Board of Directors Meeting Report – 4 December 2018

Agenda item 73/18

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. BAF Risks 1 and 8 were reviewed by the Quality Assurance Committee on 17 October. A proposal was discussed to remove BAF Risk 7 as a BAF risk as a result of the move to group model working for radiology and pathology. The risks relating to radiology and pathology at Southend University Hospital NHS Foundation Trust are included in the corporate risk register. The QAC agreed to the proposal. BAF Risks 3, 4, 5 and 6 were reviewed by the Finance & Resources Committee on 6 November 2018. BAF Risk 2 was reviewed by the Audit Committee on 23 October 2018. Following the Committee meetings, the Board Assurance Framework (BAF) has been further reviewed by the respective Site Director Leads and the Corporate Governance Group on 20 November 2018 incorporating the comments made.	
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. The Board is also asked to approve the removal of BAF Risk 7.	

RISK I.D	1	Executive Lead	Managing Director	Risk Manager	Director of Operations
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 20/11/2018 QAC 17/10/2018 Board 04/09/2018	**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	⟷

Risk score
Target
30
20
10
0
Jun-17 Aug-17 Oct-17 Dec-17 Feb-18 Apr-18 Jun-18 Aug-18 Oct-18 Dec-18

Relevant Key Performance Indicators

	Target	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct 18
ED 4hour standard	95%	95%	94.8%	92.6%	88.7%	90.6%	90.3%
Ambulance handover > 60min	0	2	2	1	11	6	5
Stranded (beds occ)	46.6		53.9	55.2	46.9	31.2	48.4
Attendance avoided (SWIFT)	TBA	50	92	68	76	74	94

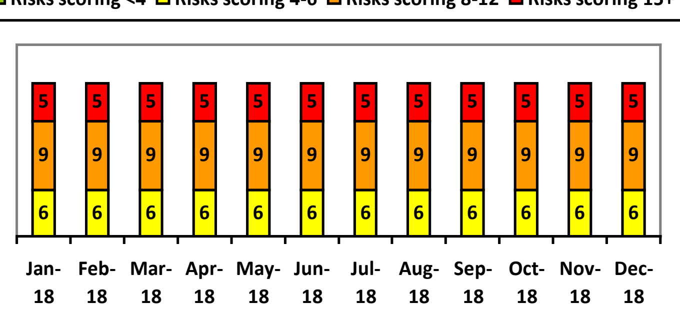
Controls: (What are we currently doing to reduce the impact or likelihood of the risk occurring?)	Gaps in Controls:
1. A&E Delivery Board chaired by the Acute Managing Director with senior director engagement from the external bodies	None
2. Five bed meetings daily	Teletracking implemented on 30th October 2018. Management information reports to be developed.
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	Job plans are not complete across the Consultant body
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	Load levelling system. Operational independently by EoE
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. 'Red to Green' days and 'SAFER'	Whiteboard rounds require embedding in Medical wards Extensive use of agency consultant and Junior Staff is a barrier to continuity of practice.
15. Full capacity protocol	None
16. Stranded patients (national measure is > 21 days LOS). A new weekly clinical review process is in place and the number of high LOS patients is reducing	None

Mitigating Actions: (What more do we need to do to fill the gaps)	**Lead**	**Target Date**
2. Development of Management information reports	Managing Director	30 Nov 2018
4. Implementation of safer staffing module on electronic staff rota	Dir of Nursing	01 Dec 2018
6. Monitoring of completion rates in Medicine and ED through weekly Intensive Support Meetings	Managing Director	31 Dec 2018
9. Mitigation to be developed for load levelling		
8. Patient-level review of interventions by SWIFT (initial and continuing) Audit complete. Joint Demand management group is developing a plan to utilise SWIFT resources for other alternative to admission pathways.	Dir of Operations	30 Nov 2018
14. A programme of re-enforcing Whiteboard processes has started and will be rolled-out across Medicine	Dir of Operations	20 Dec 2018

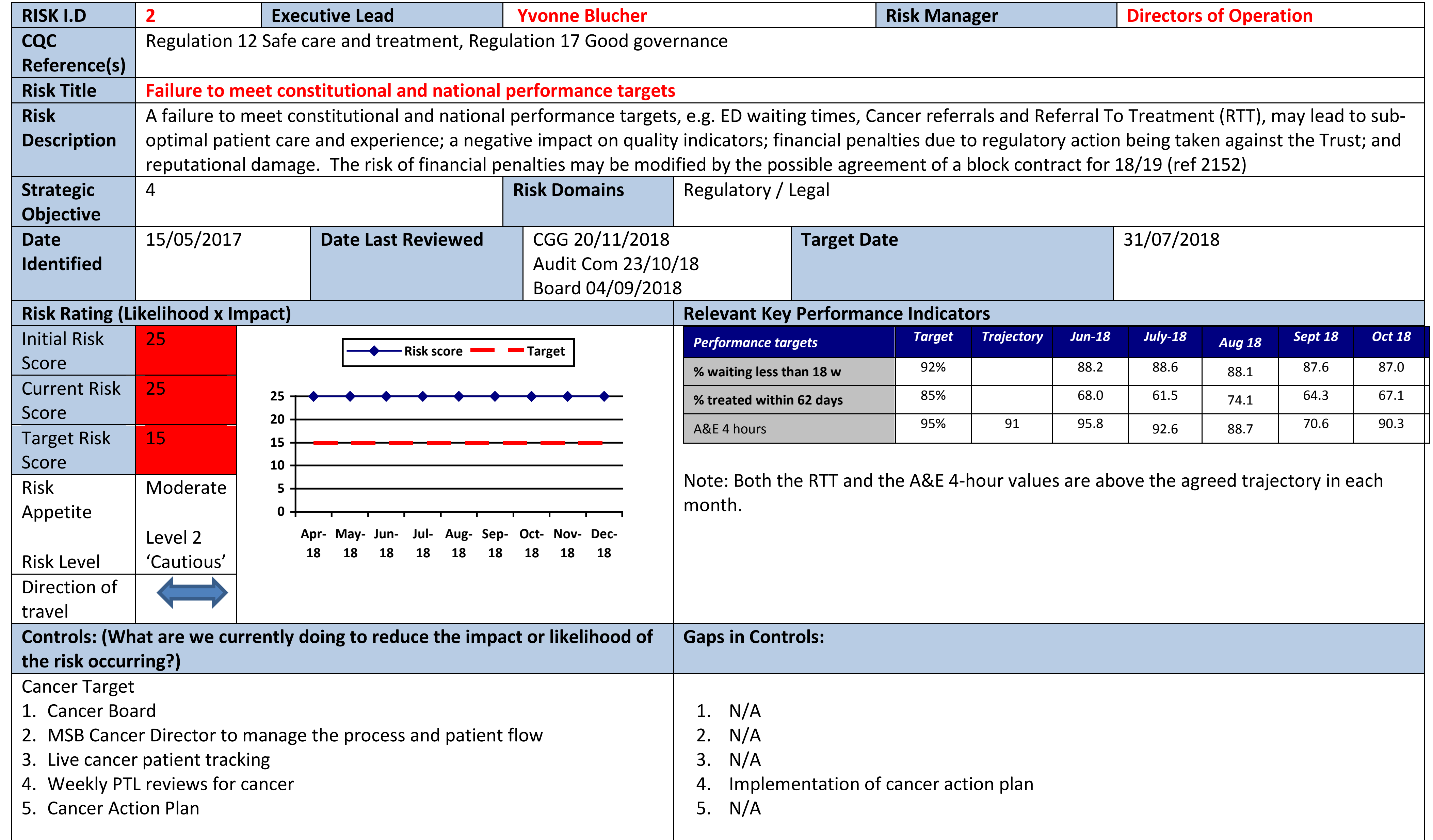
Assurances: (How will we know that what we are doing is having an impact?)

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 Output of regular reviews with NHSE and CCG	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	**8**	

	brachytherapy patients		
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.
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 20/11/2018 Audit Com 23/10/18 Board 04/09/2018	Target Date	31/07/2018

Risk Rating (Likelihood x Impact)

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

Relevant Key Performance Indicators

Performance targets	*Target*	*Trajectory*	*Jun-18*	*July-18*	*Aug 18*	*Sept 18*	*Oct 18*
% waiting less than 18 w	92%		88.2	88.6	88.1	87.6	87.0
% treated within 62 days	85%		68.0	61.5	74.1	64.3	67.1
A&E 4 hours	95%	91	95.8	92.6	88.7	70.6	90.3

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 2. MSB Cancer Director to manage the process and patient flow 3. Live cancer patient tracking 4. Weekly PTL reviews for cancer 5. Cancer Action Plan	1. N/A 2. N/A 3. N/A 4. Implementation of cancer action plan 5. N/A

RTT 6. Weekly meetings with directorates to review performance and PTL	6. N/A
A&E 4 hour 7. Patient Flow Board 8. Extended AEC service 9. Programme of task/finish groups for flow 10. Support Plans in Place for ED 11. Support plans in place for Medicine 12. Live ED breach tracking reviewed at the bed meetings 13. Full implementation of Full Capacity Protocol 14. Implementation of recommendations of discharge review	7. N/A 8. N/A 9. N/A 10. N/A 11. N/A 12. N/A 13. N/A 14. N/A

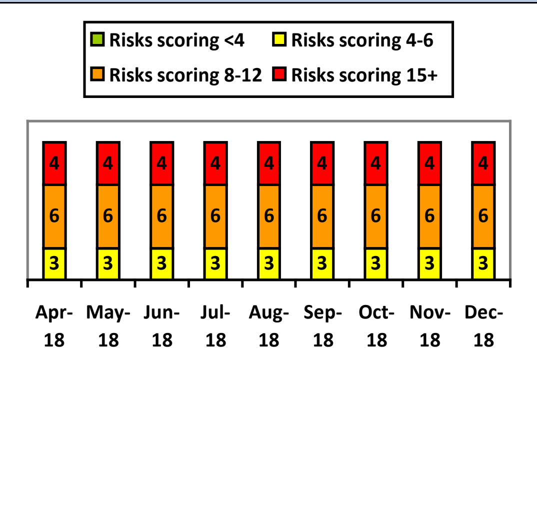
Mitigating Actions: (What more do we need to do to fill the gaps)	**Lead**	**Target Date**
4. Twice weekly reviews of action plan by MD	Yvonne Blucher	31.03.19

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))**	**Gaps in assurances**
• *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	12



	C.Difficile- ceiling of 30 may lead to reputational damage and financial penalties		
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	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	19/04/18	Date Last Reviewed	CGG 20/11/2018 Board 04/09/2018 FRC 06/11/2018	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	⬌

Risk score — Target

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Risk score	20	20	20	20	20	20	20	20	20	20	20	20
Target	15	15	15	15	15	15	15	15	15	15	15	15

Relevant Key Performance Indicators

	2018/19 £m				
	Q1	**Q2**	**Q3**	**Q4**	**Total**
Control Total (**Internal Plan**) *(deficit)/surplus*	(3.5)	(1.8)	(2.0)	(3.2)	**(10.5)**
Actual *(deficit)/surplus*	(3.7)	(2.8)			
Variance *(adverse)/positive*	**(0.2)**	**(1)**			

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 which places pressure on the Trust's financial position.
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. However, additional to this there are now a number of schemes that are not going to deliver to the levels first anticipated, creating a more significant gap of £2.3m.
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
12. Robust arrangements for the management of Agency are being put in place which includes an Agency Reduction Programme Board which will monitor the actions the Trust are putting in place to try to reduce Agency usage. This also includes the creation of Medical, Non-Medical Clinical and Professional Assurance Groups to approve and scrutinise the use of Agency at the Trust.	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.	Director of Finance	Ongoing
2. Enhance the governance and scrutiny arrangements to challenge all agency bookings above cap (nursing and Medical), and all requirements for medical agency and non-clinical Agency.	Director of Nursing/Medical Director/Director of Ops	September
3. Further focus on recruitment and retention of staff to further reduce the Agency requirements of the Trust.	Director of HR	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 CMO.	Director of Ops	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.	9. n/a
10. Detailed records of staff working between Trust's to ensure the appropriate Trust is paying for the resources expended on their projects.	10. n/a

Related Risks			
Risk Ref:	**Description**	**Score**	***Chart showing related risks***
2287	Trust fails to meet its financial targets. Closer scrutiny by NHS Improvement 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	12	
2621	The value of the Minimal Income Contract with the CCGs 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	

Risks scoring <4
Risks scoring 4-6
Risks scoring 8-12
Risks scoring 15+
Feb-18: 2 / 3
Mar-18: 4 / 1
Apr-18: 2 / 3
May-18: 2 / 3
Jun-18: 2 / 3
Jul-18: 2 / 3
Aug-18: 2 / 3
Sep-18: 2 / 3
Oct-18: 2 / 3
Nov-18: 3 / 2
Dec-18: 3 / 2

Risk Review Comments:	
22/06/18	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.
17/09/18	Risk has been reviewed and an additional control around Agency spend has been added to update the processes implemented by the Trust.
31/10/18	Amendments made to the related risks, to reflect updated scoring. Doesn't change score of overall risk.

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 20/11/2018 Board 04/09/2018 FRC 06/11/2018	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	Moderate
Risk Level	Level 2 ‘Cautious’
Direction of travel	↔

Risk score — Target

25
20
15
10
5
0

Feb-18 Mar-18 Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18

Relevant Key Performance Indicators

KPI	Target	Aug 18	Sept 18	Oct 18
Vacancy Rate	7%	13.03%	12.47%	10.07%
Vacancy Rate (nurses)	7%	16.66%	17.18%	11.14%
Vacancy Rate (consultants)	7%	11.95%	11.12%	13.11%
Agency (% of pay bill)	4.8%	9.15%	8.98%	8.79%
Turnover Rate	9.50%	12.9%	12.91%	12.41%
Appraisal	90%	80.49%	79.14%	80.78%

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 task and finish in place.
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. No gaps identified as in place
8. Leaver/ exit interview process in place	8. Exit interview rate at c20% and currently collation of feedback from interview is manual, so difficult to identify trends.
9. Annual appraisal and PDP process in place for staff	9. Compliance rates 79% 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. Enhanced rates in place to offset agency usage.
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 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 Recruitment & Retention Committee.	19. NHSI programme focused on Nursing
20. Engagement with site staff in MSB transformation and vision for future to ensure we retain through transition.	20. MSB advertising and promotional material to be developed and joined up working of services to further promote opportunities.

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**
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 and task and finish group.	POD	Completed – next step communication to site teams.
5. Interviewing candidates from India and the Philippines. Business case going to group FRC to seek approval for ongoing investment.	Head of Recruitment	Proposal being further developed to go to JEG December 2018.
6. Staff Survey Directorate action plans in place and recruitment and retention task and finish group.	POD/ Deputy Head of HR	Completed – next step to build on plans for next year.
8. Stay interviews being conducted in hot spot areas. Implement on-line exit interviews online and monitor results	Retention Lead	Online interviews delay with Procurement – new interim plan in place – currently being uploaded to system for use from November 2018.
9. Revised appraisal form introduced as a trial to June 2018 and new trajectory to be set. Trust/ CQC Action plan in place.	Deputy Head of HR	On-going
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)	Head of Recruitment	Refer a friend scheme launched 1st September 2018. Piggy bank proposal being developed for winter period. Proposal has been developed - currently reviewing across MSB.
17. Group proposal to appoint redeployment posts to support with managing redeployment across group. Risk posts to be reviewed as required.	Director of Operations and Employee Experience	Being picked up as part of HR Service transformation to be in place by April 2019.
19. Actions extended to other staff groups where applicable and hot spot Directorates and deep dive exercise completed on high turnover wards.	Retention Lead	Hotspots are in Trust action plan.

20. Group recruitment strategy being developed with MSB advertising campaign and Business case to support investment.	Resourcing and Strategic Planning Director with Comms	Group Proposal being further developed for sign off January 2019.
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.	Retention Lead	On-going in line with Trust action plan.
22. Recruitment and Retention training session developed – to be rolled out and available for new managers	Retention Lead	On-going

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 and delays for establishment vacancies
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 level, lower staff engagement score, negative feedback on on-boarding, pre-retirement surveys and exit interviews
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
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
15. CIP and Task Group minutes and actions reflect progress with recruitment	15. 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	19. negative trends demonstrated via Nursing Retention Dashboard
20. Recruitment to MSB/ Service posts and staff retained	20. Vacancy rate and turnover increase
21. Staff survey, pulse survey, engagement sess. feedback, sickness reduction	21. reduction in engagement score, increase in turnover and sickness
22.Evidence of process in recruitment paperwork (through audit), feedback from candidates, reduced turnover in first 6 months.	22. Increase in turnover in first 6 months

Related Risks			
Risk Ref:	**Description**	**Score**	***Chart showing related risks***
2808	Staffing shortages may lead to compromised patient care or experience and failure to meet Safer Staffing requirements	20	Risks scoring <4 Risks scoring 4-6 Risks scoring 8-12 Risks scoring 15+ Jan-18: 1, 2, 5 Feb-18: 1, 2, 5 Mar-18: 1, 2, 5 Apr-18: 1, 2, 5 May-18: 1, 2, 5 Jun-18: 1, 2, 5 Jul-18: 1, 2, 5 Aug-18: 1, 2, 5 Sep-18: 1, 2, 5 Oct-18: 1, 2, 5 Nov-18: 1, 2, 5 Dec-18: 1, 2, 5
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	

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 20/11/2018 FRC 06/11/2018 Board 04/09/2018	Target Date	31/03/2019

Risk Rating (Likelihood x Impact)			Relevant Key Performance Indicators
Initial Risk Score	20 (4*5)	(chart)	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 additional assurance indicator which assesses all aspects of estates and facilities management, including compliance with legislation, safety, patient experience. In addition it addresses business management and focuses on policies and procedures and auditing processes.
Current Risk Score	12 (3*4)		
Target Risk Score	9 (3*3)		
Risk Appetite Risk Level	Moderate Level 2 'Cautious'		
Direction of travel	⟺		

Controls: (What are we currently doing to reduce the impact or likelihood of the risk occurring?)	Gaps in Controls:
1. All EFM Services policies and procedures linked to statutory requirements are in place. Under the PAM assurance model, this includes policies and procedures being in place in accordance with regulatory standards.	Some policies are due or overdue a review.
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 are currently being drafted and signed by the relevant persons.
3. Hard Services – Statutory Compliance Processes Asset register, annual Planned Preventative Maintenance (PPM) programme in place. Internal and external audit by Authorising Engineer (AE). 6 Facet Condition Survey / Backlog Capital	Significant outstanding backlog issues continue to form basis for capital planning and in particular the estates master plan which is due 2019.

Programme / Incident reporting system.	
4. Soft Services – Cleaning Standards monitored against National Specification for Cleanliness Standards by Domestic supervisors and the QA team alongside nursing representatives. Reported at local level and at IPCG. Contracts monitoring also in place.	None
5. Business Continuity: 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 services.	The Maintenance BIA was due to be reviewed in October 2018 to align to BTUH BIA but due to staff changes the review target date is now December 2018.
6. Infrastructure and Plant - All assets are risk assessed and managed via the backlog maintenance programme. Funding is allocated via annual programmer and investment group.	Failure to secure all capital funding required for identified schemes. Not all assets are identified on this programme.
7. Medical Equipment – policy in place 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.	Failure to secure all capital funding required.
8. Operational Standards - BSI accreditation for 9001 (Quality), 14001 (Environment) and 18001 (H&S).	None

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. The PAM assessment is currently being reviewed against the Hard FM Compliance Audit to ensure all aspects align with risks accordingly. Development of an MSB EFM Policies Register and Review Programme to align all documents including updated documentation of processes in place.	JH	31 March 2019
2. Appointment letters are being written, signed by the Chief Director and issued to the Authorised persons to sign.	JH	31 December 2018.
3. Complete review of Backlog Maintenance Programme underway based on 6 facet survey and local knowledge to capture any missing assets. This includes working up programme for 2019-20	JH	31 December 2018
5. Review the Maintenance BIA to align to BTUH BIA model	JH	1 April 2019
6. Statutory high risk items and committed schemes approved, issues relating to non-funded items to be highlighted to investment and Approval Committee as they become apparent.	JH	1 April 2019

7. High risk items for medical equipment replacement approved, issues relating to non-funded items to be highlighted to investment and Approval Committee as they become apparent.	JH	1 April 2019
8. Development of Early warning escalation process where non-conformance actions are slow in being developed.	JH	31 Dec 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. 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.	None
2. Training skills register demonstrates compliance Authorised person appointed	None
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. Cleaning 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
4. KPI clearly identified in contract specification and reviewed at monitoring meetings	Limited assurance from FRC
5. Business Continuity plans are in place.	Failure to deal with significant incident or loss of utilities.
6. Risk assessed capital programme in place	Plant failure that has not been identified as end of life.
7/8. 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
8. Positive CQC inspection reports	Requirement for improvement following CQC inspection.

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

Chart showing related risks

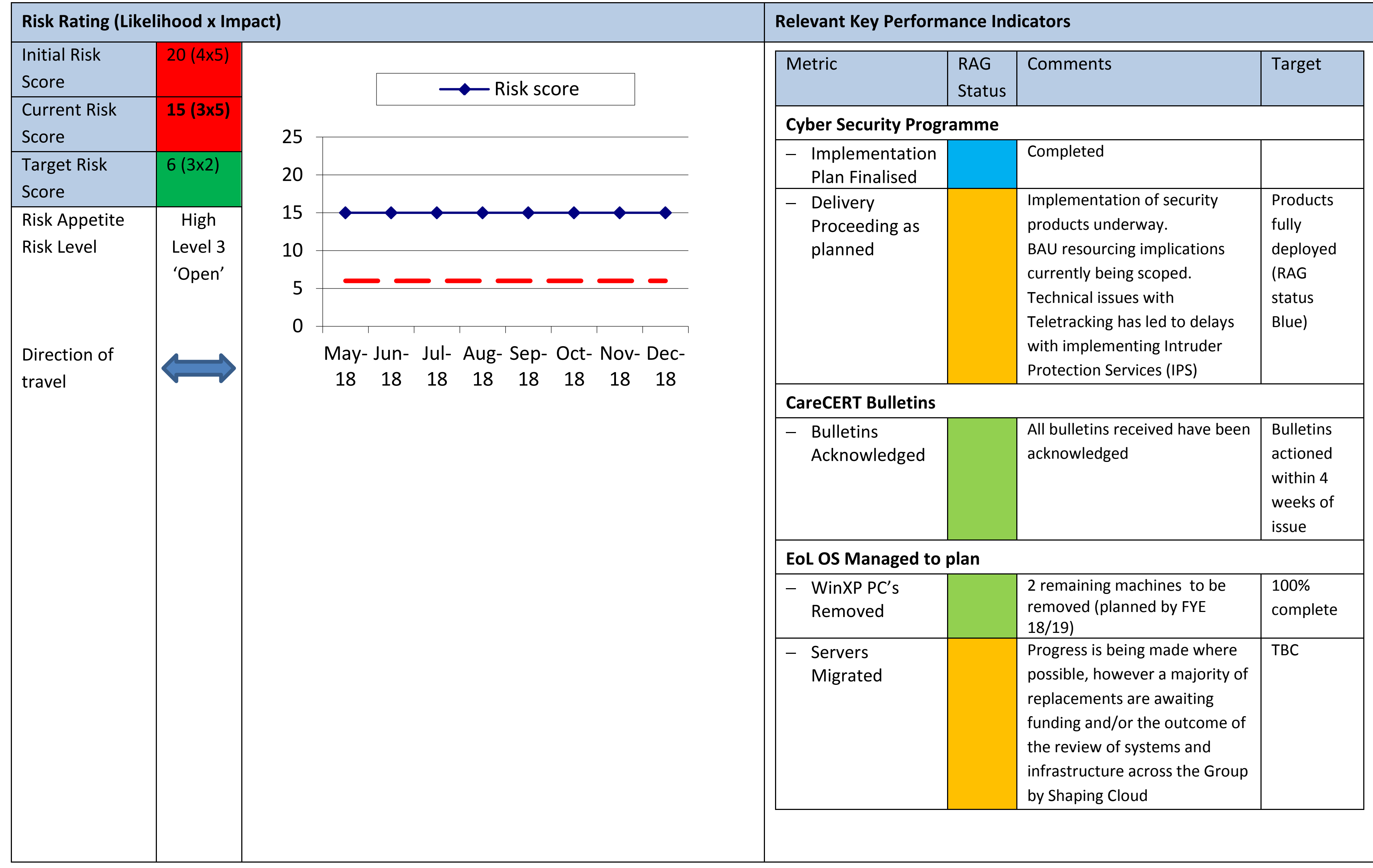
Risks scoring <4
Risks scoring 4-6
Risks scoring 8-12
Risks scoring 15+

Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
7	7	7	7	7	7	7	7	7	7	7	7

Risk Review Comments:

The related risks above are included in the EFM Risk Register which is currently under review alongside the Backlog Maintenance Programme and the PAM Model.

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	CCG 20/11/2018 FRC 06/11/2018 Board 04/09/2018	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	Target
Cyber Security Programme			
– Implementation Plan Finalised		Completed	
– Delivery Proceeding as planned		Implementation of security products underway. BAU resourcing implications currently being scoped. Technical issues with Teletracking has led to delays with implementing Intruder Protection Services (IPS)	Products fully deployed (RAG status Blue)
CareCERT Bulletins			
– Bulletins Acknowledged		All bulletins received have been acknowledged	Bulletins actioned within 4 weeks of issue
EoL OS Managed to plan			
– WinXP PC's Removed		2 remaining machines to be removed (planned by FYE 18/19)	100% complete
– Servers Migrated		Progress is being made where possible, however a majority of replacements are awaiting funding and/or the outcome of the review of systems and infrastructure across the Group by Shaping Cloud	TBC

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**	**On-going, finances continually reviewed**
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 hosting services in off-site datacentre	**NB**	**End-Feb 19 - Revised dates due to initial procurement delays and availability of resources (Prev 01/12/2018)**
2c Explore the feasibility of replicating services at other MSB locations	**NB**	
3. Review core clinical system support contracts and staffing availability/skills mix against OoH demand	**LB**	**Completed - OOH support has been reviewed across the Group & supplier support is continually reviewed in line with contract renewals (Prev 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**
1609	Loss of IT Datacentre (below towerblock) impacting patient care due to severe and lengthy disruption of IT systems and telephony	20	
2401	Failure to replace End of Life Operating Systems and Hardware (OS & HW) may lead to disruption to operational services	15	
2435	Out of Hours (OoH) support provided by system suppliers and local IT teams	12	
3008	Failure to comply with new GP clinical letter requirements may result in financial penalties	12	
2819	Medical Devices not complying with Cyber Security requirements	10	
2425	Risk of disruption and / or damage to IT systems from Cyber threats.	8	
2932	Loss of Radiotheraphy infrastructure	8	

<table>
<tr><th colspan="2">Risk Review Comments:</th></tr>
<tr><td>16/11/2018</td><td>The combined risk register for risks associated with Digital Services across the MSB Group has been consolidated and reviewed. Risk ratings have been revised based upon current likelihood and impact of disruption to services which has led to an increase in the number of risks rated 12 or over.

Where licensing and hardware are available, work continues to mitigate the risk associated with end of life Operating systems on both desktops and servers. Risks relating to telephony across the Group have been reviewed which has highlighted a number of new risks, once these have been validated against risks previously on Datix, the overall risk will be revised; it is likely that the overall rating of this risk will increase.

Risks Removed/Closed:
- Risk 2669, regarding patching processes; this has been closed following confirmation that a SOP has been drafted, agreed and implemented.

Escalated Risks:
- Risk 3008, Failure to comply with new GP clinical letter requirements may result in financial penalties.
There is a Group wide programme being established that will review the capability of systems that are used to communicate information to other care providers.
Whilst not all trust systems are able to support this requirement currently it is unlikely that all systems suppliers will able to be complaint with the required levels of technical requirements.
The true cost of potential financial penalties are also currently unclear.</td></tr>
</table>

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**	CGG20/11/2018 QAC 17/10/2018 Board 04/09/2018	**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	⟺

Risk score — Target

20, 15, 10, 5, 0

Jun-17, Jul-17, Aug-17, Sep-17, Oct-17, Nov-17, Dec-17, Jan-18, Feb-18, Mar-18, Apr-18, May-18, Jun-18, Jul-18, Aug-18, Sep-18, Oct-18, Nov-18, Dec-18

Relevant Key Performance Indicators

	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18
Incidents	101 3	794	829	921	959	881	873	946
SIs	7	8	9	6	5	5	6	4
CQC – overdue actions	2	1	0	1	1	0	1	5
Open requirement notices	5	3	3	3	3	3	3	3
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.	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. Slight slippage in the CQC action plan has occurred in October.

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. No gaps identified
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. Monitor CQC action plan and ensure actions remain on track – five actions were overdue in October, however this has reduced to three as at 16th November 18.	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~~ 12	
70	Increased use of nursing agency staff with varying skills and experience	15	

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~~ 9
2581	Risk to patient safety due to temporary opening of extra beds to increase capacity due to emergency admission demand	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

Month	Risk scoring <4	Risk scoring 4-6	Risk scoring 8-12	Risk scoring15+
Jun-17		3	3	5
Jul-17		3	5	3
Aug-17		2	6	3
Sep-17		2	6	3
Oct-17		2	6	3
Nov-17		2	6	3
Dec-17		3	5	3
Jan-18		3	5	3
Feb-18		3	5	3
Mar-18		3	5	3
Apr-18		3	4	4
May-18		3	4	4
Jun-18		3	4	4
Jul-18		3	4	4
Aug-18		4	3	4
Sep-18		4	3	4
Oct-18		4	3	4
Nov-18		3	6	2
Dec-18		3	6	2

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.
08/10/18	No change to the current risk score which remains at 9 due to the open CQC requirement notices and ongoing CQC actions. There is one action currently overdue relating to considering the preferences of young people aged 16-17 years old. This has been escalated within the Women and Children’s Directorate.
23/11/18	No change to the current risk score which remains at 9 due to the open CQC requirement notices and ongoing CQC actions. There are currently 3 overdue actions on the CQC action plan due to slight slippage in the plans but these continue to be progressed and monitored. The risk rating for 2 associated risks have changed. Risk 2690 has reduced to 12 due to the work being undertaken on 52 week waits. Risk 2540, relating to the complaints backlog, has been increased to 9 in line with the due diligence assessment.