Meeting Title	Trust Board Meeting (Session in Public)		
Meeting Date	11th June 2020	**Agenda No**	**5**
Report Title	Risk and Compliance Update		
Lead Executive Director	Diane Sarkar – Chief Nursing Officer		
Report Author	Tracy Turner, Associate Director for Risk and Compliance		
Action Required	Decision □ Discussion □ Monitoring √□ *(please tick)*		
Background / Context	The purpose of this paper is to provide the Board with an overview of the risk and compliance activity for 2019/20 and development plans for 20/21.		
Key Issue 1	**Risk Management Strategy** The new trust risk management strategy has been written which details the overarching framework and governance processes to support managers and staff in ensuring the trust is able to deliver its objectives by identifying and managing risks. The draft strategy for approval is attached (see appendix 1).		
Key Issue 2	**Board Assurance Framework (BAF)** The final BAF was presented to the Board on 7th May and it was agreed that only those risks scoring >20 on the 2019/20 BAF would be carried forward and incorporated into the 20/21 BAF. Those risks scoring <20 have been reviewed and incorporated where appropriate into the newly created corporate risk register. The BAF will be reviewed following the development and approval of the new Trust strategic objectives and will be presented to the Audit Committee in July 2020 and the subsequent Board meeting along with the updated Risk Appetite.		
Key Issue 3	**Corporate Risk Register** A risks and issues log specific for Covid 19 has been created and contains 10 risks and 3 issues. The corporate risk register for each site has been reviewed and risks / issues were either carried forward onto the new corporate risk register as a merger risk or site specific risk or has been de-escalation to be managed at site or departmental level. The updated corporate risk register will be presented to the Governance Oversight Group in June and the Audit Committee in July 2020.		
Key Issue 4	**CQC Compliance and external reviews** The combined CQC action plan was presented to the Board Assurance Committee in May 2020. There are currently 95 actions, of which 33 are closed and no actions are overdue.		

	Due to Covid 19, the approach to internal CQC compliance visits is being reviewed to ensure infection prevention and control measures are adhered to. All external reviews are currently on hold due to Covid 19 and where possible are being conducted virtually.
Key Issue 5	**Document Control** The Joint Document Control process is now well established and the team continue to support departments with the alignment and review of policies across sites.
Timescale for Benefits to be Realised	BAF: Monthly review at board sub committees Quarterly review at Board CQC: Monthly review at site and Governance Oversight
Risk	Inadequate oversight of risks increases the overall risks to patients and the trusts' reputation
Freedom of Information	*No exemptions apply (i.e., information is in the public domain)* *OR The following exemption(s) apply to this paper :*
Other *Implications Identified*	Financial implications
Recommendation	The Board are invited to: • Review the draft Risk Management Strategy • Note the 2019/20 position and development plans for 2020/21
Appendix	1 – Risk Management Strategy

Risk and Compliance Summary Report 2019/2020 and developmental plans for 2020/21

Risk Management Strategy

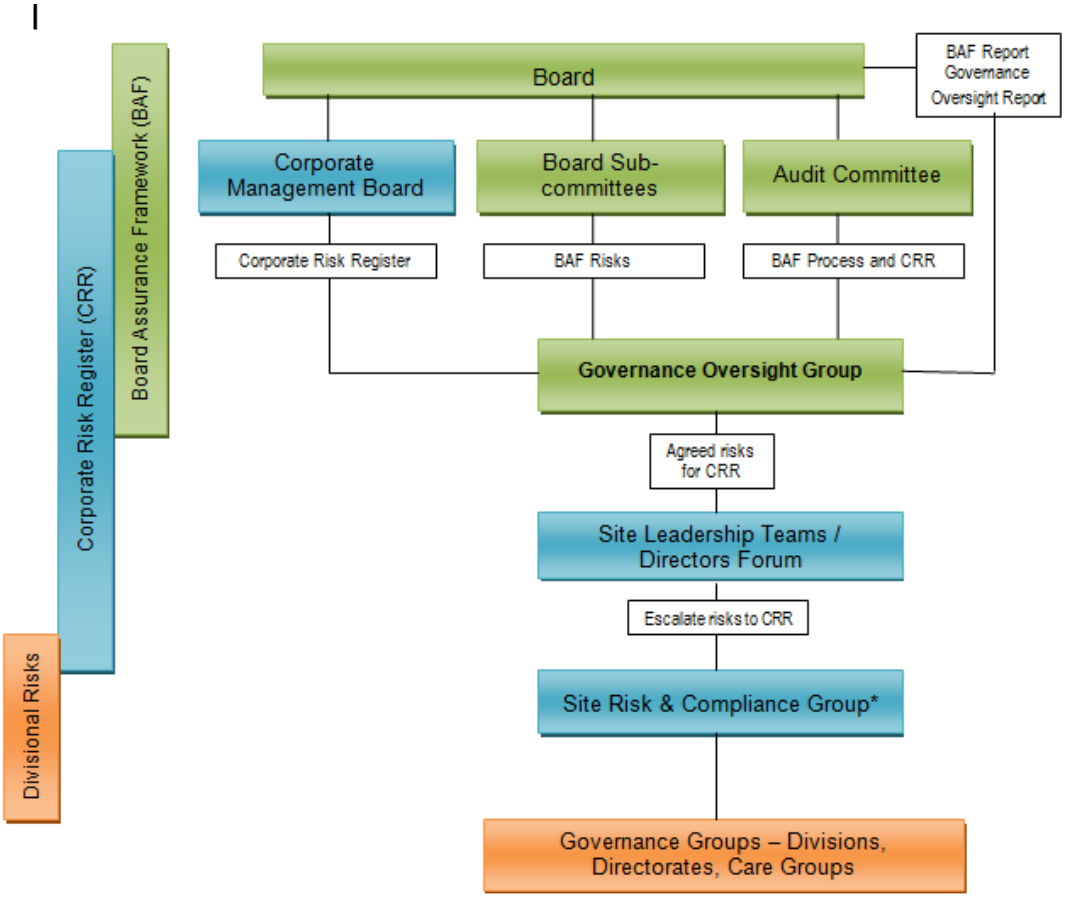
In March 2020 the Risk and Compliance Team was created following the corporate nursing consultation and subsequent re-structure. Once fully recruited, the team will support trust processes for governance including risk management, board assurance framework, central alerting system compliance, CQC compliance and other external bodies and document control including patient information. There are 5 vacancies of a team of 8 which are in the recruitment process. Staff currently in post are:

- Associate Director of Risk and Compliance
- Document Control Manager
- Document Control Officer

Risk management reporting and governance arrangements have been reviewed in line with the new organisational structures and a framework has been developed. The aim of the framework is to ensure that risks are identified, assessed, controlled and escalated as appropriate and seeks to minimise, although not necessarily eliminate, threats and maximise opportunities.

The new trust risk management strategy has been written which details the overarching framework and governance processes to support managers and staff in ensuring the trust is able to deliver its objectives by identifying and managing risks. The draft strategy for approval is attached (see appendix 1).

The updated risk reporting framework as described in the strategy is as follows:



Board Assurance Framework (BAF) 2019/20

The BAF was reported to the Boards in Common in April, June, September, and November 2019. The final BAF position was presented to the Board on 7th May 2020 and agreed only those risks scoring <20 on the 2019/20 BAF would be carried forward and incorporated into the 20/21 BAF. Those risks scoring <20 have been reviewed and incorporated where appropriate into the newly created corporate risk register.

An additional risk was added to the BAF in March 2020 in response to the Covid 19 pandemic.

The final heat map position of the BAF for 2019/20 was as follows:

Board Assurance Framework - Risk Heat Map		Current Score (likelihood x impact, arrow indicates any movement since last report/no Movement since last report)							
	Inherent Score	<=9	10	12	15	16	20	25	Target Score
1.0 Strategic Objective **Be a single, well-led, high performing and innovative organisation which joins up care for the people we serve. (Tom Abel)**									
1.1 Failure to provide a conducive environment for colleagues to design, adopt and implement innovative practices. **Tom Abell**	20				↔				15
1.2 Failure to implement the merger of three trusts into one trust leading to sub-optimal decision making **Jonathan Dunk**	20	✓ ↓							10
1.3 Failure to demonstrate sufficiently high levels of performance to achieve "Good" overall rating for CQC Well Led. Failure to deliver agreed remedial actions in a timely manner and ensure responsiveness when necessary. **Diane Sarkar**	16	✓ ↓							8
1.4 Failure to deliver improvement national performance targets in the agreed trajectories **Yvonne Blucher, Andrew Pike, Jane Farrell**	20						✓ ↔		12
1.5 Failure to enable and empower leaders in all areas of the organisation to create a culture of continuous improvement **Tom Abell**	25						↔		15
2.0 Strategic Objective **Deliver high quality, safe and responsive services shaped by best practice and our local communities. (Diane Sarkar and David Walker)**									
2.1 Failure to equip colleagues to deliver a high quality safe service against agreed trajectories. **David Walker**	16					↔			12
2.2 Failure to deliver clinical service change / reconfiguration to meet the needs of the local population currently and in the future, against agreed timescales. **David Walker**	20			↔					9
2.3 Failure to gain agreement and consensus of local communities to changes that reflect best practice. **David Walker**	25					↓			9
2.4 Failure to achieve consistent "Good" rating for CQC in Safe, Caring, Effective and Responsive domains. Failure to implement agreed remedial action plans in a timely fashion. **Diane Sarkar**	16			✓ ↓					8
2.5 Failure to deliver a high quality, safe service for our patients due to the outbreak of COVID 19 and failure to protect our staff from infectious disease transmission **David Walker**	25						↔		6
3.0 Strategic Objective **Be an employer of choice for a supported, engaged and high performing workforce. (Danny Harriam)**									
3.1 Risk of workforce instability as a result of high levels of turnover and the inability to reduce these levels, resulting in low staff morale and increased turnover **Danny Hariram**	16						↔		8

4.0 Strategic Objective Be effective and efficient with all our resources, creating an organisation that residents and staff can rely on for the long term. (Dawn Scrafield, Martin Callingham, Eamon Malone)									
4.1 Failure to achieve and deliver year on year improved financial sustainability and effective use of resources Dawn Scrafield	25							✓	15
4.2 Failure to consistently deliver safe, responsive and efficient patient care in a cost effective manner because the current estate and associated infrastructure is not fit for purpose. Failure to develop and fund a long term capital plan which addresses the clinical, estates and technological needs of the organisation Eamon Malone	25						✓		15
4.3 Failure to deliver digital transformation agenda and to ensure resilience in informatics and IT services. Martin Callingham	12					√			9
4.4 Failure to deliver transformation in corporate support to create a fit for purpose future proofed structure. Jonathan Dunk	20			√					10

Board Assurance Framework 2020/21

The BAF will be reviewed following the development and approval of the new Trust strategic objectives. The draft BAF risks will be agreed by the relevant Board Sub-Committee with operational direction by the Governance Oversight Group. The BAF will be presented to the Audit Committee in August 2020 and the subsequent Board meeting along with the updated Risk Appetite.

Corporate Risk Register 2019/20

The corporate risk register (CRR) is the corporate high level operational risk register used as a tool for managing risks and monitoring actions and plans against them. Used correctly, the CRR demonstrates that an effective risk management approach is in operation within the Trust.

The CRR typically comprises of risks that are no longer manageable within individual services (Divisions, Directorates or Departments); has a wider impact on other services; or possibly has a residual risk rating graded as extreme. The CRR also contains issues.

In March 2020 a specific Covid19 risks and issues log was created. The current risk ratings as at 02/06/2020 is as follows:

Covid 19 Risk register

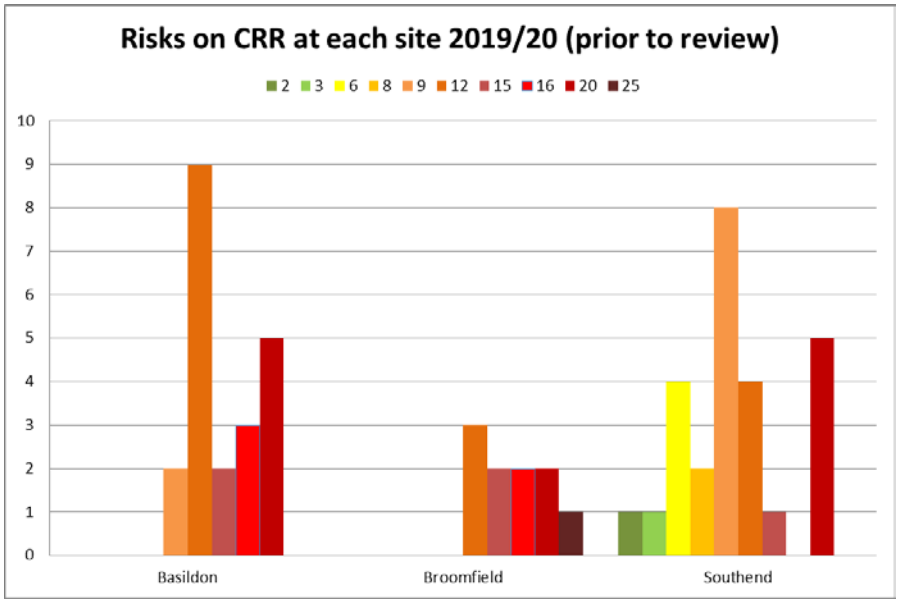
Risk ID	Risk description (A failure to…..caused by…….may lead to……)etc.	Date risk identified	Risk Rating (Total 1-25)	Action owner
1	The increase in oxygen requirements for ventilated and non-ventilated patients caused by the COVID 19 pandemic may lead to insufficient oxygen supplies and patient harm	08/04/2020	20	Eamon Malone
2	An increase in the number of deceased patients caused by the COVID 19 pandemic may lead to a shortage of capacity within the hospital mortuary	04/04/2020	6	Tom Abell
3	A shortage of clinical and non-clinical staff required to maintain safe and effective services and safely staff clinical and business critical areas caused by the COVID 19 pandemic may lead to patient harm or a cause a disruption to services	08/04/2020	20	Danny Hariram
4	A shortage in the availability of PPE caused by an increase in the number of inpatient with COVID 19 and increased requirement for PPE may lead to insufficient protection for staff	15/04/2020	20	Jonathan Dunk

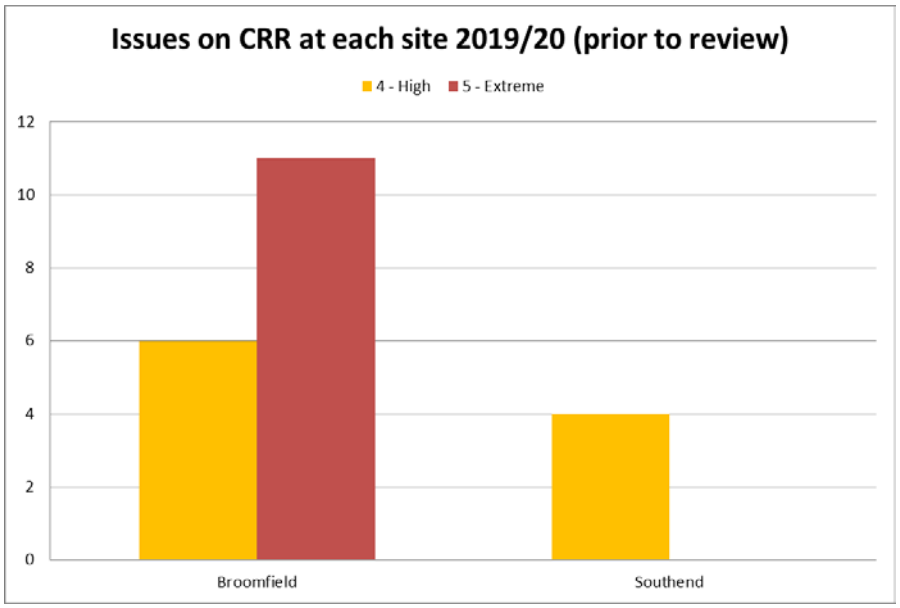
5	There is a national shortage of fluid repellent theatre gowns for use in caring for high risk Covid-19 patients. To reduce the risk to staff of a lack of Personal Protective Equipment(PPE) single use theatre gowns may be laundered and decontaminated for re-use	17/04/2020	8	Eamon Malone
6	There is a national shortage of Hemofiltration devices and the fluids which are required to run them which may result in an inability to look provide adequate haemofiltration to all patients requiring this	21/04/2020	12	Ronan Fenton
7	Lack of appropriate environment and PPE for the delivery of CPAP and BIPAP causing insufficient protection for staff may result in staff harm and reputational damage	21/04/2020	12	Diane Sarkar
8	The increased emotional demand caused by dealing with patients during the coronavirus pandemic may lead to psychological harm to staff	21/04/2020	16	Danny Hariram
9	The requirement to commence cancer surgery could put patients at risk of contracting COVID 19 if effective plans are not put in place to ensure segregation of patients according to the national guidance	29/04/2020	15	Joe Hayward
10	The national requirement to conduct a risk assessment in relation to the exposure of BAME staff may determine staff who should be redeployed from front line duties resulting in staff shortages which may lead to patient harm and disruption to services	01/05/2020	16	Danny Hariram

Covid 19 Issues log

Impact ID	Issue description	Date Issue occurred	Potential impact on project delivery (1-5)	Action owner
I1	Shortage of fit testing liquid impacting on the capacity to be able to fit test staff and provide appropriate PPE for managing COVID patients.]	08/04/2020	3	Jonathan Dunk
I2	Increasing number of consumables over and above PPE are on restricted availability and subject to shortages	16/04/2020	4	Jonathan Dunk
I3	Shortage of FFP3 face masks	12/05/2020	5	Jonathan Dunk

In 2019/20, each site had its own CRR which was maintained and reviewed by the local Site Leadership Teams. At the end of 2019/20, the risks and issues on the CRR for each site were as follows:





The top risks that were consistent across one or more of the three sites were as follows:

Area of concern	BTUH	MEHT	SUHFT
Staffing / Workforce	√ (16)	√ (20)	√ (20)
National targets / performance	√ (20)	√ (16)	√ (25)
Finance	√ (20)	√ (20)	√ (20)
CQC compliance	√ (20)	√ (20)	
End of life operating systems	√ (20)		√ (20)

Corporate Risk Register 2020/21

Each hospital site had its own CRR and a review of these highlighted that there were significant differences in the risk management approach being taken across the sites resulting in different risks and issues being held within the CRR.

The risks and issues were reviewed and have been either merged to form one risk or issue across the trust, or were de-escalated from the CRR to be managed at site or departmental level. The

updated CRR is in the process of being finalised and approved and will be presented to the Governance Oversight Group in June and the Audit Committee in July 2020.

Care Quality Commission Compliance

The CQC reports were published on 10th July 2019 for Basildon and 6th March 2020 for Southend and Broomfield with the following ratings and actions:

	Basildon Hospital	Broomfield Hospital	Southend Hospital
Rating	Good	Requires Improvement	Requires Improvement
Requirement notices	2	3	4
MUST take actions	10	6	21
SHOULD take actions	5	26	26

Requirements notices issued for each site was as follows:

Requirement notices	Basildon Hospital	Broomfield Hospital	Southend Hospital
Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment	• Diagnostic and screening procedures • Maternity and midwifery services • Treatment of disease, disorder and injury	• Diagnostic and screening procedures • Treatment of disease, disorder and injury	• Diagnostic and screening procedures • Surgical procedures • Treatment of disease, disorder and injury
Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment			• Diagnostic and screening procedures • Surgical procedures • Treatment of disease, disorder and injury
Regulation 17 HSCA (RA) Regulations 2014 Good governance	• Diagnostic and screening procedures • Maternity and midwifery services Treatment of disease, disorder and injury	• Nursing Care • Treatment of disease, disorder and injury	• Diagnostic and screening procedures • Surgical procedures • Treatment of disease, disorder and injury
Regulation 18 HSCA (RA) Regulations 2014 Staffing		• Nursing Care • Treatment of disease, disorder and injury	• Diagnostic and screening procedures • Surgical procedures • Treatment of disease, disorder and injury

COVID 19 response and CQC compliance

In March 2020, a paper was submitted to the Board to describe the interim approach taken in relation to the CQC improvement plan during the Covid 19 pandemic. It was agreed that a pragmatic approach was to be taken with the CQC actions to ensure that where possible, 'Must' take actions would be progressed and 'Should' take actions put on hold. There were a number of 'Must' take actions that could not be progressed due to the Trust Covid 19 response (such as those relating to mandatory training, staff, appraisals, audit and governance).

Developments for 2020/21

In May 2020, the Trust wide action plan was developed and presented to the Board Assurance Committee. There are 95 actions on the action plan currently with no actions overdue. The action plans are being reviewed every 2 weeks (or sooner if required) and updates presented to the relevant sites on a monthly basis.

	Action complete	Action within one week of due date OR known risk to achieving by due date	Action overdue	Action complete with evidence	Action not yet due No known risks to completion	Actions with no due date
	G	A	R	B	N	
Must take actions	4	0	0	9	25	0
Should take actions	8	0	0	12	35	2

Internal CQC Compliance Inspections

During 2019/20, the following compliance inspections were carried out across the 3 sites.

Site	Internal CQC Compliance Inspections
Broomfield	Departmental / ward inspection: 11
Basildon	Departmental / ward inspection: 4
Southend	Core service inspections: 8 Urgent and Emergency Care Medicine Surgery Critical Care Diagnostic Imaging Outpatients Maternity Children and Young People End of Life Departmental / ward inspections: 19

Internal CQC Compliance inspections plan 2020/21

The approach to internal reviews is currently be reviewed following the Covid19 pandemic to ensure exposure to potential infection is limited and recommendations adhered to. A number of approaches are being explored to balance the need to gain assurance versus infection prevention and control measures.

External reviews / visits 2019/20

Due to Covid 19, external reviews and visits have been temporarily suspended or have moved to become virtual (remote) reviews. A list of the external reviews and visits that took place during 2019/20 are listed below.

MEHT	SUHFT	BTUH
3/6/19: NHSI Infection Prevention 14/6/19: EHO (Environmental Health Officers) 16/7/19 : Neonatal ODN Peer Review 23/7/19 : Acute Commissioning Team Quality Assurance Visit 8/8/19: Trauma Network 21/8/19: Radiation Protection Advisors IR(ME)R	14/05/19 Acute Commissioning Team Quality Assurance Visit 10/07/19 Neonatal Peer Review 06/08/19 Acute Commissioning Team Quality Assurance Visit 27/09/19 Baby Friendly Initiative Assessment (BFI) 30/10/19 SQAS Breast Screening	04/04/19 Acute Joint Commissioning Team Quality Assurance Visit 30/04/19 Acute Joint Commissioning Team Quality Assurance Visit 10/07/19 Neonatal Peer Review 23/07/19 Acute Joint Commissioning Team Quality Assurance Visits

24/9/20: Acute Commissioning Team Quality Assurance Visit 3/10/19 : Joint Advisory Group 3/10/19 : Joint Commissioning team-Stand-alone Birthing Units 4/11/19 : BSI Biomedical Engineering ISO 9001:2015 accreditation 28/1/20 : Counter Terrorism Policing visit in Microbiology 29/1/20 : Paediatrics Diabetes Service peer review visit 30/1/20 : Human Tissue Authority Post Mortem Sector Assessment 6/2/20 : Cervical Screening Programme Quality Assurance visit 12/2/20: Critical Care Peer review 25/2/20: ISO 9001:2015 inspection theatres accreditation 11/3/20 : UKAS Blood Sciences assessment	12/11/19 Patient Led Assessment Clinical Environment (PLACE) 27/11/19 Health Education East of England Anaesthetics 01/12/19 East of England Critical Care network 25/02/20 Acute Commissioning Team Quality Assurance Visit	09/10/19 Critical Care Peer Review 11/11/19 Trauma Peer Review 22/01/20 Acute Joint Commissioning Team Quality Assurance Visit January 2020 BSI ISO 22301 Business Continuity Standards

Document Control Overview 2019/20

The Joint Document Management Group approved 41 documents in 2019/20. The new MSE team are in post following the recent corporate re-structure and a forward plan is in place to continue to align trust policies. The team are also working with site based departments to address the overdue status of policies and 100% compliance has already been achieved at Broomfield.

Overdue status of documents:

Basildon – 6.6%
Southend – 13.8%
Broomfield – 0%