The Princess Alexandra Hospital NHS
NHS Trust

Meeting of the Board of Directors

AGENDA

Date and Time: Thursday 2 August 2018 from 10.00 to 13.00
Venue: Boardroom, The Princess Alexandra Hospital, Harlow.

Time	Item	Subject	Action	Lead	Page
01 OPENING ADMINISTRATION					
10.00	**1.1**	Apologies	-		
	1.2	Declarations of Interest	-	Chairman	
	1.3	Minutes from Meeting on 07.06.18	Approve	Chairman	3
	1.4	Matters Arising and Action Log	Review	All	11
02 PATIENT STORY					
10.10	**2.1**	Patient Story: Ben's Story			
03 REPORT FROM CHIEF EXECUTIVE					
10.40	**3.1**	CEO's Report	Discuss	Chief Executive	13
04 RISK					
10.50	**4.1**	Board Assurance Framework	Approve	Chief Medical Officer	17
11.00	**4.2**	Significant Risk Register	Discuss	Chief Medical Officer	36
11.10	**4.3**	Risk Management Strategy	Approve	Chief Medical Officer	160
05 PERFORMANCE					
11.20	**5.1**	Integrated Performance Report	Inform	Chief Operating Officer	210
11.50	**5.2**	Sustainable Health Care Strategy 2018-2022 (incorporating Sustainability Development Management Plan 2018-2020)	Approve	Director Quality Improvement	259
06 QUALITY					
12.00	**6.1**	Nursing, Midwifery and Care Staff Levels	Inform	Chief Nurse	305
12.10	**6.2**	Mortality Update	Discuss	Chief Medical Officer	309
12.20	**6.3**	Research & Development Annual Report	Discuss	Chief Medical Officer	334
07 GOVERNANCE					
12.30	**7.1**	Medical Appraisal and Revalidation	Approve	Chief Medical Officer	341
12.40	**7.2**	Reports from Committees: • CFC.4.07.18 including Annual review and Terms of Reference • QSC.25.07.18 • WFC.23.07.18 • PAF. 23.07.18	Inform/ Approve	Chairs of Committees	401 409 411 412
08 QUESTIONS FROM THE PUBLIC					
12.50	**8.1**	Opportunity for Members of the Public	Discuss	Chairman	

		to ask questions about the Board discussions or have a question answered.			
09 CLOSING ADMINISTRATION					
	9.1	Summary of Actions and Decisions	-	Chairman/All	
	9.2	New Issues/Risks	Discuss	All	
	9.3	Reflection on Meeting	Discuss	All	
13.00	**9.4**	Any Other Business	Review	All	

TRUST BOARD 2018/19

Meetings, Purpose, Membership and Quoracy

24th May 2018 (ETB)	4th October 2018
7th June 2018	6th December 2018
2nd August 2018	7th February 2019

Board Purpose
The purpose of the Trust Board is to govern the organisation effectively and in doing so to build public and stakeholder confidence that their health and healthcare is in safe hands and ensure that the Trust is providing safe, high quality, patient-centred care. It determines strategy and monitors performance of the Trust, ensuring it meets its statutory obligations and provides the best possible service to patients, within the resources available.
Board Quoracy
One third of voting members, to include at least one Executive and one Non-Executive (excluding the Chair). Each member shall have one vote and in the event of votes being equal, the Chairman shall have the casting vote.

Board Membership and Attendance – 2018/19			
Non-Executive Director Members of the Board (voting)		**Executive Members of the Board (voting)**	
Title	**Name**	**Title**	**Name**
Trust Chairman	Alan Burns	Chief Executive	Lance McCarthy
Chair of Audit Committee (AC)	Stephen Bright	Chief Finance Officer	Trevor Smith
Chair of Quality & Safety Committee (QSC)	Dr. John Hogan	Chief Operating Officer	Stephanie Lawton
Chair of Performance and Finance Committee (PAF)	Andrew Holden	Chief Medical Officer	Andy Morris
Chair of the Workforce Committee (WFC)	Pam Court	Interim Chief Nurse	Sharon CUllen
Chair of Charitable Funds Committee (CFC)	Helen Glenister	**Executive Members of the Board (non-voting)**	
Associate Non-Executive Director	Steve Clarke	Director of Strategy	Michael Meredith
Associate Non-Executive Director	Helen Howe	Director of People	Gech Emeadi
		Director of Quality Improvement	Jim McLeish
Corporate Secretariat			
Head of Corporate Affairs	Heather Schultz	Board & Committee Secretary	Lynne Marriott

The Princess Alexandra Hospital NHS
NHS Trust

Minutes of the Trust Board Meeting in Public
Thursday 7 June 2018 from 10:00 – 12:30
Boardroom, Princess Alexandra Hospital, Harlow

Present (voting members of the Board):

Andrew Holden	**Non-Executive Director and Vice Chairman (VC)**
Lance McCarthy	Chief Executive Officer (CEO)
Stephen Bright	Non- Executive Director (NED-SB)
Pam Court	Non-Executive Director (NED-PC)
Nancy Fontaine	Chief Nurse (CN)
Helen Glenister	Non-Executive Director (NED-HG)
John Hogan	Non-Executive Director (NED-JH)
Stephanie Lawton	Chief Operating Officer (COO)
Andy Morris	Chief Medical Officer (CMO)
Trevor Smith	Chief Financial Officer (CFO)

Present (non-voting members of the Board):

Raj Bhamber (non-voting)	Interim Director of People (IDoP)
Jim McLeish (non-voting)	Director of Quality Improvement (DoQI)
Michael Meredith (non-voting)	Director of Strategy (DoS)
Steve Clarke (non-voting)	Associate Non-Executive Director (ANED-SC)

In attendance:

Lorraine Nixon	Freedom to Speak Up Guardian
Lisa Thurley	Freedom to Speak Up Guardian
Ellie Manlove	Head of HR
Lynsey Rowe	Head of Strategic Marketing and Communications and People, Organisational Development & Communications

Members of the Public/Observers/Patient Story:

Ogechi Emeadi	Incoming Director of People

Apologies

Alan Burns	Trust Chairman (TC)
Helen Howe	Associate Non-Executive Director (ANED-HH)

Secretariat:

Heather Schultz	Head of Corporate Affairs (HoCA)
Lynne Marriott	Board & Committee Secretary (B&CS)

01 OPENING ADMINISTRATION	
1.1	The Vice Chairman (VC) welcomed members to the meeting.
1.1 Apologies	
1.2	As above.
1.2 Declarations of Interest	
1.3	No declarations were made.
1.3 Minutes of Meeting on 29.03.18	
1.4	The minutes of the meeting held on 29.03.18 were agreed as a true and accurate record of that meeting with no amendments.
1.4 Matters Arising and Action Log	
1.5	There were no matters arising. <u>Action ref: TB1.29.03.18/90 – Risk 1.2 (EPR)</u> The Chief Financial Officer (CFO) confirmed that discussions had taken place at the Performance & Finance Committee (PAF) the previous week and the action had been

	closed. Action ref: TB1.29.03.18/92 – Risks: Fire Suppression/Door to Grane House The CFO updated that work had been commissioned to complete the Fire Suppression would begin at the end of June with completion by the end of August.
1.6	The VC extended a warm welcome to Michael Meredith, new Director of Strategy (DoS) and to Ogechi Emeadi, the incoming Director of People, Organisational Development and Communications. Members introduced themselves.
1.7	At this point the VC made reference to the Trust's former Chief Executive Phil Morley and the tragic events which had unfolded at the beginning of May. He extended the Board's sympathies to Phil's family.
02 STAFF STORY: FREEDOM TO SPEAK UP GUARDIANS (FTSUGs)	
2.1	The VC welcomed the Trust's Freedom to Speak Up Guardians, Lorraine Nixon, Head of Secretariat (LN-HoS) and Lisa Thurley, Radiology Assistant (LT-RA) to the meeting. LN-HoS and LT-RA provided a short resume on their time in the Trust to date, joining in 1995 and 2006 respectively.
2.2	FTSUG roles had been a recommendation following the publication of the Francis Report in 2015 to help facilitate a more transparent and open culture in the NHS. The Trust had not had a FTSUG role until April 2017 and as that person was a Board member, it was agreed to reappoint to that role. It was subsequently agreed to appoint two staff members with different skills/attributes to the role. The Guardians would act as the link between the problem and the resolve and ensure that staff had the capacity/support to speak up effectively without the fear of reprisals.
2.3	There was a requirement to report externally to the National Guardians' Office and Quarter 1 data had just been submitted – 12 cases with the main themes of bullying behaviours and discrimination.
2.4	Next steps to take the role forward would be to: • Ensure there were no consequences for staff who spoke out • Listen to staff • Be actively involved in the Staff Council • Redevelop the "In Our Shoes" programme • Have FTSU champions in each Healthcare Group (HCG) • Strive to support a safe, open and honest culture as promoted by the Trust's Board.
2.5	Associate Non-Executive Director Steve Clarke (ANED-SC) asked if there was anything that could be done to ensure there was a continued perception that it was okay for staff to speak up. In response the FTSUGs stated it would be important that all concerns raised were dealt with (not brushed under the carpet) and that there was trust between all parties.
2.6	In response to two questions raised by the Chief Nurse (CN) it was confirmed that initial feedback from staff had been good. Of the twelve cases in Q1, 11 had received positive feedback. Going forward the continued support of the Executive Team would be required.
2.7	NED John Hogan (NED-JH) asked for some brief details around the last case the Guardians had been involved in. In response it was confirmed that this had related to line management discrimination and bullying issues which had been raised as a concern by a senior manager on behalf of a more junior colleague. The CEO flagged that was a serious issue which the organisation needed to address. He added that work was underway to communicate cases (anonymously) to staff to evidence that speaking up was the right route to take and would result in issues being resolved.
2.8	In response to a question from NED Pam Court (NED-PC) it was confirmed that the trade unions had been involved in one of the recent cases.
2.9	The VC thanked the FTSUGs for their update.
03 REPORT FROM CHIEF EXECUTIVE	
3.1 CEO's Report	
3.1	The CEO drew members' attention to the key performance indicators which were outlined in

	the report for the previous month.
3.2	The Trust still struggled to achieve the 95% four hour access target although performance had continued to improve for the last few months. April and May performance had both been above the agreed trajectories as the Trust strived to achieve 90% by September. Two recent site visits by external parties had confirmed all the actions taken over the past nine months were the right ones and were starting to have a positive impact on patient care/experience.
3.3	He continued that on 24.05.18 there had been the first public Board meeting in common of NHS Improvement and NHS England, at which they had agreed how to work more closely together. In addition there were proposals for regional teams to be hosted in one of the organisations working on behalf of both in relation to quality, finance and operational performance. The Regional Directors would also support the development and identity of local STPs and ICSs and report to the two CEOs and be full members of the national NHS Executive Group. Senior appointments would be made by the end of the summer.
3.4	Consultant Advisory Appointments Committees (AACs) had been held on 08.05.18 and 23.05.18 for Trauma and Orthopaedic and Obstetrician/Gynaecologist appointments respectively. The AACs recommended to the Board the appointment of two consultants and the Board approved that recommendation.
3.5	The CEO took the opportunity to welcome Michael Meredith as the Trust's new Director of Strategy and the successful appointment to the role of Director of People, OD and Communications on a substantive basis. Ogechi Emeadi would join the organisation on 01.08.18. He also congratulated the Chief Nurse on her successful appointment to Chief Nurse at Norfolk and Norwich University Hospitals NHS Foundation Trust. The role was currently out to advertisement with interviews scheduled for 29.06.18 and the Deputy Chief Nurse would act up in the intervening period.
3.6	In response to a question from the VC in light of the recent plethora of high calibre candidates for consultant posts and potentially filling future vacancies with the unsuccessful candidates, the CEO confirmed that work around the Strategy and Vision for individual specialities and also future workforce planning was underway.
04 RISK	
4.1 Board Assurance Framework (BAF)	
4.1	This item was presented by the Head of Corporate Affairs (HoCA). She updated that the Board Committees had reviewed their risks and approval was now sought to reduce the finance risk (5.1) from 20 to 15. All other risk scores remained the same.
4.2	The VC confirmed that the discussion at PAF had been based around the agreed plan and M1 position including alignment of the organisation's activity and income plans with that of the CCG. The CFO added that the Trust had signed up to a control total and had signed off a challenging but deliverable plan. There had also been sign-off from budget holders on activity, income and expenditure. The general view was that whilst the risk consequence remained the same, the likelihood should reduce but that it would be routinely re-assessed.
4.3	In response to a question from NED-JH regarding the rationale for reducing the risk, taking into account the M1 result, the CFO responded that in his view further detailed review would be made at the end of Q1 including a forecast outturn assessment. At that point a decision could be taken to increase the rating again if that was felt necessary.
4.4	In response to the above the CEO stated clearer criteria or metrics should be identified across risks to provide a more robust indication of whether a risk should be increased/reduced. NED Helen Glenister added that at the Quality & Safety Committee (QSC) discussion around reducing risk ratings had agreed a requirement for not only hard evidence for the proposed change but also agreement of a line to be reached at which point a risk could be reduced.
4.5	The CEO stated the organisation's approach should be consistent and it should be that followed by QSC. It was requested that that be noted by all Board Committees.
ACTION **TB1.07.06.18/01**	**Board Committees to be aware of the approach for reducing BAF risk ratings.** **Lead: Head of Corporate Affairs/Executive Leads**

4.2 Significant Risk Register (SRR)	
4.6	This paper was presented by the CMO and was taken as read. The additional information previously requested was now provided in the summary sheet. It was agreed the next iteration of the report would address the following: • Appendices to be clearly labelled. • Names of former staff members to be removed and updated with current leads. • Expired target dates to be revised.
ACTION **TB1.07.06.18/02**	**In relation to the Strategic Risk Register:** • **Appendices to be clearly labelled.** • **Names of former staff members to be removed and updated with current leads.** • **Expired target dates to be revised.** **Lead: Chief Medical Officer**
05 PERFORMANCE	
5.1 Integrated Performance Report (IPR)	
5.1	The Chief Operating Officer (COO) introduced the report and the following highlights were noted under each of the 5P headings:
5.2	<u>Patients</u> • Monthly point prevalence study for VTE for the Safety Thermometer had evidenced 95% harm free for the first time in over 18 months. • VTE continued to be delivered. • 2017/18 would close on six or seven (still to be confirmed) cases of C-diff. • 2018/19 to date had seen two cases of C-diff and no MRSA bacteraemia. • SI process reviewed and improved to help facilitate better medical engagement. In response to a question from the VC in relation to the five deaths reported in April the CMO stated that he had no concerns. The Trust's process for reviewing deaths was work in progress but currently 50% of all deaths were signed off by the responsible consultant on the day following death. The rollout of the Medical Examiner roll would soon provide further assurance.
5.3	<u>Performance</u> • RTT – recovery trajectory continuing with achievements against targets in April and May. • 52 Week Breaches – no increase but still under review (18 in total of which 15 in Paediatric Urology). Robust mitigation in place to address that including additional external support. • Cancer – the position had deteriorated again in March and April mainly due to Urology issues. A recovery plan was in place and the position would ease with external support. All breached patients would form part of a harm review process. • ED – trajectory achieved in April and May (70% and 75% respectively) with best performance in the last four years recorded at the end of May (one day at 95% and another at 93%). • Paediatric ED – performance on an upward trajectory and over 95% for the majority of the previous two weeks. • 12 hour position – two breaches in May but none since. • Urgent Care Centre – SOP agreed and recruitment for a clinical lead and operational posts being discussed. • Diagnostics – standard being achieved. • Length of Stay/Capacity – significant amount of work underway led by the Clinical Lead for Surgery with good clinical engagement and a focus on Respiratory, Cardiology and General Surgery. • Outpatients – deep dive requested into short notice cancellations.
5.4	In relation to the Urology issues the COO was able to confirm, at the request of the CEO, the following actions:

	• New Clinical Lead appointed • Twice weekly meeting with the team • Two Clinical Fellows from UCLH to support as of the following week • Sessions booked with Addenbrookes as of 26.06.18 • Fortnightly call with Commissioners to discuss recovery plans • 'Super-sessions' on Cancer and urgent patients • Review of multi-disciplinary team • Support for the team from senior nurse for cancer with urology background • Out to advert for three consultant posts • Trainees to return as of summer • Daily meeting with Clinical Lead and Senior Operations Manager to review outpatient activity and emergency workload.
5.5	In response to a question from NED-JH the CMO confirmed that the longer term strategy for the service was currently under discussion as part of the STP work but no decisions had been made as of yet.
5.6	The VC flagged that the Paediatric ED team had attended PAF the previous week with a very positive update but performance had since dropped off. In response the COO confirmed there had been insufficient staff to open PAU but there were more nursing staff joining over the next two months which would address that and she was confident performance would be back on track very soon.
5.7	<u>People</u> With the exception of appraisal and agency spend, the vast majority of 'people' metrics had remained stable. However, in comparison with benchmark STP providers, performance was unfavourable for the following metrics: • Statutory/mandatory training at 85% in comparison with STP average of 89%. • Appraisal at 78% in comparison with STP average of 85%. • Sickness absence at 3.9% in comparison with STP average of 3.5%. • Agency at 8.1% in comparison with STP average of 5.6%. The following metrics compared favourably in comparison with STP providers: • Voluntary turnover at 13.02% in comparison with STP average of 16.221%. • Vacancy factor at 10.62% in comparison with STP average of 12%. • Stability at 88.12% in comparison with STP average of 83%.
The Interim Director of People left the meeting.	
5.8	<u>Places</u> April 2018 had seen the realisation of a number of patient-related initiatives, including the main entrance with the introduction of the seven day presence and the catering transformation which had seen patient satisfaction increase from 54% to over 85% in a matter of weeks. The opening of Costa Coffee and Marks and Spencer had been well received by all. The team was actively preparing for a comprehensive and challenging cost improvement programme promising to realise not only significant reoccurring savings, but improvements to core services, targeting domestic services, estates maintenance, car parking and electrical and biomedical engineering (EBME). Each of the initiatives had been developed to address anomalies highlighted within the model hospital charging data. The 2018 PLACE assessment (Patient Led Assessment of the Care Environment) would be conducted on 03.05.18 by patient representatives.
5.9	<u>Pounds</u> The M1 deficit was £3.2m, £0.1m worse than plan (£0.4m after PSF). Income had underperformed by £1.2m, of which £0.3m related to PSF funding and £0.9m to Patient Treatment income underperformance including lower levels of activity through assessment areas and less outpatient activity. That under-performance had been offset by pay and non-pay underspends although agency costs had increased from previous levels of expenditure with M1 actuals of £1m compared to planned £0.9m. Key risks to plan included 1) Delivery of CIPs 2) Commissioner QIPP schemes of £4m and 3) Delivery of agency target.
5.10	In response to a question from the CEO in relation to the plans supporting the £4m of QIPP the CFO responded that their targets were still under discussion. The Trust expected that

	any proposed QIPP contract variations went through clinical review; currently he stated there was very little detail to CCG plans.
5.11	NED Steve Clarke (NED-SC) highlighted the positive position in relation to the prompt payment of supplier invoices. In response the CFO cautioned there was some degree of distortion in the improvement as some large invoices had been settled on capital schemes which had driven that number up. Underlying performance had to further improve and would link into the modernisation of workflow processes and timely authorisations. This would be monitored by PAF.
5.12	As a final point the CFO confirmed that the team were working on trajectories for the IPR which would be incorporated into the graphs for the following month.
ACTION TB1.07.06.18/03	**Trajectories to be incorporated into the graphs presented. Lead: Chief Financial Officer**
5.13	The CEO drew members' attention to the national benchmarking data (page 122 of the report). Whilst the organisation continued to struggle with its ED performance, type 1 (more complex patients) ED performance was much improved. For Cancer targets the organisation remained in the top 7% nationally and for Diagnostics/DToCs in the top third.
5.14	In response to a request from NED-PC it was agreed that arrows would be added to the summary page of the IPR to indicate trends against the previous month.
ACTION TB1.07.06.18/04	**Arrows to be included in the summary page of the IPR to evidence whether performance had improved or deteriorated in comparison to the previous month. Lead: Chief Operating Officer**
06 QUALITY	
6.1 Nursing, Midwifery and Care Staff Levels	
6.1	This report was presented by the CN who updated members with the following key headlines: • April had seen an improved fill rate for day and night for both registered and unregistered staff. • A review of annual leave profiling for the Safer Staffing wards had confirmed that all wards were compliant with the agreed percentage. • The monthly requests for bank and agency shifts had been scrutinised to nullify the risk of double counting the demand for temporary staff which had resulted in a reduced registered staff demand and increase in fill rate. • Although unregistered bank demand had reduced, the percentage fill rate remained static. The net gain for the organisation for the rolling year was currently 18.3 WTE RNs/RMs. • Registered nurse and midwifery vacancies for the organisation were currently 25.6%; the rise was related to newly agreed funded establishments when compared to 2017/18; the areas being Nightingale, MAU and PAU.
6.2	NED-SC highlighted how welcoming the Trust was to new nurses and that should be emphasised in the next recruitment round. In response the CN stated that fact was already well known and current international staff were used to support further international recruitment. The CEO flagged that although fill rates appeared low, in comparison with other trusts PAH was not an outlier. The CN agreed.
6.3	In response to a question from the VC it was confirmed that although the paper stated there would be 11 new starters in June, that number could increase. She cautioned however that average monthly new starter numbers were now slightly lower when compared to figures for the previous year.
6.2 Mortality Update	
6.4	This paper was presented by the CMO who drew members' attention to the fact that due to the rescheduling of Board meetings to the first week of the month, the report was in draft and would change after review with the team from Dr. Foster.
6.5	The CMO continued that the number of outlier alerts had risen again to seven – some were already known and others were very small numbers. The organisation had a robust audit process in place to address those and was doing so. He was pleased to report the best

	month (in over 12) on best practice tariff for fractured neck of femur.
6.6	Members then discussed the increased use of NOACs (warfarin replacement drugs) which were causing delays to theatre (as the patient could not be operated on within three days of administration). That had been the Trust's greatest cause of delays to theatre (as detailed in the previous mortality report). It was agreed there needed to be a unified approach/practice from Haematology and Pharmacy and QSC would monitor this going forward.
ACTION **TB1.07.06.18/05**	**QSC to monitor the approach taken by clinicians in relation to theuse of NOACs to ensure a consistent approach.** **Lead: Chair of QSC/Chief Medical Officer**
6.7	In relation to the other outlier alerts the CMO updated as follows: • Pneumonia – concerns in relation to variation in practice and antibiotic prescribing – new pathway needed to become embedded. • Cancers – head/neck and ovarian were small numbers • Kidney/Ureter – a new alert which now required some close review – figures were currently un-validated but issues in Urology were already well known. A robust audit would now be worked through. • COPD – being addressed via ICA work • Septicaemia – covered by the work of the Sepsis Team/Quality First – 400 frontline staff now trained on Sepsis 6.
6.8	In relation to the new role of Medical Examiner (ME) he flagged to colleagues the onerous training which would need to be completed by successfully appointed candidates. He envisaged two levels of ME – a fully trained 'super ME' but also a general audit/RCA type ME.
6.9	The CN highlighted that the Trust's perinatal mortality was still half the national average.
6.10	As a final point the Board agreed that the Mortality reporting should miss a month to ensure availability and validation of data.
07 GOVERNANCE	
7.1 Reports from Committees	
7.1	Audit Committee (AC) 24.05.18 The AC Chair (NED-SB) took the report as read and reported the following key headlines: • Thanks to the Finance team on production of the Annual Accounts. • External Audit report on year end Accounts, Annual Report and Value for Money opinion. • Internal Audit had conducted a review of ED Standards which had received limited assurance and the review of the IG Toolkit was assigned a reasonable assurance rating. • Subject to a number of amendments, the Quality Account had been approved and recommended to Board.
7.2	Quality & Safety Committee (QSC) 23.05.18 The QSC Chair (NED-JH) reported the following key headlines: • Mortality was an on-going concern but may have plateaued. • ED performance was also an on-going concern and an improvement would need to be seen soon. • 62 Day Cancer Wait Pathway target had not been achieved in March with the same predicted for April. • New initiative to reduce Gram Negative Blood Stream Infections (GNBSIs) by 50% by 2020. • The BAF risk in relation to Clinical Engagement would not be reduced until the results of the Medical Engagement Survey were known.
7.3	Workforce Committee (WFC) 29.05.18 The WFC Chair (NED-PC) reported the following key headlines: • Concerns around compliance with statutory/mandatory training had prompted the

	establishment of a Task & Finish Group reporting into WFC. • First ever Volunteers' Report had been presented which would now be aligned to the regular Workforce Report. • Staff Survey Results were scrutinised and the ensuing action plans would be monitored by WFC.
7.4	Performance & Finance Committee (PAF) 24.05.18 The PAF Chair (NED-AH) highlighted that most areas had been discussed above with the exception of the Outline Business Case (OBC) which would be discussed in the private session.
08 QUESTIONS FROM THE PUBLIC	
8.1	There were no questions from the Public.
09 CLOSING ADMINISTRATION	
9.1 Summary of Actions and Decisions	
9.1	These are presented in the shaded boxes above.
9.2 New Issues/Risks	
9.2	No new risks or issues were identified.
9.3 Reflections on Meeting	
9.3	Not undertaken at this point.
9.4 Any Other Business (AOB)	
9.4	The VC announced the recent appointment of a new Associate NED (Helen Howe) who had a pharmacy background and would be a member of QSC and AC.

Signed as a correct record of the meeting:	
Date:	02.08.18
Signature:	
Name:	Alan Burns
Title:	Chairman

Trust Board Meeting in Public
Action Log - 02.08.18

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.29.03.18/94	Recruitment/ Vacancies	Provide an update on Recruitment/Vacancies to July Board.	IDoP	~~TB1.05.07.18~~ TB1.02.08.18	The current RN vacancy stands at 26%, but this is driven by an investment of an extra 40 WTEs in the last 2 months. Pre the investment, the RN vacancy had improved 24.03%. The investment in June, of 30 WTEs was to support the CQC recommendations and the modernised patient flow system at the front door and assessment areas, including Melvin. **Summary attached to action log as Appendix 1.**	Proposed for closure
TB1.07.06.18/01	BAF Risks	Board Committees to be aware of the approach for reducing BAF risk ratings.	HoCA Exec Leads	TB1.02.08.18	Actioned	Closed
TB1.07.06.18/02	Significant Risk Register	In relation to the Significant Risk Register: 1) Appendices to be clearly labelled. 2) Names of former staff members to be removed and updated with current leads. 3) Expired target dates to be revised.	CMO	TB1.02.08.18	Actioned	Closed
TB1.07.06.18/03	IPR	Trajectories to be incorporated into the graphs presented.	CFO	TB1.02.08.18	Actioned.	Closed
TB1.07.06.18/04	IPR	Arrows to be included in the summary page of the IPR to evidence whether performance had improved or deteriorated in comparison to the previous month.	COO	TB1.02.08.18	Actioned.	Closed
TB1.07.06.18/05	NOACs	QSC to monitor the approach taken by clinicians in relation to theuse of NOACs to ensure a consistent approach.	CMO QSC Chair	QSC.25.07.18	Actioned	Closed

Appendix 1

The Princess Alexandra Hospital NHS Trust

Quality Update: Safer Staffing

Table below shows Safer Staffing Fill rates for April, May and June in 2018.

Trust Average fill rate (%)	Days registered nurses & midwives	Days care staff	Nights registered nurses & midwives	Nights care staff
April	72.7	79.3	91.7	89.1
May	75.7	79.6	94.1	90.7
June	74.4	79	91.8	92.5

Recruitment progress:

1. Q1 starters = 39 (headcount) April 9, May 14, June 16.
2. Q2 recruitment pipeline currently = 13 RN starters, 12 pre-registration starters and 16 care staff
3. Funded establishment uplift (29.57WTE) to reflect changes made to skill-mix in ED, adult assessment and short stay facilities
4. Vacancies increased in line with increased posts funded (26%)
5. International recruitment campaign to India in July; additional 46 recruits added to pipeline
6. Successful recruitment campaign for ED including appointment of paramedics and paediatrics.

Retention progress:

1. Q1 leavers 35 (headcount) April 20, May 7, June 8.
2. Rolling 12 month position is a net gain of 42.18 WTE nurses and midwives

Your future | Our hospital

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board (Public) – 2 August 2018

3.1

Agenda Item:	3.1							
Presented by:	Lance McCarthy - CEO							
Prepared by:	Lance McCarthy - CEO							
Date prepared:	26.07.18							
Subject / Title:	CEO Report							
Purpose:	Approval	x	Decision		Information		Assurance	
Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	This report updates the Board on key issues since the last public Board meeting.							
Recommendation:	The Trust Board is asked to note the CEO report and to agree the AACs' recommendations to appoint 6 new consultants.							

Trust strategic objectives: [please indicate which of the 5Ps is relevant to the subject of the report]	Patients	People	Performance	Places	Pounds
	x	x	x	x	x

Previously considered by:	N/A
Risk / links with the BAF:	CEO report links with all the BAF risks
Legislation, regulatory, equality, diversity and dignity implications:	None
Appendices:	None

The Princess Alexandra Hospital NHS
NHS Trust

3.1

Chief Executive's Report
Trust Board: Part I – 2 August 2018

This report provides an update since the last Board meeting on the key issues facing the Trust.

(1) Key performance headlines

Some key summary performance headlines outlined below for the latest month. More detail on each of these and other key performance indicators are shown in the Integrated Performance Report later on the agenda.

Key Performance Indicator	Actual performance for latest month (June)	Comparison to last report
ED 4-hour performance	77.93%	↑ (better)
HSMR	114.8 (Mar 17 – Feb 18)	↓ (better)
CDiff numbers	1	↓ (worse)
MRSA numbers	0	→
Never Events	0	→
RTT incomplete	91.0%	↑ (better)
Cancer 62 day standard	75.9%	↓ (worse)
6-week diagnostic standard	99.6%	↑ (better)
I&E variance from plan	£50k better than plan	↑ (better)
Agency expenditure	£914k	↓ (better)

(2) Urgent care performance and flow

We continue to improve our performance against the 95% 4-hour access target for urgent care, although performance levels remain significantly below where we would wish them to be.

June's performance improved for the 4th consecutive month (the first time this has happened for more than 5 years) and at 77.93% was the 3rd highest monthly performance since December 2015. It was however below our trajectory for the month of 80.00%.

The volume of patients attending the ED continues to rise, with 2.8% more attendances year to date compared with the same period last year. We saw 8,885 attendances in June, the busiest month for 2 years, and as at the time of writing this report we had seen 6,974 patients in ED in the first 23 days of July; 7% more than for the same period last year. It is highly likely that July 2018 will be the busiest ever month for ED attendances at PAH, possibly as high as 9,400.

The significant rise in activity in recent months (8,193 (Apr); 8,830 (May); 8,885 (June); c. 9,400 (July)) has put pressure on to our department and on the flow of patients through the hospital. In recent weeks we have seen the impact of the sustained period of warm weather on our local population, with increased numbers of non-elective admissions, particularly older people, and an increase in the number of patients presenting with UTIs or post a fall. All health and care agencies locally have implemented their heatwave plans to support our patients and members of the public, particularly those who are more vulnerable. The significant recent improvements to the flow of patients in to, through and out of the hospital have been put under strain, although our assessment facilities are continuing to support the quicker diagnosis and treatment of relevant patients.

Additional inpatient capacity has been commissioned, with building due to start imminently to provide an additional 27 inpatient beds on the PAH site by Christmas to support flow through the winter. This is in addition to more community capacity in the immediate term to support patients being discharged more effectively and more timely to an appropriate care environment to best meet their needs and to

reduce inpatient bed occupancy rates. We continue to work closely with our health and care partners to ensure the right community capacity is in place to best meet the needs of our patients, and continue to develop plans for further inpatient bed capacity on the PAH site in 2019/20 to support reducing our bed occupancy further and meeting the increasing demand for our services.

We continue to make significant progress with new ways of working to support urgent care flow, including the recent implementation of criteria led discharge on the surgical wards and the agreement to develop a new frailty assessment unit in ED in the autumn.

We remain on regular system wide escalation working closely with NHS England and NHS Improvement to try to reduce blockages in the wider system.

(3) New Hospital development

Progress on Our New Hospital programme continues to be made at pace.

We are currently in a clear capital approvals and assurance process with NHS England and NHS Improvement. The first phase of this is to build on our Strategic Outline Case, submitted last year, and West Essex CCG's previous system wide clinical service planning and public engagement to develop a Pre-Consultation Business Case (PCBC) by the end of September.

The PCBC will build on *My Health, My Future, My Say* to outline how services across all health providers will be provided locally, as we transition to more care being provided out of a hospital setting in both primary and community services. It will be fully aligned with the work being undertaken across our Sustainability and Transformation Programme and locally across our West Essex Integrated Care Alliance Programme. It will be considered by the Essex Health and Overview Scrutiny Committee before being recommended to NHS England colleagues.

Running in parallel with the development of the PCBC is the work required to underpin a decision on a preferred site for the new hospital; one of 2 off site options and the potential to rebuild on the current site. In conjunction with Essex County Council we are reviewing highways and other infrastructure impacts on the local population and our people. We have also commissioned master planners to vision how each of the shortlisted sites would be able to be developed to meet the future needs of secondary care hospital provision and the resultant approximate capital requirement. The long term revenue implications of each option and a range of other evaluation criteria will be reviewed by the Board in the autumn to determine a preferred site.

Once we have PCBC approval and have made a decision on the preferred site, we will move in to the NHS Improvement assurance process, requiring a revised Strategic Outline Case, an Outline Business Case and a Full Business Case, with national NHS Improvement resource committee, Department of Health and Social Care and HM Treasury approvals. We are targeting summer 2020 for final FBC approval.

(4) Consultant appointments

We have held 5 Consultant Advisory Appointments Committees during June and July, across a range of specialties. The quality of the applicants who are applying for consultant roles here continues to increase with increasingly difficult decisions having to be made by the Appointments Committees. The AACs recommend to the Board the appointment of 6 consultants:

- OMFS Jeremy Antscheri
- Foot and ankle Kar Teoh
- Radiology Venkata Varanasi
- Histopathology Salma Al-Ramadhani
- Urology x2 Waseem Akhter & Giorgio Mazzon

The Board is asked to approve the AACs' recommendations.

These appointments take the total number of new consultants appointed during the first 7 months of 2018 to 13. We are currently in the process of developing a new consultant programme for all new appointees to support them in their first 18-24 months as a consultant at PAH.

(5) New Secretary of State for Health

Following Jeremy Hunt MP's appointment to the role of Secretary of State for Foreign and Commonwealth Affairs on 9 July 2018, Matt Hancock MP was appointed Secretary of State for Health and Social Care.

He was the Secretary of State for Digital, Culture, Media and Sport from 8 January 2018 to 9 July 2018 and previously the Minister of State for Digital from July 2016 to January 2018. He is the MP for West Suffolk.

The other DHSC ministers remain as they were:

- Stephen Barclay MP – Minister of State for Health
- Caroline Dinenage MP – Minister of State for Care
- Jackie Doyle-Price MP – Parliamentary Under Secretary of State for Mental Health and Inequalities
- Stephen Brine MP – Parliamentary Under Secretary of State for Public Health and Primary Care
- Lord O'Shaughnessy – Parliamentary Under Secretary of State for Health (Lords)

(6) Executive Director changes

I'd like to take this opportunity to welcome Ogechi Emeadi as our new Director of People and OD. Gech joined us on 1 August from Milton Keynes University Hospital NHS Foundation Trust where she has been the Director of Human Resources and Workforce Development for just over 4 years.

We have also successfully recruited to our Director of Nursing and Midwifery role on a substantive basis. Sharon McNally will join us on 1 October from Cambridge University Hospitals NHS FT where she has been the Deputy Chief Nurse for the last 6 years. Sharon will bring with her over 30 years of acute nursing experience, including 6 years as Deputy Chief Nurse, and is passionate about ensuring staff are empowered and engaged to enable great, compassionate care to flourish. I'd like to extend my thanks to Sharon Cullen, who has agreed to push back her planned retirement date to act in to the DoN role during August and September to provide us with continuity until Sharon starts.

Author: **Lance McCarthy, Chief Executive**
Date: **24 July 2018**

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The Princess Alexandra Hospital NHS Trust

Trust Board - 2 August 2018

4.1

Agenda Item:	4.1
Presented by:	Chief Medical Officer - Andy Morris
Prepared by:	Head of Corporate Affairs - Heather Schultz
Date prepared:	26 July 2018
Subject / Title:	Board Assurance Framework 2018/19

Purpose:	Approval	x	Decision		Information		Assurance	

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	The Board Assurance Framework 2018/19 is presented for review. The risks, risk ratings and outcomes of Committee reviews in month are summarised in Appendix A and the BAF is attached as Appendix B. There is one proposed change to the risk ratings: Risk 2.2 (Medical Engagement) was discussed at QSC.25.07.18 and the Committee supported the reduction of the risk rating from 16 to 12 (the target score). The Committee received and considered the results of the recent medical engagement survey in support of the proposed reduction of the risk rating.
Recommendation:	The Board is asked to approve the Board Assurance Framework and the reduction of the risk score for Risk 2.2 from 16 to 12.

Trust strategic objectives: [please indicate which of the 5Ps is relevant to the subject of the report]	Patients	People	Performance	Places	Pounds
	x	x	x	x	x

Previously considered by:	EMT 12 July and 24 July 2018, QSC on 25 July, Workforce Committee on 23July and PAF on 23 July 2018.
Risk / links with the BAF:	As reflected in the attached BAF.
Legislation, regulatory, equality, diversity and dignity implications:	Compliance with national legislation and regulations and the Code of Governance.
Appendices:	Appendix A - Summary of Residual Risk Ratings Appendix B - Board Assurance Framework 201/18

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5P	Executive Lead	BAF Risks	Current risk score	Designated Committee and outcome of Committee review.
	Chief Nurse/Chief Medial Officer	1.1 Outcomes: Inconsistent outcomes in clinical quality, safety, patient experience and 'higher than expected' mortality.	**16**	QSC Reviewed at QSC.25.07.18; rating confirmed.
	Chief Finance Officer/DoI& IT	1.2 EPR Concerns around data quality including misuse and compliance with system and system resilience as well as forward compatibility as Trust moves towards having Integrated Care Records	**16**	PAF Reviewed at PAF.23.07.18 and actions being taken to support delivery of target risk rating discussed in detail. Risk rating confirmed.
	Chief Finance Officer/DoI& IT	1.3 Coding Risk Coding issues (including clinical) within the Trust impacting on Patient Safety, Finance, Performance and Operational delivery	**16**	PAF Reviewed at PAF.23.07.18 and actions being taken to support delivery of target risk rating discussed in detail. Risk rating confirmed.
	IDoP	2.1 Workforce Capacity Concerns around staffing capacity to manage workload, deliver services of high quality and maintain national performance requirements.	**20**	WFC reviewed on 23.07.18 Risk rating confirmed.
	Chief Nurse/Chief Medial Officer	2.2 Clinical Leadership and Engagement Inconsistent Clinical Leadership & Engagement in strategy, operations, performance and delivery which impairs Trusts reputation & sustainability.	**12**	**QSC** **Reviewed at QSC.25.07.18; agreed to reduce risk rating to 12 following review of results from MES.**
	IDoP	2.3 Internal Engagement Failure to communicate key messages and organisational changes to front line staff.	**9**	WFC reviewed on 23.07.18. Risk rating confirmed.
	IDoP	2.4 Workforce Productivity Gaps in staff capability not being consistently addressed through available performance management and development processes	**9**	WFC reviewed on 23.07.18 Risk rating confirmed.
	DQI	3.1 Estates & Infrastructure Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	**20**	PAF Reviewed at PAF.23.07.18, risk rating confirmed.

	DoS	3.2 Health Economy Stability & Joined up Approach Failure of the Accountable Care Partners to integrate and work effectively as an ACP and deliver demand management, productivity and efficiency targets, undermining both hospital and system sustainability.	**16**	For review by Trust Board.2.08.18.
	DoS	3.3 Financial and Clinical Sustainability across health and social care system Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system.	**16**	For review by Trust Board.2.08.18.
	DoS	3.4 Strategic Change and Organisational Structure Capacity & capability of senior Trust leaders to influence both internally and externally the required strategic changes.	**12**	For review by Trust Board.2.08.18.
	DoS	3.5 Sustainability of local services Failure to ensure sustainable local services whilst the new hospital plans are in development.	**16**	For review by Trust Board.2.08.18.
	DCFO/DQI	4.1 Supporting Functions (including Finance, IT, and Estates and Facilities)** Concerns around the need to modernise the systems, processes, structures, capacity & capability of the business support functions.	**12**	PAF Reviewed at PAF.23.07.18, risk rating confirmed.
	COO	4.2 4 hour Emergency Department Constitutional Standard Failure to achieve ED standard	**20**	PAF Reviewed at PAF.23.07.18, risk rating confirmed.
	CFO	5.1 Finance Concerns around failure to meet financial plan including cash shortfall.	**15**	PAF Reviewed at PAF.23.07.18, and risk rating confirmed.

The Princess Alexandra Hospital NHS
NHS Trust

The Princess Alexandra Hospital Board Assurance Framework

2018-19

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Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2017-18**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
		Strategic Objective 1: Our Patients - continue to improve the quality of care we provide our patients, improving our CQC rating and exiting special measures **Strategic Objective 4: Our Performance - meet and achieve our performance targets, covering national and local operational, quality and workforce indicators**												
BAF 1.1		Inconsistent outcomes in clinical quality, safety, patient experience and 'higher than expected' mortality.	Causes: i) Inconsistent treatment stratification ii) Failure to incorporate patient feedback (including PALS) into service improvement and re-design. iii) Failure to achieve sustainable improvements in national survey results iv) Poor results in 2016 Inpatient Survey	**4 X 5= 20**	Chief Nurse/ Chief Medical Officer **Quality and Safety Committee**	i) Robust quality and safety governance structures in place including infection control ii) Performance management of unacceptable behaviour. iii) Robust Appraisal/ medical revalidation process which includes patient feedback - 360° feedback and Fitness to Practice process in nursing iv) RCA methodology workshops v) End of Life and deteriorating patient simulation programme for all staff, and Whole System Steering Group vi) Mandated & focused education & training in communication skills such as breaking bad news training. vii) Sharing the Learning Programme viii) Monthly Commissioner reviews of quality and Safety xi)Four 'Big Dots' - AKI, Sepsis, Mortality and End of Life xii) Risk Management Training Programme xiii) Monthly newsletters - Quality Matters, Pharmacy 5 Minutes xiv) Escalation processes for prescribing doctors and processes for non-medical prescribers xv) Electronic handovers and E-Obs xvi) Schwartz Rounds xvii) Redesign of ED xviii) NHSI/NHSE Oversight xix) Red2 Green Board rounds xx) Improved reporting and review process for deaths and establishment of incident management group. xxi) Patient Experience Strategy xxii) NED lead appointed for Mortality	i) National Surveys ii) Cancer Survey iii) CEO Assurance Panels iv) SIG meetings v) QSC, PAF, Risk Management Group and Board meetings vi) Patient Safety and Quality meetings vii) Infection Control Committee viii) Integrated Safeguarding meetings ix) Patient Panel meetings x) PLACE Inspections xi) Medicines Management Committee xii) CCG audits xiii) Monthly QA visits/inspections xiv) End of Life and Mortality Groups xv) Executive Assurance meetings with ED, Critical care, End of Life, Urology and General Surgery. xvi) AKI and Sepsis merged with Q1st and NED lead	i) Improvement in some areas of the National Inpatient Survey ii) CQUIN reports to PAF/QSC iii) CEO Assurance Panels. iv) Reports to QSC on Patient Experience, Serious Incidents, Safer Staffing, Patient Panel, Safeguarding, Infection Control (top quartile) v) Reports to Board from QSC and reports on clinical issues for escalation, Mortality and CN/CMO reports vi) Dr Foster reports, CQC inspection reports and GIRFT reports vii) Increase in Datix reporting and reduced harm over approx. last 18 months viii) Feedback from NHSI and Commissioners on harm reviews (positive) ix) Real time Dr Foster feedback x) Arthoplasty infections (monitoring) xi) Water Safety testing across the Trust (SMH) - normal results xiii) Local Delivery Board (LDB) xiv) GMC Trainee Results Report xv) Integrated Performance Report (IPR) xvi) Mock CQC Inspection Report xvii) Learning from deaths reports and dashboard, Mortality Presentation to Board (Oct 17) and HSMR improved to 114. ~~report to Board November 17 (fourth month of improvement)~~ xviii) ~~Qlikview~~ Outstanding NICU peer review xix) Clinical Audit report - tiaa xx) Enable East Review Review (Oct 17) xxi) Improved palliative care coding	**4x4=16**	i) Real time patient safety feedback ii) Internal/External Comms in development iii) Evolving clinical audit approach iv) Real time patient feedback system in procurement phase v) Disparity in local patient experience surveys versus inpatient survey vi) Staffing and site capacity **ACTIONS:** i) Website development ii) Inpatient Survey action plan in place iii) Medical Examiners being appointed - implementation September 2018	i) Clinical evidence of improvements made following Compliance with national audits, NICE,NCEPOD.	11/07/2018	**Risk rating not changed.**	~~4~~x3 =12 (Target date ~~March~~ Sept 2018 - to achieve 'as expected' for mortality and for patient experience, 5 personal care indicators in Quality Account in top 20%)
			Effects: i) Poor reputation ii) Increase in complaints/ claims or litigation iii) Persistent poor results in National Surveys iv) Recurrent themes in complaints involving communication failure v) Loss of confidence by external stakeholders											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2017-18**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 1: Our Patients - continue to improve the quality of care we provide our patients, improving our CQC rating and exiting special measures **Strategic Objective 5: Our Pounds – manage our pounds effectively to achieve our agreed financial targets and control totals**													
BAF 1.2		**EPR** Concerns around data quality including misuse and compliance with system and system resilience as well as forward compatibility as Trust moves towards having Integrated Care Records	Causes: i) Poor engagement with the system, usability, time/skills ii) System fixes	**5 X 4= 20**	Chief Financial Officer/Chief Operating Officer/Chief Medical Officer **Performance and Finance Committee**	i) Weekly DQ meetings held at ADO level ii) Programme management arrangements established with Data Quality Recovery Programme to 'Health Group Challenge' meetings, EMB and Trust Board. Governance via Performance and Finance Committee to Trust Board. iii) Increased training application support, mobile training support, RTT validators & staff awareness sessions. iii) Performance Mgt Framework in place. iv) Training programme. v) Super users in place to deliver focused support. vi) Transformation function extended to ensure high level issues affecting delivery of benefits and reporting are captured and managed through to process review, fix and system enhancement to improve usability vii) Access Policy viii) Functionality enhanced through deployment of alternate solutions (e-Obs, Portal, Meds management) ix) Development of capacity planning tools/information x) PWC review and actions identified xi) DQ meetings re-structured xii) ICT Newsletter issued xiii) New training process for locums xiv) Link to Quality 1st being discussed. xv) New daily ~~weekly~~ Cambio meetings/roadmap xvi) Internal daily ICT/COSMIC meetings ongoing xvii) 7.7 in development and expected in test environment by end of May ~~9.02.18~~ xviii) Real time data now available xix) Exec to Exec meetings every 2 weeks xx) Cambio to attend ICT Steering Group xxi) OBS requirements being reviewed to assess gaps xxii) Contract review - completed xxiii) ~~External Support - PWC~~ CDS 011 now live	i) Access Board ii) ICT Programme Board (chaired by CFO) iii) Board and PAF meetings iv) Weekly meetings with Cambio vi Weekly DQ meetings vi) Monthly performance reviews	i) Weekly Data Quality reports to Access Board and EDB ii) Internal Audit reports to Audit Committee iii) External Audit reports to Audit Committee on Quality Account Indicators iv) DQ Report to PAF and roadmap report September 2017 v) PWC report and action plan vi) Trust Board workshop April 2017 vii) Cambio roadmap and governance structure reports to PAF	**4 X 4= 16**	i) Continue to develop 'usability' of EPR application to aid users ii) Resource availability iii) Capacity within operational teams iv) Elements of system remain onerous (completion of discharge summaries) v) External system support vi) Executive to raise profile & awareness of implementation/ transformation opportunities with clinical leaders/consultants. vii) CCIO post now vacant viii) Compliance with refresher training ~~ix) CDS 011 issue identified with diagnosis qualifier currently in test an dequires resolution before 7.7 can go into test environment.~~ ix) Current scheduled delivery date for 7.7 SP1HF 01.02, 03 is week commencing 16 July - will be closely monitored.	Reporting mechanism on compliance of new staff/interims/junior doctors with the system and uptake of refresher training - monitoring process being developed.	Jul-18	Residual Risk rating unchanged	**4x3=12 (Sept 18)**
			Effects: i)Patient safety if data lost, incorrect, missing from the system. ii) National reporting targets may not be met/ missed. iii) Financial loss to organisation through non-recording of activity, coding of activity and penalties for not demonstrating performance iv) Inability to plan and deliver patient care appropriately							**ACTIONS:** i) Ongoing training and support ii) Restructure of IT team (resourcing) iii) Re-establishing realtionship/engagement with Cambio iv) Establishing benefits realisation programme v) Recruitment of new CCIO - in mitigation each ICT Project Board has a clinical member and AMD Q1st engaged in projects. vi) Refresher training underway vii) Revised roadmap to incorporate new statutory/legal requirements i.e. GDPR				

Risk Key		
Extreme Risk		15-25
High Risk		8-12
Medium Risk		4-6
Low Risk		1-3

The Princess Alexandra Hospital Board
Assurance Framework 2017-18

Risk No		PRINCIPAL RISKS				KEY CONTROLS	ASSURANCES ON CONTROLS	BOARD REPORTS						
		Principal Risks		RAG Rating (CXL)	Executive Lead	Key Controls	Sources of Assurance	Positive Assurances on the effectiveness of controls	Residual RAG Rating (CXL)	Gaps in Control	Gaps in Assurance	Review Date	Changes to the risk rating since the last review	Target RAG Rating (CXL)
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 1: Our Patients - continue to improve the quality of care we provide our patients, improving our CQC rating and exiting special measures **Strategic Objective 4: Our Performance - meet and achieve our performance targets, covering national and local operational, quality and workforce indicators** **Strategic Objective 5: Our Pounds – manage our pounds effectively to achieve our agreed financial targets and control totals**													
BAF 1.3		**Coding Risk** Coding issues (including clinical) within the Trust impacting on Patient Safety, Finance, Performance and Operational delivery	**Causes:** ~~i) Clinical staff not fully, accurately capturing information required in a timely manner~~ i) Liaison and education between coders and clinicians not optimal. ii) Failure to capture and code activity by national submission deadlines such as flex and freeze dates. iii) EPR issues - clinical engagement with COSMIC iv) Inconsistent engagement by HGs in addressing data completeness and clinical coding issues v) Poor notes and record keeping vi) Human element with some junior doctors not providing definitive diagnosis to facilitate coding vii) Ongoing COSMIC development/fixes viii) SOPs not in place and inconsistent compliance ix) Maintaining alignment with information systems to ongoing changes in operating models x) Capacity and capability within training team **Effects**: i) Loss of income ii) Incorrect triggering in external reports such as Dr Foster and impact on HSMR and SHMI iii) Negative impact on reputation iv) Potential safety issues v) Capacity planning and operational performance vi) Pathway and Collaboration implications vii) Costs for overtime and agency staff	**5 X 4= 20**	Director of IT **Performance and Finance Committee**	i) DQ Improvement Plan ii) Weekly Access Board meetings iii) Data quality dashboards developed iv) MediCode implemented and maintained v) Clinical lead for coding identified vi) Meetings/workshops with clinical leads on coding vii) Clinical coding pilot by clinicians viii) Additional coders employed/targeted to areas of risk ix) Weekly Specialty meetings x) CMO monthly meetings with coding re mortality xi) IM&T Programme Board xiii) Coding action plan xiv) Presentations to CWG and MAC xv) Business case for additional resource now approved xvi) Outsourcing to improve coding backlog and percentage coded by flex date. xvii) External review completed and final report recieved and presented to EMT; further actions identified and to be incorporated into coding improvement framework. xviii) Recruiting to new structure (ongoing) xix) Weekly clinical coding quality audit for the insourced/outsourced coding resource xx) Mortality validation work underway and linking with Medical Examiners Trainee coders in place xxi) Plans underway to relocate off site team members back on site to unify the team	i) Internal Audit (DQ/coding and ED) ii) Annual clinical coding audit for IG Toolkit iii) Dr Foster reports iv) Mortality reviews v) External Audit (Quality Account indicators) vii) PAF meetings	i) Internal Audit reports to Audit Committee ii) External audit report to Audit Committee (Quality Account indicators) iii) DQ Recovery Plan (PAF) iv) Monthly DQ reports (PAF) v) Weekly reports and HG dashboards to EDB and Access Board vi) Maxwell Stanley report on clinical coding	**4 X 4= 16**	i) Need to increase direct clinical coding particularly for outpatients ii) Management and quality of content of medical notes and timely availalblty of notes iii) Continue to develop 'usability' of EPR application to aid users iv) Capacity within operational teams v) Elements of system remain onerous (completion of discharge summaries) vi) External system support vii) Recruitment and retention within coding team and 2 coders on long term sickness absence **ACTIONS:** Recruitment to posts EPR meetings/negotiations Recruitment of CCIO Coding improvement framework following external review ~~and bid to NHSI for funding to support improvements.~~ Guidance for coders updated in respect of co-morbidities from discharge summaries. Coding using electronic systems e.g. radiology, theatres Maxwell Stanley project launching in August.	Current concern around timely completeness of coding has been addressed since April 17 and the focus is shifting to maintain the position and address the secondary issues endorsed by external review. Quality of outsourced coding under review and being monitored with feedback provided to close the loop. (Gaps to be addressed by coding improvement framework)	01/07/2018	No change to risk ratings.	4x3=12 August 2018 - embedding actions in Coding Improvement Framework)

Risk Key		
Extreme Risk		15-25
High Risk		8-12
Medium Risk		4-6
Low Risk		1-3

The Princess Alexandra Hospital Board
Assurance Framework 2017-18

Risk No		PRINCIPAL RISKS				KEY CONTROLS	ASSURANCES ON CONTROLS	BOARD REPORTS						
		Principal Risks		RAG Rating (CXL)	Executive Lead and Committee	Key Controls	Sources of Assurance	Positive Assurances on the effectiveness of controls	Residual RAG Rating (CXL)	Gaps in Control and Actions	Gaps in Assurance	Review Date	Changes to the risk rating since the last review	Target RAG Rating (CXL)
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 2: Our People – support our people to deliver high quality care within a culture that improves, engagement, recruitment and retention and improvements in our staff survey results													
	Strategic Objective 4: Our Performance - meet and achieve our performance targets, covering national and local operational, quality and workforce indicators													
BAF 2.1		**Workforce Capacity** Concerns around staffing capacity to manage workload, deliver services of high quality and maintain national performance requirements.	**Causes:** i) National ~~shortage~~ hotspots (Acute physicians, Stroke consultants, ED consultants, Pathologists and Care of elderly staff and registered nurses and midwives). ii) Geographical location of the Trust, close to London but without the HCA weighting. iii) Proximity to teaching hospitals which are attractive to some ~~medical~~ staff iv) ~~Uncertain future of Trust impacting on retention and attracting new staff~~ v) Lack of focus on active talent management vi) High turnover of nursing, biomedical scientists and AHP staff vii) Rewards currently available for agency working **Effects:** i) Pressure on existing staff to cope with demand leading to overworked staff ii) Low staff morale iii) Shortcuts and failure to follow processes and procedures due to workload and fatigue leading to higher chances of patient safety errors occurring iv) Staff retention and succession planning issues	**4 X 4 =16**	Interim Director of People **Workforce Committee**	i) National representation to increase international supply and supportive immigration policies. ii) Recruitment prrocesses refreshed (TRAC, benefits package, Vacancy Review Panel, Social Media and Recruitment Campaign) iii) Clear 5P Strategy and direction iv) Succession planning introduced and part of appraisal v) Talent Management Plan features as a component of new People Strategy and Operating Plan 18/19. vi) Turnover of Nursing, Biomedical Scientists and AHPs at 13.3% below STP average of 16%. vii) Agency controls in place having met regulator set target in 17/18.	i) PAF, QSC, WFC, EMT, EMB, Workforce and Board meetings ii) Health Group Boards	i) Safer Staffing Reports (monthly to QSC and Board) ii) ~~Quarterly~~ Workforce reports (progress on recruitment, retention, bank and agency) to PAF ~~and monthly HR Risks and Issues reports~~ iii) Incident reporting and monthly SI reports to QSC	**4 X 5 =20**	Inability to influence supply. Action: Continue to work with HEE to influence national policies	Director of People to review incidents and monthly SI reports.	16/07/2018	**No change to residual risk rating.**	**4x4=16 Oct 2018**

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2017-18**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
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	Strategic Objective 2: Our People – support our people to deliver high quality care within a culture that improves, engagement, recruitment and retention and improvements in our staff survey results													
BAF 2.2		**Clinical Leadership and Engagement** Inconsistent Clinical Leadership & Engagement in strategy, operations, performance and delivery which impairs Trusts reputation & sustainability.	**Causes:** i) Capability & capacity to progress change ii) Failure of organisation to transform and consistently achieve performance targets. iii) Perceived lack of listening and response from service leaders & Senior management iv) Low morale of clinicians & staff impacting on more junior staff about numerous/ recurrent changes in senior leadership. v) Perceived non involvement of key clinicians in certain areas. vi) Variable understanding of level of required transformation & efficiencies vii) Sustainable clinical change viii) Lack of OD and clear strategy	**3 X 4= 12**	Chief Nurse/ Chief Medical Officer **QSC**	i) Strong clinical engagement at EMB ii) Use of CQC KLOE for reporting and developing evidence iii) Programme of Sharing the learning for quality iv) Clinician engagement with RCA and Being Open training including Duty of Candour training v) Involving clinicians in listening events (In Your Shoes) and family/Being open meetings vi) Involving clinicians in health group and service reviews vii) Anglia Ruskin Integrated leadership scheme viii) Reporting structure for Quality Governance - Health group risk summits, Quality & Safety panels, PS&Q meetings. ix) Monthly 'Big conversation' with CEO, Board feedback to staff, CQC briefing sessions x) Monthly meeting with CMO/Clinical Leads, AMD for Quality First in post xi) GMC national survey xii) Executive attendance at MAC meetings xiii) CMO adhoc meetings with junior doctors/ registrars & FY leads xiv) Quality First Programme xv) CCIO post now vacant xvi) Junior Doctors Quality Improvement Programme xvii) Medicines Safety Officer appointed xviii) Medical revalidation process and MHPS process xix) Clinical Pathway Leads appointed xx) Deputy CMO appointed (Strategy) xxi) OD Programme and strategy in partnership with ENHT xxii) FFT for staff, Staff Council and Executive Staff Briefings xxiii) Senior Practitioners Forums and action learning sets xxiv) Guardian of Safe Working appointed xxv) CMO Clinical Fellow and PHE trainees xxvi) Schwartz Rounds xxvii) ARHP/UCLP programme for Quality First xxx) Executive Listener xxxi) Buddy arrangements MK and Coventry and Warwick xxxii) Learning from Deaths xxxiii) Clinical engagement workshops led by international experts xxxiv) ~~Multi-professional engagement workshop June 17~~ - MES results received July 2018 - positive; overall better than national average	i) CQC inspections ii) The National Inpatient and Staff Surveys iii) Trust Board - patient and staff stories iv)Improvement Board Quality First v) EMB Meetings vi) MAC meetings vii) Executive meetings with Junior doctors re industrial action viii) Health Groups Board meetings ix) JLNC meetings x) Junior Doctor meetings xi) Mock CQC Inspection report	i) CQC Reports i) In patient survey improvements with Trust in middle 60%. iii) The National Cancer Patient Experience Survey 2014 improved. iv) Complaints, compliments and PALS reports (reduction in complaints). v) DOPP strategic updates to Board vi) Reports to EMB on pathway work vii) Evaluation of Leadership Programme and 360 feedback viii) NHS Staff Survey results - improvements noted ix) 'Getting it Right First Time' reports x) School of Paeds Trainee Report xi) Deanery Reports xii) Medical Engagement Survey (some positive areas) xiii) Deloitte Review xiv) HEE Report xv) Modern Hospital Report xvi) GMC Trainee Results Report xvii) Cancer performance - top in country xviii) SP Workshop held (Feb 18) - clinicians in attendance xix) Clinical leadership on Sepsis programme	~~**4x4=16**~~ **4x3=12**	i) Operational vacancies within Health groups creating instability in Governance structures. Ii) Operational and clinical pressures precluding attendance at meetings iii) Further development needs for existing/potential junior leaders iv) Allocated budget for OD (pockets of work done) v) Appointment of Senior Nurse Information and IT	i) Engagement and internal communications to be embedded. Ii) Limited evidence of OD work	11/07/2018	**Risk rating reduced to 12 following recent MES results.**	**4 x 3 =12 (Target date ~~March~~ Sept 2018 pending outcome of further survey monkey)**
			Effects: i) Impact on workforce morale and negativity ii) Impact on retention, recruitment of high calibre clinicians iii) Lack of cohesive workforce which inhibits quality & safety delivery (e.g. Dementia & Discharge) iv) Ineffective delivery of objectives and targets v) Slow pace of transformation vi) Poor patient experience resulting from hospital and staff communication issues . vii) Adverse Trust reputation viii) Destabilisation particularly with merger of Medicine and ED. ix) Current vacancies at senior levels within Health Groups								**ACTIONS:** i) Ongoing recruitment underway ii) OD programme of support with NHSI Leadership Academy and programme for AMDs				

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		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control and Actions**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
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	Strategic Objective 2: Our People – support our people to deliver high quality care within a culture that improves, engagement, recruitment and retention and improvements in our staff survey results													
BAF 2.3		**Internal Engagement** Failure to communicate key messages and organisational changes to front line staff.	**Causes:** i) Change fatigue and 'regulation fatigue' ii) Increasing demand versus reducing resources iii) Lack of awareness around the organisation of strategic direction due to poor communication channels/tools iv) Poor attitude and behaviours v) Competing priorities vi) Collaboration with Lister, development of ACO and uncertainty about STP plan vii) Challenged Provider status viii) Insufficient management time allocated to communication with staff	**4 X 4= 16**	Director of HR **Workforce Committee**	i) Staff awards; ii) CEO weekly blog & 'In Touch'; iii) Staff Briefing sessions iv) Staff, patients and carers involved in creation of values, standards & behaviours to ensure ownership; v) Sharing the Learning events to involve staff in safety improvements, which has included the Being Open/ Duty of Candour. vi) Development and Deployment Strategy vii) Great Leaders Programme viii) Quality Fellows programme ix) National Leadership Programmes for staff x) Staff Survey xi) Schwartz Rounds xii) CQC QIP xiii) Staff Council xiv) Quality Ist Communication Plan and Newsletter xvii) Event in Tent xv) People Strategy in development xvi) Printed magazine (quarterly)	i) PAF and Board meetings ii) QSC meetings iii) Staff Engagement Working Group iv) Workforce Committee	i) Staff survey results - showing signs of improvement ii) FFT for staff - improvements iii) Workforce reports to PAF and Workforce Committee iv) IPR to PAF and Board v) OD reports to WFC vi) Learning and Development reports to WFC.	**3x3=9**	Clarity on timescales for change (SOC approval) and the future of the Trust. **Actions:** i) Monthly updates to Board on strategic developments . ii) Sustaining engagement activities following Event in a Tent iii) Recruitment to Head of Communications role. Structure of Comms team and recruitment pending - awaiting start of new DoP and Comms iv) Review of Comms function ~~underway~~ completed.		16/07/2018	**No change to risk rating.**	3x2=6 (~~July~~ September 2018 re-structure of Comms team and function
			Effects: i) Error omission ii) Poor reputation iii) Demoralised staff iv) Impact on sustainability v) Changes not embedded as business as usual vi) Disconnect between management and front line staff											

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The Princess Alexandra Hospital Board
Assurance Framework 2017-18

Risk No		PRINCIPAL RISKS				KEY CONTROLS	ASSURANCES ON CONTROLS	BOARD REPORTS						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control and Actions**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
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	Strategic Objective 2: Our People – support our people to deliver high quality care within a culture that improves, engagement, recruitment and retention and improvements in our staff survey results **Strategic Objective 4: Our Performance - meet and achieve our performance targets, covering national and local operational, quality and workforce indicators**													
BAF 2.4		**Workforce Capability** Gaps in staff capability not being consistently addressed through available performance management and development processes	**Causes:** i) Managers not prioritising performance management and development issues ii) Historic lack of management and leadership development training iii) Historic view that appraisals and performance management are not important iv) Lack of a systematic approach to determining organisational, business unit and individual objectives and development plans	**3 X 4 =12**	Interim Director of People	i) Capability Policy in place ii) Training for Managers, Band 5, 6 and 7 leadership training programmes including 'Leading difficult conversations' sessions. External funding in place. iii) HR support for managers in managing underperformance iv) Leadership development and action learning sets in place v) People Strategy vi) New appraisal system vii) Data on Informal Dispute Resolution viii) NHS Staff Survey and action plan ix) Manager training workshops in progress. x) Medical appraisals and revalidation processes xi) GMC referrals and MHPS process xii) GMC Survey	i) Board and WFC meetings	i) Employee Relations reports to WFC ii) Workforce KPIs and IPR iii) MHPS reports to Board iv) Training and developmet updates to WFC.	**3 x 3 = 9**	Talent management framework identifying key roles, individuals and gaps. Actions: i) Talent Management and Succession Planning in development ii) Leadership and Management development framework (key behaviours) in development iii) Managers Induction being developed	Confidential staff survey results via staff mobile app and outputs to be included	16/07/2018	No change to risk rating	**3 x 2 = 6 (January 2019 pending results of 2018 Staff Survey)**
			Effects: i) Impact on staff morale of perceived acceptance of underperformance ii) Impact on staff retention iii) Perpetuating cycle of overworked staff compensating for capability gaps. iv) Potential impacts on workforce productivity and income. v) Disengaged workforce.											

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	Strategic Objective 3: Our Places – maintain the safety of and improve the quality and look of our places and work with our partners to develop an OBC for a new build, aligned with the development of a West Essex and East Hertfordshire Accountable Care Partnership													
BAF 3.1		**Estates & Infrastructure** Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	**Causes:** i) Limited NHS financial resources (Revenue and Capital) ii) Long periods of underinvestment in team and structure iii) Lack of capital investment, iv) Current financial situation, v) Inherited aged estate in poor state of disrepair vi) No formal assessment of update requirements, vii) Failure to comply with estates refurbishment/ repair programme historically, viii) Under-investment in training of estate management & site development ix) Inability to undertake planned preventative maintenance x) Lack of decant facility to allow for adequate repair/maintenance particularly in wards areas. xi) Key workforce gaps in compliance, energy and engineering.	**5 X 4= 20**	Director of Quality Improvement **Performance and Finance Committee**	i) Schedule of repairs ii) Six-facet survey/ report. iii) Project Board established to review Capital requirements. iv) Potential new build/location of new hospital v) Re-profiled Capital programme - aligned to red rated risks. vi) STP Strategy being developed. vii) Clinical Infrastructure Risk review underway viii) Central returns Steering Committee ix) Modernisation Programme for Estates and Facilities x) NHSI support and application to NHSI Resources Committee (for funding) xi) Robust water safety testing processes xii) Annual asbestos survey -completed and red risks resolved. xiii) Associate Director of Estates and Facilities appointed xiv) External fire risk assessments completed following Grenfell fire. Action plan developed.	i) PAF and Board meetings ii) EMB Meetings iii) Health and Safety Meetings iv) Capital Planning Group v) External reviews by NHSI and Environmental Agency vi) Water Safety Group vii) Weekly Estates and Facilities meetings viii) First Impressions Count project group.	i)Letter from HSE - no regulatory concern raised ii) Reports to EMB iii) Fire Safety report iv) Reports on testing for legionella, asbestos v) Signed Fire Certificate vi) Annual H&S reports to Trust Board and bi-monthly to QSC vii) Ventilation audit report viii) Water Safety Report (PAH site) ix) Annual and quarterly report to PAF: Estates and Facilities x) PLACE Assessments	**5x4=20**	ii) Planned Preventative Maintenance Programme (time delay) and amber backlog maintenance risks now emerging red risks iii) Ventilation systems iv) Sewage leaks and drainage v) Electrical Safety/Rewiring (gaps) vi) SDMP Plan vii) Maintaining oversight of the volume of action plans associated with compliance. viii) Catering services modernisation ix) Lack of authorised persons within estates and facilities teams. **ACTIONS:** i) Review of Estates and Facilities infrastructure - consultation in Q1. ii) Backlog maintenance review iii) Business cases being developed Combined Heat and Power (in 18/19) iv) Applying for distressed Capital funding to mitigate areas of risk. v) Review of Catering infrastructure Consultation in Q1 vi) SDMP plan to be included in OBC work ~~- draft plan being developed~~ vii) Estates and facilities management re-structure viii) Capital Programme realigned to address red risks	i) Estates Strategy /Place Strategy developing within STP ii) Compliance with data collection and reporting iii) PPM data not as robust as required iv) PAM assurance not robustly updated. Design phase for sewage and plumbing work ~~extended~~ tendered.	16/07/2018	**Residual risk rating unchanged.**	**4 x 2 =8 (Rating which Trust aspires to achieve but will depend on relocating to new hospital site) and:** **Target rating to be confirmed once the design and technical surveys are completed.**
			Effects: i) Backlog maintenance increasing due to aged infrastructure ii) Poor patient perception and experience of care due to aging facilities. iii) Reputation impact iv) Impact on staff morale v) Poor infrastructure, vi) Deteriorating building fabric and engineering plant, much of which was in need of urgent replacement or upgrade, vii) Poor patient experience, viii) Single sex accommodation issues in specific areas, ix) Out dated bathrooms, flooring, lighting – potential breach of IPC requirements, x) Ergonomics not suitable for new models of care. xi) Failure to deliver transformation project and service changes required for performance enhancement xii) Potential slips/trips/fall to patients, staff or visitors from physical defects in floors and buildings xiii) Potential non compliance with relevant regulatory agency standards such as CQC, HSE, HTC, Environmental Health.											

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		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
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BAF 3.2		**Health Economy Stability & Joined up Approach** Failure of the Accountable Care Partners to integrate and work effectively as an ACP and deliver demand management, productivity and efficiency targets, undermining both hospital and system sustainability.	**Causes:** i) Lack of clarity re leadership and governance ii) Failure to align incentives and rewards across all partners iii) Poor IT connectivity essential for sharing of clinical information iv) Organisational sovereignty hindering joint workforce arrangements and new ways of working v) System capacity and capability to deploy population health management systems to risk stratify populations	**4 X 4= 16**	DoS **Trust Board**	i) System Leadership in place ii) CCG proposing new system governance arrangements (ACP within STP footprint which in turn reports to West Essex Partnership Board) iii) Accountable Care Partnership iv) ACP developing project management arrangements v) PAH/CCG propsal for developing a new finacial and contracting model using microsimulation of respiratory services vi) Neighbourhood approach being developed by system vii) CCG reviewing commissioning options for out of hospital services viii) CCG and system agreement on actuarial modelling with Centene and Ribera Salud. ix) CEO chairing ACP Board ~~for next 6 months.~~ x) ACP collaborative agreement signed. xi) Actuarial study completed by Milliman (delayed and impacting on OBC). xii) Board to Board held 30.11.17 xiii) CCG reviewing Urgent Care arrangements	i) Outline business case by BCG and KPMG ii) Chairs/ CEO group meetings iii) Accountable Care Provider Board iv) System leadership meetings v) ACP Board minutes	i) Minutes and reports from system/partnership meetings/Boards ii) BCG business case and KPMG report iii) Memorandum of Understanding RS/WECCG and PAH iv) STP governance proposals	**4 X 4= 16**	i) STP footprint includes whole of Herts & West Essex therefore potential for lack of focus on West Essex/East Herts system. ii) Underpinning assumptions of STP to be tested. iii) Potential £50m risk across system iv) Lack of demand and capacity modelling at ACP and STP levels **ACTIONS:** Revised internal and external governance arrangements Commissioning intentions concerning future provision of out of hospital ~~Role of Integrator being explored~~ STP finance leaders reviewing financial controls to mitigate financial risk Developing new service models and reviewing contracts for MSK, Respiratory and Urgent Care (Completion by OCtober 2018).	None identified.	25/07/2018	**No change to residual risk rating.**	**4x3=12 ~~March~~ October 2018)**
			Effects: i) No clear authority for strategic prioritisation and deployment of system resources ii) Partner organisations seeking approval for decisions from their sovereign organisation iii) Failure of other partners to take on and share risk iv) Fragmentation of provision of care v) Duplication of effort and cost vi) Capacity and capability of already overstretched system workforce not being optimised vii) Hindering introduction of new models of care viii) Potential £50m system-wide STP risk in 2017/18												

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BAF 3.3		**Financial and Clinical Sustainability across health and social care system** Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system	**Causes:** i) Limited input from clinicians and other key stakeholders into STP strategy ii) The financial bridge is based on high level assumptions iii) The development of QIPP and CIP programmes for 2017/18 has not followed a Footprint-wide approach iv) The Workstream plans do not have sufficient underpinning detail to support the delivery of the financial savings attributed to them v) The resources required for delivery at a programme and workstream level have not been defined or secured vi) The current governance structure is under development given the shift in focus from planning to delivery. vii) The collaborative productivity opportunities linked to new models of care require more joined-up ways of working, clear accountability and leadership, changes to current governance arrangements.	**4 X 4= 16**	DoS **Trust Board**	i) STP workstreams with designated leads ii) System leaders Group iii) New STP governance structure iv) STP prioritisation under review with workstream leads being nominated. v) STP PMO under development vi) CEO's forum vii) Integrated Clinical Stratgey in development	i) West Essex CCG review of local governance arrangements ii) Feedback from regulators iii) System leadership meetings iv) Proposals made around system dashboards and KPIs	i) Minutes and reports from system/partnership meetings/Boards ii) CEO reports to Board iii) PWC report on governance arrangements iv) Presentation to EMB on new STP governance structures v) STP paper on system working	**4 X 4= 16**	Lack of STP demand and capacity modelling. **ACTIONS:** System agreement on governance and programme management System leadership capacity to lead STP-wide transformation Trust to nominate representatives on proposed STP/ACP workstreams Escalation to CEO forum and West Essex actuarial piece to be shared.	Proposed governance structures to be tested.	25/07/2018	**No changes to risk rating.**	**4x3=12 Sept 2018**
			Effects: i) Lack of system confidence ii) Lack of pace in terms of driving financial savings iii) Undermining ability for effective system communication with public iv) Undermining political support for Capital programme v) More regulatory intervention											

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								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 3: Our Places – maintain the safety of and improve the quality and look of our places and work with our partners to develop an OBC for a new build, aligned with the development of a West Essex and East Hertfordshire Accountable Care Partnership													
BAF 3.4		**Strategic Change and Organisational Structure** Capacity & capability of senior Trust leaders to influence both internally and externally the required strategic changes.	**Causes:** i) Staff and stakeholders lack of awareness and/or understanding of drivers and issues cross the system ii) Change fatigue and continuous change in leadership iii) Scale, pace and complexity of change required. iv) Infrastructure (IT, buildings) not supportive of change v) Financial resources lacking to support change vi) Inability to recruit and retain innovative leaders in the Trust vii) Focus on immediate operational and financial priorities versus the longer term strategic planning viii) Lack of clarity regarding contracting and organisational models in support of ACP ix) Lack of dedicated management resource to drive change and strategy development x) Lack of shared vision and key drivers for change xi) Launched 5Ps at Event in Tent and internal programme for development and implementation of 5P plans. xii) Lack of clarity on capital prioritisation process at national level.	**4 X 4= 16**	DoS **Trust Board**	i) EMB meetings ii) Clinical specialty meetings iii) Quality 1st Improvement Board iv) Deputy CMO appointed v) Good relationships with key partner organisations vi) CEO chairing ACP leadership team vii) Legal advice taken on potential organisational/contractual models viii) PAH/ENHT Working Group established ix) OBC Steering Group ~~x) Deloitte's Governance review and action plan~~ ~~xi) PWC developing programme with timeline for OBC development and planning advisor working on planning issues~~ xii) CEO attending STP meetings xiii) DoPP actively engaged with Harlow Gilston Garden Town planning xiv) PAH attended meeting with Centre on 24 April re OBC	i)Workshops with clinical leads ii) ACP and STP meetings including acute and back office workstream meetings iii) OBC Steering Group iv) Harlow/Gilston Garden Town Co-op.	i) ~~DoPP~~ Reports to Board on strategic developments and ~~SOC/OBC~~ Our New Hospital reports to PAF/Board. ~~ii) Report to PAF and Board Feb 18 - resourcing~~	**4x3=12**	i) Financial analytical support for programme ii) Capacity and capability to develop LEAN process mapping iii) Embedding the programme iv) External training required to develop internal capacity v) Data quality impacting on business intelligence (SLR) **ACTIONS:** Trust's vision being refreshed and 5P plans underway. Establishment of a 'Strategy Committee' to be discussed at Board in September 2018. Clinical Strategy review underway. Strategy team being developed.	None identified.	25/07/2018	**Risk rating not changed.**	**4 x 2= 8 ~~May~~ October 2018)**
			Effects: i) Poor reputation ii) Imposed strategy not compatible with resources and organisational aim iii) Increased stakeholder and regulator scrutiny iv) Low staff morale v) Threatened stability and sustainability vi) Restructuring fails to achieve goals and outcomes vii) Impact on service delivery and quality of care viii) Poor staff survey ix) Failure to fully implement the transformation agenda required e.g. increase in market share, following restructure x) Undermines regulatory confidence to invest in hospital/system solutions												

Risk Key														
xtreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2017-18**											
edium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance,			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 3 : Our Places – maintain the safety of and improve the quality and look of our places and work with our partners to develop an OBC for a new build, aligned with the development of a West Essex and East Hertfordshire Accountable Care Partnership													
BAF 3.5		**Estate** Failure to ensure sustainable local services continue whilst the new hospital plans are in development	**Causes:** i) Limited NHS financial resources (Revenue and Capital) ii) Long periods of underinvestment in backlog maintenance iii) Lack of capital investment, iv) Current financial situation, v) Inherited aged estate in poor state of disrepair vi) Complexity of STP vii) Insufficient quantity and expertise in workforce capability	**4 X 4= 16**	Director of Strategy **Trust Board**	i) Potential new build/location of new hospital ii) KPMG Review iii) STP Footprint and Estate Strategy being developed. iv) Herts & West Essex STP Estates workstream v) Clinical Support Service workstream led by CEO ~~vi) Strategic Outline case for new hospital (June 2017) and meeting scheduled with Centre for 24 April 2018.~~ vii) Estates and Facilities Infrastructure subgroup for West Essex viii) SOC affordability model ix) SOC approved and submitted to NHSI and further financial analysis template submitted to DH ~~x) Planning advisor being engaged and discussions underway with Local Authorities overs site options.~~ x) Site analysis Phase I complete xi) Detailed analysis of current site option comissioned xii) Director of Strategy appointed	i) PAF and Board meetings ii) EMB Meetings iii) Capital Planning Group iv) Weekly Estates and Facilities meetings v) OBC Steering Group	i) STP reports to Board via CEO Report ii) Reports to EMB iii) KPMG Report iv) STP workplans v) Monthly ~~OBC~~ Our New Hospital reports to PAF and updates to Board.	**4 x 4 = 16**	i) Balancing short term investment in the PAH site vs the required long term investment **ACTIONS:** Strategy being developed and underpinned by 5P plans Phase II work underway Prep for meeting on 24 April 2018. ~~External strategic estates and commercail advice being sought.~~ Capital Plan submission for PAH prioritised. PCBC work commissioned Regular meetings held with regulators.	i) Strategy ~~not confirmed~~ in development	26/07/2018	**No change to residual risk rating.**	**4 x 3 =12 ~~June~~ December 2018)**
			Effects: i) Failure to deliver strategy and transformation project and service changes required for service and performance enhancement ii) Poor patient perception and experience of care due to aging facilities. iii) Reputation impact iv) Impact on staff morale v) Poor infrastructure, vi) Deteriorating building fabric and engineering plant vii) Poor patient experience, viii)Backlog maintenance ix) Potential non compliance with relevant regulatory agency standards such as CQC, HSE, HTC, Environmental Health. x) Lack of integrated approach xi) Increased risk of service failure xii) Impact on throughput of patients												

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2018-19**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 4: Our Performance - meet and achieve our performance targets, covering national and local operational, quality and workforce indicators													
BAF 4.1		**Supporting Functions (including Finance, IT and Estates and Facilities)** Capacity & capability of the business support functions including a requirement to continue to modernise systems, processes and structures.	Causes: i) High volume of internal, regulatory and STP information requirements, ii) shortage of skill sets / specialist staff, iii) limited investment / avalibility of resources iv) reliance on outsourced contractors / systems and inflexible systems, v) historical systems which are not fully integrated (vi physical space and poor office accomodation and facilities to support intergrated working. vii) Appetite for change management. viii) Trust has been given notice to vacate Mitre Buildings by November 2018 and risk to continuity.	**4x5=20**	**Exec leads** :- Chief Financial Officer, Chief Operating Officer and Director of Quality Improvement. **Committee:** Performance and Finance Committee	i) Continuous priorty reviews and workload planning, ii) business partnering approach and performance reviews, iii) Recruitment exercises - successful reduction in temporay costs, iv) increase involvement in collaborative work e.g STP, v) review of staffing structures and consultation / market testing, vi) modernisation groups and use of benchmarking to identify improvements e.g Qlikview, EROS, Carter, GIRFT, model hospital, vii) system implemenations / upgrades e.g EROS, Qlikview and ledger upgrades, viii) staff surveys / apprasials	i) Internal and external Audit reports ii) PAF and Board meetings iii) NHSI reviews/reports iv) Business case approved for ICT restructure. v) ICT Programme Board vi) Audit Committee vii) NHSI review/visit re estate	i) Outputs from NHSI deep dives ii) Internal Audit and External Audit reports including Head of Internal Audit Opinion and VFM conclusion. iii) Estates Governance review reported to Audit Committee iv) Staff survey outcomes	**4x3=12**	i) Recruitment and retention. ii) Enhanced plans to realise full benefits of system implementation / upgrades. iii) Re-location of Corporate Staff to alternative office accomodation.	i) Benefit realisation reviews	18/07/2018		**4x2=8 March 2019**
			Effects: i) Over reliance on manual processes and interventions ii) labour intensive, error prone and time consuming processes iii) Ability to attract skilled staff and retention and morale (leading to relaince on temporary staff), iv) single failure points, v) adequate value for money conclusions.							**ACTIONS:** i) Recruitment plans for areas ii) Market testing iii) ICT re-structure, iv) Alternative office accomodation options v) Income capture processes				

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2017-18**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 4: Our Performance - meet and achieve our performance targets, covering national and local operational, quality and workforce indicators													
BAF 4.2		**4 hour Emergency Department ConstitutionalStandard** Failure to achieve ED standard	**Causes:** i) Access to community and OOH services. ii) Change in Health Demography with increase in long term conditions. iii) ~~Increased turnover and lack of qualified workforce.~~ Gaps in medical and nursing workforce iv) Lack of public awareness of emergency and urgent care provision in the community. vi Attendances continue to rise annually (5.1% over the last 2 years). viii) Changes to working practice and modernisation of systems and processes viii) Attitude and behaviour challenges ix) Poor flow out of ED x) Delay in decision making	**4 X 5 = 20**	Chief Operating Officer	i) Performance recovery plans in place ii) Regular monitoring and weekly external reports iii) Daily oversight and escalation iv) Robust programme and system management v) Daily call with NHSI/ CCG/NHSE, daily report on performance. vii) Work in progress to develop new models of care viii) Local Delivery Board established ix) ~~Rapid improvement programme supported by Q1st continuing~~ x) Daily specialty response times monitored xi) Weekly meetings with ED team/~~Q1st and Executive team~~ xii) System reviewing provision of urgent care xiii) Exec attendance at safety huddles daily ~~xiv) Morning briefings in place at 8am.~~ xv) ED action plan reported to PAF/Board xvi) CO-location of ENP's, GP's, Out of hours GP'S to support minor injuries xvii) Daily review of Paeds by Clinical Lead and HoN xviii) Assessment capacity work underway	i) Access Board meetings ii) Board, PAF and EMB meetings iii) Monthly Operational Assurance Meetings iv) Monthly Local Delivery Board meetings v) Weekly System review meetings vi) Daily system executive teleconference vii) Fortnightly escalation meetings with NHSI/NHSE viii) Weekly HCG reviews	i) Daily ED reports to NHSI ii) Twice weekly reports to NHSE on DToCs iii) Escalation reports weekly to NHSE iv) Monthly PRM meetings	**4 x 5 = 20**	i) Staffing (Trust wide) and site capacity ii) System Capacity iii) Leadership issues **Actions:** i) D&D Strategy and recruitment/retention action plan ii) Local Delivery Board monitoring ED performance iii) Monthly Performance review meetings iv) Actions being taken in relation to Pauline Phillips letter ~~v) CEO Assurance Panel being held in March to review 12 hour breaches~~	None noted.	16/07/2018		4x3 =12 ~~March~~ September 2018 (on delivery of standard - 95%)
			Effects: i) Reputation impact and loss of goodwill. ii) Financial penalties. iii) Unsatisfactory patient experience. iv) Potential for poor patient outcomes v) Jeopardises future strategy. vi) Increased performance management vii) Increase in staff turnover and sickness absence levels											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2018-19**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 5: Our Pounds – manage our pounds effectively to achieve our agreed financial targets and control totals													
BAF 5.1		**Finance** Concerns around failure to meet financial plan including cash shortfall.	Causes: i) Operational performance impacting on financial performance including recovery of STF e.g ED target, ii) CCG affordability and contractual disputes and challenges, iii) ability to deliver recurrent CIPs, iv) workforce shortages v) high levels of unplanned expenditure including maintenance of aging estate, vi) capture and billing of activity. vii) Potential impact of pay settlement	**5 X 4= 20**	**Exec leads :** CFO/All Executives **Committee** : Performance and Finance Committee	i) Access to Interim Revenue Support loans ii) Cost Improvement Programme iii) Formal re-conciliation process with CCG iv) Internal and external Agency controls and reporting v) Executive Management Board, PAF and Audit Committee vi) Health Care Group CIP meetings vii) Enhanced Performance Reviews viii) Regular Balance sheet reviews ix) Approved Governance Manual x) Budget sign off process xi) Enhanced financial reporting and controls xii) Regulatory returns required e.g. agency spend xiii) Internal special measures for selected HCG to remain xiv) New medical agency protocol xv) Financial Recovery Plan - Q1 xvi) Demand and Capacity planning	i) Internal Audit & External Audit opinion. ii) External reviews iii) NHSI reporting iv) Internal Trust reporting v) Cash Management group vi) Pay award steering group	i) Monthly reports including bank balances and cash flow forecasts to PAF and Board ii) CIP Tracker reports iii) IA reports iv) Financial Recovery Plan	**5x3=15**	i) Organisational and Governance compliance e.g waivers ii) Activity and capacity planning iii) CIP reporting and run rate reductions	Service Line Reporting Demand and Capacity planning Workforce planning	18/07/2018	**Risk rating not changed.**	**5x2=10 Sept 2018**
			Effects: i) Ability to meet financial control target ii) Potential delay to payment to creditor/ suppliers ii) Increased performance management iv) Going Concern status v) Risk to recovery of sustainability funding vi) Impact on capital availability vi) Unfavourable audit opinion (VfM,Section 30 Letter) vii) Restrictions on service development viii) Recruitment & retention ix) Increased likelihood of dispute/arbitration processes x)Reputational risks xi) Increase in agency temp staff costs xii) Impact of in year Commissioner QIPP plans							**ACTIONS:** Future Modernisation Demand and Capacity Planning and Modelling Alternative accomodation for corporate staff being sought. Clinical and operational forums in place to review QIPP schemes. Improved FOT process. Review of Capital reporting. Focus on pay and non pay CIPs.				

The Princess Alexandra Hospital NHS Trust

TRUST BOARD - 2 AUGUST 2018

4.2

Agenda Item:	4.2
Presented by:	Dr Andy Morris – Chief Medical Officer
Prepared by:	Sheila O'Sullivan – Interim Associate Director of Governance & Quality Lisa Flack - Compliance and Clinical Effectiveness Manager
Date prepared:	27 July 2018
Subject / Title:	Significant Risk Register

Purpose:	Approval		Decision		Information	√	Assurance	√

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	This paper presents the latest Significant Risk Register (SRR) across the Trust. This was produced from the web based Risk Assure system. • There are 76 significant risks with score 15 and above, (Appendix 1). • 29 risks scoring 20, 24 risks score 16, 23 risks scoring 15. • 19 risks are overdue their review in this period (Appendix 2). • 16 new risks are raised since 30/5/18 (Appendix 3)
Recommendation:	The Trust Board is asked to i) Note the Significant Risk Register ii) Take assurance from the actions currently in place or planned

Trust strategic objectives: [please indicate which of the 5Ps is relevant to the subject of the report]	Patients	People	Performance	Places	Pounds
	√	√	√	√	√

Previously considered by:	Risk Management Group reviews risk and SRR according to its work plan.
Risk / links with the BAF:	There is crossover for the risks detailed in this paper and the BAF
Legislation, regulatory, equality, diversity and dignity implications:	
Appendices:	Appendix 1 – Significant Risk Register Appendix 2 – Significant risks that are overdue for their reviews Appendix 3 – New risks raised between 30/5/18 to 26/7/18

1.0 INTRODUCTION

This paper details the Significant Risk Register (SRR) across the Trust; it was prepared on 27 July 2018 and produced from the web based Risk Assure system. The Trust Risk Management Group meets monthly and reviews risks across the Trust, including significant risks. There is an annual work plan so each area can be reviewed in detail on a rotation.

2.0 CONTEXT

The Significant Risk Register (SRR) is a snap shot of risks across all Healthcare groups and corporate departments at a specific point in time including all items scoring 15 and above. The risk score is arrived at using consequence x likelihood score, with the lowest possible score being 1 and the highest 25.

There are 76 significant risks on our risk register. The breakdown by service is detailed in the table below.

	Risk Score				
	15	16	20	25	Totals
CCCS	4	3	0	0	7
Estates & Facilities	3	1	4	0	8
Finance	1	0	1	0	2
IM&T and IG	1	3	3	0	7
Non-Clinical Health & Safety	1	0	0	0	1
Nursing	0	1	0	0	1
Operational	0	1	3	0	4
Patient Safety & Quality	0	0	0	0	0
Workforce	0	1	0	0	1
Child Health	1	1	1	0	3
Safeguarding Adults	0	2	0	0	2
Safeguarding Children	0	1	0	0	1
Women's Health	1	2	1	0	4
Medicine	2	6	12	0	20
Surgery	9	2	4	0	15
Totals	23	24	29	0	76

There are 29 risks with a score of 20; the key areas are detailed below with full details of each risks and controls in place in appendix 1.

- Patients: Risks for endoscopy equipment, placing patients in post anaesthetic care unit (overnight), cashing up virtual clinics, ophthalmology care for neonates.
- People: Staff vacancies and workforce planning, staff competencies against various statutory mandatory training topics and compliance with GDPR requirements.
- Performance: Delivery of ED four hour standard and 62 day cancer standard

- Places: electrical back-up systems, medical gas pipeline, environmental temperature controls, fire suppression for IT equipment, lifts meeting LOLER regulations, doors not secure allowing access, lack of CCTV, lease on Mitre building, Williams Day unit.
- Pounds: maintaining financial controls

Most Trust risks are reviewed within the allocated timeframe. There are 19 risks that are overdue their review date, see appendix 2. For each risk, the responsible manager has been asked to update their register by 3 August 2018; this will be followed up at the next Risk Management Committee on 31 August 2018

16 new risks have been raised between 30/5/18 to 26/7/18; these are attached on appendix 3.

As per our current review process our Compliance and Clinical Effectiveness Manager is working with teams to review all new risks, ensure they have fully explained the risk and that appropriate mitigating actions and controls are detailed. These will all be reviewed as part of the Risk Management group annual work plan.

3.0 RECOMMENDATION

Trust board are asked to note the content of the SRR and take assurance from the actions currently in place or planned

Appendix 1

Serious Risk Register on 26 July 2018

Detailed Risk Register Report - Ordered by Highest Current Risk

Risk Register (Live)

Cancer Cardiology & Clinical Support Services

Cancer

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Finance	**Canc/2017/02**	**For the Williams Day Unit building to provide sufficient resources to deliver all required clinical activity to patients.**	Inadequate environmental resources Poor quality poor patient experience poor staff experience potential PALS, Complaints & Incidents lack of opportunities to develop the service	Feb 2018 - Risk updated	3	5	15	15	04	Nicola Tikasingh	Bernadette Roach	04/05/2017		31/03/2019

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Additional chairs provided from the treatment area if available to accommodate standing patients. Tea and coffee machine purchased through charitable funds to create a more patient friendly environment.	CWT records Reduction or no negative PALS and complaints Reduction or no Incidents reported	Tina Smith	When there are very busy clinics and patients come with relatives it is difficult to accommodate seats for all patients and visitors.	31/03/2019
Heating Issues: Hot drinks and blankets provided to the patients. Administrative staff wearing winter coats during the colder months.	CWT records Reduction or no negative PALS and complaints Reduction or no Incidents reported	Tina Smith	Heating issues to be audited during the colder months to ensure that we meeting health and safety requirements.	31/12/2018
Mobile screens used in phlebotomy area to aid privacy and dignity. Phlebotomy/storage area cleared daily to enhance access to resuscitation trolley when patients present.	CWT records Reduction or no negative PALS and complaints Reduction or no Incidents reported	Tina Smith	No gaps identified	31/03/2019
Substantive clinics are still being run with inadequate clinic rooms. Hand washing is sought from another clinic room when available or from the staff wash room facilities. Request for a sink made to estates. Job No: 43355. Consideration has been given to relocating clinics but there is not enough sufficient capacity elsewhere There are no controls in place for pursuing new service development.	CWT records Reduction or no negative PALS and complaints Reduction or no Incidents reported	Tina Smith	Staff have to wait for a clinic room with a sink to become available to wash their hands or to go to the treatment side of the WDU suite. Delays in seeing patients and potential that staff may not wash hands in between each patient.	31/12/2018

Treatment chair removed from Blue Area to allow access to fire exit (impacts capacity). Consideration has been given to the removal of more chairs but this will impact further on service delivery. To accommodate inpatients who require a bed, chemotherapy will be given on the ward. However, this impacts on WDU workforce capacity (2 chemotherapy trained nurses anything from 1-6 hours).	CWT records Reduction or no negative PALS and complaints Reduction or no Incidents reported	Tina Smith		31/12/2018
Action in Progress	**Action Commentary**	**Action Rating**	**PS&Q Lead**	**Review Date**
“Space” Workshop to be held to review service needs jointly with the estates department. Consideration could be given to reutilisation of space	31st May 2018 - Space workshop continues to run and review the progress. July 2018 - the refurbishment work has been deferred as funds are required for more pressing work. Plans are in place to start this work next year prior to the next financial year.	Progress Being Made But Overdue On Completion Date	Tina Smith	31/03/2019

Detailed Risk Register Report - Ordered by Highest Current Risk

Pharmacy

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**Pharm/2009/01**	**To ensure at least 70% of TTAs are prescribed at least 24 hours before patient dischargempleted**	Late requests for discharge medicines (in and out of hours) results in unsafe discharge due to medication errors, loss of income due to increased bed occupancy and overtime payments incurred by the Pharmacy Department. Currently 71% of TTA requests are for the same day of discharge and 72% of TTAs contain 1 or more errors on them before being screened by a pharmacist and approx. 25 incidents reported per month relating to TTA's.		4	5	20	16	04	John Biddulph	John Biddulph	01/01/2009		18/12/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
1. Trust policy requires at least one working days notice for TTA's (48 hours for nomad boxes and other complex TTA's).	PSQ Meeting and MMIC, MAC, healthcare group performance scrutiny Meeting reviews. Reduced number of incidents. Auditing. Reduced number of complaints	John Biddulph		31/12/2018
2.The use of POD and one stop dispensing processes helps improve the timeliness of discharge.	PSQ Meeting and MMIC, MAC, healthcare group performance scrutiny Meeting reviews. Reduced number of incidents. Auditing. Reduced number of complaints	John Biddulph		31/12/2018
3. Pharmacy staff prompt medical staff to prescribe TTA's 24hours in advance of patients' discharge.	PSQ Meeting and MMIC, MAC, healthcare group performance scrutiny Meeting reviews. Reduced number of incidents. Auditing. Reduced number of complaints	John Biddulph		31/12/2018
4.TTA performance is discussed at health group meetings and papers are sent to MAC and MMIC.	PSQ Meeting and MMIC, MAC, healthcare group performance scrutiny Meeting reviews. Reduced number of incidents. Auditing. Reduced number of complaints	John Biddulph		31/12/2018
5. Pharmacy smartcarts are used on some wards to support earlier discharge	PSQ Meeting and MMIC, MAC, healthcare group performance scrutiny Meeting reviews. Reduced number of incidents. Auditing. Reduced number of complaints	John Biddulph		31/12/2018
6. Pharmacists now provide extended services, including support with TTA's on Fleming, Tye Green, ITU/HDU, Locke, Penn, Lister, Winter and Saunders ward which helps to support earlier discharge.	PSQ Meeting and MMIC, MAC, healthcare group performance scrutiny Meeting reviews. Reduced number of incidents. Auditing. Reduced number of complaints	John Biddulph		31/12/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
1.TTA performance to be added to each health care group dashboad so that performance can be monitored and managed.		No Progress Made	John Biddulph	03/12/2018

2.TTA performance will continue to be discussed at health group meetins, MMIC and MAC.		Action On Track	John Biddulph	31/12/2018
3. Introduction of a pharmacy team for each ward and use of smartcart which will support more timely and safe discharge		Progress Being Made But Overdue On Completion Date	John Biddulph	31/12/2018
TTA figures to be revised to take out Fleming, Saunders and Melvin. The new report will commence from May 2108		Action On Track	John Biddulph	04/12/2018

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Projects and Business Continuity	**Pharm/2013/01**	**To install a new automated dispensing system in the pharmacy department**	Cause The automated dispensing system is at the end of its original shelf life and is over 13 years old. In the last year the manufacturer of the robot has had to be called out 13 times and breaks down most weeks and due to its age the only parts available are reconditioned and there are delays in getting hold of them. Effect There is a risk that it could break down resulting in significant business disruption and delays in medication supply and delay in discharge.		4	4	16	16	06	John Biddulph	John Biddulph	01/12/2013		31/12/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Any breakdown is recorded on Datix	Senior pharmacy business meeting, PSQ Meeting and Medicines Management and Incident Committee, CCCS board meeting, reduced number of incidents.	John Biddulph		31/03/2019
Repairs to system covered by contract.	Senior pharmacy business meeting, PSQ Meeting and Medicines Management and Incident Committee, CCCS board meeting, reduced number of incidents.	John Biddulph		31/03/2019
Rota of local super users to cover day to day management.	Senior pharmacy business meeting, PSQ Meeting and Medicines Management and Incident Committee, CCCS board meeting, reduced number of incidents.	John Biddulph		31/03/2019

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
A new robot will also require additional space within the dispensary and therefore potential relocation of the dispensary		No Progress Made	John Biddulph	31/03/2019
Eastern region are looking to set up contracts for robots to prevent the need to go out to tender		Action On Track	John Biddulph	31/12/2018

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Identified on CCCS annual capital plan and escalated to the Trust Board. Business case to be completed for March 2019		Progress Being Made But Overdue On Completion Date	John Biddulph	31/12/2018
Patient services and procurement technician invited suppliers to come to the department to make recommendations for a new robot. one supplier came in Dec 2017 and we are currently awaiting drawings and ecommendations		Progress Being Made But Overdue On Completion Date	John Biddulph	24/12/2018

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Projects and Business Continuity	**Pharm/2014/04**	**To have a new aseptic unit to manage the Trust chemotherapy requirements.**	Cause The aseptic production unit is no longer suitable to provide aseptic products because of its age and external audit findings (Sept 2015). Workload in the unit has increased on average by 30% compared to 2012. The air pressure control and monitoring in TSU is at a critical level with no back up unit. Effect • The risk is that patients will either not receive the required treatments or that treatments will be delayed. • Patent may need to go to other centres to receive their treatment • There is a risk of medication error • Failure to meet cancer waiting targets • Increased overtime payment to pharmacy staff		4	4	16	16	03	John Biddulph	John Biddulph	01/12/2014		31/10/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
All quality systems are now being used	senior pharmacy manager meetings	John Biddulph		31/10/2018
All staff have up to date training for processes within the aseptic unit and all SOPs have been updated	senior pharmacy business meetings	John Biddulph		31/10/2018
Business continuity plan in place to manage potential short term breakdowns in the unit	Senior pharmacy business meeting. CCCS Board meeting.	John Biddulph		31/10/2018
Dedicated staff who currently manage the workload within the Unit.	Senior pharmacy business meeting. CCCS Board meeting and Medicine Management and Incident Committee meeting . External Audits. Reduced number of incidents.	John Biddulph		31/10/2018
TPN and some chemotherapy products are purchased in.	Senior pharmacy business meeting. CCCS board meeting and Medicines Management and Incident Committee meeting . External Audits. Reduced number of incidents.	John Biddulph		31/10/2018

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Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
In line with the STP objectives the pharmacy department are working with the Lister hospital and an external company to consider a joint venture. This option has been approved by the trust board and a tender specification has been agreed. This will go out to tender in April 2017 with a view to implementation in Dec 2019		Action On Track	John Biddulph	31/10/2018
To develop a contingency plan with an external company		Action On Track	John Biddulph	31/10/2018
Trust board have agreed that the pharmacy department can go out to tender and work collaboratively with the Lister on this project with a view to completion of project by Dec 2019		Action On Track	John Biddulph	31/10/2018

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**Pharm/2017/04**	**Trust compliance to the mandatory training requirements for all staff involved in the handling of Entonox for the best practice in the use, handlings and safe storage of Entonox To have a training plan in place for the initial and on-going mandatory training of all staff involved in the handling of Entonox**	Cause Some staff are currently officially trained for use, handling and storage of Entonox Effect Staff currently use, handle and store Entonox without current training. There is no temperature monitoring for the storage of Entonox. Without training there is a lack of understanding of roles, responsibilities, procedures and best practice for safe use of Entonox Impact Non compliance to and out of date knowledge, could result in incorrect: use of cylinders, inappropriate storage resulting in lack of ownership and responsibility, inability to recognise or deal with cylinders stored at the incorrect temperature. this can result in danger to both patients and staff and could result in exposure to litigation		5	3	15	15	03	John Biddulph	John Biddulph	02/03/2017		29/09/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
No controls	MMIC, healthcare group boards	John Biddulph		

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Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
The chief nurse has ben asked to identify a lead nurse to identify staff who need training and ensure that this training is recorded and updated. This training now needs to be delivered in full and monitored by the lead nurse		Progress Being Made But Overdue On Completion Date	John Biddulph	14/12/2018

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	Pharm/2017/05	**Trust compliance to the mandatory training requirements for all staff involved in the handling of Medical Gases, adherence to the requirements of HTM 02-01, for best practice in the use and handling of medical gases. To have a training plan in place for the initial and on-going mandatory training of all staff involved in the handling of Medical Gases, inclusion in the Trust induction programme and on the statutory/mandatory training programme.**	Cause No staff are currently officially trained or registered in the HTM 02-01 mandatory training requirements for handling Medical Gases. There is no Authorised Engineer (AE), only 4 Designated Nursing Officers (DNO's) no Train the Trainers for Nurse training or for Porters. Effect Staff currently handle medical gases without current training. Shut downs are carried out without registered AP's and DNO's to authorise and sign the paperwork. Without training there is lack of understanding of their roles, responsibilities, procedures and best practice for safe use of medical gases. Impact Non compliance to the requirements of HTM 02-01 and out of date knowledge, could result in incorrect: use of cylinders and piped gases, inappropriate storage, incorrect use of regulators and flow meters. Lack of ownership and responsibility, inability to recognise or deal with gas leaks or contamination. This can result in danger to both patients and staff and could result in exposure to litigation.		5	3	15	15	03	John Biddulph	John Biddulph	16/02/2017		30/09/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date

Trained AP on site Some porters have now been trained Four DNO's trained	Medical gas committee, MMIC, healthcare group boards	John Biddulph		29/09/2018
Action in Progress	**Action Commentary**	**Action Rating**	**PS&Q Lead**	**Review Date**
• Identify available training by accredited centres and costs. • AP's must be nominated by Trust to act as authorised Persons, thus enabling registration. • A mandatory training pack must be put in place for all staff handling Medical Gases, records must be kept and yearly maintenance training must be in place. • Staff must be identified to receive the DNO training to cover site 24/7. • Training for 'Train the Trainer' needs to be in place and Trainers must be identified. Feb 2018 - 4 DNO have now been trained and trainer the trainer due to take place from June 2018 onwards	Jo Ward is leading this piece of work on behalf of the Trust	Progress Being Made But Overdue On Completion Date	John Biddulph	29/09/2018

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Therapies

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**ther/2017/03**	**1. 80% urgent referrals to Paeds Dietitian O/P clinics to be seen in 4 weeks 2. 80% of routine referrals to be seen in 8 weeks**	increased number of referrals to Dietitian Paeds Outpatient clinics leading to an increase in waiting times for appointments to over 5 months, leading to an increase in concerns raised parents, increase in phone-calls from parents and reduction in quality of dietitetic service	Feb 2018 - this risk has been updated in the action point June 2018 - updated risk	3	4	12	15	04	Susan Fullen	Susan Fullen	29/08/2017		30/09/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
1. Providing a few extra clinics 2. Providing advice over the telephone	1. Length of time patients are waiting for appointments- KPI 2. Complaints 3. Incidents	Susan Fullen	Only able to add a few extra clinics due to capacity	30/09/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Business Case submitted Option1: Only see PAH consultant referrals, and discontinue seeing CDC referrals Option 2: Secure funding for 0.3 band 6 DT to provide 1.5 clinics per week	Business Case presented at Budget meeting. Further information required regarding income and activity. Income information provided. Feb 2018 - Option 1 route is being followed through. Plans in place for next meeting 8th Feb 2018. June 2018 - met with the CCG and agreed for community referrals to be seen by community dietician which will free capacity in clinics at PAHT but this cannot start until recruited to the community dietician role which may take several months.	Action On Track	Susan Fullen	30/09/2018
Reduce DNA rate to maximize capacity	The appointment process has been changed. Rather than send out blanket appointments the parents of patients are asked to contact the department for an appointment. The DNA rate is being monitored as currently over 20% - audit regarding DNA's carried out.	Action On Track	Susan Fullen	30/09/2018

Corporate Services

Estates & Facilities

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	EF082	**Maintain a suitable, sufficient and reliable emergency electrical back-up to the site in the event of mains power failure.**	Due to the excessive electrical demand on the main back-up electrical generators (north and south side), there is a risk that the generator will fail if required in the event of a mains power failure.		4	5	20	20	04	Alison Morris	Bill Dickson	14/02/2018		30/06/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Electrical load temporarily shed from North to South sub-station therefore reducing the load requirement on the North side generator.	Weekly generator testing	Bill Dickson	This is a short term measure only. The demand on the South side generator is also increasing and will soon become excessive for the South side generator	30/06/2018
Planned preventative maintenance schedule in place.	audited by Authorising Engineer (Electrical) on an annual basis.	Bill Dickson		28/02/2019

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Installation of new generator (purchased 30/03/18) in series with current generator to provide required power in the event of mains power loss to the North sub station.	Consideration has been given to assessing essential and non-essential loads, therefore providing emergency power back-up to essential systems only. Due to the complexity of the electrical systems within the Trust and the location of supplies on varies switches, this is not possible. For this to happen, power supplies, switches and circuits would have to be relocated, changed or renewed which would cost considerably more and create high additional risks where works were undertaken.	Action On Track	Bill Dickson	30/09/2018
Procurement and installation of an additional generator to be linked in series to the existing generator, including controller upgrade.	Generator purchased 30/03/18. Generator will be installed in capital year 2018/19.	Action Fully Implemented	Bill Dickson	31/07/2018
Purchase and installation of new generator in series with current generator to provide required power in the event of mains power loss to the South sub station.	A full loading and grading survey is required prior to starting the design specification of the new generator. Consideration has been given to assessing essential and non-essential loads, therefore providing emergency power back-up to essential systems only. Due to the complexity of the electrical systems within the Trust and the location of supplies on varies switches, this is not possible. For this to happen, power supplies, switches and circuits would have to be relocated, changed or renewed which would cost considerably more and create high additional risks where works were undertaken.	Action To Be Assessed	Bill Dickson	31/03/2019

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date

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Quality	**EFM100**	**Provide a safe, compliant medical gas pipeline system to the Trust with suitable and sufficient emergency back up capability**	Critical components of the current medical gas pipeline system have come to the end of their useful life and are failing and obsolete. This will lead to an increased dependence on the emergency reserve manifold which is also failing and obsolete. The current system is non-compliant with HTM requirements and a number of extreme and high risks have been raised by both the AE (MGPS) and an independent audit carried out by an independent MGPS specialist consultant.		5	5	25	20	04	Alison Morris	Alison Morris	02/05/2018		31/03/2019

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
New build and refurbishment involving MGPS are designed and installed by approved competent persons under the control of the AP (MGPS)	All designs and installations are subject to a series of inspections and tests.	Alison Morris	The Trust does not currently have an AP (MGPS) therefore the AE (MGPS) is fulfilling this role	31/03/2019
Periodic servicing and testing is carried out on the MGPS as per HTM and regulatory requirements.	Records for part of the audit carried out by the AE (MGPS)	Alison Morris		31/03/2019
Porters have carried out training in the safe management of medical gases.	Training is certified for a specified period and repeated at pre-determined intervals.	Alison Morris		31/03/2019
The Trust has appointed an Authorising Engineer (MGPS) to audit the management processes in place for the maintenance of the MGPS.	audits are received annually and an action plan developed and monitored via PAF.	Alison Morris	The is currently no appointed AP (MGPS) therefore the action plan will be monitored by the Health, Safety and Governance Lead and the MGPS Group.	31/03/2019
The Trust has trained 6 staff members as Designated Nursing Officers (DNO). These staff have been trained in the safe management of medical gas shutdowns and isolating gases in emergency situations.	Training is certified for a specific time period.	Alison Morris	There is a requirement for a DNO to be present in all areas with a MGPS at all times.	31/03/2019

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Appointment of AP (MGPS).	An Estates engineer has now completed the training course required for appointment as AP (MGPS). The AE will carry out an assessment an appoint for low hazards in Aug 2018. The AE (MGPS) will continue to provide AP cover until the engineer can be successfully assessed for high hazard works.	Progress Being Made But Overdue On Completion Date	Alison Morris	31/01/2019
Drawings for the MGPS are required for maintenance, servicing, emergency isolation and refurbishment. The existence of suitable and sufficient drawings is a regulatory requirement to adequately design out and mitigate risk.		Progress Being Made But Overdue On Completion Date	Alison Morris	31/03/2019

Provide DNO training to relevant staff members and initiate training for all clinical staff on the safe use of MGPS and cylinders.	DNO training has begun and 'train the trainer' sessions have been completed. Training for clinical staff has been developed and role out is imminent.	Progress Being Made But Overdue On Completion Date	Alison Morris	31/12/2018
replacement of obsolete and malfunctioning compressors and renewal of emergency medical gas manifold.	Capital monies applied for in 2018/19 plan as part of backlog maintenance.	No Progress Made	Alison Morris	31/03/2019

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Projects and Business Continuity	**EFM101**	**Provide a safe working environment for staff and equipment with regard to temperature control in temperature critical areas.**	Due to the frequent failure of chiller plant across the Trust, it has become difficult or impossible to provide air cooling to critical areas that must be maintained at constant temperatures due to the equipment in the area or regulatory requirements for the activities being carried out in the area. The inability to provide cooling will have a detrimental effect on business continuity, a substantial financial impact and also adversely affect staff performance and wellbeing.		5	5	25	20	04	Tracey Burgess	Alison Morris	28/02/2018		31/03/2019

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Air handling units in some critical areas are checked as part of quarterly and annual inspections for functionality and signs of degradation.	Audit reports are received by the Estates team and used to inform the backlog maintenance plan for the following year.	Alison Morris	Chiller degradation may not be picked up on quarterly and annual inspections due to failure of internal units, or failure due to hot weather.	31/03/2019
increased temperatures notified to the Estates team are investigated as a priority and remedial works are carried out where required or possible.	The Estates helpline log all calls relating to increased temperatures and are logged as high priority.	Alison Morris	It is becoming increasingly difficult, and in some circumstances impossible to repair chiller units due to the availability of parts as they are now obsolete.	31/03/2019

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Complete a full asset register and condition assessment of all chiller units on site, along with an F-Gas register (regulatory requirement).	To be completed as part of the chiller replacement programme scheduled for 2018/19	No Progress Made	Bill Dickson	31/03/2019
Replace chiller units that are at end of life or for which parts are now obsolete. prioritisation of replacement will be carried out based on risk assessment of the chiller unit and the area it is serving.		Progress Being Made But Overdue On Completion Date	Alison Morris	31/03/2019

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Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Statutory Compliance	**EFM102**	**Provision of a safe and effective system of lifts throughout the Trust in line with the LOLER regulations.**	All equipment that lifts 'people' must be inspected under the LOLER regulations every 6 months. Remedial works that are required are identified as part of the thorough inspection. Remedial works that have an immediate risk of serious harm or injury will have to be carried out before the lifting equipment can be used again. Other faults, which are not yet serious, but have the potential to be, must be remediated in a timely manner, or as indicated on the inspection report. The Trust currently has several remedial actions outstanding as a result of thorough examinations, which, if left unaddressed will have the potential to cause serious harm. The failure to address these issues in a timely manner is in breach of statutory regulations.		5	5	25	20	04	Tracey Burgess	Bill Dickson	31/03/2019		31/03/2019

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
The lifting equipment on site is inspected thoroughly every 6 months in line with LOLER regulations. All high risk remedial works required are acted upon immediately or in the timeframe stated on the report.	remedial works will be checked prior to the lifting equipment being put back into service.	Bill Dickson		31/03/2019
The Trust has a service contract with a competent contractor to carry out remedial works required including emergency works.	full reports are provided for all works carried out on lifting equipment.	Bill Dickson		31/03/2019

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Carry out remedial works identified to eliminate or reduce risks as identified in LOLER reports for action in a timely manner based on risk.	To be carried out as part of backlog maintenance 2018/19	Action On Track	Bill Dickson	31/03/2019

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Statutory Compliance	**EFM05-18**	**sustainable workforce in the kitchen to ensure full compliance with all working directives and legislation on food hygiene and sufficient staff levels to provide a safe and efficient catering service to the wards and restaurant.**	insufficient staffing levels within the main kitchen to be able to provide a safe and effective service. Staff are working 10 days in a row and doing overtime to cover the service, paperwork is not completed in a timely fashion and staff are leaving due to the the stress associated with the shortage of staff.		4	4	16	16	01	Tracey Burgess	Diane Clarke	12/07/2018		26/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Agency staff being used to cover shifts where able.	Service is running	Tracey Burgess	Insufficient budget to have all agency staff required. Jobs are advertised however low interest	19/07/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Vacancies to be filled and full staff levels maintained	daily monitoring of staffing levels	No Progress Made	Tracey Burgess	27/07/2018

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**EfM/019**	**Maintain Patient and Staff Safety with a suitable and sufficient CCTV system**	Risk to patient and staff safety due to lack of CCTV monitoring across site. Staff and patients may suffer injuries through unidentified attacks and personal theft with no evidence to present to the police. There is currently no way of remotely monitoring sections of the Trust premises that are remote, and incidents are unknown until staff attend due to the inability to see the situation via CCTV.		3	5	15	15	02	Tracey Burgess	Dave Clarke	29/09/2014		

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
A full risk assessment has been undertaken by the LSMS for the provision of CCTV across site to identify where cameras are required.	The risk assessment has been reviewed by the AD E&FM, and will be used to inform the 2018/19 capital plan.	Tracey Burgess		31/03/2018

CCTV surveillance now available in ED reception, OPD PAH, Corridor from OPD to Melvin Ward and Ambulance entrance.		Tracey Burgess	Lack of surveillance round rest of site both internally and externally	31/07/2018
The Trust employs a security contractor that respond to incidents on site and provide support and assistance to staff from a security perspective.	Regular contract monitoring meetings take place.	Tracey Burgess		31/07/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
A specification is being produced as a result of the risk assessment carried out by the LSMS to secure capital funding.		Progress Being Made But Overdue On Completion Date	Tracey Burgess	30/03/2019

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Statutory Compliance	**EfM/031**	**Compliance with Statutory Fire Safety Regulations**	There is a risk that the Trust is currently non-compliant with aspects of fire safety regulations and healthcare fire safety best practice. This could lead to improvement notices or fines from regulators. Breaches in fire barriers also present a safety issue due to the ability for smoke or fire to spread.		5	5	25	15	05	Tracey Burgess	Bill Dickson	21/02/2014		

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Fire risk assessments for the entire site were reviewed Nov 2017. No actions requiring urgent or immediate attention were identified. All high/medium risk items are now in progress and action plans are being shared with relevant departments (see actions section).		Tracey Burgess		30/04/2018
Fire training is carried across the Trust with a mixture of e-learning, face to face and bespoke training.	training levels monitored by the Training and Development Department and content is overseen by the subject matter expert for fire (Fire adviser)	Tracey Burgess		24/04/2018
Fire wardens have been identified across the Trust and trained adequately in-house.	monitored by fire adviser	Tracey Burgess	there are areas in the Trust that are yet to identify staff members to take on the fire warden role.	30/04/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Actions detailed in fire risk assessment to be shared with relevant departments.	Action plans to be monitored by the fire officer and progress presented at Health and Safety Committee.	Action On Track	Tracey Burgess	30/04/2018
the fire stopping in the basement to prevent the spread of smoke and fire is unacceptable. There are multiple breaches that must be repaired as a matter of urgency.	Planned for 2018/19 backlog maintenance	Progress Being Made But Overdue On Completion Date	Alison Morris	31/03/2019

Finance

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Finance	**FIN014**	**Provision of new accommodation for staff currently in Mitre Building**	The leases on the Mitre buildings which houses the central support staff functions (finance, HR, ICT and Information) are not renegotiated, and notice is given to vacate the premises with out other provisions being agreed. Leading to business interruption. Current lease expires November18.	Discussions have been had with the Estates and Facilities team to consider different options, including leasing other accommodation or a more semi/perm solution on site. Discussions ongoing with landlord to extend lease.	5	4	20	20	01	Frankie Hill	Simon Covill	31/12/2017		31/08/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Action in Progress	**Action Commentary**	**Action Rating**	**PS&Q Lead**	**Review Date**
In conjunction with Estates Team other accommodation options to be reviewed	Derwent Centre visited as an option - meeting with EPUT to discuss planned for 26.7.18.	Action On Track	Frankie Hill	28/09/2018
Renegotiation talks between the Trust and Landlord have taken place with request to extend a further six months. Awaiting feedback from Landlord. Trust to make further contact with landlord for outcome of request.		Action On Track	Frankie Hill	30/07/2018

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date

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Statutory Compliance	**FIN001**	**To meet 18/19 financial plan including cash shortfall including availability of sufficient cash resources**	Failure to deliver financial plan leads to cash shortfall and breach of statutory duty. i) Operational performance impacting on financial performance including recovery of PSF e.g ED target, ii) CCG affordability and contractual disputes and challenges, iii) ability to deliver recurrent CIPs, iv) workforce shortages v) high levels of unplanned expenditure including maintenance of aging estate, vi) capture and billing of activity, vii) potential impact of CCG QIPP	Causes: i) Operational performance impacting on financial performance including recovery of PSF e.g ED target, ii) CCG affordability and contractual disputes and challenges, iii) ability to deliver recurrent CIPs, iv) workforce shortages v) high levels of unplanned expenditure including maintenance of aging estate, vi) capture and billing of activity. vii) potential impact of CCG QIPP	5	4	20	15	10	Frankie Hill	Simon Covill	20/07/2016		31/08/2018

Risk Mitigation/Controls	**Source of Assurance on Control Effectiveness eg. How would you know your control is working?**	**PS&Q Lead**	**Gaps in Control**	**Review Date**
Budget sign off.	2018/19 budget signed off and Board, HCG, NHSI approved control total.	Frankie Hill	None	29/03/2019
CIP Delivery	Internal Audit. External Audit. Enhanced Performance reviews and Stretch targets. Healthcare Group CIP Meetings. Dedicated CIP officers. Finance Assurance Meetings	Frankie Hill	Currently the CIP programme is failing to meet the target, predominantly due to the failure to reduce agency spend at the required trajectory. Plans in place to try to meet these, including a deep dive conduced by NHSI.	28/09/2018
Commissioner Contract review & triangulation process.	FIG, SPQRG, Triangulation Exercises	Frankie Hill	Enhanced income reporting SUS & SLAM reconciliation	28/09/2018
Loan financing up to value of control total has been approved by Board and NHSI.	Internal & External Audit. External Reviews Cash reporting enhanced in PAF committee Cash management group	Frankie Hill	Financial metrics to facilitate cash management to be shared with HCG	31/03/2019
Performance monitoring - PRMs	PRM Actions, FOT, Opportunities & Risk Assessment Review of delivery of financial targets by HCGs including over delivery	Frankie Hill	Governance Compliance/Waivers. Workforce Planning.	28/09/2018

Action in Progress	**Action Commentary**	**Action Rating**	**PS&Q Lead**	**Review Date**
HCGs to be asked to review progress on request to Over deliver and assess any risk and mitigations associated with inability to over deliver and add to their risk register where applicable			Frankie Hill	15/08/2018

To identify a method to review the effectiveness of the PRMs			Frankie Hill	15/08/2018

Information Governance

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Statutory Compliance	**IG10**	**Ensure the Trust continually achieves 95% staff compliance with annual IG training**	There continues to be a lack of engagement with regards to staff undertaking annual IG refresher training.Continued failure to complete will reduce compliance within the IGT and could lead to further IG breaches/ICO regulatory action.	Risk score increased to 20 at the Risk Management Group Meeting of the 21.06.18 as chaired by the CMO. Being escalated to EMB.	4	3	12	20	02	Tracy Goodacre	Tracy Goodacre	15/05/2014		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Escalations emails/letters being sent to all non compliant staff from the Chief Medical Officer/Caldicott Guardian, Chief Financial Officer (SIRO), and Chief Nurse. No new reports received to date due to system issue.	Compliance levels had increased following letter circulation. Discussed through every IGSG meeting. IGT compliance with requirement number 112. Executive escalation letters to be re-instated as of the 31.05.17.	Tracy Goodacre	Executive escalations letter yet to be re-instated.	31/07/2018
NHS Digital mandated Data Security Awareness e-learning available through ESR for which all staff are to complete on at least one occasion. Monthly reporting in place via the training department.	Monthly reports from the training department to evidence current percentage of compliance send to senior management for appropriate dissemination and follow up.	Tracy Goodacre	Trust not having yet evidenced the mandated 95% compliance rate.	31/07/2018
Statutory mandatory training handbook created which included new IG training material, which also incorporates GDPR updates. On-line IG specific handbook also in place for contractors who would not receive this.	Once handbook circulated, awareness tests will be completed and marked, which will increase current compliance upon passing.	Tracy Goodacre	This handbook was only a one off and is no longer an acceptable level of compliance for staff who have already completed on one occasions. It is mandated that staff complete the NHS Digital e-learning entitled Data Security Awareness training, which is available on the Trust's e-learning system.	31/07/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
IAMC-IGO attended the Core Statutory & Mandatory Training Steering Meeting, which took place on 13.06.18. During this meeting, the Head of Training & Development advised that in the September and October months a total of 1400 members of staff will be non-complaint with their IG training. This was because in 2017 the influx of staff undertook training by the handbook during the same period of time.	Discussions to take place at the forthcoming Core Statutory & Mandatory Training Steering Meetings.	Action To Be Assessed	Billie-Jo Croft	31/07/2018
IG looking into creating an easy read IG training presentation but taken from the NHSD data security awareness training package, to help managers assist and support staff in their teams who may have learning disabilities and who may find it difficult to complete the training via a PC, and/or would need additional assistance to read and write answers to the assessments in order to do so.	IG Officer to start reviewing an appropriate training package that could help assist managers in supporting their staff to complete and pass their annual IG training.	Action On Track	Tracy Goodacre	31/07/2018

Meeting in place during May between IG, training and the Caldicott Guardian to address future programme of training.	Follow up meeting took place 09.05.17. New proposals re hard copy handbook and assessment discussed. Escalation routes through management. Handbook now circulated Trust wide. Awaiting confirmation of staff compliance levels following the receipt and marking process via the training department. Plus new e-learning package now available incorporating latest updates around the GDPR and NDGR. Non compliance escalated to Execs. Global Comms circulated and followed up. To chase up compliance as of year end and send follow up Comms/actions to be taken email to all Trust staff.	Action Fully Implemented	Tracy Goodacre	
Risk score to be increased to 20 and escalate to EMB.	Risk score of 20 agreed during Risk Management Group meeting of 21.06.18, and therefore being escalated to EMB.	Action On Track	Tracy Goodacre	31/07/2018
Training Department to produce a trajectory for EMB to show how many additional staff require IG training over and above those who will be due to review their training ahead of the 31.10.18, to ensure a minimum of 95% compliance can be evidenced.	IGM met with Associate Director of Training, Education and Development and the Head of Core Training & Development on the 20.06.18. Actions were agreed as follows: Trajectory being compiled by Training Dept for EMB in relation to how many staff are required to complete IG training in addition to the staff numbers that will become non compliant during the months of Sept and Oct.	Action On Track	Tracy Goodacre	31/07/2018

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Statutory Compliance	**1G040**	**GDPR - Consent mechanism.**	Under GDPR, if there is no lawful basis to process data and PAH are relying on consent to process the data then PAH must obtain explicit consent to process data. The consent requires a positive opt-in, it must be specific and 'granular' and the fair processing of the consent must clear and concise. Consent mechanisms are being reviewed and conversations are taking place to need this requirement.	We have asked working group members that if they are a service that use consent for sharing information with other organisation's, marketing or secondary uses – we need an insight of this information. This information will help use scope what is required in cosmic and also within HR.	4	4	16	16	06	Billie-Jo Croft	Tracy Goodacre	31/10/2017		19/09/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Information Governance have provided feedback and comments on the Cambio COSMIC and GDPR Change Requirements Document.	The document provides assurance that Cambio are aware of GDPR and are implementing measures to meet some GDPR requirements.	Tracy Goodacre	misunderstanding of consent in the document. Guidance has been provided.	
Where consent is being used, we have already put together some guidance and templates for staff to use to build their consent models.	We have already seen staff change their existing standard operating procedures and forms.	Billie-Jo Croft	There are expected changes in Cosmic, around recording consent. We await to hear more detail on these actions.	
Working group established with good representation for working on this requirement.	The working group will provide updates into IGSG and IGSG will feed into EMB.	Billie-Jo Croft	Technology changes may not be able to meet the requirements in the overall project timeline.	

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Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Agree the functionality to address the suggested changes within Cambio proposals to meet GDPR compliance.	Interim IT Programme Manager to discuss plans going forward to address the suggested changes within Cambio to meet GDPR compliance, although some functionality should never be turned on (i.e. option to delete patient health records) as permitted in Sweden so is a function. It has been suggested a programme manager would need to be brought into work on the action plan as requires much operational input.	Action On Track	Billie-Jo Croft	
For patient consent, a service request has been made with Cambio to review what might be in the pipeline for recording consent on the patient record.	The next steps will depend on Cambio's feedback. 04.03.18, Information Governance have received a copy of Cambio's plans to meet GDPR requirements.	Action On Track	Billie-Jo Croft	19/09/2018
Meeting to be arranged between IG Manager and Head of ED Nursing, General Manager for Outpatients and Clinical Administration, Cancer, Cardiology and Clinical Support, E-Referral, Reception & Out Patient Services Manager and RTT Data Quality Manager as per DoIIT email of 29.05.18.	IGM to set up meeting as requested.	Action Fully Implemented	Billie-Jo Croft	30/06/2018
Plan of action required for consent to be recorded in cosmic in order to deliver into HL7 messaging which links to downstream systems.	Following the discussions held at the GDPR workshop of the 20.06.18 confirmation was received by the Interim IT Programme Manager that the DoIIT agreed the Trust would like the consent flag via HL7 built into the design for GDPR.	Action On Track	Billie-Jo Croft	19/09/2018

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Statutory Compliance	**IG036**	**GDPR - Requirement of recording all processing activities, expands Information Asset Management.**	The GDPR requires the Trust to document what personal data the Trust hold, where it came from and who you share it with. Carry out an organisational information audit. Develop policies and procedures to ensure the accuracy of the information the Trust holds. Maintain internal extensive records of processing activities, this must detail any linked data flows and other elements such as privacy notices, technical and security measures, contracts, conditions for processing, overseas transfer arrangements etc. these records must be provided to the supervisory authority on request. Ensure there mechanisms are in place to carry out the above.	23.04.18: Data Flow Mapping continues, implementation deadline July 2019. Progress update to take place at the end of this quarter. 04.03.18: the work still continues. Working group meetings continue to take place every 2/3 weeks. We set a task to identify data flows leaving the business. This task is probably the most important to achieving compliance, by knowing where information is, where is goes to, for what purpose forms the foundation of other requirements.	4	4	16	16	06	Fred Gregory	Tracy Goodacre	27/04/2017		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date

Data flow mapping exercise, includes various question sets is being drafted for Information Asset Owner's.	Work on track and will be presented to IGSG before 31.12.17.	Billie-Jo Croft	Activities could be missed from scope, due to lack of central guidance. staff are currently undertaking this exercise.	
Meeting with key stakeholders placed for 29.11.17.	Meeting will be minuted and discussed at IGSG.	Billie-Jo Croft	Potential of lack of stakeholder contribution and commitment.	
Recommend purchasing new IAR technology which is GDPR compliant in place of the existing technology.	SIRO report drafted which includes recommendations, figures being sourced for new technology.	Billie-Jo Croft	03.04.18: work continues, meetings continue to take place every 2/3 weeks. Staff are expected to maintain extensive and up-to-date Information Asset records detailing linked data flows and other elements such as privacy notices, contracts, conditions for processing, overseas transfer arrangements etc… Currently, our Information Asset Register does not include this activity.	
The GDPR working group meeting took place on 29.11.2017. By the close of the meeting, it was commonly understood by the attendee's that the GDPR has unavoidably imposed itself on any business using personal and sensitive data, automatically becoming a statutory business driven obligation and that the collaboration, contribution, commitment and achievements from the members of the working group is required to achieve compliance.	This is documented in the meeting notes for the meeting.	Fred Gregory	The ICO has produced a range of resources on its data protection reform website. However, it is noted that there is a lack of GDPR guidance. The ICO will continue to publish guidance as it becomes available.	
Action in Progress	**Action Commentary**	**Action Rating**	**PS&Q Lead**	**Review Date**
In preparation of the GDPR, PAH has a legal requirement to conduct a data flow mapping exercise which identifies and maps all data flows. The data flow mapping exercise being drafted for the forthcoming Working Group Meeting dated 04.01.2018.	We understand that data is collected, used, disclosed etc and that most data within the business is personally identifiable or special categories of information, what we don't completely understand is that the processing within each health group/ward/department has a legitimate basis for processing and that data protection and security has been considered and evidenced to that processing. Although there is the legal requirement to demonstrate compliance with the General Data Protection Regulation, the exercise will be a useful tool to assess data protection, data security, and privacy risks in order to make changes to improve the management of the data flow. Completion timeline to be agreed with the stakeholders. Stakeholders are working towards compliance. Ongoing review through GDPR working group.	Action On Track	Fred Gregory	31/07/2018

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New Records of Processing Activities (RoPA) Policy required.	RoPA policy created, peer reviewed through IGSG, and taken to the Trust Policy Group on the 03.07.18 for ratification. TPG requested a verbal update at the next meeting in order to consider the ratification further.	Action On Track	Billie-Jo Croft	19/09/2018

Information Management & Technology (IM&T)

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Projects and Business Continuity	**IT044**	**To provide fire suppression in the two main computer rooms on-site in order to protect patients, visitors, staff, IT servers and core network equipment in the event that a fire broke out in one of the rooms.**	No fire suppression in the PAH computer rooms.		5	4	20	20	05	Furzana Kausar	Stuart Hanlon	12/02/2013		12/10/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
No controls in place to mitigate this issue.		Furzana Kausar		

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
24/05/2018 - Update after ICT Programme Board held on 22 May, one tender received at £87k, majority is to make the rooms ready for gas suppression. Chief Finance Officer requested that a quick review is undertaken of the tender document received in order to revisit suitable options. 07/05/2018 - Tender only received one response. Trust has accepted and will go forward with this proposal so long as ICT Programme Board approve.		Progress Being Made But Overdue On Completion Date	Furzana Kausar	
26/03/2018 - Tender has gone out. Deadline for responses is 6 April 2018 after which time they can be evaluated for a preferred supplier. 09/01/2018 - Recommendations received from review. Currently with Health & Safety Officer after review by IT. 30/11/2017 - Mechanical & Engineering Consultant to review computer rooms tomorrow to put technical specification together which can go out to tender. 07/11/2017 - The Trust RMG group requested the risk score to be raised. 01/07/16 - Urgent review of risk and mitigation options. Plan to deal with this years capital fund Trust will deploy suppression or advanced detection systems 11/05/2017 - Waiting to see capital allocation funds for 2017/18 11/07/2017 - Meeting arranged between IT and the Trust Fire Officer to discuss options. 30/09/2017 - Health & Safety Officer has recommended 2 suitable companies and forwarded these to the Fire Safety Officer for a decision.	Heath & Safety Officer leading	Progress Being Made But Overdue On Completion Date	Furzana Kausar	
Develop action plan with BBC Fire Protection	Due to be fully implemented by 12th October 2018 (12 week project), more detailed timescales below.. 18th July – Kick off meeting (completed) 2 week design phase 4 weeks materials 3 weeks Computer Room B installation 3 weeks Computer Room A installation		Furzana Kausar	12/10/2018

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date

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Quality	**IT089**	**To ensure that the front door to Grane House is secure and does not sporadically remain open thus putting at risk patient notes and Service Desk equipment.**	The front door to Grane House is not closing properly. Grane House houses the Service Desk equipment, IT equipment and patient records.	Asked to reduce risk score from 25 to 20 at ICT Programme Board on Fri 15 December 2017.	5	4	20	20	05	Furzana Kausar	Furzana Kausar	25/11/2016		08/08/2018

Risk Mitigation/Controls	**Source of Assurance on Control Effectiveness eg. How would you know your control is working?**	**PS&Q Lead**	**Gaps in Control**	**Review Date**
Ask staff to be vigilant and close the front door behind when they enter or exit. This has been reported to Estates as it re-occurs regularly.		Furzana Kausar		

Action in Progress	**Action Commentary**	**Action Rating**	**PS&Q Lead**	**Review Date**
21/05/2018 - Supplier has received payment. There is an 8 week lead time. Work will start mid July and should complete by end of July. 07/05/2018 - Supplier awaiting 50% of payment before commencing work. Waiting for confirmation that payment was received 4 May.		Action On Track	Sarah Wilcox	
26/03/18 - Order for replacement door has been placed. Delivery date being evaluated. 22/02/18 - Quote has been received by Estates staff to provide an automatic door. This is being progressed by the IT Programme Manager. 15/01/2018 - Communicated with Estates regarding the on-going problem of the front door remaining open. Estates have received a quote for a manual door rather than an automatic one which would suit Coding staff. 19/12/2018 - Met with AD for Estates. Assured that solution will be sought and in the meantime Security will perform regular checks. 15/12/2017 The door is now remaining open. We are reporting it very frequently to Estates but within a day or so of it being fixed it becomes faulty again. There have been discussions regarding replacing the door but this has not progressed. 07/11/17 - The door is now remaining open very frequently. Staff are alerted to remain vigilant about closing the door behind them. Estates staff have mended the door many times but the problem	This risk re-occurs and has to be addressed each time the door fails to close.	Progress Being Made But Overdue On Completion Date	Furzana Kausar	
Approval obtained in capital from 17/18 to purchase new front door for Grane House. The order was raised in March 2018, Doors arrived at supplier at the beginning of June 2018 and where found to be faulty. A new batch of doors have been re- ordered by the supplier and are due for delivery to the supplier on 31/07/18. As soon as the doors are delivered to the supplier and its confirmed there are not manufacturing issues with the doors an install date for August is planned.		Progress Being Made But Overdue On Completion Date	Furzana Kausar	08/08/2018

Domain	**Risk Ref:**	**Objective - What are you trying to achieve**	**Description of Risk - Cause and Effect**	**Risk Comments**	**Consequence**	**Likelihood**	**Initial Risk**	**Current Risk Score**	**Target Risk Score**	**PS&Q Lead**	**Risk Lead**	**Date Risk Raised**	**Date Risk Closed**	**Risk Review Date**

Projects and Business Continuity	**IT096**	**Safe and secure infrastructure free from the threat of users clicking on insecure links or responding to insecure emails**	The Trust is taking precautions to ensure that its IT infrastructure is protected against known malware threats. The risk remains of zero day attacks which are new unknown threats and do not have a fix available.		4	3	12	16	12	Furzana Kausar	Furzana Kausar	19/05/2017		08/06/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
An anti-exploit software tool has been installed onto servers and PCs. This will help to detect potential malware.	No malware introduced onto the Trust IT infrastructure.	Furzana Kausar	Where new malware is introduced which utilises unknown patterns, this would not be detected.	30/04/2018
Procure training tool which can help decipher which end-users required further training and awareness. Educating end-users on the risks of clicking on suspicious emails or insecure web links.	No introduction of malware into the Trust.	Furzana Kausar	Current scams look very genuine and are often hard to distinguish from authentic emails and web links.	30/04/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**IT101**	**Ensure that the fleet of Acer PCs in use at the Trust are free of hazard**	Acer base unit caught fire and brought to the IT department by a member of the Estates department. It is stated that another base unit had a similar incident last year but there is no Datix for this and no base unit was brought to the department hence no evidence.		5	3	15	15	05	Furzana Kausar	Lynne Fenwick	06/02/2018	25/05/2018	08/06/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
23.03.2018 - Supplier has complete their investigation and found that the fire was caused due to an accumulation of dust. IT to carry out checks on PCs to ensure that base unit vents are not covered and domestic staff to be asked to vacuum vents to remove dust. Have written to supplier of the base unit asking if there are known issues with the particular model.		Furzana Kausar	A fire can break out at any time with electrical equipment	

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
25/05/2018 - Associate Director of Estates & Facilities to ask Domestic staff to vacuum back of the PC base units. Also IT Engineers to check PCs as they perform their daily duties.		Action Fully Implemented	Furzana Kausar	

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Non-Clinical Health & Safety

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Statutory Compliance	**NCHS001**	**Compliance with statutory regulations and best practice guidance for medical gas pipeline systems.**	Non-compliance with Health Technical Memoranda (HTM) and other relative statutory regulations relating to Medical gas pipeline systems. There are currently significant gaps in the safe design, maintenance and operation of these systems. Whilst monitoring is being carried out in all areas to ensure patient and staff safety is not adversely affected, there is a risk of plant failure, improvement notices and prosecution from regulatory bodies.		5	5	25	15	05	Alison Morris	Alison Morris	14/02/2013		31/08/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
A detailed guidline has been produced to set out the management structure (including roles and responsibilities as per statutory guidance) for the safe management of this function. The guidline has been sent to the Trust Policy Group meeting March 2017 for noting, and has been approved at the Estates and Facilities PS&Q Forum.	The management structure of Authorised and competent persons is monitored as part of policy review on an annual basis.	Alison Morris	Due to gaps in the skill mix within the estates department, there has been a delay in training and appointing the necessary staff to the recommended posts.	31/08/2018
An updated Policy is in place for the safe management of this function. The policy will be reviewed by the AE upon appointment.	The policy will be reviewed annually or in the event of changes in legislation or best practice guidance. A review will also be carried out upon appointment of the AE.	Alison Morris		31/08/2018
Any works carried out on the medical gas pipeline systems are undertaken by specialist contractors under a permit to work system. This ensures that there is a suitable and sufficient risk assessment and method satement in place for the works.	A permit to work system is in place that requires a safe system of work to be detailed before a permit is issued.	Alison Morris		31/03/2019
Authorising engineer (AE) appointed and is currently acting as AP due to recent retirement of AP		Alison Morris	All works on medical gas systems must be meticulously planned to ensure availability of AE.	31/08/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Appointment of Authorised Persons following training course and assessment by Authorising Engineer.	Staff members identified for training course.	Action On Track	Alison Morris	

Audit of medical gas pipeline system and operational procedures to be carried out by Authorising Engineer and risk assessment and compliance audit of entire system carried out by BOC.	Audit will be carried out following appointment of AE	Action Fully Implemented	Alison Morris	
The gaps in compliance identified from recent audits received in May 2018 will be used to inform the capital plan and backlog maintenance for 2018/19 and 2019/20.		Action On Track	Alison Morris	31/03/2019

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Nursing

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Workforce and Organisational Development	**SC0814001**	**To ensure staffing levels meet clinical demand and staff are fit for purpose in relation to their competency**	The high vacancy factor in registered nursing has the potential to impact on the organisation capacity and capability to deliver safe patient care and best patient experience.	20.2.18 LF SC: Successful recruitment to RMidwifery vacancies has eliminated the previous risk. Any return to persistent vacancy position will require a new risk assessment. Registered Nurse Vacancy Rate at Month 10 = 23%. Specific areas are highlighted in HCG Risk Registers	4	5	20	16	06	Sharon Cullen	Sharon Cullen	14/08/2014		01/08/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Fortnightly meetings with NHSP and the chief Nurse are in place to explore ways to augment the NHSP fill rate. Monthly performance meetings attended by ADONs		Sharon Cullen		
The Trust has a process overseen by Deputy Chief Nurse to authorise the use of temporary staff (agency) to optimise staffing levels and patient safety.	Review of rosters to demonstrate planned staffing levels are met.	Lisa Flack	Poor fill rate by agency providers may leave areas below planned staffing.	
We are currently utilising SafeCare to identify patient acuity and dependency to enable realignment of staff to meet demand.	We have a monthly Safer Staffing Report which triangulates quality data with planned and actual staffing levels to assess efficacy of the controls.	Lisa Flack	There is a possibility that demand will exceed the availability of staff.	
We have established Recruitment and Retention Meeting chaired by Chief Nurse to oversee and challenge actions in place to address nurse recruitment and reduction in turnover.	We would see a reduction in vacancies and improved retention.	Lisa Flack	Recruitment plans may not deliver required staff appointments.	
We have thrice daily safety huddles with clinical site team to oversee safe nurse staffing.	Real-time realignment of staff moves on e-roster.	Lisa Flack	Poor compliance with realignment staff moves on e-roster.	

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Introduce new roles to support patient care e.g. Senior Staff Nurse.	There is a plan to create up to six Senior Staff Nurse posts on each adult ward. Internal advertisements and expressions of interest process commenced in April 2017. 20/2/18 LF SC: Senior staff nurse role and a range of other support roles are now embedded in the organization.	Action Fully Implemented	Sharon Cullen	

Ongoing international recruitment campaign for registered nurses.	We have successfully appointed international nurses however the process for attaining COS and VISA is resulting in long delays to start date. 20.2.18 LF SC: Protracted timeline for recruited candidates to arrive continues to adversely impact. Slow and steady flow of low numbers of international nurses continues. This require on-going top up to ensure regular flow of new international nurse starters 24.5.18 Plan to undertake a recruitment campaign to India in June 2018: we will monitor impact.	Progress Being Made But Overdue On Completion Date	Sharon Cullen	01/08/2018
The Trust has developed a Staff Retention Improvement Plan, being led by Head of Recruitment and Retention. Actions are monitored monthly at the R&R Meeting. Action outstanding relates to monitoring impact of the initiatives introduced.	The Nursing Team are commencing a project with NSI which relates to receiving real time feedback from staff through the E-roster system. The output will be used to further strengthen staff experience and an aim to improve retention rates. 24.5.18 the Trust is all ready but project was delayed in starting.	Action On Track	Sharon Cullen	01/08/2018

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Operational

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Statutory Compliance	**001/2017**	**To deliver ED 4 hour standard at 95% or above**	Failure to Deliver the ED four hour standard, leading to low performance rating, external scrutiny and potential performance notices and financial penalties.		4	5	20	20	08	Phil Holland	Anne Carey	01/04/2014		18/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Daily monitoring and review of previous breaches, number/patterns of attendances to facilitate changes in ED pathway to improve or limit detrition in performance	Limited, no sustained reduction in patients exceeding 4 hours.	Phil Holland	All planning is based on historical data, which does not facilitate Live data	18/07/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
I. Complete the Accountability and Responsibility Grid (ARG) for all roles within and external to the Emergency Department, expanding each area to include clarity and further detail II. Develop a competency model III. For the roles of Nurse in Charge, Consultant in Charge and Operational Lead: i. Clarify of role ii. Develop a daily routine IV. Provide support, guidance and coaching to staff as required V. Assessment of competence of staff VI. Back to basic event to cover: i. the 4 hour standard ii. Internal professional standards iii. ED staff view i.e. what went well, what stops me from doing my role, what would change iv. If I delivered the 4 hour standard for my patients it would mean…….? VII. Development and implementation of daily review of performance against standard and IPS VIII. Improve interaction between site and ED teams		Action On Track	Phil Holland	11/07/2018

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**002/2016**	**No patient will spend a journey time greater than 12 hours from arrival to discharge from ED**	Patients in ED longer than 12 hours		4	4	16	20	09	Phil Holland	Anne Carey	27/07/2016		18/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Internal professional standards which articulates at which point a patient should be in their journey through ED.	Standards are measured by Click View and available in real time	Phil Holland		01/08/2018
Monitoring by the Senior Site Matron to enable identification and escalation of patients that have a long wait in ED with no plan.		Phil Holland	Lack of assurance on timely and effective response to escalation	18/07/2018

Trackers in place to review electronic Tracking System and escalate to Consultant and Nurse in charge if patient is not meeting internal professional standards										Phil Holland		Roles and accountabilities not clearly defined		18/07/2018
Action in Progress					**Action Commentary**					**Action Rating**		**PS&Q Lead**		**Review Date**
To identify the current system capacity required to support the demand on the urgent care pathway and agree at the Local Delivery Board which Capacity / Demand Model the Trust will be following.										Progress Being Made But Overdue On Completion Date		Phil Holland		18/07/2018
Domain	**Risk Ref:**	**Objective - What are you trying to achieve**	**Description of Risk - Cause and Effect**	**Risk Comments**	**Consequence**	**Likelihood**	**Initial Risk**	**Current Risk Score**	**Target Risk Score**	**PS&Q Lead**	**Risk Lead**	**Date Risk Raised**	**Date Risk Closed**	**Risk Review Date**
Quality	**003/2016**	**No patient to wait longer than 12 hours from a decision to admit**	Patient in ED waiting longer than 12 hours from a decision to admit		4	4	16	20	09	Phil Holland	Anne Carey	28/07/2016		18/07/2018
Risk Mitigation/Controls					**Source of Assurance on Control Effectiveness eg. How would you know your control is working?**					**PS&Q Lead**		**Gaps in Control**		**Review Date**
Internal professional standards which articulates at which point a patient should be in their journey through ED.					Standards are measured by Click View and available in real time					Phil Holland				01/08/2018
Monitoring by the Senior Site Matron to enable identification and escalation of patients that have a long wait in ED with no plan.					Lack of assurance on timely and effective response to escalation					Phil Holland				18/07/2018
Trackers in place to review electronic Tracking System and escalate to Consultant and Nurse in charge if patient is not meeting internal professional standards										Phil Holland		Roles and accountabilities not clearly defined		18/07/2018
Action in Progress					**Action Commentary**					**Action Rating**		**PS&Q Lead**		**Review Date**
To identify the current system capacity required to support the demand on the urgent care pathway and agree at the Local Delivery Board which Capacity / Demand Model the Trust will be following.										Progress Being Made But Overdue On Completion Date		Phil Holland		18/07/2018
Domain	**Risk Ref:**	**Objective - What are you trying to achieve**	**Description of Risk - Cause and Effect**	**Risk Comments**	**Consequence**	**Likelihood**	**Initial Risk**	**Current Risk Score**	**Target Risk Score**	**PS&Q Lead**	**Risk Lead**	**Date Risk Raised**	**Date Risk Closed**	**Risk Review Date**
Quality	**005/2016**	**All patients referred by a GP with suspected cancer to receive their first definitive treatment within 62 days**	Failure to meet the 62 day cancer standard		4	4	16	16	06	Anne Carey	Anne Carey	30/07/2016		01/08/2018
Risk Mitigation/Controls					**Source of Assurance on Control Effectiveness eg. How would you know your control is working?**					**PS&Q Lead**		**Gaps in Control**		**Review Date**
Recovery action plan and trajectory					Low					Anne Carey				09/07/2018

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Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Specialty level recovery plan in place, monitored daily at tumour site level and Trust level twice weekly	Urology plan on track, Endoscopy plan requires further support to deliver. CCCS managing the Histopathology capacity risks	Progress Being Made But Overdue On Completion Date	Anne Carey	09/07/2018

Workforce - Human Resources

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Workforce and Organisational Development	**WPOD01**	**To ensure the Trust has effective workforce planning processes, supported by equally effective recruitment and selection processes, to further ensure delivery of safe, effective patient care.**	A lack of effective workforce planning presents a risk that the workforce may not be fully fit for purpose to deliver services now and in the future. Currently workforce planning tends to be cost-driven rather than service driven; with the current service redesign plans, the Trust has an opportunity to address the skills it needs to deliver in the coming years.		4	4	16	16	08	Ellie Manlove	Ellie Manlove	15/06/2017		03/05/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Cost is an essential part of current workforce planning and therefore is a partial control, BUT consideration needs to be given to aligning skills to services.	Recruitment KPI's Turnover and Stability data	Ellie Manlove	Need to improve the way we align skills to services; workforce implications of service design and redesign to be an essential consideration.	

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
HR forms for Appointment/Change/termination are realigned to new establishment process	New establishment control process in place for any changes to pay and establishment	Action Fully Implemented	Ellie Manlove	30/04/2018
ESR is aligned to financial ledger		Action On Track	Ellie Manlove	31/05/2018
HR senior Team to produce a high level workforce plan based on trust data which can then be aligned to the People strategy and 5p plans	It is recognized that this will be a longer-term piece of work with 18/19 plans being developed and reviewed in September 2018 for 19/20 and beyond	Action On Track	Ellie Manlove	04/05/2018
HR Team review people risk on each HCG Risk register.		Action On Track	Ellie Manlove	29/06/2018
Workforce planning using data to inform part of the resourcing plan as outlined in the People Strategy and work plan, which is then linked to educational plans Daily recruitment summits focusing on highest vacancies. Increased use on social media for advertising. Streamlined recruitment processes with KPI's reported at PRM's		Action On Track	Ellie Manlove	04/05/2018

Family & Womens Services

Child Health

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Projects and Business Continuity	**NICU ROP Outpatient**	**Ophthalmology Retinopathy (ROP) Outpatient Follow up Clinic to be held in the eye Unit rather than the Neonatal Unit**	A weekly ROP Outpatient follow up clinic is undertaken on The Neonatal Unit. This increases the risk of Infection due to babies being brought back to the Neonatal Unit from the community. Due to the strict security access for the neonatal unit, having a clinic without knowing the attendance list, poses a risk to security for both the safety of patients and staff on the unit Poor patient experience , feedback from parent , raised "sitting room felt like a waiting room , rather than a relaxing space"	24/05/2018 Meeting not held Plan to start clinic in PAU in June following a few weeks training with PAU nursing team with Opthalmology team. Date not set 20/06/2018 No date set, email sent today to Surgery Service managers requesting update 19/07/2018 No date set, no update received	4	5	20	20	01	Claire Jakes	Janelle Gardner			20/08/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Extra staff from the Neonatal Unit booked on follow up clinic days to support Opthalmology		Claire Jakes		
List of weekly attendees received Ward Clerk contacts The Eye Unit and obtains information from Cosmic This is to ensure that staff are aware of which patients are attending the clinic for security reasons		Claire Jakes	Attendee list not always received Cosmic not always completed with patient details	
There are Infection control /hand hygiene posters up in the Neonatal Unit from the entrance for all visitors, parents and staff to heed	Hand Hygiene audit	Claire Jakes	The risk of a family coming on to the Neonatal Unit, who have been in contact with infection such as D&V, chicken pox etc is difficault to monitor	

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Ophthalmology needs to recruit Paediatric Ophthalmologist and follow up outpatient clinic to be held away from the Neonatal Unit	19/01/2018 ophthalmology consultant has been recruited. Awaiting HR checks and start date. MDT meeting requested with all stakeholders to discuss the ROP clinic and staffing. 22/02/2018 Email sent to Assistant Service Manager, General Surgery by C Jakes requesting update on new Paediatric Ophthalmologist and enquire about the booking of Outpatient Appointments away from the Neonatal Unit. 27.03.2018 New Paediatric Ophthalmologist commencing in post in Sept 2018 Meeting still not been held to discuss outpatient clinics being held in Eye clinic and not within the neonatal unit for ROP follow ups	Progress Being Made But Overdue On Completion Date	Claire Jakes	

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	CH/OPHTHALMOLOGY05/17	**To maintain patient safety ensure the KPIs for pathways for the management of babies with ROP, children with an acute eye problem or children requiring eye surgery is followed and we cause no harm.**	The Ophthalmology service for children has been suspended and is not accepting any new referrals. There are limited follow up appointments available and children with ROP are still being seen but there have been interruptions to the pathway. Any child with an eye emergency is being seen within the emergency Eye Unit clinics as before.This is because of the departure of the Paediatric Ophthalmologist and the difficulties in recruiting a replacement. The risk is that children may not receive care in a timely manner and potentially come to harm. New Consultant apt form Sept 2018 01/02/2018 There are 8 outstanding babies from Cosmic which have been highlighted to Ophthalmology team to review and book appointments as required. This has not been actioned DATIX completed	This risk sits within the Surgical Health Care Group but the impact of this risk is for Family and Womens Services This risk has not changed and there is concern about the lack of response. 24/05/2018 Discussion with Surgical Service manager last week regarding outstanding babies. Awaiting reply 20/06/2018 No reply received, email sent to Surgical Service managers today requesting update on progress 19/07/2018 No update received	3	4	12	16	08	Claire Jakes	Priya Prakash	22/05/2017		20/08/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date

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List of infants who had not completed ROP pathway received and sent to Ophthalmology and Surgical Group	Infants will receive timely follow ups and this will be documented on Cosmic, Badger net and within the infant's notes	Claire Jakes		
Since June 2017 a dedicated Neonatal member of staff has maintained a New ROP screening book . All neonates are seen following the correct ROP pathway within the Neonatal Unit by Ophthalmologist Registrar until they are 40 weeks gestation, when they are referred to Ophthalmology Outpatients.	Badgernet ROP book	Claire Jakes		

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Notes to be reviewed regarding follow up undertaken	From January 2018 ,clinics for current NICU babies are being set up for these babies within the Eye Outpatient Dept following their discharge from the Neonatal Unit. Risk will be reviewed in February with plan to reduce, once clinics up and running. 22/02/2018 Email sent to Assistant Service Manager, General Surgery by C Jakes requesting update on new Paediatric Ophthalmologist and enquire about the booking of Outpatient Appointments away from the Neonatal Unit. 27.03.18 No email received in answer to email sent 22.02.18 Phone call to Assistant Service Manager, General Surgery New consultant commencing September 2018- 2 days a week Mr Butt to continue seeing neonatal babies within the Neonatal Unit, including those babies discharged home. Outpatient clinics have NOT been set up Combined ophthalmology and Neonatal meeting has been cancelled several times by surgery.	Progress Being Made But Overdue On Completion Date	Claire Jakes	

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**CHPaeds discharg esummar ies2017**	**All discharge summaries from Paediatric ED and Dolphin will be completed and sent to Child's GP and/or other relevant health care partners within 72 hours of discharge**	Summaries are not being completed within the KPI of 72hours and important details of the ongoing care will be missed because the GP and/or other relevant health care partners will not have timely information regarding the attendance at Paeds ED or following an inpatient stay on Dolphin This could result in delays in follow up actions. It also means that there is inaccurate data about the numbers of patients using or being discharged from the service which has financial risk/implications	21/06/2018 428/1738 Paediatric ED summaries not completed in May 19/07/2018 443/1541 Paediatric ED summaries not completed x1 Doctor being paid to complete	3	5	15	15	06	Claire Jakes	Fiona Hikmet	03/04/2017		20/08/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
CSG lead allocates Drs to undertake discharge summaries	There will be a reduction in outstanding discharge summaries. Working towards daily completion	Claire Jakes	It is on an adhoc basis with dependence on medical staffing	

Plan for better facilities and more computers once the New Paediatric ED is open Each Dr will have a tray in Paediatric ED Doctors office , this will enable the Doctors to complete discharge summaries more easily as they will be accessible		Claire Jakes	New Paediatric ED not opened as yet	
Action in Progress	**Action Commentary**	**Action Rating**	**PS&Q Lead**	**Review Date**
Time required for Doctors to complete Discharge summaries	25/01/2018 Audit recently been undertaken by Informatics Matron, presented to FAWS Health care group board meeting. Daily and weekly reports emailed to informatics matron. 22/02/2018 This continues to be monitored, Weekly and daily emails continue from informatics. Dolphin summaries currently about 80% completed. Paeds ED Numbers vary 27.03.2018 Dolphin Summaries January 2018 98.86% completed February 2018 82.43% completed ED Summaries January 2018 62.14% 777 not completed out of 2067 February 2018 56.99% 818 not completed out of 1902	Progress Being Made But Overdue On Completion Date	Claire Jakes	

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Safeguarding Adults

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**Adult SG Mental Capacity 06/17**	**To improve staff knowledge and application of The Mental Capacity Act and understanding of DoLS in relation to planning of care for Patients**	The Trust is not following the legislation and guidance on the mental capacity act 2005, and the Deprivation of Liberty Safeguards. This could lead to where care and treatment is not provided in line with peoples decisions about consent. Applications to authorized DoLS are not made appropriately in a timely way.	24/04/2018 Team recruited a Band 7 who started on 28th March 2018. Once induction complete, the MCAs will be audited 21/6/2018 Team are working with quality first team to audit this area	4	4	16	16	04	Fiona Lodge	Fiona Lodge	13/06/2017		20/08/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Specific training package developed on MCA and DoLS for staff. Key professionals are being identified to receive this training A flow chart has been devised for staff guidance.	Staff compliance on training An audit has been devised to collect qualitative data. 3/10/2017 audits have been completed which have demonstrated in improvement in the completion of best interest decision The DNACPR form has been updated with the MCA form as part of this	Fiona Lodge	Staff being released for training Safeguarding time to train.	02/01/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Audit required on training undertaken over last 12 weeks	25/08/17 MCA training occurring for 12 weeks 22/02/2018 MCA training is included as part of safe gurading training, there is a specific training for staff regarding MCA. Training compliance remains an issue across the Trust. Level 2- 72%	Action On Track	Fiona Lodge	

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Statutory Compliance	**Adult SG Training 06/17**	**All Health staff will receive Safeguarding Adult training according to their role and responsibilities. This is in line with Local Guidance from The Safeguarding Board. In order for the Trust to meet their KPI's.**	Without the correct Safe Guarding knowledge and skill:- An adult may be at risk of significant harm that is not recognised and responded to appropriately by staff. An adult may remain in a harmful environment that should have been escalated to partner agencies, such as social service/police, to trigger their statutory duties.	20/06/2018 May 2018 Trust-wide figures Safeguarding level 1 94% Safeguarding level 2 83% 19/07/2018 Trust-wide Figures Safeguarding level 1 94% Safeguarding level 2 84%	4	4	16	16	06	Claire Jakes	Nicole Anderson	13/06/2017		20/08/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date

An extra 6 training sessions a week are being facilitated by the Safeguarding team with the support of the Training department to provide venues The sessions are publicized to the Health Care groups to cascade to their teams	Attendance figures collated by the training team. Monitoring of the training compliance Copies of extra session attendees kept by Safeguarding Team 3/10/2017 training data is provided to the health groups on a monthly basis	Fiona Lodge	Staff are not released to attend the sessions due to clinical work load.	
Action in Progress	**Action Commentary**	**Action Rating**	**PS&Q Lead**	**Review Date**
Adult Safe Guarding Training sessions being undertaken	16/01/2018 Meeting with SKL currently at Level 1 93% level 2 77% - moving in the right direction 22/02/2018 January 2018 percentages Level 1 93% level 2 77% 27/03/2018 February 2018 percentages Level 1 92% level 2 78%	Action On Track	Claire Jakes	

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Safeguarding Children

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Statutory Compliance	**CH/SG supervision/Oct16**	**To deliver minimum of 80% safeguarding supervision to all staff who work directly with children, this includes paediatric staff and community midwives currently.**	Insufficient supervisors available to meet the demands of the organisation. resulting in staff not having their educative and emotional needs met in relation to their safeguarding work. There also will be a lack of managerial oversight of safeguarding practice.	09/05/2018 Quarter 4 supervision is 34% In- Trac consultancy agency contacted regarding a 2 day supervisory course 20/06/2018 Quarter 1 figures available in July 2018 18/07/2018 Quarter 1 supervision figures 62.2% Paediatric Surgery 67% Paediatric ED 76% NICU 36% Paediatric Outpatients 100% Dolphin 32% Funding for 15 Supervisory places booked for October 2018 An expression of interest will be sent to staff within Paediatrics	4	4	16	16	04	Claire Jakes	Nicole Anderson	16/10/2016		24/09/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Weekly supervision meetings undertaken in all Paediatric areas	Supervision meeting records and attendee list	Claire Jakes		

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
More supervisors required once further courses have been identified	24/04/2018 The Named Nurse will continue providing group safeguarding supervision to the Head of Children Services, the Paediatric Matron and Managers on a three monthly basis. This will include paediatric matron, Dolphin Ward Manager, Paediatric A&E Lead nurse, NICU Manager, Paediatric Oncology Nurse Specialist, Paediatric Risk Facilitator, Paediatric Diabetic team and Paediatric HDU facilitator The safeguarding children team contributes to support the monthly doctors peer review group. This is to enable a multi-disciplinary review of cases where lessons have been learned or cases where things have gone well. CSE, FGM and more recently Fabricated/Induced Illness have been topics for discussion including case review. Dr Gheeta Kugan has attended the Drs peer review this year. The Named Midwife and the Named Nurse for Safeguarding Children are supervised by the Designated and Deputy Designated Nurse on a six weekly basis. Supervision has been assessed as a risk to the organisation and is on the risk register. Risk score increased to 16 (4x4) as supervision figures have continued to decrease 19/07/2018 funding received for 15 Supervisor training places in October 2018	Progress Being Made But Overdue On Completion Date	Claire Jakes	

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Womens Health

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Workforce and Organisational Development	**Womens 24**	**To maintain a high standard of care for women receiving treatment on Nightingale and to increase the Staffing Numbers and morale**	Insufficient number of registered nurses on Nightingale Ward to provide safe and effective care. Staff on the ward are often agency staff so do not have the gynaecology competencies to be able to undertake certain duties.	19/07/2018 - ward establishment should be 12.99 WTE Registered Nurses. 10.3 WTE Health care assistants. Current Vacancy rate is 6WTE Registered Nurses, 6.28 WTE Health Care Assistants.	5	4	20	20	06	Erin Harrison	Jacqui Featherstone	04/12/2017		31/08/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Currently lines of work agency staff are available to cover shifts, interviews for staff across the bands are taking place over January.	Less agency covering shifts and substantive employment of both registered nurses and health care assistants.	Erin Harrison	Still relying heavily on Agency staff.	

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Advertisement for health care assistants for Nightingale Ward Schedule interviews from shortlist of applicants	Interviews have been successfully completed and Nightingale should be at full establishment for HCAs if all applicants start as planned	Action On Track	Erin Harrison	
Job roles advertised on NHS jobs for Registered nurses and Healthcare assistants.	Job Advert closed for Registered Nurses, successful interviews were held and 5 RN's are awaiting a start date or qualification to enter the professional register.	Action On Track	Erin Harrison	
Recruitment of band 5 nurses to Nightingale Ward. Advertisement has been published Interviews to be scheduled for shortlist of applicants Plan to re advertise for nursing posts again in June 2018		Action On Track	Erin Harrison	
Regular Agency staff are used who know the ward and the daily routines to create a better working environment. The Lines of Agency staff are able to administer Intravenous Drugs, use cosmic and access the Trust Guidelines.	Substantive jobs are available and staff across the Trust have been encouraged to apply.	Action Fully Implemented	Erin Harrison	

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	Womens 26	Improve the newborn bloodspot error rate for the Trust	Currently having multiple rejections so the Trust is not achieving KPI target for newborn and antenatal screening. Nov 17: 5 Samples rejected (1.5%) Dec 17: 8 samples rejected (1.4%) Jan 18: 10 samples rejected (1.5%) Feb 18: 6 samples rejected (2%) Mar 18: 7 samples rejected (2.5%) Quarter 4 final data (2.0%) failure to meet KPI. Awaiting quarter 1 data for April-June 2018.	Rejection rate is increasing causing babies to be re-bled. where rejections have occurred due to sampling error the staff involved are spoken to by the screening team and bought into the Trust for further training.	4	4	16	16	04	Erin Harrison	Sarah Fiadjoe	18/01/2018		31/08/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Staff are bought in house for one to one training where a sampling error has occurred. The training is also discussed at mandatory updates for all staff within maternity.	reduction in error rates.	Erin Harrison	If staff fail to attend mandatory updates they are not receiving the most up to date information.	

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
All staff who attend mandatory updates are given the newest information relating to antenatal screening and the blood spot service.		Action Fully Implemented	Erin Harrison	
All team midwives are to have the blood spot cards checked by a second checker before being sent to GOS	All midwives aware of the action to reduce the number of blood spots cards being rejected by GOS	Action On Track	Erin Harrison	
business plan to be created surrounding bring the bloodspot service into the hospital to try to reduce the reduction by the failsafe team reviewing all blood spots undertaken.	19/07/2018 - no business case has been developed at present.	No Progress Made	Erin Harrison	
Individual midwives who have been named as having blood spot cards being returned due to errors are to meet with their line manager and retraining put in place	Those midwives identified with errors have appointments to meet with their line manager	Action On Track	Erin Harrison	
Maternity Community Teams with the most blood spot errors have now to bring completed blood spot cards into the hospital to be checked by the failsafe or screening team midwives	This action commenced in May 2018, team midwives have been made aware of the action.	Action On Track	Erin Harrison	

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Quality	**Womens 9**	**Initiatives to reduce LSCS rate. Women transferred to main theatre if maternity theatre in use. Business case put forward to trust board for maternity rebuild to include a second theatre.**	One maternity theatre inadequate for increasing birth rate, and caesarean section rate. Leading to delay in perineal repairs and delays in delivery. Approx 4 reported patient safety incidents per week.	Plans for a prefabricated maternity theatre to be placed on site are under discussion. Business case already underway. 05.06.2017 risk score amended to 16 as increase in datix reporting due to delays and the use of main theatre. Non compliance with national standards. 04/06/2018 - building work is underway with an anticipated hand over date of end of June. 19/07/2018- building work continues and is into the final phase. No estimated completion date has been confirmed at present	4	4	16	16	04	Erin Harrison	Alison Steele	22/11/2011		31/08/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Business case put forward to trust board for maternity rebuild to include a second theatre.	by the approval of a second theatre for maternity	Erin Harrison	if the business plan is rejected.	
Initiatives to reduce LSCS rate.	to see a gradual decrease in the LSCS rate.	Erin Harrison	Due to some emergency situations not all LSCS are avoidable, this may mean that the rate fluctuates.	
Women transferred to main theatre if maternity theatre in use.	The safe transfer to main theatre for delivery, no SI's due to no operating theatre being available.	Erin Harrison	There may be a time when main theatre is busy so emergency cases have to be prioritized accordingly.	

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
04.01.17 No change to risk. The current Theatre refurbishment is planned for later this year. 3 incidents in december for delays in transfer.	October 2017 - Work has begun on new theatre and recovery area Business plan submitted. awaiting date for commencement of build 25/08/2017 building work due to commence in October 2017 for second maternity theatre. March 2018- work is continuing on labour ward theatre. currently behind schedule June 2018 - work remains behind schedule. 19/07/2018 -work remains behind schedule	Progress Being Made But Overdue On Completion Date	Erin Harrison	
18.7.2014 Maternity expansion plan has been submitted to the TDA-awaitng decsion.	March 2018- work is continuing on labour ward theatre. currently behind schedule June 2018 - work remains behind schedule. 19/07/2018 -work remains behind schedule	Progress Being Made But Overdue On Completion Date	Erin Harrison	
26.1.15 No change with plans, however now on CCG radar following their visit in Dec14	October 2017 - work has begun on new theatre and recovery area 25/08/2017 - business plan accepted and building work due to start October 2017 March 2018- work is continuing on labour ward theatre. currently behind schedule June 2018 - work remains behind schedule. 19/07/2018 -work remains behind schedule	Progress Being Made But Overdue On Completion Date	Erin Harrison	
Elective LSCS moved to main theatre. Awaiting outcome of proposed maternity refurb, plans and business proposal submitted to trust board.	October 2017 - Work has begun on new theatre and recovery area. ELLSCS proposed to move from ADSU to new theatre once the works are completed. 25/08/2017 - building work confirmed to commence October 2017 March 2018- work is continuing on labour ward theatre. currently behind schedule 04/06/2018 - building works remain behind schedule, anticipated hand over date currently end of June. 19/07/2018 -work remains behind schedule	Progress Being Made But Overdue On Completion Date	Erin Harrison	

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Workforce and Organisational Development	**Womens 30**	**A full running second theatre on labour ward covering a 24 hour period 7 days a week.**	Currently the theatre is under construction however when they are completed the second theatre will need to be used for emergencies with full medical staffing. The current situation would not be sustainable as currently we only have 1 registrar, 1 SHO and 1 on call consultant covering out of hours. In order to have a running second theatre the staffing would need to increase by a minimum of 1 junior doctor.		3	5	15	15	01	Erin Harrison	Andrea Philip	20/04/2018		31/08/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Currently the on-call consultant would be asked to attend, which will remain the case. The SHO would then be asked to assist when possible.	No adverse incidents reported for the last 6 months	Erin Harrison	Only one SHO out of hours so in a situation where there are more than one emergencies a delay could occur with potential serious consequence.	

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Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Business case to be developed and presented to the Trust board.	20/04/2018: business case submitted to the executive team and is under review 04.05.18 A paper was presented to the COO for review prior to it being presented to EMB 19/07/2018 - Business case was accepted with funding for 3 SHO vacancies to be filled.	Action On Track	Erin Harrison	

Medicine Healthcare Group (MHCG)

Accident & Emergency (A&E)

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**ED Staff 01**	**Ensure all patients receive safe, quality care within a safely staffed clinical environment**	There are currently high number of Band 5 vacancies across the MHC. The potential impact is that: *Patients may not receive consistent standards of care. *Decrease in staff morale and increased level of sickness. *Reduced ability to comply with the requirements of clinical effectiveness, assurance and safety standards	Reviewed 13/4/2018 Vacancy Factor Band 5 - 13 WTE - Risk score remains the same due to inconsistent staffing numbers	4	5	20	20	08	Lesley Chandler	Victoria Barnes	01/07/2014		31/10/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
*Agency staff used to support numbers. These staff are regular workers and now complete an induction pack and competencies similar to permanent staff	Daily review by Senior ED team and escalation to Senior Medical Health Group team	Lesley Chandler		31/10/2018
Daily use of safe care		Lesley Chandler		31/10/2018
ENP team supporting RAT process and ED staffing when required	Daily review and escalation of requirements	Lesley Chandler		31/10/2018
Safety checklist and new patient documentation has been introduced	Audit of documentation to be undertaken	Lesley Chandler		31/07/2018
Safety huddles		Lesley Chandler		31/10/2018
Staffing monitored on a shift by shift basis	Daily review and escalation	Lesley Chandler		31/10/2018
Working closely with Workforce in relation to recruitment and retention	Monthly HR reports Staffing reports	Lesley Chandler		31/10/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Agency Paramedics currently being utilised on a daily basis. Plans are to recruit to these posts substantively		Action On Track	Lesley Chandler	31/07/2018
Review of current establishment to move Band5 funding to create Band 6 roles and advertise externally for new posts to be filled by Sept/Oct		Action On Track	Lesley Chandler	31/07/2018

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Support from ITU and Matron team. Working in ED Resus 1 shift per week	Support is no longer limited to ITU and Matrons and is extended to entire Medical Health Group and Surgical if required	Action On Track	Lesley Chandler	30/09/2018

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**ED012**	**To ensure the Trust is able to deliver the National Emergency Department (ED) 4 hour standard whilst ensuring safe, quality care is provided to patient's within the department**	There is potential risk to: *Patient safety due to the impact on patient flow and associated risk of crowding within the department *The ability to complete ambulance offload and handover in a timely manner *Financial penalties against KPI's that are not achieved	21/5/18 Month to date March - 60.66% Month to date April - 73.77% Year to date performance 73.99%	4	5	20	20	04	Lesley Chandler	Curtis Emordi	01/07/2016		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Ambulance Escalation and offload SOP in place		Lesley Chandler		31/07/2018
Daily monitoring and reporting of ED 4 hour performance by Information Team and shared with Health Group and Executive team	Monitroing of 4 hour performance figures	Lesley Chandler		31/07/2018
ED manager of the day	Non elective pathway, steering group and board. Reporting to Senior Management Team. Medical Healthcare Board and ED PSQ meetings	Lesley Chandler		31/07/2018
ED trialed the Rapid Assessment and Treatment (RAT) process is now fully implemented. RAT is model is a structured approach to the way that patients are received and assessed within the Emergency Department. It is a senior decision maker-led approach to ensuring patients are assessed and initial care plan requirements quickly put in place also a way of ensuring those patients with immediate / acuity care needs are promptly assessed. RAT Standard Operating Procedure (SOP)in place.		Lesley Chandler	IT maintain a record of daily performance RAT SOP in draft, peer reviewed and agreed, awaiting noting at Trust Policy Group	31/07/2018
Monitoring of compliance with escalation triggers through floor walkers and Patient Journey Trackers	Non elective pathway, steering group and board. Reporting to Senior Management Team. Medical Healthcare Board and ED PSQ meetings	Lesley Chandler		31/07/2018
RCA reports to be completed to review any failures in the patient journey and identify the learning		Lesley Chandler		31/07/2018
Reopening of Clinical Decisions Unit on the 8th December 2017 has allowed for movement of patients awaiting diagnostics results from the ED thus creating capacity within the department		Lesley Chandler	Patients referred to specialty can be delayed due to delays in clinicians attending ED within the agreed Internal Professional Standards	31/07/2018

Safety Round SOP in place	Non elective pathway, steering group and board. Reporting to Senior Management Team. Medical Healthcare Board and ED PSQ meetings	Lesley Chandler	Safety round protocols constantly under review, therefore reducing the risk of staff not understanding the need for change and adopting safety round processes in line with changes - ongoing education with staff	31/07/2018
The Trusts transforming our care programme has seen an improvement in discharges across all wards. This has in turn supported patient flow which allows for patients with decisions to admit to be transferred to the wards		Lesley Chandler		31/07/2018
There is a revised escalation policy with clear triggers for escalation and actions to be taken which is supported by a review of daily operational functions within the Trust	Daily review meetings held	Lesley Chandler		22/07/2018
There is an ED remedial action plan in place which supports the non elective pathway		Lesley Chandler		31/07/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Daily monitoring and reporting of ED 4 hour performance by Information team and shared with the Health Group and Executive Team		Action Fully Implemented	Lesley Chandler	22/07/2018

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**ED006**	**Ensure timely communication of patient ED discharge summaries with GP's and/or other relevant health care partners**	There is a consistent delay in completion of discharge summaries from Emergency department . This results in: *Untimely information being given to GPs about the on-going care of their patients and could result in delays in follow up actions. *Inaccurate data about the numbers of patients using or being discharged from the service *Financial and reputational risk/implications.	Compliance with completion of discharge summaries: Mar 18 60.96% Apr 18 67.24%	3	5	15	15	04	Lesley Chandler	Curtis Emordi	01/03/2014		30/09/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
3 Full time coders now employed to support real time discharges of patients in ED. Any concerns relating to discharge information can be challenged at the time.		Lesley Chandler		30/09/2018
Daily activity review and challenge to clinicans		Lesley Chandler		30/09/2018

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Datix incident to be completed to highlight which doctors are not completing the discharge summaries and highlight to the Lead for ED	Review of Datix to highlight any concerns	Lesley Chandler		30/09/2018
ED coders assist with identification of missing/incorrect discharge summaries. These are then shared with the relevant service lead for action. Daily activity review to ensure the use of correct ED discharge summary template	Incident reports ED PS&Q meetings	Lesley Chandler	Not all staff responsible for completion of discharge summaries are based in ED and it can therefore pose a risk to getting these amended in a timely manner.	30/09/2018
EPR changes to simplfy the process. Setting expectation for good practice for the team. Currently reviewing the need for discharge summaries for patients admitted via Emergency Department	Audit and performance review.	Lesley Chandler		31/07/2018
EPR lead based in ED to support doctors and monitor process.		Lesley Chandler		31/07/2018
Action in Progress	**Action Commentary**	**Action Rating**	**PS&Q Lead**	**Review Date**
May 2016 A shortened ED discharge letter template has been developed. Awaiting go live date from Cosmic.		Progress Being Made But Overdue On Completion Date	Lesley Chandler	30/09/2018

Dermatology

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**Derm003**	**Patients to be followed up in clinic**	No capacity to accommodate approx.3000 follow up patients . Insufficient capacity for the amount of patients on the review list to be seen in clinics. Number of follow ups is constantly increasing with some patients on high risk drugs.	21/06/2018 - Review list: 01.04.2017 – 31.05.2018: 2204 patients. HRD: 70 patients No capacity for patients to be seen again in clinic within 6 weeks: 400 patients. Trajectory to clear backlog to be established at meeting on 28/06/2018.	4	3	12	15	06	Lauren Springham	Karyn Bann	13/04/2018		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Booker and Assistant Service Manager review the review list weekly to see Drs outcome. If the Drs have marked the patients as on a High Risk Drug (HRD) then these patients will be prioritised.	Weekly monitoring by ASM and Booker. Exception reports at Medical Healthcare Group Board. Monitored at Access Board.	Lauren Springham		31/07/2018
Importance of marking patients HRD is raised continuously at Clinical Service Group meetings. If any patient is found to be as HRD in the patients letter but not on cosmic, ASM amends the record.	Weekly monitoring by Service Team. Clinical Service Group meetings.	Lauren Springham		31/07/2018
Patients who report increase In symptoms are prioritized and given a clinic slot. Clinic is either overbooked or other slots are amended.	Incident reports. PALS and Complaints.	Lauren Springham		31/07/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Additional all day clinics booked for the end of April which will accommodate 48 patients.		Action Fully Implemented	Lauren Springham	31/05/2018
Business case to be developed for additional Clinical Nurse Specialists and Consultants	Meeting scheduled for 22/05/2018 - cancelled and rescheduled to 28/06/2018.	Action On Track	Lauren Springham	30/06/2018
Clinical review by Dr of approx. 10 patients twice a week, outside of clinics.		Action On Track	Lauren Springham	31/07/2018

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Endoscopy

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**Endo002**	**To ensure continuity of service and patient safety with the provision of appropriately supported equipment within the endoscopy department.**	Endoscopy decontamination washer breakdown. Cancellation of patients due to no clean endoscopes. Not meeting cancer waiting times, poor patient experience and reputation of the trust. This would affect our maintaining JAG accreditation	Contract for breakdowns of the machines under Gold standard is 10 a year - so far in the last year we have had 80 call outs May 2018 - 10 x Call Outs Incidents reported Machines are guaranteed for 21,000 cycles machine 139 is at 20321 and machine 115 is at 21071	5	5	25	20	06	Claire McClements	Claire Viney	01/10/2017		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Early escalation to Gastro Matron, Service Team, EBME and the company	Datixs Permit to work forms	Claire McClements		31/07/2018
Mitigation of this risk is to use colposcopy decontamination area, We are using Colposcopy3/4 times on a weekly basis		Claire McClements		31/07/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
An agreement to be put into place with the Rivers hospital Sawbridgeworth that they will help with decontamination when the Trusts washers are down		No Progress Made	Claire McClements	19/08/2018
Business Case for a new washers and a rebuild for a decontamination unit to meet JAG guidance		Progress Being Made But Overdue On Completion Date	Claire McClements	31/07/2018
It the decontamination washers came to their end of life, to request a Mobile decontamination unit to be delivered and used on trust site. The cost per week £6,600		Progress Being Made But Overdue On Completion Date	Claire McClements	19/08/2018
To review the cost of courier and the level of insurance cover to transport to Rivers Hospital Sawbridgeworth in the event of the Washers going down.	The Trust courier has only cover for £5,000, The scopes are valued at higher cost.	Action Fully Implemented	Claire McClements	

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date

Quality	**Endo - 04**	**Ensure all patients receive safe, quality care within a safely staffed clinical environment.**	There are currently high numbers of Endoscopy nursing staff vacancies within the unit: The potential impact is that: -Patients may not receive consistent standards of care. -Decrease in staff morale and increase level of sickness. -Reduced ability to comply with the requirements of clinical effectiveness, assurance and safety standards.	13/04/18 Vacancy Factor Band 5 - 8 WTE - 2 WTE starting in May 2018. 18/06/18 Vacancy Factor Band 8 x 1 Band 5 x 9 Band 3 x 1 Band 2 x 0.71 1 x Band 6 starting July 2018 1 x Band 5 starting July 2018 1 x band 5 starting September 2018 2 x Skype Interviews planned for 20th June 2018 for Band 5's	4	5	20	16	08	Claire McClements	Claire Viney	01/07/2017		31/07/2018

Risk Mitigation/Controls	**Source of Assurance on Control Effectiveness eg. How would you know your control is working?**	**PS&Q Lead**	**Gaps in Control**	**Review Date**
MHCG working closely with HR to review recruitment and retention processes.	Monthly HR reports. Staffing reports.	Claire McClements		31/07/2018
Monitoring of all incidents reported daily with the Patient Safety and Quality team and the Matrons. Incidents escalated where appropriate	Near Miss, Moderate and Severe Incidents discussed daily at the Incident Oversight meeting	Claire McClements		31/07/2018
Regular agency staff workers now complete an induction pack and competencies similar to permanent staff.	Monthly HR reports staffing reports.	Claire McClements		31/07/2018
Use of NHSP and agency staff to ensure safety in the unit. Line of agency booked. Regular only Endoscopy trained NHSP trained	Audit compliance. Workforce report. Exception report. Datix.	Claire McClements		31/07/2018
Weekly and daily review of staffing by Nurse in Charge/ Gastro Matron to ensure area is appropriately staffed to ensure patient safety.		Claire McClements		31/07/2018

Action in Progress	**Action Commentary**	**Action Rating**	**PS&Q Lead**	**Review Date**
Rolling recruitment programme. Alternate monthly schedule of recruitment open days throughout 2018 aimed at nursing staff. Skype Interviews Gastro Open day Endoscopy Open evening booked for July 2018	This is an ongoing action for the trust.	Action On Track	Claire McClements	31/07/2018

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Gibberd Ward

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**Gibberd01**	**Ensure all patients receive safe, quality care within a safely staffed clinical environment**	There are currently high numbers of Band 5 vacancies across MHCG. The potential impact is that: -Patients may not receive consistent standards of care. -Decrease in staff morale and increase level of sickness. -Reduced ability to comply with the requirements of clinical effectiveness, assurance and safety standards	Vacancy Factor Band 5 - March 2018 =16 WTE April 2018 = 15.76 WTE May 2018 = 15.76 WTE 89% Vacancy WTE should be 17.76 New starters 1 x 0.8 Supernumerary started 1 x 0.33 start date 23rd June 2018 2 x WTE awaiting start date 3 x Incident reported for staffing	4	5	20	20	08	Claire McClements	Michelle Ashman	20/07/2014		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
3 x daily review of staffing by Matrons to ensure each area is appropriately staffed to ensure patient safety. Daily use of "Safe Care"	3 x daily meetings	Lesley Chandler		31/07/2018
Block bookings of NHSP and agency staff to ensure safety on the ward.	Audit compliance. Workforce report. Exception report. DATIX.	Claire McClements		31/07/2018
MHCG working closely with HR to review recruitment and retention processes.	Monthly HR reports. Staffing reports.	Lesley Chandler		31/07/2018
Monitoring of all incidents reported daily with the Patient Safety and Quality team and the Matrons. Incidents escalated where appropriate	Near Miss, Moderate and Severe Incidents discussed daily at the Incident Oversight meeting	Lesley Chandler		31/07/2018
Regular agency staff workers now complete an induction pack and competencies similar to permanent staff	monthly HR reports staffing reports	Lesley Chandler		31/07/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Cohort of pre-reg nurses working towards OSCE		Action On Track	Lesley Chandler	31/07/2018
Rolling recruitment programme. Alternate monthly schedule of recruitment open days throughout 2018 aimed at nursing staff Next recruitment day is 30th June 2018	This is an ongoing action for the trust.	Action On Track	Claire McClements	31/07/2018

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Harold Ward

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**Harold02**	**Ensure all patients receive safe, quality care within a safely staffed clinical environment**	There are currently high numbers of Band 5 vacancies across MHCG. The potential impact is that: -Patients may not receive consistent standards of care. -Decrease in staff morale and increase level of sickness. -Reduced ability to comply with the requirements of clinical effectiveness, assurance and safety standards	Band 5 vacancy factor March 2018 = 9 WTE April 2018 = 10.24 WTE April 2018 6 x Staffing incidents reported	4	5	20	20	08	Lauren Springham	Helen Webber	20/07/2014		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
3 x daily review of staffing by Matrons to ensure each area is appropriately staffed to ensure patient safety. Daily use of "Safe Care"	3 x daily meetings	Lauren Springham		31/07/2018
MHCG working closely with HR to review recruitment and retention processes.	Monthly HR reports. Staffing reports.	Lesley Chandler		31/07/2018
Monitoring of all incidents reported daily with the Patient Safety and Quality team and the Matrons. Incidents escalated where appropriate.	Near Miss, Moderate and Severe Incidents discussed daily at the Incident Oversight meeting	Lauren Springham		31/07/2018
Regular agency staff workers now complete an induction pack and competencies similar to permanent staff	monthly HR reports staffing reports	Lauren Springham		31/07/2018
Use of NHSP and agency staff to ensure safety on the ward.	Audit compliance. Workforce report. Exception report. Datix.	Lauren Springham		31/07/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Cohort of pre-reg nurses working towards OSCE		Action On Track	Lauren Springham	31/07/2018
Rolling recruitment programme, alternate monthly schedule of recruitment open days throughout 2018 aimed at nursing satff	This is an ongoing action for the trust.	Action On Track	Lauren Springham	31/07/2018

Harvey Ward

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**HARV01**	**Ensure all patients receive safe, quality care within a safely staffed clinical environment**	There are currently high numbers of Band 5 vacancies across MHCG. The potential impact is that: -Patients may not receive consistent standards of care. -Decrease in staff morale and increase level of sickness. -Reduced ability to comply with the requirements of clinical effectiveness, assurance and safety standards	April 2018 Vacancy Factor Band 5 - 11.1 WTE May 2018 Vacancy Factor Band 5 - 11.11 WTE Staffing Incidents 1 reported for May 2018	4	5	20	16	06	Claire McClements	Jill Holden	01/07/2014		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
3 x daily review of staffing by Matrons to ensure each area is appropriately staffed to ensure patient safety. Daily use of "Safe Care"	3x Daily meetings	Lesley Chandler		31/07/2018
MHCG working closely with HR to review recruitment and retention processes.	Monthly HR reports. Staffing reports.	Lesley Chandler		31/07/2018
Monitoring of all incidents reported daily with the Patient Safety and Quality team and the Matrons. Incidents escalated where appropriate	Near Miss, Moderate and Severe Incidents discussed daily at the Incident Oversight meeting	Lesley Chandler		31/07/2018
Regular agency staff workers now complete an induction pack and competencies similar to permanent staff	monthly HR reports staffing reports	Lesley Chandler		31/07/2018
Use of NHSP and agency staff to ensure safety on the ward.	Audit compliance. Workforce report. Exception report. DATIX.	Lauren Springham	Capped on NHSP and Agency. Ward often has high acuity patients. Non arrival of bank and agency staff.	13/12/2017

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Cohort of pre-reg nurses working towards OSCE		Action On Track	Lesley Chandler	31/07/2018
Rolling recruitment programme. Alternate monthly schedule of recruitment open days throughout 2018 aimed at nursing staff	This is an ongoing action for the trust.	Action On Track	Claire McClements	31/07/2018

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date

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Quality	**HARV04**	**Ensure all patients admitted to the acute medical wards are assessed and care plans put in place to minimize the risk of falls.**	Patients in hospital are at particular risk of falling and injuring themselves because of intercurrent illness, general frailty, confusion and the effects of the hospital environment.	No Falls resulting in Moderate harm, Severe harm, or death, were reported in the last between Oct 2017 and April 2018. Total of 6 Falls reported in May 2018, 2 of which were Moderate harms awaiting ECSP.	4	3	12	09	06	Claire McClements	Jill Holden	01/01/2013		31/07/2018

Risk Mitigation/Controls	**Source of Assurance on Control Effectiveness eg. How would you know your control is working?**	**PS&Q Lead**	**Gaps in Control**	**Review Date**
All staff are trained on new Morse Tool to efficiently calculate risk of falls, and instigate appropriate mitigations to minimise avoidable falls.	Evidence of reduction of the severity of falls and that any fall occurring is unavoidable. This will be monitored through incident report and Essential Care Scrutiny panels, which are highlighted through to Trust PS&QC.	Jill Holden		31/01/2018
Processes are described within the falls policy as a control.	Evidence of reduction of the severity of falls and that any fall occurring is unavoidable. This will be monitored through incident report and Essential Care Scrutiny panels, which are highlighted through to Trust PS&QC.	Jill Holden		31/01/2018

Action in Progress	**Action Commentary**	**Action Rating**	**PS&Q Lead**	**Review Date**
High risk fallers are identified and assessed for low rise bed, bed rails, confusion and other co-morbidities.	Patients meeting the criteria are nursed in an observable bed. Encourage carers and relatives to sit with the patients Night light left on Falls risk assessments completed on admission and escalated to specialist falls nurse if required. Medication review. Blood pressure assessment. Line and standing BP	Action On Track	Lauren Springham	14/05/2018

John Snow Ward

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**JS 02**	**Ensure all patients receive safe, quality care within a safely staffed clinical environment**	There are currently high numbers of Band 5 vacancies across MHCG. The potential impact is that: -Patients may not receive consistent standards of care. -Decrease in staff morale and increase level of sickness. -Reduced ability to comply with the requirements of clinical effectiveness, assurance and safety standards	Vacancy Factor Band 5 March 2018 - 9 WTE April 2018 - 9.77 WTE April 2018 = 0 Staffing incidents reported	4	5	20	20	08	Lauren Springham	Peter Robinson	01/07/2014		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
3 x daily review of staffing by Matrons to ensure each area is appropriately staffed to ensure patient safety. Daily use of "Safe Care"	3 x daily meetings	Lauren Springham		31/07/2018
MHCG working closely with HR to review recruitment and retention processes.	Monthly HR reports. Staffing reports.	Lauren Springham		31/07/2018
Monitoring of all incidents reported daily with the Patient Safety and Quality team and the Matrons. Incidents escalated where appropriate.	Near Miss, Moderate and Severe Incidents discussed daily at the Incident Oversight meeting.	Lauren Springham		31/07/2018
Regular agency staff workers now complete an induction pack and competencies similar to permanent staff	monthly HR reports staffing reports	Lauren Springham		31/07/2018
Use of NHSP and agency staff to ensure safety on the ward.	Audit compliance. Workforce report. Exception report. Datix.	Lauren Springham		31/07/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Cohort of pre-reg nurses working towards OSCE		Action On Track	Lauren Springham	31/07/2018
Rolling recruitment programme. Alternate monthly schedule of recruitment open days throughout 2018 aimed at nursing staff	This is an ongoing action for the trust.	Action On Track	Lauren Springham	31/07/2018

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Lister Ward

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**List 02**	**Ensure all patients receive safe, quality care within a safely staffed clinical environment**	There are currently high numbers of Band 5 vacancies across MHCG. The potential impact is that: -Patients may not receive consistent standards of care. -Decrease in staff morale and increase level of sickness. -Reduced ability to comply with the requirements of clinical effectiveness, assurance and safety standards	Vacancy Factor Band 5 March 2018 - 12 WTE April 2018 - 11.31 WTE May 2018 - 11.31 WTE should be 18.31 WTE 67.42% Vacancy May 2018 1 x Incident reported for staffing	4	5	20	16	06	Claire McClements	June Barnard	20/07/2014		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
3 x daily review of staffing by Matrons to ensure each area is appropriately staffed to ensure patient safety. Daily use of "Safe Care"	3 x daily meetings	Claire McClements		31/07/2018
MHCG working closely with HR to review recruitment and retention processes.	Monthly HR reports. Staffing reports.	Claire McClements		31/07/2018
Monitoring of all incidents reported daily with the Patient Safety and Quality team and the Matrons. Incidents escalated where appropriate	Near Miss, Moderate and Severe Incidents discussed daily at the Incident Oversight meeting	Claire McClements		31/07/2018
Regular agency staff workers now complete an induction pack and competencies similar to permanent staff	monthly HR reports staffing reports	Claire McClements		31/07/2018
Use of NHSP and agency staff to ensure safety on the ward.	Audit compliance. Workforce report. Exception report. DATIX.	Claire McClements		31/07/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Cohort of pre-reg nurses working towards OSCE	This is an ongoing action for the trust	Action On Track	Claire McClements	31/07/2018
Rolling recruitment programme. Alternate monthly schedule of recruitment open days throughout 2018 aimed at nursing staff.	This is an ongoing action for the trust.	Action On Track	Claire McClements	31/07/2018

Medical Assessment Unit - Fleming

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**MAU FLEM-03**	**Ensure all patients receive safe, quality care within a safely staffed clinical environment**	There are currently high numbers of Band 5 vacancies across MHCG. The potential impact is that: -Patients may not receive consistent standards of care. -Decrease in staff morale and increase level of sickness. -Reduced ability to comply with the requirements of clinical effectiveness, assurance and safety standards	Reviewed 13/04/18 Vacancy Factor Band 5 - 22 WTE No staffing incidents reported for April 2018	4	5	20	20	08	Lauren Springham	Louise Barnes	01/07/2014		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
3 x daily review of staffing by Matrons to ensure each area is appropriately staffed to ensure patient safety. Daily use of "Safe Care"	3 x daily meetings	Lauren Springham		31/07/2018
MHCG working closely with HR to review recruitment and retention processes.	Monthly HR reports. Staffing reports.	Lauren Springham		31/07/2018
Monitoring of all incidents reported daily with the Patient Safety and Quality team and the Matrons. Incidents escalated where appropriate	Near Miss, Moderate and Severe Incidents discussed daily at the Incident Oversight meeting	Lauren Springham		31/07/2018
Use of NHSP and agency staff to ensure safety on the ward.	Audit compliance. Workforce report. Exception report. Datix.	Lauren Springham		31/07/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Cohort of pre-reg nurses working towards OSCE		Action On Track	Lauren Springham	31/07/2018
Rolling recruitment programme. Alternate monthly schedule of recruitment open days throughout 2018 aimed at nursing staff.	This is an ongoing action for the trust.	Action On Track	Lauren Springham	31/07/2018

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Medical Short Stay Saunders

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**Saun 04**	**Ensure all patients receive safe, quality care within a safely staffed clinical environment**	There are currently high numbers of Band 5 vacancies across MHCG. The potential impact is that: -Patients may not receive consistent standards of care. -Decrease in staff morale and increase level of sickness. -Reduced ability to comply with the requirements of clinical effectiveness, assurance and safety standards	April 2018 = 7 staffing incidents reported	4	5	20	20	08	Lauren Springham	Johncy John	01/07/2014		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
3 x daily review of staffing by Matrons to ensure each area is appropriately staffed to ensure patient safety. Daily use of "Safe Care"	3 x daily meetings	Lauren Springham		31/07/2018
MHCG working closely with HR to review recruitment and retention processes.	Monthly HR reports. Staffing reports.	Lauren Springham		31/07/2018
Monitoring of all incidents reported daily with the Patient Safety and Quality team and the Matrons. Incidents escalated where appropriate	Near Miss, Moderate and Severe Incidents discussed daily at the Incident Oversight meeting.	Lauren Springham		31/07/2018
Regular agency staff workers now complete an induction pack and competencies similar to permanent staff.	monthly HR reports staffing reports.	Lauren Springham		31/07/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Cohort of pre-reg nurses working towards OSCE		Action On Track	Lauren Springham	31/07/2018
Rolling recruitment programme. Alternate monthly schedule of recruitment open days throughout 2018 aimed at nursing staff.	This is an ongoing action for the trust	Action On Track	Lauren Springham	31/07/2018

Medicine - Operational

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Workforce and Organisational Development	**MED04**	**Ensure all patients receive safe, quality care within a safely staffed clinical environment.**	There are currently high numbers of Band 5 vacancies across MHCG. Patients may not receive consistent standards of care. Staff morale may be decreased with increased levels of sickness. Reduced ability to comply with the requirements of clinical effectiveness and assurance and safety standards.	18/04/2018 - 130 WTE vacancies	4	5	20	20	08	June Barnard	June Barnard	23/07/2014		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
3 x daily review of staffing by Matrons to ensure each area is appropriately staffed to ensure patient safety.	3 x daily meetings	June Barnard		31/07/2018
Associate Director of Nursing for MHCG facilitating career clinics. Head facilitating itchy feet		June Barnard		31/07/2018
MHCG working closely with HR to review recruitment and retention processes.	Monthly HR reports. Staffing reports.	June Barnard		31/07/2018
Provision of staff development through secondment/work experience in other clinical areas	Appraisals and 1:1 meetings	June Barnard		31/07/2018
Weekly meetings with recruitment to understand progress of international recruits and ensuring contact is maintained so that staff do not loose interest in joining the Trust.	Weekly meetings	June Barnard		31/07/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Anglia Ruskin University Open Days		Action On Track	June Barnard	31/07/2018
Recruitment open days. Rolling recruitment programme. Alternate monthly schedule of recruitment open days throughout 2018 aimed at nursing staff.		Action On Track	June Barnard	31/07/2018
Relaunch exit interview process and analyse data to inform initiatives		Action On Track	June Barnard	31/07/2018
Rolling adverts on NHS jobs.	Application and interviews monitored and arranged by HR	Action On Track	June Barnard	31/07/2018
Utilising social media when advertising posts and to engage current and potential workforce.	Communications monitor social media activity levels. Senior staff members on social media.	Action On Track	June Barnard	31/07/2018

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Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**MED57**	**To ensure the Trust is able deliver the national Emergency Department (ED) 4 hour standard whilst ensuring safe, quality care is provided to patients within the department.**	The trust has not been able to deliver performance against the 4 hour standard for a significant period of time. This is a potential risk to : -Patient safety -Patient flow -Crowding This has a significant impact on our ability to : -Complete ambulance offload and handover in a timely manner -Meet KPI's which in turn may incur Financial penalties	22.05.18 Month to date April - 73.77% Year to date performance 73.99%	4	5	20	20	04	June Barnard	Curtis Emordi	01/07/2016		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Ambulance Escalation and Offload SOP in place		June Barnard		30/06/2018
Daily monitoring and reporting of ED 4 hour performance by Information team and shared with the Health Group and the Executive team.	Monitoring of 4 hour performance figures	Lesley Chandler		31/07/2018
ED manager of the day	Non elective pathway, steering group and board. Reporting to Senior Management Team, Medical Healthcare Board, Emergency Department PSQ meeting.	Lesley Chandler		31/07/2018
ED trialed the Rapid Assessment and Treatment (RAT) process is now fully implemented. RAT is model is a structured approach to the way that patients are received and assessed within the Emergency Department. It is a senior decision maker-led approach to ensuring patients are assessed and initial care plan requirements quickly put in place also a way of ensuring those patients with immediate / acuity care needs are promptly assessed. RAT Standard Operating Procedure (SOP)in place.	IT maintain a record of daily performance. Datix reports.	Lesley Chandler	RAT SOP currently in draft - peer reviewed and agreed however requires noting at Trust Policy Group.	19/06/2018
Monitor compliance with Escalation triggers through ED Floor Walkers and Patient Journey Tracker.	Non elective pathway, steering group and board. Reporting to Senior Management Team, Medical Healthcare board, ED Patient Safety & Quality meeting.	Lesley Chandler		19/06/2018
Reopening of Clinical Decisions Unit on 8th December 2017 has allowed for the movement of patients who are awaiting diagnostic results to be moved from the ED thus creating capacity within the department		June Barnard	Patients referred to specialty can be delayed due to delays in clinicians attending ED within the agreed internal professional guidance.	30/06/2018
Root Cause Analysis reports are completed to review any failures in the patient journey and identify the learning		June Barnard		30/06/2018

Safety round Standard Operating Procedure in place.	Non elective pathway, steering group and board. Reporting to Senior Management Team, Medical Healthcare board, ED Patient Safety & Quality meeting	Lesley Chandler	Safety round protocols constantly under review, therefore having the risk of staff not understanding the need for change and adapting safety round processed in line with changes - ongoing education with staff.	30/06/2018
The Trust transforming our care programme has seen an improvement in discharges across all wards. This has in turn supported patient flow which allows for patients with decisions to admit to get to the wards.		June Barnard		30/06/2018
There is a revised escalation policy with clear triggers for escalation and actions to be taken which is supported by a review of daily operational functions within the Trust	Daily review meetings are held	June Barnard		30/06/2018
There is an ED remedial action plan in place which supports the non elective pathway		June Barnard		30/06/2018
Trust Escalation processes in place to identify Trust-wide and external stakeholder support i.e. Ambulance Trust and Community Services.	Non elective pathway, steering group and board. Reporting to Senior Management Team, Medical Healthcare Board, ED Patient Safety & Quality meeting	Lesley Chandler		30/06/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Finance	**MED61**	**To maintain Financial balance within the Healthcare Group.**	Significant risks re: Meeting the income target, including making up the Income deficit (over £700k) from month 1. Identifying Expenditure CIP (particularly Pay) for which the target increases each month. At the very least, maintaining the relatively low level of Agency Costs.	21/06/2018 - £1.4m behind plan by the end of month 2, although there is an encouraging improvement in month 2 which was only £372k behind plan. Also there are budgets yet to be issued which would reduce the month 2 variance to £185k, and the year to date variance to £1.05m. (narrative provided by Finance - requires triumvirate review and approval)	4	4	16	16	09	June Barnard		20/12/2017		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date

Activity is being monitored closely.	MAU activity in particular is expected to increase through the early part of the year. CDU activity is also expected to be able to be increased with more consistent staffing.	Lesley Chandler		31/07/2018
Non pay expenditure at senior sign off only		June Barnard		30/06/2018
Project plan for recruitment of substantive staff		June Barnard		30/06/2018
Regular reviews and challenges of financial expenditures	Weekly challenge review for medical plans and spends Monthly performance review with Executive Directors and CEO Monthly Health Group Board Monthly finance SLAM report Monthly financial expenditure statements Monthly year end forecast	June Barnard		30/06/2018
Restriction to use of agency staff.		June Barnard		30/06/2018
Review of all pay related payments i.e. SPA, on call rates, travel etc.		June Barnard		30/06/2018
Review of cost improvement plans and budgets (CIPs)		June Barnard		30/06/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Budget-holders will be asked to identify CIP savings from within their own budgets.	Specialties will be held accountable for delivering their fair share of the CIP, based on the aggregation of individual cost centres targets. This is being done through the Model Hospital meetings and discussions.	Action On Track	Lesley Chandler	31/07/2018
There are plans in place to recruit into the roles Agency Paramedics are fulfilling currently which will contribute reductions in agency costs.		Action On Track	Lesley Chandler	31/07/2018
Tighter controls on medical agency usage	On-going. Agency approved by Chief Medical Officer.	Action On Track	June Barnard	30/06/2018
Tighter controls on non-pay		Action On Track	June Barnard	30/06/2018

Patient at Home

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Projects and Business Continuity	**P@H 3**	**Full establishment of Staff Recruitment to maintain safety and viability of the service provision. This includes both Medical and Nursing recruitment**	Inability to maintain set trajectory safely and at high risk of service closure. Income related Financial loss to Trust. Nursing ratios at risk. In light of recent leavers and maternity leave we will have a total of 9.00 WTE nursing staff on a 7 day rota, therefore we would only be able to achieve an average of 35 discharges a month, that's 64 discharges less of our target of 98 a month. With 9.00 WTE nursing staff the service would also need to review the current medical locum doctor cover because the nursing ratios wouldn't support the need for our current 4 locum doctors.	Currently we have recruited new Locum doctors until we recruit to substantive staff We have 2 locum SHO Monday - Friday, one GP working 3 days a week and 1 Consultant working weekends. Our advert for Consultant recruitment will be extended to the BMJ Our Clinical Lead Dr Tal Heymann has had to take emergency sick leave and which will take her contract to the end date - 31st July 2018. The post for substantive Consultant is out of advert and in the interim we will try and recruit to a fixed term consultant post. We currently have 9.00 WTE nursing posts against a plan of 19.31 WTE. Band 7 nurse recruited and starts on 09/07/18. We would like support to use some of our budget for fixed term agency staff to bridge the vacant posts whilst we try and recruit.	4	4	16	20	02	Hiral Patel	Hiral Patel	10/08/2017		29/08/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date

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Recruitment Plan to detail interim workforce solution by use of locum and agency staff	We recruit to fixed term appointment to allow enough time for business continuity whilst substantive staff commence employment. Check KPIs to see activity increase	Hiral Patel		29/08/2018
Action in Progress	**Action Commentary**	**Action Rating**	**PS&Q Lead**	**Review Date**
Clinical Service Manager on long term sick Recruitment of Band 6 and 7. New vacancy request uploaded on TRAC has been achieved. Advert on NHS jobs until 16/05/17	Once advert closes for Band 6 and 7 16/05/18. Shortlisting thereafter and recruit to vacant posts	Progress Being Made But Overdue On Completion Date	Tal Heymann	29/06/2018
Recruitment of locum / agency staff to bridge the gap until substantive recruitment is complete	Medical Staffing Team have assisted to book suitable agency doctors. Currently we have enough locum medical staff and we will continue to maintain this staff until we achieve substantive recruitment.	Progress Being Made But Overdue On Completion Date	Tal Heymann	17/05/2018
Substantive job descriptions agreed by Royal College for Acute Consultant post SHO posts out to advert on NHS jobs. Progression on recruiting medical posts currently on hold until the service gains clarity on supportive substantive nursing posts and direction of the service.	Team supported by Clinical lead. Locum medical support remains. Acute General Clinician JD and person spec agreed with Royal College. SHO job advert on NHS jobs. Current workforce 2 full time SHO Bank 1 part time GP Bank Leadership - Clinical lead The service needs recruitment plan clarity regarding nursing vacancies, until this is clarified the substantive medical recruitment will be on hold and the service will continue to reduce its ability to increase activity numbers.	No Progress Made	Tal Heymann	22/05/2018

Ray Ward

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**RAY01**	**Ensure all patients receive safe, quality care within a safely staffed clinical environment**	There are currently high numbers of Band 5 vacancies across MHCG. The potential impact is that: -Patients may not receive consistent standards of care. -Decrease in staff morale and increase level of sickness. -Reduced ability to comply with the requirements of clinical effectiveness, assurance and safety standards	Vacancy Factor Band 5 - March 2018 = 12 WTE April 2018 = 9.97 WTE April 2018 7 x staffing incidents reported	4	5	20	20	08	Lauren Springham	Jiji Phillip	01/07/2014		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
3 x daily review of staffing by Matrons to ensure each area is appropriately staffed to ensure patient safety. Daily use of "Safe Care"	3 x daily meetings	Lauren Springham		31/07/2018
MHCG working closely with HR to review recruitment and retention processes.	Monthly HR reports. Staffing reports.	Lauren Springham		31/07/2018
Monitoring of all incidents reported daily with the Patient Safety and Quality team and the Matrons. Incidents escalated where appropriate.	Near Miss, Moderate and Severe Incidents discussed daily at the Incident Oversight meeting.	Lauren Springham		31/07/2018
Regular agency staff workers now complete an induction pack and competencies similar to permanent staff.	monthly HR reports staffing reports.	Lauren Springham		31/07/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Cohort of pre-reg nurses working towards OSCE		Action On Track	Lauren Springham	31/07/2018
Rolling recruitment programme. Alternate monthly schedule of recruitment open days throughout 2018 aimed at nursing staff.	This is an ongoing action for the trust	Action On Track	Lauren Springham	31/07/2018

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Respiratory

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	Resp002	Requirement for a new Lung Function Machine.	Lung function machine life span is 7 - 10 years. PAHT machine is 15-18 years old with no maintenance or service contract. Windows XP therefore not virus protected or supported by Microsoft.		4	4	16	16	04	Claire McClements	Karyn Bann	21/06/2018		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Escalation to Assistant Service Manager and company for call outs.		Lauren Springham		31/07/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Capital bid has been made for a new Machine this year.		Action On Track	Claire McClements	31/07/2018

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	Resp003	Clear backlog of patients awaiting Lung Function Testing.	There is a backlog of patients waiting for Lung Function testing. This backlog goes back to late 2017.		4	4	16	16	04	Claire McClements	Karyn Bann	21/06/2018		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Lung function technician is working extra Saturday clinics in an effort to reduce the backlog. Assistant Service Manager picking up lung function technicians admin work load.		Claire McClements		31/07/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Benchmark costing's of out sourcing.	To be initiated	Action On Track	Claire McClements	31/07/2018

Surgery & Critical Care

All Surgery

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Workforce and Organisational Development	**S&CC001 /2016**	**For all wards to run with full staffing numbers and correct skill mix to enable a safe and continuous service.**	Staffing &Skill Mix - There is a risk of poor quality care & patient experience due to the insufficient number of staff and a high number of juniors on wards & departments. This is due to current vacancies, maternity & unplanned leave. On a daily basis staff are required to move wards, which disrupts continuity of care and reduces staff morale. It also affects the ability of staff teams to complete clinical assessments, clinical audits, training & appraisals within required timeframes. This risks more staff leaving the trust to find alternative employment, further increasing the healthcare groups vacancy levels. Linked to risk SACC01	Risk Ref changed 27/09/17 (Previously SACC 124) Vacancy April 2018: Add Prof Scientific and Technic 20.73% Additional Clinical Services 18.85% Administrative and Clerical 8.27% Allied Health Professionals 8.49% Estates and Ancillary 7.06% Healthcare Scientists 21.05% Medical and Dental 8.03% Nursing and Midwifery Registered 22.13% Surgery Total 15.47%	4	5	20	15	06	Pam Humphrey	Sarah Lincoln	01/09/2016		31/08/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
All shifts are escalated to NHSP at the time the rota is completed.		Sarah Lincoln		
Band 7's are cancelling management days to cover band 5 roles and patient care.		Sarah Lincoln		
Each health group is renewing recruitment strategies to fill posts.		Sarah Lincoln		
HCSW development opportunities - Recognising talent and potential from band 1 to 5 Optimise pathway for career progression through "Bright Futures", Foundation degree pathways, Nursing Associate leadership and management development - Provide a range of leadership and management development specifically focused ot the needs of staff at diffeerent stages of career progression. Offer role development programmes (Band 6 programme estabblished, Band 7 programme under construction, matron development programme running, senior staff nurse programme commencing in September		Sarah Lincoln		

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If shifts are not filled one week in advance these are then escalated out to agency.		Sarah Lincoln		
Preceptorship - Newly recruited registered nurses and midwives are supported in their career progression Staff wellbeing - Staff are supported to take break, looked after each other as well as our patients and for the whole team to finish on time Staff engagement - Improve the team commaraderie and inclusiveness for all staff, students agency workers and patients Transfer opportunities - Retain staff by providing seamless opportunities across the Trust Career pathway - For every nurse and midwife to have the opportunity to map out their desired career pathway Career Clinics - Provide access to senior advice: education, Improvement Leadership, Practice Itchy feet - Achieve 'happy at Harlow staff' Trust wide activities - Enhanced staff wellbeing and engagement New roles - A workforce fit for purpose to meet the needs of patients Expanding skillsets - Every member of staff feels valued for their contribution Team Building - Improving morale and productivity		Sarah Lincoln		
The Trust is looking at recruitment oversees.		Sarah Lincoln		
To ensure we can manage all areas safely the health group Matrons oversee staffing on shift by shift basis and ensure that staff are shared around the Trust as appropriate. When out of hours this is undertaken by the duty matron, senior manager on call and executive on call possible.		Sarah Lincoln		

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
08/06/16 (EH) - Further recruitment days are to take place.	This is a rolling process	Action On Track	Sarah Lincoln	
A recruitment road show is to be scheduled.	Scheduled for Saturday 17th June, each ward will have their own table to educate potential employees about their areas. Same day interviews will be held. Update - Recruitment road show cancelled due to only 4 applicants, could not justify asking staff to come in at a weekend so made alternatives plans for those that applied. January 18 Update - A recruitment roadshow has been organised for the end of February 18.	Action Fully Implemented	Sarah Lincoln	
Regular recruitment and continuous monitoring of agency/NHSP expenditure & bank and agency fill rates.		Action On Track	Sarah Lincoln	

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date

Workforce and Organisational Development	**S&CC002 /2017**	**To retain both clinical and non clinical members of staff to enable a safe, fully functioning service and increase organisational memory.**	We are unable to retain staff due to our current number of high vacancies resulting in current staff feeling as though they are under increasing pressure. Posts are frequently put out to advert but the inability to recruit, further adds to this risk.	Risk Ref changed 27/9/17 (Previously S&CC01) April 2018 Turnover Rate: Add Prof Scientific and Technic 16.83% Additional Clinical Services 9.79% Administrative and Clerical 13.35% Allied Health Professionals 29.79% Estates and Ancillary 0% Healthcare Scientists 0% Medical and Dental 9.95% Nursing and Midwifery Registered 15.65% Surgery Total 12.16%	4	5	20	15	03	Pam Humphrey	Sarah Lincoln	10/03/2017		30/06/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
HCSW development opportunities - Recognising talent and potential from band 1 to 5 Optimise pathway for career progression through "Bright Futures", Foundation degree pathways, Nursing Associate leadership and management development - Provide a range of leadership and management development specifically focused ot the needs of staff at diffeerent stages of career progression. Offer role development programmes (Band 6 programme establlished, Band 7 programme under construction, matron development programme running, senior staff nurse programme commencing in September		Sarah Lincoln		
Preceptorship - Newly recruited registered nurses and midwives are supported in their career progression Staff wellbeing - Staff are supported to take break, looked after each other as well as our patients and for the whole team to finish on time Staff engagement - Improve the team commaraderie and inclusiveness for all staff, students agency workers and patients Transfer opportunities - Retain staff by providing seamless opportunities across the Trust Career pathway - For every nurse and midwife to have the opportunity to map out their desired career pathway Career Clinics - Provide access to senior advice: education, Improvement Leadership, Practice Itchy feet - Achieve 'happy at Harlow staff' Trust wide activities - Enhanced staff wellbeing and engagement New roles - A workforce fit for purpose to meet the needs of patients Expanding skillsets - Every member of staff feels valued for their contribution Team Building - Improving morale and productivity		Sarah Lincoln		
Staff recognition and long service awards held to highlight how the trust values members of staff and recognises their efforts, to boost staff morale.		Kirstie Heys		

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Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Action Plan attached - The above controls are ongoing.		Action On Track	Sarah Lincoln	

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Finance	S&CC002/2018	**To achieve Financial balance for the year 2018-19 for income and expenditure meeting the planned contribution rate.**	Operational pressures (beds, staffing levels) may lead to the level of income not being to the planned level. Elective bed capacity may lead to elective cancellations leading to reduced income. Medical staffing gaps may impact on pay rate if agency is not controlled to within plan. Month 1 provisional budget headlines. Contribution £379 below plan. Expenditure £41K below draft budget. Income £420K below plan. (Budget £4,780K actual £4,360) variance 8.78% variance of budget	Month 1 draft budget indicates behind plan on income therefore contribution is suppressed. Month 3 financial position improved £1.5K.	5	5	25	15	12	Julie Matthews	Julie Matthews	21/05/2018		30/06/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
• Daily and weekly monitoring of income performance, agency use. • Senior sign off for purchase. • Weekly challenge meetings with Execs. • Monthly budget review with all budget holders. • Grip and control for theatre bookings and utilisation of theatres implemented.	• Increase in activity over plan as monitored via Finance order book. • Budget statements provided monthly. • Reduction in agency as monitored weekly by agency specialist.	Heather Keoghoe	• Delays in reporting of Finance which is monthly however mitigated by Senior sign off and weekly monitoring of agency and income	30/06/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Daily and weekly monitoring to continue.		Action On Track	Heather Keoghoe	

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date

Quality	**S&CC005 /2017**	**For the optimum number of staff, both clinical and non clinical to be RCA trained to reduce the risk of investigations becoming overdue and improve shared learning.**	Lack of RCA trained staff within the Surgical health group risks a lack of understanding of the RCA process which further risks investigations becoming overdue. Currently 50% of SI are over due and 100% of RED investigations. This negatively impacts on lessons learnt from investigations and Trust reputation.	Of the 46 members of staff detailed on the central RCA training log. x9 have left the trust/surgery. Only x11 members of staff would require minimal support to write an RCA, with only x1 of these being a Dr.	4	5	20	15	04	Pam Humphrey	Sarah Lincoln	29/09/2017		30/06/2018

Risk Mitigation/Controls	**Source of Assurance on Control Effectiveness eg. How would you know your control is working?**	**PS&Q Lead**	**Gaps in Control**	**Review Date**
A new trust process is being rolled out which includes a 20 day meeting with senior HG attendance and a 35 day meeting with the Exec team to ensure investigations are progressing within timeframe.	SI/RED tracker CCG feedback Inquest feedback	Pam Humphrey	Clinical engagement still remains a concern.	
There is a core of senior RCA trained nursing staff that are able to mitigate this risk.	Quality assurance dashboard, Datix, Complaints. Legal,	Pam Humphrey	Staff turnover	

Action in Progress	**Action Commentary**	**Action Rating**	**PS&Q Lead**	**Review Date**
To arrange bespoke RCA training for Drs during protected Audit day.	Trust RCA training has been reduced to one day to aid staff attendance.	Progress Being Made But Overdue On Completion Date	Pam Humphrey	
x2 Senior staff to be RCA trained per ward/clinical area. a minimum of x2 senior Drs to be RCA trained per speciality.		No Progress Made	Pam Humphrey	

Detailed Risk Register Report - Ordered by Highest Current Risk

General Surgery

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	GEN002/2018	For all virtual and telephone clinics to be 'cashed up' after outcoming To ensure all follow up activities are booked/planned For all historic virtual and telephone clinics to be retrospectively cashed up For harm reviews to be carried out for the backlog of un-cashed up clinics	Patients on the straight to test colorectal cancer pathway are booked for a endoscopy or radiology procedure without being seen in clinic. Patients are then booked onto a virtual clinic. A consultant reviews the results and makes a treatment plan which includes to discharge completely, remove from cancer pathway but request further investigations and appointment or remain on the pathway. Patients at risk are the cohort who are removed from the cwt pathway but require further appointments/investigations as there is not an agreed process for 'cashing up' these clinics after outcome. This means that the follow up activities do not happen	19/6/2018 - Yet to be approved by healthgroup	4	5	20	20	01	Kirstie Heys	Carol Allgrove	07/06/2018		20/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Action in Progress	**Action Commentary**	**Action Rating**	**PS&Q Lead**	**Review Date**
Backlog of patients not cashed up to be reviewed for harm		No Progress Made	Kirstie Heys	
SOP agreed for virtual/telephone clinics to enable clinics to be cashed up	Waiting SOP to be signed off and agreed	Progress Being Made But Overdue On Completion Date	Kirstie Heys	

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date

Quality	**GEN001/2018**	**For the General surgery radiology report inbox to be regularly monitored to ensure patient reports are reviewed and actioned as appropriate. For appropriate harm reviews to be carried out for the backlog of unread emails.**	There are currently 5000+ unread emails in the General surgery radiology reports inbox. This risks that patients have not been followed up correctly and that radiology reports have not been acted on.	26/01/18 Approved by ADON 21/05/18 Previous RMG requested current report to be linked to risk as an update however the report has been sent to the CCG and feedback has requested a re-write and change of scope. Lead investigator is meeting with CCG week of 28th May.	5	5	25	15	06	Dawn Savage	Carol Allgrove	26/01/2018		30/06/2018

Risk Mitigation/Controls	**Source of Assurance on Control Effectiveness eg. How would you know your control is working?**	**PS&Q Lead**	**Gaps in Control**	**Review Date**
Emails are now being picked up daily by the Consultant covering wards. A spot check is carried out by the Service Manger to ensure that all emails are opened. An email was sent out by the Lead Clinician to all consultants advising them of their responsibility to review this daily.	Service manager has oversight of email inbox. Weekly HG update meeting.	Dawn Savage	Admin support is needed to review the backlog of emails and harm reviews are to take place to ensure patient safety.	

Action in Progress	**Action Commentary**	**Action Rating**	**PS&Q Lead**	**Review Date**
For the backlog of 5000+ emails to have appropriate harm reviews and where harm is believed to have occurred a Datix to be completed to alert the PS&Q lead that the incident requires escalation.	We now know this to be a trust wide issue that is being investigated. A harm review plan is being devised for all inboxes that have not been monitored.	Progress Being Made But Overdue On Completion Date	Dawn Savage	

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PACU

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**PACU001/2018**	**For all patients requiring inpatient stay to be allocated an appropriate bed on a ward to eliminate the need to ward patients in PACU**	Patients remaining in Post Anaesthetic Care Unit (PACU) due to the lack of in patient beds. Impact – •Lack of capacity to accept post anaesthetic patients from theatres following surgery •Delay in sending for patients once PACU full potentially causing cancellations due to lack of theatre time/overrunning of lists •Need to book additional staff (bank/agency) to care for this patient group in the day and night •If unable to locate staff to fill the shift potentially would cause emergency provision to cease as staff rostered caring for patient in PACU •Breach of Eliminating Mixed Sex Accommodation (EMSA) guidance	23/05/18 YET TO BE APPROVED BY HG	4	5	20	20	06	Gail De Souza	Maxine Priest	22/05/2018		30/06/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
•Patients who have been identified to stay overnight in PACU are segregated using curtains and cohorted into one area of PACU •Patients are recovered in theatres when there is no capacity in PACU •Patients cancelled on the day before or on the day of surgery due to lack of capacity		Gail De Souza		

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Daily/Weekly monitoring of theatre schedules and trust bed status		Action On Track	Gail De Souza	

Pre-Assessment

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	PRE002/2017	To provide a suitable pre-assessment area to improve patient safety and experience.	The current Pre-Assessment unit is located within the Netteswell admissions unit, mixing both patients awaiting elective surgery and those being assessed for future surgery. The unit is frequently overcrowded and is unable to supply adequate workspace for Drs/Nurses to admit patients to theatre. The patient seating area does not allow for male and females to be separated and already identified 'Clean' patients are often sitting alongside patients that have not yet been swabbed. There is a risk that patients being admitted to theatre could come into contact with possible infections.	Risk Ref changed 28/09/17 (Previously PRE02)	3	5	15	15	03	Karen Whitworth	Julie Matthews	16/06/2017		30/06/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
All elective orthopaedic patients that have been swabbed are now admitted straight to OSU reducing patient numbers within the unit and reducing the risk of further infection.	SSI data. Patient feedback	Karen Whitworth	The unit still mixes patients that are ready for theatre with pre-assessment patients. The unit still remains over crowded.	

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Relocation of Pre assessment	A plan is being put together relocate outpatient clinics/fracture clinic/OSU and pre assessment to enable better location of services. linked with risks OSU01 and #Clinic01	Action On Track	Karen Whitworth	
SBAR submitted.	Awaiting Exec approval.	Action Fully Implemented	Karen Whitworth	

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Theatre

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**THE001/2018**	**Purchase storage nodes for trust PACS for storage of images captured during laparoscopic**	Trust purchased stack systems from Karl Storz for laparoscopic surgery (the stacks can also be used for minimally invasive urology procedures such as transurethral resection of prostate). The stacks comprise one or two monitors, a camera system, a gas insufflator and a light source. The stacks also come with a printer so still images can be printed during surgery for storage in the integrated patient notes, and an Advanced Image and Data Acquisition (AIDA) module, that captures and stores still and moving images. At time of purchase, no consideration was given to the long term archiving and retrieval upon demand of the captured images. The AIDA module has a limited storage space which diminishes with use, to a point where the module is full and no further images can be captured and stored.	24/05/18 YET TO BE APPROVED BY HG. TARGET RISK SCORE TO BE ADDED BY DEPT.	3	5	15	15		Kirstie Heys	Maxine Priest	29/03/2018		30/06/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
As an interim measure, and act of goodwill, the trust IT service desk has arranged for a service person to transfer the images from the AIDA modules that are full so that the stack can be returned to use. The images are then transferred to a location on the trust network. Currently the only way an image can be retrieved at a later date is by logging a call with the IT service desk.		Pat Cleary		

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
The AIDA modules are DICOM work list compatible, with the purchase of additional storage nodes, the trust can implement a business process whereby images are uploaded to PACS and available as per other trust imaging e.g. MRI scans.		No Progress Made	Pat Cleary	

Trauma & Orthopaedics

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**T&O001/2017**	**To provide the most appropriate location for Fracture Clinic.**	The Fracture Clinic is currently based off site over at Herts & Essex Hospital Bishops Stortford. 1.The clinicians and nursing staff in the Emergency Department are unable source support/advice, leading to delays in treatment and inappropriate referrals to clinic resulting in some patients being given a follow up that is not required. 2.Junior doctors are unable to attend fracture clinic due to poor staffing numbers they need to be based at the PAH Main Site. This is having an impact on their training and has resulted in negative feedback to the Deaneries which, if it continues, could result in the loss of funded doctor training posts from the Deaneries. 3) The internal professional standards for specialist response times to ED are not being met on a daily basis, T&O Drs being over at H&E are further adding to this issue. 4) Due to the dislocation of ED and Fracture Clinic additional staffing has been required to support the Fracture Clinic at H&E. X1 additional Plaster technician has had to be sought and further agency cover during periods of annual leave/sickness.	Risk Ref changed 27/9/17 (Previously #CLINIC01) Plans in place to move Fracture clinic back to PAH, to Trust HQ. Project group set up and Estates department facilitating structural design and planning permission. Lead Dr. Kousgue.	3	4	12	15	06	Julie Matthews	Dawn Savage	10/03/2017		31/08/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date

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The Fracture Clinic supervisor escalates any delays with the first fracture clinic appointments.	Escalation emails, datix, complaints	Julie Matthews		
Action in Progress	**Action Commentary**	**Action Rating**	**PS&Q Lead**	**Review Date**
Business case to be produced	The CEO has advised that a new build fracture clinic is too expensive at this moment in time. Other alternatives to relocation of Fracture Clinic are now being looked at.	No Progress Made	Julie Matthews	
Relocation of Fracture Clinics	A plan is being put together relocate outpatient clinics/fracture clinic/OSU and pre assessment to enable better location of services. linked with risks OSU01 and PRE02	Action On Track	Julie Matthews	
Service team to review job plans/clinic room availability to see if alterations can be made to enable fracture appointments to return to PAH.		Action Fully Implemented	Julie Matthews	
Submit SBAR to Executive Team .	The Plan is going through.	Action On Track	Julie Matthews	

Urology

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	URO004/2018	**Robust methods of monitoring and tracking patients who have undergone a stent insertion within Urology.**	No methods to electronically monitor stent insertions which risks patients receiving overdue treatment to change/remove their existing stent(s).	24/07/18 Risk approved DOOPS	5	4	20	20	06	Julie Matthews	Dawn Savage	08/06/2018		31/08/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Manual methods of stent monitoring.		Julie Matthews		

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Explore completion of stent registry on BAUS		Action On Track	Julie Matthews	31/08/2018
To explore methods with Cosmic for monitoring stents with current system.		Action On Track	Julie Matthews	31/08/2018

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	URO007/2018	**Robust interface of IT systems to ensure that patients can be tracked and monitored through any pathway with notification in real time including changes to status. Electronic stent register.**	Cosmic/Infoflex do not have a two way interface and information must be entered in both systems. There is not an electronic method of stent insertion removals.	24.7.2018 Risk approved Director of OPs - Julie Matthews	5	4	20	20	06	Julie Matthews	Dawn Savage	11/04/2018		31/08/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
MDT Coordinators monitor patients on Cancer pathway. Manual method of stent recording and tracking.		Julie Matthews		

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Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Investigate the use of Cosmic to monitor stent changes. Investigate the use of the Audit from BAUS		Action To Be Assessed	Julie Matthews	31/08/2018

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Workforce and Organisational Development	**URO001/ 2015**	**To provide a safe, responsive, fully established urology service**	Workforce – depleted due to leavers sick leave and removal of junior staff from rotation	Inter Risk Ref changed 28/09/17 (Previously SACC 131) 20/04/18 Risk re-written Detail as at 20/04/18 Total Budget 6.31 WTE Consultants in post 4.45 WTE – Vacancies 1.86 0.4 WTE on Sick leave / unpaid leave 1.00 WTE on sick leave – leaving April 2018 1.00 WTE Speciality leaving June 2018 1.00 Fy2 Removed 1.00 Registrar removed Agency 2 WTE consultants currently 2 WTE Registrars 2.6 WTE SHO Recruiting 3 WTE Consultants 1 WTE Middle Grade Reviewing establishment to facilitate clinical Nurse Practitioners Interviews undertaken and 3 positions offered as Consultants	5	5	25	16	06	Julie Matthews	Julie Matthews	19/06/2015		31/08/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Agency Consultants in post Agency Junior doctor support Commissioned RCU review Reviewed consultant job plans and instigated daily consultant led ward rounds Discussions with West Essex Clinical Commissioning Group Additional sessions created with existing workforce Support requested from external partners Situation escalated to London Cancer Vanguard	Rota's Patients notes Royal college feedback	Julie Matthews		

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Implementation of actions from College review		Action On Track	Julie Matthews	
Reinstating Junior to urology rotation		Action On Track	Julie Matthews	
Substantive recruitment of Consultant post		Action On Track	Julie Matthews	

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Statutory Compliance	**URO002/ 2018**	**To ensure that patients are treated within the national standard for cancer (14 days first apt, 62 days referral to treatment).**	Insufficient capacity to meet demand. Currently 365 patients on the Urology Cancer Pathway.	24/07/18 RISK APPROVED BY DOOPS June Data - 365 patients on Urology Cancer Pathway. *Link attached	4	5	20	16	09	Julie Matthews	Dawn Savage	31/03/2018		31/08/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
OPA and Diagnostic capacity can be flexed depending on need. This is reviewed weekly. Timelines followed in accordance with the London Cancer Prostate Cancer Diagnostic Pathway Daily Monitoring meetings to ensure that new patients are being seen within the required timeframe and escalation of any concerns to appropriate managers UCLH continuing to provide 2 sessions per week to support the Cancer pathway	PTL - Seeing patients within 7 days.	Julie Matthews		

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Average weekly required capacity: Fast track - 30 clinic slots TRUS' - 25 procedures Post Biopsy - 20 clinic slots		Action On Track	Julie Matthews	31/08/2018

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date

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Quality	**URO001/ 2017**	**For the urology radiology report inbox to be regularly monitored to ensure patient reports are reviewed and actioned as appropriate. For appropriate harm reviews to be carried out for the backlog of unread emails.**	There are currently 9958 unread emails in the urology radiology reports inbox. This risks that patients have not been followed up correctly and that radiology reports have not been acted on.	30/11/2017 Approved by ADON. 21/05/18 Previous RMG requested current report to be linked to risk as an update however the report has been sent to the CCG and feedback has requested a re-write and change of scope. Lead investigator is meeting with CCG week of 28th May.	5	5	25	15	06	Kirstie Heys	Dawn Savage	30/11/2017		30/06/2018

Risk Mitigation/Controls	**Source of Assurance on Control Effectiveness eg. How would you know your control is working?**	**PS&Q Lead**	**Gaps in Control**	**Review Date**
Emails are now being picked up daily by the Consultant covering wards. A spot check is carried out by the Service Manger to ensure that all emails are opened. An email was sent out by the Lead Clinician to all consultants advising them of their responsibility to review this daily.	Service manger has oversight of email inbox. Datix. Weekly HG update meetings.	Dawn Savage	Admin support is needed to review the backlog of emails and harm reviews are to take place to ensure patient safety.	

Action in Progress	**Action Commentary**	**Action Rating**	**PS&Q Lead**	**Review Date**
Completion of SI RCA to be submitted to the CCG.	SI declared 29/11/17 change of investigator due to this now being a trust wide issue.	Progress Being Made But Overdue On Completion Date	Dawn Savage	
For the backlog of 9958 emails to have appropriate harm reviews and where harm is believed to have occurred a Datix is to be completed to alert the PS&Q lead that the incident requires escalation.	We now know this to be a trust wide issue that is being investigated. A harm review plan is being devised for all inboxes that have not been monitored.	Progress Being Made But Overdue On Completion Date	Dawn Savage	

Appendix 2

15 Plus SRR - Overdue Review by 26 July 2018

Detailed Risk Register Report - Ordered by Highest Current Risk

Risk Register (Live)

Corporate Services

Estates & Facilities

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	EF082	**Maintain a suitable, sufficient and reliable emergency electrical back-up to the site in the event of mains power failure.**	Due to the excessive electrical demand on the main back-up electrical generators (north and south side), there is a risk that the generator will fail if required in the event of a mains power failure.		4	5	20	20	04	Alison Morris	Bill Dickson	14/02/2018		30/06/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Electrical load temporarily shed from North to South sub-station therefore reducing the load requirement on the North side generator.	Weekly generator testing	Bill Dickson	This is a short term measure only. The demand on the South side generator is also increasing and will soon become excessive for the South side generator	30/06/2018
Planned preventative maintenance schedule in place.	audited by Authorising Engineer (Electrical) on an annual basis.	Bill Dickson		28/02/2019

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Installation of new generator (purchased 30/03/18) in series with current generator to provide required power in the event of mains power loss to the North sub station.	Consideration has been given to assessing essential and non-essential loads, therefore providing emergency power back-up to essential systems only. Due to the complexity of the electrical systems within the Trust and the location of supplies on varies switches, this is not possible. For this to happen, power supplies, switches and circuits would have to be relocated, changed or renewed which would cost considerably more and create high additional risks where works were undertaken.	Action On Track	Bill Dickson	30/09/2018
Procurement and installation of an additional generator to be linked in series to the existing generator, including controller upgrade.	Generator purchased 30/03/18. Generator will be installed in capital year 2018/19.	Action Fully Implemented	Bill Dickson	31/07/2018

Purchase and installation of new generator in series with current generator to provide required power in the event of mains power loss to the South sub station.					A full loading and grading survey is required prior to starting the design specification of the new generator. Consideration has been given to assessing essential and non-essential loads, therefore providing emergency power back-up to essential systems only. Due to the complexity of the electrical systems within the Trust and the location of supplies on varies switches, this is not possible. For this to happen, power supplies, switches and circuits would have to be relocated, changed or renewed which would cost considerably more and create high additional risks where works were undertaken.					Action To Be Assessed		Bill Dickson		31/03/2019
Domain	**Risk Ref:**	**Objective - What are you trying to achieve**	**Description of Risk - Cause and Effect**	**Risk Comments**	**Consequence**	**Likelihood**	**Initial Risk**	**Current Risk Score**	**Target Risk Score**	**PS&Q Lead**	**Risk Lead**	**Date Risk Raised**	**Date Risk Closed**	**Risk Review Date**
Statutory Compliance	**EFM05-18**	**sustainable workforce in the kitchen to ensure full compliance with all working directives and legislation on food hygiene and sufficient staff levels to provide a safe and efficient catering service to the wards and restaurant.**	insufficient staffing levels within the main kitchen to be able to provide a safe and effective service. Staff are working 10 days in a row and doing overtime to cover the service, paperwork is not completed in a timely fashion and staff are leaving due to the the stress associated with the shortage of staff.		4	4	16	16	01	Tracey Burgess	Diane Clarke	12/07/2018		26/07/2018
Risk Mitigation/Controls					**Source of Assurance on Control Effectiveness eg. How would you know your control is working?**					**PS&Q Lead**		**Gaps in Control**		**Review Date**
Agency staff being used to cover shifts where able.					Service is running					Tracey Burgess		Insufficient budget to have all agency staff required. Jobs are advertised however low interest		19/07/2018
Action in Progress					**Action Commentary**					**Action Rating**		**PS&Q Lead**		**Review Date**
Vacancies to be filled and full staff levels maintained					daily monitoring of staffing levels					No Progress Made		Tracey Burgess		27/07/2018
Domain	**Risk Ref:**	**Objective - What are you trying to achieve**	**Description of Risk - Cause and Effect**	**Risk Comments**	**Consequence**	**Likelihood**	**Initial Risk**	**Current Risk Score**	**Target Risk Score**	**PS&Q Lead**	**Risk Lead**	**Date Risk Raised**	**Date Risk Closed**	**Risk Review Date**

Detailed Risk Register Report - Ordered by Highest Current Risk

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**EfM/019**	**Maintain Patient and Staff Safety with a suitable and sufficient CCTV system**	Risk to patient and staff safety due to lack of CCTV monitoring across site. Staff and patients may suffer injuries through unidentified attacks and personal theft with no evidence to present to the police. There is currently no way of remotely monitoring sections of the Trust premises that are remote, and incidents are unknown until staff attend due to the inability to see the situation via CCTV.		3	5	15	15	02	Tracey Burgess	Dave Clarke	29/09/2014		

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
A full risk assessment has been undertaken by the LSMS for the provision of CCTV across site to identify where cameras are required.	The risk assessment has been reviewed by the AD E&FM, and will be used to inform the 2018/19 capital plan.	Tracey Burgess		31/03/2018
CCTV surveillance now available in ED reception, OPD PAH, Corridor from OPD to Melvin Ward and Ambulance entrance.		Tracey Burgess	Lack of surveillance round rest of site both internally and externally	31/07/2018
The Trust employs a security contractor that respond to incidents on site and provide support and assistance to staff from a security perspective.	Regular contract monitoring meetings take place.	Tracey Burgess		31/07/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
A specification is being produced as a result of the risk assessment carried out by the LSMS to secure capital funding.		Progress Being Made But Overdue On Completion Date	Tracey Burgess	30/03/2019

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Statutory Compliance	**EfM/031**	**Compliance with Statutory Fire Safety Regulations**	There is a risk that the Trust is currently non-compliant with aspects of fire safety regulations and healthcare fire safety best practice. This could lead to improvement notices or fines from regulators. Breaches in fire barriers also present a safety issue due to the ability for smoke or fire to spread.		5	5	25	15	05	Tracey Burgess	Bill Dickson	21/02/2014		

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date

Fire risk assessments for the entire site were reviewed Nov 2017. No actions requiring urgent or immediate attention were identified. All high/medium risk items are now in progress and action plans are being shared with relevant departments (see actions section).		Tracey Burgess		30/04/2018
Fire training is carried across the Trust with a mixture of e-learning, face to face and bespoke training.	training levels monitored by the Training and Development Department and content is overseen by the subject matter expert for fire (Fire adviser)	Tracey Burgess		24/04/2018
Fire wardens have been identified across the Trust and trained adequately in-house.	monitored by fire adviser	Tracey Burgess	there are areas in the Trust that are yet to identify staff members to take on the fire warden role.	30/04/2018
Action in Progress	**Action Commentary**	**Action Rating**	**PS&Q Lead**	**Review Date**
Actions detailed in fire risk assessment to be shared with relevant departments.	Action plans to be monitored by the fire officer and progress presented at Health and Safety Committee.	Action On Track	Tracey Burgess	30/04/2018
the fire stopping in the basement to prevent the spread of smoke and fire is unacceptable. There are multiple breaches that must be repaired as a matter of urgency.	Planned for 2018/19 backlog maintenance	Progress Being Made But Overdue On Completion Date	Alison Morris	31/03/2019

Detailed Risk Register Report - Ordered by Highest Current Risk

Information Management & Technology (IM&T)

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Projects and Business Continuity	**IT096**	**Safe and secure infrastructure free from the threat of users clicking on insecure links or responding to insecure emails**	The Trust is taking precautions to ensure that its IT infrastructure is protected against known malware threats. The risk remains of zero day attacks which are new unknown threats and do not have a fix available.		4	3	12	16	12	Furzana Kausar	Furzana Kausar	19/05/2017		08/06/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
An anti-exploit software tool has been installed onto servers and PCs. This will help to detect potential malware.	No malware introduced onto the Trust IT infrastructure.	Furzana Kausar	Where new malware is introduced which utilises unknown patterns, this would not be detected.	30/04/2018
Procure training tool which can help decipher which end-users required further training and awareness. Educating end-users on the risks of clicking on suspicious emails or insecure web links.	No introduction of malware into the Trust.	Furzana Kausar	Current scams look very genuine and are often hard to distinguish from authentic emails and web links.	30/04/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**IT101**	**Ensure that the fleet of Acer PCs in use at the Trust are free of hazard**	Acer base unit caught fire and brought to the IT department by a member of the Estates department. It is stated that another base unit had a similar incident last year but there is no Datix for this and no base unit was brought to the department hence no evidence.		5	3	15	15	05	Furzana Kausar	Lynne Fenwick	06/02/2018	25/05/2018	08/06/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
23.03.2018 - Supplier has complete their investigation and found that the fire was caused due to an accumulation of dust. IT to carry out checks on PCs to ensure that base unit vents are not covered and domestic staff to be asked to vacuum vents to remove dust. Have written to supplier of the base unit asking if there are known issues with the particular model.		Furzana Kausar	A fire can break out at any time with electrical equipment	

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
25/05/2018 - Associate Director of Estates & Facilities to ask Domestic staff to vacuum back of the PC base units. Also IT Engineers to check PCs as they perform their daily duties.		Action Fully Implemented	Furzana Kausar	

Detailed Risk Register Report - Ordered by Highest Current Risk

Operational

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Statutory Compliance	**001/2017**	**To deliver ED 4 hour standard at 95% or above**	Failure to Deliver the ED four hour standard, leading to low performance rating, external scrutiny and potential performance notices and financial penalties.		4	5	20	20	08	Phil Holland	Anne Carey	01/04/2014		18/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Daily monitoring and review of previous breaches, number/patterns of attendances to facilitate changes in ED pathway to improve or limit detrition in performance	Limited, no sustained reduction in patients exceeding 4 hours.	Phil Holland	All planning is based on historical data, which does not facilitate Live data	18/07/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
I. Complete the Accountability and Responsibility Grid (ARG) for all roles within and external to the Emergency Department, expanding each area to include clarity and further detail II. Develop a competency model III. For the roles of Nurse in Charge, Consultant in Charge and Operational Lead: i. Clarify of role ii. Develop a daily routine IV. Provide support, guidance and coaching to staff as required V. Assessment of competence of staff VI. Back to basic event to cover: i. the 4 hour standard ii. Internal professional standards iii. ED staff view i.e. what went well, what stops me from doing my role, what would change iv. If I delivered the 4 hour standard for my patients it would mean…….? VII. Development and implementation of daily review of performance against standard and IPS VIII. Improve interaction between site and ED teams		Action On Track	Phil Holland	11/07/2018

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**002/2016**	**No patient will spend a journey time greater than 12 hours from arrival to discharge from ED**	Patients in ED longer than 12 hours		4	4	16	20	09	Phil Holland	Anne Carey	27/07/2016		18/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Internal professional standards which articulates at which point a patient should be in their journey through ED.	Standards are measured by Click View and available in real time	Phil Holland		01/08/2018
Monitoring by the Senior Site Matron to enable identification and escalation of patients that have a long wait in ED with no plan.		Phil Holland	Lack of assurance on timely and effective response to escalation	18/07/2018

Trackers in place to review electronic Tracking System and escalate to Consultant and Nurse in charge if patient is not meeting internal professional standards										Phil Holland		Roles and accountabilities not clearly defined		18/07/2018
Action in Progress					**Action Commentary**					**Action Rating**		**PS&Q Lead**		**Review Date**
To identify the current system capacity required to support the demand on the urgent care pathway and agree at the Local Delivery Board which Capacity / Demand Model the Trust will be following.										Progress Being Made But Overdue On Completion Date		Phil Holland		18/07/2018
Domain	**Risk Ref:**	**Objective - What are you trying to achieve**	**Description of Risk - Cause and Effect**	**Risk Comments**	**Consequence**	**Likelihood**	**Initial Risk**	**Current Risk Score**	**Target Risk Score**	**PS&Q Lead**	**Risk Lead**	**Date Risk Raised**	**Date Risk Closed**	**Risk Review Date**
Quality	**003/2016**	**No patient to wait longer than 12 hours from a decision to admit**	Patient in ED waiting longer than 12 hours from a decision to admit		4	4	16	20	09	Phil Holland	Anne Carey	28/07/2016		18/07/2018
Risk Mitigation/Controls					**Source of Assurance on Control Effectiveness eg. How would you know your control is working?**					**PS&Q Lead**		**Gaps in Control**		**Review Date**
Internal professional standards which articulates at which point a patient should be in their journey through ED.					Standards are measured by Click View and available in real time					Phil Holland				01/08/2018
Monitoring by the Senior Site Matron to enable identification and escalation of patients that have a long wait in ED with no plan.					Lack of assurance on timely and effective response to escalation					Phil Holland				18/07/2018
Trackers in place to review electronic Tracking System and escalate to Consultant and Nurse in charge if patient is not meeting internal professional standards										Phil Holland		Roles and accountabilities not clearly defined		18/07/2018
Action in Progress					**Action Commentary**					**Action Rating**		**PS&Q Lead**		**Review Date**
To identify the current system capacity required to support the demand on the urgent care pathway and agree at the Local Delivery Board which Capacity / Demand Model the Trust will be following.										Progress Being Made But Overdue On Completion Date		Phil Holland		18/07/2018

Detailed Risk Register Report - Ordered by Highest Current Risk

Workforce - Human Resources

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Workforce and Organisational Development	**WPOD01**	**To ensure the Trust has effective workforce planning processes, supported by equally effective recruitment and selection processes, to further ensure delivery of safe, effective patient care.**	A lack of effective workforce planning presents a risk that the workforce may not be fully fit for purpose to deliver services now and in the future. Currently workforce planning tends to be cost-driven rather than service driven; with the current service redesign plans, the Trust has an opportunity to address the skills it needs to deliver in the coming years.		4	4	16	16	08	Ellie Manlove	Ellie Manlove	15/06/2017		03/05/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Cost is an essential part of current workforce planning and therefore is a partial control, BUT consideration needs to be given to aligning skills to services.	Recruitment KPI's Turnover and Stability data	Ellie Manlove	Need to improve the way we align skills to services; workforce implications of service design and redesign to be an essential consideration.	

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
HR forms for Appointment/Change/termination are realigned to new establishment process	New establishment control process in place for any changes to pay and establishment	Action Fully Implemented	Ellie Manlove	30/04/2018
ESR is aligned to financial ledger		Action On Track	Ellie Manlove	31/05/2018
HR senior Team to produce a high level workforce plan based on trust data which can then be aligned to the People strategy and 5p plans	It is recognized that this will be a longer-term piece of work with 18/19 plans being developed and reviewed in September 2018 for 19/20 and beyond	Action On Track	Ellie Manlove	04/05/2018
HR Team review people risk on each HCG Risk register.		Action On Track	Ellie Manlove	29/06/2018
Workforce planning using data to inform part of the resourcing plan as outlined in the People Strategy and work plan, which is then linked to educational plans Daily recruitment summits focusing on highest vacancies. Increased use on social media for advertising. Streamlined recruitment processes with KPI's reported at PRM's		Action On Track	Ellie Manlove	04/05/2018

Surgery & Critical Care

All Surgery

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Workforce and Organisational Development	**S&CC002 /2017**	**To retain both clinical and non clinical members of staff to enable a safe, fully functioning service and increase organisational memory.**	We are unable to retain staff due to our current number of high vacancies resulting in current staff feeling as though they are under increasing pressure. Posts are frequently put out to advert but the inability to recruit, further adds to this risk.	Risk Ref changed 27/9/17 (Previously S&CC01) April 2018 Turnover Rate: Add Prof Scientific and Technic 16.83% Additional Clinical Services 9.79% Administrative and Clerical 13.35% Allied Health Professionals 29.79% Estates and Ancillary 0% Healthcare Scientists 0% Medical and Dental 9.95% Nursing and Midwifery Registered 15.65% Surgery Total 12.16%	4	5	20	15	03	Pam Humphrey	Sarah Lincoln	10/03/2017		30/06/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
HCSW development opportunities - Recognising talent and potential from band 1 to 5 Optimise pathway for career progression through "Bright Futures", Foundation degree pathways, Nursing Associate leadership and management development - Provide a range of leadership and management development specifically focused ot the needs of staff at diffeerent stages of career progression. Offer role development programmes (Band 6 programme establlished, Band 7 programme under construction, matron development programme running, senior staff nurse programme commencing in September		Sarah Lincoln		

Detailed Risk Register Report - Ordered by Highest Current Risk

Preceptorship - Newly recruited registered nurses and midwives are supported in their career progression Staff wellbeing - Staff are supported to take break, looked after each other as well as our patients and for the whole team to finish on time Staff engagement - Improve the team commaraderie and inclusiveness for all staff, students agency workers and patients Transfer opportunities - Retain staff by providing seamless opportunities across the Trust Career pathway - For every nurse and midwife to have the opportunity to map out their desired career pathway Career Clinics - Provide access to senior advice: education, Improvement Leadership, Practice Itchy feet - Achieve 'happy at Harlow staff' Trust wide activities - Enhanced staff wellbeing and engagement New roles - A workforce fit for purpose to meet the needs of patients Expanding skillsets - Every member of staff feels valued for their contribution Team Building - Improving morale and productivity		Sarah Lincoln		
Staff recognition and long service awards held to highlight how the trust values members of staff and recognises their efforts, to boost staff morale.		Kirstie Heys		

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Action Plan attached - The above controls are ongoing.		Action On Track	Sarah Lincoln	

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Finance	**S&CC002/2018**	**To achieve Financial balance for the year 2018-19 for income and expenditure meeting the planned contribution rate.**	Operational pressures (beds, staffing levels) may lead to the level of income not being to the planned level. Elective bed capacity may lead to elective cancellations leading to reduced income. Medical staffing gaps may impact on pay rate if agency is not controlled to within plan. Month 1 provisional budget headlines. Contribution £379 below plan. Expenditure £41K below draft budget. Income £420K below plan. (Budget £4,780K actual £4,360) variance 8.78% variance of budget	Month 1 draft budget indicates behind plan on income therefore contribution is suppressed. Month 3 financial position improved £1.5K.	5	5	25	15	12	Julie Matthews	Julie Matthews	21/05/2018		30/06/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
• Daily and weekly monitoring of income performance, agency use. • Senior sign off for purchase. • Weekly challenge meetings with Execs. • Monthly budget review with all budget holders. • Grip and control for theatre bookings and utilisation of theatres implemented.	• Increase in activity over plan as monitored via Finance order book. • Budget statements provided monthly. • Reduction in agency as monitored weekly by agency specialist.	Heather Keoghoe	• Delays in reporting of Finance which is monthly however mitigated by Senior sign off and weekly monitoring of agency and income	30/06/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Daily and weekly monitoring to continue.		Action On Track	Heather Keoghoe	

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**S&CC005/2017**	**For the optimum number of staff, both clinical and non clinical to be RCA trained to reduce the risk of investigations becoming overdue and improve shared learning.**	Lack of RCA trained staff within the Surgical health group risks a lack of understanding of the RCA process which further risks investigations becoming overdue. Currently 50% of SI are over due and 100% of RED investigations. This negatively impacts on lessons learnt from investigations and Trust reputation.	Of the 46 members of staff detailed on the central RCA training log. x9 have left the trust/surgery. Only x11 members of staff would require minimal support to write an RCA, with only x1 of these being a Dr.	4	5	20	15	04	Pam Humphrey	Sarah Lincoln	29/09/2017		30/06/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
A new trust process is being rolled out which includes a 20 day meeting with senior HG attendance and a 35 day meeting with the Exec team to ensure investigations are progressing within timeframe.	SI/RED tracker CCG feedback Inquest feedback	Pam Humphrey	Clinical engagement still remains a concern.	
There is a core of senior RCA trained nursing staff that are able to mitigate this risk.	Quality assurance dashboard, Datix, Complaints. Legal,	Pam Humphrey	Staff turnover	

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
To arrange bespoke RCA training for Drs during protected Audit day.	Trust RCA training has been reduced to one day to aid staff attendance.	Progress Being Made But Overdue On Completion Date	Pam Humphrey	
x2 Senior staff to be RCA trained per ward/clinical area. a minimum of x2 senior Drs to be RCA trained per speciality.		No Progress Made	Pam Humphrey	

Detailed Risk Register Report - Ordered by Highest Current Risk

General Surgery

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	GEN002/2018	For all virtual and telephone clinics to be 'cashed up' after outcoming To ensure all follow up activities are booked/planned For all historic virtual and telephone clinics to be retrospectively cashed up For harm reviews to be carried out for the backlog of un-cashed up clinics	Patients on the straight to test colorectal cancer pathway are booked for a endoscopy or radiology procedure without being seen in clinic. Patients are then booked onto a virtual clinic. A consultant reviews the results and makes a treatment plan which includes to discharge completely, remove from cancer pathway but request further investigations and appointment or remain on the pathway. Patients at risk are the cohort who are removed from the cwt pathway but require further appointments/investigations as there is not an agreed process for 'cashing up' these clinics after outcome. This means that the follow up activities do not happen	19/6/2018 - Yet to be approved by healthgroup	4	5	20	20	01	Kirstie Heys	Carol Allgrove	07/06/2018		20/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Action in Progress	**Action Commentary**	**Action Rating**	**PS&Q Lead**	**Review Date**
Backlog of patients not cashed up to be reviewed for harm		No Progress Made	Kirstie Heys	
SOP agreed for virtual/telephone clinics to enable clinics to be cashed up	Waiting SOP to be signed off and agreed	Progress Being Made But Overdue On Completion Date	Kirstie Heys	

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date

Quality	**GEN001/2018**	**For the General surgery radiology report inbox to be regularly monitored to ensure patient reports are reviewed and actioned as appropriate. For appropriate harm reviews to be carried out for the backlog of unread emails.**	There are currently 5000+ unread emails in the General surgery radiology reports inbox. This risks that patients have not been followed up correctly and that radiology reports have not been acted on.	26/01/18 Approved by ADON 21/05/18 Previous RMG requested current report to be linked to risk as an update however the report has been sent to the CCG and feedback has requested a re-write and change of scope. Lead investigator is meeting with CCG week of 28th May.	5	5	25	15	06	Dawn Savage	Carol Allgrove	26/01/2018		30/06/2018

Risk Mitigation/Controls	**Source of Assurance on Control Effectiveness eg. How would you know your control is working?**	**PS&Q Lead**	**Gaps in Control**	**Review Date**
Emails are now being picked up daily by the Consultant covering wards. A spot check is carried out by the Service Manger to ensure that all emails are opened. An email was sent out by the Lead Clinician to all consultants advising them of their responsibility to review this daily.	Service manager has oversight of email inbox. Weekly HG update meeting.	Dawn Savage	Admin support is needed to review the backlog of emails and harm reviews are to take place to ensure patient safety.	

Action in Progress	**Action Commentary**	**Action Rating**	**PS&Q Lead**	**Review Date**
For the backlog of 5000+ emails to have appropriate harm reviews and where harm is believed to have occurred a Datix to be completed to alert the PS&Q lead that the incident requires escalation.	We now know this to be a trust wide issue that is being investigated. A harm review plan is being devised for all inboxes that have not been monitored.	Progress Being Made But Overdue On Completion Date	Dawn Savage	

Detailed Risk Register Report - Ordered by Highest Current Risk

PACU

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**PACU001/2018**	**For all patients requiring inpatient stay to be allocated an appropriate bed on a ward to eliminate the need to ward patients in PACU**	Patients remaining in Post Anaesthetic Care Unit (PACU) due to the lack of in patient beds. Impact – •Lack of capacity to accept post anaesthetic patients from theatres following surgery •Delay in sending for patients once PACU full potentially causing cancellations due to lack of theatre time/overrunning of lists •Need to book additional staff (bank/agency) to care for this patient group in the day and night •If unable to locate staff to fill the shift potentially would cause emergency provision to cease as staff rostered caring for patient in PACU •Breach of Eliminating Mixed Sex Accommodation (EMSA) guidance	23/05/18 YET TO BE APPROVED BY HG	4	5	20	20	06	Gail De Souza	Maxine Priest	22/05/2018		30/06/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
•Patients who have been identified to stay overnight in PACU are segregated using curtains and cohorted into one area of PACU •Patients are recovered in theatres when there is no capacity in PACU •Patients cancelled on the day before or on the day of surgery due to lack of capacity		Gail De Souza		

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Daily/Weekly monitoring of theatre schedules and trust bed status		Action On Track	Gail De Souza	

Pre-Assessment

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	PRE002/2017	To provide a suitable pre-assessment area to improve patient safety and experience.	The current Pre-Assessment unit is located within the Netteswell admissions unit, mixing both patients awaiting elective surgery and those being assessed for future surgery. The unit is frequently overcrowded and is unable to supply adequate workspace for Drs/Nurses to admit patients to theatre. The patient seating area does not allow for male and females to be separated and already identified 'Clean' patients are often sitting alongside patients that have not yet been swabbed. There is a risk that patients being admitted to theatre could come into contact with possible infections.	Risk Ref changed 28/09/17 (Previously PRE02)	3	5	15	15	03	Karen Whitworth	Julie Matthews	16/06/2017		30/06/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
All elective orthopaedic patients that have been swabbed are now admitted straight to OSU reducing patient numbers within the unit and reducing the risk of further infection.	SSI data. Patient feedback	Karen Whitworth	The unit still mixes patients that are ready for theatre with pre-assessment patients. The unit still remains over crowded.	

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Relocation of Pre assessment	A plan is being put together relocate outpatient clinics/fracture clinic/OSU and pre assessment to enable better location of services. linked with risks OSU01 and #Clinic01	Action On Track	Karen Whitworth	
SBAR submitted.	Awaiting Exec approval.	Action Fully Implemented	Karen Whitworth	

Detailed Risk Register Report - Ordered by Highest Current Risk

Theatre

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**THE001/2018**	**Purchase storage nodes for trust PACS for storage of images captured during laparoscopic**	Trust purchased stack systems from Karl Storz for laparoscopic surgery (the stacks can also be used for minimally invasive urology procedures such as transurethral resection of prostate). The stacks comprise one or two monitors, a camera system, a gas insufflator and a light source. The stacks also come with a printer so still images can be printed during surgery for storage in the integrated patient notes, and an Advanced Image and Data Acquisition (AIDA) module, that captures and stores still and moving images. At time of purchase, no consideration was given to the long term archiving and retrieval upon demand of the captured images. The AIDA module has a limited storage space which diminishes with use, to a point where the module is full and no further images can be captured and stored.	24/05/18 YET TO BE APPROVED BY HG. TARGET RISK SCORE TO BE ADDED BY DEPT.	3	5	15	15		Kirstie Heys	Maxine Priest	29/03/2018		30/06/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
As an interim measure, and act of goodwill, the trust IT service desk has arranged for a service person to transfer the images from the AIDA modules that are full so that the stack can be returned to use. The images are then transferred to a location on the trust network. Currently the only way an image can be retrieved at a later date is by logging a call with the IT service desk.		Pat Cleary		

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
The AIDA modules are DICOM work list compatible, with the purchase of additional storage nodes, the trust can implement a business process whereby images are uploaded to PACS and available as per other trust imaging e.g. MRI scans.		No Progress Made	Pat Cleary	

Urology

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**URO001/2017**	**For the urology radiology report inbox to be regularly monitored to ensure patient reports are reviewed and actioned as appropriate. For appropriate harm reviews to be carried out for the backlog of unread emails.**	There are currently 9958 unread emails in the urology radiology reports inbox. This risks that patients have not been followed up correctly and that radiology reports have not been acted on.	30/11/2017 Approved by ADON. 21/05/18 Previous RMG requested current report to be linked to risk as an update however the report has been sent to the CCG and feedback has requested a re-write and change of scope. Lead investigator is meeting with CCG week of 28th May.	5	5	25	15	06	Kirstie Heys	Dawn Savage	30/11/2017		30/06/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Emails are now being picked up daily by the Consultant covering wards. A spot check is carried out by the Service Manger to ensure that all emails are opened. An email was sent out by the Lead Clinician to all consultants advising them of their responsibility to review this daily.	Service manger has oversight of email inbox. Datix. Weekly HG update meetings.	Dawn Savage	Admin support is needed to review the backlog of emails and harm reviews are to take place to ensure patient safety.	

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Completion of SI RCA to be submitted to the CCG.	SI declared 29/11/17 change of investigator due to this now being a trust wide issue.	Progress Being Made But Overdue On Completion Date	Dawn Savage	
For the backlog of 9958 emails to have appropriate harm reviews and where harm is believed to have occurred a Datix is to be completed to alert the PS&Q lead that the incident requires escalation.	We now know this to be a trust wide issue that is being investigated. A harm review plan is being devised for all inboxes that have not been monitored.	Progress Being Made But Overdue On Completion Date	Dawn Savage	

Appendix 3

New Risks Raised between 30 May to 26 July 2018

Detailed Risk Register Report - Ordered by Highest Current Risk with Parameters for Current Risk Score

The Princess Alexandra Hospital NHS Trust

Risk Register (Live)

Cancer Cardiology & Clinical Support Services

Clinical Administration Medical Records

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Statutory Compliance	**Adm/2018/01**	**To ensure that the Trust conforms to all statutory compliance which includes the storage, handling and access of all patient records and in accordance with the new General Data Protection Regulation.**	The Trust is currently holding sexual health records that we cannot identify as this service has been sourced by Provide who did not wish to take the patients previous healthcare records. This means that the trust continues to hold these records however cannot access them should a patient or healthcare professional contact for information as these records are coded so that patients names cannot be identified. This can now lead to the trust being fined and the new GDPR rules	3	5	15	10	02 (1x2)	Lorraine Talbot	Talbot Lorraine	18/07/2018		30/11/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Any patient requesting this historical information is being referred to their GP or sexual health clinic for advice and guidance.	Review of any concerns, complaints or PALS from patients and GP's– collate any themes and trends and escalate where required.	Nicola Faber		30/11/2018

Action in Progress	Action Commentary	PS&Q Lead	Review Date
To review the number of requests for access of these historical records 2018/2019 and escalate concerns should there be a high number of request or if patients are unable to obtain information that they need via their GP		Nicola Faber	30/11/2018

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date

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Finance	**Adm/2018/02**	**Awareness of the income loss in the current financial year 18/19 and beyond due to the new GDPR's.**	Changes to the Data Protection Act on 25th May 2018 to General Data Protection Regulation (GDPR) will remove the entitlement to charge for Subject Access Requests (SAR) equating to a loss of income of potentially £42,000. The removal of charges means that the trust can no longer charge for SAR's and this will also potentially increase the demand.	2	5	10	10		Lorraine Talbot	Talbot Lorraine	18/07/2018		30/11/2018

Risk Mitigation/Controls	**Source of Assurance on Control Effectiveness eg. How would you know your control is working?**	**PS&Q Lead**	**Gaps in Control**	**Review Date**
There is no mitigation available Process however will be reviewed as new information is available from the Information Commissioners Office		Nicola Faber	There is no mitigation available	30/11/2018

Action in Progress	**Action Commentary**	**PS&Q Lead**	**Review Date**
Review the income and expenditure for medical records to identify the severity of the financial impact for this department over the course of 2018/2019		Nicola Faber	30/11/2018

Radiology

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Projects and Business Continuity	**RAD2018/01**	**To ensure that the Radiology department has equipment that is safe and fit for purpose**	The CT 1 scanner is now 10 years old. Recommendations for replacement of imaging equipment is a lifespan of 8 years. This scanner is a key piece of equipment ensuring the timely scanning and diagnosis of all ED and In-patients	4	2	8	04	01 (1x1)	Zowie Copeman	Zowie Copeman	29/06/2018		30/06/2019

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
There are 2 CT scanners at PAH- CT 2 could undertake the work of CT1, and then a mobile scanner would be required to undertake the OP's and CWT scans Equipment has a Gold service contract and is regularly maintained- Parts are also easily accessible for this scanner	Waiting times would be maintained Datix incidences	Zowie Copeman		30/06/2019

Action in Progress	Action Commentary	PS&Q Lead	Review Date
Capital replacement programme in place. Will be added to the capital bids for 2019/20 All downtime is audited Business plan being worked-up	Some actions cannot be fulfilled until capital replacement programme has been identified for 2019/20	Zowie Copeman	30/06/2019

Therapies

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**ther/2018/02**	**Trust compliance with BDA nutrition and hydration digest recommendations that were made part of the legal NHS contract in 2016.**	Risk is that patients are given unsafe diets which include allergies and texture modification.	4	3	12	12	02 (2x1)	Susan Fullen	Susan Fullen	29/06/2018		29/09/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
1. Highlighted concerns to catering team 2. Raised awareness at ps&q 3 Looked at low fibre/low residue menu and provided feedback 4. relaunched protected meal times	Control 1 and 2 have not had an impact on reducing the risk at present, but have raised awareness. Control number 3: The fibre feedback would be seen implemented in the menus. 4. Nutrition practitioner to audit effectiveness of protected meal times.	Joanne Ward	There are numerous gaps in the controls and these will be addressed in the action plan.	29/09/2018

Action in Progress	Action Commentary	PS&Q Lead	Review Date
1. Get frozen foods for allergen free diet 2. Put together flowchart for managing safe provision of food for food allergies 3. Start looking at training for kitchen staff and ward domestics 4. adhoc work to support development kitchen menus		Susan Fullen	30/09/2018
Add to agenda in nutrition steering group		Susan Fullen	30/09/2018
Business case for secondment of staff to implement the changes required		Susan Fullen	30/09/2018
Monitor and incidents related to this risk		Susan Fullen	30/09/2018

Corporate Services

Estates & Facilities

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Statutory Compliance	**EFM05-18**	**sustainable workforce in the kitchen to ensure full compliance with all working directives and legislation on food hygiene and sufficient staff levels to provide a safe and efficient catering service to the wards and restaurant.**	insufficient staffing levels within the main kitchen to be able to provide a safe and effective service. Staff are working 10 days in a row and doing overtime to cover the service, paperwork is not completed in a timely fashion and staff are leaving due to the the stress associated with the shortage of staff.	4	4	16	16	01(1x1)	Tracey Burgess	Diane Clarke	12/07/2018		26/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Agency staff being used to cover shifts where able.	Service is running	Tracey Burgess	Insufficient budget to have all agency staff required. Jobs are advertised however low interest	19/07/2018

Action in Progress	Action Commentary	PS&Q Lead	Review Date
Vacancies to be filled and full staff levels maintained	daily monitoring of staffing levels	Tracey Burgess	27/07/2018

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Statutory Compliance	**CAP100**	**Provide a safe environment with regard to fire safety in Labour ward following refurbishment works.**	The new fire safety systems that have been installed in Labour ward have not had final calibration and conformity certificates issued for the functionality of the fire dampers. This means that the Trust do not have full assurances on the correct functionality of the fire dampers.	2	5	10	10	05 (1x5)	Alison Morris	Clive Austin	21/06/2018		29/06/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
All staff are trained in the fire safety procedures set out by the Trust	Monitoring of training via the training and development department.	Bill Dickson		30/06/2019

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The fire alarm system has been installed by proved competent contractors who have issued a certificate of installation.	Certificate of installation	Clive Austin	The fire alarm system has not yet been commissioned by the Trust fire alarm contractor to prove it is linked to the central fire alarm system.	24/06/2018
Action in Progress	**Action Commentary**		**PS&Q Lead**	**Review Date**
Calibration of the new fire alarm system in Labour ward by the Trust fire alarm contractor			Alison Morris	24/06/2018
Certificate of calibration and conformity of the fire dampers for the new installed fire alarm system in Labour ward.			Alison Morris	22/07/2018
Complete minor fire stopping around maternity theatre and install all fire safety signage at exits.			Alison Morris	24/06/2018

Research Development & Innovation

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Finance	**R&D 17.07.18 02**	**To ensure that resources are available in order to deliver high quality clinical trials and observational studies for the wellbeing of the local population.**	If resources are not available to deliver studies this will result in a reduction in budget from North Thames Clinical Research Network, and from commercial activity. This will also impact on the Trust reputation.	5	4	20	10	10 (5x2)	Chris Cook	Chris Cook	17/07/2018		03/12/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
For research to remain and recognised across the Trust as core business.	Continued recognition from the Trust executive team through quality & safety reporting, risk reporting, RD&I group meetings, annual reporting and quality account.	Chris Cook	Where staff in some areas of the Trust still do not recognise the importance of research in the NHS.	03/12/2018

Action in Progress	Action Commentary	PS&Q Lead	Review Date

Detailed Risk Register Report - Ordered by Highest Current Risk with Parameters for Current Risk Score

Medicine Healthcare Group (MHCG)

Diabetes

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**Diab 001**	**Patients to be followed up in clinic**	No capacity to accommodate approx. 500 follow up patients . Insufficient capacity for the amount of patients on the review list to be seen in clinics. Number of follow ups is constantly increasing	4	3	12	09	04 (2x2)	Claire McClements	Karyn Bann	21/06/2018		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Consultant reviewing review list and sending out letters to patients that may not require a further follow-up appointment requesting for them to have a blood test, to confirm that no follow-up appointment is required	Reduction in the review list	Claire McClements		31/07/2018
Consultants reviewing patients on review list weekly and highlights to service team any urgent patients to book	Monitoring of review lists	Claire McClements		31/07/2018

Action in Progress	Action Commentary	PS&Q Lead	Review Date
Interviews for Consultant taking place end of July 2018		Claire McClements	31/07/2018
Review of the Diabetes/Endo nurses clinics to see further patients		Claire McClements	31/07/2018

Respiratory

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	Resp002	Requirement for a new Lung Function Machine.	Lung function machine life span is 7 - 10 years. PAHT machine is 15-18 years old with no maintenance or service contract. Windows XP therefore not virus protected or supported by Microsoft.	4	4	16	16	04 (2x2)	Claire McClements	Karyn Bann	21/06/2018		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Escalation to Assistant Service Manager and company for call outs.		Lauren Springham		31/07/2018

Action in Progress	Action Commentary	PS&Q Lead	Review Date
Capital bid has been made for a new Machine this year.		Claire McClements	31/07/2018

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	Resp003	Clear backlog of patients awaiting Lung Function Testing.	There is a backlog of patients waiting for Lung Function testing. This backlog goes back to late 2017.	4	4	16	16	04 (2x2)	Claire McClements	Karyn Bann	21/06/2018		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Lung function technician is working extra Saturday clinics in an effort to reduce the backlog. Assistant Service Manager picking up lung function technicians admin work load.		Claire McClements		31/07/2018

Action in Progress	Action Commentary	PS&Q Lead	Review Date
Benchmark costing's of out sourcing.	To be initiated	Claire McClements	31/07/2018

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Surgery & Critical Care

General Surgery

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	GEN002/2018	**For all virtual and telephone clinics to be 'cashed up' after outcoming To ensure all follow up activities are booked/planned For all historic virtual and telephone clinics to be retrospectively cashed up For harm reviews to be carried out for the backlog of un-cashed up clinics**	Patients on the straight to test colorectal cancer pathway are booked for a endoscopy or radiology procedure without being seen in clinic. Patients are then booked onto a virtual clinic. A consultant reviews the results and makes a treatment plan which includes to discharge completely, remove from cancer pathway but request further investigations and appointment or remain on the pathway. Patients at risk are the cohort who are removed from the cwt pathway but require further appointments/investigations as there is not an agreed process for 'cashing up' these clinics after outcome. This means that the follow up activities do not happen	4	5	20	20	01 (1X1)	Kirstie Heys	Carol Allgrove	07/06/2018		20/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Action in Progress	**Action Commentary**		**PS&Q Lead**	**Review Date**
Backlog of patients not cashed up to be reviewed for harm			Kirstie Heys	
SOP agreed for virtual/telephone clinics to enable clinics to be cashed up	Waiting SOP to be signed off and agreed		Kirstie Heys	

Urology

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	URO004/2018	Robust methods of monitoring and tracking patients who have undergone a stent insertion within Urology.	No methods to electronically monitor stent insertions which risks patients receiving overdue treatment to change/remove their existing stent (s).	5	4	20	20	06 (2X3)	Julie Matthews	Dawn Savage	08/06/2018		31/08/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Manual methods of stent monitoring.		Julie Matthews		

Action in Progress	Action Commentary	PS&Q Lead	Review Date
Explore completion of stent registry on BAUS		Julie Matthews	31/08/2018
To explore methods with Cosmic for monitoring stents with current system.		Julie Matthews	31/08/2018

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	URO009/2018	To ensure all paediatric patients are seen by a suitably qualified Consultant.	Currently no paediatric consultant available for urology therefore delays in children being seen and managed in a timely fashion.	5	5	25	12	04 (2X2)	Julie Matthews	Julie Matthews	30/06/2018		31/08/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Addenbrooks are currently supporting the service 2 days a week. urology are currently closed to all new paediatric GP referals.		Julie Matthews		

Action in Progress	Action Commentary	PS&Q Lead	Review Date
To further extend the service at Addenbrooks		Julie Matthews	31/08/2018
To recruit a paediatric urology consultant.		Julie Matthews	31/08/2018

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Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**URO008/ 2018**	**To ensure robust management of urology pathways for both inpatients and outpatients.**	Currently urology services are delivered across three sites. Invasive OPD procedures are undertaken out of SMH. IP at PAH, Theatre at PAH, ED at PAH and HEH OPD only. RCU recommended across two sites only.	3	3	9	09	06 (2x3)	Julie Matthews	Dawn Savage	31/05/2018		31/08/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Currently reducing OPD service at HEH		Julie Matthews		

Action in Progress	Action Commentary	PS&Q Lead	Review Date
Ongoing review of the Oak Unit located at SMH.		Julie Matthews	31/08/2018

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**URO005/ 2018**	**Clear patient pathway for patients who require catheter TWOC following urological procedures. Easy access and clear referral points to be made to ensure seamless care for patients.**	No clear pathway for patients who require TWOC service or have a long term catheter. Patients will either stay in hospital until they have a successful TWOC (increasing length of stay) or are discharged home to District Nurses. If they have any issues once home they attend ED for further intervention. - Poor patient experience, disjointed pathways for care and increased ED attendances.	3	4	12	08	03 (1x3)	Pam Humphrey	Dawn Savage	31/05/2018		31/08/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Patients remain as inpatients until successful TWOC. Patients are referred to District Nurse or TWOC clinic at SMH for ongoing care		Pam Humphrey	Negative impact on patient flow and experience. This mitigation is not robust enough.	

Action in Progress	Action Commentary	PS&Q Lead	Review Date
Workstream to commenced with community teams to develop a robust TWOC/Long term catheter pathway with clear referral points and access to urgent care as needed.		Pam Humphrey	31/08/2018

Detailed Risk Register Report - Ordered by Highest Current Risk with Parameters for Current Risk Score

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Workforce and Organisational Development	**URO003/ 2018**	**To ensure adequate operational support for the Urology service.**	Urology currently have the following gaps within the service team - 1) Service Manager 2) Booker	3	3	9	06	04 (2X2)	Julie Matthews	Dawn Savage	31/05/2018		31/08/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Bookers cross covering. Assistant service manager in post General manager supporting team.		Julie Matthews		
Service Manager now recruited and in post Booker now recruited and in post.		Julie Matthews	Risk to be reduced in one month due to service manager only starting week of 23/07/18	

Action in Progress	Action Commentary	PS&Q Lead	Review Date
New Service Manager started week of the 23/07/18. To complete trust induction. Risk to be closed in one month.		Julie Matthews	31/08/2018

The Princess Alexandra Hospital NHS Trust

Trust Board 2 August 2018

4.3

Agenda Item:	4.3
Presented by:	Andy Morris - Chief Medical Officer
Prepared by:	Lisa Flack, Compliance & Clinical Effectiveness Manager
Date prepared:	18.07.2018
Subject / Title:	Risk Management Strategy

Purpose:	Approval	X	Decision		Information		Assurance	

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	The Risk Management Strategy is submitted for approval by the Trust Board. It has been updated to reflect the Trust Plans, Objectives and Values (Section 5). Consideration has also been given to review and incorporate, where agreed, feedback provided as a result of review by members of the Risk Management Group and Executive Management Board.
Recommendation:	The Board is asked to approve the strategy.

Trust strategic objectives: [please indicate which of the 5Ps is relevant to the subject of the report]	Patients	People	Performance	Places	Pounds
	X	X	X	X	X

Previously considered by:	Members of the Risk Management Group – feedback provided by: Sheila O'Sullivan Andy Morris Chris Allen Heather Schultz Executive Management Board – feedback provided by: Heather Schultz, Trevor Smith.
Risk / links with the BAF:	The Policy describes the Risk Management process including the management of the BAF
Legislation, regulatory, equality, diversity and dignity implications:	Regulatory requirement
Appendices:	Risk Management Strategy

The Princess Alexandra Hospital NHS Trust

Risk Management Strategy

(Including Policy and Procedure)

Version and What's superseded:	10 (Supersedes Risk Management Strategy 9 issued Feb17).
Disclaimer: The current version of any policy is the one held in the Trust's Public Folders and not a printed version. Staff should refer to the Trust's Public Folder for the latest version.	
Ratified by:	
Date ratified:	
Name of originator/author/ reviewer:	Dr Oyejumoke Okubadejo Lisa Flack
Name of responsible individual, sponsor and committee (If appropriate):	Dr Andy Morris – Chief Medical Officer – Executive Sponsor
Date issued:	
Review date:	
Target audience:	All Trust Employees and other relevant Stakeholders

Contents

1 Statement of Intent

1.1 The Trust Board accepts its responsibilities imposed under legislation and national standards. The Trust will ensure, so far as is reasonably practicable, the health, safety and welfare at work of its employees, and the health and safety of other persons using health service premises controlled by The Princess Alexandra Hospital NHS Trust (PAH). It will strive to eliminate risks wherever possible and when this cannot be achieved, it will implement appropriate control measures to ensure that risks to all concerned are minimised and are maintained at an acceptable level.

1.2 The Trust operates within a clear risk management framework which sets out how risks are identified, assimilated into the risk register, reported, monitored and escalated throughout the Trust's governance structures. The framework is set out in this Risk Management Strategy (including Policy and Procedure) and is supported by relevant policies, such as Incident Management Policy and Procedure. All associated policies are listed in section 4 below.

1.3 Summary of the Organisation's Risk Management Arrangements.

Risk is identified and escalated bottom up as well as top down and across the organisation. This is outlined in the organisation's Risk Identification & Escalation Process Flowchart in appendix 2 and summarised below.

1.3.1 **Top Down** – Risks to the organisation's objectives are identified, assessed and recorded on the Trust's Board Assurance Framework (BAF). Trust Board committees take responsibility for specific risks and obtain assurance on its management and controls on behalf of the Board. The Executive Directors review the BAF risks allocated to them regularly (usually once a month) while the Board receives and reviews the BAF bi-monthly.

1.3.2 **Bottom up and across** – Risks are identified at health care group level (across wards and services), and are escalated via health care group governance processes to the Associate Medical Director (AMD), Associate Director of Operations (ADoPs) and the Associate Director of Nursing (ADoN) through regular reviews at the health care group governance meetings. Where risks are identified within non-clinical health care groups such as Estates and Facilities or Finance, they should be escalated via the senior line management route and their management reviewed and monitored at team meetings.

Risks identified at committees or other groups are fed either to the relevant health care group or escalated to the Trust's Risk Management Group (RMG) if it is unclear where it should sit for a discussion in the first instance. The health care and corporate groups are challenged on the identification and management of risks at the Risk Management Group and at the performance Review Panels, Patient quality and Safety group and the Quality & Safety Committee. All significant risks (risks scoring 15 and above) are reviewed by the Risk Management Group in the first instance and recommendations made to the Executive Directors at the Executive Management Board (EMB).

The Executive Directors reviews the recommendations from the RMG and then decides on the significant risks for urgent escalation to the Board. Where it is agreed that the risk is

significant enough to affect the organisation's objectives, it is added as an addendum to the BAF and reviewed regularly with other risks on the BAF until mitigated. It is then deescalated back to the original risk owner/ health care group. Board receives urgent escalated significant risks as soon as possible following Executive review and decision but receives/ reviews the Trust-wide Significant Risk Register (SRR) quarterly. The SRR is a snapshot in time of all risks scoring 15 and above across all health care corporate groups.

2 Introduction

2.1 Risk Management refers to the systematic application of principles, an approach and a process to the tasks of identifying and assessing risks, and then planning and implementing risk responses (OGC 2004).

2.2 Risk is the effect of uncertainty on objectives. This effect may be positive, negative or a deviation from the expected (ISO 31000, 2009). Risk is described by an event, a change in circumstance or consequence. 'A*n uncertain event or set of events that, should it occur, will have an effect on the achievement of objectives' (OGC 2004).*

2.3 Risk is inherent in all that we do. The Trust recognises that healthcare provision and the activities associated with caring for patients, employing staff, providing premises and managing finances are all, by their very nature, risk activities and will therefore involve a degree of risk. The Trust is committed to ensuring that risks are identified and mitigated as low as reasonably practicable in order to ensure the safety of its staff, patients and visitors.

2.4 Risk management awareness and practice at all levels is a critical success factor for any organisation. At PAH, there is a systematic and consistent approach to risk management throughout the organisation and across all functions and activities. This enables us to fulfil our statutory obligations to our staff, patients and the public.

2.5 It provides the organisation with a basis to deliver safe and responsive care and promotes continual learning.

2.6 The successful implementation of an effective Risk Management Strategy (including Policy and Procedure) and associated processes help the Board to produce its **Annual Governance Statement** (AGS) for inclusion in its Annual Report. This is a key part of evidence required for the Internal Audit opinion.

2.7 The Strategy (including Policy and Procedure) will be reviewed annually and updated with changes in organisational objectives, current best practice and/or any relevant change in legislation.

3 Purpose

3.1 This Strategy (including Policy and Procedure) defines and documents our commitment to Risk Management. It draws inspiration from available best practice such as Enterprise Risk Management Standards from the International Standard of Risk ISO 31000, Office of Government Commerce (OGC) Management of Risk approach and the Institute of Risk Management (IRM).

Its aim is to ensure that:

3.2 Risk management is integrated into all we do and it is used to proactively anticipate and respond to continuous changing circumstances in the health sector.

3.3 Risk management informs operational and policy decisions whereby risks and their consequences are identified and findings fed into the decision making process and proposed approaches. This should help provide a more cost effective service and/or cost reduction by eliminating or reducing unnecessary risks and by ensuring risks are not unduly transferred elsewhere in the system.

3.4 The processes for identification, assessment, management and escalation of risks are clear and known by staff (appendix 3).

3.5 There is clear description of roles, responsibilities and management structure for overseeing risks (appendix 10).

3.6 The processes for maintenance of the risk registers and the Board Assurance Framework are clear.

4 Scope and Associated Documentation

4.1 The Strategy (including Policy and Procedure) applies to all staff of the Trust including contractors, agency staff, locums, volunteers, students and those employed on honorary contracts.

4.2 Risk Management is everyone's responsibility and everyone has a duty to identify and report risks and/or concerns.

4.3 The Risk Management Strategy (incl. Policy & Procedures) should be read in conjunction with the Trust's other risk related policies, including Incident Management Policy & Procedure, Complaints, Claims, Infection Control, Whistle Blowing, Dignity at Work, Zero Tolerance and Health and Safety policies.

5 Trust Plans, Objectives and Values

5.1 Our plans, objectives and values influence our approach to risk management. Risks to achievement are identified and are being addressed.

5.2 'Your future, our hospital' is the name of the Trusts long term plan for the future. The plan is designed to help the Trust go from strength to strength to achieve the CQC rating of 'Outstanding' by:

i. Providing outstanding healthcare and being a first choice for patients locally
ii. Having a sustainable workforce, proud of PAHT
iii. Being well-networked with sustainable services operating as part of an accountable care system
iv. Having first class clinical facilities – new hospital (2025)
v. Having financial sustainability across the local health system

5.3 This Plan has developed into five Trust objectives known as the Five P's

i. Our Patients: We will continue to improve the quality of care we provide our patients, improving our CQC rating.
ii. Our People: Our people will deliver high quality care within a culture that improves engagement, recruitment and retention reinforced by improvements in our staff survey results
iii. Our Performance: We will meet and achieve our performance standards, covering national and local operational, quality and workforce indicators
iv. Our Places: We will maintain the safety of our places and improve the quality of our environment, whilst working with our partners to develop a stron case for a new build. This will be aligned with the development of a West Essex and East Hertfordshire Accountable Care Partnership.
v. Our pounds: We will manage our pounds and resources effectively to achieve our financial targets and control totals.

5.4 Our Values describe the behaviours we expect which guide us daily in our journey to excellence and achieving our objectives.

Figure 1 – PAH Values and Standards

6 Board and Committee Structure

6.1 The Trust operates a culture of openness, transparency, learning and improvement and expects these from its entire staff. The Trust supports a positive culture that avoids a predisposition to blame and fear but rather supports staff and encourages them to speak up when there are safety concerns.

6.2 The Trust's structure is aimed at fostering an integrated, coherent approach to governance including risk management and ensuring that there is effective communication and cross communication among the committees and sub structures. A current detailed structure is available on request. See appendix 1.

6.3 Risk identification and management is a standing agenda item on every Trust committee or group and relevant risks are identified, assessed and recorded as part of the action log so agreed action can be documented and followed up. Where the risk is specific to a health care group, it is escalated to the health care group risk register.

6.4 **Duties and Responsibilities** – Risk management duties and responsibilities are detailed in appendix 10.

6.5 **Authority of all Managers with regards to level of risk**

Risk should be managed as detailed in the Trust's risk escalation process flowchart.

Risks that do not breach the organisation's 'risk appetite trigger' should be dealt with locally within health care groups except where the manager/lead director requests otherwise. Where it is decided, upon agreement with the lead director, that a risk within their department or area of responsibility cannot be managed locally within the health care group, this should be escalated appropriately to the Executive Management Board. See appendix 2 for the risk escalation process flowchart and Table 5 of the risk assessment matrix (appendix 4).

6.6 Risk Definitions

These provide a clear definition and common language of risk management within the organisation. These are listed in appendix 8.

7 The Risk Management Process

The first important step in the risk management process based on the International Standard of Risk (ISO 31000) is 'Establishing Context'. This encompasses the articulation of the organisation's objectives, the defining of the external and internal parameters to be taken into account when managing risk, and these set the scope and risk criteria for the remaining part of the risk management process.

The figure below shows the stages in the risk management process.

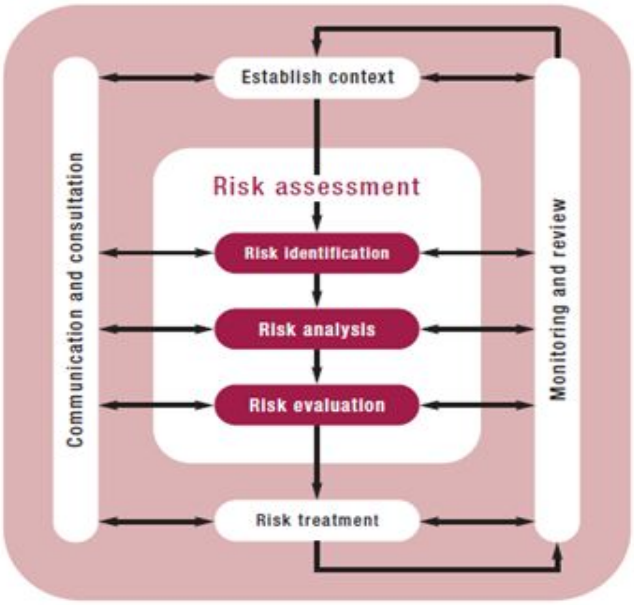


Figure 2: Risk Management process based on ISO 31000

The full explanation of requirements of the risk management process can be found in appendix 3.

7.1 Types of Risks

These will fall into the following broad categories:

i. **Strategic risks** – These are risks that directly threaten an organisation's principal objectives. These are recorded on the Board Assurance Framework (BAF) and overseen at a strategic/ board level.

ii. **Tactical/Project risks** – These are short range risks, usually less than a year or those related to specific projects that the organisation might undertake within a defined period. It considers short range plans and how the organisation anticipates, responds to and navigates any associated or potential risk. Tactical risk management requires that the organisation provides guidance on the identification, evaluation, mitigation and monitoring of risks so that all operate within a defined risk management standard and processes. This is within the remit of the Executive Management Board.

iii. **Operational risks** – These are risks that arise from the day to day running of the organisation across all services and at the frontline. These are usually managed at service or health care group level but where an operational risk or a combination of risks threatens achievement of a strategic objective, its effect becomes strategic and is then escalated upwards as a significant risk.

7.2 Process for Risk Assessment

This is detailed in appendix 3 as part of the risk management process.

7.3 Risk Identification and Escalation Flow chart

This is detailed in appendix 2.

8 Risk Appetite

8.1 Risk management has to function in an environment in which the risk appetite is defined (HMT 2004). When the risks are identified, the Board, Directors and Senior Managers must agree on tolerable levels of those risks that will not disrupt the organisation's primary business. This determination is made taking into consideration all relevant external influences such as external regulation and political influences hence the need for clearly defined risk appetite or escalation point. The aim is to better align decision making and risk and may help identify if organisations are responding to risks appropriately (HMT 2009).

8.2 Risk appetite is the amount of risk which is judged to be tolerable and justifiable. It is the amount of risk that an organisation is prepared to accept, tolerate or be exposed to at any point in time and it is expressed in the same terms as those used in assessing risks (HMT 2009).

8.3 Risk appetite is best expressed as a series of boundaries (tolerance limits) authorised by management that give each level of the organisation clear guidance on the limits of risk which they can take (HMT 2009). This helps to identify at what point decisions regarding the management of a risk is escalated.

8.4 The Trust has agreed its 7 key risk elements/ domains and these have been matched to the Trust's 5X5 risk assessment matrix. The domains are Quality, Workforce and Organisational Development, Statutory compliance, Reputation, Projects and Business continuity, Finance and lastly Research & Innovation. See appendix 4, Risk Assessment Matrix.

8.5 It is important to define risk appetite in the same terms as those used in assessing risk[1], both quantitatively and qualitatively. This helps minimise confusion, aiding understanding of risk escalation.

8.6 The Trust's agreed approach to Risk Appetite is described below:

i. A clear organisation wide qualitative risk appetite statement that summarises the Trust's commitment to mitigating risks.

ii. An assessment of individual risks (as currently occurs)

iii. A clearly defined **'risk appetite trigger point' –** This is based on **a current (residual)** risk assessment score (Consequence X Likelihood) for risks and is set at **15**. These significant risks are referred to the Risk Management Group for review and discussion in the first instance. The Group then makes recommendations to the EMB.

iv. Use of the Good Governance Institute (GGI) matrix in discussing risks at EMB, Committees of the Trust Board and at Board level. Risk appetite discussions for elements on the PAH risk matrix not currently in the GGI matrix, namely Workforce & Organisational development, Research and Project & Business continuity, can be discussed under any of the GGI key elements. (See appendix 9)

v. On-going monitoring and discussion.

8.7 Qualitative Risk Appetite Statement

The Board agreed its Qualitative Risk Appetite statement for 2017/18 as follows:

8.7.1 *The Trust's highest objective is to deliver excellence in the delivery of seamless high quality, safe and effective care; delivered efficiently and within the confines of both regulation and the resources made available to us. We will never accept risks that materially impede, negate or impact on this prime objective. We will always look to mitigate risks that may negatively impact upon our reputation or ability to so deliver. We will never compromise on safety or on delivering compassionate care*

9 Risk Management Tools

9.1 Risk Assessment Matrix

The Princess Alexandra Hospitals NHS Trust uses a 5 X 5 matrix for risk assessment. This is a quantitative tool for assessing the consequence of a risk multiplied by its likelihood of occurrence to provide a risk rating. This can be found in appendix 4.

9.2 Risk Assessment Form

Risk can be documented into a risk assessment form or directly into the risk register. Where an assessment is completed on the form, it must be shared with the relevant manager for approval and added to the health care group risk register. Please see appendix 5 for a template form.

9.3 Risk Registers (Please see appendix 6 for a risk register template)

9.3.1 Health Care Group Risk Registers – Each health care group must have an active,

dynamic risk register for all its risks. These should be reviewed regularly, at least monthly, to ensure that all relevant information for each risk including risk descriptions, scoring and mitigating actions are up to date. The health care group risk register is the responsibility of the Health care group Associate Medical Directors. The health care group AMD's are accountable for ensuring that it is updated and current. The risk registers are stored on the Trust's RiskAssure system.

All health care groups present their risk registers to the Trusts Risk Management Group for review and challenge according the work plan. This also enables the identification of similar risks across health care groups which help to build a picture of the burden of risk across the Trust.

9.3.2 **Significant Risk Register** (SRR) – This is a snap shot in time of all risks scoring 15 and above across all risk registers within the Trust. It is populated from risks identified across the health care group/ departments that have breached the **'risk appetite trigger point'** and are being considered for Board escalation.

The SRR is reviewed in the first instance by the Trust's Risk Management Group (RMG). Recommendations and suggested next steps are then presented to the EMB. This may include risks that should be escalated to the Board or risks that should be downgraded from current scores. The EMB reviews the SRR bi monthly before presentation to the Board and can accept or reject the recommendations from the RMG. In they receive a monthly summary of discussions from the Risk Management Group. A tolerance range may be set by the Executive Directors for each significant risk.

The Board reviews the SRR bi monthly after the EMB review.

For urgent significant risks health care groups are able to raise these outside of this regular SRR review. This can either be through the RMG or directly to the Executives if the risk cannot wait till the next RMG meeting. If this is the case, a decision is made regarding urgent escalation to the Board if required after discussion with the Executives. Where it is agreed a risk should be escalated urgently, it is reported to the Board at the next meeting following the decision.

If the effect of any of the reviewed individual significant risk or burden of risks irrespective of risk rating across the health care groups risk registers is likely to be strategic, impacting on achievement and/or delivery of the organisations objectives, it is added into the BAF as a Significant Risk Register addendum. When the Board are assured mitigating actions have been proven to be effective in reducing risks to within tolerable levels, the risk is de-escalated/down-graded from the BAF (2009, Good Governance Institute). Where there is a common theme from significant risks escalated by health care groups into the SRR, this will be summed up and escalated up as a single significant risk to the Board.

9.4 **The Board Assurance Framework**

The Board Assurance Framework (BAF) encompasses systems, processes and procedures that enable the Trust to define and identify the risks to achieving its principal objectives, and to ensure that effective controls are in place to reduce these risks to within tolerable levels.

9.4.1 The purpose of establishing the BAF is to ensure that the Trust Board are confident that their principal objectives can be achieved and to support the Annual Governance Statement that internal controls are operating effectively. The current template for the BAF is in appendix 7.

9.4.2 The BAF is owned by the board. The CMO is the executive lead with responsibility for Risk Management and the Head of Corporate Affairs is responsible for leading on the update of the BAF on behalf of the CMO. The BAF is stored on the Trust's shared X-drive.

9.4.3 Process for Developing and Maintaining the BAF

The steps for populating the BAF are as follows:

i. The Board agrees the annual strategic objectives for the year.

ii. The principal/ strategic risks that may threaten the achievement of these objectives are identified either retrospectively or prospectively including horizon scanning and it should cover all major areas of the Trust's activity.

iii. The causes and effects are identified and risks are scored.

iv. Key controls to manage these principal risks are then identified.

v. Arrangements for obtaining assurance on the effectiveness of key controls across all areas of principal risk are put in place

vi. Evaluation of the assurance across all areas of principal risk takes place

vii. Positive or negative assurances and areas where there are gaps in controls and /or assurances are identified. Please see appendix 8 for definitions.

viii. Plans to take corrective action where gaps have been identified in relation to principal risks are developed and implemented with clear accountability, timescales and monitoring.

The Assurance Framework will be revised at least annually in light of any changes to the organisation's annual objectives.

9.4.4 Concept of Assurance

Assurance in relation to risk management is about the provision of evidence that the organisation has identified its risks and that the necessary controls are in place to mitigate the risks.

Assurances may be internal or external, positive or negative. They should be evaluated to determine whether they evidence the effectiveness of controls. The process for gaining assurance about the effectiveness of the key controls is to triangulate the relevant evidence.

i. **Positive assurance** – Evidence that controls in managing risks are effective, operating as intended, resulting in risk being reasonably managed and objectives are being achieved.

ii. **Negative Assurance** – Evidence that controls in managing risks are not effective or operating as intended.

To obtain assurance on effectiveness of controls, these can either be from internal or from external sources.

9.4.5.1 Sources of Assurance

For each key control, risk or control system, the organisation should identify potential sources of assurance. It is important to acknowledge that many of the potential sources are reviewers who need primarily to satisfy their own legal or regulatory objectives, and the assurances that Boards may derive are a by-product of this process. Therefore, the issue is one of establishing whether there is an overlap between the work of a potential assurer and the organisation's own assurance needs (DH 2003). Where the assurer's report is confirmed as relevant, the organisation must endeavour to confirm that sufficient work has been undertaken in the review to be able to place reliance on the conclusions drawn.

Sources of assurance can be internal or external.

i. **Internal sources** include management reports, reviews, internal audit reports and reports from inspections from those who are part of the organisation, such as Clinical or Multi- Professional Audit or management peer review.
ii. **External sources** include reviews, internal auditors and inspectors from outside the organisation, External Audit, Care Quality Commission (CQC), Professional bodies or Royal Colleges. These are usually independent sources of assurance and carry more weight than internal sources.

9.4.5.2 Gaps in Control or Assurance

These are where following evaluation of existing controls and assurance, a control that is needed is not in place and/or it is identified that further controls are needed or where evidence on the effectiveness of a control in place is not yet available or yet to be ascertained. These are failure to gain sufficient evidence that policies, procedures, practices or organisational structures on which reliance are placed are operating effectively.
They are defined as follows:

9.4.5.2.1 **Gaps in Control –** There is a clear conclusion, based on sufficient and relevant work, that one or more of the key controls on which the organisation is relying are not effective (DH, 2003).

9.4.5.2.2 **Gaps in Assurance –** There is lack of assurance, either positive or negative, about the effectiveness of one or more control. This may be as a result of lack of relevant reviews, or concerns about the scope or depth of the reviews that have taken place. (DH 2003).

Further action to address the gaps must be identified. This should be recorded as these are honest flags of what is still lacking.

9.4.5.3 How Assurance can be coordinated

The Board will obtain assurance on the effectiveness of implemented controls as part of the BAF.

It determines the source and level of assurance that should be available to them for the strategic risks to enable them to obtain reasonable assurance and the level of independent assurance reporting that is appropriate given the risks and controls that have been identified (DH,2002).

The department of health advised that Boards and Audit Committees need to understand that different types of auditors and assessors, even when they are examining the same systems, are not producing the same opinions (DH, 2002). The department of health further suggested that Boards need to be aware of testing methodologies and clarify from auditors how evidence is collected and evaluated (DH, 2002, GGI 2009). The auditors and assessors should be asked, if possible, to explain in clear terms how these tests are deployed, the sample sizes used and the value that can be derived from the resulting opinion.

Please see appendix 9 for details provided by the DH to inform this process.

9.4.5.4 Reasonable Assurance Rating

The principle of **reasonable assurance** is employed as it is acknowledged that absolute assurance cannot be achieved even with the best of controls (DH, 2002).

Reasonable assurance balances the likelihood of a risk and its consequences should it materialise against the cost of mitigating the risk within available resources. With this in mind, the Board will reach a consensus on what is **'reasonable'** for the organisation for each risk as part of their review of the BAF. Only **current** assurances should be relied on.

Reasonable assurance level is determined using a four point scale – Blue, Red, Amber or Green, following a review of the controls and assurances available. The Board could either endorse the proposed assurance level rating or suggest a new rating.

i. **Blue** – Effective controls are definitely in place and there is sufficient evidence and appropriate reasonable assurances on its effectiveness. The target risk score has been achieved and sustained over a period of six months.
ii. **Green** – Effective Controls are in place and there is sufficient evidence and assurance on its effectiveness. However, the target risk reduction is yet to be achieved.
iii. **Amber** – Effective control thought to be in place but assurances on its effectiveness are uncertain and/or insufficient.
iv. **Red** – Effective controls are not in place and assurances are not available to the board.

(Based on the 2009, Good Governance Institute 3 – point scale Reasonable Assurance Rating)

Rationale for assurance should be explained in the appropriate section on the BAF.

9.4.5.5 Levels of Assurance

There are five levels of assurance: This 5 point scale helps to delineate requests for assurance.

i. Level I assurance is largely about the availability and regularity of data that provides assurance

ii. Level II concerns the source, integrity and provenance of any data including its interpretation and what conclusions are drawn

iii. Level III reflects the confidence of the data and its triangulation with other sources that give confirmation and affirmation of conclusions

iv. Level IV is independent verification and multiple authentication

v. Level V is the non-repudiation and longevity of the assurance

A level of assurance is assigned to the assurance provided and that enables the readers to assess how strong the assurance actually is.

9.4.6 BAF Monitoring and Reporting

Each risk on the BAF has a named lead executive. Risks on the BAF are also allocated to Trust Board committees whose responsibility is to review and challenge the management of the risk as well as the effectiveness and assurances on control for each risk on behalf of the Board. Assurances on this review are provided to the Board at its bi-monthly review of the BAF along with any changes to the BAF since last review. The risks on the BAF are reviewed regularly by the lead Executive Directors (usually monthly), at the relevant Trust Board Committees (bi-monthly) and by the Board (bi-monthly). Changes to the BAF are also presented to the Trust Risk management Group by exception.

Where individual risks or the burden of risks across the health care group risk registers have a potential to impact upon the achievement and/or delivery of a Trust strategic objective, this is recommended for addition as an addendum to the BAF. The process is as described in section 9.3.2.

The Internal Auditors review the effectiveness of the Risk Management Strategy (including Policy & Procedure) and BAF yearly.

Where changes are required, this is included in the BAF by the Head of Corporate Affairs but tracked so that there is an audit trail of changes made through each version of the BAF.

9.5 Link between the BAF and the Health care group Risk Registers

The review of all health care group risk registers, Significant Risk Register and identification of the burden of risk across the Trust at the Risk Management Group serves as the link between the BAF and the health care group Risk Registers.

If the effect of any of the reviewed individual significant risk or burden of risks irrespective of risk rating across the health care groups risk registers is likely to be strategic, impacting on achievement and/or delivery of the organisations objectives, it is recommenced for addition to into the BAF as a Significant Risk Register addendum. The process is as described in section 9.3.2 above.

The health care group, if required, are able to view the BAF. This is stored on the shared drive and read access can be requested from the Head of Corporate Affairs.

10 Risk Management Training Arrangements

10.1 All board members and senior managers will receive relevant risk management awareness training in accordance with the Trust's Training Needs Analysis.

10.2 All new non-executive directors receive an induction pack with the Trust's Risk Management Strategy (including Policy & Procedure). This is then followed by a session with the Associate Director of Governance & Quality to explain the Trust's Risk Management processes. This fulfils the training requirements for non-executive directors. Confirmation that this session has taken place is recorded on the non-executive directors induction schedule and kept in their personnel file.

10.3 Training will include risk identification, articulation, assessment, monitoring and escalation, including the concept of risk appetite. Ad hoc training sessions based on individual's training needs as defined by their annual appraisal or job description will also be provided.

10.4 Risk Management training for all new starters is covered at the Trust's Corporate Induction.

10.5 The process for recording attendance and for the follow-up of non-attendance will be in accordance with the Trust's Statutory and Mandatory Training Policy. Monitoring of the same is also covered in the Trust's Statutory and Mandatory Training Policy. See section 13 below for monitoring arrangements for this Strategy.

11 Communication and Dissemination

The Trust's Risk Management Strategy (including Policy and Procedure) will be made available to all staff via the Trust's Public Folders. A global communication will sent to notify staff of the updated document.

12 Process for Review and Archiving

The Associate Director of Governance & Quality is responsible for reviewing the Strategy annually and updating it with changes in organisational objectives, current best practice and/or any relevant change in legislation. Old versions are removed from the Trust's Public Folders and archived as described in the Trust's Procedural Document.

13 Risk Management Monitoring Arrangements

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
Organisational risk management structure detailing all those committees/sub-committees/groups which have some responsibility for risk	ADGQ/HoCA	Review of systems including a review of minutes and reports	Annual	Trust Board	Required actions and leads will be identified. Actions to be completed in a specified timeframe	Lessons will be shared with all relevant stakeholders
Process for Board or high level committees review of the BAF and SRR	BAF – HoCA SRR - ADGQ	Review of systems including a review of minutes and reports	Annual	Trust Board	Required actions and leads will be identified. Actions to be completed in a specified timeframe	Lessons will be shared with all relevant stakeholders
Effectiveness of Organisational risk management arrangements	Internal Audit	Internal Audit	Annual	Audit Committee	Required actions and leads will be identified. Actions to be completed in a specified timeframe	Lessons will be shared with all relevant stakeholders
Duties – risk management activities	ADGQ/HoCA	Review of systems including a review of minutes and reports	Annual	Trust Board	Required actions and leads will be identified. Actions to be completed in a specified timeframe	Lessons will be shared with all relevant stakeholders
Authority of all managers with regard to managing risk	ADGQ/HoCA	Review of systems including a review of minutes and reports	Annual	Trust Board	Required actions and leads will be identified. Actions to be completed in a specified timeframe	Lessons will be shared with all relevant stakeholders
Risk as a standing item on every committee agenda	HoCA	Review of systems including a review of minutes and reports	Annual	RMG/ EMB	Required actions and leads will be identified. Actions to be completed in a specified timeframe	Lessons will be shared with all relevant stakeholders

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
Terms of Reference for high level committees with overarching responsibility for risk Duties Reporting arrangements to the Board Membership, including nominated deputy where appropriate Required frequency of attendance by members Reporting arrangements into the high level committee(s) Requirements for a quorum	HoCA	Review of Terms of Reference, minutes, reports and attendance registers	Annual	Trust Board	Required actions and leads will be identified. Actions to be completed in a specified timeframe.	Lessons will be shared with all relevant stakeholders
Risk Management Process/ Stewardship reporting and management of risk locally Process for assessing all types of risk Process for ensuring a continual, systematic approach to all risk assessments is followed throughout the organisation Assignment of management responsibility for different levels of risk within the organisation	Compliance/ Clinical Effectiveness Manager /ADGQ	Audit of Risk Assessments/ Health care group Risk registers	Quarterly (One Health care group per Quarter)	Risk Management Group/ EMB	Required actions and leads will be identified. Actions to be completed in a specified timeframe	Lessons will be shared with all relevant stakeholders
Risk Register Description of the risk Risk score	Compliance/ Clinical Effectiveness Manager /ADGQ	Review of Risk Registers	Ongoing during monthly Risk Management Group	EMB	Required actions and leads will be identified. Actions to be completed in a specified timeframe	Lessons will be shared with all relevant stakeholders

Summary risk treatment plan Date of review Residual risk rating						
Risk Awareness Training for Senior Management Process for ensuring that all Board members and senior managers receive relevant risk management awareness training Process for recording attendance Process for following up non-attendance	**Please see Monitoring Section of the Trust's Statutory and Mandatory Training Policy**					

14 References

i. Crown copyright 2004, The Orange Book Management of Risk – Principles and Concepts, HM Treasury

ii. Crown copyright 2006 Thinking about risk Managing your risk appetite: A practitioners guide, HM Treasury

iii. Controls Assurance Support Unit (Keele University) and The Risk Management Working Group (2002) *Making it Happen – A Guide for Risk Managers on How to Populate a Risk Register*

iv. Department of Health (2002), *Assurance: The Board Agenda*

v. Department of Health (2003), *Building the assurance framework: A Practical Guide for NHS Governing Body's*

vi. Good Governance Institute (2009), *A Simple Rules Guide for the NHS: Board Assurance Frameworks.*

vii. Health Care Standards Unit (Keele University) 2004 and The Risk Management Working Group, *Making it work – Guidance for Risk Managers on designing and using a risk Matrix*

viii. National Patient Safety Agency (2008), *Risk Matrix for Risk Managers*

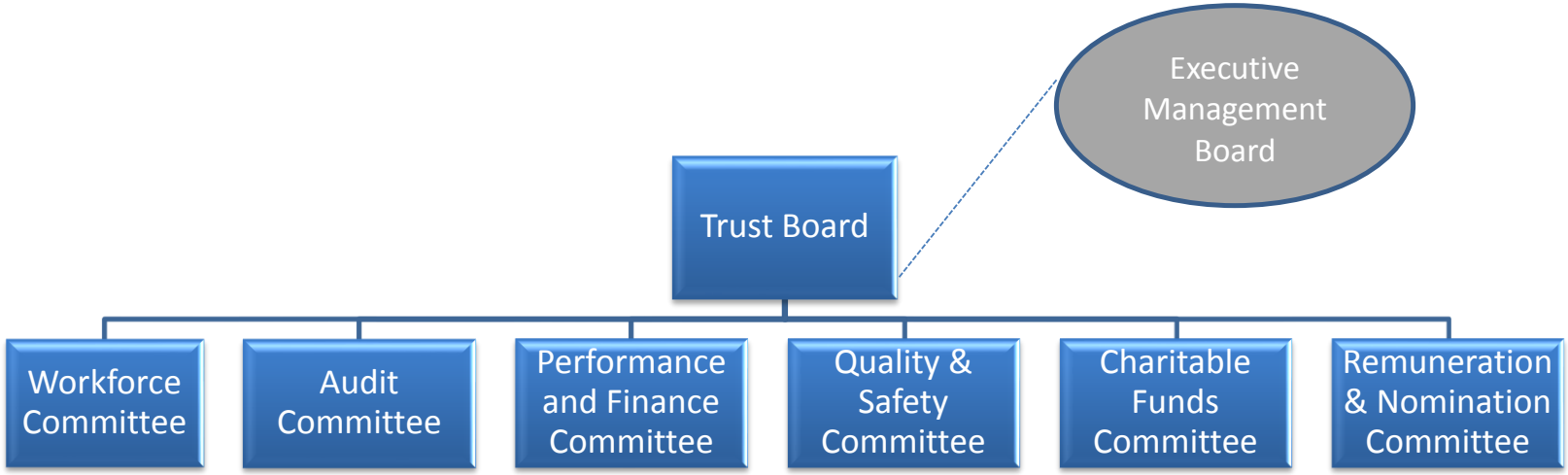
ix. Australian New Zealand Risk Management Standards (1999)

x. University of Alberta – Risk Management Strategy and Appetite (n.d)

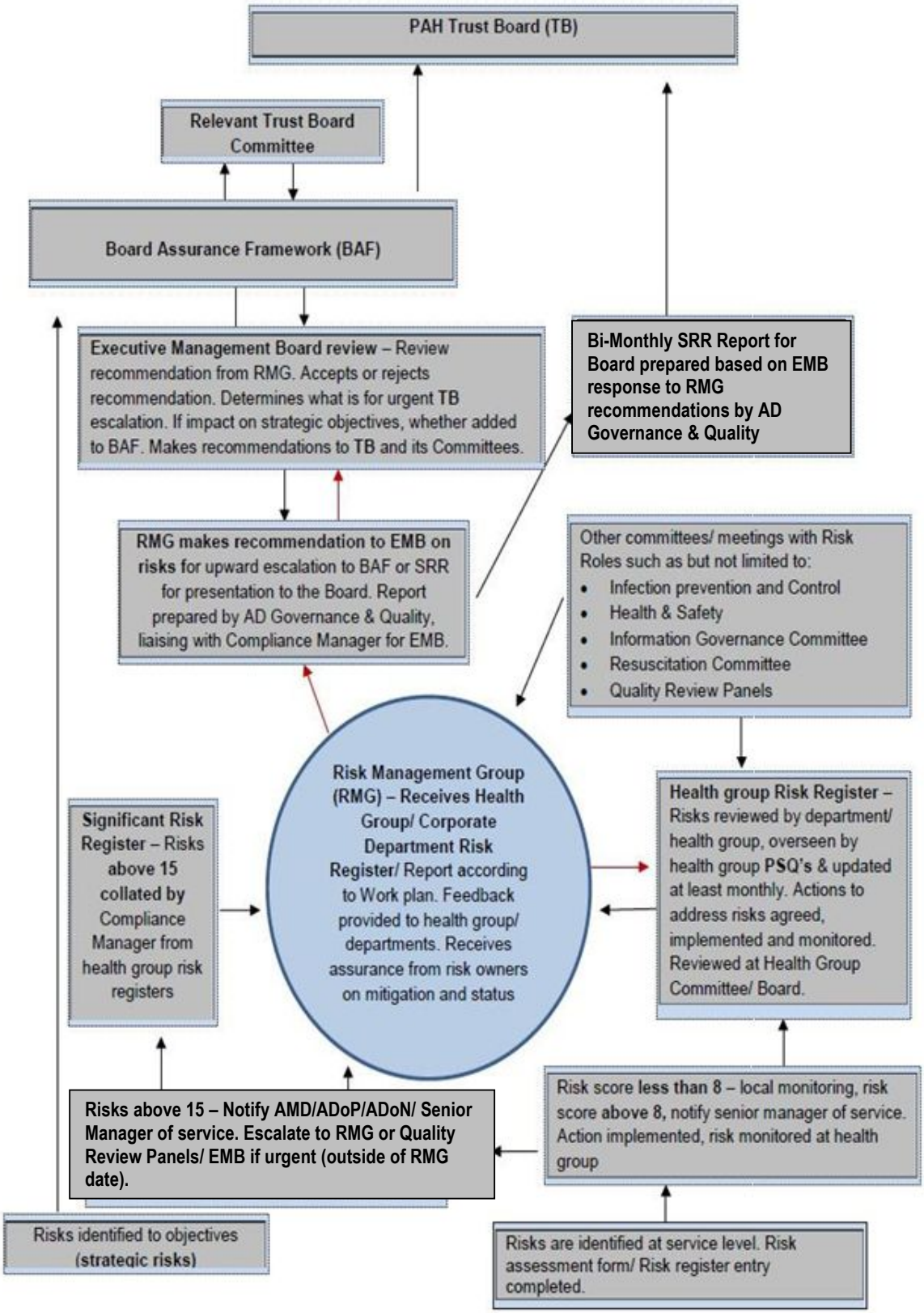
xi. Office of Government Commerce (OGC) website

15 Appendices

15.1 Appendix 1 – Board and Committee Structure including Main Management Meetings



15.2 Appendix 2 – Risk Identification and Escalation Process Flowchart

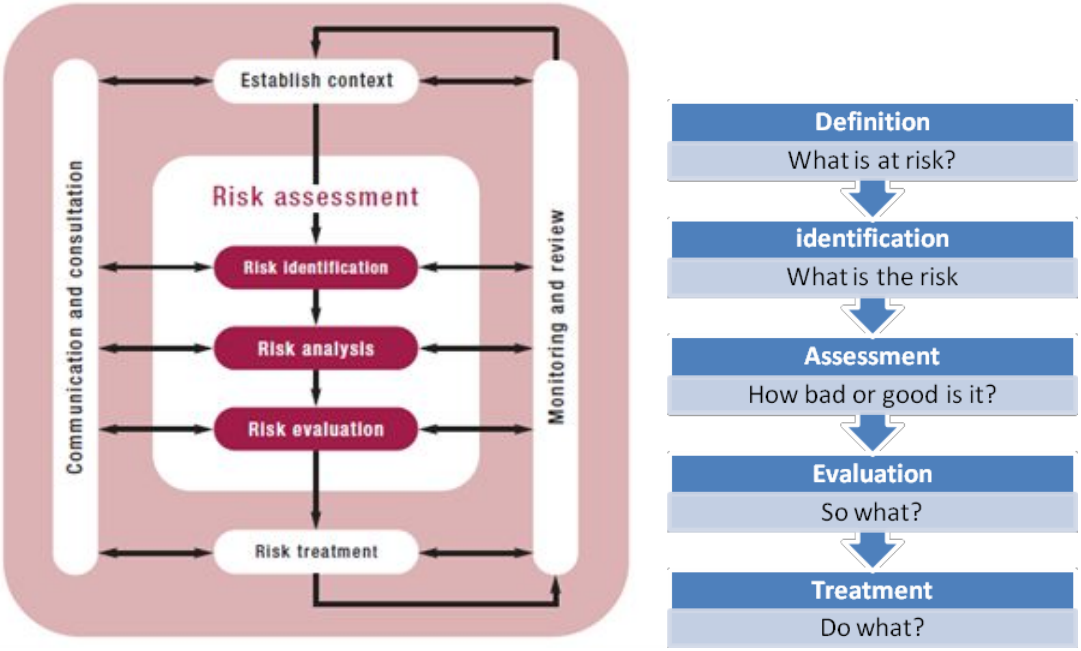


15.3 Appendix 3 – The Risk Management Process

1 Risk Management Process

Risk Management is a proactive systematic process of risk identification, analysis, evaluation and treatment of potential and actual risks. The primary purpose of Risk Management is to enable individuals and the Trust to deal competently with all key risks, clinical or non-clinical. The Trust will apply a uniform approach to assessing all risks that is broadly based on the ISO31000 (2009) which superseded the well-known Australian/New Zealand Risk Management Standard (AS/NZS 4360:1999). As ISO 31000 describes the framework for implementing risk management rather than supporting risk management process (IRM 2010), the Trust will also reference other risk management standards and principles to enable it to achieve a simple, integrated and coherent approach that fits in with its Strategy and is easily understood by staff.

Figure 3: Risk Management process based on ISO 31000 and lay man terms of what it means



The process for Risk Management is as follows:

1.1 Establishing the context

This is about defining the activity for which risk is being assessed and identifying how it impacts on the goals and objectives of the Trust. Without proper definition, it is difficult to identify and assess the risk fully.

This should be done taking into consideration the external and internal parameters that influence risk management:

i. the external influences (legal, regulatory, financial, national, regional or local, stakeholder relationships, perceptions and values),

ii. internal context (Trust objectives, project, process, or activity objectives, policy, standards, guidelines and models adopted by the Trust, contractual relationships) and
iii. risk management context (objectives, scope, responsibilities, methods, risk criteria, measures, tolerance levels).

The Trust's objectives form a framework for the risk register and assessment of the principal risks associated with these, forms the basis of the Board Assurance Framework. Identified risks on the register should be linked to the Trust's objectives as appropriate.

1.2 Risk Assessment

This is the process of quantifying a risk in terms of its impact and likelihood of occurrence. The Trust uses the 5 by 5 matrix in assessing risks (see appendix 4). Risks should be assessed in the following stages:

1.2.1 Stage 1 – Identify risks

This is about finding, recognising and describing the risks that the organisation may be exposed to. It requires in-depth knowledge of the organisation, its business and the context in which the Trust operates. It is important to ensure that both threats and opportunities that may affect achievement of objectives are identified (IRM 2010).

1.2.1.1 Risks can be identified

i. **Prospectively** from business planning, national standards, external assessments, risk assessments, workshops and brainstorming exercises, SWOT analysis of projects or processes, flowchart or dependency analysis or

ii. **Retrospectively** from review of incidents, complaints or claims, review of policies and procedures, results of audits or surveys, review of progress towards objectives.

In addition to the initial identification of risks, it is important to continuously scan and identify new risks or emerging threats and whether previously identified risks are still relevant to the organisation.

1.2.1.2 Describing the risks – Identified risks should be described in terms of causes and effects. This will enable correct allocation of appropriate and/or effective controls and treatment. It is important to ensure and be confident that the risk captured and described really says what it means.

a. **Risk** – the adverse event (which you assess and analyse)

b. **Cause** – the underlying circumstance, internal or external, causing the risk (which you target for treatment and/or control).

c. **Effect** – the impact of the risk materialising on the objectives, business, project. (Stating this enhances understanding in terms of the objectives).

For example: As a result of (cause), (uncertain event/ risk) may occur, which would lead to (effect). It can also be presented as a set of bullet points under the respective headings.

1.2.2 Stage 2 – Analyse/ Assess the risk

Risk analysis involves consideration of the sources of risk, causes, their consequences and the likelihood of occurrence. A risk score is obtained by combining estimates of consequences and likelihood using the Trust's 5 X 5 risk assessment matrix.

1.2.2.1 Three key assessments and ratings per risk should be recorded:

i. **Inherent score** – Generated from an assessment of the risk as it stands without any controls in place. This allows an organisation to know its risk exposure should a control fail.
ii. **Current/ residual/ mitigated score** – Generated from an assessment of the risk after controls have been applied to manage the risk. This is the actual exposure of the organisation to the risk at the present time.
iii. **Target score** – Generated from an assessment of where the Trust hopes to reach in managing the risk in question. This helps to evaluate proposed actions and controls. It also enables the organisation to manage resources and not spend more than is necessary in controlling a risk.

The purpose of risk analysis is to provide a basis for risk evaluation and decisions on treatment and management of risks. It helps to separate out the minor risks that the organisation may be willing to tolerate from the major ones that require attention.

1.2.3 Stage 3 – Evaluate and rank the risk

The purpose of risk evaluation and ranking is to enable decision making about which risks require treatment so these can be prioritised based on results of risk analysis. This helps to ensure that resources are directed to areas where they are needed the most. It takes into account the wider context the organisation operates in.

The escalation of any risk following evaluation should be based on the current/ residual score, which should be compared with the organisation's **'risk appetite trigger point'**. The absolute value of an assessed risk is in itself not important but it is whether or not the organisation regards it as tolerable or how far it is from tolerability (HMT 2004). The risk appetite trigger point for escalation to the Board is set at 15.

1.3 Risk Treatment/ Mitigation

There are four main types of responses to risks following risk assessment:

i. **Terminate/ Avoid** – This includes stopping or not commencing the risky activity. This removes the source of the risk.
ii. **Transfer** – This involves transferring or sharing the risk to/with third parties such as through insurance, contracts, risk financing.
iii. **Tolerate/ Accept** – Certain risks can be tolerated where nothing can be done to mitigate them. In some instances, there will be business contingency in place to manage the impact of the risk should it materialise. There are also risks that may be tolerated so the Trust can pursue the opportunity associated with the risk. The decision to accept risk should be an informed one and should be determined by the Trust Board for all significant risks.
iv. **Treat** – This is about reducing or mitigating risk with the aim of affecting either the consequence or in most cases, the likelihood to an acceptable level.

1.3.1.1 Types of controls for risk treatment

There are four main options regarding risk treatment. Controls can be preventive, corrective, directive or detective.

i. **Preventive controls** – These are designed to limit the possibility of an unwanted impact. Examples include: authorised signatory and limits,
ii. **Corrective controls** – These are damage limiting controls that are implemented when unwanted impacts have already materialised. Examples include contingency planning, contract clauses/ variations that limit losses.
iii. **Directive controls** – These are controls that seek to ensure that particular desired outcomes are realised. They are usually associated with health & safety or security. Examples include wearing of protective equipment, training of staff,
iv. **Detective controls** – These help identify unwanted outcomes after it has materialised (or starting to materialise). Its aim is to learn lessons that can be applied in future or make changes to mitigate further unwanted effects. Examples include post implementation reviews, asset checks and monitoring activities.

Risk treatment is about balancing the costs and efforts of implementing a control against the benefits derived from it. The control should be proportional to the risk. It is important to note that implementing a control may itself introduce a risk which would then need to be managed. It is therefore important to assess if proposed actions/ controls have an impact on any other service to ensure the risk is not being transferred elsewhere.

It is sufficient to design control to give reasonable assurance of confining the loss to within the risk appetite of the organisation (HMT 2004).

1.3.1.2 Documenting risks – All identified and assessed risks should either be documented on the risk assessment form in the first instance for onward transfer to the risk register (see appendix 5) or directly into the risk register. Each health care group is expected to have its own risk register which must be regularly reviewed, at least monthly. As risks are assessed at all levels, there is a Trust risk escalation process that facilitates movement of risk upwards and downwards across the organisation. See the risk identification and escalation process (appendix 2).

1.4 Monitoring, Review and Communication

This is an integral part of the risk management process. Its aim is to:

i. Assess and monitor the risk profile so any change can be detected and to
ii. Gain assurance about the effectiveness of risk management and whether further action is necessary.

Each risk has a lead/owner that is responsible for ensuring that risks allocated to them are being actively managed, reviewed and updated on a regular basis. The risk in its entirety and the residual risk score must be re-evaluated when new controls are implemented or where changes have been made to the risk definition. Controls must be assessed to ensure they are effective.

All changes should be documented within the risk register and versions tracked. Risks should be discussed/ communicated with staff at the relevant health care group meetings to promote understanding, ownership and to encourage an open risk culture.

In the case of the Board Assurance Framework, each risk has a lead Executive Director that ensures the risk is reviewed and managed appropriately. Risks are also allocated to Trust

Board Committees so that effective challenge of the risk, its management and mitigation can occur.

All health care groups present their risk registers to the Risk Management Group for review and challenge as part of the Trusts Risk Management Process. Risks can be upgraded or downgraded based on recommendations from the group.

1.4.1.1 Review process tools include:

i. **Risk assessment** – on-going as above (section 1.2)
ii. **Stewardship reporting** – Health care groups report on their risk profiles and management of their significant risks as timetabled through the Risk Management Group. This provides assurance to management that health care groups are reviewing their risks and concerns are being escalated as necessary.
iii. **Assessment of Risk Maturity** – This can be done once a year through the use of assessment tools to be agreed.
iv. **Internal Audit assessment** – This is carried out once a year by the Trust's Internal Auditors to assess the effectiveness of risk management arrangements within the organisation.

15.4 Appendix 4 – Risk Assessment Matrix

The Princess Alexandra Hospital NHS
NHS Trust

RISK ASSESSMENT MATRIX

Instructions for Use:

- Select a domain/descriptor that best fits the issue/risk in question from the first column on the left hand side of the consequence table.
- Following the row of the selected domain, select the most appropriate description for the issue. The number at the top of the column of that description is your consequence score (from a scale of 1 to 5). Note the Risk Appetite category.
- Select the likelihood of occurrence from the likelihood table using either the frequency or probability of occurrence
- Multiply your consequence score with the likelihood score (CXL) to arrive at the risk scoring (Table 4)
- Record on the risk assessment form and/or risk register. Identify level at which action is required and how this fits in with the Trust's Risk Management Strategy (Table 5) and whether it breaches the Trust's Risk Appetite.

Table 1 – Consequence/ Severity score (C)

Risk Categories		1	2	3	4	5
	Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Quality	**Impact on the safety of patients, staff or public (physical/psychological harm)**	Minimal injury requiring no/minimal intervention or treatment. Minor injury not requiring first aid. No time off work	Minor injury or illness, requiring minor intervention, first aid treatment needed. Requiring time off work for ≤3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability (e.g. loss of limb). Requiring time off work for >14 days Increase in length of hospital stay by >15 days	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
	Patient experience	Unsatisfactory patient experience not directly related to patient care.	Unsatisfactory patient experience – readily resolvable.	Mismanagement of patient care.	Serious mismanagement of patient care with long term effects.	Totally unsatisfactory patient outcome or experience with permanent effects
	Complaints	Informal complaint/inquiry Locally resolved.	Justified complaint peripheral to clinical care. Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution	Justified complaint involving lack of appropriate care. Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review)	Multiple complaints/ independent review Critical report	Inquest/ombudsman inquiry
	Claims	Risk of claim remote	Claim less than £10,000	Claim(s) between £10,000 and £100,000	Claim(s) between £100,000 and £1 million	Multiple claims (on similar/same issue) or single major claim Claim(s) >£1 million
	Quality/ Audit (incl. productivity and performance)	Peripheral element of treatment or service suboptimal	Single failure to meet internal standards Minor implications for patient safety if unresolved	Treatment or service has significantly reduced effectiveness Repeated failure to meet internal standards Major patient safety implications	Non-compliance with national standards with significant risk to patients if unresolved	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Gross failure to meet national

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				if findings are not acted on		standards
Workforce and Organisational Development	**Human resources/ organisational development/staffing/ competence**	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory compliance	**Statutory duty/ inspections/**	No or minimal impact or breech of guidance/ statutory duty Minor recommendations. Minor non-compliance with standards.	Breech of statutory legislation Reduced performance rating if unresolved Recommendations given. Non-compliance with standards	Single breech in statutory duty Challenging external recommendations / improvement notice Reduced rating.	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report Major non-compliance with standards.	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Reputation	**Adverse publicity/ reputation**	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met Minor effect on staff morale.	Local media coverage – long-term reduction in public confidence Significant effect on staff morale.	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation MP concerned (questions in the House) Total loss of public confidence
Projects and Business Continuity	**Business objectives/ projects**	Insignificant cost increase/ schedule slippage Barely noticeable reduction in scope or quality.	<5 per cent over project budget Schedule slippage Minor reduction in quality/scope.	5–10 per cent over project budget Schedule slippage Reduction in scope or quality.	10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
	Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment
Finance	**Finance**	Small loss	Loss of 0.1–0.25 per cent of budget	Loss of 0.25–0.5 per cent of budget	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results
Research & Innovation (R&I)	**Research & Innovation (R&I)**	R&I risk description may fit into any of above domains.	R&I risk description may fit into any of above domains.	R&I risk description may fit into any of above domains.	R&I risk description may fit into any of above domains.	R&I risk description may fit into any of above domains.

Table 2 – Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur Not Expected to recur for years	Do not expect it to happen/recur but it is possible it may do so Expected to occur at least annually	Might happen or recur occasionally Expected to occur at least monthly.	Will probably happen/recur but it is not a persisting issue Expected to occur at least weekly.	Will undoubtedly happen/recur,possibly frequently Expected to occur at least daily.
	<1%	1-5%	6-20%	21-50%	>50%
Probability	Will occur in exceptional circumstances.	Unlikely to occur.	Reasonable chance of occurring.	Likely to occur.	More likely to occur than not.

Note: the above table can be tailored to meet the needs of the individual organisation.

Some organisations may want to use probability for scoring likelihood, especially for specific areas of risk which are time limited.

Table 3 – Consequence modifiers

Modifiers may be necessary for certain consequences involving the probability (not frequency) of a risk affecting more than one person or involving a risk to minor or very important services, projects, or objectives. Modifiers should only be used when scoring consequences with descriptors highlighted in the same colours as in the modifier table.

	C = -1 (Minimum 1).	C= + 1 (Maximum 5).	C= +2 (Maximum 5).
Number of people affected.		More than a single Ward or Department.	More than the whole Trust (Local health economy).
Importance of service, project, or object at risk.	Minor service/project/objective.	Service /project/objective important to the whole Trust.	Service /project/objective critical to the whole Trust.

Table 4 – Risk scoring = Consequence x Likelihood (C x L)

	Likelihood				
Likelihood score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

	1 - 3	Low risk
	4 - 6	Moderate risk
	8 - 12	High risk
	15 - 25	Extreme risk

Table 5 – Risk follow up/ action/ escalation required:

	Risk Score	Risk Group	Action Required
	1 - 3	Low risk	Routine risks which can be managed by routine procedures locally.
	4 - 6	Moderate risk	Action implemented as soon as possible, not later than a year.
	8 - 12	High risk	Urgent health group senior management attention required. Action planned within the month.
	15 - 25	Extreme risk	Immediate action required by a Director who must be informed immediately. This is the Trust's risk appetite trigger point. Risks for review by the Executive Management Board and the Trust Board as defined in Strategy.

(Adapted by OO from HCSA (Keele University) Risk Matrix 2004 and NPSA Risk Matrix for Risk Managers 2008)

15.5 Appendix 5 – Risk Assessment Form

Health care group…….... Department: ……

Date of Assessment: ……. **Name of Assessor……..**

Job title: ……..

Establishing Context: What is the objective in relation to the proposed risk / What do you want to achieve?		
Source of Risk	**Description of Risk** (What is at Risk?) Include Causes and Effects	**Category of Risk** (Use Domains on Risk Assessment Matrix)

Inherent Risk Score – Assessment of risk without controls

Consequence **(C)** (1-5)	Likelihood **(L)** (1-5)	Rating (initial) **C x L**

Current/ Residual Risk Score

Current Controls – This may affect your initial consequence or likelihood score *(e.g. policies, guidelines, laws and regulations, training etc)*	Rating (current) – **New C x L**	**Sources of Assurance (on effectiveness of controls)** (*examples : audits reports, staff surveys, training records, external assessments etc)*

Target Risk Score

Further action required/ Risk Treatment plan – Any other controls / action that can reduce risk further	Rating (target) **New C x L**	Investment required (state amount) if applicable

Person Responsible/ Risk owner	Review date

Reviewed by Manager/ Director (Name & signature): ……

Date:…….

Completed Forms should be sent to your Health Care Group Patient Safety & Quality Manager so that risk can be included on the relevant risk register.

15.6 Appendix 6 – Risk Register Template

The Princess Alexandra Hospital NHS Trust
Directorate Risk Register

Table of Risk Sources	Variance from last assessment	Grading	
E - External Reviews - CQC, HSE	NO CHANGE ◄►	1 - 3	
I - Internal monitoring - Audits, Inspections,	REDUCTION ▼	4 - 6	
C - Claims, complaints, incidents	INCREASE ▲	8 - 12	
R - Review of Objectives		15 - 25	
P - Performance and targets			

Reference	CQC Standard	Risk Source	Risk Description: Describe the cause and effect	Risk Lead	Original/ Inherent Consequence Score	Original/ Inherent Likelihood Score	Original/ Inherent Risk rating	Controls (what is in place to reduce and / or manage the risk)	Current/ Residual Consequence Score	Current/ Residual Likelihood Score	Current/ Residual Risk Rating	Risk Movement from last assessment ◄►/ ▼/ ▲	Compare to Risk Appetite (Does this require escalation? Y or N. Discuss with HON, HOP, CD))	Action required to eliminate or reduce the risk to its lowest acceptable level. (Once action has been taken these may become part of the Controls)	Action Deadline	Forecast/ Target Consequences (post actions)	Forecast/ Target Likelihood (post actions)	Forecast/ Target Risk Rating (post actions)	Date added to Register	Interdependencies (ie does it impact on any others	Assurances on Controls (Test of effectiveness of controls)

15.7 Appendix 7 – Board Assurance Framework Template

Risk Key	
Extreme Risk	15-25
High Risk	8-12
Medium Risk	4-6
Low Risk	1-3

The Princess Alexandra Hospital Board Assurance Framework

		PRINCIPAL RISKS				KEY CONTROLS	ASSURANCES ON CONTROLS	BOARD REPORTS						
Risk No	Old BAF Ref.	Principal Risks		RAG Rating (CXL)	Executive Lead	Key Controls	Sources of Assurance	Positive Assurances on the effectiveness of controls	Residual RAG Rating (CXL)	Gaps in Control	Gaps in Assurance	Review Date	Changes to the risk rating since the last review	Target RAG Rating (CXL)
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which			
								Evidence should link to a report from a Committee or Board.						
1	Trust Objective													

15.8 Appendix 8 – Risk Definitions

i. **Risk –** is the effect of uncertainty on objectives. This effect may be positive, negative or a deviation from the expected. (ISO 31000) Risk is described by an event, a change in circumstance or consequence.

ii. **Risk appetite** – It is the amount of risk that an organisation is prepared to accept, tolerate or be exposed to at any point in time (HMT 2006).

iii. **Risk register** – Register which contains the source of the risk, risk description, residual risk level summary of the risk plan, date of review and progress against actions.

iv. **Risk management** – Process for having in place a systematic approach across the organisation for evaluating and addressing the impact of risk in a cost effective way and having staff with the necessary skills to identify and assess the potential for a risk to arise.

v. **Risk escalation** – This is where risk is moved up to a higher level of management e.g. from local department to divisional risk management level.

vi. **Risk Assessment** – This is the process of quantifying a risk in terms of its impact and likelihood of occurrence.

vii. **Consequence** – The level of harm that may occur as a result of exposure to or contact with a hazard.

viii. **Likelihood** – The chance of harm occurring as a result of exposure to a hazard.

ix. **Risk mitigation** – The action/control that aims to prevent or reduce the impact of a risk if realised.

x. **Strategic Objectives** – Those that are critical to the success of the organisation and that are the key focus of Board deliberation. Those that are used to populate the BAF reflect the current priorities.

xi. **Principal/ strategic risks –** Those that directly threaten the achievement of the organisation's objectives. These can be derived from both hard and soft intelligence available within an organisation and will highlight any obstacles or barriers to achieving the objectives, as well as the associated consequences.

xii. **Tactical/Project risks** – These are short range risks, usually less than a year or those related to specific projects that the organisation might undertake within a defined period. It considers short range plans, business continuity plans and how the organisation anticipates, responds to and navigates any associated or potential risk.

xiii. **Operational risks –** These are risks that arise from the day to day running of the organisation across all services. These are usually managed at service or health c a r e group level

xiv. **Board Assurance Framework** – The BAF is a tool which enables a board to identify record and monitor the principal/strategic risks to achievement of its objectives. It maps out the controls to manage the risks as well as how the board have gained assurance on effectiveness of the controls.

xv. **Assurance** – Assurances provide evidence that the organisation has identified the risks and has the necessary controls in place. Assurances may be internal or external, positive or negative. They should be evaluated to determine whether they

evidence the effectiveness of controls. The process for gaining assurance about the effectiveness of the key controls is to triangulate the relevant evidence.

xvi. **External Assurance** – Assurances provided by reviewers, auditors and inspectors from outside the organisation, such as External Audit, CQC, Professional bodies or Royal Colleges.

xvii. **Internal Assurance** - Assurances provided by reviewers, auditors and inspectors who are part of the organisation, such as Clinical or Multi- Professional Audit or management peer review.

xviii. **Positive assurance** – Evidence that controls in managing risks are effective, operating as intended, resulting in risk being reasonably managed and objectives are being achieved.

xix. **Control** – Controls are the systems, procedures, behaviours which will if properly applied make a- risk less likely to happen or contain its effect to some extent if it does happen. Controls can be

a. **Preventive** – Limits or prevents possibility of the undesirable event happening,

b. **Corrective** – Corrects unwanted effects once realised. This is mainly the arena of contingency planning and business continuity,

c. **Directive** – If followed is designed to ensure to ensure particular safe outcome e.g. use of protective equipment, training etc

d. **Detective** – Implemented to provide early warning of undesirable outcomes been realised or early notification of unwanted outcomes that have materialised.

xx. **Assurances on control** – Can be positive or negative assurance on the effectiveness of a control.

xxi. **Gaps in Assurances** – Failure to gain sufficient evidence that controls e.g. policies, procedures, practices or organisational structures on which reliance is placed, are operating effectively.

xxii. **Gaps in control** – Failure to put in place sufficiently effective controls e.g. policies, procedures, practices or organisational structures, to manage risks and achieve objectives

xxiii. **Hazard** – Anything that may cause harm (what could go wrong) e.g. working on ladders, wet floor etc

xxiv. **Inherent Risk rating** – Exposure arising from any risk before any controls are put in place. It relates to the uncertainty of outcome of process or activities that comprise the process - that exists if nothing is done to control/mitigate/eliminate the risk.

xxv. **Residual risk rating** – Residual risk is a risk that theoretically remains after mitigation i.e. after controls have been put in place, assuming that controls are all working as planned. It is important for the decision makers to be well informed about the nature and extent of the residual risk. For this purpose, residual risks should always be documented and subjected to regular monitor-and-review procedures.

xxvi. **Target risk rating** – Target risk is the residual risk aimed for: i.e. the amount of exposure the Trust is planning to accept. It is the desired risk level after planned actions are implemented to improve risk response.

15.9 Appendix 9 – Testing Methodologies – Assurance on System of Internal Control *(Source: DH 2002: Assurance The Board Agenda)*

APPENDIX 3: Assurances on systems of internal control

To fulfil their role, Boards must obtain assurances that the arrangements they have put in place to achieve the organisation's objectives and manage risks are effective and operating as intended. This is also a statutory requirement for completion of the Statement on Internal Control. It is important that Boards have sufficient understanding of the techniques used by auditors and other reviewers to satisfy themselves that the assurance arrangements they have in place are both comprehensive and efficient.

The assurance process requires a systematic and analytical approach with the level of supporting evidence required carefully matched to the importance of the activity to the organisation's objectives and the level of risk. Good systems with effective embedded controls and sound risk assessment arrangements are fundamental to good management and efficient assurance arrangements.

The principles for achieving assurances are the same irrespective of whether clinical, financial or other areas of activity are involved. They all require systems to be evaluated for their ability to prevent or minimise error and then checked to ensure they are actually working as intended, or if not, the effect of weaknesses. This is known as the systems audit approach. It provides an assurance about the whole system and help in reducing ongoing problems. Whilst it is possible to gain some assurance through the examination of individual incidents or transactions, this can be very time-consuming and does not provide an insight into the whole system.

The table below sets out the more common of the different techniques and testing methods that can be used to confirm the effectiveness of the Board's arrangements. It should be noted that where systems are inadequate this leads to significant increases in both the numbers and depth of tests required to provide assurances.

TECHNIQUE	METHOD	STRENGTHS	WEAKNESSES	SOME POSSIBLE APPLICATIONS
Systems-based Auditing				
Reflects the theory that the achievement of objectives/prevention of error on an ongoing basis is more likely when a sound system has been implemented.	The system is identified and documented, with particular note being taken of the controls and checks that have been built into it. The auditor/reviewer will determine what the objective(s) of the system is and assess whether the system is adequately designed to deliver that objective. The auditor/reviewer will also confirm that there are adequate controls built into the system at key points to ensure that breaches of the system and/or significant errors are identified and flagged up. If the system appears to have significant weaknesses in control, the auditor/reviewer should suggest how this might be rectified. At this point consideration should also be given as to whether to undertake detailed (substantive) testing to ascertain whether the weaknesses have had any serious consequences.	Confirms that there are controls in place to prevent/identify major operational failures. Gives comfort that a system exists to manage the risks.	Is not designed to pick up individual problems, unless accompanied by other testing. Not possible where no system has been in operation, which is the case in some emerging or dissolving organisations	Any area of operation

TECHNIQUE	METHOD	STRENGTHS	WEAKNESSES	SOME POSSIBLE APPLICATIONS
Walk-through Test				
Used to confirm that the system described is that used in practice and that the expected controls do exist	A very small number of transactions/cases/incidents etc are followed through the system	Quick confirmation for the reviewer that the system is as understood and so helps prevent erroneous testing	Too small a sample on which to form a judgement on effectiveness of the system or the consistency of its use	Should always be used before any large-scale/detailed testing is undertaken
Compliance Test				
Used to provide evidence that internal control/quality procedures are being applied as prescribed	A sample of transactions/cases/incidents etc is selected and followed through the system to ensure that the expected controls have been applied. The number of items selected will depend on the level of assurance required.	Enables assurance to be given that the system of internal control is being followed. Testing may reveal breakdowns in the system and consideration of the underlying cause of these can help in refining the system.	Does not enable assurance to be given on the effectiveness of the system. Investigation into breaches of the system can be difficult and time-consuming	All systems

TECHNIQUE	METHOD	STRENGTHS	WEAKNESSES	APPLICATIONS
Substantive testing				
The usual purpose is to enable an opinion to be formed as to the completeness, accuracy and validity of information and records. May be necessary where the organisation has poor/no formal systems in place. New and dissolving organisations may be in this position.	There are a number of ways in which this can be done, including *analytical review (see below),* however it frequently involves testing on a large scale using scientifically designed, statistical methods.	Correctly done, this can provide a high level of assurance on the effectiveness of the system and its controls. Alternatively can provide a high level of comfort where control systems are poor or absent.	Can be very time-consuming both to set up and to conduct. The cost of obtaining this level of assurance where there is a low tolerance of error can be prohibitive. Needs to be used with care	Systems covering high risk areas. Clinical audit. Where there are known system weaknesses and information is unreliable.

TECHNIQUE	METHOD	STRENGTHS	WEAKNESSES	APPLICATIONS
Analytical review				
A textbook definition is 'A form of substantive testing (see above). Often used in conjunction with detailed substantive testing and enables that testing to be more accurately directed.' However it is also a term widely used to describe a review aimed at ascertaining whether there is any glaring evidence that might point to the need for a more thorough and detailed review. Care should be taken to ensure that the extent of the work undertaken is clear when relying on this for assurance purposes.	Uses significant ratios, trends, or other statistics to determine areas for more detailed review. Where the review confirms an expected outcome no further work may be necessary	Low cost. Very efficient in the right circumstances.	Relies upon the accuracy of the data on which it is based, the reviewer's understanding of the organisation and knowledge of any operational changes which might have taken place which could have affected the expected outcome. Will only identify major discrepancies unless used in conjunction with more detailed tests. Does not give assurance on the system design	As an indicator of where in depth testing should be undertaken. In place of detailed testing in low risk areas As supplementary evidence on the effectiveness of a system As a means of ensuring that obvious large scale irregularities have not been overlooked.

15.10 Appendix 10 – Good Governance Institute Risk Appetite for NHS Organisation

Risk Appetite for NHS Organisations
A matrix to support better risk sensitivity in decision taking

Developed in partnership with the board of Southwark Pathfinder CCG and Southwark BSU – January 2012

Good Governance Institute

Risk levels ▶ / Key elements ▼	0 **Avoid** Avoidance of risk and uncertainty is a Key Organisational objective	1 **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – "investment capital" type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to "break the mould" and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently "breaking the mould" and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	NONE	LOW	MODERATE	HIGH	SIGNIFICANT	

15.11 Appendix 11 – Risk Management Duties and Responsibilities within the Organisation

1 Duties within the Organisation

1.1 Chief Executive

i. Is the Accountable Officer with overall responsibility for risk management in the PAH. Has responsibility for ensuring that it meets its statutory and legal requirements.

ii. Is accountable to the Board for the implementation of the Risk Management Strategy (including Policy & Procedure).

iii. Has statutory responsibility for the quality of care and is the Accountable Officer for the financial resources controlled by the Trust.

iv. Is required to sign the Annual Governance Statement.

v. Has delegated responsibility for risk to some Executive Directors but remains the Accountable Officer.

vi. Is accountable for ensuring the Trust operates in accordance with statutory and legal provisions and that there is appropriate stewardship and corporate governance processes within the Trust.

vii. Is accountable for ensuring that standing orders and standing financial instructions of the Trust are maintained, communicated and up to date.

viii. Has executive responsibility for Health & Safety, Estates and infrastructure.

1.2 Chief Medical Officer (CMO)

i. Is the Trust's Executive Director with delegated responsibility for risk management, ensuring that all risk policies are updated and in line with best practice and/or legislation and that staff are supported in the implementation of the organisation's risk policies and processes.

ii. Leads the Risk Register and Board Assurance Framework (BAF) activity and ensures the BAF is updated regularly and fit for purpose.

iii. Is the Executive lead for Management of Serious Incidents (SI's), Quality, Clinical Effectiveness, Research, Development & Innovation

iv. Ensures the Trust is compliant with other relevant risk standards.

v. The CMO is supported by the Associated Director of Governance & Quality in carrying out relevant responsibilities.

vi. Is the Caldecott Guardian

vii. Is the professional lead for the Trust's medical staff

viii. Has executive responsibility for revalidation and relicensing of practitioners.

ix. Supported by a Deputy CMO.

1.3 Chief Nurse

i. Has executive responsibility for Infection prevention & control and Safe guarding

ii. Is the professional lead for all Trust Nurses, Midwives and Allied Health Professionals.

iii. Is the Executive lead for complaints and patient experience.

iv. Is the executive lead for clams and legal services and the oversight of CQC inspection preparedness.

1.4 Chief Finance Officer

i. Holds executive responsibility for financial risk management and is accountable to the Chief Executive.

ii. Has professional responsibility for internal audit.

iii. Is the Senior Information Risk Officer (SIRO)

iv. Ensures compliance with the core Financial Management Controls Assurance standard, Auditors Local Evaluations and Key Lines of Enquiry.

v. Ensures the effectiveness of the organisation's financial control systems

vi. Ensures that the significant financial risks faced by the Trust are identified and managed effectively

vii. Ensuring that the Trust's Audit Committee and internal audit provider understand their roles in assuring the effectiveness of the organisation's system of internal control

1.5 Chief Operating Officer

i. Has executive responsibility for performance, emergency planning and business continuity.

ii. Is the Accountable Officer for controlled drugs

1.6 Associate Director of Governance & Quality

i. Provides the lead and expertise on risk management and risk related issues.

ii. Responsible for reviewing the Risk Management Strategy (Including Policy & Procedure) annually.

iii. Manages the Compliance Manager who takes on responsibility for providing day to day support and challenge to health care groups in the operational management of the risk registers.

1.7 Head of Corporate Affairs

i. Supporting the Chief Executive and the Chair, monitors and co-ordinates the implementation of the statutory and legal provisions required within the Trust, including appropriate stewardship and Board governance processes and advises on action required.

ii. Is responsible for ensuring that standing orders and standing financial instructions of the Trust are maintained, communicated and up to date

iii. Leads on the Board Assurance Framework on behalf of the Chief Medical Officer

1.8 Health care group Associate Medical Directors/ Associate Director of Nursing and Associate Directors of Operations

i. The Health care group Associate Medical Directors is responsible for ensuring that risks are appropriately managed within their health care group according to the Trust's Strategy.

ii. The Health care group Associate Medical Directors/ Associate Director of Nursing and Associate Directors of Operations are all jointly responsible for ensuring that their Business Unit and / or health care group is appropriately represented at Trust and Local Risk Management related Committees, Groups and Forums, ensuring that decisions arising from such meetings which affect their area of control are fully implemented.

iii. Ensure the implementation of the Risk Management Strategy (incl. Policy & Procedure) within their area.

iv. Ensuring that Ward/Departmental Managers carry out suitable and sufficient departmental risk assessments / inspections at regular intervals; that reports and recommendations are made and reviewed on a regular basis.

v. Ensures that all duties and responsibilities for all aspects of Health and Safety as detailed in the relevant Trust policy are carried out and monitored.

vi. Supporting staff to take appropriate remedial action to mitigate identified risks and escalating risk as detailed in the Trust's Risk escalation flowchart where required (See appendix 2) and Table 5 of the Risk Assessment Matrix (appendix 4)

vii. Ensuring members of their staff receive risk management training in accordance with the Trust's Training Needs Analysis.

viii. Ensures compliance with the Trust's Incident Management Policy and other guidance offered by the Trust's specialist advisors (such as Health & Safety, Infection control, Staff Health & Well-being etc.).

ix. Bring to the attention of all other appropriate Managers within the Trust, any problems that may affect the safe operation of their health care group.

x. Dissemination of risk related information e.g. Hazard/Safety Notices/Device Alerts, to appropriate Ward/Departmental Managers for action and monitoring response.

1.9 All Managers

i. Ensuring the Risk Management Strategy (including Policy & Procedure) and other risk related policies and procedures are implemented within their area of responsibility.
ii. Undertaking on-going risk assessments of environment and services to identify risks to patients and staff and escalating to appropriate management level risks that cannot be mitigated locally.
iii. Ensuring that the risk registers are populated with identified risks.
iv. Keeping staff informed of the risks faced by the organisation and what is being done to treat the risks
v. Identifying and rectifying poor performance on a timely basis
vi. Fostering a supportive environment that facilitates the open and honest reporting of risks and incidents, implements learning from these incidents across the organisation, and takes appropriate responsibility for failures in the provision of high quality care.
vii. Ensuring staff under their management have access to opportunities for training and development including attendance at mandatory risk management training.
viii. Ensuring that staff attend the mandatory training appropriate for their level and specialty and acting to ensure that non-attendance is followed up**.**

1.10 All Staff

i. Responsibility to comply with the Risk Management Strategy (including Policy & Procedure) and other risk related policies, taking care for their own safety and that of others that may be affected by any errors or omissions.
ii. To attend all mandatory training as identified, whether as a new member of staff, or staff transfer or in a new role.
iii. To contribute to identifying and assessing risks in own role and any potential risks to patients, users and visitors as well as bringing these to the attention of their managers.
iv. Responsibility for carrying out any individual action plan point allocated to them.
v. Reporting any unsafe occurrences, risks, incidents and near misses or serious incidents using appropriate policies and procedures and taking remedial action in accordance with the organisation's Risk Management policies and procedures.
vi. Maintaining safe systems of work.
vii. Meeting professional registration requirements required for their role, including any Continuing Professional Development.

1.10.1 The Trust Board

i. The purpose of the Trust Board is to govern the organisation effectively and in doing so to build public and stakeholder confidence that their health and healthcare is in safe hands and ensure that the Trust is providing safe, high quality, patient-centred care.

In relation to risk management:

ii. Is responsible for approving and ratifying the Risk Management Strategy (including Policy & Procedure) and the Board Assurance Framework (BAF) through which it

ensures the Trust approaches the control of risks and assurance in a strategic and organised manner.

iii. Agrees the risk appetite statement.

iv. Receives the Board Assurance Framework (BAF) bi-monthly with a cover paper highlighting any changes, deletions or additions since it was last received.

v. The Board has delegated more in-depth oversight of risks on the BAF to committees with responsibility for risk as appropriate to the individual committees' terms of reference.

vi. To receive assurance regarding actions being taken to address the risks.

vii. To receive the Significant Risk Register (SRR) quarterly.

1.10.2 The Executive Directors

i. Responsible for implementing the Risk Management Strategy (including Policy & Procedure).

ii. Reviews the risks on the BAF for which they are the named owner, monthly to ensure that risks are up to date and actions are progressing as required.

iii. The Executive lead for each risk feeds back on progress and assurances received.

iv. The Executive lead for each risk is responsible for providing status updates and assurances on control for each risk to the assurance committee with delegated authority from the Board to review that risk on behalf of the Board.

v. The Executive Directors receives regular reports/ recommendations from the Risk Management Group on emerging risks as presented to the group monthly by the health care groups and quarterly recommendations on the Significant Risk Register for consideration prior to Board review.

vi. Each Executive Director is accountable and responsible for identifying and managing risks within their area of responsibility, ensuring the achievement of departmental, local or organisational objectives within their department.

vii. Each Executive Director is responsible for putting in place within their area of responsibility systems that link in with the risk management processes described within this policy to ensure that a coherent approach to risk management exists.

1.10.3 Committees with Responsibility for Risk

1.10.3.1 Risk Management Group

i. This is the management group responsible for the review of the Significant Risk Register and the identification of the burden of risks across the Trust from all health care groups and corporate risk registers.

ii. The group receives all health care groups and corporate department risk registers according to a predetermined work plan and provides challenge on the scores and the management of the risks.

iii. The group makes recommendations to the Executive Management Board on risks that should be escalated to the BAF if they are likely to impact on delivery of the strategic objectives or those significant risks that should be brought to the attention of the Board.

iv. The group is chaired by the Chief Medical Officer as the Executive lead for Risk Management

1.10.3.2 Audit Committee

i. Reviews the establishment and maintenance of an effective system of integrated governance, internal control and risk management across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievement of the Trust's objectives.

ii. The Audit Committee does not review risks but reviews the effectiveness and adequacy of the Risk Management process on behalf of the Trust Board through the annual programme of internal audits.

iii. Maintains an oversight of the Trust's general risk management structures, processes and responsibilities especially in relation to the achievement of the Trust's strategic objectives.

iv. Follows up actions from the internal audit reports.

1.10.3.3 Other Trust Committees or Groups responsible for operational management of certain risks

Committees within the organisation, whether they report to the Board or the Executives will have responsibility for managing risks within their remit. These arrangements are monitored and detailed in section 13 of this document. The full remit of each committee can be found in their relevant Terms of Reference which is updated annually.

15.12 Appendix 12 – Equality Impact Assessment Tool

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	N/A	
4.	**Is the impact of the policy/guidance likely to be negative?**	N/A	
5.	**If so can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action?**	N/A	

If you have identified a potential discriminatory impact of this procedural document, please contact the Director of Nursing & Quality, Trust's lead for Equality & Diversity, together with any suggestions as to the action required to avoid/reduce this impact. A full impact assessment will need to be undertaken the results of which will then need to be reviewed

15.13 Appendix 13 – Privacy Impact Assessment

Privacy impact assessments (PIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet individual's expectations of privacy. The first step in the PIA process is identifying the need for an assessment. **The following screening questions will help decide whether a PIA is necessary. Answering 'yes' to any of these questions is an indication that a PIA would be a useful exercise and requires senior management support, at this stage the Information Governance Manager must be involved.**			
Name of Document:	Risk Management Strategy (Including Policy & Procedure) Version 9.0		
Completed by:	Oyejumoke Okubadejo		
Job title	Associate Director – Governance & Quality	Date	10 Jan 2017
			Yes or No
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.			No
2. Will the process described in the document compel individuals to provide information about themselves? This is information in excess of what is required to carry out the process described within the document.			No
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information?			No
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?			No
5. Does the process involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.			No
6. Will the process result in decisions being made or action taken against individuals in ways which can have a significant impact on them?			No
7. Is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.			No
8. Will the process require you to contact individuals in ways which they may find intrusive?			No
If the answer to any of these questions is 'Yes' please contact the Information Governance Manager, Tel: 01279 444455 - Extn: 1272 / Mobile: 07908 632215 tracy.goodacre@pah.nhs.uk / tracy.goodacre@nhs.net. In this case, ratification of a procedural document will not take place until approved by the Information Governance Manager.			
IG Manager approval **Name:**			
Date of approval			

15.14 Appendix 14 – Version Control Sheet

To be completed with the issuing or reviewing of procedural documents

Version	Date	Author	Status	Comment
6.0	Jan 12	Derek Greening, Trust Secretary		
6.1	Jun12	Matt Hayday, Head of Corporate Governance	Draft	Draft review for discussion at Quality & Performance Committee
7.0	June 2014	Oyejumoke Okubadejo, Head of Quality & Safety		Complete overhaul and rewrite of the previous policy. Ratified by the Board July 2014.
8.0	June 2016	Oyejumoke Okubadejo, Assoc Director of Governance & Quality	Approved	Update of policy with new processes, risk review frequency and revised approach to risk appetite.
9.0	January 2017	Oyejumoke Okubadejo, Assoc Director of Governance & Quality		Update of policy with revised escalation process involving new Risk Management Group. Now woven through entire document.
10.0	May 2018 June 2018	Lisa Flack, Compliance and Clinical Effectiveness Manager		Update of Section 5 to reflect current Trust Plans, Objectives and Values Respond to feedback including relating to frequency of SRR review by Board