NHS
Mid Essex, Southend and Basildon
Hospitals

MSB Board Assurance Framework

2018/19

June 2019

Ambition

Improve health and wellbeing through excellent, financially sustainable services, provided by staff supported to develop, innovate and build rewarding careers.

Strategic Objectives (Approved 15th October 2018)

1. Be a single, well-led, high performing and innovative organisation which joins up care for the people we serve.
2. Deliver high quality, safe and responsive services shaped by best practice and our local communities.
3. Be an employer of choice for a supported, engaged and high performing workforce.
4. Be effective and efficient with all our resources, creating an organisation that residents and staff can rely on for the long term.

CQC Regulations

Strategy Objective: To deliver all regulations prescribed by CQC; Department of Health and other regulatory bodies.

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	
Regulation	**Description**
Regulation 4	Requirements where the service provider is an individual or partnership
Regulation 5	Fit and proper persons – directors
Regulation 6	Requirement where the service provider is a body other than partnership
Regulation 7	Requirements relating to registered managers
Regulation 8	General
Regulation 9	Person-centred care
Regulation 10	Dignity and Respect
Regulation 11	Need for Consent
Regulation 12	Safe care and treatment
Regulation 13	Safeguarding service users from abuse and improper treatment
Regulation 14	Meeting nutritional and hydration needs
Regulation 15	Premises and equipment
Regulation 16	Receiving and acting on complaints
Regulation 17	Good governance
Regulation 18	Staffing

Regulation 19	Fit and proper persons – employed
Regulation 20	Duty of candour
Regulation 20A	Requirement as to display of performance assessments
Care Quality Commission (Registration) Regulations 2009 (Part 4)	
Regulation 12	Statement of purpose
Regulation 13	Financial position
Regulation 14	Notice of absence
Regulation 15	Notice of changes
Regulation 16	Notification of death of service user
Regulation 17	Notification of death or unauthorised absence of a service user who is detained or liable to be detained under the Mental Health Act 1983
Regulation 18	Notifications of other incidents
Regulation 19	Fees
Regulation 20	Requirements relating to termination of pregnancies
Regulation 22A	Form of notifications to the Commissioner

Other Regulatory Requirements

Board Assurance Risk Heat Map – January 2019

Board Assurance Framework - Risk Heat Map		Current Score (likelihood x impact, arrow indicates any movement since last report/no Movement since last report)							
	Inherent Score	<=9	10	12	15	16	20	25	Target Score
1.0 Strategic Objective **Be a single, well-led, high performing and innovative organisation which joins up care for the people we serve. (Tom Abel)**									
1.1 Failure to provide a conducive environment for colleagues to design, adopt and implement innovative practices. **Tom Abell**	**20**				√ ↔				**15**
1.2 Failure to implement the merger of three trusts into one trust leading to sub-optimal decision making **Jonathan Dunk**	**20**					✓ ↔			**10**
1.3 Failure to demonstrate sufficiently high levels of performance to achieve "Good" overall rating for CQC Well Led. Failure to deliver agreed remedial actions in a timely manner and ensure responsiveness when necessary. **Diane Sarkar**	**16**					✓ ↔			**8**
1.4 Failure to deliver improvement national performance targets in the agreed trajectories **Yvonne Blucher, Andrew Pike, Jane Farrell**	**20**						✓ ↔		**12**
1.5 Failure to enable and empower leaders in all areas of the organisation to create a culture of continuous improvement **Tom Abell**	**25**						√ ↔		**15**

2.0 Strategic Objective **Deliver high quality, safe and responsive services shaped by best practice and our local communities. (Celia Skinner and Diane Sarkar)**									
2.1 Failure to equip colleagues to deliver a high quality safe service against agreed trajectories. **Celia Skinner**	**16**					√ ↔			**12**
2.2 Failure to deliver clinical service change / reconfiguration to meet the needs of the local population currently and in the future, against agreed timescales. **Celia Skinner**	**20**					√ ↔			**9**
2.3 Failure to gain agreement and consensus of local communities to changes that reflect best practice. **Celia Skinner**	**25**						√ ↔		**9**
2.4 Failure to achieve consistent "Good" rating for CQC in Safe, Caring, Effective and Responsive domains. Failure to implement agreed remedial action plans in a timely fashion. **Diane Sarkar**	**16**					✓ ↔			**8**
3.0 Strategic Objective **Be an employer of choice for a supported, engaged and high performing workforce. (Danny Harriam)**									
3.1 Failure to create workforce stability with vacancy and retention rates within the top quartile for acute trusts. **Danny Hariram**	**16**						√ ↑		**8**
3.2 Failure to be the demonstrable employer of choice for people with right values, behaviours, skills and experience. **Danny Hariram**	**25**						✓ ↔		**10**
3.3 Failure to lead and develop colleagues to ensure they demonstrate support, engagement and high levels of performance in order to drive improvement.	**20**					✓ ↔			**12**

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

Strategic Objective	Be a single, well-led, high performing and innovative organisation which joins up care for the people we serve						
Principal Risk	Failure to provide a conducive environment for colleagues to design, adopt and implement innovative practices.						
MSB Risk ID	1.1	**Executive Lead**	Tom Abell	**Current Risk Score and movement since last month:**	15	**Risk Appetite:**	High 3 – Open
Date identified	November 2018	**Date last reviewed**	May 2019	**Target date**	March 2019 - Achieved		
Risk Rating (Likelihood x Impact)							
Inherent Score: 4 x 5 (20)				**Target Score:** 3 x 5 (15)			
Relevant Key Performance Indicators / Risk Indicators							

Key identified deliverables:

1. The merger of the three trusts into one, including the building of a new foundation trust governance model.
2. Describe the leadership culture and values for the new organisation.
3. Roll out an expanded 'hospital at home' service.
4. Develop productive strategic relationships with external partners, including primary care providers through the expansion of our QI offer to general practice.
5. Establishment of Group Performance Management function and new relationship with regulators.
6. Expansion of innovation fellowships

Key Measures:

Measure	**Status update**
Number of patients supported at home or other place of residence by our services	Hospital at Home: Jan-19: Transfers in 45; Feb-19: 48; Mar-19: 37; Apr-19: 45 Measurement tool for other services (e.g. bridging) is being established.
Number of medically fit and DTOC rates.	See Integrated Performance Report
Income raised from non-traditional sources (e.g. community services offer, private patients, innovation etc.)	Measurement tool.
Improvement trajectories in finance, operations, workforce and quality are achieved.	See Integrated Performance Report

Applicable link to regulation requirements (CQC / NHSI)	CQC Well-Led	**Board sub-committee monitoring**	Future Organisation Form Programme Board Joint Quality Committees in Common

Existing Key Controls	**The merger of the three trusts into one, including the building of a new foundation trust governance model** 1. Appointment of a programme team to support the merger project and established system of assurance in place with a Future Organisational Form Programme Board established and in place. Regular reports against merger milestones reported to the Board. 2. Governance model development being progressed with governors and patient council members through the Constitution Task and Finish Group which reports to the Programme Board. 3. Ongoing engagement with NHS Improvement (NHSI) as regulator to confirm support, including Board to Board meeting held in November 2018. Ongoing engagement with Competition and Markets Authority with NHSI support. 4. New communications plan developed and being activated, additional interim resource in place to support group communications in advance of communications and engagement team restructure due summer/autumn 2019. **Describe the leadership culture and values of the new organisation** 5. Organisational development programme agreed by Joint Executive Group in March 2018, including cultural audit survey and programme of staff listening events, "first 100 development programme" – Senior Staff Development College 6. Listening sessions completed in early April 2019 for Senior Staff Development College participants with CEO, CHRD and group directors 7. Work underway to support leadership development for JEG and SLT aligning with values of the new organisation **Roll out an expanded Hospital at Home service** 8. Mobilisation of Hospital at Home service across all three sites has commenced, Basildon at 30 places, MEHT at 18 increasing to 22 in June 2019 and Southend at 22 increasing to 30 in July 2019. 9. Agreement with local authorities to expand domiciliary care bridging services over winter period. **Develop productive strategic relationships with external partners, including primary care providers through the expansion of our QI offer to general practice**

	1. Engagement initiated with STP primary care leadership group on co-design of new models of place based care especially newly emerging primary care networks. 2. Developed partnership with other expert training providers to bid for system wide QI leadership programme. Attracted £83,000 funding from Health Education England through the Local Workforce Action Board for the STP. 3. Funding secured for combined Primary Care QI/MSE Institute programme for Mid Essex CCG, 3 clinical leads appointed March 2019. **Establishment of Group Performance Management function and new relationship with regulators** 4. New operational planning guidance for 2019/20 drafted for consideration at December Board. 5. Combined group winter resilience plan in place; alongside agreed system management activities. 6. New Integrated Performance Report now in place. **Expansion of innovation fellowships** 1. Prof Tony Young appointed as the Associate Medical Director for Innovation to MSE Group with additional funding support from STP. This will further strengthen links with national NHS clinical entrepreneurship programme where he is the lead 2. STP Innovation Advisory Group established and first meeting took place in April 2019. This STP wide group will support development and implementation of future system-wide innovation programmes including next cohort of Innovation Fellows across wider footprint. 3. Review of first year of innovation fellowships adding to the development of business case for next cohort that will be agreed in June 2019 4. First project under "Ways of Working" approach with industry (approved by MSE STP Partnership Board) will focus on childhood asthma with industry partners lined up for support.
Gaps in Controls	**Describe the leadership culture and values of the new organisation** 1. No oversight group to track delivery of the agreed organisational development plan currently meeting. 2. Refresh of improvement capability building strategy to be undertaken. **Develop productive strategic relationships with external partners, including primary care providers through the expansion of our QI offer to general practice.**

		~~3.~~ Design and Delivery Group for STP QI leadership programme now meeting since March to support the design and delivery of the programme, this will report into the LWAB and Clinical cabinet. Need a coordinated Delivery group across the two QI projects. **Expansion of innovation fellowships** 4. Lack of single IP, innovation and commercialisation policies across the three trusts. 5. Need to clarify procurement routes (scoping in progress)
Assurance	**Internal**	**The merger of the three trusts into one, including the building of a new foundation trust governance model.** 1. Programme Board papers and minutes, reports received by Board 2. Additional meetings with specialties making progress at local level being supported via Strategy Unit; operational management session held February 2019 to engage corporate services and governance colleagues in clinical integration. 3. Communications and engagement plan. **Describe the leadership culture and values of the new organisation** 1. Current programme oversight continues via Group Director and Director HR & OD for Senior Staff Development College. 2. Updated analysis presented to JEG and SLT in Feb-March 2019 from surveys and diagnostics to support development of future interventions for JEG, SLT and group. 3. Senior Staff Development College participant listening exercise undertook in April 2019 with feedback from 34 senior leaders to Chief Exec, Group Director of HR & POD and Group Director of Strategy and New Care Models. The outputs and themes are being used for design and development of future cohorts as well as staff engagement. **Roll out an expanded Hospital at Home service** 4. Utilisation of Hospital at Home capacity and resulting impact on bed occupancy and performance. **Develop productive strategic relationships with external partners, including primary care providers through the expansion of our QI offer to general practice.** 5. Group Quality Improvement strategy (previously approved by the JWB) includes expansion to Primary Care; existing work programme within the Local Workforce Action Board which includes project oversight and tracking. Local Delivery Group to meet from April 2019. Strategy Unit to evaluate late 2019.

		6. Regular updates to Clinical Programme Board on progress **Establishment of Group Performance Management function and new relationship with regulators.** 7. New operational planning guidance for 2019/20. **Expansion of innovation fellowships** 8. Msb innovation Fellows monitored by Innovation Working Group and through decision-tree to support their trials developed by R&D. 9. Msb Strategy Unit will evaluate the impact of the first fellowship in May-June 2019 to inform the business case for cohort 2 to be developed as part of partnership working across the STP from June 2019.
	External	**The merger of the three trusts into one, including the building of a new foundation trust governance model.** 1. NHS Improvement Board to Board outcome. **Describe the leadership culture and values of the new organisation** 2. Staff survey and cultural alignment results. **Roll out an expanded Hospital at Home service** 3. Patient feedback. **Develop productive strategic relationships with external partners, including primary care providers through the expansion of our QI offer to general practice.** 4. Primary care QI leads appointed against a target of 2 with CCG funding additional post. Regular reporting through Local Workforce Action Board reporting includes project oversight and tracking. **Establishment of Group Performance Management function and new relationship with regulators.** 5. NHS Improvement Performance Review Meeting outcome and improved sharing of information with NHS Improvement between Performance Review Meetings **Expansion of innovation fellowships** 6. Lack of single IP, innovation and commercialisation policies across the three trusts. 7. Need to clarify procurement routes (scoping in progress)

	Level of Assurance	NA
Gaps in Assurance		1. In current oversight, more could be done to provide assurance and oversight of delivery on the timelines for activity and benefits realisation models required as part of supporting capital case and long-term financial model for future organisational form. 2. No clear route to agreement on overall narrative or "change story" for the future organisation. Some gaps in resource and clarity of expectation within People & Organisational Development to support further work 2019/20.
Mitigating Actions		1. Ongoing pathway development to support full utilisation of Hospital at Home service. 2. 2 further staff enrolled on QSIR college so that they are able to deliver Improvement Training, alongside the development of a Human Factors faculty across the group. 3. Development of single IP, innovation and commercialisation strategy, alongside compliant routes to market. 4. Target culture of new organisation to be established to support work on future organisational design. 5. Refresh of quality improvement strategy. 6. Communications and engagement team restructure.

Strategic Objective	Be a single, well-led, high performing and innovative organisation which joins up care for the people we serve						
Principal Risk	Failure to implement the merger of three trusts into one trust leading to sub-optimal decision making						
MSB Risk ID	1.2	**Executive Lead**	Jonathan Dunk	**Current Risk Score and movement since last month:**	16 – no movement since last month.	**Risk Appetite:**	Significant 4 - Seek
Date identified	Aug 2018	**Date last reviewed**	May 31st 2019	**Target date**	April 2020		
Risk Rating (Likelihood x Impact)							
Inherent Score: 20			**Target Score: 10**				
Relevant Key Performance Indicators / Risk Indicators							
Not achieving the merged organisation							
Applicable link to regulation requirements (CQC / NHSI)	Regulations 4-20			**Board sub-committee monitoring**	Merger Programme Board		
Existing Key Controls	1. Strategic Case Submitted to NHSI in May 2018. Approval given by NHSI for the transaction to proceed with a number of areas of feedback given on risks that needs to be managed. 2. Governance and leadership structures to deliver transaction in place 3. External stakeholder management ongoing (Commissioners, Regulators, Local and National Politicians, etc.). Stakeholder management plan agreed and being implemented. Additional communications resources recruited to support merger and transformation. 4. Strategic Partner to deliver transaction appointed and team on-site supporting the transaction. 5. Case studies for patient benefits case continue to be developed, which is critical for CMA approvals. Ongoing discussions with legal and competition advisers on best approach for CMA. 6 Acquiring body for the transaction identified and agreed by Boards in Common. 7. Due diligence ongoing. The majority of the Internal Due Diligence (HR, Environmental and Health and Safety, and Clinical) has now been completed and approved. 8. External due diligence undertaken by the external advisors has commenced – most of the data required for this has been collected. 9. Initial set of Integration meetings with the 41 clinical service specialties completed. 'Review and Confirmation' meetings in mid-June. Formal sign-off of the plans by the Executive Team in July 2019.						

	10. Owners identified for sections in the Post Transaction Implementation Plans and Business Case. Meetings being held over early June with these owners to scope out the requirements for completing the documents. 11. Work ongoing to decouple the merger from patient benefits that require external capital so that the merger is not reliant on the Capital SOC/OBC timelines.	
Gaps in Controls	1. Though the merger is being decoupled from the Capital OBC, there is a concern that the LTFM will not add up without capital dependent benefits. 2. Referral to Secretary of State by Southend and Thurrock HOSCs may delay progress on clinical pathway design. 3. Day to day Trusts performance (financial or operational) may not improve and lead to loss of regulatory agreement to proceed. 4. CQC review planned at Basildon ahead of transaction completion. Report due in May 2019. Adverse findings would place at risk merger completion. 5. Three way merger concept is novel and has not been tested with CMA regards impact on competition. May lead to a Stage 2 referral with them with material timeline implications. 6. Communications Plan with internal stakeholders, most notably staff groups has to be progressed as a matter of priority. 7. Benefits in merger case must be explicitly aligned with commissioner assumptions for all years of the detailed business case, specifically agreeing with benefits identified in capital submissions. 8. Early indications that NHSI will want the acute sector to reach recurrent financial balance by the end of 2023/24. 9. STP has to submit a revised Strategic Estates Strategy to NHS England by July which includes much improved plans for Out of Hospital Care, otherwise it may threaten the availability of funding that has already been allocated as an STP, including the £118m for the acute reconfiguration.	
Assurance	**Internal**	1. Due Diligence process completed by September 2019 with no material issues identified that cause any party to delay/cease merger. 2. Merger business case agreed by NHSI and Boards in Common. 3. Patient Benefits Case produced and agreed with NHSI and CMA such that they clear the merger transaction with no competition concerns 4. LTFM produced that is agreed with by NHSI, the Boards in Common and the assumptions signed off by Commissioners. 5. Transaction formally completed by April 2020 6. Post Transaction Implementation Plan in place and delivered successfully, particularly days 1-100 post merger. 7. Financial, Clinical and performance benefits delivered as per plan post implementation.
	External	1. Reporting Accountant provides an independent view of the transaction. 2. NHSI support during the transaction, including specific support during the transaction process.

		3. External advisors have a track record of delivering successful mergers.
	Level of Assurance	Medium, given the number of external risks that are outside the control of the Trusts. However, there is a strong assurance framework in place following the recommendations of NHSI guidance on Transactions.
Gaps in Assurance		We have followed advice and guidance on the Transactions process so there is no immediate gap in assurance.
Mitigating Actions		1. Assess and continually monitor the escalating key risks to the timelines from deteriorating performance in the Trusts, the delivery of the numerous transaction products required, and possible impact from Capital Strategic Outline Business Case and the risk of a referral to the Secretary of State if capital dependent benefits are needed for the LTFM. 2. Ensure operational and financial performance at three Trusts improves through targeted interventions and continued focus to turnaround the organisation. 3. Additional dedicated merger communications resources have been recruited. Delivery of an agreed communications and engagement strategy, rollout of a cultural survey and broader staff engagement. 4. Additional resource being deployed, as requested and agreed, consistent with the overall Merger Transformation envelope. KPMG capacity being deployed where appropriate, under terms of engagement contract, to ensure any residual gaps in capacity are appropriately covered. 5. Continue the work in LTFM and modelling to understand what is required to get the Trusts into balance. 6. Engagement in STP workgroup to develop revised STP Estates Strategy and track progress of the completion of the case in the relevant internal meetings. 7. Comprehensive overarching Programme Plan and work-stream plans for revised transaction date drawn up that identifies interdependencies of the various elements of the transaction.

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Principal Risk	Failure to demonstrate sufficiently high levels of performance to achieve "Good" overall rating for CQC Well Led. Failure to deliver agreed remedial actions in a timely manner and ensure responsiveness when necessary.						
MSB Risk ID	1.3	**Executive Lead**	Diane Sarkar	**Current Risk Score and movement since last month:**	16 ⟺	**Risk Appetite:**	High 3 – Open
Date identified	November 2018	**Date last reviewed**	May 2019 Group Risk and Compliance Group	**Target date**	Following CQC inspections		
Risk Rating (Likelihood x Impact)							
Inherent Score: 20 (5 x 4)			**Target Score**: 8 (2 x 4)				
Relevant Key Performance Indicators / Risk Indicators							
• No requirement / warning notices • Reducing number of "Must Take" actions • Reducing number of "Should Do" actions • Achievement of "Good" overall rating on all three sites for overall provider rating for Well Led							
Applicable link to regulation requirements (CQC / NHSI)	• Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) • Care Quality Commission (Registration) Regulations 2009 (Part 4)			**Board sub-committee monitoring**	Group Risk and Compliance Group with direct report to Board		

<table>
<tr><td colspan="2"></td><td></td><td></td><td>and Quality Committee in Common</td></tr>
<tr><td>Existing Key Controls</td><td colspan="4">• Executive leadership with local site ownership
• Weekly Executive Team meetings with agenda and minutes
• Executive presence at site leadership meetings
• Standardised compliance documentation and review methodology
• Governance structures / quality work underpinned by CQC Key Line of Enquiry (KLoE)
• Site based weekly internal compliance monitoring meetings with documented evidence of tracking progress
• Executive experience in core service and well led executive reviewer experience
• Well led domain inspected as part of internal compliance
• Support from NHSi
• Governance structure now developed but yet to be finalised
• Development of Board and joint committees in common
• Improvement plan now developed for MEHT
• Plan in place for SUHFT</td></tr>
<tr><td>Gaps in Controls</td><td colspan="4">• Developing site leadership teams
• Significant number of meetings which duplicate information streams
• Inconsistent reporting arrangements</td></tr>
<tr><td rowspan="3">Assurance</td><td>Internal</td><td colspan="3">• Annual well led internal self-assessment reported to JWB
• Site base well led self-assessments carried out on an annual basis</td></tr>
<tr><td>External</td><td colspan="3">• Auditors reviews
• No issues raised at SUHFT or MEHT recent CQC inspections that the management teams were not aware of and/or there wasn’t an improvement plan in place.
• January 2019 – MEHT CQC Inspection – Requires Improvement
• BTUH Well Led inspection – March 2019 – verbal feedback was positive
• Draft report received for BTUH and factual accuracy returned on the 28th May 2019</td></tr>
<tr><td>Level of Assurance</td><td colspan="3">Well Led CQC Inspections - NB SUHFT New style CQC well led inspection
<table>
<tr><th></th><th>MEHT –Jan2019</th><th>BTUH – March 2015</th><th>SUHFT – April 2018</th></tr>
<tr><td>Well-led</td><td>Requires Improvement</td><td>Good</td><td>Good</td></tr>
</table></td></tr>
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Gaps in Assurance	• Consultation for corporate teams progress • Further development of Board governance framework
Mitigating Actions	• Sharing of experience and best practice both internal and external • Meeting for review of meetings across all three sites now in progress • Group governance structure reviewed – yet to be implemented

Strategic Objective	Be a single, well-led, high performing and innovative organisation which joins up care for the people we serve						
Principal Risk	Failure to deliver improvement national performance targets in the agreed trajectories						
MSB Risk ID	1.4	**Executive Lead**	Yvonne Blucher Andrew Pike Jane Farrell	**Current Risk Score and movement since last month:**	20 ↔	**Risk Appetite:**	Moderate 2 – Cautious
Date identified	November 2018	**Date last reviewed**	June 2019	**Target date**	Q3 and March 2019		
Risk Rating (Likelihood x Impact)							
Inherent Score: 5 x 5 (25)				**Target Score: 3 x 4 (12)**			
Relevant Key Performance Indicators / Risk Indicators							
RTT + 52 Weeks **Cancer + 104 wait** **ED 4 Hour Standard** **Diagnostics**							
Applicable link to regulation requirements (CQC / NHSI)	CQC / NHS I / NHS E			**Board sub-committee monitoring**	• Site specific board committee oversight • MSB Integrated Committee		
Existing Key Controls	• Site specific daily, weekly and month performance oversight arrangements. • Site specific monthly integrated performance reviews / accountability meetings. • MD and JEG weekly oversight of MSB Integrated Performance by target. • Site specific Recovery Programme arrangements and supporting accountability arrangements • Quality in Common Committee. • Joint Working Board and strengthened joint infrastructure and leadership.						
Gaps in Controls	• New and integrated governance arrangements embedding. • Consistent and reliable reporting across all three sites. • Continued development and evolvement of “group” delivery where mutually reliant.						

		• Mismatch in capacity versus demand subject to seasonal variation. • Impact of seasonal pressure has heightened risk to access targets. • Daily Director of Ops Cancer calls; daily tracking information on the back log and alignment of capacity • RTT – Failure to reach a financial settlement with the CCG to address the back log.
Assurance	**Internal**	• Performance / Recovery meeting and monthly "exception reporting" mechanism. • Effective flow of information escalation and de-escalation. • Performance improvement in line with trajectories.
	External	• NHS I / E oversight of compliance is part of MSB Group priorities. • PRM and QRM NHS I Reviews.
	Level of Assurance	At PRM
Mitigating Actions		• Robust revised governance arrangements. • Move to strengthened and stable leadership teams in place. • Development of Peer Reviewing methodology across three sites. • Weekly MD joint working sessions to foster more integrated and standardised approach to performance improvement. • Increased focus on 3 site solution to improve delivery and resilience. • Strengthened daily and weekly oversight and support – site specific.

Strategic Objective	Be a single, well-led, high performing and innovative organisation which joins up care for the people we serve						
Principal Risk	Failure to enable and empower leaders in all areas of the organisation to create a culture of continuous improvement.						
MSB Risk ID	1.5	**Executive Lead**	Tom Abell	**Current Risk Score and movement since last month:**	20 ⟺	**Risk Appetite:**	High 3 – Open
Date identified	November 2018	**Date last reviewed**	May 2019	**Target date**	April 2019		

Risk Rating (Likelihood x Impact)	
Inherent Score: 5 x 5 (25)	**Target Score: 3 x 5 (15)**

Relevant Key Performance Indicators / Risk Indicators

	Target number	**Total to date**
Basic level training (e-learning)	14,000	0
Foundation improvement training (QSIR-F)	1,400	38
Advanced improvement training (QSIR-P)	700	172
Leading transformational change	200	0
Improvement experts	118	0

Number of quality improvement projects underway within service areas.
Cultural alignment survey analysis
NHS staff survey results

Applicable link to regulation requirements (CQC / NHSI)	CQC Well Led NHSI Use of Resources	**Board sub-committee monitoring**	Workforce

Existing Key Controls	- Single Quality Improvement Strategy developed and reviewed at the Joint Quality and Safety Committee. - QSIR, Human Factors Faculties being developed through NHSI and UCLP support. - Initial cultural alignment survey with top 100 leaders completed. - Initial consultant survey completed. - First cohorts of the Staff Development College has been completed.

Gaps in Controls	- Actions identified within the Quality Improvement Strategy are still being implemented. - Organisational design of the single merged organisation still to be completed to include clearer leadership for continuous improvement within and across the organisation. - QSIR training volumes limited by capacity of in-house qualified QSIR trainers. - Basic level training package to be developed and launched.	
Assurance	**Internal**	-Cultural alignment, consultant survey result. -Evidence of continuous / quality improvement projects and initiatives in place across all three trusts. -Number of staff trained and qualified in continuous / quality improvement techniques.
	External	-NHS staff survey results.
	Level of Assurance	Low as a result of limited measures currently available to assess progress against objective. New proxy measures to be established (as outlined within actions below).
Gaps in Assurance		-Vacancies still remain in Improvement and Change Management functions across sites, particularly within the MEHT site team. -Time is required (at least 6-12 months) between initial survey baselines and repeat to assess progress and success of actions and initiatives undertaken
Mitigating Actions		-Delivery of actions identified within the Quality Improvement Strategy. -Complete organisational design of single merged organisation; and clarification of role of quality and continuous improvement in the working model of the trusts. -Complete appointment to Improvement and Change Management functions across sites. -Complete set up and training of QSIR and Human Factors faculties to increase training provision to staff in CI/QI skills. -New proxy measures to be developed to assess progress against delivery of objective. -Repeat cultural alignment survey -Commission basic training package. -Launch of new identity to assist in development of a virtual community of CI/QI practice.

Strategic Objective	Deliver high quality, safe and responsive services shaped by best practice and our local communities						
Principal Risk	Failure to equip colleagues to deliver a high quality, safe service against agreed trajectories						
MSB Risk ID	2.1	**Executive Lead**	Celia Skinner	**Current Risk Score and movement since last month:**	16 ⟺	**Risk Appetite:**	High 3 – Open
Date identified	November 2018	**Date last reviewed**	May 2019	**Target date**	September 2019		
Risk Rating (Likelihood x Impact)							
Inherent Score: 16 (4x4)				**Target Score: 12 (3 x 4)**			
Relevant Key Performance Indicators / Risk Indicators							
SHMI and HSMR Harm free care metrics Speciality level outcome metrics (TBD)							
Applicable link to regulation requirements (CQC / NHSI)	Regulation 12 Achievement of "Good" rating on all three sites for safe and effect care provider ratings			**Board sub-committee monitoring**	Quality Committee in Common		
Existing Key Controls	1. Monthly integrated performance report 2. Site based quality metrics 3. Site based quality improvement plans and mortality groups 4. MEHT recovery plan for quality 5. National audit and NICE compliance 6. GIRFT submissions						
Gaps in Controls	1. GIRFT outputs not yet embedded in operational or quality performance reporting 2. Under-developed quality improvement capability 3. Limited support from informatics for local dashboards to support real-time quality measures 4. Operational pressures limits clinician availability for quality improvement activities 5. Workforce gaps						
Assurance	**Internal**	1.Improving mortality performance at SUFT and BTUH 2.Stabilised harm free care metrics					

	External	CQRG NHSI oversight and monitoring , January inspection rated IPC at MEHT GREEN
	Level of Assurance	CQC
Gaps in Assurance		1. Group governance structure reviewed – yet to be implemented leading to key gaps in staffing and expertise 2. Current HCAI and VTE performance at MEHT 3. Current HMSR metrics at MEHT and SUFT
Mitigating Actions		1. Quality Improvement capacity building signed off at QCiC as enabler in Nov 2018 2. Sharing of experience and best practice both internal and external 3. Sharing staff across sites 4. Using clinical integration planning to bring clinical teams together 5. Establishing group structures for harm free care, consultations in process 6. MEHT recovery plan for VTE goes live in June

Strategic Objective	Deliver high quality, safe and responsive services shaped by best practice and our local communities						
Principal Risk	Failure to deliver clinical service change/reconfiguration to meet the needs of the local population currently and in the future, against agreed timescales.						
MSB Risk ID	2.2	**Executive Lead**	Celia Skinner	**Current Risk Score and movement since last month:**	16 ⟺	**Risk Appetite:**	Significant 4 – Seek
Date identified	November 2017	**Date last reviewed**	May 2019	**Target date**	April 2022		
Risk Rating (Likelihood x Impact)							
Inherent Score: 20(5x4)				**Target Score: 9(3x3)**			
Relevant Key Performance Indicators / Risk Indicators							
Speciality level clinical outcomes							
Applicable link to regulation requirements (CQC / NHSI)	NA			**Board sub-committee monitoring**	Future organisational form		

Existing Key Controls		1. Clinical Programme Board 2. Change Team to support clinical teams 3. Development of strategy unit 4. Appointments to clinical leadership posts to lead pathway change
Gaps in Controls		1. Informatics and finance support to develop business cases whilst operating as three statutory Trusts with separate control totals 2. Limited clinical and operational capacity to support change because of operational pressures 3. Legacy commissioning structures supporting different models of care
Assurance	**Internal**	Individual service specific business cases Capital strategic outline case
	External	Pre-consultation Business Case (PCBC) Decision Making Business Case “Your care in the right place” public consultation independent report

	Level of Assurance NHSI	Outcome of NHS England National Assurance review of PCBC
Gaps in Assurance		1. Referral from Southend Oversight HOSC and Thurrock. Delaying implementation and release of £118m capital 2. Failure to develop business cases 3. Operational pressures and high bed occupancy limiting opportunity for clinical re-configuration 4. Funding for transformation costs has yet to be agreed
Mitigating Actions		1. Local capital plans are being re-aligned 2. Clinical change programmes has been re-focused on local re-design and standardisation that is not dependent on capital or pathway re-configuration across sites 3. Bed modelling completed across MSE and to understand local demand risks.

Strategic Objective	Deliver high quality, safe and responsive services shaped by best practice and our local communities						
Principal Risk	Failure to gain agreement and consensus of local communities to changes that reflect best practice						
MSB Risk ID	2.3	**Executive Lead**	Celia Skinner	**Current Risk Score and movement since last month:**	20 ⟺	**Risk Appetite:**	High 3 – Open
Date identified	November 2016	**Date last reviewed**	May 2019	**Target date**	November 2019		
Risk Rating (Likelihood x Impact)							
Inherent Score: 25 (5x5)				**Target Score: 9 (3x3)**			
Relevant Key Performance Indicators / Risk Indicators							
Adverse media reports on clinical re-configuration changes **Lack of local/national political support**							
Applicable link to regulation requirements (CQC / NHSI)	NA			**Board sub-committee monitoring**	Group Portfolio Steering Group to JWB STP Programme Board		

Existing Key Controls	1. Decision Making Business Case submitted to Joint Commissioning Group (JCG) in spring 2018, following public consultation on re-configuration changes. 2. Approval given by JCG for implementation of all 19 recommendations in July 2019. 3. External stakeholder management ongoing (Commissioners, Regulators, Local and National Politicians, etc.). Stakeholder management plan agreed and being implemented. 4. Strong leadership and representation at STP clinical cabinet 5. Clinical Leadership of clinical pathway re-configuration established and supported with PMO and coaching 6. Patient co-design basic principal of pathway re-design 7. Strategic relationships established with academic partners, (UCLP and Nuffield) to strengthen evidence and case for change. 8. Experienced and appropriate legal support in place
Gaps in Controls	1. Referral to Secretary of State by Southend HOSC and Thurrock will delay progress on clinical pathway design and fuel public scepticism

Assurance	**Internal**	1. Strong governance framework to develop decision making business case with relevant external expertise 2. All change has been developed by local clinicians
	External	4. East of England Senate has endorsed clinical re-configuration changes 5. NHSE clinical leadership have supported stroke pathway changes
	Level of Assurance	Medium, given the number of external risks that are outside the control of the Trusts.
Gaps in Assurance		We have followed advice and guidance on the clinical re-configuration process so there is no immediate gap in assurance.
Mitigating Actions		1. Get agreed communications and engagement strategy ensure there is the long term communications resources dedicated, along with rollout of a cultural survey and broader staff engagement plan. 2. Demonstrate improved clinical outcomes through pathway change

Strategic Objective	Deliver high quality, safe and responsive services shaped by best practice and our local communities						
Principal Risk	Failure to achieve consistent "Good" rating for CQC in Safe, Caring, Effective and Responsive domains. Failure to implement agreed remedial action plans in a timely fashion.						
MSB Risk ID	2.4	**Executive Lead**	Diane Sarkar	**Current Risk Score and movement since last month:**	16 ⟺	**Risk Appetite:**	Significant 4 – Seek
Date identified	November 2018	**Date last reviewed**	May 2019	**Target date**	Following CQC inspections		
Risk Rating (Likelihood x Impact)							
Inherent Score: 20(4 x 5)			**Target Score:** 8 (2 x 4)				
Relevant Key Performance Indicators / Risk Indicators							
• No requirement / warning notices • Reducing number of "Must Take" actions • Reducing number of "Should Do" actions • Achievement of "Good" overall rating on all three sites							
Applicable link to regulation requirements (CQC / NHSI)	• Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) • Care Quality Commission (Registration) Regulations 2009 (Part 4)			**Board sub-committee monitoring**	Group Risk and Compliance Group with direct report to Board		
Existing Key Controls	• Executive leadership with local site ownership • Group wide risk and compliance structure embedded with robust internal compliance peer review methodology utilising a MDT approach • Standardised compliance documentation and review methodology • Monthly reporting to the Board (Risk and Compliance report) • Quality Committee in Common established with formal compliance reporting as standard agenda item • Relationship meetings for each site with CQC • Governance structures / quality work underpinned by CQC Key Line of Enquiry (KLoE) • Site based weekly internal compliance monitoring meetings (Internal Compliance Action Group (ICAG)with documented evidence of tracking progress						

<table>
<tr><td></td><td colspan="2">Forums established to share learning
Executive experience in core service and well led executive reviewer experience
BTUH Core, Use of Resource and Well Led inspections completed March 2019 March.
Monthly reporting to CQC on Maternity Services for BTUH
Monthly reporting to CQC on MEHT Improvement Plan</td></tr>
<tr><td>Gaps in Controls</td><td colspan="2">Movement of approval and implementation of newly created risk and compliance governance structures
Consistent and reliable reporting on all three sites
Monthly meeting structure for group and sites now defined and developed, to be finalised and implementation May/June 2019
Terms of Reference of ICAG not consistent across the group</td></tr>
<tr><td rowspan="3">Assurance</td><td>Internal</td><td>Weekly internal compliance meetings
Internal compliance mock inspections
Established forums for sharing information</td></tr>
<tr><td>External</td><td>JCT reviews / Peer reviews
CQC inspections
NHSi support and reviews
CQC inspections that do not yield any surprises and there are improvement plans in place
January 2019 CQC Report for MEHT – overall RI
No “warning notices” received as part of the BTUH CQC inspection (March 2019)
NHSI supportive review of maternity services, feedback provide indicating opportunities and positive reinforcement of actions taken
Draft report received, factual accuracy returned on 28th May
Unannounced responsive inspection at MEHT on 21/05/19 – satisfied with actions taken and no new concerns identified</td></tr>
<tr><td>Level of Assurance</td><td>Latest CQC Reports
<table>
<tr><th></th><th>MEHT – Jan 2019</th><th>BTUH – March 2015</th><th>SUHFT – April 2018</th></tr>
<tr><td>Safe</td><td>RI</td><td>Good</td><td>Requires Improvement</td></tr>
<tr><td>Effective</td><td>RI</td><td>Good</td><td>Good</td></tr>
<tr><td>Caring</td><td>Good</td><td>Good</td><td>Good</td></tr>
<tr><td>Responsive</td><td>RI</td><td>Good</td><td>Good</td></tr>
<tr><td>Well-led</td><td>RI</td><td>Good</td><td>Good</td></tr>
<tr><td>Overall</td><td>Requires Improvement</td><td>Good</td><td>Requires Improvement</td></tr>
</table></td></tr>
</table>

Gaps in Assurance	• When not all core services are inspected by the CQC and have previously been rated as requires improvement • Reliable, consistent data
Mitigating Actions	• Weekly internal compliance meetings and Systematic internal compliance reviews • Alignment with JCT reviews • Follow through / peer review methodology • Standardisation of methodology • Preparation for well led and core services inspection for SUHFT commenced

Strategic Objective	Be an employer of choice for a supported, engaged and high performing workforce						
Principal Risk	**Failure to create workforce stability with vacancy and retention rates within the top quartile for acute trusts**						
MSB Risk ID	3.1	**Executive Lead**	Danny Hariram, MSB Chief People Organisational Development Director	**Current Risk Score and movement since last month:**	20 ↑	**Risk Appetite:**	Significant Level 4 – Seek
Date identified	November 2018	**Date last reviewed**	May 2019	**Target date**	Q4		
Risk Rating (Likelihood x Impact)							
Inherent Score: 16				**Target Score: 8**			

Relevant Key Performance Indicators / Risk Indicators

KPI	BTUH			SUHFT			MEHT			(Target)
Qtr3 18/19	O	N	D	O	N	D	O	N	D	
Vacancy Rate	12.4	11.9	12	9.99	10.8	11.1	18	17.6	16.6	7.00%
Vacancy Rate (nurses)	16	15.5	14.9	10.9	12.1	12.8	24.8	23.2	23.3	7.00%
Vacancy Rate (medical)	16.4	16.2	16.5	13.8	16.4	15.3	11.8	12.9	8.27	7.00%
Agency (% of paybill)	7.2	6.6	5.68	7.7	7.75	5.46	11	10.3	9.36	6.43%
Turnover Rate (Total, 12 months)	12.1	11.9	11.1	12.5	13.2	13.4	16	15.6	15.2	9.50%
Appraisal	86.5	88.4	87.9	80.8	83.9	84	79.6	77.9	76.7	90.00%

Applicable link to regulation requirements (CQC / NHSI)	Regulation 5: Fit and Proper Persons – Directors Regulation 18: Staffing Regulation 19 : Fit and Proper Persons - Employed	**Board sub-committee monitoring**	Workforce

Existing Key Controls	1. Group HR KPIS are reviewed by Site Governance Forums, People & OD committee in common Boards in common. 2. Workforce recruitment plan approved by JWB June 2018. 3. Nursing and Midwifery retention strategy approved by JWB June 2018. 4. Nursing and Midwifery R&R board established.

	5. HR & OD governance group to be established. 6. Continued overseas recruitment.to recruit to 400 registered nursing posts over a 12-18 month period, 30 doctors and 50 Allied health professionals By April 2020 nursing registered vacancy factor of 17%. 7. Recruitment agencies utilised for hard to fill vacancies across clinical areas. 8. Group VCP panel and pay steering group set up to review go live of recruitment exercises, ensuring budget is in place and HR processes are followed. 9. Standardising and harmonising HR processes across the group, which will allow for improved delivery of the HR service. Proposed time to hire target of 47 days. 10. Harmonising medical and nursing Bank rates across the Group, creating consistency across group and to attract from agency to bank. Harmonised rates are leading to further savings at BTUH.	
Gaps in Controls	1. Consistent data quality. 2. Inability to attract to specialist positions and registered nurses. 3. Inability to convert agency to bank/agency contract. 4. The inability to confirm an MSB organisation brand across Group. Work has commenced on developing a new organisational identity in preparation for a new merged organisation. 5. HR workforce instability due to the corporate restructure. 6. Action plans fail to deliver a reduction in turnover. 7. Retention of retirees. 8. Lengthy timeframes in rolling out group actions due to capacity. 9. Inability to completely standardise marketing material due to variance in terms and conditions. 10. Outsourced contracts will delay full implementation, Inability to identify the required investment in Year one.	
Assurance	**Internal**	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 reduction – still much work to achieve target across the group. 5. Where cost effective, standardise rates are introduced – reduce the pay bill. 6. Reduction in agency spend – a lot more work underway to achieve target. 7. Standardised Nurse Bank Rates plus Bank Incentive Bonus communicated to staff with April 1st start date. 8. Feedback from HR customers. 9. Milestones in recruitment and retention plan achieved.
	External	• Staff survey • CQC Well Led KLOE

<table>
<tr><td></td><td></td><td colspan="3">• Culture analysis</td></tr>
<tr><td></td><td>Level of Assurance</td><td colspan="3">Partial assurance</td></tr>
<tr><td colspan="2">Gaps in Assurance</td><td colspan="3">• A national shortfall of a range of staff leads to a difficulty in achieving agreed trajectories.
• Uncertainty of the EU Exit.
• Need to have clear governance structures in place around delivery and accountability for programme.
• Lack of dedicated support.
• High level of vacancies in the OD team.
• Lack of dedicated site support.
• Positive impact on HR Key performance indicators.
• The merging of the HR and OD teams will enable deployment of resources more widely.</td></tr>
<tr><td colspan="2">Mitigating Actions</td><td>1. Develop Group nursing recruitment information pack
2. Develop a detailed operational model to introduce one bank and agency service – Bank & Agency Consultation launching March 2019.
3. Align the bank and agency pay rates across the three trusts
4. Develop Group staff survey action plans
o Group Health and well-being activities
5. Implementation of In-house Bank & Agency Service commencing June 2019
6. Detailed design of recruitment and transactional services – consolidated of related HR services commences start April 2019.
7. First draft of people strategy developed
8. Reconcile Group vacancies with actions taken to recruit.
9. Deliver retention strategy
10. Deliver recruitment plan – International Recruitment Business Case in finalisation stage.
11. AD Resourcing, Heads of Temporary Recruitment, Head of Permanent Recruitment for MSB appointed.</td><td>CHRD/ CNO/HR
CHRD/GHRDs

CHRD/CNO/CMO
HRDs/Head of OH
CHRD/GHRDs
CHRD/GHRDs
CHRD/GHRDs
CHRD/GHRDs
CNO/GHRDs
CHRD/GGRDs</td><td>June 2019

April 2019

August 2019

June 2019

July 2018

May 2019
June 2019</td></tr>
</table>

Strategic Objective	Be an employer of choice for a supported, engaged and high performing workforce						
Principal Risk	**Failure to be the demonstrable employer of choice for people with right values, behaviours, skills and experience**						
MSB Risk ID	3.2	**Executive Lead**	Danny Hariram, MSB Chief People Organisational Development Director	**Current Risk Score and movement since last month:**	20 ↔	**Risk Appetite:**	Open – Level 3
Date identified	June 2018	**Date last reviewed**	May	**Target date**	Q4		
Risk Rating (Likelihood x Impact)							
Inherent Score: 25				**Target Score: 10**			

Relevant Key Performance Indicators / Risk Indicators

Staff Survey	**2018**	
% Response Rate NHS Acute Trust Avg. 44%	MEHT	33
	SUFT	49
	BTUH	42
Engagement Score NHS Acute Trust Avg. 7.0	MEHT	6.8
	SUFT	6.9
	BTUH	7.0

Applicable link to regulation requirements (CQC / NHSI)	• Regulation 5: Fit and Proper Persons – Directors • Regulation 18: Staffing • Regulation 19: Fit and Proper Persons – Employed	**Board sub-committee monitoring**	FRCP

Existing Key Controls	The Group's vision is to have an engaged and healthy organisational culture, supported by a sustainable and capable, engaged workforce working in an integrated and co-ordinated approach across our hospitals. This vision is articulated in the Group draft People Strategy. The Key Pillars/themes contained in the Strategy are: 1. Recruit and Retain 2. Staff Engagement 3. Improving performance 4. Workforce redesign 5. Staff HWB Delivery of these themes will ensure that the above risk is mitigated. Below is a list of initiatives which are being run across the three sites albeit in different phases and stages. There are plans to widen our talent pool through the creation of an employee referral scheme (Pillar 2)

	• Create values based recruitment processes (Pillars 1,2,3) • Creating centres of excellence around clear career pathways for nursing (Pillars 2, 3 and 4) • Enhanced and innovative approaches to flexibility of roles and work/life balance (Pillars 2, 3, 4, 5 and 6) • Best practice employee support via CIC, Speak Up Guardian and health and wellbeing campaigns (Pillars 1, 2, 3, 4, 5 and 6) • Stay campaign and Exit Interviews (Pillars 2, 3) • Retire and return programme (Pillars 2, 3) • Respect Programme (Pillars 1, 2, 3, 4, 5 and 6) • Whistleblowing policies (Pillars 1, 2, 3, 4, 5 and 6) • Best practice integrated learning and development practices, supported by e-learning and flexible delivery models (Pillars 1, 2, 3, 4, 5) • Annual appraisal and PDP process in place for staff (Pillars 2, 3 and 4) • Nursing and Midwifery Retention Strategy approved by JWB June 2018 (Pillar 2) • Extensive engagement with hospital staff through surveys, listening events and staff briefings (Pillar 3) • NHSI Cultural Survey for all staff undertaken, results analysed and disseminated to Group and Sites. Site owned Cultural Action Plans in place (Pillar 3) • Staff Survey results, analysis and Group and Directorate Action Plans in place (Pillars 1, 2, 3, 4, 5 and 6) together with communication plan and KPIs' for 2019 NHS Staff Survey. • Group wide marketing campaign featuring Trust staff (Pillars 1, 2) • Group wide co-ordinated medical recruitment programme roll out (Pillars 1,2)	
Gaps in Controls	Currently all three Trusts have different values. There is a requirement to build a single set of values to nurture a new identity and enable a move away from legacy identities. Due to capacity issues not all work areas are running to plan. The OD team has a number of vacancies for key roles which it has struggled to fill; however, newly appointed staff have now joined the team and are starting to settle in. Not all Sites have been able to develop action plans against the key themes to drive some of this work through due to the lack of dedicated support for the areas of work. However, the consolidation of HR services and development of a new senior structure will lend itself better to supporting these areas. The current organisational change agenda has impacted staff engagement and morale. Mitigating actions are in place to ensure on-going communications and engagement including dedicated resource to support the development of team dynamics and new ways of working for the new teams.	
Assurance	**Internal**	• On target to achieve vacancy, turnover, appraisal, stat man and sickness trajectory. • Positive impact on HR Key performance indicators. • The merging of the HR and OD teams will eventually enable deployment of resources more widely. • Increase in applications to the "retire & return" programme.

		• Appointment of new OD director to commence April 2019. • Confirmation of appointment in the Group HR structure March 2019 for all posts at Band 8a and above. • Increase in flexible working contracts/temporary arrangements. • Delivery of a range of leadership programmes.
	External	• Improved engagement score in NHS Staff Survey results • CQC Well Led KLOE
	Level of Assurance	Partial assurance
Gaps in Assurance		• Need to have clear governance structures in place around delivery and accountability for programme • Lack of dedicated support • High level of vacancies in the OD team • The inability to confirm an MSB organisation brand across Group.
Mitigating Actions		• Creation of a single Group workforce committee to oversee the implementation of the actions • The work stream to harmonise the statutory and mandatory training offer across the MSB group continues. Project Manager for Stat/Man harmonisation in post since Jan 2019. To date progress is being made on Prevent, IG, Equality and Diversity, Fire, Safeguarding. Other areas still to respond and are being chased. • Other actions as detailed in the Group Leadership and Talent Team action plan (see POD HR Update paper). • Named leads against each pillar/theme to be delivered • Ensure a suite of training is available for staff and managers to enable culture shift • Culture programme to be agreed and initiated to respond to analysis and progress towards creation of a new organisation • Visibility of initiatives and availability of opportunities for staff across the Group.

Strategic Objective	Be an employer of choice for a supported, engaged and high performing workforce						
Principal Risk	**Failure to lead and develop colleagues to ensure they demonstrate support, engagement and high levels of performance in order to drive improvement – Leadership and management development**						
MSB Risk ID	3.3	**Executive Lead**	Danny Hariram, MSB Chief People Organisational Development Director	**Current Risk Score and movement since last month:**	16 ⟷	**Risk Appetite:**	Significant 4 – Seek to reduce
Date identified	June 2018	**Date last reviewed**	May	**Target date**	Q4		

Risk Rating (Likelihood x Impact)

Inherent Score: 20	**Target Score: 12**

Relevant Key Performance Indicators / Risk Indicators

See 3.1 for Turnover and Appraisal Rates.

Performance		SUHFT				MEHT				BTUH				Mid & South Essex			
		KPI	Dec-17	Nov-18	Dec-18	KPI	Dec-17	Nov-18	Dec-18	KPI	Dec-17	Nov-18	Dec-18	KPI	Dec-17	Nov-18	Dec-18
Training	All Statutory and Mandatory Training	85.00%	87.06%	86.76%	87.18%	85.00%	85.56%	86.56%	88.07%	85.00%	83.05%	82.48%	78.92%	85.00%	85.70%	85.88%	85.88%
	Information Governance	95.00%	84.44%	86.97%	90.10%	95.00%	82.83%	84.06%	86.99%	95.00%	79.22%	80.36%	80.65%	95.00%	82.09%	83.73%	85.80%

Applicable link to regulation requirements (CQC / NHSI)	• Regulation 5: Fit and Proper Persons – Directors • Regulation 18: Staffing • Regulation 19: Fit and Proper Persons – Employed	**Board sub-committee monitoring**	Workforce

Existing Key Controls	The Group's vision is to be an employer of choice which has an engaged and healthy organisational culture, supported by a sustainable and capable, engaged workforce working in an integrated and co-ordinated approach across our hospitals. This vision is articulated in the Group People Strategy. The Key Pillars/themes contained in the Strategy are: 1.Nurturing a new identity 2.Recruit and Retain 3.Staff Engagement 4.Improving performance 5.Workforce redesign 6.Staff Health Wellbeing The Group is providing leadership and management training through a range of the programmes currently on offer to staff include:

		• Leadership Plan for the MSB Group with a portfolio of leadership and management development options including an MBA qualification as part of the education and training available to staff. • Development of an inclusive Talent Management Plan to support career pathways that supports improvement in retention / turnover target and appraisal completion rates • Implementation of QSIR and innovation strategy that leads to staff feel empowered to make improvement and changes. Measurably we would want to see an improve in staff engagement scores • Retention and Engagement skills programme for leaders/managers. Improvement in turnover target • Mental Health First Aiders trained at MEHT & BTUH – gap for SUHFT. Reduction in sickness level attributable to stress.
Gaps in Controls		• No centralised group process for accessing all education and training programmes, a number of programmes are still site based. • Need clarity around governance processes. • TNA for the group still to be undertaken - complexity of current group model arrangements. • Assessment of impact of Training and development already undertaken and the impact for the Group. • Ability to release staff to attend training due to operational pressures.
Assurance	**Internal**	• On target to achieve vacancy, turnover, appraisal, stat man and sickness trajectory. • Positive impact on HR Key performance indicators. • Progress against milestones for the Clinical Reconfiguration and Redesign Programme. • Increase in flexible working contracts/temporary arrangements. • Increase in uptake of Leadership development opportunities. • Succession planning and internal promotion data. • Improved staff engagement scores. • External interim employment reduction. • QSIR data
	External	• Improved engagement score in NHS Staff Survey results • CQC Well Led KLOE
	Level of Assurance	Partial assurance
Gaps in Assurance		• Need to have clear governance structures in place around delivery and accountability for centralised education and Training • Lack of dedicated support

Mitigating Actions	• Visibility of initiatives and availability of opportunities for staff across the Group. • Creation of a strong attract, recruit and retain brand based on values and behaviours of the MSB Group • Further career paths to be developed to cover all staff groups • Succession/Talent Pool to be created to support internal promotion and career progressive that improves turnover target • Creation of a Leadership and Behaviour framework for the Group in line with the NHSi Leadership Framework • Development of a TNA to meet the requirements for delivering a highly developed, engaged employee • Named Leads against each of the deliverables who will report into the Workforce Committee • LMS Business case in progress (Group Investment Committee) to enable MSB wide marketing and access of learning opportunities and content 24/7. Also to support constant flow TNA. • Provision of a wide range of Leadership development opportunities for staff at all levels, to include in-house, outsourced, apprenticeships, performance support. • Provision of a coaching service within MSB

Strategic Objective	Be effective and efficient with all our resources, creating an organisation that residents and staff can rely on for the long term.						
Principal Risk	Failure to deliver financial plan						
MSB Risk ID	4.1	**Executive Lead**	James O'Sullivan	**Current Risk Score and movement since last month:**	25 ⟷	**Risk Appetite:**	Cautious 3 - Open
Date identified	November 2018	**Date last reviewed**	May 2019	**Target date**	March 2020		
Risk Rating (Likelihood x Impact)							
Inherent Score: 25				**Target Score: 15 (likelihood 3 x impact 5)**			
Relevant Key Performance Indicators / Risk Indicators							
• Individual Trust monthly and YTD financial performance • Financial forecasts versus plan							
Applicable link to regulation requirements (CQC / NHSI)	Use of resources			**Board sub-committee monitoring**	Finance & Performance		
Existing Key Controls	Expenditure control processes CIP tracking and review meetings Financial recovery plan at MEHT Guaranteed income contracts with main CCGs						
Gaps in Controls	High levels of agency spend due to vacancies Unidentified CIPs and under delivery on CIP schemes Some areas of poor productivity Residue of income on PBR contracts						
Assurance	**Internal**	Regular reviews of financial performance at Finance Committees Financial position reported monthly at JWB and quarterly at Trust Boards					
	External	Regular communication with NHSI regarding financial performance Revised forecast for MEHT submitted to NHSI and performance being tracked against that					

	Level of Assurance	NHSI Single Oversight Framework, rating 3 (3 Trust average)
Gaps in Assurance		Financial performance behind internal plans for all three Trusts at mid-2018/19 Arrangements for funding group transformation spend not concluded with NHSI
Mitigating Actions		• Recovery plans in are already in place for all three Trusts. Progress is reported monthly at Finance and Performance Committee. • NHSI fully sighted on group transformation spend and ongoing dialogue to conclude this. It has now been confirmed with NHSI that the expenditure for 2018/19 will be borne in full by MEHT. • Group work to harmonise approach to agency usage and bank rates. New agency preferred supplier list introduced January 2019. Standardised bank rates being introduced by end of May 2019. • Working with lead commissioners to bring further commissioners into guaranteed income contract arrangement if possible. To be agreed by end March 2019.

Strategic Objective	Be effective and efficient with all our resources, creating an organisation that residents and staff can rely on for the long term.						
Principal Risk	Failure to develop and fund long term long term capital plan which addresses the clinical, estates and technology needs of the organisation						
MSB Risk ID	4.2	**Executive Lead**	James O'Sullivan	**Current Risk Score and movement since last month:**	20 ⟷	**Risk Appetite:**	Cautious 3 - Open
Date identified	November 2018	**Date last reviewed**	May 2019	**Target date**	March 2020		
Risk Rating (Likelihood x Impact)							
Inherent Score: 25				**Target Score: 15 (likelihood 3 x impact 5)**			
Relevant Key Performance Indicators / Risk Indicators							
• Efficiency of capital investment – to be developed							
Applicable link to regulation requirements (CQC / NHSI)	Use of Resources			**Board sub-committee monitoring**	Finance & Performance		
Existing Key Controls	• Existing processes in each of the Trusts to prioritise annual capital plan to fund essential investments • Work underway to produce the OBC and FBC to secure the £118m strategic capital allocated from national funds • Sale proceeds from Fossets Farm land sale ring fenced to support early development of strategic capital investment						
Gaps in Controls	Estates strategy not yet developed Digital investment strategy not yet developed Funding solutions not yet identified for multi-year digital and medical equipment investment						
Assurance	**Internal**	• Monthly tracking and reporting of capital expenditure • Essential capital investment required to maintain services is being funded at present • Additional investment has been enabled using STF bonus funds					
	External	Support from commissioners for Trusts clinical reconfiguration plans and capital investment case to support this Support from regulators for merger plan and capital investment required to deliver clinical reconfiguration					
	Level of Assurance	NHSI Single Oversight Framework, rating 3 (3 Trust average)					
Gaps in Assurance	Access to the £118m strategic capital is dependent on development of the estates strategy and demonstration of value for money through detailed benefits cases for clinical reconfiguration						

Mitigating Actions	• Multi-year digital investment strategy case being developed. To be shared with Boards in April 2019. • Alternative funding sources being explored. Proposal to be developed by May 2019.

Strategic Objective	Be effective and efficient with all our resources, creating an organisation that residents and staff can rely on for the long term.						
Principal Risk	Failure to deliver digital transformation agenda and to ensure resilience in informatics and IT Services.						
MSB Risk ID	4.3	**Executive Lead**	Martin Callingham	**Current Risk Score and movement since last month:**	**20 (4x5)**	**Risk Appetite:**	**4 – Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).
Date identified	27th April 2017 Re-baselined 17th April 2019			**Date last reviewed**	13th May 2019	**Target date**	End-March 2020
Risk Rating (Likelihood x Impact)							
Inherent Score: 20 (4x5)				**Target Score: 9 (3x3)**			
Relevant Key Performance Indicators / Risk Indicators							
• Tactical Informatics Strategy in place October 2017 • Final Informatics Strategy being developed through the to deliver quality through innovation agreed and supported and aligned to clinical and operational strategies • Sufficient financial resources to be agreed to support the delivery of the Digital Investment Strategy • Centralised process established for the management, procurement and development of systems. • Business continuity processes clearly defined, documented and regularly tested. • Staff recruitment and retention rates							
Applicable link to regulation requirements (CQC / NHSI)	Regulation 12 – Safe care and treatment; Regulation 15 – Premises and equipment; Regulation 17 – Good governance.			**Board sub-committee monitoring**	Joint Finance & Resource Committee		
Existing Key Controls	1. The high-level strategy is being finalised, meanwhile tactical solutions are being implemented to ensure service stability 2. Governance processes are being embedded across all Informatics disciplines to review risks and identify themes across the Group 3. Senior leadership structure across MSB in Informatics now in place 4. Dedicated Cyber Security officer in place across the Group 5. Staffing gaps are being addressed through the use of agency as required 6. Policies aligned across the Group for Digital Services & Information Governance 7. MEHT: Lorenzo Operational Group has been established to re-launch the use of Lorenzo with a specific focus on RTT tracking						

Gaps in Controls	1. Restructure to commence in order to align resources within the teams across the Group 2. Formal governance structures are being reviewed in order to align Informatics with evolving Group governance structures 3. Interim Senior Team structures are in place whilst the services are redesigned across the group 4. Funding and/or suitable resourcing is not available to address gaps in staffing and manage increasing service demand 5. A shortfall in the availability of funding to support delivery of the proposed capital programme.	
Assurance	**Internal**	1. Group Informatics Strategy review and monitoring in accordance with reporting frameworks 2. Escalation of concerns or significant deviation from delivery plan via Joint Working Board and Joint Board in Common 3. Regular reports provided to Audit, Finance & Resource and Quality & Safety committees
	External	Actively participate in service specific audits, and audits of other service areas when required
	Level of Assurance	The level of assurance has been assessed as Medium, given the number of gaps in controls which are outside the direct control of the service.
Gaps in Assurance		Insufficient resources and funding available to deliver the agreed strategy
Mitigating Actions		1. Develop plan for centralised services, to include single group Informatics Management Structures and staff consultation – **completed, awaiting approval to launch (anticipated May2019)** 2. Finalising the MSB Informatics Strategy underpinned by Digital Essex 2020 to reflect / identify new ways of working and delivery of supporting technology 3. Single group wide governance approach to ensure communications with operational and corporate redesign teams to ensure alignment of programmes across the MSB Group - **groups established and becoming embedded** 4. Develop a plan for a centralised intelligence centre including complete restructure of service to meet the present and future needs of the MSB Group – **Plan developed, awaiting approval to launch staff consultation (anticipated May2019)** 5. Review Informatics capital programme, with aim of aligning and prioritising projects to deliver direct benefit across the group – **underway as incorporated into financial planning for 19/20** 6. Participating in review of overarching MSB capital plans in order to qualify risk ensure correct prioritised funding 7. The Digital Investment Strategy (Shaping Cloud) is being reviewed to establish an affordable phased delivery, this will also explore potential sources of external funding and alternative funding approaches; including the use of managed or subscription services which could be revenue funded to reduce capital requirements – **completed, currently being finalised.**

Strategic Objective	Be effective and efficient with all our resources, creating an organisation that residents and staff can rely on for the long term.						
Principal Risk	Failure to deliver transformation in corporate support to create a fit for purpose future proofed structure.						
MSB Risk ID	4.4	**Executive Lead**	Jonathan Dunk	**Current Risk Score and movement since last month:**	16 (Same as last month)	**Risk Appetite:**	High 3 – Open
Date identified	November 2018	**Date last reviewed**	31 May 2019	**Target date**	30 September 2019		
Risk Rating (Likelihood x Impact)							
Inherent Score: 20				**Target Score: 10**			
Relevant Key Performance Indicators / Risk Indicators							
Corporate services staff fill rates / vacancy levels Response times for key corporate services Staff survey scores Cost of delivering corporate services Expenditure on bank and agency Procurement expenditure							
Applicable link to regulation requirements (CQC / NHSI)	NA			**Board sub-committee monitoring**	Group Portfolio Steering Group		
Existing As Key Controls	• Executive SRO assigned in May 2018 accountable for delivery of the transformation programme • 2018/19 and 2019/20 programme budget confirmed and an internal programme team supported by external consultancy SMEs in place to ensure robust designs developed and implemented taking into account benchmarking information available. • Corporate Services Programme Board established in June 2018 providing oversight and direction to all corporate service transformations. • Weekly Corporate Executives escalation meetings in place to address immediate issues when they arise. • Corporate function transformations led and owned by relevant Corporate Executive JEG leader. • Stakeholder engagement with affected corporate staff, Staff side representations, Trust Boards and Site Leadership Teams. Change Management programme wide work to ensure stakeholder engagement is maintained and staff to feel motivated to work in the newly designed services. • Monthly staff briefing sessions with Finance, HR, Procurement and Informatics staff now in place						

		• Communication started with the wider organisation including updates at the CEO briefings, Site Leadership Team meetings and 1weekly bulletins. • Implementation readiness checklists in place to support corporate functions in ensuring a consistent approach to consolidation of services.
Gaps in Controls		• Further stakeholder engagement with wider users of Corporate services to be completed. • Future oversight of corporate service delivery to be agreed when BAU state is reached. Discussions started and Executive team discussion to be scheduled.
Assurance	**Internal**	• The Programme use the MSE wide programme methodology of gateway review stages to ensure robust decision making at key points within a project lifecycle. • Improvement team CMO resource to evaluate project post implementation and feedback of lessons learned through the June 2019 Programme Board.
	External	• External consultancy SME support assigned in experienced in delivery this level of change to corporate services at other NHS organisations
	Level of Assurance	Medium, given the level of change and staff impact that this programme has.
Gaps in Assurance		- Development of process improvements between services post implementation of single site corporate hub are not yet as advanced as individual service improvement plans - Development of end state model for the corporate services hub with streamlined end to end processes still in design phase. This will release further benefits to users of the services.
Mitigating Actions		- Improvement work to start in summer 2019 on the first set of end to end processes to be redesigned as part of the corporate services hub end state model. - Additional services being taken through same full programme methodology to ensure proposals are consistent with broader corporate offerings. IT/Information to bring forward case for future service configuration by early 2019.

Strategic Objective	Be effective and efficient with all our resources, creating an organisation that residents and staff can rely on for the long term.						
Principal Risk	Failure to achieve and deliver on long term financial sustainability and effective use of resources						
MSB Risk ID	4.5	**Executive Lead**	James O'Sullivan	**Current Risk Score and movement since last month:**	20 ⟷	**Risk Appetite:**	Cautious 3 – Open
Date identified	November 2018	**Date last reviewed**	May 2019	**Target date**	March 2020		
Risk Rating (Likelihood x Impact)							
Inherent Score: 25			**Target Score: 15 (likelihood 3 x impact 5)**				
Relevant Key Performance Indicators / Risk Indicators							
• Trusts' YTD deficit positions versus plan • Trusts' financial plans versus multi-year plan							
Applicable link to regulation requirements (CQC / NHSI)	Use of Resources			**Board sub-committee monitoring**	Finance & Performance		
Existing Key Controls	Multi-year plan to eliminate deficits Multi-year guaranteed income contract with STP CCGs						
Gaps in Controls	Dependency on out of hospital solutions being delivered by other parties Continued growth in demand Group transformation schemes only partly developed						
Assurance	**Internal**	Delivery of annual financial plans Development of business cases to deliver reconfiguration and improvement initiatives					
	External	Support from commissioners for Trusts clinical reconfiguration plans Support from regulators for merger plan					
	Level of Assurance	Medium, given the level of change and staff impact that this programme has.					
Gaps in Assurance	Multi-year CIP plans not yet developed						

	Strategic, merger enabled savings plans not yet developed
Mitigating Actions	• Multi-year CIP plans will be developed to support LTFM. This will be developed for mid-May 2019 • Clinical reconfiguration plans and benefits cases being developed to support capital OBC by the end of April 2019 • Engagement with commissioners to develop effective demand management plans. Target date of end of May 2019.

Strategic Objective	Be effective and efficient with all our resources, creating an organisation that residents and staff can rely on for the long term.						
Principal Risk	Failure to consistently deliver safe, responsive and efficient patience care in a cost effective manner because current estate and infrastructure is not fit for purpose						
MSB Risk ID	4.6	**Executive Lead**	Eamon Malone	**Current Risk Score and movement since last month:**	16 (4*4) Increase from 12 previously, this is to reflect increasing concern over limited capital to address critical backlog issues.	**Risk Appetite:**	Moderate 2 - Cautious
Date identified	15/05/2017	**Date last reviewed**	CGG 11/10/2018 Board 04/12/2018 FRC 11/01/2019	**Target date**	31/03/2020		
Risk Rating (Likelihood x Impact)							
Inherent Score: 20 (4*5)				**Target Score:** 9 (3*3)			
Relevant Key Performance Indicators / Risk Indicators							
Performance KPI's have been identified which demonstrate the effectiveness of the service delivery. These are included within the estates and facilities section of the Integrated Performance Report. The Premises Assurance Model (PAM) provides an additional assurance indicator which assesses all aspects of estates and facilities management, including compliance with legislation, safety, patient experience. In addition it addresses business management and focuses on policies and procedures and auditing processes.							
Applicable link to regulation requirements (CQC / NHSI)	Regulation 12 - Safe care and treatment, Regulation 15 – premises and equipment, Regulation 17 - Good governance			**Board sub-committee monitoring**	Estates Divisional Board		
Existing Key Controls	1. All EFM Services policies and procedures linked to statutory requirements are in place. Under the PAM assurance model, this includes policies and procedures being in place in accordance with regulatory standards. 2. EFM Training to ensure the workforce has the skills required to maintain the estate and to support the appointment of Authorised Persons and or Competent persons.						

	3. Hard Services Governance – Statutory Compliance Processes Asset register, annual Planned Preventative Maintenance (PPM) programme in place. Internal and external audit by Authorising Engineer (AE). 6 Facet Condition Survey / Backlog Capital Programme / Incident reporting system. 4. Soft Services – Cleaning Standards monitored against National Specification for Cleanliness Standards by Domestic supervisors and the QA team alongside nursing representatives. Reported at local level and at IPCG. Contracts monitoring also in place. 5. Business Continuity: SUHFT adopted Basildon Business Impact Assessment (BIA) model on recommendation from Emergency Planning Services. Completed BIA's with action cards are in place for EFM services. 6. Infrastructure and Plant - All assets are risk assessed and managed via the backlog maintenance programme. Funding is allocated via annual programmer and investment group. 7. Medical Equipment – policy in place in accordance with MHRA guidance. ISO 9001 registered. Asset register, risk assessed PPM programme. Control over purchase and disposal of equipment. Evidenced user training programme. Equipment condition/fitness for purpose annually risk assessed for inclusion in capital programme. Equipment related incidents investigated. 8. Operational Standards - BSI accreditation for 9001 (Quality), 14001 (Environment) and 18001 (H&S).	
Gaps in Controls	1. Some policies are due or overdue a review. 2. Appointment letters have been issued. A review of Authorised Persons will be undertaken as part of the PAM process. 3. Development of governance and assurance reporting required. 4. None 5. The review meeting to align to BTUH BIA has commenced. 6. Failure to secure all capital funding required for identified schemes. Not all assets are identified on this programme. 7. Failure to secure all capital funding required. 8. None	
Assurance	**Internal**	1. Policies updated within required timescales, annual audits to confirm implementation and action plans where required. Evidence available for HSE and CQC inspections. Premises Assurance Model completed with identified action plan. 2. Training skills register demonstrates compliance. Authorised persons now appointed. 3. CAFM holds Asset register and annual programme of PPM, KPI audit reports submitted to the Trust Board. Estates Risk Assessed Capital Programme prioritises investment to remove high risk statutory items. Action plans available linked to incident reporting. Internet Access to Hard Services Tasks / response times and performance now available for staff / managers to monitor progress (4)

		4. Cleaning audit reports are sent to the services and action plans developed / implemented. Repeat unannounced audits undertaken to ensure actions are completed. KPI reports to QAC/ H+S and the Trust Board. KPI clearly identified in contract specification and reviewed at monitoring meetings
	External	5. Business Continuity plans are in place. 6. Risk assessed capital programme in place 7. Monthly performance KPI's reported to board, Internal audit schedule, External (BSI) audit schedule, Quarterly medical devices safety report, Risk assessed capital programme 8. Positive CQC inspection reports
	Level of Assurance	Moderate assurance.
Gaps in Assurance		1. Some policies are overdue for review. 2. None 3. Estates governance team in place with implemented audit and review. Further work required on reporting templates to EFM board. 4. Failures in cleaning standards identified in CQC reports. Limited assurance from FRC 5. Plans are untested 6. Required capital allocation has not been met for all high risk items. 7. Required capital allocation has not been met for all high risk items. 8. Requirement for improvement following CQC inspection.
Mitigating Actions		1. Estates and its related services are integral to the delivery of high quality, safe, effective and efficient clinical care. The 2016 NHS Premises Assurance Model (PAM) has been updated to reflect changes in policy, strategy, regulation, technology and supports the NHS Constitutional right. The PAM assessment is currently being reviewed against the Hard FM Compliance Audit to ensure all aspects align with risks accordingly. Development of an MSB EFM Policies Register and Review Programme to align all documents including updated documentation of processes in place. 2. Appointment letters have been written, signed by the Chief Director and issued to the Authorised persons to sign. 3. Development of reporting templates is underway; any known or emerging concerns are escalated to the EFM board and the estates management team. These are added to the Corporate risk register. 5. Review the Maintenance BIA to align to BTUH BIA model 6. Mitigation varies dependent upon the type of requirement and location but as an example In the event of a failure to key infrastructure services such as heating, cooling, electrical systems, medical systems etc. Mitigation is by way of undertaking planned and reactive works to minimise and remedy the failure. Skilled teams are available 24x7 to react and a number of specialist contractors are engaged. Additional technical audits on the delivery of the service in

	accordance with Health Technical Memorandums are undertaken by Authorising engineers. Action plans are produced and monitored. Within Life support areas these services are provided on an N+1 basis such that in the event of M&E failure a standby system is automatically enacted such as UPS or emergency generation. 7. High risk items for medical equipment replacement approved, issues relating to non-funded items to be highlighted to investment and Approval Committee as they become apparent. 8. Development of Early warning escalation process where non-conformance actions are slow in being developed.