NHS
Mid and South Essex
University Hospitals Group

one team, working together

MSB Board Assurance Framework

2019/20

August 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

NHS
Mid and South Essex
University Hospitals Group

one team, working together

Board Assurance Risk Heat Map – September 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			✓ ↓ From 16					8
1.4 Failure to deliver improvement national performance targets in the agreed trajectories **Yvonne Blucher, Andrew Pike, Jane Farrell**	25						✓ ↔		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. **Chief Medical Officer**	**20**					√ ↔			**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. **Chief Medical Officer**	**20**					√ ↔			**9**
2.3 Failure to gain agreement and consensus of local communities to changes that reflect best practice. **Chief Medical Officer**	**25**				√ ↓ **From 20**		↔		**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**	**20**					✓ ↔			**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** **August 2019 – reviewed and amalgamated with 3.2 and 3.3**	**16**						√ ↑		**8**
3.2 Failure to be the demonstrable employer of choice for people with right values, behaviours, skills and experience. **Danny Hariram** **August 2019 – reviewed and amalgamated with 3.1 and 3.3**	**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. **Danny Hariram** **August 2019 – reviewed and amalgamated with 3.1 and 3.2**	**20**					✓ ↔			**12**

New 3.1 Amalgamation of 3.1, 3.2 and 3.3 Risk of workforce instability as a result of high levels of turnover and the inability to reduce these levels, resulting in low staff morale and increased turnover.	**16**					✓			**8**
4.0 Strategic Objective **Be effective and efficient with all our resources, creating an organisation that residents and staff can rely on for the long term. (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. **Eamon Malone** **August 2019 – reviewed and merged with 4.6**	**25**							√	**15**
New 4.2 Amalgamation of 4.2 and 4.6 Failure to consistently deliver safe, responsive and efficient care in a cost effective manner because current estate and infrastructure is not fit for purpose. Failure to develop and fund long term capital plan which addresses the clinical, estates and technology needs of the organisation	**20**						✓		**9**
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**			√ **From 16**					**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** **August 2019 – reviewed and merged with 4.2**	**20**				√				**9**

NHS
Mid and South Essex
University Hospitals Group

one team, working together

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**	August 2019	**Target date**	March 2019 April 2020		

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. Delivery of out of hospital service model to support continuity of care.
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 Transfers in: Nov-18: 41 Dec-18: 34 Jan-19: 41 Feb-19: 43 Mar-19: 41 Apr-19: 35 May-19: 54 Jun-19: 51 Measurement tool for other services (e.g. bridging) is being established.
Number of medically fit and DTOC rates.	See Integrated Performance Report
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** Programme Team in place to support production of merger products with programme management monitoring tools in use. Approved clinical strategy and model following resolution of referrals to Secretary of State by Southend and Thurrock councils on the proposed clinical model. Communications plan in place. Appointment of Group Clinical Directors and the transition of specialist services to Managing Directors, commencing with Vascular and Orthopaedics. **Describe the leadership culture and values of the new organisation** 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 Listening sessions completed in early April 2019 for Senior Staff Development College participants with CEO, CHRD and group directors Work underway to support leadership development for JEG and SLT and newly appointed Group Clinical directors aligning with values of the new organisation **Delivery of out of hospital model** Mobilisation of Hospital at Home service fully implemented at Basildon and Southend. Broomfield service currently at 22 cases and will move to full capacity by October 2019. Agreement with local authorities to expand domiciliary care bridging (Thurrock, Essex) and enhanced re-ablement services (Thurrock). **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. South East Essex keen to work on two place based examples using newly developed PCNs. Thurrock keen to try out cross boundary working with one PCN. 2. Extended MSE QI offer to primary care with options for primary care colleagues to attend MSE run QSIR training days and/or

	QI clinics which are now run monthly across the 3 sites 3. 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. The 13 system leaders participating in the programme attending QI clinics run by MSE group 4. Funding secured for combined Primary Care QI/MSE Institute programme for Mid Essex CCG, 3 clinical leads appointed March 2019. 2 GPs completed QI training run by UCLP, data training from EQUIP and attended MSE QI clinic for support on local projects. **Establishment of Group Performance Management function and new relationship with regulators** 5. New operational planning guidance for 2019/20 drafted for consideration at December Joint Working Board. 6. Combined group winter resilience plan in place; alongside agreed system management activities. 7. 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. Business case for Innovation programme for 2019-20 agreed at Exec group in July 2019 with expansion of the Innovation fellowship to the STP. The aim is to launch the next cohort of Innovation Fellowships in September 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. STP Clinical cabinet and STP paediatric steering group have agreed to support this work.	
Gaps in Controls	**Describe the leadership culture and values of the new organisation** No oversight group to track delivery of the agreed organisational development plan currently meeting. **Develop productive strategic relationships with external partners, including primary care providers through the expansion of our QI offer to general practice.** Lack of relationships with newly formed PCN leaders. **Expansion of innovation fellowships** Lack of single IP, innovation and commercialisation policies across the three trusts.	
Assurance	**Internal**	**The merger of the three trusts into one, including the building of a new foundation trust governance model.** Programme Board papers and minutes, reports received by Joint Working Board and Trust Boards.

		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. Communications and engagement plan, including launch of group identity. **Describe the leadership culture and values of the new organisation** Current programme oversight continues via Group Director and Director HR & OD for Senior Staff Development College. 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. 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. **Delivery of out of hospital model** Routine service monitoring reports on service delivery, length of stay monitoring. **Develop productive strategic relationships with external partners, including primary care providers through the expansion of our QI offer to general practice.** 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 and faculty group meeting since April 2019. Strategy Unit evaluation of the STP QI leadership programme underway to report in Feb/March 2019. Regular updates to Clinical Programme Board on progress **Establishment of Group Performance Management function and new relationship with regulators.** New operational planning guidance for 2019/20. **Expansion of innovation fellowships** Msb innovation Fellows monitored by Innovation Working Group and through decision-tree to support their trials developed by R&D. Evaluation of first innovation fellowship included in and learnings informed the business case for Innovation programme for 2019-20. Strategy Unit have set up an extensive evaluation framework for 19-20 innovation programme.
	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. 2. Independent Reconfiguration Panel advice to Secretary of State and decision of Secretary of State. **Describe the leadership culture and values of the new organisation**

<table>
<tr><td></td><td></td><td>Staff survey and cultural alignment results.
Delivery of out of hospital model
Commissioner and service user feedback.
Develop productive strategic relationships with external partners, including primary care providers through the expansion of our QI offer to general practice.
Regular reporting through Local Workforce Action Board reporting includes project oversight and tracking.
Update on STP QI leadership programme also sent to STP Partnership Board and STP Clinical cabinet

Establishment of Group Performance Management function and new relationship with regulators.
7. NHS Improvement Performance Review Meeting outcome and improved sharing of information with NHS Improvement between Performance Review Meetings

Expansion of innovation fellowships

8. STP Innovation Advisory group set up and meeting since April 2019. This reports/links into the STP Partnership Board and STP Digital workstreams</td></tr>
<tr><td></td><td>Level of Assurance</td><td>NA</td></tr>
<tr><td colspan="2">Gaps in Assurance</td><td>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.</td></tr>
<tr><td colspan="2">Mitigating Actions</td><td>
<table>
<tr><th>Action</th><th>Responsible</th><th>Target date</th></tr>
<tr><td>Continue hospital at home mobilisation to full 30 case model at Broomfield</td><td>Group Director, Integrated Care</td><td>October 2019</td></tr>
<tr><td>Approval of single IP, innovation and commercialisation strategy at Audit Committees in Common</td><td>Group Director, Strategy</td><td>September 2019</td></tr>
<tr><td>Commence communication and engagement team restructure</td><td>Deputy Chief Executive</td><td>October 2019</td></tr>
<tr><td>Development of future operating model including target culture for merged organisation.</td><td>Chief HR and OD Officer</td><td>December 2019</td></tr>
</table>
</td></tr>
</table>

NHS
Mid and South Essex
University Hospitals Group

one team, working together

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**	August 2019	**Target date**	Aug 2019		
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 need 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 supporting 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. Draft consolidated Due Diligence document completed. Going through the appropriate approvals process prior to sign off by Boards in Common on 11th September. 9. Initial draft of PTIP considered by Executive Team and Programme Board. Detailed Integration plans due by the end of this month. 10. First draft of Transaction Business Case due by end of August. 11. Work completed to decouple the merger from patient benefits that require external capital so that the merger is not reliant on the Capital SOC/OBC timelines. 12. Referral to Secretary of State by Southend and Thurrock HOSCs has now been resolved. 13. Revised STP Estates Strategy has been submitted with informal feedback from NHSI that is reached the required standards to obtain a “Good” rating.
Gaps in Controls	1. Day to day Trusts performance (financial or operational) may not improve and lead to loss of regulatory agreement to proceed. 2. 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. 3. Communications Plan with internal stakeholders, most notably staff groups has to be continue, following the transitional

	communications in June. 4. 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. 5. Early indications that NHSI will want the acute sector to reach recurrent financial balance by the end of 2023/24. 6. NHSI/E approvals and governance process newly set up and this may introduce delays in obtaining regulatory approvals. 7. Recent Provider Information Request from CQC for Southend and Mid-Essex will stretch internal resources to meet these requirements whilst also finalising a number of transaction documents and deliverables.	
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, 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. Clear linkage between the Due Diligence and the Integration plans. 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 if capital dependent benefits are needed for the LTFM. 2. Detailed Programme plan to ensure key actions undertaken to meet all key deliverable timelines. Development of a suite of assurance documents to track that key risks are addressed in integration plans and that interdependencies are identified, tracked and delivered. 3. Ensure operational and financial performance at three Trusts improves through targeted interventions and continued focus to turnaround the organisation. 4. Additional dedicated merger communications resources continue to deliver an agreed communications and engagement strategy, rollout of a cultural survey and broader staff engagement. 5. 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. 6. Continue the work in LTFM and modelling to understand what is required to get the Trusts into balance. 7. Engagement in STP workgroup to develop revised STP Estates Strategy and track progress of the completion of the case in the relevant internal meetings. 8. Continued engagement with NHSI in weekly catch ups to ensure early sight of issues and clear understanding on both sides of expectations in terms of timescales for delivery. 9. Continued engagement with internal resources to ensure delivery to timescales and If there is conflicting requirements, rigorous prioritisation or escalation to get resolution if significant possible issue.

NHS
Mid and South Essex
University Hospitals Group

one team, working together

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 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:**	(3 x 4) 12 (was 16) ↓	**Risk Appetite:**	High 3 – Open
Date identified	November 2018	**Date last reviewed**	August 2019 Quality Committee in Common	**Target date**	Following CQC inspections		
Risk Rating (Likelihood x Impact)							
Inherent Score: 16 (4 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 and Quality Committee in Common		
Existing Key Controls	• 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						

<table>
<tr><td></td><td colspan="2">

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 - first draft approved
Development of Board and joint committees in common – Board in common and Joint committees established
Improvement plan now developed for MEHT - reviewed at Site Governance Forums and shared monthly with CQC
Plan in place for SUHFT
Standardisation of Terms of Reference for internal compliance meetings and name to “Maintaining High Standards”

</td></tr>
<tr><td>Gaps in Controls</td><td colspan="2">

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>

Annual well led internal self-assessment reported to Board
Site base well led self-assessments carried out on an annual basis

</td></tr>
<tr><td>External</td><td>

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. Still awaiting final report
Final report received for BTUH. Overall rating for Well Led - GOOD

</td></tr>
<tr><td>Level of Assurance</td><td>Well Led CQC Inspections - NB SUHFT New style CQC well led inspection
<table>
<tr><td></td><td>MEHT –Jan2019</td><td>BTUH – March 2015, March 2019</td><td>SUHFT – April 2018</td></tr>
<tr><td>Well-led</td><td>Requires Improvement</td><td>Good
GOOD</td><td>Good</td></tr>
</table>
</td></tr>
<tr><td colspan="2">Gaps in Assurance</td><td>

Consultation for corporate teams progress – near completion
Further development of Board governance framework

</td></tr>
<tr><td colspan="2">Mitigating Actions</td><td>

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

</td></tr>
</table>

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**	August 2019	**Target date**	Q3		
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 Executive Team weekly oversight of MSE Integrated Performance by target. • Site specific Recovery Programme arrangements and supporting accountability arrangements • Quality in Common Committee. • Trust Boards in Common; underpinned by strengthened joint infrastructure and leadership. • Daily Director of Ops Cancer calls; daily tracking information on the back log and alignment of capacity						
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. • 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.

NHS
Mid and South Essex
University Hospitals Group

one team, working together

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**	August 2019	**Target date**	April 2020		

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

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. - Launch of monthly QI clinics for staff across all sites.	
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. -Staff participation in QI clinics.
	External	-NHS staff survey results.

<table>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td>Level of Assurance</td><td>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).</td></tr>
<tr><td colspan="2">Gaps in Assurance</td><td>-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</td></tr>
<tr><td colspan="2">Mitigating Actions</td><td>
<table>
<tr><th>Action</th><th>Responsible</th><th>Date</th></tr>
<tr><td>Refresh of Quality Improvement Strategy for Board approval</td><td>Deputy Chief Executive</td><td>December 2019</td></tr>
<tr><td>Complete organisational design of single organisation</td><td>Chief People and OD Officer</td><td>December 2019</td></tr>
<tr><td>Fill vacancies within Improvement and Change Management functions</td><td>Deputy Chief Executive</td><td>November 2019</td></tr>
<tr><td>Commission basic QI e-learning package.</td><td>Deputy Chief Executive</td><td>January 2020</td></tr>
</table>
</td></tr>
</table>

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**	CMO	**Current Risk Score and movement since last month:**	16 ⟺	**Risk Appetite:**	High 3 – Open
Date identified	November 2018	**Date last reviewed**	August 2019	**Target date**	September 2019		
Risk Rating (Likelihood x Impact)							
Inherent Score: 20 (5x4)				**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 JWB		
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 7. BTUH maternity improvement plan 8. Internal action plans following internal compliance visits						
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 2.Stabilised harm free care metrics					
	External	CQRG NHSI oversight and monitoring , January inspection rated IPC at MEHT GREEN JCT visits Internal Audit					

	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 HMSR metrics at MEHT an 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 -Infection Control now complete

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**	Chief Medical Officer	**Current Risk Score and movement since last month:**	16 ⟺	**Risk Appetite:**	Significant 4 – Seek
Date identified	November 2017	**Date last reviewed**	August 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 and Group Clinical Directors 5. Outcome of Independent Reconfiguration Panel and Secretary of State decision making on referrals by Southend and Thurrock councils. 6. Ongoing public and patient engagement activities.
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 4. Risk of delay in decision making as a result of dispute between sites and/or lack of sufficient corporate resource to enable change.
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 IRP Advice and Secretary of State decision on Southend and Thurrock council referrals.
	Level of Assurance	Outcome of NHS England National Assurance review of PCBC

NHSI	
Gaps in Assurance	
Mitigating Actions	

Actions	Responsible	Date
Delivery of phase 1 of clinical reconfiguration (IR, Vascular, Orthopaedics)	Deputy CEO, Managing Directors	November 2019
Development of phase 2 business cases for clinical reconfiguration for Board approval.	Deputy CEO, Managing Directors	January 2020
Board approval of Capital OBC.	Chief Commercial Officer	September 2019
Board approval of service specific integration plans (within Post Transaction Implementation Plan)	Chief Commercial Officer	November 2019

NHS
Mid and South Essex
University Hospitals Group

one team, working together

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**	Chief Medical Officer	**Current Risk Score and movement since last month:**	15 (was 20) ↓	**Risk Appetite:**	High 3 – Open
Date identified	November 2016	**Date last reviewed**	August 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**	Executive Team		

Existing Key Controls		1. Decision Making Business Case approved by CCG Joint Committee in July 2018, following public consultation on re-configuration changes. 2. External stakeholder management ongoing (Commissioners, Regulators, Local and National Politicians, etc.). Stakeholder management plan agreed and underway. 3. MSE hospital presence within STP forums (clinical cabinet, board, transport working group). 4. Development of leaders to enable successful service change. 5. Patient co-design basic principal of pathway re-design. 6. Strategic relationships established with academic partners, (UCLP and Nuffield) to strengthen evidence and case for change. 7. Experienced and appropriate legal support in place. 8. Regular briefings to governors. 9. Engagement and representation at individual Health and Wellbeing Board meetings. 10. IRP advice and Secretary of State Decision on referrals allowing for implementation of the new clinical model.
Gaps in Controls		1. Ongoing opposition to service changes by pressure groups and local authorities.
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 3. Media monitoring mechanisms.
	External	4. East of England Senate has endorsed clinical re-configuration changes

<table>
<tr><td></td><td></td><td>5. NHSE clinical leadership have supported stroke pathway changes
6. Detail on regular briefings undertaken with governors, local authorities and other stakeholders.
7. Ongoing public and patient engagement of service changes.</td></tr>
<tr><td></td><td>Level of Assurance</td><td>Medium, given the number of external risks that are outside the control of the Trusts.</td></tr>
<tr><td colspan="2">Gaps in Assurance</td><td>We have followed advice and guidance on the clinical re-configuration process so there is no immediate gap in assurance.</td></tr>
<tr><td colspan="2">Mitigating Actions</td><td>
<table>
<tr><th>Actions</th><th>Responsible</th><th>Date</th></tr>
<tr><td>Commence reorganisation of communications and engagement functions.</td><td>Deputy CEO</td><td>October 2019</td></tr>
<tr><td>Publish report on the treat and transfer pilot</td><td>Deputy CEO</td><td>December 2019</td></tr>
<tr><td>Launch of stakeholder newsletter</td><td>Deputy CEO</td><td>October 2019</td></tr>
</table>
</td></tr>
</table>

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**	August 2019 Quality Committee in Common	**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

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 • 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. • Monthly reporting to CQC on Maternity Services for BTUH

<table>
<tr><td></td><td colspan="2">• Monthly reporting to CQC on MEHT Improvement Plan
• Site based internal compliance groups now have standardised Terms of Reference and name “Maintaining High Standards”</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
• Terms of Reference of ICAG not consistent across the group – now completed
• First draft of governance structures approved, currently being refined, for implementation September 2019</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 – awaiting final report. Received and published
• Unannounced responsive inspection at MEHT on 21/05/19 – satisfied with actions taken and no new concerns identified – awaiting report. Report received and factual accuracy completed
• Internal audit report – “Substantial” assurance for CQC Action plan and monitoring</td></tr>
<tr><td>Level of Assurance</td><td>Latest CQC Reports
<table>
<tr><th></th><th>MEHT – Jan 2019</th><th>BTUH – March 2019</th><th>SUHFT – April 2018</th></tr>
<tr><td>Safe</td><td>RI</td><td>RI</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>RI</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>
<tr><td colspan="2">Gaps in Assurance</td><td>• When not all core services are inspected by the CQC and have previously been rated as requires improvement
• Reliable, consistent data</td></tr>
<tr><td colspan="2">Mitigating Actions</td><td>• Weekly internal compliance meetings and Systematic internal compliance reviews
• Alignment with JCT reviews
• Follow through / peer review methodology
• Standardisation of methodology</td></tr>
</table>

	• 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	Risk of workforce instability as a result of high levels of turnover and the inability to reduce these levels, resulting in low staff morale and increased turnover						
MSE Risk ID	3.1 (amalgamated 3.1, 3.2 and 3.3)	**Executive Lead**	Danny Hariram, MSE Chief People Organisational Development Director	**Current Risk Score and movement since last month**	16 (tbc)	**Risk Appetite**	Significant Level 3 – Open
Date identified	May 2019	**Date last reviewed**	June 2019	**Target date**	Monthly in line with merger project plan		
Risk Rating (Likelihood x Impact)							
Inherent Score: 16			**Target Score: 8**				

Relevant Key Performance Indicators / Risk Indicators

KPI	BTUH %			SUHFT %			MEHT %			MSE Group %			Target % MSE
Q1 2019/20	April	May	June	April	May	June	April	May	June	April	May	June	%
Vacancy rate (all)	13.1	13.2		12.8	13.2		17.8	18.5		14.6	15.0		12.5
Vacancy rate nursing	17.2	16.5		17.2	17.0		24.1	24.8		19.7	19.6		18.0
Vacancy rate medical	14.78	14.67		15.40	15.19		12.10	12.78		14.06	14.19		12.5
Agency (% of pay bill)	5.86	5.81		2.42	4.34		7.55	9.85		5.42	6.77		8.3
Trust turnover (excl. Jnr Docs)	12.59	12.65		15.60	15.80		15.02	14.19		14.29	14.12		12
Appraisal	86.99	86.62		78.58	79.65		73.76	74.94		80.37	80.91		90
Statutory & mandatory training	80.30	81.12		88.89	89.73		89.67	89.95		87.22	87.87		85

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**	People and OD (POD)

Existing Key Controls	1. Group HR KPIs are reviewed by Site Governance Forums, People and OD committee in common, Boards in common. 2. Workforce recruitment and retention plan approved by JWB June 2018 and is monitored monthly by the Recruitment & Retention Board. 3. Nursing and Midwifery (N&M) retention strategy approved by JWB June 2018 and is monitored monthly by the N&M Recruitment and Retention Board. 4. N&M Recruitment and Retention board established and meets monthly, chaired by Di Sarkar, Chief Nurse. 5. HR and OD governance group established in May 2019 and meets weekly. 6. Continued overseas recruitment to recruit to 400 registered nursing posts over a 12-18 month period, 30 doctors and 50 Allied health professionals; target of April 2020 to reduce nursing registered vacancy factor of 17%. 7. Recruitment agencies utilised for hard to fill vacancies across clinical areas, ensuring framework agencies wherever possible. Also compiling a list of hard to fill or specialist posts to ensure succession plans in place for these. 8. Group VCP panel and pay steering group fully mobilised with any post subject to consultation either held or recruited to on a fixed-term basis only; recruitment team check redeployment register for every post agreed by GVCP before advertising. 9. Standardising and harmonising HR processes across the group resulting in 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 and reducing competition across group and attracting people to transfer from agency to bank. Savings realised to be between £2.2m and £1m.
Gaps in Controls	1. Consistent data quality. 2. None – regularly takes place. 3. Inability to convert agency to bank/agency contract. 4. Action plans fail to deliver a reduction in turnover. 5. None – control in place. 6. Overseas recruits are at different stages of their on-boarding; work is being undertaken to understand the actual conversion rates (and any attrition for this particular group). 7. Inability to attract to specialist positions and registered nurses. 8. None – GVCP in place and audit trail available (minutes of decisions). 9. Target of 47 days not always met for overseas recruits. 10. Outsourced contracts will delay full implementation resulting in inability to identify the required investment in Year one.
Assurance - Internal	1. On target to achieve vacancy, turnover, appraisal and agency trajectory. 2. Milestones in recruitment and retention plan achieved. 3. Reduction in agency spend. Where cost effective, standardised rates are introduced – reduce the pay bill. Standardised Nurse Bank Rates plus Bank Incentive Bonus communicated to staff with April 1st start date 4. Improved engagement score in Pulse and NHS staff survey results.

	5. Positive feedback from candidates/student nurses % offered and accepted the post. 6. Time to hire reduction – monitored by recruitment and retention committee. 7. Minutes of HR and OD Governance meetings are distributed to the senior team. 8. Minutes of GVCP meetings. 9. Feedback from HR customers on recruitment experience. 10. MSE senior team now in place (with the exception of Head of Employee Relations) to drive implementation; dedicated resource to deliver each mitigating action.
Assurance - External	No's 1, 4, 5 and 9. Staff survey No's 2, 6, 7, 8 and 10. CQC Well Led Key Lines of Enquiry (KLOE) No's 1, 4, 5 and 9. Culture analysis
Level of Assurance	Partial assurance
Gaps in Assurance	1. A national shortfall of a range of staff (particularly nursing) and the uncertainty of EU Exit leading to a difficulty in achieving agreed trajectories (see mitigating actions under 1 and 2 below). 2. Need to have clear governance structures in place around delivery and accountability for programme (see mitigating actions under 3 below). 3. HR workforce instability due to the corporate restructure, particularly high level of vacancies in the recruitment team, impacting on ability to deliver high volumes of timely recruitment (see mitigating actions under 3 below). 4. Lack of dedicated site support – will be addressed following consultation through new HR structure from mid-July onwards (currently mobilising post-consultation). (See mitigating actions under 3 below.)
Mitigating Actions	**1. Recruitment Focus** • Attracting talent: a. Group brand for MSE developed Transformation Group and launched in June 2019. Agreed to showcase the unique selling point (USP) of the MSE group and career opportunities by virtue of being a larger employer. **Action:** Agree succession plan and development programme for top two tiers of clinical leaders; this will encompass part of the career pathway focus that will feed into the investment business case for recruitment and retention. • Reducing internal competition: a. Collaborative Bank established for group: bank and agency transformation project is progressing with a view to completion by October 2019. b. MoU under development between the three Trusts to establish no poaching arrangement across the group: passport developed to enable staff to work across sites as bank resources whether substantive or pure bank. c. Preferred Supplier List agencies prohibited from using MSE trust staff filling agency shifts at MSE sites. d. **Action:** Logistics for cross site working will be part of the rotational plan development for mobility across MSE

- Developing values based recruitment and streamlining recruitment processes:
    a. Values based recruitment: all recruitment processes under review as part of the HR transformation.
    b. Training program under development to ensure consistency and improved level of service across the group. ETD: 09/19.
    c. Streamlining processes: Time to Hire processes are a key focus of the HR transformation with a consolidated target of 47 days. Alignment of processes, retrain staff and divisions / directorates. 18 month lead time but with significant progress on the way.
    d. **Action**: to embed a High Performance Culture: training and SLA development within HR and divisions / directorates (also link with strategy and culture work) – SLA work milestone part of merger project plan for review/status update by **September 2019**.

- Developing a strategic approach to temporary staffing:
    a. Standardise bank rates aligned across all Trusts in MSE: General nursing bank rates have been implemented by MEHT and SUHFT, BTUH to implement by July 1st.
    b. Discussions on-going for ED, Theatres and Critical Care with view to implementing on phased approach at BTUH and SUHFT in September 2019 and MEHT in April 2020.
    c. Establish Temporary Staffing Team: Bank and Agency consultation outcome for in-house staff delivered. Notice given to Bank Partners at MEHT and consultation underway.
    d. **Action:** Notice to be given to NHSP and Medacs between now and **October 2019**.

- Reducing Reliance on Bank and Agency:
    a. Recruitment campaigns to employ staff substantively: Recruitment and Retention proposal under development to utilise existing channels for International, Newly Qualified and Direct Hire Nurses plus investment in practise development, ward support, retention initiatives and leveraging internal referral. Aim of proposal to reduce band 5 vacancies from 29% across MSE to 9% by end **July 2020** = 445 band 5 nurses. This is a challenging target where nurses require a certificate of sponsorship.
    b. Deploy retention toolkit to guide managers in retention conversations with staff who may be at risk of leaving: SUHFT retention tool kit to roll out across MSE trusts and use of Stay Interviews
    c. Refer-A-Friend Scheme to encourage staff referrals for substantive and bank roles rolled out at SUHT, to roll out across MSE Group commencing in **June 2019**.

2. Retention Focus

- Culture, values and engagement:
    a. Appraisal process is under review to incorporate ''stay'' interviews and a specific focus on staff who wish to retire and return.
    b. Work streams feeding in to the programme board include: Culture, values and engagement, career pathways, education and development, innovation and transformation, leadership and succession planning.

c. Results of Culture Survey disseminated to Site leadership and AD/CD team. Culture Action Plans in place to address specific issues raised at Site.
d. Engagement plan in place to improve staff recognition, engagement and retention. 18 listening events have taken place in April/May 2019 and "You said, we did" roadshows at each site June/July 2019. Implementation of "You Said We Did" Intranet sites at each Trust. Publication of all staff survey Group, Site and Directorate Action Plans to encourage transparency. Progress updates and management VLOGs published monthly (commenced April 2019). Staff Engagement Calendar in place at SUHT and rolling out to MEHT May 2019, BTUH June 2019. Pulse Surveys planned for Q1, 2 and 4.
e. **Action:** Culture development programme in development by POD, **for delivery by May 2020** (in line with the HR and POD merger project plan). As part of this work, Communications team and POD and transformation teams to review current site values and propose plan for Group values development and engagement piece. Focussed work on exit information to understand why staff leave and address the "avoidable" reasons.

- Developing career pathways:
  a. Develop career progression map and toolkit: Currently different programs exist across MSE; consolidated programs to be developed ensuring consistency and equity across nursing groups. Program development for managerial or specialty pathways.
  b. Focus on BAME into leadership – the Equality, Diversity and Inclusion Committee have oversight of equality-specific recruitment training which will support this (ToRs presented for approval at July EDIC meeting).
  c. Utilisation of the apprenticeship levy to continue development of a nursing career pathway for bands 2-4 to support Assistant Practitioner, Trainee Nursing Associates and top up to Nursing Degree opportunities
  d. **Action**: Build on existing Trust-based rotational programmes to develop cross-MSE programmes to leverage our clinical specialties and attract more staff to work here (will be a feature of the interim people strategy – draft will be presented for approval in **August 2019**).

- Education and development:
  a. Review of induction Programme/Welcome packs has commenced for new staff to include Welcome meeting by the Chief Nurse and DONs: the on-boarding process for recruitment is also looking at the pre-boarding aspect for joiners including communication from senior staff members on job offer acceptance. Timeline for completion is in conjunction with our merger project plan – **end of October 2019.**
  b. Guidelines for managers for keeping in touch with joiners in the pipeline and scoping the first 90 days in department have been issued.
  c. Action:
    i. Create Mandatory Ward Manager Training, to include expectations of the role, leadership and Management; consolidate existing practice and provide blended learning.

ii. Roll out the Ward Accreditation programme.

- Leadership and succession planning:
  - **a.** Develop a coaching programme and in-house pool: POD have developed an in-house coaching proposal to instil a culture of coaching as leadership, differentiating between mentoring and consulting. This is complimentary to deployment of other leadership styles as appropriate. **All leadership interventions form part of merger project plan – for delivery by end of March 2020.**
  - b. **Action**: Senior leadership team to demonstrate visibility: a communications plan is being developed to improve communications and visibility of senior staff together with a review of effectiveness of information dissemination by middle management – **by end of September 2019**.

- Embedding a high performance culture:
  - a. Health Education England Global Learners Programme. Investigate placements in MSE Trusts for overseas nurses (3 year programme): Reviewed the proposal from HEE which is more expensive than normal agency channels. Also 40 week lead time which is approx. 25% longer than current pipelines. Therefore the HEE proposal will not be continued and will be removed from our plan.
  - b. Implement a group international recruitment plan: Review of international proposal illustrated that current pipelines negate the need for new international campaign which would cost approx. £3.5million.
    Action: new proposal to increase support for international and newly qualified nursing staff to improve on-boarding, assimilation and retention. This will require investment but with a greater focus on retention and encouraging loyalty and staff engagement.
    Delivery in line with nursing recruitment and retention plan.

3. Governance

- Inconsistent data quality:
  Action:
  - a. Developing new group-wide process for the provision of data/information for various Board reports, to ensure accurate data is provided in a timely manner, minimising workload impact on the team; new process also to be mobilised for all NHSI/CQC returns. New process to be defined by **September 2019**.
  - **b.** Interim Head of HR Projects and Governance setting up workshop to support key contributors to reports; workshop to be chaired by Group HR Director Resourcing in **September 2019.**

- Governance structures for delivery and accountability of the programme:
  - a. Held to account for delivery by Site Governance meetings, recruitment and retention committee, Boards and Committees in Common and Future Organisational Form Delivery Group (FOFDG).

Action:

i. development of group-wide interim people strategy – for approval by PODCIC in **August 2019**, ready for submission with the PTIP and with a view to obtaining Board approval in December 2019.

ii. delivery of milestones under the HR and OD Project Plan through the Workforce Merger Delivery Group monitored by the FOFDG and accountable to NHSI. Plan has milestones between now and **May 2020**.

iii. Moving all HR work streams, processes, policies and procedures to a group model to achieve synergy and efficiency, enabling development and progression across the team. Taking to Site Governance Forums starting with Southend in **July 2019**.

iv. Existing group-wide vacancy control process to reflect national changes to agency rules that come into effect in September 2019 and ensure essential recruitment is enabled to prevent risk to service delivery across all departments including HR and OD. Process updates to be completed by and implemented in **September 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 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**	August 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	1. High levels of agency spend due to vacancies 2. Unidentified CIPs and under delivery on CIP schemes 3. Some areas of poor productivity 4. Residue of income on PBR contracts						
Assurance	**Internal**	Regular reviews of financial performance at Finance Committees Financial position reported monthly at F&PCiC and BiC					
	External	Regular communication with NHSI regarding financial performance					
	Level of Assurance	NHSI Single Oversight Framework, rating 3 (3 Trust average)					

Gaps in Assurance	• CIP plans not yet fully identified • BTUH financial position behind plan in months 1&2
Mitigating Actions	1. Recruitment plans being developed as part of recovery plan at BTUH. Plan will be completed by 31 July with a reduction in agency spend of £12m as per 19/20 plan. 2. Remainder of CIP schemes to be confirmed by end of September for BTUH and end of August for SUHFT. 3. Draft medium term recovery plan being developed at MEHT. Will be presented to F&PCiC in October 2019. 4. Activity recovery plan developed for BTUH to recover income shortfall by the end of the financial year. Full BTUH recovery plan to be presented to F&PCiC on 2nd August

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. 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 / 4.6 Merged BAFs	**Executive Lead**	Eamon Malone	**Current Risk Score and movement since last month:**	25 Increased from 20	**Risk Appetite:**	Cautious 3 - Open
Date identified	15/05/2017	**Date last reviewed**	18/08/2019	**Target date**	31/03/2020		
Risk Rating (Likelihood x Impact)							
Inherent Score: 20 (4x5)				**Target Score:** 9 (3x3)			
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). 9. Existing processes in each of the Trusts to prioritise annual capital plan to fund essential developments 10. Work underway to produce the OBC and FBC to secure the £118m strategic capital allocated from national funds 11. Sale proceeds from Fossets Farm land sale ring fenced to support early development of strategic capital investment
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 9. Developments dependent upon successful receipt of STP capital funding as yet undetermined 10. None 11. 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 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, Quarterly medical devices safety report, Risk assessed capital programme 8. None

		9. Monthly report to Capital investment committee 10. Monthly reports to steering group 11. None
	External	1. BSI and Authorising Engineer audits 2. BSI and Authorising Engineer audits 3. BSI and Authorising Engineer audits 4. PLACE audits, CQC inspection 5. BSI audits 6. None 7. BSI audits 8. BSI audits 9. None 10. NHSI oversight 11. None
	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. 9. 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 10. 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 11. None
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. 4. Review the Maintenance BIA to align to BTUH BIA model 5. 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. 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. 6. Development of Early warning escalation process where non-conformance actions are slow in being developed. 7. N/A 8. Proactive development of estate on a priority basis. 9. Consultant engagement with robust programme management to ensure on track to deliver. 10. N/A

NHS
Mid and South Essex
University Hospitals Group

one team, working together

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**	12 August 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 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 – **Digital Services and Information consultation closed 24th July and the outcomes shared with staff on 8th August. The Clinical Coding, Data Quality & Health Records consultation is currently under review.** 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. Review Informatics capital programme, with aim of aligning and prioritising projects to deliver direct benefit across the group – **Completed, final financial budgets for 19/20 have been set; availability of funding will be monitored against planned expenditure and any unplanned demands.** 5. Participating in review of overarching MSB capital plans in order to qualify risk ensure correct prioritised funding. 6. 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.**

NHS
Mid and South Essex
University Hospitals Group

one team, working together

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:**	12 (Down from 16)	**Risk Appetite:**	High 3 – Open
Date identified	November 2018	**Date last reviewed**	6 August 2019	**Target date**	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 to the Programme Board. • Evidence that a number of workforce consultations are now complete and teams are starting to move to their new structures. The majority of new structures expected to be in place by end 2019.
	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. - A number of smaller corporate services (e.g. legal, board secretariat) are still to be taken through the reconfiguration process
Mitigating Actions		- Additional services being taken through same full programme methodology to ensure proposals are consistent with broader corporate offerings. Intent is to try and manage majority of these through ahead of merger transaction date. - Full update on next steps for corporate programme to be brought to October Board seminar session, setting out proposals as to how to deliver the service improvement phase of activity will be advanced, as the reconfiguration phase concludes.

NHS
Mid and South Essex
University Hospitals Group

one team, working together

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**	July 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		1. Dependency on out of hospital solutions being delivered by other parties 2. Continued growth in demand
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		3. Multi-year CIP plans are not yet developed 4. Strategic, merger enabled savings plans not yet fully developed

Mitigating Actions	1. System solution being revisited as part of STP plan development. Submission due November 2019. 2. System Demand Management Group addressing this 3. Multi-year CIP plans to be presented to F&PCiC on 2nd August. 4. Merger related savings plans being developed as part of LTFM work. To be completed by end of September