Southend University Hospital NHS
NHS Foundation Trust

Board of Directors Meeting Report – 4 September 2018

Agenda item 49/18

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. All recommendations made in the report have now been implemented.

BAF Risks 1, 7 and 8 were reviewed by the Quality Assurance Committee on 15 August 2018 and the recommendations made by the Committee were incorporated in the respective BAF risks.

BAF Risks 3, 4, 5 and 6 were reviewed by the Finance & Resources Committee on 3 July 2018 and the recommendations made by the Committee were incorporated in the respective BAF risks.

BAF Risk 2 was reviewed by the Audit Committee on 24 July 2018.

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
Essex Success Regime	The BAF has been aligned with Joint Working Board BAF.
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.

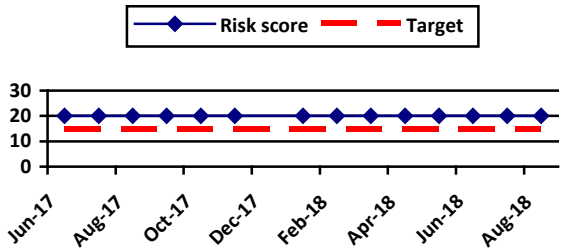
Recommendations: The Board is asked to review and approve the BAF.

Southend University Hospital NHS
NHS Foundation Trust

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 23/08/2018 QAC 15/08/2018 Board 24/05/2018	Target Date	31/03/2019

Risk Rating (Likelihood x Impact)

Initial Risk Score	20 (4x5)
Current Risk Score	20 (4x5)
Target Risk Score	15 (3x5)
Risk Appetite Risk levels	High Level 3 'Open'
Direction of travel	⟺



Relevant Key Performance Indicators

	Apr-18	May-18	Jun-18	Jul-18	Aug-18
ED 4hour standard	90%	95%	94.8%		
Ambulance handover > 60min	8	2	0	1	
Stranded (beds occ)			53.9	55.2	46.9
Attendance avoided (SWIFT)	14	66	128	n/a	

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	Accurate real-time bed state, resolved by TeleTracking Implemented Oct 2018
3. Safe at Southend meetings	None

4. Monitoring of staffing levels, gaps, risks and mitigations	Sufficient workforce to maintain capacity
5. Monitoring of the medical rota	None
6. Capacity plan for each directorate	None
7. System escalation calls, standard and critical	None
8. CCG QIPP scheme focused on reducing demand	Evidence of reduced admissions through SWIFT scheme
9. Ambulance tripartite document for the management of ambulance delays	None
10. Critical incident SOP for attending clinicians	None
11. Individual risk assessments undertaken for cancelled surgery	None
12. Risk assessments for direct admissions	None
13. 'Buddy' ward system	None
14. Re-launch of 'Red to Green' days and 'SAFER'	None
15. Full capacity protocol	None
16. Stranded patients	National benchmarking available; ward-level challenge and review to be implemented Aug 18

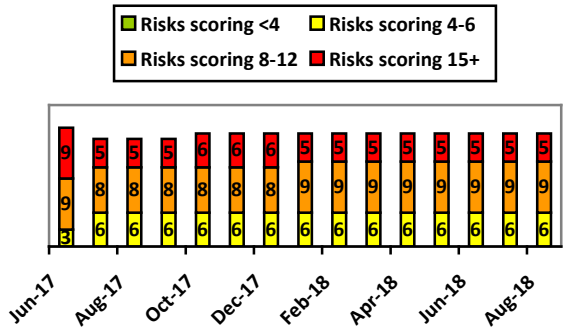
Mitigating Actions: (What more do we need to do to fill the gaps)	**Lead**	**Target Date**
2. Introduction of TeleTracking system	Managing Director	31 Oct 2018
4. Implementation of safer staffing module on electronic staff rota	Dir of Nursing	30 Nov 2018
8. Patient-level review of interventions by SWIFT (initial and continuing)	Dir of Operations	30 Sept 2018
16. Challenge and review meetings for stranded patients (> 14 days LOS)	Dir Ops/ Dir Nurs	31 Aug 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 commissioner action Deteriorating KPI values

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**

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	**6**



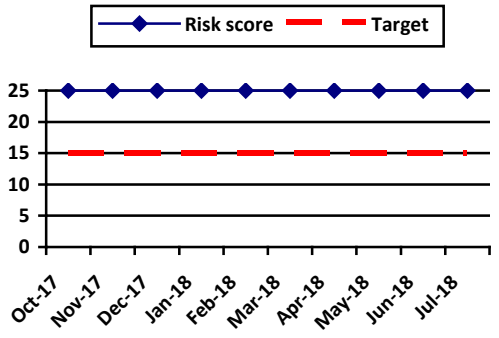
	reduced quality of care and experience		
2153	Delay to Head and Neck and upper GI Cancer Pathway	**6**	
2292	Chemotherapy Capacity- Inability to meet the demand for chemotherapy in CTU; causing patient access delay.	**6**	
2147	Bed pressures impact on Surgical Directorate and lead to cancellation of 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.
16/04/2018	BAF Risk reviewed in line of new financial year

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. The risk of financial penalties may be modified by the possible agreement of a block contract for 18/19 (ref 2152)				
Strategic Objective	4		**Risk Domains**	Regulatory / Legal	
Date Identified	15/05/2017	**Date Last Reviewed**	CGG 23/08/2018 Audit Com 24/07/18 Board 24/05/2018	**Target Date**	31/07/2018

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	*Mar-18*	*Apr-18*	*May-18*	*Jun-18*	*July-18*
% waiting less than 18 w	84.7	86.3	87.4	88.2	88.6
% treated within 62 days	70.6	76.8	74.1	68.0	61.5
A&E 4 hours	79.9	89.5	95.0	94.8	92.6

Note: Both the RTT and the A&E 4-hour values are above the agreed trajectory in each month.

Controls: (What are we currently doing to reduce the impact or likelihood of the risk occurring?)	**Gaps in Controls:**
Cancer Target	
1. Cancer Board	1. N/A
2. MSB Cancer Director to manage the process and patient flow	2. N/A
3. Live cancer patient tracking	3. Delays in patient pathways
4. Weekly PTL reviews for cancer	4. N/A
5. Joint Basildon / Southend Cancer improvement post to address late referrals	5. Continuing late referrals from other Trusts. A process for reporting of Harm reviews needs to be in place
6. Capacity to meet the demand	6. Availability theatre lists
RTT	
7. Weekly meetings with directorates to review performance and PTL	7. N/A

A&E 4 hour 8. Patient Flow Board 9. Extended AEC service 10. Programme of task/finish groups for flow 11. Support Plans in Place for ED 12. Support plans in place for Medicine 13. Live ED breach tracking reviewed at the bed meetings 14. Full implementation of Full Capacity Protocol 15. Implementation of recommendations of discharge review	 8. N/A 9. N/A 10. N/A 11. N/A 12. N/A 13. N/A 14. N/A 15. N/A

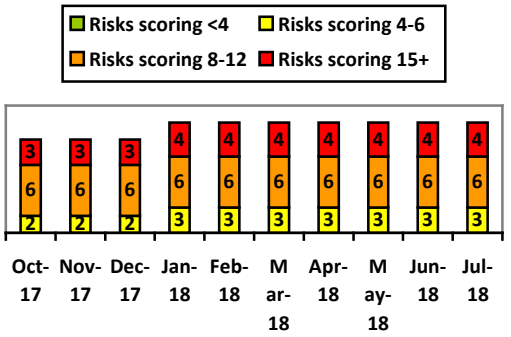
Mitigating Actions: (What more do we need to do to fill the gaps)	**Lead**	**Target Date**
3. Review of SUHFT cancer action plan by NHSI Cancer Lead	Yvonne Blutcher	30/09/2018
5. Development of an msb cancer recovery plan	Yvonne Blutcher	30/09/2018
6. Use of robot lists in MEHT by SUFHT urology	Clare Burns	31/10/2018
5. Clarification of the Governance process for reporting outcome of Harm Reviews	Clare Burns /Neil Rothnie	30/09/2018

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))**	**Gaps in assurances**
• *Independent external review of discharge and 4hr target* • *Positive internal audits*	Regulator and commissioners notice	Clarity on delivery of BTUH recovery plan

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



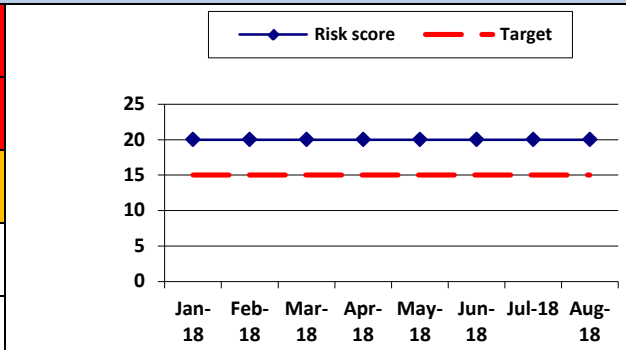
2655	Diabetes and Endocrinology Backlog for follow-up patients	12	
1803	Failure to stay within DoH ceiling for C.Difficile- ceiling of 30 may lead to reputational damage and financial penalties	12	
2715	Failure to meet 52 week target for interventional radiology procedures in Urology	12	
2673	Failure 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:	

Southend University Hospital NHS
NHS Foundation Trust

RISK I.D	3	Executive Lead	Louisa Cowell	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	19/4/18	Date Last Reviewed	CGG 23/08/2018 FRC 03/07/18 Board 24/05/18	Target Date	31/03/2019

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 Risk Level	Moderate 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	-7.35	**-15.12**
Variance *(deficit)/(surplus)*	-	**0.02**	**-0.12**	**0.03**	**-0.07**

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 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.	2. The 2018/19 programme has identified approximately £11.8m against a target of £12m which leaves a small gap. There is slippage in some previously identified schemes, which increases this 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 2018/19 and has arranged an uncommitted revenue support loan.	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 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 services or staff are shared across the MSB, the Trust will ensure that there is a clear and fair basis of financial recharge or apportionment between the organisations and that there is adequate backfill arrangements where it involves Trust staff.	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.	LC	Ongoing
2. Enhance the governance and scrutiny arrangements to challenge all agency bookings above cap (nursing and Medical), and all requirements for medical agency.	DT/NR	September
3. Further focus on recruitment and retention of staff to further reduce the Agency requirements of the Trust.	SB/AC	Ongoing
4. The Trust is still identifying additional 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.	LC/CB/KR	Ongoing

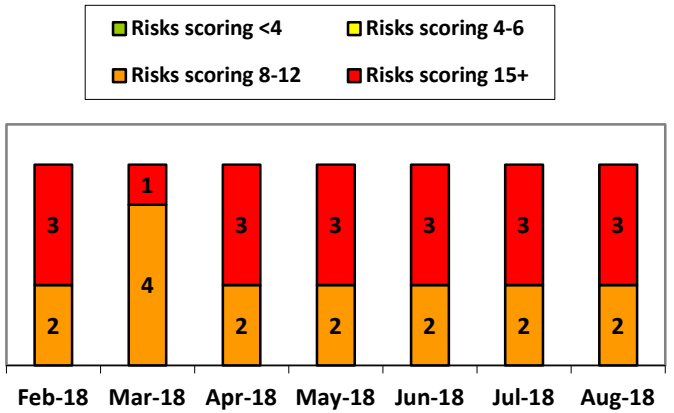
Assurances: (How will we know that what we are doing is having an impact?)	
Positive Assurances: (evidence that shows the controls are effective (for example metrics, inspections etc))	**Negative Assurances: (evidence we won't find if the controls are effective (for example incidents, complaints etc))**
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.	1. The regular meetings with NHSI have not highlighted any significant specific action that the Trust is not already taking.
2. Board & FRC agenda and minutes. The Trust has a track record of delivering its set control total for the past several years.	2. n/a
3. Agenda and minutes from the Executive Business meeting and Directorate PRM action logs	3. n/a
4. Agenda and meeting notes from the Vacancy & Revenue Panel	4. n/a
5. The notes of the weekly Finance Management Group showing that the current cash position is being discussed.	5. Absence of late payment charges (from suppliers) during 2016/17 and 2017/18
6. Investment Approval Committee and Revenues Approval Committee minutes / notes.	6. n/a
7. Agreement of the loan with NHSI. Compliance with the Section 42 conditions which are a requirement of the loan.	7. n/a
8. Training certificates and training records in addition to the outcome from clinical audits	8. n/a

9. The detailed planning and budget setting meetings that have taken place between clinicians, senior managers and external advisors to arrive at the agreed plan. 10. Detailed records of staff working between Trusts	9. n/a 10. n/a

Related Risks

Risk Ref:	Description	Score
2287	Trust fails to meet its financial targets. Closer scrutiny by Monitor and possible enforcement action	20
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	15
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

Chart showing related risks

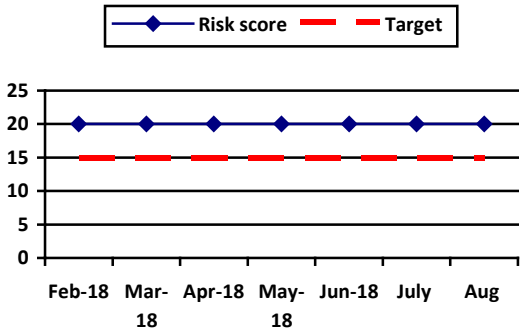


Risk Review Comments:	
22/6/18	There have been no changes to the detailed risks above since the last report.
24/08/18	Risk has been reviewed, controls have been refreshed and mitigations enhanced.

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	18/06/2018	Date Last Reviewed	CGG 23/08/2018 FRC 03/07/2018 Board 24/05/2018	Target Date	31/03/2019

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	Mar 18	Apr 18	May18
Vacancy Rate	7%	10.55%	11.36%	12.16%
Vacancy Rate (nurses)	7%	12.81%	14.43%	15.00%
Vacancy Rate (consultants)	7%	10.69%	12.55%	13.69%
Agency (% of pay bill)	6%	11.53%	10.01%	8.77%
Turnover Rate	9.50%	12.55%	12.66%	12.33%
Appraisal	90%	78.05%	74.34%	77.28%

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

1. Key performance indicators for establishment, vacancies and turnover in place and reviewed by Directorates Boards and Executive Performance Boards monthly.

Gaps in Controls/Actions

1. No gaps identified as in place

2. Speciality Review meetings held for specialities with highest vacancy/ agency spend.	2. No gaps identified. Being undertaken and on-going
3. Recruitment Officer and Directorate Managers meetings to ensure recruitment plans are in place for every vacancy.	3. No gaps identified. Being undertaken and on-going
4. HR Organisational Development Strategy in place	4. Strategy not fully effective in addressing staff retention and recruiting hard to fill posts. Recruitment and Retention T&F in place
5. International and national recruitment campaigns are in place	5. Recruitment pipeline from overseas nursing is not delivering the expected numbers. New recruitment strategy being developed across MSB
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. . Recruitment and Retention T&F in place
7. Corporate induction programme and on-boarding process in place	7. No gaps identified as in place
8. Leaver/ exit interview process in place	8. Exit interview rate at 22% and currently collation of feedback from interview is manual, so difficult to identify trends. Electronic Leavers form in place as of Q3. 2018.
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. NAURP and MARUP Groups in place to address bank and agency usage. Enhanced rates in place to offset agency usage. Paper submitted to Board for continued enhancement rates within Nursing June 2018.
12. Dedicated medical and non-medical recruitment officers in place	12. No gaps identified as in place
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 HR team to ensure Recruitment and Retention issues are addressed.	15. No gaps identified as in place
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.	16. No gaps identified as in place
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 as in place
19. Primary drivers for improving retention have been identified through the NHSI Staff Retention Programme. Implementation of a SMART Action Plan containing 40 work streams is under way and monitored by the	19. NHSI programme focused on Nursing

Recruitment & Retention Committee.		
20. Engagement with site staff in MSB transformation and vision for future to ensure we retain through transition.	20. Difficulty in staff attending designated sessions and focus on clinical reconfiguration. First HR Away Day in May 2018 and second scheduled June 2018 with all areas of HR Recruitment.	
21. Managing impact of additional workload from operational pressures and MSB on staff.	21. Resilience training offer and additional resource available for MSB work	
22. Manager ability to recruit and retain staff in line with the appropriate skills, competence and behaviour (values)	22. Training and development offer for new managers	
Mitigating Actions: (What more do we need to do to fill the gaps)	**Lead**	**Target Date**
1. Monthly Nursing Recruitment and Retention Group established to review data and develop approach and reporting.	NB/ JF	On-going
2. Further Analysis of workforce and service requirements for opportunities to adopt different workforce models – targeting hard to recruit areas.	NB/ JF	30th September 2018
3. N/A		
4. People Strategy being developed for MSB and site to address gaps. Separate Recruitment and Retention/ engagement strategies also being developed to ensure appropriate focus, supported by action plan	POD/ NB. SW	Completed – next step communication to site teams.
5. Further overseas initiatives being explored including Ireland campaign and India plan being developed with procurement.	NB	End of June 2018
6. POD holding engagement sessions with staff and stakeholders to develop staff survey action plan, along with Trust and Directorate action plans being put in place.	POD/ FK	End of June 2018 – engagement sessions held, feedback to be communicated and incorporated into staff survey action plan.
7. N/A		
8. Implement on-line exit interviews online and monitor results	SW	End of September 2018
9. Revised appraisal form introduced as a trial to June 2018 and new trajectory to be set. Trust/ CQC Action plan in place.	FK	End of October 2018
10. N/A		
11. Increase the size, availability and competence of the bank pool (especially for HCA, nurses and medical staff) via rolling recruitment campaigns, review of incentives, retire and return, bank rates and conversion of agency (TSAP action plan/ Top 10 agency)	NB	On-going
12. N/A		
13. N/A		
14. N/A		
15. N/A		

16. N/A 17. Group proposal to appoint redeployment posts to support with above implementation and managing across group. Risk posts to be reviewed as required. 18. N/A 19. Actions extended to other staff groups where applicable and hot spot Directorates and deep dive exercise completed on high turnover wards. 20. Engagement sessions being held with teams by POD to shape MSB work programme/ transition. 21. Business case being taken to JEG to finance transition roles and support. Health and wellbeing and staff benefits initiatives – action plan in place in line with retention programme. 22. Recruitment and Retention training session developed – to be rolled out and available for new managers	MSB and SB SW POD MSB SW FK, SW and POD	End of May 2018 and on-going Hotspots are in Trust action plan. End of June 2018 – request for roll out plan Update required – understand approved and will be recruited to. On-going in line with Trust action plan. End of August 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. 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. 2. Speciality Review meeting minutes and actions, changes in posts in establishment (to reflect new posts), reduction in vacancy KPI. Exit interviews reflect 'pull' not 'push' factors. 3. Audit results demonstrate that all vacant post are being advertised on TRAC 4. Evidence of retention strategy in place, with monitored implementation plan, reduction in turnover KPI. Improved staff survey engagement results. Positive trends demonstrated via Nursing Retention Dashboard. 5. Trajectory for HCA apprenticeship training and recruitment in place and	1. Increase in recruitment timeline - TRAC KPI's and retention dashboard targets not met. 2. Speciality action plans not delivering specific recruitment targets. 3. Recruitment not taking place and delays for establishment vacancies 4. Increasing turnover rates at staff level, lower staff engagement score, negative feedback on on-boarding, pre-retirement surveys and exit interviews 5. Implementation plan not delivering HCA apprenticeship targets	

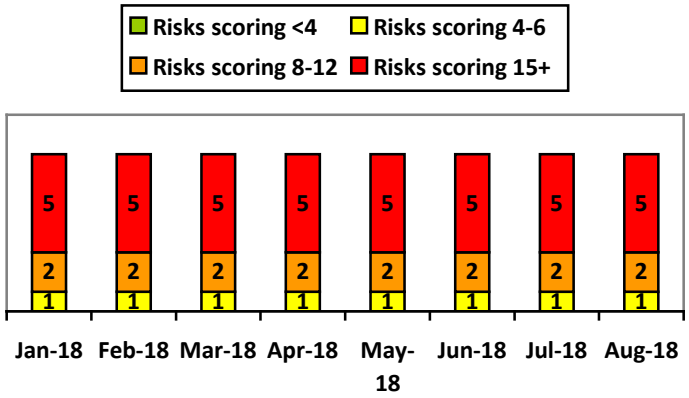
implementation plan monitored and tracked. Numbers of HCA's trained and recruited meet the trajectories and nursing vacancy KPI reduction.	
6. see point 4 above.	6. See point 4 above
7. Evidence of template and guidance in place. Feedback from new starters through targeted survey and national staff survey 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	11. Increase in agency booking/ spend for HCA and nurses
12. See point 1 above	12. Increase in recruitment timeline – TRAC KPI's not met
13. N/A	13. N/A
14. N/A	14. N/A
15. CIP and Task Group minutes and actions reflect progress with recruitment	15. N/A
16. N/A	16. N/A
17. Vacancy fill rates through redeployment and recruitment timelines improve	17. Increase in recruitment timeline – TRAC, KPI's not met
18. Recruitment and Retention Committee approval of activities and initiatives	18. N/A

19. SLT and FRC monitoring of Retention Programme plans and outcomes 20. Staff survey, pulse survey, engagement sess. feedback, sickness reduction 21. Evidence of process in recruitment paperwork (through audit), feedback from candidates, reduced turnover in first 6 months	19. negative trends demonstrated via Nursing Retention Dashboard 20. reduction in engagement score, increase in turnover 21. Increase in turnover in first 6 months

Related Risks

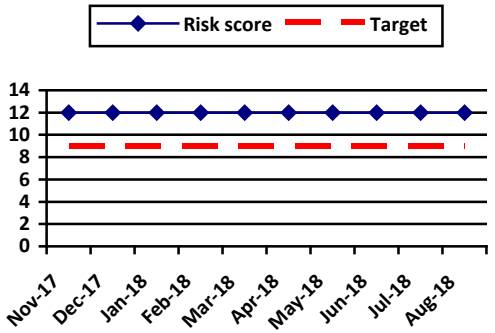
Risk Ref:	Description	Score
2808	Staffing shortages may lead to compromised patient care or experience and failure to meet Safer Staffing requirements	20
1949	Risk to patient safety due to shortage of medical staff across the Medicine Directorate	20
2365	Risk to patient safety due to Nursing vacancies in the medical wards	16
2730	Implementation of the Success Regime may lead to poor staff engagement and morale	16
70	Increased use of nursing agency staff with varying skills and experience	15
2451	Inability to recruit staff which will lead to a failure to meet expenditure targets	12
1855	Risk of compromising continuity and quality of care, service delivery and patient safety due to inadequate staffing	8
2146	Compromise of patient care and safety due to staffing levels	6

Chart showing related risks



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 23/08/2018 FRC 03/07/2018 Board 24/05/2018	**Target Date**	31/03/2019

Risk Rating (Likelihood x Impact)		**Relevant Key Performance Indicators**
Initial Risk Score	20 (4*5)	Performance KPI's have been identified which demonstrate the effectiveness of the service delivery. These are included within the estates and facilities section of the Integrated Performance Report. The Premises Assurance model (PAM) provides an indicator which is more closely aligned to BAF 5.
Current Risk Score	12 (3*4)	
Target Risk Score	9 (3*3)	
Risk Appetite Risk Level	Moderate Level 2 'Cautious'	
Direction of travel		



Domain	**Overall rating**
Safety (Hard services)	Good
Safety (soft services)	Good
Patient Experience	Good
Efficiency	Good
Effectiveness	Good
Governance	Good

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.	Remedial actions following completion of Premises Assurance Model. Review of urgent actions completed - none for Southend, peer review to be undertaken.
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.	Appointment letters to be reviewed and issued.
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	None

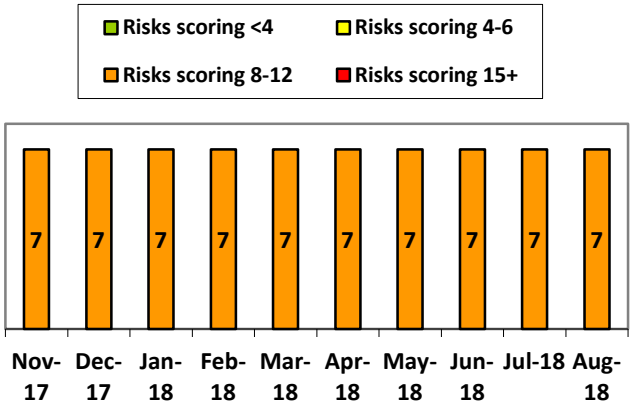
Survey / Backlog Capital Programme / Incident reporting system.	
4. Soft Services – Cleaning Standards Standard operating procedures monitored by domestic supervisors Internal QA uses C4C to monitor cleaning standards for domestic and nursing staff.	None
5. Contract Monitoring	None
6. Business Continuity Plans	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 inclusion in capital programme. Equipment related incidents investigated.	None
9. (2701) Upgrades phased through capital programme	None
10. (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.
11. (2702) Design development progressing. Phased programme drafted to avoid reduction in mortuary capacity during peak winter demand period. Capital expenditure required.	Capital works progressing, awaiting planning permission for next stage works. Funded from Sustainable Transformation Fund, on-going discussion with Essex County Council regarding capital contribution..
12. (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 2018/19 within financial year.	None
13. (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. Out to tender for design consultant to provide remedy.
14. (2477) Capital investment plan over two years, Phase 1 fire door replacement completed, Phase 2 fire door replacement currently underway.	None
15. (2445) Regular planned inspections.	A site wide review is underway to determine priorities and reconfiguration, a program for which is in the planning stage

<table>
<tr><th>Mitigating Actions: (What more do we need to do to fill the gaps)</th><th>Lead</th><th>Target Date</th></tr>
<tr><td>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.</td><td>JH</td><td>1st April 2019
100% assurance reports completed.
Actions identified, plan to be implemented and updated on an ongoing basis.</td></tr>
<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 2019</td></tr>
<tr><td>11. (2700) Capital funding to sought from 18/19 allocation.</td><td>JH</td><td>Identified from STF funding</td></tr>
<tr><td>13 (2485) Legal action underway against designers and installers of the system</td><td>JH</td><td>1 April 2019</td></tr>
<tr><td>15 (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><th colspan="3">Assurances: (How will we know that what we are doing is having an impact?)</th></tr>
<tr><th colspan="2">Positive Assurances: (evidence that shows the controls are effective (for example metrics, inspections etc))</th><th>Negative Assurances: (evidence we won’t find if the controls are effective (for example incidents, complaints etc))</th></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>None</td></tr>
<tr><td colspan="2">2. Training skills register demonstrates compliance
Authorised person appointed</td><td>None</td></tr>
<tr><td colspan="2">3. CAFM holds Asset register and annual programme of PPM, KPI audit reports submitted to the Trust Board. Estates Risk Assessed Capital Programme prioritises</td><td>None</td></tr>
</table>

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)	
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 in CQC reports
5. KPI clearly identified in contract specification and reviewed at monitoring meetings	Limited assurance from FRC
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. Full provision of Medical gas services	Failure of medical gas provision.
10. Positive CQC inspection reports	Requirement for improvement following CQC inspection.
11. Mortuary Service that is fit for purpose	Requirement to close mortuary due to regulatory requirement.
12. Fire spread managed and contained	Uncontained fire spread following failure of fire dampers
13. Water leak that disables heating and hot water to the hospital	Cancelled theatre lists and ward closures.
14. Fire spread managed and contained	Uncontained fire spread following failure of fire doors.
15. Power sustained to the hospital	Loss of power to the hospital

Related Risks

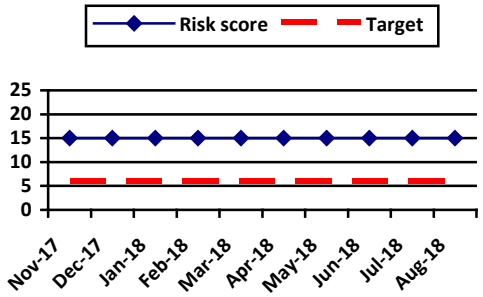
Risk Ref:	Description	Score
2701	Medical Gases improvement works (Trust deferred capital improvements project) (risk awaiting approval)	12
2700	CQC Planned works (Trust deferred Project) Drug room air conditioning Sanitary Ware replacement (risk is under review)	12

2702	Mortuary - Capital Improvement Project (deferred 2017/18) (risk awaiting final approval)	9	***Chart showing related risks*** 
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	
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	In order to deliver ambitious, efficient and innovative ways of working, the Informatics Strategy must support a degree of risk in relation to seeking opportunities for innovation and the improvement of quality outcomes at local sites and across the MSB Group. Failure to develop and embed a robust Informatics Strategy may lead to technical, operational and financial inefficiencies, therefore increasing the potential for patient harm, operational disruption and exacerbated current financial pressures. The Trust's legacy infrastructure includes single points of failures and multiple, outdated hardware and operating systems which increases the potential risk of future cyber-attacks. In particular, failure to ensure adequate investment in the delivery of the local service development plan in order to support the overall Informatics Strategy and improve digital defences to deter cyber-attacks, may lead to patient harm, financial loss, and disruption or damage to the reputation of the Trust through failure of our information technology systems.				
Strategic Objective	Excellent Patient Outcomes, Excellent Patient Experience and financial and operational sustainability	Risk Domains	Infrastructure, Technical, Patient safety, Financial, Reputational		
Date Identified	15/05/2017	Date Last Reviewed	CGG 23/08/2018 FRC 03/07/2018 Board 24/05/2018	Target Date	31/03/2019

Risk Rating (Likelihood x Impact)

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



Relevant Key Performance Indicators

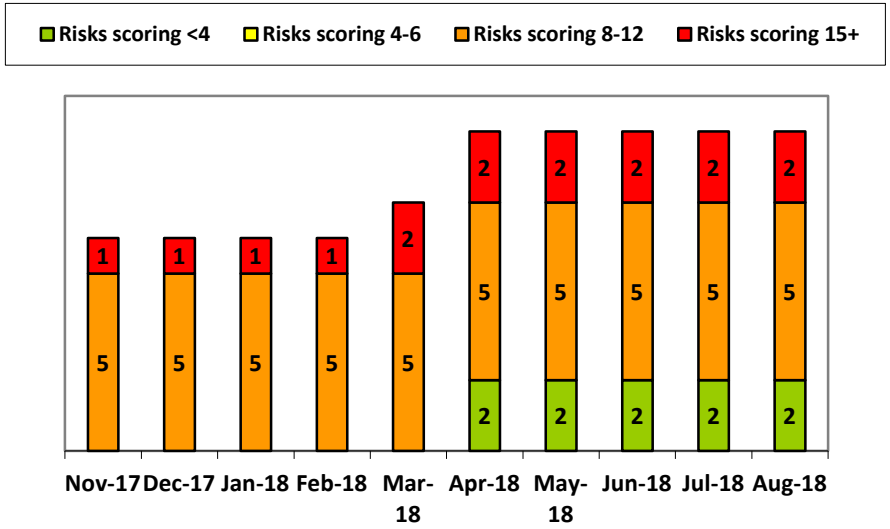
Metric	RAG Status	Comments
EoL OS Managed to plan		
– PC's Removed		4 remaining machines to be replaced
– Servers Migrated		Progress being made where possible, some tasks awaiting funding and/or the outcome of the Cloud Navigator review
Cyber Security Programme		
– Detailed Plan Finalised		On plan
– Delivery Proceeding as planned		Implementation already commenced

Further KPI's will be added once the combined risk register has been finalised.

Controls: **(What are we currently doing to reduce the impact or likelihood of the risk occurring?)**	**Gaps in Controls:**
1. Continual assessment of existing operational demands and stability of IT infrastructure and software (Risk Ref 2401)	Availability of funding will impact upon the timely replacement of hardware infrastructure and associated operating systems
2. Data centre environment (below towerblock) has maintained power supply / UPS, air con is monitored via facilities BMS, fire detection system in place and suppression and water detection system (Risk Ref 1609) Microsoft Cloud Navigator exercise currently in progress to assess which digital systems can hosted in a remote data centre (Risk Ref 1609)	There is currently no resilient data centre room which would be able to host critical services in the event of a catastrophic environmental or IT infrastructure failure. This review is likely to take some time and is dependent upon business case approval and the availability of funding. Whilst some digital services will be suitable for migration to a remote, highly resilient data centre (cloud), network connectivity remains a single point of failure as all data connections are terminated in the current data centre.
3. Limited in-house on call service provision available to support systems out of hours; support contracts are currently being reviewed to ensure that they are robust and offer values for money (Risk Ref 2435)	In-house resources do not are not able to provide support 24/7, 365 days.
4. Across 3 IT departments there is a cyber-security action plan in place which is reviewed on a regular basis (Risk Refs 2819 & 2425)	No gaps identified

Mitigating Actions: (What more do we need to do to fill the gaps)	**Lead**	**Target Date**
1. Review approved funding and prioritise replacement programme	**AT**	**01/06/2018**
2a Second main network hub room at west end of site	**SLB**	**Deferred due to availability of funding (Prev 27/03/2018)**
2b Complete the feasibility review of Microsoft Cloud Navigator solution (hosted off-site datacentre)	**NB**	**01/09/2018**
2c Explore the feasibility of replicating services at other MSB locations	**NB**	**01/09/2018**
3. Review core clinical system support contracts and staffing availability/skills mix against OoH demand	**LB**	**01/12/2018**
4. Cyber Security programme across the MSB Group to be fully implemented	**AT**	**End Mar-19**

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

Related Risks			
Risk Ref:	**Description**	**Score**	**Chart showing related risks**
2401	Loss of digital systems impacting patient care due to ageing and unsupported IT infrastructure and software	20	
1609	Loss of IT Datacentre (below towerblock) impacting patient care due to severe and lengthy disruption of IT systems and telephony	15	
2435	IT System Support Provision does not reflect criticality of system or hours of usage.	12	
2669	Lack of Server operating system patching process	12	
2819	Risk of virus attacks against Medical Equipment with Embedded Operating System that cannot be patched	10	
2425	Risk of disruption and / or damage to IT systems from Cyber threats.	8	
2932	Loss of Radiotheraphy infrastructure	8	
2865	Lack of Uninterrupted Power (UPS) at Orsett Eye Unit. Power failure would mean a complete power loss within ophthalmology service	3	
623	Printing of PII to a "default printer" without checking the location	2	

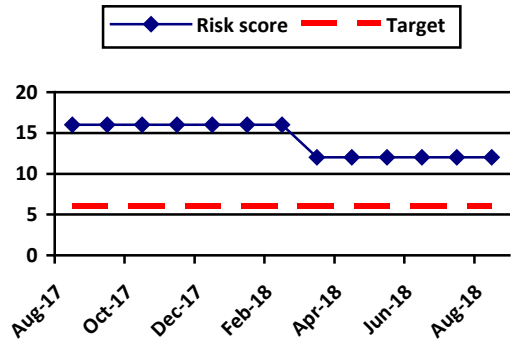
Risk Review Comments:	
22/08/2017	Risk reviewed and risk score maintained at 12 as actions remain unchanged. Controls and gaps reviewed to be more strategic in approach
03/10/2017	Start date added for dedicated Digital (Cyber) Security Officer and current risk score updated to maintain following feedback at FRC
27/10/2017	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
19/04/2018	The risk description has been revised to reflect those risks currently identified as linked to it. Currently all risks across Digital Services are being reviewed and reassessed to ensure that they are still relevant, accurate with appropriate KPI's identified; it is anticipated that this will be completed within the next 6-8 weeks.
14/05/2018	Due to the restrictive capital programme work due to commence of the delivery of a second datacentre has been deferred. The previous mitigating action (2a) has been updated and addition actions (2b&c) have been identified. Mitigating action (4) relating to Cyber security has been revised and JWB papers regarding the delivery of the Cyber Security programme and overall assurance provided to Company Secretary, B.Sittapah for wider circulation.
20/06/2018	A breakdown of actions to mitigate the risk associated with EoL infrastructure (Risk ref 2401) has been provided in the information attached to the report covering paper. In addition to the breakdown of current legacy systems, authorisation to proceed with a Group wide review of all systems and platforms (Cloud Navigator) is expected to be imminent ; this will review and make recommendations on how best to mitigate the overall position with regards to OS coming to EoL. Mitigating action (3), relating to the review clinical system support contracts, has been reviewed with Lissa Bullard and updated in terms of ownership and timescales. The support contracts for the core clinical systems in use at the Trust will be reviewed in order to ensure that they are robust and offer value for money to the organisation. Staffing arrangements and skills mix within the existing team to support out of hours issues is being reviewed as part of the overall staffing structure for Digital Services across the Group.
21/08/2018	**Risk reviewed and KPI performance has been updated to reflect progress**

Southend University Hospital NHS
NHS Foundation Trust

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 23/08/2018 QAC 15/08/2018 Board 24/05/2018	Target Date	31/03/2019

Risk Rating (Likelihood x Impact)

Initial Risk Score	25 (5x5)
Current Risk Score	12 (3x4)
Target Risk Score	6 (2x3)
Risk Appetite Risk Level	Moderate Level 2 'Cautious'
Direction of travel	⟷



Relevant Key Performance Indicators

	Mar 18	Apr 18	May18	Jun 18	Jul 18
Incidents	107	100	105	160	tbc
SIs	0	1	1	0	tbc
IRMER reports	0	0	0	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

Gaps in Controls:

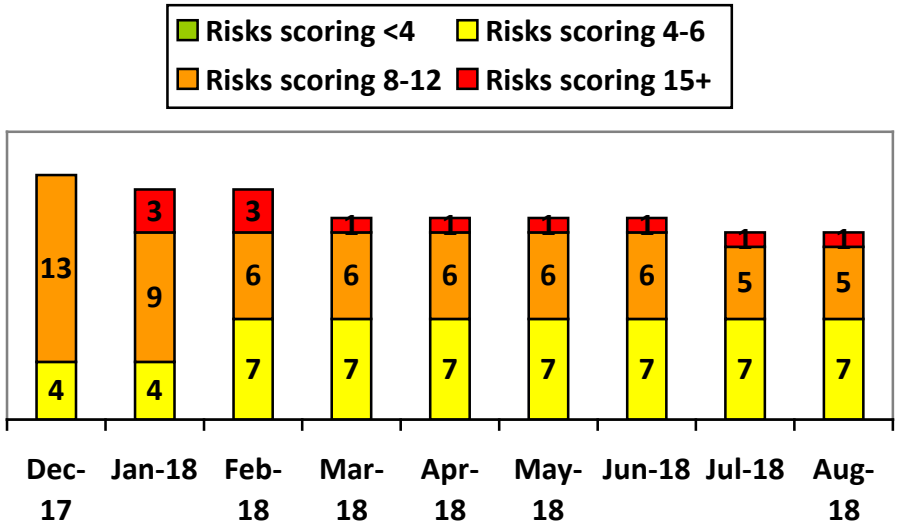
1. Weekend cover not included; spares for end of life equipment not available.

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	2. Timeliness of response / resolution 3. National shortage of these professions 4. Human error 5. 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. Ultrasound scanner evaluations completed and scanner to be ordered (RA 2875)	Darren Taylor	30/8/2018
2. Radiographers are currently being recruited and appointments being processed by recruitment team.	Darren Taylor	30/09/2018
3. Case to for interventional / fluoroscopy equipment being drafted (RA2962), first project meeting held	Darren Taylor	30/09/2018
4. Radiologist recruitment underway (RA2423), new candidates due to start, 1 by -mid August and 1 by end September	Darren Taylor	30/10/2018
5. Regular meeting with Pathology First, clinical subgroups, clinical meetings and contract meetings in place to address issues.	Sarah Mapplebeck	30/09/2018
6. SUHT consultant biochemist involved with training of technical staff to help minimise errors. Additional training provided to staff within immunology	Sarah Mapplebeck	30/09/2018

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))**
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***
2962	Fluoroscopy / Interventional radiology suite room 8 and 6 overdue for replacement [1]	15	
2625	The potential for transcription error(s) in radiological reports	6	
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	9	
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	6	
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 due to Pathology IT failure	6	
2835	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	



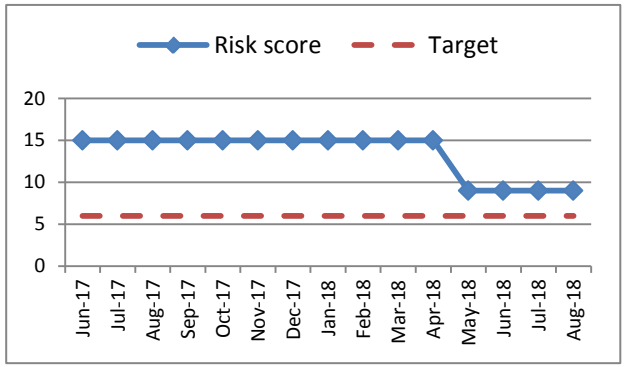
[1] Not a corporate risk

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:			
7/06/18	Progress has been made on some actions. The related risks have been reviewed and updated. 2875 – This scanner is due to be ordered asap – once completed, this risk can be closed. 2512 – Radiographer recruitment is on-going and several posts have been appointed to 2423 – Radiologist recruitment recently appointed 2 overseas candidates who are being processed. This will bring us up to establishment. In the interim an agency locum consultant is in post. 2698 – Removed as Microbiologist appointment made 2835 – Downgraded from 8 to 6		

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 3 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 23/08/2018 QAC 15/08/2018 Board 24/05/2018	Target Date	31/03/2018

Risk Rating (Likelihood x Impact)

Initial Risk Score	25 (5 x 5)
Current Risk Score	9 (3 x 3)
Target Risk Score	6 (2 x3)
Risk Appetite	Level 2 'Cautious'
Direction of travel	⟷



Relevant Key Performance Indicators

	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18
Incidents	1001	1259	1054	1013	794	829	921	TBC
SIs	2	14	8	7	8	9	6	TBC
CQC – overdue actions	2	3	3	2	1	0	1	1
Open requirement notices	5	5	5	5	3	3	3	3
CQC rating	RI	RI	RI	RI	RI	RI	RI	RI

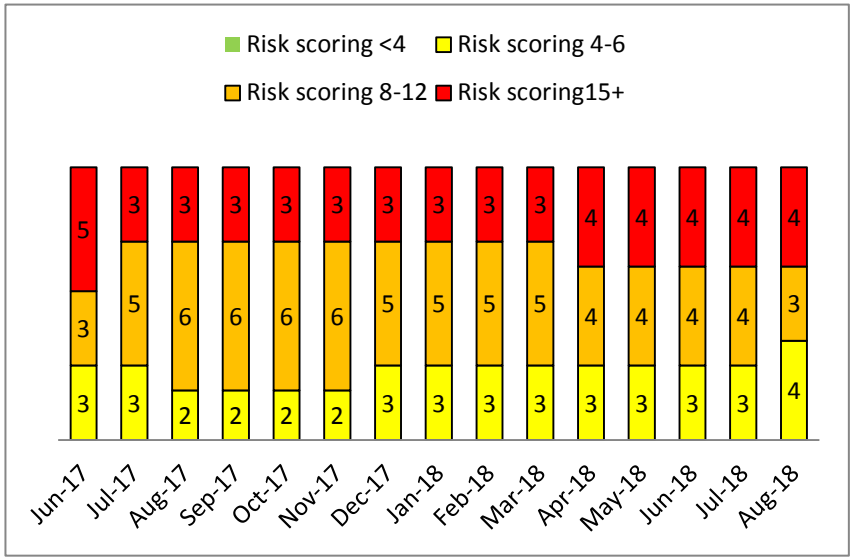
Controls: (What are we currently doing to reduce the impact or likelihood of the risk occurring?)	Gaps in Controls:
1. Mock CQC inspections and quality visits are conducted to assess current compliance with health and social care (HSC) regulations. Action plans are developed in response to these inspections to address areas of concern or non-compliance.	1. No gaps identified
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	2. No gaps identified

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.	3. No gaps identified
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	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. 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	5. No gaps identified
6. A programme of peer reviews across all 3 sites is in place which will involve monthly site compliance visits across 2 areas.	6. Mock inspections have commenced and dates for all 3 sites shared. Due to team capacity not all inspections can be supported externally

Mitigating Actions: (What more do we need to do to fill the gaps)	**Lead**	**Target Date**
1. Complete actions against requirement notices – awaiting recent inspection report to assess which ones can be closed – action plan reviewed and actions now closed. New action plan in place	Yvonne Blucher	30/04/2018 complete
2. Complete additional actions on the CQC action plan and obtain assurance that these are complete –Action plan updated fortnightly. Action relating to mental health suite remains overdue and needs to be escalated again	Denise Townsend	31/08/2018
3. Awaiting publication of CQC inspection report to determine whether any additional actions are required – Action plan updated and submitted to CQC on 18th May.	Tracy Turner	30/04/2018 Complete
4. Monitor new CQC action plan and ensure actions remain on track.	Tracy Turner	31/12/2018 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. Self- assessment reports against KLOE	1. Gaps in evidence required against KLOE
2. Provider information request returns	2. Gaps in available evidence required or out of date evidence
3. Mock CQC inspection reports and action plan reports	3. Overdue action plans
4. Formal CQC action plan reports and clinical audit reports	4. CQC requirement notices

Related Risks			
Risk Ref:	**Description**	**Score**	***Chart showing related risks***
2359	Mortuary services ensure the deceased are managed with dignity and respect (capacity)	16	
2365	Risk to patient safety due to nursing vacancies in the medical wards	16	
2690	RTT admitted backlog - surgery	16	
70	Increased use of nursing agency staff with varying skills and experience	15	
2581	Risk to patient safety due to temporary opening of extra beds to increase capacity due to emergency admission demand	~~12~~ 6	
2700	Estates and facilities CQC planned works – trust deferred project	12	
1690	Paediatric patients will be treated and wait in adult ED	10	
2702	Mortuary – capital improvement project deferred 2017/18	9	
2540	Complaints backlog	6	
336	Deviation from standard security procedures may lead to uncontrolled departure of child attending the emergency department – reception updated and intercom repaired	4	
2156	Risk of harm to patients when RTT waits going on longer than 52 weeks	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.
13/04/18	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 the ratings for these risks have not changed
17/05/18	The risk score has reduced to 9 (3x3) due to the significant increase in the number of areas being rated as 'good' by the CQC despite the overall rating remaining as 'requires improvement'. The impact has been reduced to moderate due to the reduction in the number of requirement notices issues to the trust from five to three. The associated risks have been reviewed to include those relating to the MUST take actions or requirement notices.
02/08/18	There has been no change in the risk score which remains at 9 (3x3) due to the open CQC requirement notices and outstanding CQC actions required to address the concerns raised by the recent CQC inspection. There is one overdue risk relating to an operational SOP for the mental health suite which includes the staffing arrangements. This has been escalated but needs to be further escalated.