. None
12. None
13. None
14. Sufficient workforce recruitment gaps and impact assessments</td></tr>
</table>

15. Monitoring of the medical rota	15. Overview of actual workforce in relation to workforce, maternity leave and long term sickness Impact assessment of junior doctor contracts
16. Capacity plan for each directorate	16. None
17. Winter plan developed to increase capacity	17. Winter plan dependant on staffing

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
2854	Overarching risk: Failure to meet national performance targets for care and treatment may lead to patient harm resulting in reputational damage	20
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 beds to increase capacity due to emergency admission demand	12
2656	Cardiology and Respiratory Backlog for follow-up appointments	12
2617	Patients planned for orthopaedic surgery on escalating waiting list breaching the 18weeks	12

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

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

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
10/10/2017	Winter plan has been developed to increase capacity to support winter pressures. This will be monitored via the A&E Delivery Board and weekly by the Site Leadership Team. Cancer: trajectory for September has been achieved and SUHFT has achieved 85.3% for the first time, above trajectory

RISK I.D	2	Executive Lead	Yvonne Blucher	Risk Manager	Ranjini Beveridge
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	4	**Risk Domains**	Regulatory / Legal		

Date Identified	15/05/2017	**Date Last Reviewed**	CGG 15/05/2017 Audit Com 25/10/2017 Board 05/09/2017	**Target Date**	31/03/2018

Risk Rating (Likelihood x Impact)	
Initial Risk Score	25
Current Risk Score	25
Target Risk Score	15
Risk Appetite	
Direction of travel	⟷

Risk score — Target

25, 20, 15, 10, 5, 0

Jun-17, Jul-17, Aug-17, Sep-17, Oct-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 2. ESR Cancer Director to manage the process and patient flow 3. Live cancer patient tracking 4. Urgent Care Board 5. Theatre Utilisation Board 6. ED Operational Improvement Group – ECIP recommended weekly PTL reviews for cancer and RTT 7. Live ED breech tracking reviewed at the bed meetings 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	1. Lack of planned elective care pathway 2. N/A 3. Lack of HDU 4. Clinical Decisions Unit 5. Lack of shared database across ESR sites to prevent late referrals 6. RTT / Cancer Standards dependent on capacity at sub speciality level. 7. Greater focus on capacity at stages of treatment at speciality 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	Yvonne Blucher	31/12/2017
2. Access to the Somerset cancer database	Director of Cancer	31/12/2017
3. Opening of Clinical Decisions Unit	Yvonne Blucher	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
2156	Risk of harm to patients when Referral to Treatment (RTT) waits going on longer than 52 weeks.	4

Chart showing related risks

Risk Review Comments:

Southend University Hospital NHS
NHS Foundation Trust

RISK I.D	3	Executive Lead	Adrian Buggle	Risk Manager	Marie Miller
CQC Reference(s)	Regulation 9 – Person-centred care; Regulation 12 – Safe care & treatment; Regulation 17-Good governance				
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	4	**Risk Domains**	Financial, regulatory / legal, reputation		
Date Identified	15/05/2017	**Date Last Reviewed**	CGG 05/10/2017 FRC 31/10/17 Board 05/09/17	**Target Date**	31/03/2018

Risk Rating (Likelihood x Impact)

Initial Risk Score	25 (5 x 5)
Current Risk Score	20 (4 x 5)
Target Risk Score	15 (3 x 5)
Risk Appetite	Level 2 'Cautious'
Direction of travel	⟺

Risk score — Target

25
20
15
10
5
0

Jun-17 Jul-17 Aug-17 Sep-17 Oct-17

Relevant Key Performance Indicators

	2017/18				
	Q1	**Q2**	**Q3**	**Q4**	**Total**
Control Total *(deficit)/surplus*	(3.56)	(2.03)	(4.63)	(4.83)	**(15.05)**
Actual *(deficit)/surplus*	(3.56)	(2.01)			
Variance *(deficit)/(surplus)*	-	**0.02**			

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.	1. 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 September 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**
1. 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 further opportunities are being sought	AB	Ongoing

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. 2. Board & FRC agenda and minutes, The Trust's financial position for 2016/17 achieved the plan 3. Agenda and minutes from the Executive Business meeting and Directorate PRM action logs 4. Agenda and meeting notes from the Vacancy & Revenue Panel 5. 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. 6. Investment Approval Committee and Revenues Approval Committee minutes / notes. 7. Agreement with Leaseguard and the increase in the volume of leases as evidenced made by the payment made under the general ledger. 8. Agreement of the loan with NHSI. Compliance with the Section 42 conditions which are a requirement of the loan. 9. Training certificates and training records in addition to the outcome from clinical audits 10. The detailed planning and budget setting meetings that have taken place between clinicians, senior managers and external advisors to arrive at the agreed plan. 11. Detailed records of staff working between Trusts	1. The regular meetings with NHSI have not highlighted any significant specific action that the Trust is not already taking. 2. n/a 3. n/a 4. n/a 5. Absence of late payment charges (from suppliers) during 2016/17 and 2017/18 6. n/a 7. n/a 8. n/a 9. n/a 10. n/a 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; Risks scoring 8-12; Risks scoring 15+ Jun-17: 3 (15+), 2 (8-12) Jul-17: 3 (15+), 2 (8-12) Aug-17: 3 (15+), 2 (8-12) Sep-17: 3 (15+), 2 (8-12) Oct-17: 3 (15+), 2 (8-12)
2003	In-year demands on the capital programme exceed the funding available	25	
1458	Incorrect coding or delay in coding may lead to financial loss for the Trust	16	
2621	The value of the block contract for clinical income may not be sufficient to reimburse the Trust for the costs of activity	12	
2620	The implementation of the Success Regime disrupts the Trust's own financial plans	9	

Risk Review Comments:	
24/10/17	Risk Rating has been reviewed and the proposal is that the risk rating is maintained at 20. KPI figures added.

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 05/10/2017 FRC 31/10/2017 Board 05/09/2017	**Target Date**	13/03/2018

Risk Rating (Likelihood x Impact)

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

Risk score — Target

	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Risk score	20	20	20	20	20
Target	15	15	15	15	15

Relevant Key Performance Indicators

KPI	Target	July 17	August 17	Sept 17
Qtr2 17/18				
Vacancy Rate	7%	12.14%	12.63%	11.53%
Vacancy Rate (nurses)	7%	13.89%	13.78%	14.06%
Vacancy Rate (consultants)	7%	13.57%	13.57%	11.85%
Agency (% of pay bill)	10%	8.87%	10.6%	8.94%
Turnover Rate	9.5%	13.49%	13.24%	13.01%
Appraisal	90%	73.82%	76.94%	76.57%

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 rates now reconciled between HR, Finance and Directorates and on-going reviews taking place with PMO and Recruitment.
2. Speciality Review meetings held for specialities with highest vacancy/ agency spend.	2. Inability to attract to specialist positions e.g. Paediatrics and Theatre nursing staff
3. Recruitment Officer and Directorate Managers meetings to ensure recruitment plans are in place for every vacancy.	3. No gaps identified – vacancies are now reviewed by RO and Directorate to ensure these are on TRAC (checklist launched

	to support).
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 77% 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. 3 medical Recruitment Officers and 3 non-Medical Recruitment Officers covering all directorates
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
15. CIP and Task and Finish groups are attended by a member of the Recruitment team to ensure Recruitment issues are prioritised and addressed	15. No gaps identified
16. Collaborative working between HR, Finance and Directorates including more efficient weekly meetings, review of pipeline, iterative reconciliation and agreement of workforce status, rolling adverts and strategies for hard to recruit areas to support identify and resolve issues.	16. No gaps identified
17. Vacancy being filled by staff 'at risk' through department consultations and restructures (retain staff and avoiding redundancy costs.	17. Prioritising internal staff at risk is impact and limiting some roles to internal recruitment impacts on recruitment timelines.

Mitigating Actions: (What more do we need to do to fill the gaps)	Lead	Target Date
1. On-going reviews taking place - next scheduled 18/10/17 with PMO and Recruitment (current focus on nursing establishment).	NB	On-going On-going
2. Analyse workforce and service requirements for opportunities to adopt different workforce models. Action planning session for Paeds being held on 19.10.17.	JF and NB	Completed On-going
3. Reconcile established vacancies with actions taken to recruit.	NB	On-going
4. Develop retention initiatives and strategy in line with the National nursing retention campaign launched by NHSI and NHS employers – NHSI workshop -31/10.	SB and DT	
5. - Reduce reliance on overseas nurse recruitment by using apprenticeship levy to up-skill HCA's to nurses. Procurement exercise for providers of apprenticeships completed. Plans and governance framework being pulled together by POD for SLT agreement.	JT - POD	Procurement sign-off completed 30th November 2017
– Review KPI's with synergy agency for overseas recruitment to improve contract performance and focus overseas recruitment on Europe, including Finland	NB	Completed
6. See point 4 above. Health and wellbeing and staff benefits initiatives – action plan in place. Resilience sessions being further developed for staff.	SB/ POD	30th November 2017 Completed and on-going.
7. Template induction plans and guidance in place for all staff groups.	EF with Directorate lead	Completed
- Trust local induction checklist in place – sign posting and promotion. Reinforced in welcome day.		
- Locum induction and guidance in place	AB	30th October 2017
8. Implement electronic leaver form, which notifies TRAC to initiate recruitment –1st phase IT developing electronic form/ 2nd phase to link to TRAC	AK	Form design completed – now IT testing phase. Launch due subject to testing end of November 2017.
9. Escalate via performance review meetings and continue to promote the benefits	SB and Site leads	
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 and bank initiatives including enhanced rates to match fringe high cost supplement, reviewing the training provision offered to staff and automatic process of inviting retirees to return on bank.	NB	On-going
- Review of bank pay rates underway with expectation to deliver completive market rates by the end of October. All retirees from beginning of year contacted to encourage registration on bank, total number of contacts 96 from all job types. Rolling adverts now in place to encourage bank recruitment.	NB	30th October and on-going
12. Reinforce expectations to Clinical Leads in relation to recruitment timelines and the use of	NR, NB	Completed

TRAC. Directorates to identify administration support for TRAC, with further support provided by the Medical Recruitment Officers. 13. N/A 14. N/A 15. N/A 16. N/A 17. SR At-Risk process being reviewed and further developed in line with Organisational change policy.	NB/SB	30th 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. Business case approval and Directorate administration posts recruited to. Establishment and vacancy rates are accurate and vacancy rate (KPI) reduces.	1. Increase in recruitment timeline - TRAC KPI's not met
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.	2. Speciality action plans not delivering specific recruitment targets.
3. Audit results demonstrate that all vacant post are being advertised on TRAC	3. Recruitment not taking place for establishment vacancies, increase in recruitment timeline
4. Evidence of retention strategy in place, with monitored implementation plan, reduction in turnover KPI. Improved staff survey engagement results.	4. Increasing turnover rates
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.	5. Implementation plan not delivering HCA apprenticeship targets
6. See point 4 above.	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.	7. Directorates with no local induction guidance and templates and increasing turnover rates. Poor staff survey response rate.
8. Vacancy rate and TRAC timescales KPI improvement	8. Timescale from resignation to advertising on TRAC increases
9. Improvement in appraisal KPI, quality and ratios. Directorate PRM minutes/ actions	9. Low appraisal numbers taking place
10. N/A	10. N/A

11. Increase in active bank numbers for HCA and nurses 12. See point 1 above 13. N/A 14. N/A 15. CIP and Task Group minutes and actions reflect progress with recruitment issues 16. N/A 17. Vacancy fill rates through redeployment and recruitment timelines improve	11. Increase in agency booking/ spend for HCA and nurses 12. Increase in recruitment timeline – TRAC KPI's not met 13. N/A 14. N/A 15. N/A 16. N/A 17. Increase in recruitment timeline – TRAC, KPI's not met

Related Risks

Risk Ref:	Description	Score
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
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

Chart showing related risks

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

	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Risks scoring 15+	5	5	5	5	5
Risks scoring 8-12	3	3	2	2	2
Risks scoring 4-6	1	1	1	1	1

Risk Review Comments:

Southend University Hospital NHS
NHS Foundation Trust

RISK I.D	5	Executive Lead	John Henry	Risk Manager	John Henry
CQC Reference(s)					
Risk Title	**Current and future estates, infrastructure and equipment may 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 an almost certain 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	4		**Risk Domains**	Regulatory / Legal/ Infrastructure/ Technical/ patient safety	
Date Identified	15/05/2017	**Date Last Reviewed**	CGG 05/10/2017 QAC 18/10/2017 Board 05/09/2017	**Target Date**	31/03/2018

Risk Rating (Likelihood x Impact)		Relevant Key Performance Indicators
Initial Risk Score	20	The estates service operates a reactive service for which there are KPI's for multiple priority requests. It also operates a planned preventative maintenance service PPM which has associated KPI's. Medical Equipment Management has turnaround, response and KPI targets. These are reported to the Board in the Integrated performance Board report.
Current Risk Score	12	
Target Risk Score	9	
Risk Appetite		
Direction of travel	⟺	

Risk score — Target

	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Axis	0 – 14				

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 Preventative Maintenance (PPM) programme in place. Internal and external audit by	None

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	Previously developed 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.	A site wide review is underway to determine priorities and reconfiguration, a program for which is in the planning stage

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: '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	JH	June 2017, Overdue - 90% complete.
6. Updated Business Continuity plans to be finalised.	JH	Completion target 30th November.
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	Transformer is commissioned but takes very little load.

<table>
<tr><td colspan="2"></td><td></td><td>Rebalancing requires a reconfiguration of site electrical system. A long term plan is in development.</td></tr>
<tr><th colspan="4">Assurances: (How will we know that what we are doing is having an impact?)</th></tr>
<tr><th>Positive Assurances: (evidence that shows the controls are effective (for example metrics, inspections etc))</th><th colspan="3">Negative Assurances: (evidence we won't find if the controls are effective (for example incidents, complaints etc))</th></tr>
<tr><td>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.</td><td colspan="3">Gaps in Premises assurance model outcomes</td></tr>
<tr><td>2. Training skills register demonstrates compliance
Authorised person appointed</td><td colspan="3">None</td></tr>
<tr><td>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)</td><td colspan="3">None</td></tr>
<tr><td>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</td><td colspan="3">Failures in cleaning standards identified up in CQC reports</td></tr>
<tr><td>5. KPI clearly identified in contract specification and reviewed at monitoring meetings</td><td colspan="3">Limited assurance from QAC</td></tr>
<tr><td>6. Business Continuity plans are in place.</td><td colspan="3">Failure to deal with significant incident or loss of utilities.</td></tr>
<tr><td>7. Risk assessed capital programme in place</td><td colspan="3">Plant failure that has not been identified as end of life.</td></tr>
<tr><td>8. Monthly performance KPI's reported to board, Internal audit schedule, External (BSI) audit schedule, Quarterly medical devices</td><td colspan="3">Major failure of equipment impacting patient care
Instances of equipment impacting patient care being unavailable</td></tr>
</table>

safety report, Risk assessed capital programme	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**
2672	Risk of failure of the AER (automatic endoscopic reprocessor) machines – Risk eliminated, equipment removed and service provided from SSD	Closed
2701	Medical Gases improvement works (Trust deferred capital improvements project)	12
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	12

Chart showing related risks

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

8
8
8
7
7

Jun-17
Jul-17
Aug-17
Sep-17
Oct-17

	presence of fire doors that required replacement (Trust deferred Estates Project)		
2445	Failure to maintain integrity of electrical utilities to hospital areas fed from electrical sub-station 3	8	
Risk Review Comments:			

RISK I.D	6	Executive Lead	Site Director of Finance	Risk Manager	Head of Digital Services
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 05/10/2017 FRC 31/10/2017 Board 05/09/2017	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	⟺

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?)

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)
2. Microsoft Cloud Navigator exercise currently in progress to assess what digital systems can hosted in a remote data centre

Gaps in Controls:

1. Don't currently have a resilient data centre room

2. Some digital services will be migrated to a remote, highly resilient data centre (cloud) however network connectivity remains a single point of failure as all data connections are terminated in

<table>
<tr><td colspan="3">3. Across 3 IT departments there is a cyber-security action plan in place which is reviewed on a weekly basis.
4. Limited scope on call service (2435)</td><td colspan="3">the current data centre
3. No gaps identified
4. In-house resources do not support required hours 24/7, 365 days</td></tr>
<tr><td colspan="4">Mitigating Actions: (What more do we need to do to fill the gaps)</td><td>Lead</td><td>Target Date</td></tr>
<tr><td colspan="4">1. Second main network hub room at west end of site</td><td>SLB</td><td>27/03/18</td></tr>
<tr><td colspan="4">2. Recruit dedicated cyber security officer across the MSB hospital group</td><td>AT</td><td>Complete</td></tr>
<tr><td colspan="6">Assurances: (How will we know that what we are doing is having an impact?)</td></tr>
<tr><td colspan="3">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 colspan="3">Report on cyber threats and response to them
Annual penetration test report and certificate</td><td colspan="3">Unplanned downtime
IT incidents</td></tr>
<tr><td colspan="6">Related Risks</td></tr>
<tr><td>Risk Ref:</td><td>Description</td><td>Score</td><td colspan="3">Chart showing related risks</td></tr>
<tr><td>1609</td><td>Loss of Datacentre</td><td>15</td><td colspan="3" rowspan="6">Risks scoring <4 | Risks scoring 4-6 | Risks scoring 8-12 | Risks scoring 15+
Jun-17: 5, 1
Jul-17: 5, 1
Aug-17: 5, 1
Sep-17: 5, 1
Oct-17: 5, 1</td></tr>
<tr><td>2669 – not yet approved</td><td>Lack of server operating system patching process</td><td>12</td></tr>
<tr><td>2435</td><td>IT system support provision does not reflect criticality of system or hours of usage</td><td>12</td></tr>
<tr><td>2719 – not yet approved</td><td>Antivirus support ending for windows XP and server 2003</td><td>8</td></tr>
<tr><td>2425</td><td>Risk of disruption and / or damage to IT systems from cyber threats</td><td>8</td></tr>
<tr><td>2727 – not yet approved</td><td>Risk of virus attacks against IT systems running old operating systems</td><td>8</td></tr>
<tr><td colspan="6">Risk Review Comments:</td></tr>
<tr><td>22/08/17</td><td colspan="5">Risk reviewed and risk score maintained at 12 as actions remain unchanged. Controls and gaps reviewed to be more strategic in approach</td></tr>
<tr><td>03/10/17</td><td colspan="5">Start date added for dedicated Digital (Cyber) Security Officer and current risk score updated to maintain following feedback at FRC</td></tr>
<tr><td>27/10/17</td><td colspan="5">Digital Cyber Security Officer appointed</td></tr>
</table>

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 05/10/2017 QAC 18/10/2017 Board 05/09/2017	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	⟷

Risk score — Target

20, 15, 10, 5, 0

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

Relevant Key Performance Indicators

	Jun17	Jul 17	Aug 17	Sept 17
Incidents	82	39	100	109
SIs	0	1	2	0
IRMER reports	0	1 (potential)	1	0

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; spares for end of life equipment not available.
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
2511	Fluoroscopy / Interventional radiology suite room 8 overdue for replacement	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
2222	Lack of Histopathology Consultant could compromise turnaround times and lead to patient	9

Chart showing related risks

Risks scoring <4
Risks scoring 4-6
Risks scoring 8-12
Risks scoring 15+
Jun-17: 10, 2
Jul-17: 4, 13
Aug-17: 4, 13
Sep-17: 4, 13
Oct-17: 4, 13

	breaches		
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:			
10/10/17	The overall risk rating remains unchanged as the actions are still outstanding. The related risks have been updated; 1 risk has been removed from the risk register and 1 new risk (2511) has been added. An added gap in control 1 has been added as certain parts are no longer available for end of live equipment.		

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 05/10/2017 QAC 18/10/2017 Board 05/09/2017	**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	Oct-17
Risk score	15	15	15	15	15
Target	5	5	5	5	5

Relevant Key Performance Indicators

	Jun 17	Jul 17	Aug 17	Sept 17
Incidents	1041	1087	898	826
SIs	9	16	15	6
CQC – overdue actions	1	2	1	1
Open requirement notices	5	5	5	5
CQC rating	RI	RI	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 health and social care (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 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

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
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 – in progress	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 - COMPLETE	Simon Worrall	31/10/2017
d. Review do not resuscitate 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 – in progress	Yvonne Brierley	30/09/2017
4. Complete actions following NHSI infection prevention and control review – in progress	Denise Townsend	30/09/2017
5. Submit CQC provider information request - COMPLETE	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
70	Increased use of nursing agency staff with varying skills and experience	15
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	Estates and facilities 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	12
1499	Unauthorised use of mortuary service tunnel may lead to injury	6

Chart showing related risks

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

	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Risks scoring 15+	5	3	3	3	3
Risks scoring 8-12	3	5	6	6	6
Risks scoring 4-6	3	3	2	2	2

336	Deviation from standard security procedures may lead to uncontrolled departure of child attending the emergency department	4	
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.		
03/10/17	Associated risks reviewed in line with new grading matrix. Risk score has reduced for risks 70 (from 20 to 15) and risk score has increased for 2143 (from 6 to 12) due to alarm system being disabled whilst lift refurbishment underway. The overall risk remains the same sure to requirement notices still being outstanding and feedback following the recent mock inspection and NHSI IPC review. The well led review is currently being carried out.		