NHS
Mid and
South Essex
University Hospitals Group

MSB Board Assurance Framework

2019/2020

February 2020

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 – February 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. (Diane Sarkar and David Walker)**									
2.1 Failure to equip colleagues to deliver a high quality safe service against agreed trajectories. **David Walker**	**16**					√ ↔			**12**
2.2 Failure to deliver clinical service change / reconfiguration to meet the needs of the local population currently and in the future, against agreed timescales. **David Walker**	**20**			√ ↓					**9**
2.3 Failure to gain agreement and consensus of local communities to changes that reflect best practice. **David Walker**	**25**						√ ↔		**9**
2.4 Failure to achieve consistent "Good" rating for CQC in Safe, Caring, Effective and Responsive domains. Failure to implement agreed remedial action plans in a timely fashion. **Diane Sarkar**	**16**					✓ ↔			**8**
3.0 Strategic Objective **Be an employer of choice for a supported, engaged and high performing workforce. (Danny Harriam)**									
3.1 Risk of workforce instability as a result of high levels of turnover and the inability to reduce these levels, resulting in low staff morale and increased turnover **Danny Hariram**	**16**						√ ↔		**8**
4.0 Strategic Objective **Be effective and efficient with all our resources, creating an organisation that residents and staff can rely on for the long term. (Dawn Scrafield, Martin Callingham, Eamon Malone)**									
4.1 Failure to achieve and deliver year on year improved financial sustainability and effective use of resources	**25**							✓ ↔	**15**

Dawn Scrafield										
4.2 Failure to consistently deliver safe, responsive and efficient patient care in a cost effective manner because the current estate and associated infrastructure is not fit for purpose. Failure to develop and fund a long term capital plan which addresses the clinical, estates and technological needs of the organisation **Eamon Malone**	**25**						✓		**15**
4.3 Failure to deliver digital transformation agenda and to ensure resilience in informatics and IT services. **Martin Callingham**	**12**					√			**9**
4.4 Failure to deliver transformation in corporate support to create a fit for purpose future proofed structure. **Jonathan Dunk**	**20**					√			**10**

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**	Jan 2020	**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:

<table>
<tr><th>Measure</th><th>Status update</th></tr>
<tr><td>Number of patients supported at home or other place of residence by our services</td><td>Hospital at Home:

<table><tr><td></td><td>Jan-19</td><td>Feb-19</td><td>Mar-19</td><td>Apr-19</td></tr><tr><td>Transfers in</td><td>45</td><td>48</td><td>37</td><td>45</td></tr></table>
Measurement tool for other services (e.g. bridging) is being established.</td></tr>
<tr><td>Number of medically fit and DTOC rates.</td><td>See Integrated Performance Report</td></tr>
</table>

Income raised from non-traditional sources (e.g. community services offer, private patients, innovation etc.)	Measurement tool. £100k received from NHSE to support the Outpatients transformation programme across STP with allocation towards innovation/digital-first agenda. Receiving 30k to run a support project for the Basildon Hospital as Anchor programme by past innovation fellow. Creating one job locally. Supporting Gloucestershire Fit for Future programme through consultancy services for IIA through MSE Strategy Unit. Phase 1 income is £17k. Successful bid to NHS Improvement for £541kwith ShiftPartner innovation fellow for Workforce Development Systems, intelligent e-rostering proposal.
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 Joint Working Board and three Trust Boards. 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. Two new cohorts of Senior Staff Development College launched with training starting in November 2019
7. Work underway to support leadership development for JEG and SLT and newly appointed Group Clinical directors aligning with values of the new organisation. Two cohorts of newly launch Care Redesign programme for teams participating in a change/transformation projects now available with training started in October 2019.
8. Group Clinical Strategy Board launched June 2019 to build clinical engagement in strategy, and help facilitate clinical integration to improve outcomes and build team relationships.

Roll out an expanded Hospital at Home service

9. 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.
10. 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. South East Essex – work completed on COPD predictive modelling for localities in SEE, this is now being taken to other places as an example..
2. STP system QI leadership programme completed with a summit on 21 Jan which was well received. The STP has expressed interest in running the programme again with bigger cohorts.
3. Mid Essex CCG has expressed interest in running further QI programme for its PCNs.

	Establishment of Group Performance Management function and new relationship with regulators 4. New operational planning guidance for 2019/20 drafted for consideration at December Joint Working 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 support development and implementation of future system-wide innovation programmes including next cohort of Innovation Fellows across wider footprint. 3. New MSE STP Innovation fellowships has recruited 7 new fellows with a launch that took place on 25 Nov 2019 Three further Fellows likely to join as pst of an application to support a test of innovative drone deployment, led by Tony Young and with ARU. 4. First project under "Ways of Working" approach with industry (approved by MSE STP Partnership Board) focusing on childhood asthma with industry partners lined up for support. STP Clinical cabinet and STP paediatric steering group have agreed to support this work. Meeting between Southend CCG lead and industry partners has taken place with agreement on various aspects of the childhood asthma project that will be supported by industry being finalised. Innovative products have been identified through a Innovation Marketplace which took place in December 2019. Three other projects supporting outpatients transformation are in the pipeline as of September 2019, involving digital medium sized enterprises and support from pharma and MedTech industry. 5. MSE Innovation programme was presented at various forums in National conference - NHS Expo, held on 4-5 Sep 2019 in Manchester, and at NHS Clinical Entrepreneur Pit Stop events nationally.
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. 3. Further plan for senior staff development – following 2018/9 programme to be finalised. This is now completed with new cohort launching in November. **Develop productive strategic relationships with external partners, including primary care providers through the expansion of our QI**

		offer to general practice. MSE led STP QI leadership programme next cohort in development. IT will be linked in with the STP Board and LWAB Board deliverables going forward. **Expansion of innovation fellowships** 4. Lack of single IP, innovation and commercialisation policies across the three trusts 5. Paper on Innovation procurement process, jointly written with procurement team and inputs from Finance, finalised and taken to the Oversight committee in August 2019; meeting with Directors October 2019 agreed a further paper on MSE approach to the innovation process to come to the Board in 2020 – this is in progress, awaiting some update from national policy. 6. Legal advice being engaged to design development and commercialisation options; session with Board of Directors 14 October 2019 options to be written up and review intellectual property approaches in 2020/21.
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 Joint Working Board and Trust Boards. 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. 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 have been used for design and development of future cohorts as well as staff engagement. An update is being planned for this cohort to capture impact one year following the last meeting. **Roll out an expanded Hospital at Home service** 3. 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. 4. 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. 5. Regular updates to Clinical Services Reconfiguration 6. 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. Evaluation of first innovation fellowship included in and learnings informed the business case for Innovation programme for 2019-20. 10. Strategy Unit have set up an extensive evaluation framework for 20-21 innovation programme 11. Honorary contracts and development contracts for innovators in place
	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. Regular reporting through Local Workforce Action Board reporting includes project oversight and tracking. 5. 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.** 6. NHS Improvement Performance Review Meeting outcome and improved sharing of information with NHS Improvement between Performance Review Meetings **Expansion of innovation fellowships** 7. Contract in place for external support on intellectual property, evaluation and product development with Health Enterprise East; legal support in place for procurement and commercialisation. 8. STP Innovation Advisory group set up and meeting since April 2019. This reports/links into the STP Partnership Board and STP Digital workstreams
	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 in progress of single IP, innovation and commercialisation strategy, based around a matrix of options alongside compliant routes to market. 4. Refresh of procurement arrangements for innovations that are market ready. 5. Target culture of new organisation to be established to support work on future organisational design. 6. Refresh of quality improvement strategy. 7. 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 BAF.	**Risk Appetite:**	Significant 4 - Seek
Date identified	Aug 2018	**Date last reviewed**	Jan 2020	**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 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. Communications plan leading up to merger developed and being implemented. 5. Strategic Partner to deliver transaction appointed and team on-site supporting the transaction. 6. Case studies for patient benefits case developed for NHSI approval. 7. Acquiring body for the transaction identified and agreed by Boards in Common. 8. Consolidated Due Diligence document completed and signed off by Boards in Common on 11th September. 9. PTIP, Transaction Business Case and Patient Benefits Case signed off by Boards in Common on 11th December 2019 10. 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. 11. Referral to Secretary of State by Southend and Thurrock HOSCs has now been resolved. 12. Revised STP Estates Strategy submitted in July 2019 reached the required standards to obtain a “Good” rating.						
Gaps in	1. Day to day Trusts performance (financial or operational) may not improve and lead to loss of regulatory agreement to proceed.						

Controls	2. NHSI will want the acute sector to reach recurrent financial balance by the end of 2023/24. 3. NHSI/E approvals and governance process newly set up and this may introduce delays in obtaining regulatory approvals, for example with the Capital SOC/OBC. 4. Difficulties in gathering required information for NHSI and the Reporting Accountant prior to the merger. 5. Challenges in providing accurate and complete pensions data. 6. Unauthorised assignment or novation could lead to the relevant Trust losing the right to use the asset which may be essential to the operation of the Trust(s).	
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. 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. 8. Constructive meetings held with NHSI and EY (Reporting Accountant) during information gathering stage in January and February 2020.
	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, and the delivery of the numerous transaction products required concurrently with BAU. 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, 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. Work completed on the LTFM and modelling to understand what is required to get the Trusts into balance. 7. 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. 8. 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. 9. Engagement with NHSI re decision making process for the transaction to minimise any impact on merger timetable. 10. Appropriate documents provided for the Reporting Accountant and NHSI prior to their visits to the Trusts. 11. Constructive and collaborative meetings held with NHSI and the Reporting Accountant during their site information gathering stage. 12. Resources been allocated to do a full data cleanse of ESR data for pensions. 13. To ensure appropriate novation of contracts, legal novation letters drafted to all suppliers. 14. Benefits in merger case explicitly aligned with commissioner assumptions for all years of the detailed business case, specifically agreeing with benefits identified in capital submissions.

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**	January 2020 November2019 MSE	**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
  As of September 2109

	Must take actions	**Should take actions**
MEHT	32	25
SUHFT	14	15
BTUH	10	5
Totals	**56**	**45**

Applicable link to regulation requirements (CQC / NHSI)	• Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) • Care Quality Commission (Registration) Regulations	**Board sub-committee monitoring**	MSE Governance Oversight Group with direct report to Board

	2009 (Part 4)		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 (Maintaining High Standards) 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 for well led inspections • 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 – now completed • Plan in place for SUHFT and MEHT core services inspection and well led and UoR for SUHFT – now completed • Standardisation of Terms of Reference for internal compliance meetings and name to “Maintaining High Standards”	
Gaps in Controls	• Continuing developing site leadership teams, this has stabilised, but ongoing development of teams continues • Significant number of meetings which duplicate information streams • Decreasing numbers of inconsistent reporting arrangements	
Assurance	**Internal**	• Annual well led internal self-assessment reported to Board • Site base well led self-assessments carried out on an annual basis • NHSI reviews
	External	• 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. • Final report received for BTUH. Overall rating for Well Led – GOOD

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

No warning notices received as part of core service inspections at either MEHT or SUHFT
NHSI and Reporting Accountant reviews in progress

</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 – Completed, Outcomes – 6th December. Now completed for implementation 1st March 2020
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
Significant peer review from NHSI and CCG

</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
				Reason for risk movement			
Date identified	November 2018	**Date last reviewed**	July 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 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. • Use of waiting list money is now being used for in and out sourcing. • The risk of a 52 week breach above the agreed numbers for the group remains high. • Mitigation for Cancer is a risk summit and external review to be completed in March

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
				Reason for Risk Movement			
Date identified	November 2018	**Date last reviewed**	June 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 NHSE/I and UCLP support. - Initial cultural alignment survey with top 100 leaders completed. - Initial consultant survey completed. - Staff Development College in place. - Monthly QI clinics for staff in place. - Appointment of Associate Clinical Director, Improvement across the group.
Gaps in Controls	- Actions identified within the Quality Improvement Strategy are still being implemented. Recent internal audit has identified a number of areas for future work. - Cultural and organisational design of the single merged organisation still to be completed to include clearer leadership for continuous improvement within and across the organisation.

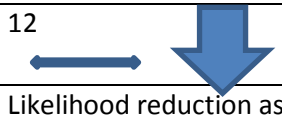
<table>
<tr><td></td><td colspan="2">- QSIR training volumes limited by capacity of in-house qualified QSIR trainers.
- Basic level training package to be developed and launched.</td></tr>
<tr><td rowspan="3">Assurance</td><td>Internal</td><td>-Cultural alignment, consultant survey result.
-Evidence 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.</td></tr>
<tr><td>External</td><td>-NHS staff survey results.
-Internal Audit review of QI provided ‘partial assurance’.</td></tr>
<tr><td>Level of Assurance</td><td>Partial 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>-Resource available to support QI activities is limited given Improvement and Change Team focus on implementing major change programmes and supporting efficiency / CIP activities across the trusts.

-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>Chief Medical Officer</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>Commission basic QI e-learning package.</td><td>Chief Medical Officer</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**	David Walker	**Current Risk Score and movement since last month:**	16 ⟷	**Risk Appetite:**	High 3 – Open
				Reason for Risk Movement			
Date identified	November 2018	**Date last reviewed**	September 2019	**Target date**	September 2019 (will now be reviewed)		
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 Board 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 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 3. Clinical integration meetings between sites started under leadership of group clinical directors.
	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 6. Internal audit currently reviewing quality improvement methodology and implementation, debrief meeting 30/9/19, outputs expected in October 2019.

Strategic	Deliver high quality, safe and responsive services shaped by best practice and our local communities

Objective							
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**	David Walker	**Current Risk Score and movement since last month:**	12 	**Risk Appetite:**	Significant 4 – Seek
				Reason for Risk Movement	Likelihood reduction as a result of the implementation of stage 1 now complete / underway.		
Date identified	November 2017	**Date last reviewed**	December 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 and Group Clinical Strategy Board in place, alongside weekly discussions at Executive Team to ensure progress. 2. Change Team in place to support reconfiguration implementation within defined methodology. 3. Strategy unit in place to provide business analyst support for business case development. 4. Group Clinical Directors / Clinical Leads in place to provide clinical leadership for phase 1 implementation and work up of subsequent stages. 5. Outcome of Secretary of State referrals supporting implementation of reconfiguration. 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.						

<table>
<tr><td rowspan="3">Assurance</td><td>Internal</td><td>Approved individual service specific business cases</td></tr>
<tr><td>External</td><td>NHSE / Commissioner Approved Pre-consultation Business Case (PCBC) and Decision Making Business Case (DMBC), including East of England Clinical Senate Review.
Secretary of State dismissal of Southend and Thurrock council referrals and supporting implementation of reconfiguration.
DHSC approved Strategic Outline Case (capital)</td></tr>
<tr><td>Level of Assurance NHSI</td><td>Outcome of NHS England National Assurance review of PCBC/DMBC</td></tr>
<tr><td colspan="2">Gaps in Assurance</td><td></td></tr>
<tr><td colspan="2">Mitigating Actions</td><td>
<table>
<tr><th>Actions</th><th>Responsible</th><th>Date</th></tr>
<tr><td>Delivery of phase 1 of clinical reconfiguration (IR, Vascular, Orthopaedics)</td><td>Deputy CEO, Managing Directors</td><td>Interventional Radiology – implemented in December
Orthopaedics – implemented in December
Vascular – planned go live on 20th January.</td></tr>
<tr><td>Development of phase 2 business cases for clinical reconfiguration for Board approval.</td><td>Deputy CEO, Managing Directors</td><td>Given delays above, anticipated February / March 2020.</td></tr>
<tr><td>Board approval of Capital OBC.</td><td>Chief Commercial Officer</td><td>Approved December 2019</td></tr>
<tr><td>Board approval of service specific integration plans (within Post</td><td>Chief Commercial Officer</td><td>Completed</td></tr>
</table>
</td></tr>
</table>

	Transaction Implementation Plan)		

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**	David Walker	**Current Risk Score and movement since last month:**	20 ⟷	**Risk Appetite:**	High 3 – Open
				Reason for Risk Movement			
Date identified	November 2016	**Date last reviewed**	December 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 Board in Common		
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 (Care Redesign Programme). 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. Secretary of State dismissal of Southend/Thurrock referrals. (Aug 2019)						
Gaps in Controls	1. Ongoing opposition to any service changes by pressure groups and local authorities. 2. Final plans for reorganisation of community-hospital based services ongoing						

<table>
<tr><td rowspan="3">Assurance</td><td>Internal</td><td>1. Outcome of assurance processes on reconfiguration plans with relevant external expertise
2. All change has been developed by local clinicians
3. Media monitoring mechanisms.
4. Implementation planning groups in place with clinical, commissioner and routes for lay/public involvement.</td></tr>
<tr><td>External</td><td>1. East of England Senate has endorsed clinical re-configuration changes
2. NHSE clinical leadership have supported stroke pathway changes
3. Detail on regular briefings undertaken with governors, local authorities and other stakeholders.</td></tr>
<tr><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>Undertake reorganisation of communication and engagement functions in order for a co-ordinated communications and engagement strategy to be implemented</td><td>Deputy CEO</td><td>Underway – completion expected March 2020</td></tr>
<tr><td>Demonstrate improved clinical outcomes through pathway change in vascular, orthopaedics and interventional radiology</td><td>Deputy CEO, Managing Directors, Chief Medical Officer, Clinical Leads</td><td>Following Stage 1 implementation data is now being gathered with a view for initial evaluations in March/April 2020.</td></tr>
<tr><td>Ongoing public engagement, briefings to stakeholders</td><td>Chief Executive/Deputy Chief Executive</td><td>Ongoing</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**	January 2020	**Target date**	Following CQC inspections		
Risk Rating (Likelihood x Impact)							
Inherent Score: 12 (3 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 • 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) (Maintaining High Standards) with documented evidence of tracking progress Forums established to share learning • Executive experience in core service and well led executive reviewer experience						

<table>
<tr><td></td><td colspan="2">BTUH Core, Use of Resource and Well Led inspections completed March 2019.
Monthly reporting to CQC on Maternity Services for BTUH – now completed and signed off by CQC
Monthly reporting to CQC on MEHT Improvement Plan - completed
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 – now in final versions. Completed and for implementation 1st March 2020
Consistent and reliable reporting on all three sites
Monthly meeting structure for group and sites now defined and developed, to be finalised</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
No warning notice issued as part of core services inspection for MEHT and SUHFT
NHSI and Reporting Accountant reviews in progress</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>
</table></td></tr>
</table>

	Overall	Requires Improvement	Good	Requires Improvement
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 • Preparation for MEHT well led and core services inspection in progress – now complete • Significant support from CCG / NHSI and BTUH			

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	**Executive Lead**	Danny Hariram, MSE Chief People Organisational Development Director	**Current Risk Score and movement since last month**	20	**Risk Appetite**	Significant Level 3 – Open
				Reason for Risk Movement			
Date identified	May 2019	**Date last reviewed**	January 2020	**Target date**	Monthly in line with merger project plan		

Risk Rating (Likelihood x Impact)	
Inherent Score: 20	**Target Score: 8**

Relevant Key Performance Indicators / Risk Indicators

KPI	BTUH%				SUHFT %				MEHT%				MSE Group %				Target % MSE
Q3 2019/20	Oct	Nov	Dec	Jan	Oct	Nov	Dec	Jan	Oct	Nov	Dec	Jan	Oct	Nov	Dec	Jan	
Vacancy rate (all)	12.43	12.56	12.00	11.98	14.37	12.80	10.84	10.59	16.10	15.21	14.43	15.79	14.31	13.42	12.48	12.88	12.50%
Vacancy rate nursing	15.18	15.30	15.46	15.69	13.98	11.63	10.88	10.88	22.15	20.92	20.36	19.97	17.30	16.22	15.87	15.84	18.00%
Vacancy rate medical	12.61	11.82	11.04	10.43	13.54	12.70	12.27	12.29	9.80	10.23	12.15	15.08	11.93	11.55	11.81	12.63	12.50%
Agency (% of pay bill)	5.83	5.39	4.41	4.64	4.45	4.49	3.78	3.86	9.22	8.12	8.13	8.86	6.59	6.04	5.49	5.86	8.30%
Trust turnover (excl. Jnr Docs)	12.22	12.72	11.95	12.03	15.60	15.06	14.78	14.69	13.87	13.29	13.24	13.22	13.79	13.64	13.24	13.24	12.00%
Appraisal	86.52	85.85	84.62	84.25	81.04	81.32	82.52	81.96	81.14	74.76	81.58	78.38	83.60	81.02	83.06	81.74	90.00%
Statutory & mandatory training	80.47	80.53	81.15	80.01	90.45	90.42	90.27	89.95	94.92	94.98	94.24	93.39	89.59	89.49	89.50	88.85	85.00%

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**	People and OD (POD)
Existing Key	1. Group HR KPIs are reviewed by Site Governance Forums, People and OD committee in common, Boards in common. Scrutiny in this way ensures areas		

Controls	of non-compliance followed up in a timely manner. 2. Workforce recruitment plan approved by JWB June 2018 and is monitored monthly by the Recruitment & Retention Board to ensure no deviations from plan. 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. Following a review of the effectiveness of the Committee we have refreshed the Committee and this will be in place for March 2020. 5. Continued overseas recruitment to recruit to 500 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 target as agreed at Board. 6. Recruitment agencies utilised for hard to fill vacancies across clinical areas, ensuring framework agencies wherever possible. 7. Recruitment team check redeployment register for every post agreed by GVCP before advertising. 8. Standardising and harmonising HR processes across the group resulting in improved delivery of the HR service and improved candidate experience. Proposed time to hire target of 47 days. November 2019 76.2, December 2019 62.7%, January 73.2%. It was acknowledged that January would go up due to a number of HR and site operational staff being on annual leave in December. In addition, winter pressure has been impactful. Current position is an improvement on legacy position.
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 is an ambitious outcome – approach is working with sites to improve turnaround times on manager's actions. Training within HR has been on-going to achieve recruitment time scales. New centralised recruitment service implemented – working with the sites to embed new practises. It is clear that the processes are not significant change for two sites but increased engagement and support is being provided to one of the sites where practices are quite different.
Assurance - Internal	1. On target to achieve vacancy, turnover and agency trajectory. 2. Milestones in recruitment and retention plan achieved but further reviews are required in order to meet desired KPI's. 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 2019. Two out of three sites on track to meet internal agency ceiling. Recovery plans and increased controls implemented for BTUH.

	4. Time to hire reduction. 5. Minutes of GVCP meetings.
Level of Assurance	Partial assurance
Gaps in Assurance	1. A national shortfall of a range of staff (particularly nursing) 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, impacting on ability to deliver high volumes of timely recruitment (see mitigating actions under 3 below). 4. Lack of dedicated site support – currently mobilising all services post-consultation. (See mitigating actions under 3 below.)
Mitigating Actions	• **Recruitment Focus** • Attracting talent: Group brand for MSE developed Transformation Group and launched in June 2019. New organisation name approved by the Board in January 2020. Agreed to showcase the unique selling point (USP) of the MSE group and career opportunities by virtue of being a larger employer. • Reducing internal competition: • BTUH transfer took place in September 2019 and was less successful than implementation of MEHT transfer. A rapid recovery project was established and was able to resolve the critical issues regarding (visibility of booking shifts and paying workers) within three weeks. Remaining issues have moved in to BAU and are being monitored on a weekly basis with highlight reports back to site. • Collaborative Bank established for group: all external provision is now insourced. . February 2020 final implementation of the bank consolidation with the requirement to increase medical supply and implementation of a Locum App for SUHFT and BTUH. • Preferred Supplier List agencies prohibited from using MSE trust staff filling agency shifts at MSE sites. This has been developed for Nursing and working towards the same approach for the medical workforce. The new established bank now has greater ability to scrutinise. • A new task and finish group has been established in February 2020 to: a. Address areas of high medical agency spend with targeted recruitment campaigns. b. Eliminate areas of poor practise on agency spend e.g. payment for breaks. c. Reduce down rates with agencies. d. Work with EoE to achieve compliance on agency rates and create medical PSL. e. Implement reduction in Bank rates across the trusts.

f. Increase take up of Locums Nest and Direct Engagement.

.

- Developing values based recruitment and streamlining recruitment processes:
  a. Values based recruitment: all recruitment processes under review as part of the HR transformation programme of work.
  b. Training program under development to ensure consistency and improved level of service across the group.
  c. Streamlining processes: Time to Hire processes are a key focus of the HR transformation with a consolidated target of 47 days with an improvement trajectory to be built – that sets out when the 47 days will be achieved; note that this timeline runs from date of live advertisement through to unconditional offer to candidate and does not include any notice period that the candidate needs to give in their current role. Alignment of processes, retrain staff and divisions / directorates.
  d. New consolidated recruitment service went live in August 2019 within the new corporate hub based in Southend. To date there has been significant backlog and process issues dealing with recruitment activity. An emergency task and finish team has been set up for each site along with the current BAU teams to address the issue of backlog. The immediate backlog issues and activity have been addressed. . The BAU team are focussing in on activity from 1st October and improvement requirements including process mapping and the new standard operating procedures (SOPs). Senior leadership has been dedicated to both the task and finish team and BAU team. In addition, senior support is provided on each site to ensure interface with site managers and the recruitment team – this ensures maintenance of the action logs and dealing with issues expediently. Original backlog has now been closed.
  e. Draft SLAs have been issued to site SLTs for discussion and review.
  f. **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 - COMPLETED**
  SLAs are being developed and new corporate programme board established to monitor HR / recruitment KPIs. An SLA has been developed and development of a revised Group recruitment policy is taking place. Next steps implementation of new processes and policies.

- 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, SUHFT and BTUH since July 2019. Medical bank harmonisation in place apart from specific specialities where there are a high vacancy levels.
  b. Discussions on-going for Nursing ED, Theatres and Critical Care with view to implementing via phased approach. . Further analysis is being provided in order to confirm an agreement). Delays in implementation due to vacancies and risks.
- Reducing Reliance on Bank and Agency:
  a. Recruitment campaigns to employ staff substantively: Recruitment and Retention plans are in place but further reviews are being

undertaken to improve domestic nurse recruitment and medical staff both domestic and internationally A strategic partnership approach is emerging through a university in India, with a pilot at Southend hospital. Discussion has taken place through POD CiC in January 2020.

b. .Aim to reduce band 5 vacancies from 29% across MSE to agreed board target of 17% by end **July 2020**. This is a challenging target where nurses require a certificate of sponsorship. **Credit card limits increased across the HR/recruitment function to avoid delays in COS payments.**

c. 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

- **Retention & Engagement**

- Culture, values and engagement:
  a. A new approach to appraisals is currently being piloted across Corporate Services in Q1 2020/21 with coaching skills development to facilitate more regular, enabling conversations as well as annual assessment of behaviours and performance against agreed objectives and meet Agenda for Change pay progression requirements.
  b. 'Stay' interviews and stay resources are now available for all managers across the Group via the Retention & Engagement team and dedicated intranet pages. This action is completed as of Q4 2019/20
  c. Approach to MSE Culture Programme agreed at Board on 15-Jan-20. As part of this work, Communications team, 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. A single set of values and a behaviour framework for the group will be co-produced as well as the development of a single MSE narrative, a new Leadership Development offer and an Exec and Board Development offer.
  d. Delivery of an annual calendar of staff engagement initiatives and social events – Q4 19/20-Q3 20/21
  e. Retention & engagement information, resources and skills training being delivered to managers Q4 19/20 – Q3 20/21 with a target of 500 managers
  f. New consultancy service for retention & engagement 'hotspot' areas – Q4 19/20 – Q2 20/21 – targeting 6 hotspot areas.
  g. Facilitate the creation and alignment of a MSE Staff Recognition Strategy and Action Plan target completion 1 May 2020
  h. Support the delivery of the MSE Recruitment and Retention Action Plan (this requires review following a workshop event with NHSI).
  i. Co-facilitate a single, aligned MSE Staff Benefits portfolio and communication plan – Q3 20/21
  (All of these initiatives will take time to embed)
- Developing career pathways:

a. Ensure that education courses are appropriately commissioned according to specific pathways as requested via Retention plan
b. Maximise the apprentice levy to ensure work based learning develops the whole workforce, including hard to recruit groups such as clinical coding and post graduate management and advanced clinical practice.. Utilise the levy to support the development of a pipeline to Registered Nursing via Nursing Associate and Assistant practitioner pathways.

- Induction
  a. Review of induction Programme has been completed. A new corporate induction day to be initiated in April, subject to authorisation of a new organisation.
  b. Guidelines for managers for keeping in touch with new starters in the pipeline and scoping the first 90 days in department have been issued. Action completed in Q2 of 2019/20.

Governance

- 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 **September 2019** – Action completed
     ii. Delivery of milestones under the HR and OD Project Plan through the Workforce Merger Delivery Group monitored by the FOFDG. Plan has milestones between now and **May 2020**.

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 year on year improved financial sustainability and effective use of resources						
MSB Risk ID	4.1 (including what was 4.5)	**Executive Lead**	Dawn Scrafield	**Current Risk Score and movement since last month:**	25 ⟷	**Risk Appetite:**	Cautious 3 - Open
				Reason for Risk Movement			
Date identified	November 2018	**Date last reviewed**	October 2019	**Target date**	March 2029		
Risk Rating (Likelihood x Impact)							
Inherent Score: 25				**Target Score: 15 (likelihood 3 x impact 5)**			
Relevant Key Performance Indicators / Risk Indicators							
The scope of the risk is considered over the life of the Long Term Financial Plan period, which is 10 years until 2029. Indicators that could be monitors to assess the management of the risk are as follows: • Financial performance trend compared to year on year spending – seeking year on year financial improvement. Using In month, year to date and forecast financial performance as indicators • Cost Improvement Programme delivery – particularly the ratio of recurrent achievement v non-recurrent achievement. Using In month, year to date and forecast cost improvement programme performance as indicators as well as the ratio of Recurrent to Non-Recurrent delivery. • The ambition is to be in the top quartile of efficient trust in Model Hospital - Improvement in cost behaviours achieved being the indicator of success							
Applicable link to regulation requirements (CQC / NHSI)	Use of resources			**Board sub-committee monitoring**	Finance & Performance		
Existing Key Controls	Expenditure control processes Financial recovery plans at MEHT and Basildon Multi-year plan to eliminate deficits Multi-year guaranteed income contract with STP CCGs Commencement of the Efficiency Programme Board – to oversee the efficiency delivery and realisation of CIP across MSE						
Gaps in Controls	1. Existing key controls are not systematically effective across all 3 sites 2. High levels of agency and bank spend due to vacancies (bank rates are not always preferential to agency) 3. High levels of unidentified CIPs and under delivery on CIP schemes as well as proportionately low levels of recurrent CIP						

	4. Poor CIP planning for future years 5. Some areas of poor productivity 6. Residue of income on PBR contracts for which activity is not always effectively captured 7. Poor budget setting, including effective resources plans for capacity to meet demand and workforce requirements 8. Inconsistent processes for investment appraisal and decision making 9. Weak financial analytics for monthly reporting 10. Inconsistency in workforce recording/ reporting due to misalignment of establishment with roster and ESR 11. Continued growth in demand, with demand and capacity is not understood, including dependency on out of hospital solutions being delivered by other parties 12. Development of Service line reporting to allow services a greater understanding of the costs and resources linked with activity and performance	
Assurance	**Internal**	Regular reviews of financial performance at Finance Committees Financial position reported monthly at F&PCiC and BiC Financial recovery plans reported at Site Governance Forums Delivery of annual financial plans Development of business cases to deliver reconfiguration and improvement initiatives
	External	Internal Audit reviews Support from commissioners for Trusts clinical reconfiguration plans Support from regulators for merger plan Third party assurance for Basildon by PWC at a recent review
	Level of Assurance	NHSI Single Oversight Framework, rating 3 (3 Trust average)
Gaps in Assurance	• Low CIP delivery • Basildon forecast is not able to deliver the control total set for 2019/20 after recovery actions • Multi-year CIP plans are not yet fully developed • Strategic, merger enabled savings plans not yet fully developed	

Mitigating Actions

Mitigating Action	Timeline	Status
In Basildon weekly review of divisional performance against pay control totals to achieve as a minimum the revised forecast	On going until end of March 2020	Recovery meetings with divisions were established since November 2020. Increased controls for signing off recruitment and agency staff have been implemented at Basildon. Improvement in pay run rate eveidenced.
LTFM drafted and agreed with system partners. Control totals for the group are set on the basis of the merger counterfactual position	Complete.	The System long Term Plan has been agreed. Financial Recovery Fund for the system has been agreed on the basis of the system control total. The majority of this would be available for MSE due to the deficit balance sitting in MSE.
Development of a cost improvement plan to achieve the control total. Merger related savings plans to be incorporated as part of this plan.	March 2020	Initial outline of a plan has been circulated with Executives in January 2020. Further work to progress the delivery of "Business as Usual" CIP to be progressed with budget holders.
Revised Investment Group arrangements proposed and supported by Executives in October 2019. New arrangements to be established by end of December 2019.	Complete.	First meeting held in December. Finance & Performance Committee reviewed in Janaury and will be a standing item update for future F&PCiC
Draft approach to CIP proposed for consideration by Executives in November 2019. CIP workshop 18th November to consider the opportunities and agree an MSE approach	Complete.	The outcome of this work has informed the structure of the programme and the development of the efficiency programme team which will be in place for April 2020.
System support for shortfall in forecast against control total – approach will facilitate a means to strengthen system working and establish some principles for future management of financial risk in the system.	March 2020	System discussion progressing positively for 2019/20 and it is expected that a resolution for the Basildon gap will be achieved, which will result in the achievement of the MSE PSF/FRF.
Joint work with system partners progressing on demand and capacity to establish the opportunities and the shortfalls. Financial plans will be set on the basis of current activity delivered, with an incremental plan for any growth expected.	March 2020	The modelling work for demand and capacity has been completed. As part of budget setting this will now be used to inform the procutivity that can be achieved to deliver activity above the budget setting base of 6 + 6
Proposed approach to budget setting drafted for review by the Finance & Performance Committee in Common in November 2019. Budget setting to progress later in November 2019 on the basis of a Zero Based approach. It is expected this will elevate the level of CIP requirement, but will establish a true baseline of underlying cost for delivering services.	Complete.	Budget setting is under way with regular reports to the F&PCiC. First cut of budgets has provided the baseline to assess CIP opportunities. The guidance was issued as per the timeline.
Independent review of finance capability to develop the right skills and technics for high performing financial analytical reporting across the organisation.	February 2020	RSM have commenced the review and the survey was launched in December 2019. The outcome of the review will inform the future service provision and standards.
Proposal for Service Line Reporting in development	Complete.	Options considered and a plan has been developed to progress this for full implementation from April 2021.
Development of a plan to align workforce reporting to establish one version of the truth and enhance triangulation of workforce reporting with performance and activity	August 2020	As part of the transition to a single ESR the new herarchy will be developed and this needs to be aligned to E-Roster. The establishment for the budget setting is reviewing actual staff in post and budgets and will highlight anomolies. This is a high risk area as as been highlined through internal audit.
Increased visibility of Model Hospital reporting and other such benchmarking opportunities to challenge the Group on the productivity and effective use of resources	Complete.	Routine reports now included in the workplan for F&PCiC. Initial reported highlighted current status. Draft CIP approach targets key areas highlighted in model hospital as opportunitues.
Establishment of a comprehensive Finance & Performance work plan to ensure that supporting mechanisms, such as capacity and demand and cost improvement can provide positive assurances	May 2020	Objectives have been set for the directorate, however the management portfolios across finance will be concluded following a senior finance leadership consultation process which is due to conclude for 1st April 2020. A directorate plan will be developed for 2020/21 to drive delivery in areas of weakness.
Establish a system approach to managing the NHS pound across Mid and South Essex; this will support the longer term financial sustainability strategy.	Ongoing	Work plan drafted and due for consideration and the MSE Partnership Board on 23rd January 2020. If approved this will offer a mandate for the System Finance Leadership Group to progress system wide work in this area.
Develop a financial sustainability plan for MSE	Jun-20	Tendered support for a strategic delivery partner, with the core aim of aligning financial improvement with quality and operational improvements. First task of the partner is to support the development of financial sustainaibility plan.
Efficiency programme governance	Apr-20	Consultation of the senior finance leadership team launched with the new Head of efficiency proposed and support team. First Efficiency Programme Board met 17th February, reviewing the schemes for the 20/21 plan. Arrangements should be established by the end of April 2020.

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 patient care in a cost effective manner because the current estate and associated infrastructure is not fit for purpose. Failure to develop and fund a long term capital plan which addresses the clinical, estates and technological needs of the organisation						
MSE Risk ID	4.2 / 4.6 Merged BAFs	**Executive Lead**	Eamon Malone	**Current Risk Score and movement since last month:**	20 ⟷ Taken the highest risk which previously sat with risk ID 4.2.	**Risk Appetite:**	Cautious 3 - Open
				Reason for risk movement	Actions taken have not yet reduced risk score.		
Date identified	15/05/2017	**Date last reviewed**	18/02/2020	**Target date**	31/03/2023		
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, and 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 to be in place. Under the Premises Assurance Model, this requires policies and procedures to be in place in accordance with regulatory requirements. 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 – Compliance tracker, annual Planned Preventative Maintenance (PPM) programme in place. Internal and external audit by Authorising Engineer (AE). Six 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: Completed BIA's with action cards/processes are in place for EFM services. 6. Infrastructure and Plant - All assets should be risk assessed and managed via the backlog maintenance programme. Funding is allocated via annual programme and investment group. 7. Medical Equipment – policy in place in accordance with MHRA guidance. ISO 9001 accredited. 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 45001 (H&S) at Southend. 9. Existing processes in each of the Trusts to prioritise annual capital plan to fund essential maintenance/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. A review of Authorised Persons is currently underway as part of the PAM process. 3. Development of governance and assurance reporting required. 4. None 5. The strategy to further develop the BIA and action cards/processes has been created. 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 scheduled for update within required timescales, annual audits to confirm implementation and action plans created where required. Evidence available for HSE and CQC inspections. Premises Assurance Model rolling programme with identified action plans. 2. Training skills register provides evidence of staff competence. Authorised persons now appointed. 3. CAFM systems hold asset registers and annual programme of PPM, KPI audit reports submitted to the Trust Board. Estates risk assessed capital programme prioritises investment to lower the risk associated with high risk statutory items. Action plans available resulting from incident reporting where required. Internet access to hard services tasks/response times and performance now available for staff/managers to monitor progress. 4. Cleaning audit reports are sent to the services and action plans developed and implemented. Repeat unannounced

		audits undertaken to ensure actions are completed. KPI reports to QAC/H&SC and the Trust Board. KPI clearly identified in contract specification and reviewed at monitoring meetings. 5. Business Impact Assessments and action cards/processes are in place. ISO22301 in place at Basildon. 6. Risk assessed and prioritised 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. Authorising Engineer audits (and BSI audits at Southend) 2. Authorising Engineer audits (and BSI audits at Southend) 3. Authorising Engineer audits (and BSI audits at Southend) 4. PLACE audits, CQC inspections 5. BSI audits at Southend 6. None 7. BSI audits at Southend 8. BSI audits at Southend 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 process. Further work required on reporting templates to EFM board. 4. Failures in cleaning standards identified in CQC reports. Limited assurance from FRC. 5. Plans have been tested (scenarios and live incidents) for various incident types, however ongoing testing is required. 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) is currently being updated to reflect changes in policy, strategy, regulation, technology and supports the NHS constitutional right. The PAM self-assessment is currently being reviewed against the Hard FM Compliance Audit to ensure all aspects align with risks accordingly. Development of an MSE 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 Estates & Facilities Officer 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 registers. 4. 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 registers. 5. Review the E&F BIAs on a regular basis to ensure updated systems and processes. 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 pre-planned reactive works to minimise and remedy the failure. Skilled teams are available 24/7 to react accordingly and a number of specialist contractors are also 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 are identified. 7. Development of early warning escalation process where non-conformance actions are slow in being developed. 8. N/A 9. Planned development of the estates on a priority basis. 10. Consultant engagement with robust programme management to ensure on deliver on track. 11. N/A

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:**	**16 (4x4)**	**Risk Appetite:**	**4 – Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).
				Reason for Risk Movement			
Date identified	27th April 2017 Re-baselined 17th April 2019			**Date last reviewed**	29th January 2020	**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	12. **Strategy** – a high-level strategy for the transformation of Digital Services across the MSE Group is finalised further work on clinical system reconfiguration is in train. 13. **Governance Processes** – processes are embedded across all disciplines to review risks and identify themes across the Group. 14. **Leadership** – the senior leadership structure is in place for Informatics across MSE Group. 15. **Cyber Security** – a dedicated Cyber Security function in place for the Group. 16. **Staffing Levels** – any gaps are being addressed through the use of agency as required. 17. **Policies** – all policies are aligned across the Group for Digital Services & Information Governance. 18. **Training** – regular reviews of mandatory and professional training to ensure the workforce has the skills and knowledge required to support and maintain hardware and software solutions. 19. **Business Continuity** – Business Impact Analysis have been completed for Digital Services delivered at each Trust site. 20. **Capital Planning** – Existing processes in place for the Group to prioritise annual capital plan to fund essential systems developments and the						

	overall digital Digital Transformation Programme.	
Gaps in Controls	1. Strategy – whilst the Digital Transformation Strategy has been finalised tactical solutions are still being implemented to ensure service stability. 2. Governance Processes – processes are slow to become established as staff transition into the new business operating model. The development of formalised governance and assurance reporting is still being embedded. 3. Leadership – the top level leadership team has been recruited however the scale and pace of change and BAU pressure creates an the ability to maintain consistent service delivery 4. Cyber Security – whilst the Cyber Security Officer is in place the additional Cyber Security analyst role, as identified in the staff consultation, is vacant and currently being recruited to. 5. Staffing levels – active recruitment is underway where posts are still vacant following the staff consultation, staffing levels continue to be monitored. 6. Policies – None 7. Training – access to timely and accurate mandatory training information from each Trust site is a challenge to ensuring that staff are up to date. Professional training requirements, including any knowledge and skills that can be transferred between the teams, is being identified as part of the transitional plans currently being documented. 8. Business Continuity – the current continuity plans at Southend are in need of review and standardisation to align them with the documentation sets used at the other 2 sites. 9. Capital Planning – The delivery of identified service developments and the overall Digital Transformation programme is dependent upon the availability of capital funding over multiple financial years.	
Assurance	**Internal**	1. Strategy – the outline business case for the delivery of the Digital Transformation Programme, which is the basis for the Digital Transformation Strategy, has been reviewed and was approved by the MSE Board October 2019. 2. Governance Processes – regular reports are presented to various Groups at each Trust site, these provide an update on the progress of establishing internal governance processes and Information Governance related matters, including IG breaches and progress on the DSP Toolkit return. The Digital portfolio steering board provide oversight of digital transformation workstreams 3. Leadership – the senior leadership team, including heads of service areas, are in place following the restructure and are engaging with the relevant service areas at each Trust site. 4. Cyber Security – regular cyber security updates are provided to the Head of Digital Services and the Group CIO for dissemination and discussion at appropriate site and Group leadership forums. 5. Staffing Levels – continuous progress reviews for staff recruitment and retention with HR business partner take place, where there are concerns or issues these are escalated within Digital Services and HR. 6. Policies – All policies are fully approved and within review timescales. 7. Training - reports are presented to Risk & Compliance Groups at the Trust sites which include mandatory training compliance.

		8. Business Continuity – Business Impact Assessments and action cards/processes are in place for services at Mid Essex and Basildon. 9. Capital Planning – Risk assessed and prioritised capital programme in place and a monthly update report is provided to the Group Investment Committee.
	External	1. Strategy – the outline business case for the delivery of the Digital Transformation Programme has been shared with KPMG as part of the due diligence reviews that are on-going in the run up to the Group merger. 2. Governance processes – annual DSTP Toolkit returns, successful compliance to the Cyber Essentials for the MSE Group (April2019) and ISO22301 standard at Basildon (Jan 2019). 3. Leadership – none 4. Cyber Security – successful compliance to the Cyber Essentials for the MSE Group (April2019), NHS Digital IT Health check in relation to meeting Cyber Essentials Plus accreditation by June 2021. 5. Staffing levels – none 6. Policies – these have been shared with KPMG, RSM and other external review bodies as part of regular service reviews, following review changes have been made to meet recommendations made. 7. Training – CQC inspections at each Trust site, DSTP Toolkit return, NHS Digital IT Health checks. 8. Business Continuity – successfully audited against ISO22301 standards at Basildon in Jan 2019. 9. Capital Planning – NHSI oversight.
	Level of Assurance	The level of assurance has been assessed as Moderate, given the number of gaps in controls which are outside the direct control of the service.
Gaps in Assurance		1. Strategy – further work is required to finalise the high-level Clinical system reconfiguration strategy. 2. Governance processes – further work is required to embed review groups and on completion of reporting templates. 3. Leadership – key performance indicators are being developed to identify if service levels drop 4. Cyber Security – working towards compliance to the NHS Digital Cyber Essentials Plus by June 2021. 5. Staffing levels – none 6. Policies – all policies are within review dates however some are overdue an internal annual review. 7. Training –information provided from each is not timely to reflect staff training completion and the format varies making it difficult to accurately assure that training undertaken is on trajectory for completion. 8. Business Continuity – Plans are tested using table top scenarios and live incidents for various incident types, however the collation of accurate documentation and ongoing testing is required. Further work is required on the continuity documentation for Southend site. 9. Capital Planning – Required capital allocation has not been met to deliver all essential systems developments and the overall

	Digital Transformation programme.
Mitigating Actions	1. Strategy – Finalising the MSB Informatics Strategy underpinned by Digital Essex 2020 to reflect / identify new ways of working and delivery of supporting technology. 2. Governance Processes – Single group wide governance approach to ensure communications with operational and corporate redesign teams to ensure alignment of programmes across the MSB Group. 3. Leadership – Escalation of issues to Executive team and Digital services portfolio steering board 4. Cyber Security – continue to work towards meeting the Cyber Essentials Plus standards whilst recruiting to the vacant Cyber Security Analyst role, where areas of non-compliance are identified these will be escalated to the Head of Digital Services and Group CIO. 5. Staffing levels – N/A 6. Policies – annual internal reviews have commenced, any revised policies will be resubmitted to the Group Document Review Group for ratification and publication. 7. Training – manual training updates are collated by team leads and ratified against information received from each site, where there are discrepancies these are escalated to the training and development teams. 8. Business continuity – a plan for reviewing Southend documentation is being drawn up and an Incidents & Outages review group will be established to ensure that live incidents are accurately recorded and documented on the Hornbill service management system. 9. Capital Planning – The overall Informatics capital programme has been reviewed, with aim of aligning and prioritising projects to deliver direct benefit across the group. The senior management team actively participate in review of overarching MSB capital plans in order to qualify risk ensure correct prioritised funding.

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 (No change)	**Risk Appetite:**	High 3 – Open
Date identified	November 2018	**Date last reviewed**	10th January 2020	**Target date**	01 April 2020		
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)	N/A	**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 and supported in their personal development. • Monthly staff briefing sessions with all Corporate Service teams ongoing and specific staff survey to determine format of future sessions.						

	• Communication ongoing with the wider organisation including updates at the CEO briefings, Site Leadership Team meetings and 1weekly bulletins. • Strengthening of Implementation readiness checklists started in October 19 to support corporate functions in ensuring a consistent approach to consolidation of services and risk assess the impact of change through the transition. Where required cases approved for additional interim resource to support teams to stabilise.	
Gaps in Controls	• Further stakeholder engagement with wider users of Corporate services to be completed post new models implementation. • Future oversight of corporate service delivery to be agreed when BAU state is reached. Corporate Services Management Board now agreed and due to start in January 2020. Membership to include corporate executive leads and Managing Directors.	
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 March 2020. • Improvement plan development ongoing and priority areas identified for the first tranche of consolidated corporate services • Resource plan documented to facilitate delivery of key improvement projects
	External	• External consultancy SME support commissioned with experience in delivery of 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		- Post service consultations being concluded, there has been a need for further detailed work up of service improvement plans. Some legacy issues in corporate services have been revealed through consolidation and will be addressed through the plans, as well as addressing post change implementation issues that have been identified. - 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 through automation. - Resources required to deliver the improvement phase of the programme are yet to be formally confirmed pending business case review and agreement of 20/21 Group Transformation Funding. These resources will

	include central programme resource and then service specific change needs.
Mitigating Actions	- Additional services being taken through same full programme methodology to ensure all individual corporate service proposals are consistent with broader corporate offerings. - Proposal setting out the improvement phase benefits versus cost to deliver discussed in December 19. Further work required to detail timelines for delivery and scale of benefits. Updated proposal to be shared in January 2020. - Improvement plans have been generated with each service area in draft and where appropriate, are to be managed on a live basis by the programme to ensure delivery.