Southend University Hospital NHS
NHS Foundation Trust

Board of Directors Meeting Report – 6 March 2018

Agenda item 13/18

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 subject to ongoing review by the Site Director Leads.

A review of the BAF and Risk Management process was undertaken by our internal auditor, TIAA, in January 2018 and a substantial assurance opinion was obtained. The overall conclusion with regards the BAF is as follows:

- The mechanism for receiving assurances on the BAF was found to be sound, which is complemented by a good governance structure.
- The BAF document was clearly laid out and sufficiently detailed. Risks were aligned to strategic objectives and controls, assurances, gaps in controls and mitigating actions were stated in all cases. However, gaps in assurances were not stated in all cases.

The BAF will be reviewed further in the next few months to take into consideration the recommendations of the internal auditor.

BAF Risks 1, 5, 7 and 8 were reviewed by the Quality Assurance Committee on 14 February 2018.

BAF Risk 2 was reviewed by the Audit Committee on 22 February 2018.

BAF Risks 3, 4 and 6 were reviewed by the Finance & Resources Committee on 9 January 2018.

Related Trust Objective	Excellent Patient Outcomes Excellent Patient Experience Engaged and Valued Staff Financial and Operational Sustainability – Financial, Operational, Estate
Related Risk	Risk 1 - Failure to provide adequate patient safety , quality of care and patient experience due to capacity, demand and external agency stakeholder engagement Risk 2 - Failure to meet constitutional and national performance targets Risk 3 - Trust not being financially sustainable Risk 4 - Inability to recruit and retain staff

	Risk 5 - Current and future estates, infrastructure and equipment does not comply with national specifications, meet service needs and/or service user needs Risk 6 - Lack of robust IT infrastructures, Business Continuity Plans and digital defences against cyber security Risk 7 - Failure to provide effective and reliable clinical support services Risk 8 - Failing to meet CQC Health & Social Care regulations
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.	

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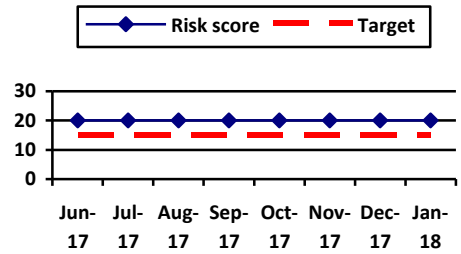
RISK I.D	**1**	**Executive Lead**	**Managing Director**	**Risk Manager**	**Directors of Operation**
CQC Reference(s)	Regulation 12 Safe care and treatment, Regulation 17 Good governance				
Risk Title	**Failure to provide adequate patient safety, quality of care and patient experience due to capacity, demand and external agency stakeholder engagement**				
Risk Description	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.				
Strategic Objective	Excellent patient outcomes Excellent patient experience	**Risk Domains**	Safe; Effective; Caring; Responsive; Well Led		
Date Identified	15/05/2017	**Date Last Reviewed**	CGG 07/12/2017 QAC 14/02/2018 Board 04/12/2017	**Target Date**	31/03/2018

Risk Rating (Likelihood x Impact)			**Relevant Key Performance Indicators**
Initial Risk Score	20 (4x5)		ED 4 hour RTT Cancer 62 day Ambulance waiting times Cancelled electives Delayed discharges
Current Risk Score	20 (4x5)		
Target Risk Score	15 (3x5)		
Risk Appetite Risk levels	High Level 3 'Open'		
Direction of travel			

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	None
2. Five bed meetings daily	None
3. Safe at Southend meetings	None
4. Monitoring of staffing levels	Sufficient workforce recruitment gaps and impact

	assessments Overview of actual workforce in relation to workforce, maternity leave and long term sickness
5. Monitoring of the medical rota	Impact assessment of junior doctor contracts
6. Capacity plan for each directorate	None
7. Winter plan developed to increase capacity	Winter plan dependant on staffing
8. System escalation calls, standard and critical	None
9. CCG QIPP scheme focused on reducing demand	None
10. Ambulance tripartite document for the management of ambulance delays	None
11. Critical incident SOP for attending clinicians	None
12. Individual risk assessments undertaken for cancelled surgery	None
13. Risk assessments for direct admissions	None
14. 'Buddy' ward system	None
15. Introduction of 'Red to Green' days and 'SAFER'	None
16. Outsourcing agreement re ophthalmology	Successful introduction of outsourcing
17. Full capacity protocol	None

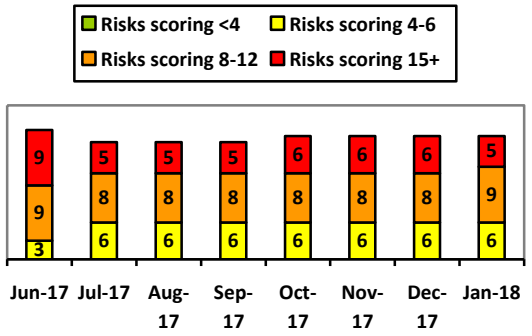
Mitigating Actions: (What more do we need to do to fill the gaps)	**Lead**	**Target Date**
Review of the actual workforce	Head of HR	31/03/2018
RTT Backlog clearance programme with the CCG and NHSI	Dept. Head of Operation	31/03/2018
Cancer pathways review	Dept. Head of Operation	31/03/2018

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	**20**

	resulting in reputational damage	
2838	Routine appointment delays up to 28 weeks to first appointment for Respiratory patients	**20**
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**
2874	Risk to patient safety due to additional inpatients beds being opened across Medicine where there are significant vacancies	**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**
2582	Direct medical admissions and medical outliers may result in delayed care and treatment and result in patient harm	**12**
2617	Patients planned for orthopaedic surgery on escalating waiting list breaching the 18weeks	**12**
2926	Risk to patient safety due to high number of cancelled clinics across medical specialties	**12**
1837	Critical Care at maximum capacity impacting on admission, discharges, elective surgery income, waiting time & patient experience	**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**



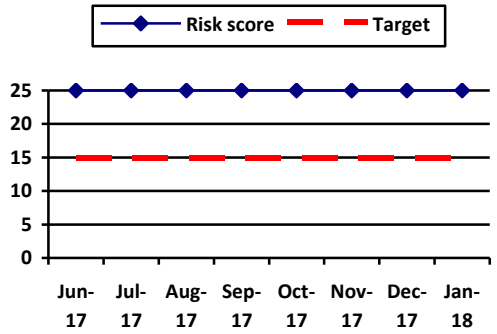
2153	Delay to Head and Neck and upper GI Cancer Pathway	**6**	
2292	Chemotherapy Capacity- Inability to meet the demand for chemotherapy in CTU; causing patient access delay.	**6**	
2147	Bed pressures impact on Surgical Directorate and lead to cancellation of Elective Admissions	**4**	
2156	Risk of harm 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
08/12/2017	RTT: Backlog clearance programme progressing to plan.

RISK I.D	2	Executive Lead	Yvonne Blucher	Risk Manager	Directors of Operation
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 07/12/2017 Audit Com 22/02/18 Board 04/12/2017	Target Date	31/03/2018

Risk Rating (Likelihood x Impact)

Initial Risk Score	25
Current Risk Score	25
Target Risk Score	15
Risk Appetite Risk Level	Moderate Level 2 'Cautious'
Direction of travel	⟷



Relevant Key Performance Indicators

Performance targets	*Nov-17*	*Dec-17*	*Jan-18*
% waiting less than 18 w	84.2	85	84.3
% treated within 62 days	80.3	80.6	74.8

4 Hour Target Performance (Current YTD)

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2017/18 YTD
95.30%	91.74%	90.71%	91.66%	91.11%	87.54%	89.38%	85.72%	76.65%	79.12%	84.56%		
Q1			Q2			Q3			Q4			
92.51%			90.14%			83.98%			80.51%			87.78%

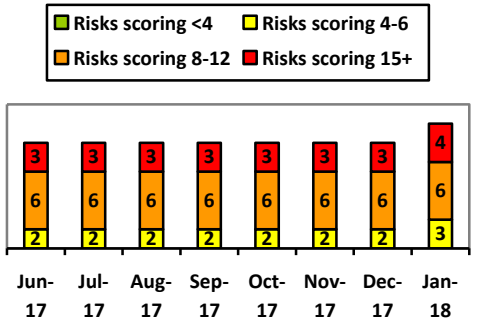
Controls: (What are we currently doing to reduce the impact or likelihood of the risk occurring?)	Gaps in Controls:
Cancer Target 1. Cancer Board 2. ESR Cancer Director to manage the process and patient flow 3. Live cancer patient tracking	1. N/A 2. N/A 3. Delays in patient pathways

4. Weekly PTL reviews for cancer 5. Joint Basildon / Southend Cancer improvement post to address late referrals 6. Capacity to meet the demand RTT 7. Weekly meetings with directorates to review performance and PTL A&E 4 hour 8. Patient Flow Board 9. Extended AEC service 10. Programme of task/finish groups for flow 11. Live ED breech tracking reviewed at the bed meetings 12. Full implementation of Full Capacity Protocol	4. Delays in patient pathways 5. Continuing late referrals from other Trusts 6. Availability of outpatient slots/ theatre lists/ ITU beds 7. Availability outpatient slots/ theatre lists/inpatient beds 8. N/A 9. N/A 10. N/A 11. N/A 12. N/A

Mitigating Actions: (What more do we need to do to fill the gaps)	**Lead**	**Target Date**
3&4. Introduction of 'next step in 7 days pathway'	Clare Burns	31/03/2018
5. Weekly monitoring of levels of late referrals from other trust	Clare Burns	05/02/2018
6. Opening of High Dependence Unit	Yvonne Blucher	31/03/2018
6. Speciality level demand and capacity reviews	Clare Burns	15/02/2018
7. Increased outsourcing for key specialities	Clare Burns	31/03/2018
7. Increased Insourcing for key specialities	Clare Burns	31/03/2018
7. increasing use of day stay	Clare Burns	31/03/2018

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))**
• *Independent external review of discharge and 4hr target* • *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
1823	Failure to stay within Department of Health targets for MRSA Bacteraemia	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
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
2259	Failure to comply with same sex accommodation requirements for interventional recovery areas	8
321	Failure to meet Information Toolkit requirements may lead to reputational and financial harm	6

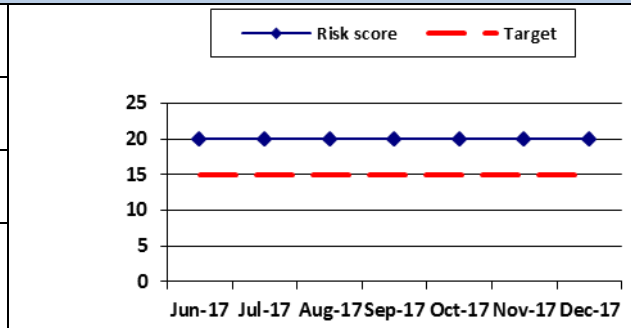


2443	Delayed compliance with MHRA requirements according to Guidance for Specials Manufacturers Revision 1 published Jan 2015	5	
2156	Risk of harm to patients when Referral to Treatment (RTT) waits going on longer than 52 weeks.	4	

Risk Review Comments:	

RISK I.D	3	Executive Lead	Adrian Buggle	Risk Manager	Marie Miller
CQC Reference(s)	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 0712/2017 FRC 09/01/18 Board 04/12/17	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	Moderate
Risk Level	Level 2 'Cautious'
Direction of travel	⟺



Relevant Key Performance Indicators

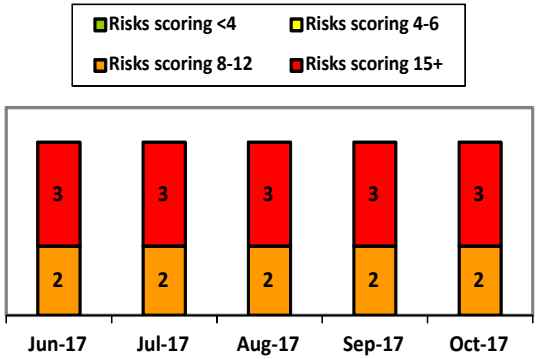
	2017/18				
	Q1	Q2	Q3	Q4	Total
Control Total *(deficit)/surplus*	(3.56)	(2.03)	(2.08)	(7.38)	**(15.05)**
Actual *(deficit)/surplus*	(3.56)	(2.01)	(2.20)		
Variance *(deficit)/(surplus)*	-	**0.02**	**0.06**		

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.	While the Trust is on plan with its 2017/18 cost-improvement programme, the 2018/19 programme has identified approximately £8m against a target of £12m and there is still a significant 'gap'

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	None
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 MSB Group to grow.	AB	Ongoing
3. The Trust is still in the process of identifying cost improvement schemes for 2018/19 and has a CIP Programme Board chaired by the Director of Operations – Planned Care and supported by the PMO and Finance Director.	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

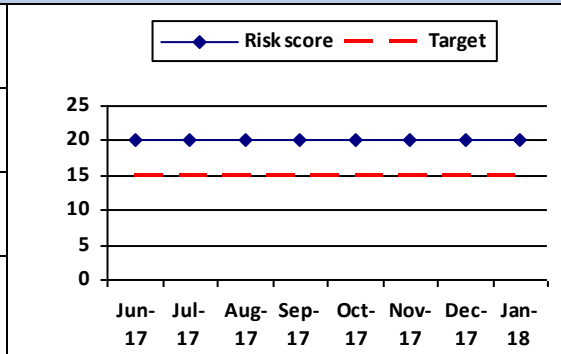
Related Risks			
Risk Ref:	**Description**	**Score**	***Chart showing related risks***
2287	Trust fails to meet its financial targets. Closer scrutiny by Monitor and possible enforcement action	16	
2003	In-year demands on the capital programme exceed the funding available	16	
1458	Incorrect coding or delay in coding may lead to financial loss for the Trust	20	
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	12	
2321	Income lower than plan	12	
2837	Risk to Sexual Health Income due to Southend Borough Council reducing contract size	10	
2794	Financial risk associated with new activity predictred as a urology cancer centre	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.
20/12/17	Related risks scores have been reviewed: Risk 2287 score changed from 15 to 12, Risk 2003 from 25 to 16.
31/1/18	Risks rating has been reviewed and Risk 2258 has been increased from 12 to 16 while Risk 2620 has been increased from 9 to 12

RISK I.D	4	Executive Lead	Sue Bridge	Risk Manager	Niki Butler and Stephanie Wilson
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 07/12/2017 FRC 09/01/18 Board 04/12/17	Target Date	13/03/2018

Risk Rating (Likelihood x Impact)

Initial Risk Score	25 (5x5)
Current Risk Score	20 (4x5)
Target Risk Score	15 (3x5)
Risk Appetite Risk Level	Moderate Level 2 'Cautious'
Direction of travel	⟺



Relevant Key Performance Indicators

KPI	Target	Nov 17	Dec 17	Jan 18
Qtr3 17/18				
Vacancy Rate	7%	11.28%	11.28%	10.81%
Vacancy Rate (nurses)	7%	12.45%	12.10%	11.84%
Vacancy Rate (consultants)	7%	12.45%	11.64%	9.62%
Agency (% of pay bill)	6%	9.55%	9.81%	9.67%
Turnover Rate	9.50%	12.90%	12.95%	13.04%
Appraisal	90%	78.20%	79.20%	78.76%

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. Exit interview rate at 17%. Those at pre-retirement are contacted 3 months prior to leaving us, not enough time to influence an extension or return.
9. Annual appraisal and PDP process in place for staff	9. Compliance rates 78% versus target of 90%
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	15. No gaps identified

Recruitment team and HR team to ensure Recruitment and Retention issues are prioritised and addressed.		
16. Collaborative working between HR, Practice Development, 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.	
18. Recruitment and Retention Committee established to measure, monitor and review recruitment and retention activities within nursing.	18. No gaps identified	
19. Primary drivers for improving retention have been identified through the NHSI Staff Retention Programme. A SMART Action Plan has now been agreed by the Site Leadership Team.	19. Number of gaps identified	
Mitigating Actions: (What more do we need to do to fill the gaps)	**Lead**	**Target Date**
1. On-going reviews taking place with PMO and Recruitment (current focus on nursing establishment). Implement nursing retention and ageing workforce dashboard to measure and monitor retention and inform redeployment.	NB	On-going
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	Completed
4. Implement retention initiatives and strategy in line with the drivers identified in Phase 1 of the NHSI Retention Programme	SW	On-going
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	On-going Procurement sign-off completed 30th November 2017. Plans to be delivered to SLT by end of January 2018.
– 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 and will be further developed in line with point 4.	FK / DM	30th January 2018
7. Template induction plans and guidance in place for all staff groups. - Trust local induction checklist in place – sign posting and promotion. Reinforced in welcome day.	EF with Directorate lead	Completed
- Locum induction and guidance in place	AB	On-Going
8. Implement electronic leaver form, which notifies TRAC to initiate recruitment –1st phase IT developing electronic form/ 2nd phase to link to TRAC. Move exit interviews online and monitor results	AK	Completed. On-going
9. Escalate via performance review meetings and continue to promote the benefits	SB and Site leads	On-going
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. - Review of bank pay rates underway with expectation to deliver completive market rates by end of March 2018. Retirees and friends and family being contacted to encourage registration on bank. Rolling adverts now in place to encourage bank recruitment.	NB	On-going - Review of rates underway led by COD/ NB however following conference call between all three sites and EoECPH led by COD decision to delay until announcements regarding HMRC and NHSi are made as these will have significant impact on rate levels
12. Reinforce expectations to Clinical Leads in relation to recruitment timelines and the use of TRAC. Directorates to identify administration support for TRAC, with further support provided by the Medical Recruitment Officers.	NR, NB	Completed
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 – further work required across MSB group to implement. 18. N/A 19. Next steps for the NHSI retention programme are: - Improve access to targeted health and wellbeing initiatives - Improve access to staff benefits and review offering - Improve on-boarding process, including an on-boarding survey at 3, 9 and 18 months, pastoral support and explore pay retention opportunities - Improve retention within nursing via internal transfer and rotational nursing programmes - Create Band 5.5 Senior Staff Nurse Role - Implement career and redeployment to support staff through transition - Review Flexible Working Policy - Improve standardisation across wards - Review succession planning approach for 55+ workforce - Develop pre-retirement programme for 50+ workforce - Deliver International Nurse Day event to attract retirees and create Nurse Alumni Group - Review Flexible Retirement Policy 20. Review of Enhanced Bank Rates across all three sites to ensure that there is transparency and comparatively within all directorates E.G Emergency Departments	NB/SB SW NB	28th February 2018 Ongoing Ongoing

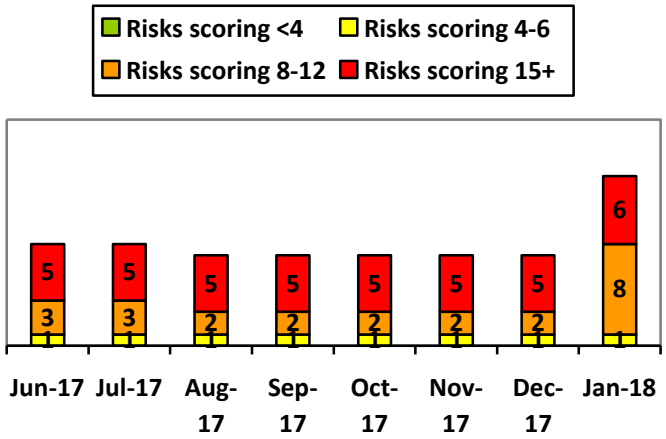
Assurances: (How will we know that what we are doing is having an impact?)	
Positive Assurances: (evidence that shows the controls are effective (for example metrics, inspections etc))	**Negative Assurances: (evidence we won't find if the controls are effective (for example incidents, complaints etc))**
1. Business case approval and Directorate administration posts recruited to. Establishment and vacancy rates are accurate and vacancy rate (KPI) reduces. Negative trends demonstrated via relevant dashboards.	1. Increase in recruitment timeline - TRAC KPI's and retention dashboard targets 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. Positive trends demonstrated via Nursing Retention Dashboard.	4. Increasing turnover rates at staff group level, lower staff engagement score, negative feedback on on-boarding, pre-retirement surveys and exit questionnaire
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 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 18. Recruitment and Retention Committee approval of retention activities and initiatives 19. SLT and FRC monitoring of NHSI Staff Retention Programme plans and outcomes	10. N/A 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 18. N/A 19. negative trends demonstrated via Nursing Retention Dashboard

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

Chart showing related risks

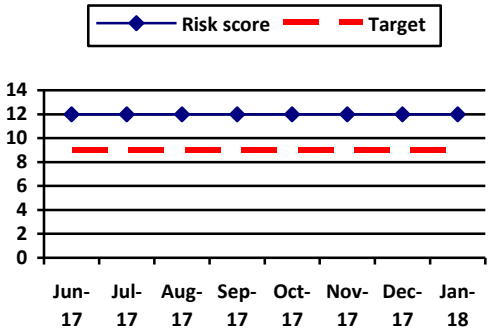


2365	Risk to patient safety due to Nursing vacancies in the medical wards	16	
2730	Implementation of the Success Regime may lead to poor staff engagement and morale	16	
2500	Staffing Shortages on Castlepoint Ward & Shopland Ward	12	
2512	Shortage of Radiographers results in risk of harm to patients due to delay in diagnosis that is dependent on imaging.	9	
2894	17 WTE band 5 nursing vacancies (plus 10 WTE for winter planning) in surgery and unable to recruit into.	9	
1852	Insufficient Paediatric Nurses on Neptune ward and PAU may lead to suboptimal care and harm	9	
2231	Risk to patient safety due to nursing vacancies in A&E	8	
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	
2698	Failure to recruit a substantive Consultant Microbiologist may have an inpact on quality service delivery	8	
2205	Lack of paediatric junior medical staff	6	

RISK I.D	5	Executive Lead	John Henry	Risk Manager	John Henry
CQC Reference(s)	Regulation 12 - Safe care and treatment, Regulation 15 – premises and equipment, Regulation 17 - Good governance				
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 07/12/2017 QAC 14/02/2018 Board 04/12/2017	Target Date	31/03/2018

Risk Rating (Likelihood x Impact)

Initial Risk Score	20 (4*5)
Current Risk Score	12 (3*4)
Target Risk Score	9 (3*3)
Risk Appetite Risk Level	Moderate Level 2 'Cautious'
Direction of travel	⟷



Relevant Key Performance Indicators

Metric	Target	Nov – 17	Dec -17
EFM referrals	N/A	1533	1082
EFM tasks remaining open	N/A	627	628
Reactive P1	95%	91%	100%
Reactive P2	75%	64%	70%
Reactive P3	65%	54%	46%
Reactive P4	80%	97%	67%
Reactive P5	90%	100%	94%
PPM	75%	58%	90%
Catering V High Risk	99%	99%	99%
Catering High Risk	98%	98%	98%
Catering sig Risk	98%	98%	98%
Catering Low Risk	98%	98%	98%
Domestics V High Risk	98%	99%	99%
Domestics High Risk	95%	98%	98%
Domestics sig risk	85%	98%	91%
Domestics Low Risk	75%	96%	80%
Nurse clean v high Risk	98%	98%	99%
Nurse clean High Risk	95%	96%	96%
Nurse clean sig Risk	85%	98%	98%
Nurse Clean Low Risk	75%	98%	N/A
Telephony P1	95%	96%	95%

			Telephony P2	95%	88%	85%
			Telephony P3	95%	90%	83%
			Telephony P4	85%	88%	75%
			Helpdesk calls answer times	95%	97%	95%
			MEMS activity	N/A	1448	1105
			MEMS turnaround Critical	85%	100%	85%
			MEMS turnaround High	85%	100%	100%
			MEMS turnaround Medium	85%	89%	94%
			MEMS PPM	78%	79%	84%
			MEMS Helpdesk	95%	89%	90%
			Equipment Loans	N/A	88%	87%

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 Authorising Engineer (AE). Six Facet Condition Survey / Backlog Capital Programme / Incident reporting system.	None
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	Business Impact statements complete, finalisation of continuity plans required.
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	None

	inclusion in capital programme. Equipment related incidents investigated.	
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	Works largely undertaken, ward/environment improvements require allocation of capital resource.
12.	(2702) Design development progressing. Phased programme drafted to avoid reduction in mortuary capacity during peak winter demand period. Capital expenditure required.	Enabling works undertaken, source of funding to be identified for completion of scheme. Agreement to seek external loan for mortuary refurbishment. Plan shared with Essex County Hospital and subsequent proposal for increased charge sent to Essex County Council for their agreement. Awaiting response and date for follow up meeting.
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

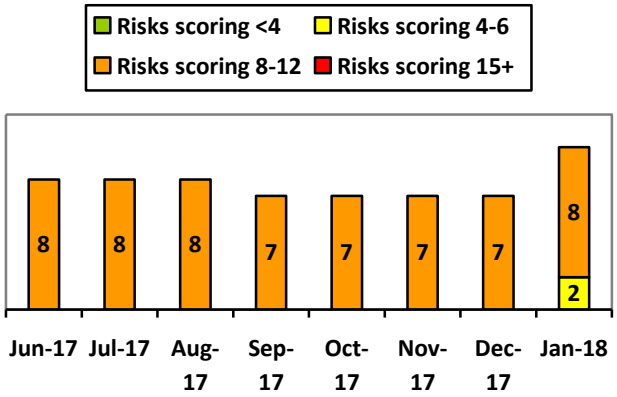
Mitigating Actions: (What more do we need to do to fill the gaps)	**Lead**	**Target Date**
1. Estates and its related services are integral to the delivery of high quality, safe, effective and efficient clinical care. The 2016 NHS Premises Assurance Model (PAM) has been updated to reflect changes in policy, strategy, regulation, technology and supports the NHS Constitutional right.	JH	31 March 2018 100% (Currently at 90-95%) completion of assurance reports should be achieved by end Feb 2018

<table>
<tr><td>6. Updated Business Continuity plans for EFM Services.
SUHFT adopted Basildon Business impact Assessment (BIA) model on recommendation from Emergency Planning Services
Completed BIA's with action cards are in place for EFM associated following services:
<table>
<tr><td>Accommodation</td><td>Catering</td><td>Catering (Medirest)</td></tr>
<tr><td>Domestic services</td><td>EFM Maintenance</td><td>Linen services</td></tr>
<tr><td>Medical Equipment</td><td>Portering</td><td>Security</td></tr>
<tr><td>Sterile Services Department</td><td>Switch (Telephony)</td><td>Waste Management</td></tr>
</table>
Additionally - Main major impact Estates plan in place</td><td>JH</td><td>Review of Estates Major impact plan due October 2018</td></tr>
<tr><td>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.</td><td>JH</td><td>1 April 2018</td></tr>
<tr><td>11. (2700) Capital funding to sought from 18/19 allocation.</td><td>JH</td><td>1 April 2018</td></tr>
<tr><td>12 (2702) Capital funding to be identified.</td><td>JH</td><td>1 July 2018</td></tr>
<tr><td>14 (2485) Legal action underway against designers and installers of the system</td><td>JH</td><td>1 April 2018</td></tr>
<tr><td>16 (2445) Commission transformer</td><td>JH</td><td>Transformer is commissioned but takes very little load. Rebalancing requires a reconfiguration of site electrical system. A long term plan is in development.</td></tr>
<tr><td colspan="3">Assurances: (How will we know that what we are doing is having an impact?)</td></tr>
<tr><td colspan="2">Positive Assurances: (evidence that shows the controls are effective (for example metrics, inspections etc))</td><td>Negative Assurances: (evidence we won't find if the controls are effective (for example incidents, complaints etc))</td></tr>
<tr><td colspan="2">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>Gaps in Premises assurance model outcomes</td></tr>
<tr><td colspan="2">2. Training skills register demonstrates compliance
Authorised person appointed</td><td>None</td></tr>
</table>

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**
2701	Medical Gases improvement works (Trust deferred capital improvements project) (risk awaiting approval)	12
2700	CQC Planned works (Trust deferred Project) Drug room air conditioning Sanitary Ware replacement (risk is under review)	12
2702	Mortuary - Capital Improvement Project (deferred 2017/18) (risk awaiting final approval)	9
2504	Testing of fire & smoke dampers & ensuring fire stopping integrity (Trust deferred Capital improvement project)	8
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)	9
2445	Failure to maintain integrity of electrical utilities to hospital areas fed from electrical sub-station 3	8
2445	Failure to maintain integrity of electrical utilities to hospital	8

Chart showing related risks

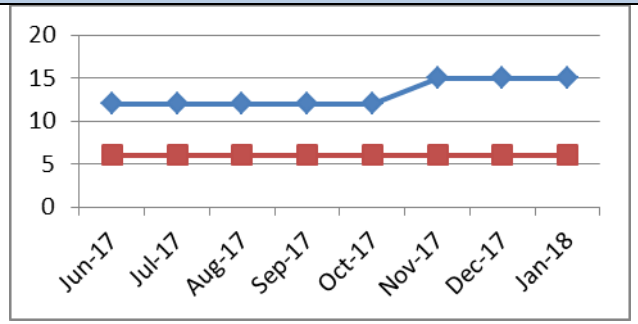


	areas fed from electrical sub-station 3		
2479	Tower Block Repairs (CP ON HOLD)	6	
223	Inappropriate use and management of faulty medical equipment	6	
Risk Review Comments:			

RISK I.D	6	Executive Lead	Chief Information Officer	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 attack**				
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. This may result in technical and financial vulnerabilities, resulting in significant financial pressure and the potential for patient harm. A failure to ensure appropriate investment in, and the investment and deployment of digital defences to deter cyber-attacks could lead to patient harm; financial loss; and disruption and/or damage to the reputation of the Trust from the failure of information technology systems as a consequence of cyber attack.				
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 07/12/2017 Board 04/12/2017 FRC 09/01/2018	Target Date	31/03/2018

Risk Rating (Likelihood x Impact)

Initial Risk Score	20 (4x5)
Current Risk Score	**15 (3x5)**
Target Risk Score	6 (3x2)
Risk Appetite	High
Risk Level	Level 3 'Open'
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)

Gaps in Controls:

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

2. Some digital services will be migrated to a remote, highly

2. Microsoft Cloud Navigator exercise currently in progress to assess what digital systems can hosted in a remote data centre 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)	resilient data centre (cloud) however network connectivity remains a single point of failure as all data connections are terminated in the current data centre 3. No gaps identified 4. 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 the MSB hospital group	**AT**	**Complete**

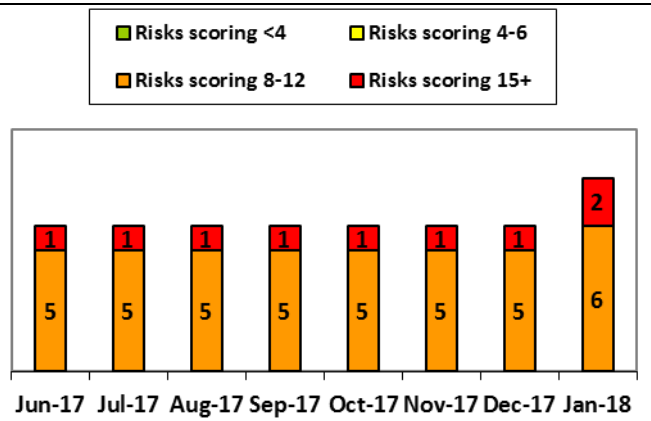
Assurances: (How will we know that what we are doing is having an impact?)

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**
2401	Loss of digital systems impacting patient care due to ageing and unsupported IT infrastructure and software	20
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
2932	Loss of Radiotheraphy infrastructure	8
2719 – not yet approved	Antivirus support ending for windows XP and server 2003	8

Chart showing related risks

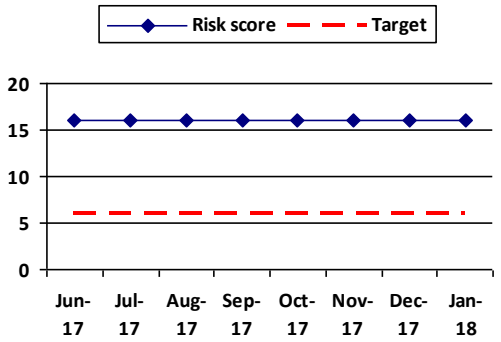


2425	Risk of disruption and / or damage to IT systems from cyber threats	8	
2727 – not yet approved	Risk of virus attacks against IT systems running old operating systems	8	
Risk Review Comments:			
22/08/17	Risk reviewed and risk score maintained at 12 as actions remain unchanged. Controls and gaps reviewed to be more strategic in approach		
03/10/17	Start date added for dedicated Digital (Cyber) Security Officer and current risk score updated to maintain following feedback at FRC		
27/10/17	Digital Cyber Security Officer appointed		
10/01/2018	**Risk score amended (requested by FRC 31/10/2017) to reflect combined impact of cyber attack and shortfall in datacentre resilience**		

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 07/12/2017 QAC 14/02/2018 Board 05/12/2017	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 Risk Level	Moderate Level 2 'Cautious'
Direction of travel	⟷



Relevant Key Performance Indicators

	Sept 17	Oct 17	Nov 17	Dec 17
Incidents	109	38	57	71
SIs	0	0	0	0
IRMER reports	0	3 (2 referrer error)	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

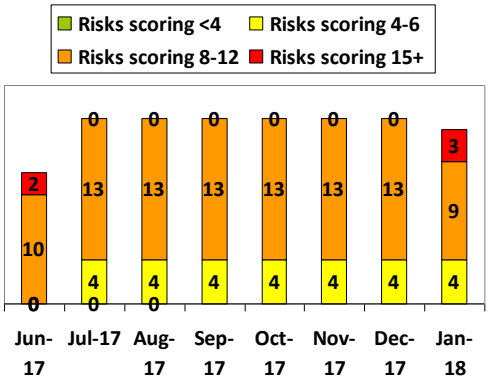
Gaps in Controls:

1. Weekend cover not included; spares for end of life equipment not available.

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	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**
1. 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
2. Develop business case to support replacement of ultrasound scanner	Darren Taylor	30/02/18
3. Radiographers / Sonographers are currently being recruited	Darren Taylor	31/12/17
4. Case to be presented to Vacancy Control Panel for fixed term locum to cover the gaps	Darren Taylor	31/08/17
5. Case to for interventional / fluoroscopy equipment being drafted	Darren Taylor	01/03/18
6. Interviews for microbiology position taking place w/b 5th February.	Darren Taylor	12/02/18

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**	***Chart showing related risks***
2511	Fluoroscopy / Interventional radiology suite room 8 overdue for replacement[1]	15	
2044	Effect on patient care due to failure of MRI equipment	12	
2045	Fluoroscopy room 6 overdue for replacement and could impact on patient care and diagnosis[1]	15	
2625	The potential for transcription error(s) in radiological reports	12	
2875	EPAU Ultrasound scanner providing suboptimal imaging.	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	6	
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	
2684	Delays in diagnosis or treatment due to reduced pathology service	6	
2698	Failure to recruit a substantive Consultant Microbiologist may have an impact on quality service delivery	8	

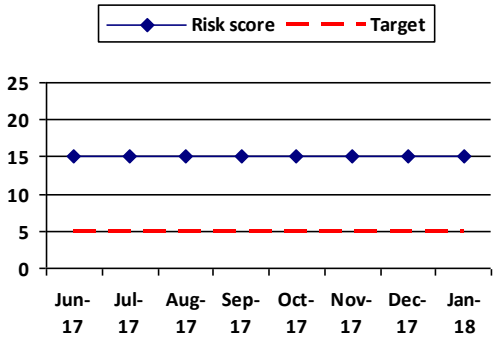
[1] Not a corporate risk

2835 – risk not yet approved	Patients could be diagnosed or treated incorrectly due to inappropriate release of results from hub lab biochemistry	8	
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:			
02/02/18	The overall risk rating remains unchanged as the actions are still outstanding. The related risks have been updated; 1 new risk (2045) has been added. 2511 and 2044 have been regarded following confirmation from the manufacturer that spare parts are no longer available should the equipment fail. 2875 has been regarded following increased complaints from Sonographers regarding image quality and an increased number of recalls. 2423 has been downgraded due to successful recruitment. 2831 and 2830 have been removed. 2222 removed as fixed term locum consultant in post.		

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 07/12/2017 QAC 14/02/2018 Board 05/12/2017	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	Moderate
Risk level	Level 2 'Cautious'
Direction of travel	⟷



Relevant Key Performance Indicators

	Jun 17	Jul 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18
Incidents	10 41	10 87	89 8	82 6	91 6	93 5	10 01	
SIs	9	16	15	6	9	14	2	
CQC – overdue actions	1	2	1	1	0	0	2	3
Open requirement notices	5	5	5	5	5	5	5	5
CQC rating	RI	RI	RI	RI	RI	RI	RI	

Controls: (What are we currently doing to reduce the impact or likelihood of the risk occurring?)	Gaps in Controls:
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 meet regularly to review the approach to achieving and maintaining compliance with the HSC regulations. The group are sharing learning from each organisation to improve compliance on each site. 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 6.A programme of peer reviews across all 3 sites is currently being worked on which will involve monthly site compliance visits across 2 areas.	1. No gaps identified 2. No gaps identified 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 5. No gaps identified 6. Process is still in draft and no date has yet been agreed to commence this programme. A whole site mock inspection is planned at MEHT

Mitigating Actions: (What more do we need to do to fill the gaps)	Lead	Target Date
1. Complete actions against requirement notices	Yvonne Blucher	31/10/2017
a. Develop annexe and provide discreet access to the mortuary – this is part of overall mortuary improvement plan. Discreet access is via the mortuary tunnel. Improvement works within the tunnel to improve its condition has recently been completed including the installation of pumps to remove any flood water	Dominic Hall	28/10/2016
b. Review do not resuscitate forms following audit results – action not possible – additional training, audit feedback of forms in progress – DNACPR has now become a QIP and compliance will be assessed on a quarterly basis	Resuscitation Lead	31/01/2018

2. Complete actions on CQC action plan – initial actions are complete and additional actions have now been added to the action plan to provide assurance	Denise Townsend	31/12/2017
3. Complete additional actions on the CQC action plan and obtain assurance that these are complete	Denise Townsend	31/03/2018
4. Awaiting publication of CQC inspection report to determine whether any additional actions are required	Tracy Turner	31/03/2018

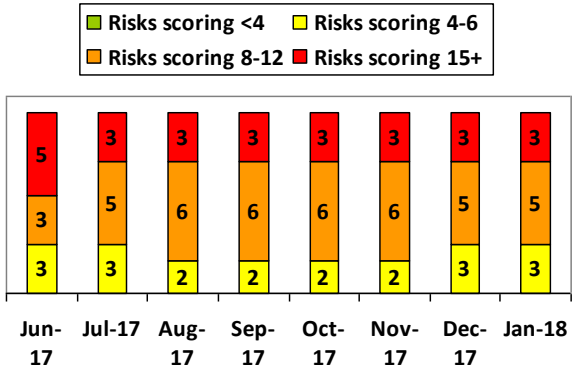
Assurances: (How will we know that what we are doing is having an impact?)

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~~ 9

Chart showing related risks



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~~ 4	
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 the emergency department – reception updated and intercom repaired	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.		
08/12/17	There has been no change in the risk score which remains at 15 (3x5). This is due to the lack of robust evidence in order to close the CQC requirement notices although a large number of actions have been taken to address the issues. The risk rating for the underlying risks have also not changed. The trust is currently having a CQC review of both core services and the well led domain. Initial feedback has been provided following the core services inspection and the well led review is due to take place on 13th and 14th December 2017. Formal feedback in not expected until Spring 2018.		
01/02/18	There has been no change in the risk score which remains at 15 (3x5) due to the open CQC requirement notices and outstanding CQC actions required to address the concerns raised during the recent and previous inspections. Once the final inspection report has been received the rating will be reviewed to determine whether the risk has reduced. The associated risks have been reviewed and 2 risks have recently been downgraded due to progress made with the actions.		