| | | | |
|---|---|---|---|
| **Meeting Title** | Mid and South Essex Acute Trusts Joint Working Board (meeting in public) | | |
| **Meeting Date** | 4th April 2108 | **Agenda No** | **8** |
| **Report Title** | Risk Management and Compliance Update | | |
| **Lead Executive Director** | Diane Sarkar – Chief Nursing Officer | | |
| **Report Author** | Diane Sarkar – Chief Nursing Officer | | |
| **Action Required** | Decision □ Discussion √□ □ | | |
| **Background / Context** | A more strategic approach to risk management is required from a JWB perspective and this is underway.<br><br>Each local site continues to work in developing its own risk management framework and mitigating risks. | | |
| **Key Issue 1** | **Risk - BAF**<br>Following the meeting with BDO, the written output from the meeting has now been received and a small working group meeting is planned for 4th April to discuss the feedback and progress the development of a revised BAF. For this reason, prior to the development of the new BAF, the existing BAF has been reviewed by the JEG to ensure the current identified risks are being managed (Appendix 1)<br><br>**Summary of current BAF**<br>The BAF has been reviewed by the Executives accordingly. BAF Risk 8B has progressed with waiting list management of 6 weeks diagnostics. Both SUHFT and BTUGH are sustaining ≥ compliance whilst MEHT remains as an outlier for Ultrasound.<br>This risk is offered for retirement from the BAF, with oversight maintained at site level.<br><br>**Escalation of Risks from Sites**<br>There are no risks to escalate. | | |
| **Key Issue 2** | **Compliance**<br>A standardised policy template has been developed and agreed for implementation across the three sites for all new policies.<br><br>Review of actions following SUHFT CQC inspection in December continues across BTUH and MEHT.<br><br>Both BTUH and MEHT have now established weekly CQC monitoring meeting to ensure actions taken following mock inspections.<br><br>**SUHFT**<br>CQC - The action plan continues to be monitored on a weekly basis. The final CQC report is still awaited from the CQC.<br><br>**BTUH** | | |

| | |
|---|---|
| | CQC – Internal Well Led Review. This is still in progress, some interviews / meetings have been delayed due to capacity issues and the report will be taken to the May BTUH Board.<br><br>**MEHT**<br>The internal CQC compliance review which was delayed from February has now taken place. The "Well Led" review will commence at the end of April / beginning of May. There is acknowledgment that performance against a number of national safety and quality indicators / targets is a significant cause for concern. This has led to additional scrutiny from the site leadership team and regulators and focussed work is being undertaken to make rapid improvements. The trust is currently rated as "Good" with the CQC and there is a risk that this will not be sustained at further inspection both at core service and well led level. Actions have been and continue to be taken and weekly monitoring is in place. |
| **Timescale for Benefits to be Realised** | April 2018 |
| **Assessment of Implications** | |
| **Financial** | Does this proposal have revenue (recurrent or non-recurrent) implications for the Trusts? Not currently |
| **Risk** | Inadequate oversight of strategic risks and lack of consistency and standardisation increases the overall risks collectively and demonstrates poor governance arrangements. |
| **Freedom of Information** | *No exemptions apply (i.e., information is in the public domain)*<br>*OR The following exemption(s) apply to this paper :* |
| **Other *Implications Identified*** | • Regulatory impact may be evident |
| **Recommendation** | The Joint Working Board are invited to:<br>• Note and discuss the report |
| **Appendix** | 1. Current BAF (reviewed March 2018) |

Mid Essex, Southend and Basildon Hospitals

# Mid Essex, Southend and Basildon Hospitals

# BOARD ASSURANCE FRAMEWORK

# Quarter 4 2017/18

| **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** |
| **1A.** Effective cross system capacity and demand management and achievement of National and Constitutional targets. **Exec Lead – Chief Transformation Officer** | **25** | | | | | | ↔ | | **10** |
| **1B.** Effective cross system capacity and demand management for Ophthalmology services **Exec Lead – Chief Medical Officer** | **20** | | | | | ↔ | | | **6** |
| **2**. Financial Sustainability. **Exec Lead – Chief Financial Officer** | **25** | | | | | | ↔ | | **10** |
| **3**. Staff Recruitment and Retention. **Exec Lead – Chief Human Resources Director** | **20** | | | | | | ↔ | | **12** |
| **4A**. Current estate and infrastructure compromises the ability to consistently deliver safe, responsive and efficient patient care - PREMISES **Exec Lead – Chief Estates and Facilities Director** | **12** | | | ↔ | | | | | **9** |
| **4B.** Ageing/Unsupported medical equipment compromises the ability to consistently deliver safe, responsive and efficient patient care **Exec Lead – Chief Estates and Facilities Director** | **12** | | | ↔ | | | | | **9** |
| **5.** IT Strategy and Healthcare Informatics capability. **Exec Lead – Chief Information Officer** | **12** | | | ↔ | | | | | **9** |
| **6.** Business Interruption and Cyber Security. **Exec Lead – Chief Information Officer** | **16** | | | ↔ | | | | | **8** |
| **7A.** Failure to deliver the external facing elements of the Sustainability and Transformation Plan (STP) and the potential for political instability. **Exec Lead – Chief Transformation Officer** | **20** | | | | | | ↔ | | **8** |
| **7B.** Failure to achieve the internal elements of the Essex Success Regime Transformation Plan. **Exec Lead – Chief Transformation Officer** | **20** | | | | | | ↔ | | **8** |
| **8A**. Effective and reliable Clinical Support Services. **Exec Lead – Chief Medical Officer** | **20** | | | ↔ | | | | | **12** |
| **8B.** Effective and reliable Radiology Services **Exec Lead – Chief Medical Officer** | **20** | | | ↔ | | | | | **TBC** |
| **9A**. Regulatory Compliance with National Standards and the Health & Social Care Act (HSCA) Regulations. **Exec Lead – Chief Nursing Officer** | **12** | | | ↔ | | | | | **3** |

| | Inherent Score | <=9 | 10 | 12 | 15 | 16 | 20 | 25 | Target Score |
|---|---|---|---|---|---|---|---|---|---|
| **9B.** Infection Prevention and Control<br>**Exec Lead – Chief Nursing Officer** | **15** | | | | ↔ | | | | **3** |

| MSB Group RISK ID | **Joint Risk 1.0A** | Joint Group Executive Lead | Chief Transformation Officer (CTO) | MSB Group Risk Appetite |
|---|---|---|---|---|
| CQC Reference(s) | Regulation 9 – Person-centred care, Regulation 10 - Dignity and respect, Regulation 12 - Safe care and treatment & Regulation 17 – Good governance | | | |
| Risk Title | **Effective cross system capacity and demand management and achievement of National and Constitutional targets** | | | |

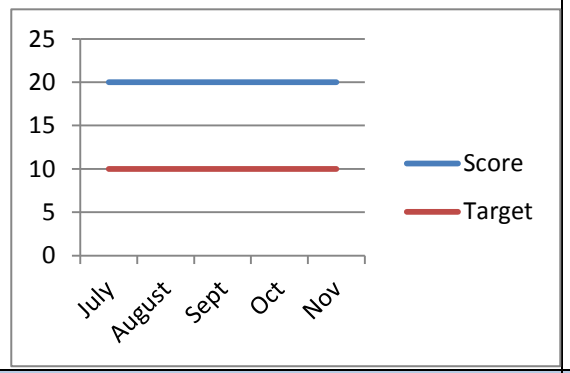
| | | | | | |
|---|---|---|---|---|---|
| **Risk Description** | Failure to manage patient flow and capacity, develop new pathways and lack of delivery of external partners against the Transformation Plan may lead to failure to deliver the standards of the NHS Constitution.<br><br>Patient flow and internal capacity is currently a challenge for all 3 trusts impacting on the plans and ability to focus on the strategic objectives. | | | | |
| **Group Strategic Objective** | 1, 2, 3, 4, 5 and 6 may all apply. | | **Risk Category** | Business objectives/projects | |
| **Date Identified** | 27 April 2017 | **Date Last Reviewed** | CTO – March 2018 | **Target Date** | March 2018 |

**Risk Rating (Likelihood x Impact)**

| | |
|---|---|
| Initial Risk Score | 25 (5x5) |
| Current Risk Score | 20 (4X5) |
| Target Risk Score | 10 (2x5) |

L x C
4x5

Risk Trajectory




**Relevant Key Performance Indicators**

| KPI | BTUH | | | SUHFT | | | MEHT | | |
|---|---|---|---|---|---|---|---|---|---|
| Qtr3 17/18 | O | N | D | O | N | D | O | N | D |
| Target (%) | 95 | | | 95 | | | 95 | | |
| ED 4 hrs (%) | 90.2 | 85.7 | 83.6 | 89.4 | 85.7 | 76.6 | 92.9 | 83.4 | 74.1 |
| Target (%) | 92 | | | 92 | | | 92 | | |
| RTT (%) | 83.2 | 83.6 | 83.1 | 84.2 | 85.0 | 84.3 | 75.8 | 72.4 | 69.4 |
| Target (%) | 85 | | | 85 | | | 85 | | |
| Cancer 62 Day (%) | 72.8 | 72.7 | | 80.3 | 80.6 | | 72.4 | 73.0 | |

**Controls: (What are we currently doing about the risk?)**

1. Cross site Operations Board in place, chaired by Managing Directors to co-ordinate and agree mutual support arrangements across all aspects of operational delivery.
2. Clinical redesign groups in place focusing on improving clinical pathways for winter, including implementation of strengthened and consistent ambulatory pathways.
3. Secured £3m capital funding to support the development of primary and community stream within A&E departments.
4. Cancer Programme Director appointed and additional funding secured from NHS England to support improvement in cancer delivery standards, alongside development of cancer improvement plan.
5. Strategic trust led projects in development to support the development of additional focused capacity in pressured service areas (e.g. Orthopaedic Centre in Mid Essex).
6. STP Winter Room now in place to support operation of emergency care pathways across the

**Gaps in Controls:**

1. Lack of detailed implementation plans for clinical redesign, primary care streaming, cancer to be finalised for approval and implementation during the summer. - **COMPLETE**

2. Cross trust operational plans to be developed to articulate mutual support arrangements to support operational delivery.

| | | | |
|---|---|---|---|
| | system, particularly focusing on supporting complex discharging and ambulance load sharing | | |
| **Mitigating Actions: (What more do we need to do to fill the gaps)** | | **Lead** | **Target Date** |
| 1. | Cross trust operational plans to be developed and implemented for each Constitutional standard area outlining mutual support arrangements to support operational pressures, including joined up winter plan. | MDs | October 2017 **COMPLETE** |
| 2. | Public consultation for new operating model to be completed | CTO | March 2018/CCG discussions end May/June 2018 **IN PROGRESS** |
| 3. | Development and approval of system delivery architecture to support implementation of service change across system | CTO | February 2018 **IN PROGRESS** |
| 4. | Developing a single complex discharge service and system | CTO | January 2018 **IN PROGRESS** |
| 5. | "winter Room" to co-ordinate community response and support to urgent care | CTO | January 2018 **COMPLETE** |
| **2018Assurances: (How will we know that what we are doing is having an impact?)** | | | |
| **1.** | Improvement against key performance indicators. | | |
| 2. | Site based winter plans in place | | |
| **Risk Review Comments:** | | | |
| 06 June 2017 | New Risk 1.0 reviewed and re-crafted by the Chief Transformation Officer in advance of JEG on 21 June 2017. | | |
| 24 Aug 2017 | Risk reviewed. Data available to date added to the KPIs | | |
| 20 Sept 2017 | Risk reviewed. Data available to date added to the KPIs | | |
| 27 Oct 2017 | Risk reviewed by the CTO. For further development and alignment of CMO projects to ensure that all elements of project risks are suitably articulated | | |
| 24 Nov 2017 | Risk reviewed by CTO. CMO project risks aligned. | | |
| 03 Jan 2018 | Risk reviewed by CTO. Additional control added (No 6) | | |
| 27 March 2018 | Risk reviewed and updates added in RED | | |

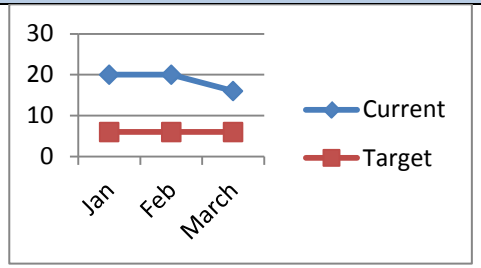
| MSB Group RISK ID | **Joint Risk 1.0B** | Joint Group Executive Lead | Chief Medical Officer (CMO) | MSB Group Risk Appetite |
|---|---|---|---|---|
| CQC Reference(s) | Regulation 9 – Person-centred care, Regulation 10 - Dignity and respect, Regulation 12 - Safe care and treatment & Regulation 17 – Good governance | | | |
| Risk Title | **Effective cross system capacity and demand management for Ophthalmology services** | | | |
| Risk Description | Failure to manage patient flow and capacity within ophthalmology services may lead to significant delays and result in patient harm and reputational damage.<br>Patient flow and internal capacity within ophthalmology is currently a challenge at Southend Hospital and Mid Essex Hospital as it is not possible to see all patients within the timescales that are clinically recommended. Key issues relate to the increasing number of referrals and high number of doctor vacancies | | | |
| Group Strategic Objective | 1, 2, 3, 4, 5 and 6 may all apply. | Risk Category | Impact on the safety of patients/Quality/Adverse publicity | |
| Date Identified | 26 June 2017 – New Risk | Date Last Reviewed | CMO – March 2018 | Target Date: March 2019 |

**Risk Rating (Likelihood x Impact)**

| | |
|---|---|
| Initial Risk Score | 20 (5x4) |
| Current Risk Score | 16 (4x4) |
| Target Risk Score | 6 (2x3) |

L x C
4 x 4

**Risk Trajectory**




**Relevant Key Performance Indicators**

| KPI*** | SUHFT | | | MEHT | | |
|---|---|---|---|---|---|---|
| Qtr1 17/18/19 | Q3 | Q4 | Q1 | Q3 | Q4 | Q1 |
| Number in backlog | 1808 | 1573 | | | 5105 | |
| Number new SIs declared | 1 | 1 | | 0 | 0 | (0) |

| Controls: (What are we currently doing about the risk?) SUHT | Gaps in Controls: |
|---|---|
| 1. SUH has a QUIPP programme in place to increase number patients being seen in community | 1. Latest position for QUIPP is with the CCG regarding the need to commission alternative capacity to enable patients care to be moved out of the hospital. |
| 2. On-going recruitment plan in place for doctors | 2. Currently have 7 consultant and speciality doctor vacancies but have offered 6. Will be going through recruitment processes – **This situation has improved** |
| 3. Patients are prioritised according to their clinical need | 3. Although patients are prioritised, due to the number of urgent patients and those who are post-op, SUH are still unable to meet the timescales required. Each patient is reported on Datix and investigated |

| | | |
|---|---|---|
| Controls: (What are we currently doing about the risk?) MEHT | | |
| 4. Consultant Ophthalmologist review of last clinic letter for patients in the backlog. | 4. Capacity for patients needing to be brought forward. | |
| 5. Additional clinics run on a Saturday. | 5. Insufficient additional capacity. | |
| 6. Ophthalmology Improvement Plan (MEHT) | 6. External stakeholder engagement. | |
| **Mitigating Actions: (What more do we need to do to fill the gaps)** | **Lead** | **Target Date** |
| Commissioning of a post-operative pathway. **This starts at MEHT on 08.01.18** | **CCG** | **Mid July 2017** |
| Employment of an additional MR consultant considered. Insufficient space to locate an additional MR consultant. We are recruiting for vacancies: 1 x glaucoma consultant, 2 x middle grades. | MEHT, Ophthalmology Service Manager | **NOT ACTIONED** |
| Exploration of insourcing options to create capacity. Exploration undertaken. Options paper submitted to ADO. Further paper to be submitted to SMG in relation to ongoing validation of backlog patients and insourcing. | MEHT, Ophthalmology Service Manager | August 2017, **revised date January 2018** |
| Work with commissioners to produce a specification for community services. The model of care for Mid and South Essex has been agreed. Work is ongoing with commissioners in relation to MECs, triage and intermediate care. Financial risks are being investigated by the two Trusts. | MEHT, Ophthalmology Service Manager | On-going (monthly Essex Ophthalmology Network Meetings) |
| Capacity and demand modelling (MEHT). | MEHT, Ophthalmology Service Manager | |
| **Assurances: (How will we know that what we are doing is having an impact?)** | | |
| **3.** Update on SUHT QUIPP.<br>**Shared Care Glaucoma:**<br>**Post Operative Cataract:** Not yet commenced as training on community system for HES staff has not been completed – working with MEHT and LOC to organise suitable date.<br>**Glaucoma Repeat Reading:** Community based service to ensure criteria for HES referral are met. Working well as the trust rarely received referrals directly for suspected glaucoma. | | |
| 4. Number of vacancies 2 consultant vacancies – 1 appointed to, start date March 2018, 1 re-advertised as no suitable candidates. 3 specialty doctor vacancies – 1 appointed to, start date to be confirmed – remainder out to advert | | |
| 5. No serious incidents relating to patient harm due to backlog and capacity issues | | |
| 6. Establishment of an Ophthalmology Risk Summit to monitor progress (MEHT). | | |
| 7. Reduction of backlog. | | |
| 8. | | |
| **Risk Review Comments:** | | |
| 26 June 2017 | New Risk 1.0B identified at JRMG and created jointly by Southend Hospital and Mid Essex Hospital for review by the Chief Medical Officer in advance of | |

| | |
|---|---|
| | next JEG |
| 24 August 2017 | No changes to risk rating. Requires further development |
| 27 Sept 2017 | Further data required to populate KPIs – requested form MEHT and SUHFT |
| 12 Oct 2017 | No further data received |
| 22 Nov 2017 | Joint SUHFT/MEHT Visioning Event held in October. New model of a care presented at Joint CCG Board. Working group and plan established with the first meeting in Nov 2017 |
| 2 January 2018 | The model of care for Mid and South Essex has been agreed. Work is ongoing with commissioners in relation to MECs, triage and intermediate care. Updated KPIs have yet to be received.<br>CMO Review – this continues to be a national issue. There are changes with the Commissioning Model and further work with the commissioners regarding the contract needs to be completed. SUHFT are outsourcing and insourcing to address the issues. Future KPIS to collated per financial quarter. Working groups have been established |
| March 2018 | Business case for Phase 1 - Primary Care community service – MECS and triage and supporting IT system due to go to JEG for approval end Mar/early April |

| MSB Group RISK ID | **Joint Risk 2.0** | Joint Executive Group Lead/Risk Owner | **Chief Finance Officer** | MSB Group Risk Appetite |
|---|---|---|---|---|
| CQC Reference(s) | Regulation 9 – Person-centred care; Regulation 12 – Safe care & treatment; Regulation 17-Good governance | | | |
| Risk Title | **Financial Sustainability** | | | |
| Risk Description | Risk that the group is unable to achieve its annual control totals and return to financial balance by 2020/21 | | | |
| Group Strategic Objective | 1, 2, 3, 5, 6 | Risk Domains | Business objectives/projects | |
| Date Identified | 27 April 2017 | Date Last Reviewed | CFO – Mar 2018 | Target Date: March 2018 |

| Risk Rating (Likelihood x Impact) | |
|---|---|
| Initial Risk Score | 25 (5 x 5) |
| Current Risk Score | 20 (4 x 5) |
| Target Risk Score | 10 (2 x 5) |

L x C
4x5

**Risk Trajectory**


**Relevant Key Performance Indicators**

| KPI | BTUH | | | | SUHFT | | | | MEHT | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Qtr 17/18 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| Target Trust deficits / (surplus) | 7.6 | 6.2 | 4.8 | (6.1) | 3.6 | 2.0 | 2.0 | 7.4 | 9.4 | 5.5 | 4.5 | 5.1 |
| Actual deficits/(surplus ) | 7.6 | 7.4 | 9.1 | | 3.6 | 1.5 | 2.1 | | 9.9 | 12.3 | 14.6 | |
| Variance | 0 | -1.2 | -4.3 | | 0 | 0.5 | 0.1 | | 0 | -6.8 | -10.1 | |

| Controls: (What are we currently doing about the risk?) | Gaps in Controls: |
|---|---|
| 1. Annual plans for each Trust to achieve control totals | 1. System financial gap is growing |
| 2. STP system multi-year plan to achieve financial balance | 2. - Commissioners are not yet aligned to deliver joint strategic initiatives<br>- Capital for strategic investment not yet secured |
| 3. Review of multi-year plans at joint FRC | 3. Strategic initiatives to close financial gap are not well developed |
| 4. The financial oversight group between the Trusts and CCGs meet regularly to review financial plan<br>5. Financial recovery plan for Mid Essex | 4. On-going contractual challenges from commissioners impacting on Trusts' financial positions and mitigating against system working<br>5. Control and accountability weaknesses at Mid Essex |

| Mitigating Actions: (What more do we need to do to fill the gaps) | Lead | Target Date |
|---|---|---|
| 1. Continue to develop detailed plan for integration and service reconfiguration | James O'Sullivan / Tom Abel | 31/03/2018 |
| 2. Continue to work with STP partner organisations to develop deliverable plans for the wider health | James O'Sullivan / Tom Abel | 31/03/2018 |

| | | |
|---|---|---|
| care system | | |
| 3. Capital allocation for strategic investment was confirmed in the autumn statement. | James O'Sullivan/Tom Abel | 04/10/2018 |

| **Assurances: (How will we know that what we are doing is having an impact?)** |
|---|
| 1. Delivery of the annual financial plans |
| 2. a. Regular joint STP meetings with commissioners |
| b. Continued support from Regulator for the STP plans |
| 3. Strategic initiatives to improve financial position developed into specific agreed actions |
| 4. Strategic capital investment committed by national bodies |

| **Risk Review Comments:** | |
|---|---|
| 02 June 2017 | Risk reviewed and crafted by Chief Finance Officer in advance of JEG – 21 June 2017 |
| 28 June 2017 | Further refinement of the risk made. KPIs to be populated |
| 30 August 2017 | Risk description reviewed by Chief Finance Officer. KPIs added. |
| 29 September 17 | Controls and assurances have been refined. |
| 04 Jan 2018<br>20 March 2018 | Risk reviewed by CFO<br>Risk reviewed by CFO |

| MSB Group RISK ID | Joint Risk 3.0 | Joint Executive Group Lead | Chief Human Resources Director | MSB Group Risk Appetite |
|---|---|---|---|---|
| CQC Reference(s) | Regulation 5 – Fit and proper persons – directors; Regulation 18 – Staffing; Regulation 19 – Fit and proper persons employed | | | |
| Risk Title | Staff Recruitment and Retention | | | |

| | |
|---|---|
| **Risk Description** | The failure to recruit and retain an appropriate workforce to meet the needs of the current and future patient base may lead to an increased in poor patient experience and low staff morale.<br><br>The inability to recruit to key posts due to turnover and an aging workforce. The external risk includes an increasingly shrinking and highly competitive national and international market, regulators and national decisions related to patient care models, education commissioning, safer staffing and terms and conditions.<br><br>The inability to manage the significant demand on the HR and POD teams arising from the corporate, non –clinical and clinical service transformation plans. Lack of capacity to provide proactive support e.g. designing new roles, support for teams and individuals affected by change, strategic workforce planning, planning new service delivery models. |

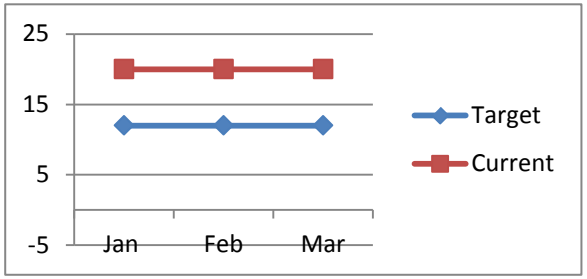
| | | | | | |
|---|---|---|---|---|---|
| **Group Strategic Objective** | 3 | **Risk Category** | Human Resources/OD/Staffing Competence | | |
| **Date Identified** | 27/4/2017 | **Date Last Reviewed** | March 2018 | **Target Date** | March 2018 |

**Risk Rating (Likelihood x Impact)**

| | |
|---|---|
| Initial Risk Score | 20(4x5) |
| Current Risk Score | 20(4x5) |
| Target Risk Score | 12(3x 4) |

4 L x C5

**Risk Trajectory**




**Relevant Key Performance Indicators**

| KPI | BTUH | | | SUHFT | | | MEHT | | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Qtr17/18 | D | J | F | D | J | F | D | J | F | |
| Vacancy Rate | | 11.56 | | | 10.81 | | | 16.17 | | 7.00 |
| Vacancy Rate (nurses) | | 15.74 | | | 11.84 | | | 20.38 | | 7.00 |
| Vacancy Rate (consultants) | | 3.30 | | | 9.62 | | | 11.84 | | 7.00 |
| Agency (% of paybill) | | 5.98 | | | 9.67 | | | 13.25 | | 10.00 |
| Turnover Rate | | 13.81 | | | 13.04 | | | 18.45 | | 9.50 |

**Controls: (What are we currently doing about the risk?)**

1. Group HR KPIS are reviewed by JWB, Site and Group FRCs
2. International and national recruitment in place
3. Group agency review committee
4. Develop of a MSB recruitment and retention strategy for nurses
5. Align HR recruitment, policies, procedures and marketing literature

**Gaps in Controls:**

1. Data quality , Not all KPIs definitions are standardised
2. Inability to attract to specialist positions and registered nurses
3. inability to convert agency to bank/agency contract
4. Action plans fail to deliver a reduction in retention
5. Inability to completely standardise marketing material due to variance in

| | |
|---|---|
| 6. OBC to centralise HR transactional services (Recruitment, Occupational Health, Bank and agency) | terms and conditions<br>6. Outsourced contracts will delay full implementation, Inability to identify the required investment in Year one |

| Mitigating Actions: (What more do we need to do to fill the gaps) | Lead | Target Date |
|---|---|---|
| 1. Consistent KPIS in Group and Site BAF and IPR. | CHRD/HRDs | **Oct 2017 ✓** |
| 2. Develop recruitment and retention plan for nurses | CHRD/CNO | **Sep 2017 ✓** |
| 3. Align personal spec/JD and selection process for band 5, 6, and 7 nurses | CHRD/HRDs | **Oct 2017 ✓** |
| 4. Develop Group nursing recruitment information pack | CHRD/ CNO | **Oct 2017 X** |
| 5. Develop a detailed operational model to introduce one bank and agency service | CHRD/GHRDs | **Sept 2017 X** |
| 6. Align the bank rates across the three trusts | CHRD/GHRDs | **Aug 2017** |
| 7. Develop the first draft of the People Strategy | GD POD/CHRD | **Nov 2017 ✓** |
| 8. Develop a Group staff survey action plans | HRDs/Head of OH | **June 2017 ✓** |
| o Bully and Harassment/Pulse survey | | **Oct 2017 ✓** |
| o Group Health and well-being activities | | **Nov 2017 x** |
| 9. Introduce a Group workforce committee | CHRD/GDPOD | **TBD** |
| 10. Detailed design of bank and agency service | CHRD/GHRDs | |
| 11. Detailed design of recruitment and transactional services | CHRD/GHRDs | |
| 12. First draft of HR Strategy developed | CHRD/GHRDs | **June 2018** |
| 13. Reconcile Group vacancies with actions taken to recruit. | CHRD/GHRDs | **July 2018** |

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

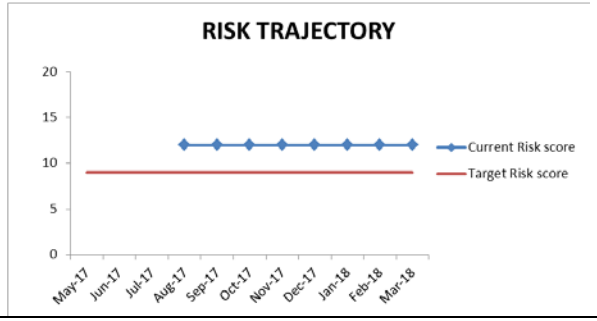
1. On target to achieve vacancy, turnover, appraisal and agency trajectory.
2. Improved engagement score in Pulse and NHS staff survey results
3. Positive Feedback from candidates/student nurses % offered and accept the post
4. Time to hire reduces
5. Where cost effective, standardise rates are introduced – reduce the pay bill
6. Reduction in agency spend
7. Feedback from HR customers
8. Milestones in recruitment and retention plan achieved

| Risk Review Comments: | |
|---|---|
| **28 June 2017** | Additional KPI data added |
| 30 Aug 2017 | KPI data updated |
| **09 Oct 2017** | **No changes noted** |

| | |
|---|---|
| **04 Jan 2018** | **No update received to date** |
| **19 Mar 2018** | **Additional mitigation included, updated status against target dates** |

| MSB Group RISK ID | **Joint Risk 4.0A** | Joint Executive Group Lead | Chief Estates & Facilities Officer | MSB Group Risk Appetite |
|---|---|---|---|---|
| CQC Reference(s) | Regulation 12 – Safe care and treatment; Regulation 15 – Premises | | | Minimal |
| Risk Title | **Current estate and infrastructure compromises the ability to consistently deliver safe, responsive and efficient patient care** | | | |
| Risk Description | Failure to ensure compliance with Fundamental Standard 15, Premises and Equipment, may lead to regulatory action and/or financial penalty through patient or staff harm and result in missed opportunities to support the delivery of outstanding services. Failure to comply with statutory obligation could lead to prosecution and could result in staff and patient harm.<br>• It is essential that the physical condition of the NHS estate is accurately assessed and maintained to ensure it is fit for purpose and safe for patients and staff. It is equally important that appropriate investment programmes are undertaken to improve the condition of sub-standard assets and maintain them at an acceptable level. Once the risks associated with sub-standard assets have been assessed, high and significant risk elements should be addressed as a priority as part of the estate investment planning process.<br>• It is essential that the physical condition of the NHS estate is accurately assessed and maintained to ensure it is fit for purpose and safe for patients and staff. It is equally important that appropriate investment programmes are undertaken to improve the condition of sub-standard assets and maintain them at an acceptable level. Once the risks associated with sub-standard assets have been assessed, high and significant risk elements should be addressed as a priority as part of the estate investment planning process. The trust board should take account of both immediate investment needs and longer-term demands to upgrade and develop new facilities.<br>• Building and engineering fabric deteriorate over time and requires investment for lifecycle replacement. Legislation change from time to time and organisations are required to comply with the prevailing law. Investment is required to ensure the Trust continues to comply with its legal obligation to provide a safe environment and compliance with all applicable legislation related to building, engineering and infrastructure legislation. Year on year investment levels, both revenue and capital fall short of the risks identified according to the national DH methodology of establishing backlog.<br>• Non-compliance with statutory instruments relating to building and engineering to ensure safety can lead to enforcement action and patient, visitor and staff safety incidents | | | |

| | | | | | |
|---|---|---|---|---|---|
| **Group Strategic Objective** | 1, 2, 4, 5 | | **Risk Domains** | Inspection/ Audit, Service/Business interruption | |
| **Date Identified** | 27 April 2017 | **Date Last Reviewed** | March 2018 | **Target Date** | May 2018 |

| **Risk Rating (Likelihood x Impact)** | | **Risk Trajectory** |
|---|---|---|
| Initial Risk Score | 12 (3x4) |  |
| Current Risk Score | 12 (3x4) | |
| Target Risk Score | 9 (3x3) | |

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**Capital Plans and spend against plan are reported to each Trust's Finance Committees and reported to Board.**
**Further KPIs under review**

| Controls: (What are we currently doing about the risk?) | Gaps in Controls: |
|---|---|
| 1. Itemised site risk registers in line with DH guidance identifies those systems at greater risk and impact ensures regular review and escalation of non-compliances – although this needs to be standardised across sites<br>2. Capital investment allocation via investment groups | • CQC requirement notice on Southend site.<br>• Consistent reporting across all three sites to the same degree of detail<br>• Consistent approach to in-year funding requests being prioritised over high and very high risk backlog priorities<br>• Assessment of impact of end of year enforced slippage<br>• Contingency arrangements are not in place for all critical systems due to the nature of which areas the critical systems serve. |

| **Mitigating Actions: (What more do we need to do to fill the gaps)** | **Lead** | **Target Date** |
|---|---|---|
| 1. Business continuity arrangements in place for some systems in some areas | CEFO | **End Q4** |
| 2. Assessment of impact of erosion of capital investment earmarked for important infrastructure investments | CEFO | **End Q4** |
| 3. Consistent assessment of risk with a single methodology | CEFO | **End Q4** |
| 4. Assess the impact of enforced slippage of capital programme for infrastructure investments at year end | CEFO | **End Q4** |
| 5. Clarity across all sites of each of the underpinning risks associated with environment and infrastructure which may not be included in the backlog and equipment replacement programme and prioritise areas for improvement | CEFO | **End Q4** |

| **Assurances: (How will we know that what we are doing is having an impact?)** |
|---|
| 1. Service failure impact in case of breakdown or failure could be minimised |
| 2. Consistent reporting of delivery against investment plan |
| 3. Quantum of Very High Risk Backlog reduces |

| | |
|---|---|
| 4. Quantum of high Risk Backlog reduces | |
| **Risk Review Comments:** | |
| 09 June 2017 | Risk reviewed and crafted by Chief Estates and Facilities Officer in advance of JEG – 21 June 2017 |
| 23 June 2017 | Risk further populated by CEFO with a view to divide this risk for the next iteration allowing for greater detail on the separate elements of Premises and Equipment. These will be entered as Risk 4.0A and 4.0B. |
| 28 June 2017 | Risk has now been divided |
| August 2017 | Six facet survey work completed with peer review of backlog risks – performance data not routinely collected – work in progress |
| September 2017 | In-year prioritisation continues – pressure on revenue budgets. Through finance reports to each Finance Committee ref capital programme spend and slippage |
| October 2017 | As per September 2017. |
| November 2017 | As per October 2017 |
| January 2018 | No change. A compliance review from each site has been requested by the Chief Estates & Facilities Officer. Once complete this will inform full review of this risk. |
| **March 2018** | **The compliance review is still underway - MEHT review drafted, BTUH and SUHFT still to complete. Premises Assurance Model also being completed by all 3 sites as at end March 2018 – this will inform a full review of the risk for 2018-19.** |

| MSB Group RISK ID | Joint Risk 4.0B | Joint Executive Group Lead/Risk Owner | Chief Estates & Facilities Officer | MSB Group Risk Appetite |
|---|---|---|---|---|
| CQC Reference(s) | Regulation 12 – Safe care and treatment; Regulation 15 – Equipment | | | Minimal |
| Risk Title | **Ageing/Unsupported medical equipment compromises the ability to consistently deliver safe, responsive and efficient patient care** | | | |
| Risk Description | Failure to ensure compliance with Fundamental Standard 15, Premises and Equipment, in respect of purchase, maintenance, repair and replacement of equipment may lead to regulatory action and/or financial penalty through patient or staff harm and result in missed opportunities to support the delivery of outstanding services. Failure to comply with statutory obligation could lead to prosecution and could result in staff and patient harm.<br><br>Effective processes to ensure medical equipment maintenance, repair, replacement and safe use are essential to the provision of outstanding services. | | | |
| Group Strategic Objective | 1, 2, 4, 5 | Risk Domains | Inspection/ Audit, Service/Business interruption | |
| Date Identified | 27 April 2017 | Date Last Reviewed | March 2018 | Target Date: May 2018 |

| Risk Rating (Likelihood x Impact) | |
|---|---|
| Initial Risk Score | 12 (3x4) |
| Current Risk Score | 12 (3x4) |
| Target Risk Score | 9 (3x3) |

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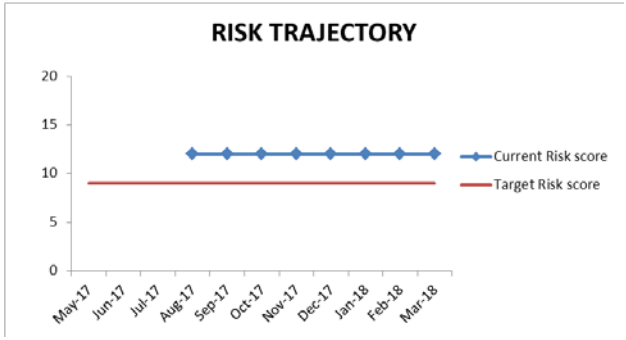
3 x 4

**Risk Trajectory**




**Capital allocation, spend and slippage reported as part of each finance committee**
**Further KPIs under review**

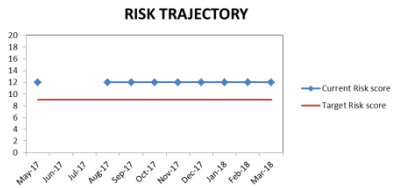
| Controls: (What are we currently doing about the risk?) | Gaps in Controls: |
|---|---|
| 1. Centrally held equipment replacement programme is now in place and reviewed annually. BME liaise with clinical users and prepare ATIs for submission to the Site Investment Groups<br>2. The Capital Programme indicates the associated risk score and highlights the funding required for those highest risks<br>3. Individual directorate RAFs contain medical equipment risks to facilitate effective risk management | • Consistent approach to in-year funding requests being prioritised over high and very high risk equipment priorities<br>• Assessment of impact of end of year enforced slippage |

| Mitigating Actions: (What more do we need to do to fill the gaps) | Lead | Target Date |
|---|---|---|

| | | |
|---|---|---|
| 1. Business continuity arrangements in place for some systems in some areas | CEFO | **End Q4** |
| 2. Consistent assessment of risk with a single methodology | CEFO | **End Q4** |
| **Assurances: (How will we know that what we are doing is having an impact?)** | | |
| 1. Service failure impact in case of breakdown or failure could be minimised | | |
| 2. Quantum of High Risk Medical Device replacement reduces | | |
| **Risk Review Comments:** | | |
| 09 June 2017 | Risk reviewed and crafted by Chief Estates and Facilities Officer in advance of JEG – 21 June 2017 | |
| 23 June 2017 | Risk further populated by CEFO with a view to divide this risk for the next iteration allowing for greater detail on the separate elements of Premises and Equipment. These will be entered as Risk 4.0A and 4.0B. | |
| August 2017 | Risk now split. Performance metric data collection not routinely collected – work in progress. | |
| September 2017 | Reports to each Finance Committee from CFO ref spend against capital allocation | |
| October 2017 | As per September 2017 | |
| November 2017 | As per October 2017 | |
| **January 2018** | **No change. A compliance review from each site has been requested by the Chief Estates & Facilities Officer. Once complete this will inform full review of this risk.** | |
| **March 2018** | **The compliance review is still underway - MEHT review completed, BTUH and SUHFT still to complete. Premises Assurance Model also being completed by all 3 sites as at end March 2018 – this will inform a full review of the risk for 2018-19.** | |

| MSB Group RISK ID | **Joint Risk 5.0** | Joint Executive Group Lead | Chief Information Officer | MSB Group Risk Appetite |
|---|---|---|---|---|
| CQC Reference(s) | Regulation 12 – Safe care and treatment; Regulation 17 – Good governance | | | Seek |
| Risk Title | **Informatics Strategy and healthcare informatics capability** | | | |
| Risk Description | In order to deliver ambitious, innovative ways of working, the Informatics Strategy must support risk seeking decision taking in relation to opportunities for innovation and quality outcomes.<br>Failure to develop and embed a robust Informatics Strategy may lead to technical and financial inefficiencies, with the potential for patient harm and further financial pressure.<br>All three trusts are currently working on different IT systems which are not interfaced to each other. There is no clear central process for the procuring, developing and implementing of IT software solutions. | | | |

| Group Strategic Objective | All | Risk Domains | Impact on the safety of patients, staff or public/Business objectives/projects | |
|---|---|---|---|---|
| Date Identified | 27 April 2017 | Date Last Reviewed | March 2018 | Target Date: March 2019 |

| Risk Rating (Likelihood x Impact) | | Risk trajectory | Relevant Key Performance Indicators |
|---|---|---|---|
| Initial Risk Score | 12 (3x4) |  | • Overarching Informatics Strategy in place from October 2017<br>• An improvement plan developed on the basis of the Informatics Strategy will identify site based and overarching KPIs. |
| Current Risk Score | 12 (3x4) | | |
| Target Risk Score | 9 (3x3) | | |
| L x C<br>3 x 4 | | | |



| Controls: (What are we currently doing about the risk?) | Gaps in Controls: |
|---|---|
| 1. Each Trust within the SR has their individual Informatics Strategy in place | Overarching Clinical and Informatics Strategies required to allow the identification and planned approach to prioritisation of work streams |
| 2. Site teams are working closely together on a project by project basis with regular meetings held to support informed joint working | The impact of implementation of Lorenzo at MEHT has resulted in increased resources from across the MSB being directed to deal with issues arising and data validation. |
| 3. Senior leadership across MSB in Informatics now in place with quarterly performance / governance meeting with senior team in place from January 2018 | |

| Mitigating Actions: (What more do we need to do to fill the gaps) | Lead | Target Date |
|---|---|---|
| 1. Development of the MSB Informatics Strategy in progress underpinned by Digital Essex 2020 to reflect / identify new ways of working and delivery of supporting technology - **completed** | MC | October 2017 |
| 2. Develop plan for centralised services, to include single group Informatics Management Structure and staff consultation – **completed and to be in place 2/10/2017** | MC | September 2017 |
| 3. Review Informatics capital programme, with aim of rationalising | MC | February 2018 |
| 4. MEHT: Lorenzo Steering Group reinvigorated to progress mitigation of issues and risks and revised structure for | MC | December 2017 |

| | | |
|---|---|---|
| Lorenzo project team being developed. | | |
| **Assurances: (How will we know that what we are doing is having an impact?)** | | |
| 1. Site Informatics Strategy review and monitoring in accordance with reporting frameworks | | |
| 2. Escalation of concerns via JWB, JEG | | |
| 3. MEHT Lorenzo work streams reported via at local PS&QC and Trust Board | | |
| **Risk Review Comments:** | | |
| 02 June 2017 | Risk reviewed and crafted by Chief Information Officer in advance of JEG – 21 June 2017. | |
| 27 June 2017 | | |
| 29 Aug 2017 | Reviewed by CIO – no changes to the risk. Trajectory graph baseline amended. | |
| September 2017 | Paper mapping out approach for the development of a digital strategy agreed at JEG September 2017. This will define the next steps. | |
| October 2017 | Current risks identified at MEHT related to Lorenzo implementation and changed ways of working include clinical outcoming of RTT, inaccurate patient tracking list, backlog of letters with medical secretaries and provision of discharge summaries. There are financial implications to the additional resource put in place to mitigate the risks. | |
| 09 November | Initial reviews of cloud navigator and informatics strategy nearing completion with review in early December | |
| 02 January 2018 | No change to risk score, first quarterly performance / governance meeting January 2018. Feedback on future strategy for technical transformation to go to JEG and non executive representatives in January 2018. | |
| **16 March 2018** | **A high level approach to a digital strategy has been identified and discussed through a range of meetings. A number of challenges have been identified that require further work over the next two months:**<br>• **Specific technology option appraisals**<br>• **Phased development plan**<br>• **Mapping of implementation to group redesign priorities e.g. Future organisational form and clinical redesign**<br>• **Financial cost analysis of the plan**<br>• **Benefits realisation plan** | |

| MSB Group RISK ID | **Joint Risk 6.0** | Joint Executive Group Lead | Chief Information Officer | MSB Group Risk Appetite |
|---|---|---|---|---|
| CQC Reference(s) | Regulation 12 – Safe care and treatment & Regulation 15 – Premises and equipment | | | Minimal |
| Risk Title | **Business Interruptions and Cyber Risks** | | | |
| Risk Description | Robust Business Continuity arrangements are essential to ensure effective response and recovery from emergency situations that threaten the normal running of services.<br>In particular, failure to ensure appropriate investment in and application of, digital defences to deter cyber-attacks may lead to patient harm, financial loss, and disruption or damage to the reputation of the Trust through failure of our information technology systems. | | | |
| Group Strategic Objective | 1, 2, 3, 4, 5, 6 | Risk Domains | Service/business interruption | |
| Date Identified | 27 April 2017 | Date Last Reviewed | March 2018 | Target Date: March 2018 |

**Risk Rating (Likelihood x Impact)**

| | |
|---|---|
| Initial Risk Score | 16 (4x4) |
| Current Risk Score | 12 (3x4) |
| Target Risk Score | 8 (2x4) |

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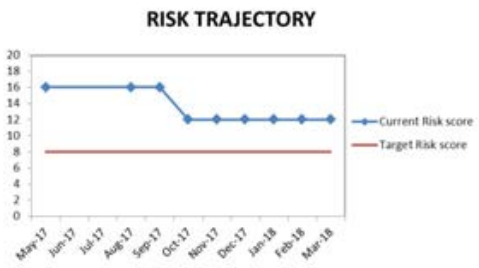
3 x 4

Risk Trajectory




**Relevant Key Performance Indicators**

| KPI | BTUH | | | SUHFT | | | MEHT | | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Qtr117/18 | A | M | J | A | M | J | A | M | J | |
| All relevant patches tested and implemented | | | | | | | | | | |
| | | | | | | | | | | |

- SOP in place for rolling out patches / software releases with report by exception to Site SMGs
- Once finalised, Independent review action plan on track

**Controls: (What are we currently doing about the risk?)**

1. Continuity plans in place and tested across all sites
2. Emergency Planning policies and procedures in place across 3 sites
3. MEHT site, all PCs and Servers have up to date antivirus software installed.
4. IT programme to maintain safe systems including effective antivirus software on all system
5. Regular communications to staff on responsibilities and threats
6. Independent review including governance arrangements, vulnerabilities, threat management and lessons learnt and risk of recurrence across all sites completed

**Gaps in Controls:**

- Management of third party contracts to ensure on-going maintenance of defence against cyber attacks

| Mitigating Actions: (What more do we need to do to fill the gaps) | Lead | Target Date |
|---|---|---|
| 1. Action plan being finalised in response to independent review across all sites | MC | July 2017 |
| 2. Standardise and merge to a single patching process across all sites | MC | August 2017 |

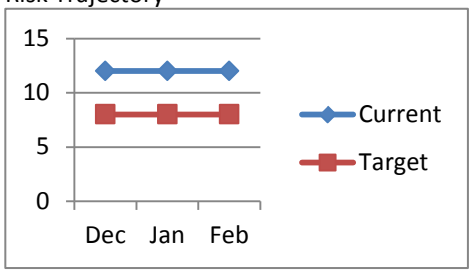
| | | |
|---|---|---|
| 3. Recruit to Cyber security lead post – appointment to post made | MC | October 2017 - completed |
| **Assurances: (How will we know that what we are doing is having an impact?)** | | |
| 1. Independent Review to be shared with JEG and local Site Senior Management Groups, absence of successful cyber attacks | | |
| 2. Internal audit on risk of cyber attack to be include in annual programme of work across all sites | | |
| **Risk Review Comments:** | | |
| 02 June 2017 | Risk reviewed and crafted by Chief Information Officer in advance of JEG – 21 June 2017 | |
| 27 June 2017 | Independent Review report completed and action plan with leads and timescales being finalised. | |
| 29 Aug 2017 | Reviewed by the CIO | |
| 25 September 2017 | Independent Review report action plan with leads and timescales in place. Group wide Cyber security post being in place by mid-October | |
| 2 January 2018 | Cyber Security lead is reviewing and progressing the independent review action plan. | |
| **16 March 2018** | **Received confirmation 12/03 that the Trust has been successful in its bid to NHS England for investment to strengthen and enhance protection against cyber threats. The funding will be used to improve anti-virus protection, upgrade firewalls, strengthen network resilience and security to minimise risk to medical devices. The current risk score can be reassessed once these technologies have been deployed.** | |

| MSB Group RISK ID | **Joint Risk 7.0A** | Joint Executive Group Lead | Chief Transformation Officer | MSB Group Risk Appetite |
|---|---|---|---|---|
| CQC Reference(s) | Regulation 9 – Person-centred care; Regulation 12 – Safe care and treatment; Regulation 15 – Premises and equipment; Regulation 17 – Good governance & Regulation 19 – Fit and proper persons employed | | | |
| Risk Title | **Failure to deliver the external facing elements of the Sustainability and Transformation Plan (STP) and the Pre-consultation Business Case (PCBC) and the potential for political instability.** | | | |
| Risk Description | Failure to deliver the strategic transformation plan may lead to poor patient outcome, poor patient and staff experience and financial instability resulting in regulatory and statutory sanctions and increased reputational risk. | | | |
| Group Strategic Objective | All | Risk Domains | Impact on the safety of patients/Finance | |
| Date Identified | 27 April 2017 | Date Last Reviewed | CTO – March 2018 | Target Date: March 2018 |

| Risk Rating (Likelihood x Impact) | |
|---|---|
| Initial Risk Score | 20 (5x4) |
| Current Risk Score | 20 (5x4) |
| Target Risk Score | 8 (2x4) |

L x C
5 x 4

Risk Trajectory




**Relevant Key Performance Indicators**

| Programme Area | RAG Rate Against Plan |
|---|---|
| Clinical Support | A |
| Corporate Support | A |
| Clinical Redesign & Reconfiguration | A |

| Controls: (What are we currently doing about the risk?) | Gaps in Controls: |
|---|---|
| 1. Joint Working Board in place | Appropriate level of operational comms resource in the Trusts. |
| 2. Site Leadership Team in place for each Trust | Clearly defined escalation points to remove blockages. |
| 3. Project / working Groups in place to develop transformation / improvement plans | |
| 4. There is one Group communications gatekeeper to ensure outward facing communication is dealt with appropriately and inputs monitored. | |
| 5. STP assurance and governance mechanisms in place including the Programme Executive, inter Trust/CCG engagement meetings. | |
| 6. CCG Joint Committee in place | |
| 7. Portfolio structure now in place with NED involvement at the group Portfolio Steering group | |

| Mitigating Actions: (What more do we need to do to fill the gaps) | Lead | Target Date |
|---|---|---|
| Implementation of extensive community and internal staff engagement programme across mid and south Essex regarding service change proposals to inform future model of care. | Tom Abell | September 2017 **COMPLETE** |
| Complete revised acute clinical pathways | Tom Abell | September 2017 |

| | | |
|---|---|---|
| | | (Completed) |
| Obtain PCBC endorsement by CCGs and JWB | Tom Abell | September 2017 (Completed) |
| Commence public consultation | Tom Abell | **IN PROGRESS** |
| Review of existing STP governance and leadership architecture with a view to refresh and build on current arrangements | Tom Abell | **March 2018** |
| Complete clinical senate stage 2 preparation and submission | Tom Abell | **April 2018** |
| Completion and approval of Strategic Outline Case for capital funding drawn down. | Tom Abell | **July 2018** |
| Completion and approval of Decision Making Business Case and CCG decision on final clinical model post consultation | Tom Abell | **July 2018** |
| **Assurances: (How will we know that what we are doing is having an impact?)** | | |
| 1) Programmes are meeting their key milestones. | | |
| 2) There is a clear corporate governance structure which enables decisions to be taken in a timely way at the appropriate level, with a clearly defined escalation process. | | |
| 3) Documentation from meetings identifies decisions clearly and terms of reference identify mechanisms for urgent decision making which are then noted. | | |
| 4) Resource pressures are being monitored, quantified and escalated through steering Groups and to portfolio steering Group and to the Joint Acute Steering Group. The Directors of Finance are involved in reviewing resourcing levels to establish the finance commitments. | | |
| 5) Through the PCBC service user engagement activities patients and citizens are kept engaged in the journey and supportive of the purpose. | | |
| 6) Staff actively proposing new ways of working and new solutions to help drive us further faster. | | |
| 7) Monitor progress update against baseline plan via weekly status report and monthly checkpoint to NHSE. | | |
| 8) Positive external media coverage. | | |
| 9) Clinical senate support NHS England Investment Committee approvals; HM Treasury support announced in Autumn Budget | | |
| **Risk Review Comments:** | | |
| 07 June 2017 | Risk reviewed and crafted by Chief Transformation Officer in advance of JEG – 21 June 2017 | |
| 16 June 2017 | Risk further reviewed by Chief Transformation Officer. | |
| 24 Aug 2017 | Risk reviewed and KPIs added. | |
| 20 Sept 2017 | Risk reviewed and KPIs added. | |
| 24 Nov 2017 | Risk reviewed. KPIs to be changed to match the portfolio milestone tracking. Further controls added to reflect the progress being made | |
| 04 Jan 2018 | Further actions added. Further work is required on producing meaningful KPIs. | |
| 27 March 2018 | Further mitigating actions added by CTO. All programme areas are now rated Amber | |

| MSB Group RISK ID | **Joint Risk 7.0B** | Joint Executive Group Lead/Risk Owner | **Chief Transformation Officer** | MSB Group Risk Appetite |
|---|---|---|---|---|
| CQC Reference(s) | Regulation 9 – Person-centred care; Regulation 12 – Safe care and treatment; Regulation 15 – Premises and equipment; Regulation 17 – Good governance & Regulation 19 – Fit and proper persons employed | | | |
| Risk Title | **Failure to achieve the internal elements of the STP (Group).** | | | |
| Risk Description | Failure to achieve the internal transformation objectives of the Group may lead to poor patient outcome, poor patient and staff experience, inefficient use of resources and financial instability. Resulting in statutory sanctions, increased reputational risk and difficulty retaining staff. | | | |
| Group Strategic Objective | All | Risk Domains | Impact on the safety of patients/Finance | |
| Date Identified | 27 April 2017 | Date Last Reviewed | CTO – March 2018 | Target Date: March 2018 |

| Risk Rating (Likelihood x Impact) | | | Relevant Key Performance Indicators | |
|---|---|---|---|---|
| Initial Risk Score | 20 (5x4) | Risk Trajectory | **Programme Area** | **RAG Rate Against Plan** |
| Current Risk Score | 20 (5x4) | | **Clinical Support** | A |
| Target Risk Score | 8 (3x4) | | **Under Corporate Support** | A |
| L x C<br>5 x 4 | | | **Clinical Redesign & Reconfiguration** | A |

| Controls: (What are we currently doing about the risk?) | Gaps in Controls: |
|---|---|
| 1. Joint Working Board in place. | |
| 2. Joint Executive Team in place for each Trust. | Detailed proposals to be developed for corporate service areas. |
| 3. Portfolio, programme and project structure agreed and in place. | Clearly defined escalation points to remove blockages. |
| 4. Working with work stream leads and SROs to prioritise projects, assign leads and produce project baseline reports outlining status and benefit. | Clearly defined project plans, including realistic benefits realisation plans. |
| 5. Established clear and consistent project documentation, language and methodology across all programmes. | Pipeline for 2017/18 corporate support changes to be developed beyond current consultations. |
| 6. Agreement of priority pathway / service change areas for clinical redesign and clinical support services and clinical leadership roles appointed for these areas, clinical working groups in place. | |
| 7. Project level gate review of portfolio completed, creating a timeline of key milestones and | |

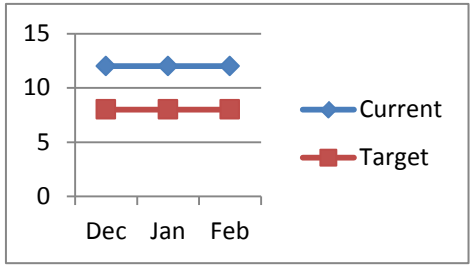
| | | |
|---|---|---|
| identification of blockages and mitigating actions. | | |
| **Mitigating Actions: (What more do we need to do to fill the gaps)** | **Lead** | **Target Date** |
| Gather project baseline reports outlining benefits and where possible including cost savings. | Ogo Ojukwu | Complete |
| Clinical working Groups to be setup to refine detailed proposals regarding clinical service model. | Sarah Seaholme | Complete |
| Formation of single change/PMO function to support the delivery of cross trust change programmes | Tom Abell | Complete |
| Programme harmonisation across the individual and collective change programmes. | Tom Abell | Complete |
| Pipeline for 2017/18 corporate support changes to be developed. | James O'Sullivan | Jan 2018 (Adjusted from Oct 2017) **IN PROGRESS** |
| Corporate services visioning work and approval to proceed to design phase still ongoing. Secured external support to provide recommendations for next steps for the Corporate Support programme to the JWB. Eastcote Consulting report now produced with recommendations about how to accelerate the design phase of the programme. | James O'Sullivan | Complete |
| Recruitment to the Change Management Office and Improvement teams | Tom Abell | In Progress |
| **Informatics and finance resourcing gaps in relation to the clinical changes to be addressed.** | Martin Callingham / James O'Sullivan | January 2018 **IN PROGRESS** |
| **Prioritisation of clinical support programme to be undertaken within available change management resources to provide greater confidence of delivery.** | Owen O'Sullivan / Solomon Oloniyo | February 2018 **IN PROGRESS** |
| **Refine benefits case post public consultation and benefits realisation framework** | Tom Abell | July 2018 |
| **Assurances: (How will we know that what we are doing is having an impact?)** | | |
| 1) Robust delivery plans in place and demonstrable delivery of critical paths and benefits. | | |
| 2) Delivery of the portfolio of change projects | | |
| **Risk Review Comments:** | | |
| 07 June 2017 | Risk reviewed and crafted by Chief Transformation Officer in advance of JEG – 21 June 2017. | |
| 16 June 2017 | Risk further reviewed by Chief Transformation Officer. | |
| 24 August 2017 | Risk reviewed KPIs added | |
| 20 Sept 2017 | Risk reviewed KPIs added | |
| 24 Nov 2017 | Risk reviewed. KPIs to be aligned with portfolio milestones | |
| 03 Jan 2018 | Further mitigating actions added and meaningful KPIs to be added | |
| 27 March 2018 | Further mitigating action added and RAG rating added to the programme projects | |

| MSB Group RISK ID | Joint Risk 8.0A | Joint Executive Group Lead | Chief Medical Officer | MSB Group Risk Appetite |
|---|---|---|---|---|
| CQC Reference(s) | Regulation 9 – Person-centred care; Regulation 12 - Safe care and treatment & Regulation 17 - Good governance | | | |
| Risk Title | Effective and reliable clinical support services | | | |
| Risk Description | Failure to provide robust and reliable services within pathology may result in patient harm and reputational damage due to incorrect results, lack of services and significant delays | | | |
| Group Strategic Objective | 1. Establish reformed clinical services based on the best available evidence | Risk Domains | Impact on the safety of patients/Quality/Adverse publicity | |
| Date Identified | 27 April 2017 | Date Last Reviewed | CMO – March 2018 | Target Date: March 2018 |

**Risk Rating (Likelihood x Impact)**

| | |
|---|---|
| Initial Risk Score | 20 (4x5) |
| Current Risk Score | 12 (3x4) |
| Target Risk Score | 8 (2x4) |

L x C
3 x 4




**Relevant Key Performance Indicators**

| KPI | BTUH | | | SUHFT | | | Target |
|---|---|---|---|---|---|---|---|
| 17/18 | D | J | F | O | N | D | |
| Incidents | 26 | 25 | 24 | 19 | 27 | | |
| Serious Incidents | 1 | 0 | 0 | 0 | 0 | | |
| | | | | | | | |

**Controls: (What are we currently doing about the risk?)**

1. Formal meetings occur with the senior managers of both organisations and are ongoing.
2. Teleconferences with main stakeholders – 3 per week.
3. Monthly contract meetings.
4. Senior IT/technological leadership has been drafted into iPP to assist with the failure reviews and to consider the configurations of the LIMS and server clusters to allow for greater stability.
5. Pathology First is continuing to conduct daily monitoring of outstanding lists to ensure time frames are met.
6. Senior management is leading action plans with iPP's core suppliers CliniSys WinPAth Enterprise LIMS and Beckman Coulter.
7. Further personnel have been drafted in from the Taunton laboratories and further personnel recruited to support the senior management team.
8. Senior Manager from BTUH seconded to iPP to support
9. PWC commissioned to undertake an focused review, report received and action plan developed

**Gaps in Controls:**

Contract was due to be reviewed in December 2016 but did not take place. This is now due for December 2017

Poor communication

KPIs are not sufficient to monitor the current issues with incorrect results and delays

Failure to identify, report and act upon issues in a timely manner and investigate incidents and concerns and provide feedback

Service is currently running on high number of locums and staff with limited experience

| Mitigating Actions: (What more do we need to do to fill the gaps) | Lead | Target Date |
|---|---|---|
| 1. Open evening with local GPs planned for November | Lisa Allen | November 2017 |

| | | |
|---|---|---|
| 2. GP user Group to be established | Stephen Whiting | December 2017 |
| **Assurances: (How will we know that what we are doing is having an impact?)** | | |
| 1. KPI's remain stable | | |
| 2. CCG doing focused review in September . Draft report has been received for Factual Accuracy Check and due back to the CCG 29 September 2017 | | |
| **Risk Review Comments:** | | |
| 07 June 2017 | Risk reviewed and crafted by Chief Medical Officer in advance of JEG – 21 June 2017. | |
| 21/8/2017 | Risk reviewed by CMO – KPIs need populating | |
| 27 Sept 2017 | KPIs require population. Final CCG report awaited | |
| 9th Oct 2017 | CCG report received , no major concerns , KPIs still require population . Laboratory KPIs stable | |
| 22 Nov 2017 | Joint assurance meeting with all CCGs/GPs, iPP, SUHFT and BTUH held. Good engagement and improved communications. Primary Care and Acute Trust working groups being established. B&B providing commissioning leadership. | |
| 03 Jan 2017 | Cervical Screening SI report still awaited, however remedial actions have been taken and assurance given to PHE. The backlog is predicted to be cleared during early 2018. KPIs are being reviewed and will be reported on a quarterly basis moving forward | |
| March 2018 | The next South Essex Cervical Screening Serious Incident (SI) Meeting was scheduled on 23 March, when it was envisaged that all cases would have been reviewed. The CCG Quality Review Visit Action Plan continues to progress with actions either completed or not yet due. No data received from SUHFT to date | |

| MSB Group RISK ID | **Joint Risk 8.0B** | Joint Executive Group Lead/Risk Owner | Chief Medical Officer | MSB Group Risk Appetite |
|---|---|---|---|---|
| CQC Reference(s) | Regulation 9 – Person-centred care; Regulation 12 – Safe care and treatment & Regulation 17 – Good governance | | | |
| Risk Title | **Effective and reliable Radiology Services** | | | |
| Risk Description | Failure to provide robust and reliable services within radiology, may result in patient harm and reputational damage due to significant delays in diagnostic and therapeutic appointments<br><br>Equipment within Radiology services are reaching "end of life" or are experiencing regular technical or mechanical failure that leads to planned activities being cancelled which may have an negative impact on the patient pathway/RTT/Cancer targets. This situation is further compounded by the shortage of Interventional Radiologists on some sites. | | | |
| Group Strategic Objective | 3. Establish reformed clinical services based on the best available evidence | Risk Domains | Impact on the safety of patients/Quality/Adverse publicity | |
| Date Identified | 26 June 2017 | Date Last Reviewed | CMO – March 2018 | Target Date: March 2018 |

| Risk Rating (Likelihood x Impact) | | |
|---|---|---|
| Initial Risk Score | 20 (4x5) | Risk Trajectory |
| Current Risk Score | 12 (3x4) | MET |
| Target Risk Score 12 | | |
|  L x C 3 x 4 | | |

**Relevant Key Performance Indicators**

6 Week Diagnostic Radiology Wait

| | SUHFT | | | BTUH | | | METH | | |
|---|---|---|---|---|---|---|---|---|---|
| | W/L | Breach | | W/L | Breach | | W/L | Breach |
| Dec | 2412 | 3 | Dec | 4498 | 100 | Dec | | |
| Jan | 2528 | 4 | Jan | 4916 | 150 | Jan | | |
| | | | | | | | | |
| | | | | | | | | |

| Controls: (What are we currently doing about the risk?) | Gaps in Controls: |
|---|---|
| 1. Outsourcing of activity | Financial pressure increased through this |
| 2. Monitoring of activity and equipment performance | |
| 3. Included in replacement programme and STP capital funding | Reliant on available funds for the replacement period |
| 4. Liaise with other Group trusts for cover | Not always the cover available |
| 5. Continued recruitment for IR radiologists | National Shortage |

| Mitigating Actions: (What more do we need to do to fill the gaps) | Lead | Target Date |
|---|---|---|
| Radiology Quality Improvement Project: diagnostic completed by BCG | Tom Abel | Aug 2017 |
| Implement efficiency plan and shadow Group model for radiology | Qaiser Malik | Start Sept 2017 |
| Operational Dashboard Developed | Darren Taylor | Start Sept 2017 |

| **Assurances: (How will we know that what we are doing is having an impact?)** | |
|---|---|
| 1. | |
| **Risk Review Comments:** | |
| 28 June 2017 | Risk divided into 8.0A and 8.0B. Further review and population required by CMO |
| 21 Aug 2017 | Risk reviewed by CMO – KPIs need to be identified |
| 27 Sept 2017 | Risks reviewed by CMO and KPIS identified. Awaiting data to populate KPIs |
| 09 Oct 2017 | No further data received |
| 09 Oct 2017 | Risk Reviewed by CMO |
| 22 Nov 2017 | New MRI at MEHT being installed that will alleviate some of the pressure. BTUH have had remedial work carried out on the current machinery that will allow for less likelihood of failure. |
| 03 Jan 2018 | Risk remains the same. KPIs requested from all sites |
| 29 March 2018 | Progress has been made with regards to the waiting list management. Both SUHFT and BTUH are maintaining ≥ 96%. MEHT is still experiencing difficulties in managing the Ultrasound waiting list. Iinterventional radiology is now better recruited to and has moved to a MSB 7 day service This risk is offered for retirement from the BAF and to be continued to be managed at local level. |

| MSB Group RISK ID | Joint Risk 9.0A | Joint Group Executive Lead | Chief Nursing Officer | MSB Group Risk Appetite |
|---|---|---|---|---|
| CQC Reference(s) | All Health and Social Care Act Regulations known as the Fundamental Standards apply. | | | SEEK |
| Risk Title | Regulatory Compliance with the Health and Social Care Act (HSCA) and National Standards | | | |
| Risk Description | Failure to consistently meet the requirements of the Fundamental Standards or other national standards may lead to regulatory action being taken against Trusts within the Group | | | |
| Group Strategic Objective | All | Risk Category | Statutory duty/inspections | |
| Date Identified | 27 April 2017 | Date Last Reviewed | CNO–March 2018 | Target Date: April 2018 |

| Risk Rating (Likelihood x Impact) | | | Relevant Key Performance Indicators |
|---|---|---|---|
| Initial Risk Score | 12 | Risk Trajectory<br>• Next Regulatory Inspection | • No CQC Requirement Notices<br>• All CQC 'Must Take' Actions removed<br>• Achievement of a rating of 'Good' across all 3 sites including the tertiary Essex Cardiothoracic Centre<br>• Achievement of Good in Well Led in self-assessment<br>• Internal compliance review of 3 sites Q3/4 |
| Current Risk Score | 12 | | |
| Target Risk Score | 3 | | |
| L x C<br>4 x 3 | | | |

| Controls: (What are we currently doing about the risk?) | Gaps in Controls: |
|---|---|
| 1. CQC compliance status and actions reviewed by JWB | 1. Consistent structures for governance, reporting and monitoring |
| 2. JWB are sighted on revised key lines of enquiry utilised by the CQC and incorporating the "Well Led" component and updated versions | 2. Due to embryonic stages of new and developing models, no formal evaluation to date |
| 3. Development of a single Group portfolio of change activities to allow for uniformity across the area | 3. Newly appointed Site leadership teams in post with some gaps that require further support and development. Gaps now identified and plans in place for further development |
| 4. Development of integrated governance structure; performance reports and reviews to provide oversight to determine additional assurance that may be required | 4. Outstanding core services not easily recognized |
| 5. Committee in Common for Quality and Patient Safety established to improve safety systems and assurances. | 5. Consistent approach to Internal Compliance across all 3 sites, has developed but still requires some refinement |
| 6. Executive leads have clearly defined portfolios to ensure a focus on learning with cross site working to share best practice. | 6. Some areas are not confirmed to date where a rating of 'Good' is not achievable due to external factors. |
| 7. Joint Risk Management Group established to ensure proactive Risk approach; Group Risk Strategy, BAF and Corporate Risk processes realigned. | 7. Governance structures have been reviewed and new structure developed but with finance for costing – to be implemented by Q1 2018<br><br>April 2018 – final version now complete |
| 8. Joint Executive Group (JEG) in place reporting to the Joint Working Board (JWB). | 8. Continued development and evolvement of group risk management |

| | | | |
|---|---|---|---|
| | April 2018 – external support provided by BDO and further work continues | | |
| 9. Internal Quality Assurance and Compliance Team (IQACT) on site at BTUH. | | | |
| 10. Well led assessment of JWB completed | | | |
| 11. Well led assessment of SUHFT completed and about to commence for BTUH | | | |
| 12. Compliance reviews of 3 sites planned for Q3 /4–<br>SUHFT internal compliance review completed September 2017<br>BTUH Internal compliance review completed December 2017<br>BTUH Well Led inspection March / April<br>MEHT commenced March 2018 | April 2018 – Well Led assessment commenced at BTUH, due to be completed by end of April and MEHT to commence end of April / beginning of May | | |
| 13. PIR completed for SUHFT – learning to be shared across other 2 sites | | | |
| 14. CQC Core Service Inspection SUHFT undertaken in November and Well Led Inspection completed December 2017 | | | |
| **March 2018** | | | |
| 15.Weekly CQC monitoring meetings commenced on each site | | | |
| 16. MEHT refocus of quality priorities and CQC action plan | | | |
| **Mitigating Actions: (What more do we need to do to fill the gaps)** | | **Lead** | **Target Date** |
| 1. Complete review of:<br>• Governance and Risk structures<br>• Safeguarding structures<br>• Falls/Infection Control/Tissue Viability structures<br>• Patient Experience & Engagement structures<br>**Update October**<br>• Structures completed – September 2017. Final costings and supporting documentation in progress<br>**Update January 2018**<br>• Structures still with finance for costing<br>**Update March 2018**<br>• Final costings received from finance and consultation document now being developed for circulation | | CNO | September 2017<br><br>October 2017<br><br>January 2018<br><br>May 2018 |
| 2. Establish formal mechanisms for sharing best practice<br>**Update October**<br>• Structures completed but need to be implemented<br>**Update January 2018**<br>• Group Medical Director / Director of Nursing / CNO/CMO group established<br>• Group safety newsletter to be developed<br>**Update March 2018**<br>• Weekly local updates circulated, first version of in development | | DS - CNO | September 2017<br><br>November 2017<br><br>December 2017<br>January 2018<br><br>April 2018 |
| 3. Realignment, monitoring and measurement of existing reporting mechanisms and health informatics data | | DS - CNO | September 2017 |

| | | |
|---|---|---|
| **Update October**<br>• Consistency in maternity safety metrics complete.<br>• Agreed quality KPI and reporting framework with CCGs within a single CQRG<br>**Update January 2018**<br>• Combined CQRG to commence January 2018<br>**Update March 2018**<br>• Group CQRG now established and consistent reporting mechanisms now in progress and agreement for consistent KPIs agreed for 2018/19 | | January 2018<br><br>Completed |
| 4. Realign corporate governance arrangements and structures<br>**Update October**<br>• Draft structures described but need further scoping<br>**Update January 2018**<br>• As above<br>**Update March 2018**<br>• Following return of finance costings further review has been undertaken<br>• Corporate group governance and assurance committee review commenced | DS - CNO | September 2017<br><br>November 2017<br><br>January 2018<br><br>May 2018<br>April 2018 |
| 5. All areas of concern escalated/identified on Corporate Risk Registers/BAF and have clear plans/mitigations in place to ensure safety and preventable harm.<br>**Update March 2018**<br>• Session with BDO held to support the group realign and make further improvements to the group BAF.<br>• Small working group identified to progress BDO work | DS - CNO | On-going<br><br>May 2018 |
| 6. Consistent documentation and methodology is being adopted across the 3 sites for compliance reviews<br>**Update October**<br>• Compliance review undertaken utilising standardised documentation<br>• Well led assessments carried out utilising standardised documentation<br>**Update January 2018**<br>• Have been consistently used across two sites with continued review and refinement<br>**Update March 2018**<br>• Utilised across all three sites – will continually be reviewed | DS - CNO | September 2017<br><br>January 2018<br><br>Completed |
| 7. Peer review process being adopted for compliance reviews –<br>**Update October**<br>Completed, Agreed for each compliance review > 60% of team will be external | DS - CNO | September 2017<br><br>Completed |
| **Assurances: (How will we know that what we are doing is having an impact?)** | | |
| 1. NHSI oversight of compliance is part of the MSB Group priorities | | |
| 2. Removal of CQC Requirement Notices at MEHT and SUHFT sites and no further CQC Requirement Notices issued | | |
| 3. Effective flow of information escalation and de-escalation | | |
| 4. Six monthly Internal Compliance Reviews of each site with all areas receiving a 'Good' rating | | |

| | |
|---|---|
| 5. Areas not achieving a 'Good' rating will be assessed on a quarterly basis | |
| 6. Annual review of effectiveness of governance systems | |
| **Risk Review Comments:** | |
| 07 June 2017 | This is a NEW BAF Risk - reviewed and Risk populated by Executive Lead – Chief Nursing Officer in advance of planned JEG review of BAF 21 June 2017. |
| 28 Aug 2017 | This risk should also be reviewed in conjunction with relevant papers submitted to JWB on CQC compliance |
| 05 October 2017 | Further controls added and annotations throughout |
| 05 January 2018 | Further review of controls added, gaps in control refined and updates provided |
| 28 March 2018 | Review of controls and mitigating actions. |

| MSB Group RISK ID | **Joint Risk 9.0B** | Joint Group Executive Lead | Chief Nursing Officer | MSB Group Risk Appetite |
|---|---|---|---|---|
| CQC Reference(s) | Regulation 09 – Person centred care; Regulation 12 - Safe care and treatment; Regulation 15 - Premises and equipment; Regulation 18 - Staffing | | | **SEEK** |
| Risk Title | **Infection Prevention and Control** | | | |
| Risk Description | Failure to achieve planned trajectories may result in avoidable patient harm and financial penalties. | | | |
| Group Strategic Objective | All | Risk Category | Patient Safety, Quality, Statutory Duty | |
| Date Identified | 14 June 20217 | Date Last Reviewed | CNO- March 2018 | Target Date: April 2018 |

| Risk Rating (Likelihood x Impact) | | Relevant Key Performance Indicators |
|---|---|---|
| Initial Risk Score | **15** | |
| Current Risk Score | **15** | |
| Target Risk Score | **3** | |
| L x C<br>3 x 5 | | |

Risk Trajectory

Group achievement of below collective trajectory for C Diff, MRSA bacteraemia

Reduction in E Coli bacteraemia (need to get trajectory)

Green NHSI rag rating on follow up visit for all 3 sites ( Current SUHFT – Red, BTUH – Amber, MEHT – Green following NHSI Aug 17)

| C Diff | 17/18 BTUH | SUHFT | MEHT |
|---|---|---|---|
| **Total** | 9 | 15 | 19 |
| **Trajectory** | 31 | 30 | 13 |

| MRSA | 17/18 BTUH | SUHFT | MEHT |
|---|---|---|---|
| | 3 | 1 | 2 |

| Controls: (What are we currently doing about the risk?) | Gaps in Controls: |
|---|---|
| DIPC in post on each site and local site infection control teams | Reliability of audit processes |
| Local site Infection Prevention and Control Meetings in place | Inconsistent practices with PPE |
| Local policies and procedures in place | Non achievement of mandatory training compliance |
| Audit mechanisms in place | Vacancies in infection control teams |
| Infection control mandatory training | Robust governance arrangements consistently across the 3 sites |
| Peer panel review processes in place with local CCGs | Consistency in training and monitoring and auditing |
| Anti microbial stewardship in place | New structures not in place as structures still with finance for costing |
| Training planned in consistent monitoring from NHSI | |
| Self-Assessment Hygiene Code compliance review, to then undergo a “check and challenge” | |
| NHSi assessment of each site and comprehensive action plan now in place to address concerns and issues raised | |

| Mitigating Actions: (What more do we need to do to fill the gaps) | Lead | Target Date |
|---|---|---|
| Review of current structures for infection control<br>**Update January 2018** | CNO | End Sept – completed |

| | | |
|---|---|---|
| • Not in place yet due to structures still with finance for costing<br>**Update March 2018**<br>• Final costings received and structures reviewed – consultation document now being written | | January 2018<br><br>May 2018 |
| Review of current training provision and compliance<br>**Update October**<br>• Further work re training compliance and Group model provision required<br>**Update January 2018**<br>• Will be completed when new structures in place<br>**Update March 2018**<br>• As above | CNO | End Sept – not completed<br><br><br><br>January 2018<br><br>May 2018 |
| Review of current audit practices and compliance<br>**Update October**<br>• In progress – further work is required<br>• NHSi review of 3 sites<br>• Self assessment Hygiene Code Compliance completed<br>**Update January 2018**<br>NHSI review of BTUH in October now green<br>Follow up visit to SUHFT – January to review compliance<br>**Update March 2018**<br>• SUHFT de-escalated to amber – revisit in May 2018 | CNO | End Sept<br><br><br><br><br><br><br>January 2018<br><br>May 2018 |
| Review of cleaning schedules<br>**Update October**<br>• Standardised approach being taken from a clinical perspective across the 3 sites<br>**Update January 2018**<br>• Focus on bed space areas completed but further work now required<br>**Update March 2018**<br>• Above completed but requires ongoing monitoring and review | CNO | End Sept<br><br>End October<br><br>February 2018<br><br>completed |
| Need to start collecting and monitoring E Coli rates | CNO /DIPC | End July – completed and reported on a monthly basis |
| Review of governance arrangements for infection control across the 3 sites and reporting to JWB<br>**Update October**<br>• Completed | CNO / DIPC | End Sept |
| **Assurances: (How will we know that what we are doing is having an impact?)** | | |
| Infection rates below trajectory | | |
| Evidence of improved compliance with audits | | |
| No evidence of avoidable patient harm | | |
| Compliance with Hygiene Code | | |

| Green rag rating from NHSI on follow up compliance review | |
|---|---|
| **Risk Review Comments:** | |
| 14 June 2017 | This is a NEW BAF Risk - reviewed and Risk populated by Executive Lead – Chief Nursing Officer in advance of JEG – 21 June 2017 |
| 28 August 2017 | This updated risk must be reviewed in conjunction with Infection Control paper to JWB |
| 05 October 2017 | Further controls added and annotations throughout risk |
| 05 January 2018 | Updates provided |
| 28 March 2018 | Updates provided |