

Meeting Title	Mid and South Essex Acute Trusts Joint Working Board (meeting in public)		
Meeting Date	4 th 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 <input type="checkbox"/> Discussion <input checked="" type="checkbox"/> <input type="checkbox"/>		
Background / Context	<p>A more strategic approach to risk management is required from a JWB perspective and this is underway.</p> <p>Each local site continues to work in developing its own risk management framework and mitigating risks.</p>		
Key Issue 1	<p>Risk - BAF 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)</p> <p>Summary of current BAF 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. This risk is offered for retirement from the BAF, with oversight maintained at site level.</p> <p>Escalation of Risks from Sites There are no risks to escalate.</p>		
Key Issue 2	<p>Compliance A standardised policy template has been developed and agreed for implementation across the three sites for all new policies.</p> <p>Review of actions following SUHFT CQC inspection in December continues across BTUH and MEHT.</p> <p>Both BTUH and MEHT have now established weekly CQC monitoring meeting to ensure actions taken following mock inspections.</p> <p>SUHFT CQC - The action plan continues to be monitored on a weekly basis. The final CQC report is still awaited from the CQC.</p> <p>BTUH</p>		

	<p>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.</p> <p>MEHT 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.</p>
Timescale for Benefits to be Realised	April 2018
Assessment of Implications	
Financial	Does this proposal have <u>revenue</u> (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	<i>No exemptions apply (i.e., information is in the public domain) OR The following exemption(s) apply to this paper :</i>
Other Implications Identified	<ul style="list-style-type: none"> Regulatory impact may be evident
Recommendation	The Joint Working Board are invited to: <ul style="list-style-type: none"> Note and discuss the report
Appendix	1. Current BAF (reviewed March 2018)



Mid Essex, Southend and Basildon Hospitals

BOARD ASSURANCE FRAMEWORK

Quarter 4 2017/18

Board Assurance Framework - Risk Heat Map	Inherent Score	Current Score (likelihood x impact, arrow indicates any movement since last report/no Movement since last report)							Target Score
		<=9	10	12	15	16	20	25	
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 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. 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)					Relevant Key Performance Indicators									
Initial Risk Score	25 (5x5)		Risk Trajectory		KPI	BTUH		SUHFT		MEHT				
Current Risk Score	20 (4x5)				Qtr3 17/18	O	N	D	O	N	D	O	N	D
Target Risk Score	10 (2x5)				Target (%)	95		95		95				
					ED 4 hrs (%)	90	85	83	89	85	76	92	83	74
				.2	.7	.6	.4	.7	.6	.9	.4	.1		
				Target (%)	92		92		92					
				RTT (%)	83	83	83	84	85	84	75	72	69	
				.2	.6	.1	.2	.0	.3	.8	.4	.4		
				Target (%)	85		85		85					
				Cancer 62 Day (%)	72	72		80	80		72	73		
				.8	.7		.3	.6		.4	.0			
Controls: (What are we currently doing about the risk?)					Gaps in Controls:									
<ol style="list-style-type: none"> Cross site Operations Board in place, chaired by Managing Directors to co-ordinate and agree mutual support arrangements across all aspects of operational delivery. Clinical redesign groups in place focusing on improving clinical pathways for winter, including implementation of strengthened and consistent ambulatory pathways. Secured £3m capital funding to support the development of primary and community stream within A&E departments. Cancer Programme Director appointed and additional funding secured from NHS England to support improvement in cancer delivery standards, alongside development of cancer improvement plan. 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). STP Winter Room now in place to support operation of emergency care pathways across the 					<ol style="list-style-type: none"> Lack of detailed implementation plans for clinical redesign, primary care streaming, cancer to be finalised for approval and implementation during the summer. - COMPLETE 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	<p>Failure to manage patient flow and capacity within ophthalmology services may lead to significant delays and result in patient harm and reputational damage.</p> <p>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</p>									
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)				Relevant Key Performance Indicators						
Initial Risk Score	20 (5x4)	Risk Trajectory		KPI***	SUHFT		MEHT			
Current Risk Score	16 (4x4)	<p>L x C 4 x 4</p>		Qtr1 17/18/19	Q3	Q4	Q1	Q3	Q4	Q1
Target Risk Score	6 (2x3)			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?)		
<p>3. Update on SUHT QUIPP.</p> <p>Shared Care Glaucoma:</p> <p>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.</p> <p>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.</p>		
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. 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)	Risk Trajectory			Relevant Key Performance Indicators												
Initial Risk Score	25 (5 x 5)			KPI	BTUH				SUHFT				MEHT			
Current Risk Score	20 (4 x 5)			Qtr 17/18	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Target Risk Score	10 (2 x 5)			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 - 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				4. On-going contractual challenges from commissioners impacting on Trusts' financial positions and mitigating against system working												
5. Financial recovery plan for Mid Essex				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	Risk reviewed by CFO	
20 March 2018	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	<p>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.</p> <p>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.</p> <p>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.</p>															
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)	Risk Trajectory		Relevant Key Performance Indicators													
Initial Risk Score	20(4x5)					KPI	BTUH			SUHFT			MEHT		Target	
Current Risk Score	20(4x5)					Qtr17/18	D	J	F	D	J	F	D	J	F	
Target Risk Score	12(3x 4)					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?)			Gaps in Controls:										
<ol style="list-style-type: none"> Group HR KPIS are reviewed by JWB, Site and Group FRCs International and national recruitment in place Group agency review committee Develop of a MSB recruitment and retention strategy for nurses Align HR recruitment, policies, procedures and marketing literature 			<ol style="list-style-type: none"> Data quality , Not all KPIs definitions are standardised Inability to attract to specialist positions and registered nurses inability to convert agency to bank/agency contract Action plans fail to deliver a reduction in retention 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 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
<ol style="list-style-type: none"> 1. Consistent KPIS in Group and Site BAF and IPR. 2. Develop recruitment and retention plan for nurses 3. Align personal spec/JD and selection process for band 5, 6, and 7 nurses 4. Develop Group nursing recruitment information pack 5. Develop a detailed operational model to introduce one bank and agency service 6. Align the bank rates across the three trusts 7. Develop the first draft of the People Strategy 8. Develop a Group staff survey action plans <ul style="list-style-type: none"> o Bully and Harassment/Pulse survey o Group Health and well-being activities 9. Introduce a Group workforce committee 10. Detailed design of bank and agency service 11. Detailed design of recruitment and transactional services 12. First draft of HR Strategy developed 13. Reconcile Group vacancies with actions taken to recruit. 	<p>CHRD/HRDs CHRD/CNO CHRD/HRDs CHRD/ CNO CHRD/GHRDs CHRD/GHRDs GD POD/CHRD HRDs/Head of OH</p> <p>CHRD/GDPOD CHRD/GHRDs CHRD/GHRDs CHRD/GHRDs CHRD/GHRDs</p>	<p>Oct 2017 ✓ Sep 2017 ✓ Oct 2017 ✓ Oct 2017 X Sept 2017 X Aug 2017 Nov 2017 ✓ June 2017 ✓ Oct 2017 ✓ Nov 2017 x</p> <p>TBD</p> <p>June 2018 July 2018</p>	
Assurances: (How will we know that what we are doing is having an impact?)			
<ol style="list-style-type: none"> 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	<p>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.</p> <ul style="list-style-type: none"> • 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. • 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. • 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. • 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)	<p>RISK TRAJECTORY</p> <p>The chart displays the risk trajectory over time. The Y-axis represents the Risk Score (0 to 20), and the X-axis represents time from May-17 to Mar-18. A blue line with diamond markers represents the 'Current Risk score', which remains constant at 12. A red horizontal line represents the 'Target Risk score', which is constant at 9. The current score is consistently above the target score.</p>			
Current Risk Score	12 (3x4)				
Target Risk Score	9 (3x3)				
<p>L x C 3 x 4</p>					
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:		
<ol style="list-style-type: none"> 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 Capital investment allocation via investment groups 			<ul style="list-style-type: none"> CQC requirement notice on Southend site. Consistent reporting across all three sites to the same degree of detail Consistent approach to in-year funding requests being prioritised over high and very high risk backlog priorities Assessment of impact of end of year enforced slippage 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	<p>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.</p> <p>Effective processes to ensure medical equipment maintenance, repair, replacement and safe use are essential to the provision of outstanding services.</p>			
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)	<p>RISK TRAJECTORY</p> <p>The chart displays the risk score over time from May 2017 to March 2018. The Y-axis represents the risk score from 0 to 20. The X-axis shows monthly intervals. A blue line with diamond markers represents the 'Current Risk score', which remains constant at 12. A red horizontal line represents the 'Target Risk score', which is constant at 9. The current score is consistently above the target score.</p>		
Current Risk Score	12 (3x4)			
Target Risk Score	9 (3x3)			
	<p>L x C 3 x 4</p> <p>→</p>			
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:	
<ol style="list-style-type: none"> 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 The Capital Programme indicates the associated risk score and highlights the funding required for those highest risks Individual directorate RAFs contain medical equipment risks to facilitate effective risk management 			<ul style="list-style-type: none"> Consistent approach to in-year funding requests being prioritised over high and very high risk equipment priorities 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

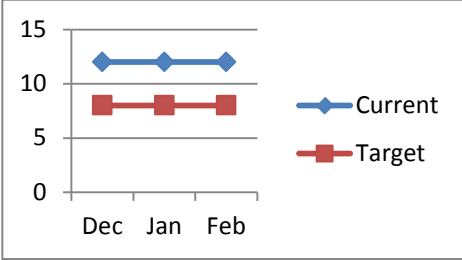

1. Business continuity arrangements in place for some systems in some areas	CEFO	End Q4
2. Consistent assessment of risk with a single methodology	CEFO	End Q4
Assurances: (How will we know that what we are doing is having an impact?)		
1. Service failure impact in case of breakdown or failure could be 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	<p>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.</p> <p>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.</p> <p>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.</p>			
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)	<p>RISK TRAJECTORY</p> <p>Y-axis: 0 to 20. X-axis: May-17, Jul-17, Sep-17, Nov-17, Jan-18, Feb-18, Mar-18.</p> <p>Legend: Current Risk score (blue line), Target Risk score (red line).</p>		<ul style="list-style-type: none"> Overarching Informatics Strategy in place from October 2017 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)			
<p>L x C 3 x 4</p>				
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
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
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
3. Review Informatics capital programme, with aim of rationalising				MC
4. MEHT: Lorenzo Steering Group reinvigorated to progress mitigation of issues and risks and revised structure for				MC
				Target Date
				October 2017
				September 2017
				February 2018
				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	<p>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:</p> <ul style="list-style-type: none"> • Specific technology option appraisals • Phased development plan • Mapping of implementation to group redesign priorities e.g. Future organisational form and clinical redesign • Financial cost analysis of the plan • 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. 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)					Relevant Key Performance Indicators														
Initial Risk Score	16 (4x4)		Risk Trajectory			KPI	BTUH		SUHFT		MEHT		Target						
Current Risk Score	12 (3x4)		<p>RISK TRAJECTORY</p> <p>20 18 16 14 12 10 8 6 4 2 0</p> <p>May-17 Jun-17 Jul-17 Aug-17 Sep-17 Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 Mar-18</p> <p>— Current Risk score — Target Risk score</p>			Qtr117/18	A	M	J	A	M	J	A	M	J				
Target Risk Score	8 (2x4)					All relevant patches tested and implemented													
	<p>L x C 3 x 4</p>																		
Controls: (What are we currently doing about the risk?)					Gaps in Controls:														
<ol style="list-style-type: none"> Continuity plans in place and tested across all sites Emergency Planning policies and procedures in place across 3 sites MEHT site, all PCs and Servers have up to date antivirus software installed. IT programme to maintain safe systems including effective antivirus software on all system Regular communications to staff on responsibilities and threats Independent review including governance arrangements, vulnerabilities, threat management and lessons learnt and risk of recurrence across all sites completed 					<ul style="list-style-type: none"> 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)			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 (2x4)			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	
Target Risk Score	8 (3x4)			Under Corporate Support	
 L x C 5 x 4			Clinical Redesign & Reconfiguration		
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)			Relevant Key Performance Indicators						
Initial Risk Score	20 (4x5)	<p>Risk</p> <p>15 10 5 0</p> <p>Dec Jan Feb</p> <p>◆ Current ■ Target</p>	KPI	BTUH		SUHFT		Target	
Current Risk Score	12 (3x4)		17/18	D	J	F	O	N	D
Target Risk Score	8 (2x4)		Incidents	26	25	24	19	27	
	<p>L x C 3 x 4</p>		Serious Incidents	1	0	0	0	0	
Controls: (What are we currently doing about the risk?)			Gaps in Controls:						
<ol style="list-style-type: none"> Formal meetings occur with the senior managers of both organisations and are ongoing. Teleconferences with main stakeholders – 3 per week. Monthly contract meetings. 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. Pathology First is continuing to conduct daily monitoring of outstanding lists to ensure time frames are met. Senior management is leading action plans with iPP's core suppliers CliniSys WinPath Enterprise LIMS and Beckman Coulter. Further personnel have been drafted in from the Taunton laboratories and further personnel recruited to support the senior management team. Senior Manager from BTUH seconded to iPP to support PWC commissioned to undertake an focused review, report received and action plan developed 			<p>Contract was due to be reviewed in December 2016 but did not take place. This is now due for December 2017</p> <p>Poor communication</p> <p>KPIs are not sufficient to monitor the current issues with incorrect results and delays</p> <p>Failure to identify, report and act upon issues in a timely manner and investigate incidents and concerns and provide feedback</p> <p>Service is currently running on high number of locums and staff with limited experience</p>						
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	
9 th 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	

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 $\geq 96\%$. MEHT is still experiencing difficulties in managing the Ultrasound waiting list. Interventional 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 • Next Regulatory Inspection		<ul style="list-style-type: none"> No CQC Requirement Notices All CQC ‘Must Take’ Actions removed Achievement of a rating of ‘Good’ across all 3 sites including the tertiary Essex Cardiothoracic Centre Achievement of Good in Well Led in self-assessment Internal compliance review of 3 sites Q3/4
Current Risk Score	12			
Target Risk Score	3			
 L x C 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 April 2018 – final version now complete	
8. Joint Executive Group (JEG) in place reporting to the Joint Working Board (JWB).			8. Continued development and evolution of group risk management	

<p>Update October</p> <ul style="list-style-type: none"> Consistency in maternity safety metrics complete. Agreed quality KPI and reporting framework with CCGs within a single CQRG <p>Update January 2018</p> <ul style="list-style-type: none"> Combined CQRG to commence January 2018 <p>Update March 2018</p> <ul style="list-style-type: none"> Group CQRG now established and consistent reporting mechanisms now in progress and agreement for consistent KPIs agreed for 2018/19 		<p>January 2018</p> <p>Completed</p>
<p>4. Realign corporate governance arrangements and structures</p> <p>Update October</p> <ul style="list-style-type: none"> Draft structures described but need further scoping <p>Update January 2018</p> <ul style="list-style-type: none"> As above <p>Update March 2018</p> <ul style="list-style-type: none"> Following return of finance costings further review has been undertaken Corporate group governance and assurance committee review commenced 	DS - CNO	<p>September 2017</p> <p>November 2017</p> <p>January 2018</p> <p>May 2018</p> <p>April 2018</p>
<p>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.</p> <p>Update March 2018</p> <ul style="list-style-type: none"> Session with BDO held to support the group realign and make further improvements to the group BAF. Small working group identified to progress BDO work 	DS - CNO	<p>On-going</p> <p>May 2018</p>
<p>6. Consistent documentation and methodology is being adopted across the 3 sites for compliance reviews</p> <p>Update October</p> <ul style="list-style-type: none"> Compliance review undertaken utilising standardised documentation Well led assessments carried out utilising standardised documentation <p>Update January 2018</p> <ul style="list-style-type: none"> Have been consistently used across two sites with continued review and refinement <p>Update March 2018</p> <ul style="list-style-type: none"> Utilised across all three sites – will continually be reviewed 	DS - CNO	<p>September 2017</p> <p>January 2018</p> <p>Completed</p>
<p>7. Peer review process being adopted for compliance reviews –</p> <p>Update October</p> <p>Completed, Agreed for each compliance review > 60% of team will be external</p>	DS - CNO	<p>September 2017</p> <p>Completed</p>
<p>Assurances: (How will we know that what we are doing is having an impact?)</p>		
<p>1. NHSI oversight of compliance is part of the MSB Group priorities</p>		
<p>2. Removal of CQC Requirement Notices at MEHT and SUHFT sites and no further CQC Requirement Notices issued</p>		
<p>3. Effective flow of information escalation and de-escalation</p>		
<p>4. Six monthly Internal Compliance Reviews of each site with all areas receiving a 'Good' rating</p>		

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	Risk Trajectory		<table border="0"> <tr> <td>C Diff</td> <td colspan="3">17/18</td> </tr> <tr> <td></td> <td>BTUH</td> <td>SUHFT</td> <td>MEHT</td> </tr> <tr> <td>Total Trajectory</td> <td>9</td> <td>15</td> <td>19</td> </tr> <tr> <td></td> <td>31</td> <td>30</td> <td>13</td> </tr> <tr> <td>MRSA</td> <td colspan="3">17/18</td> </tr> <tr> <td></td> <td>BTUH</td> <td>SUHFT</td> <td>MEHT</td> </tr> <tr> <td></td> <td>3</td> <td>1</td> <td>2</td> </tr> </table>			C Diff	17/18				BTUH	SUHFT	MEHT	Total Trajectory	9	15	19		31	30	13	MRSA	17/18				BTUH	SUHFT	MEHT		3	1	2
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Current Risk Score	15	Group achievement of below collective trajectory for C Diff, MRSA bacteraemia																																
Target Risk Score	3	Reduction in E Coli bacteraemia (need to get trajectory)																																
 <p>L x C 3 x 5</p>		Green NHSI rag rating on follow up visit for all 3 sites (Current SUHFT – Red, BTUH – Amber, MEHT – Green following NHSI Aug 17)																																
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 Update January 2018				CNO	End Sept – completed																													

<ul style="list-style-type: none"> Not in place yet due to structures still with finance for costing Update March 2018 <ul style="list-style-type: none"> Final costings received and structures reviewed – consultation document now being written 		January 2018 May 2018
Review of current training provision and compliance Update October <ul style="list-style-type: none"> Further work re training compliance and Group model provision required Update January 2018 <ul style="list-style-type: none"> Will be completed when new structures in place Update March 2018 <ul style="list-style-type: none"> As above 	CNO	End Sept – not completed January 2018 May 2018
Review of current audit practices and compliance Update October <ul style="list-style-type: none"> In progress – further work is required NHSi review of 3 sites Self assessment Hygiene Code Compliance completed Update January 2018 NHSI review of BTUH in October now green Follow up visit to SUHFT – January to review compliance Update March 2018 <ul style="list-style-type: none"> SUHFT de-escalated to amber – revisit in May 2018 	CNO	End Sept January 2018 May 2018
Review of cleaning schedules Update October <ul style="list-style-type: none"> Standardised approach being taken from a clinical perspective across the 3 sites Update January 2018 <ul style="list-style-type: none"> Focus on bed space areas completed but further work now required Update March 2018 <ul style="list-style-type: none"> Above completed but requires ongoing monitoring and review 	CNO	End Sept End October February 2018 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 Update October <ul style="list-style-type: none"> 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