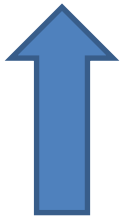
Red risk scores shown with asterisks (for example ***16***) indicate those that have a red rating for at least the previous two month period.

Risk Ref:	Risk level: / Risk:	Risk Owner	Target	May 2018	June 2018	July 2018	Aug 2018	Sept 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	March 2019	April 2019	May 2019
W125	Performance Failure: A&E 4 hour standard	DW / JL	15	***20↔***	***20↔***	***20↔***	***20↔***	***20↔***	***20↔***	***20↔***	***20↔***	***20↔***	***20↔***	***20↔***	***20↔***	***20↔***
W157	Performance failure: IAPT Access – 3.75% per quarter	DW / JL	15	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	15↑	15↔	***15↔***	20↑
W221	Lack of assurance of safe care at Princess Alexandra Hospital with overall HSMR rates higher than expected.	CM	4	***16↔***	***16↔***	***16↔***	***16↔***	***16↔***	***16↔***	***16↔***	***16↔***	***16↔***	***16↔***	***16↔***	***16↔***	***16↔***
W230	Ambulance response times affected by ARP and PAH handover performance	LH	9	***16↔***	To be advised	16	16↔	16↔	To be advised	16	16↔	***16↔***	***16↔***	***16↔***	***16↔***	***16↔***
W249	Lack of bedded and non-bedded capacity over the winter period, including the availability of D2A and community beds. This could lead to limited patients flow out of hospital.	LH/MB	4							New 16	16	***16↔***	***16↔***	***16↔***	***16↔***	***16↔***
W242 (+ W243)	Failure of WECCG and system to achieve the NHSE Quality premium targets for <15% of decision support tool (DST) assessments & >80% of all new DST assessments within the 28 day target.	JK/GW	12						New 15	15↔	***15↔***	***15↔***	***15↔***	***15↔***	***15↔***	***15↔***

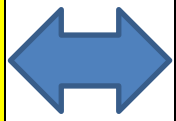
Risk Ref:	Risk level: Risk:	Risk Owner	Target	May 2018	June 2018	July 2018	Aug 2018	Sept 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	March 2019	April 2019	May 2019
W227	Essex wide health systems ability to manage any mass casualty event (including transport incidents, acts of terrorism, infectious diseases, CBRN) where number, type and severity of casualties could overwhelm the local health provision.	IT	10	*15↔*	*15↔*	*15↔*	*15↔*	*15↔*	*15↔*	*15↔*	*15↔*	*15↔*	*15↔*	*15↔*	*15↔*	*15↔*

Risk ref + date added to register + responsible committee + corresponding Strategic Objective	Risk description & categories	Current controls	Impact	Likelihood	Current risk rating (I x L)	Future or additional controls / actions planned to mitigate risk	In year target risk rating (I x L)	Last review date + projected closure date
Risk ref: W125 Date added: December 2014 Responsible committee: Finance & Performance Committee Corresponding strategic objective: SO.1	**Risk description:** Performance Failure: A&E 4 Hour Standard. Standard: 95% <u>Mar 19</u> PAH: 72.4% <u>Feb 19</u> Adden: 81.2% Barts: 82.5% **Risk categories:** **Clinical** **Operational** **Reputational** **Safety**	PAH: • Urgent Care Centre (UCC) opened, operational and clinical leads appointed • Provision of AEC at least 12 hours a day, 7 days a week and wo ED trackers in place. • Monday Deep dive into weekend performance • Local Delivery Operational Group reviewing system wide performance and impact on a fortnightly basis • New Integrated Urgent Care (IUC) service live from 1st April • Re-profiling of existing Extended Access appointments Addenbrookes: • The ED action plan has been updated to provide more detail around recovery actions, and the new plan is reviewed on a weekly basis by the members of the daily ED Performance Group. • The Acute Hub was launched on the 14th November • An ED Opportunities action plan has been agreed that is reviewed weekly by the COO and Operational Teams Barts: • New improvement approach introduced – Optimum Conditions Model • Working with the Emergency Care Improvement Programme (ECIP) across its A&E provider sites • This work has been crystallised into a series of Trust level strategic actions as well as tactical actions developed for each of the Trust sites	4	5	20	PAH: • Trajectory agreed with regulators to improve to 90% by March 20 • National Clinical Review of NHS Access Standards – currently being piloted. Likely to lead to revisions in national A&E KPIs. Further advice to follow in the Autumn • The weekly escalation meetings with NHSE have temporarily ceased following Paul Watson's move to his new post, and the CCG's transition from the Midlands to the East NHSE team. It is expected that these will resume in the near future. • Frailty programme ongoing • Complex patient programme ongoing • Additional Paediatric dedicated ED doctor support Addenbrookes: • Report from March ECIST visit awaited. Assessment focussed on: front door assessment, access to ambulatory care and medical/nursing staffing • Pilot for extending access hours to EAU Barts: • Continued work with the Emergency Care Improvement Programme (ECIP). Key actions from Royal London specific patient flow improvement programme to be rolled out at Whipps Cross • Work is underway with a highly experienced econometrician on the design and build of an emergency and elective demand and capacity model. The model is due to be completed by April and will provide operation managers with better data to plan emergency and elective flow	3 x 5 =15	Last review date: **May 2019** Projected closure date: {03/20} 

Risk ref + date added to register + responsible committee + corresponding Strategic Objective	Risk description & categories	Current controls	Impact	Likelihood	Current risk rating (I x L)	Future or additional controls / actions planned to mitigate risk	In year target risk rating (I x L)	Last review date + projected closure date
W157 July 2015 SO. 1 Finance & Performance Committee	Risk description: Performance failure: Improving Access to Psychological Therapies (IAPT) Standard: Q1-3 4.2% per Q Q4 4.75% Performance: Q1 2.93% Q2 3.10% Q3 4.19% Q4 3.47% Note: HPFT are currently only commissioned for 3.75% per quarter Risk categories: Clinical Financial Operational Reputational Safety	• A range of actions have been agreed targeted at increasing referrals • Monthly dedicated RAP Review • NHSE monthly reporting in place due to under performance • Dashboard for Practice and Neighbourhood level IAPT data agreed • Regular attendance at Neighbourhood meetings • SystmOne and EMIS electronic referral forms now in place • Performance against the Recovery and 1st Treatment standards remains compliant. • A workshop was held on 16th August and the Remedial Action Plan in place was fully reviewed and refreshed: • Contractual penalties applied until September • Q3 performance significantly improved and achieved contracted standards, however performance returned to historic rates in Q4	4	5	20	NHSE aware that 4.75% national standards have been missed by some margin in 2018/19. Focus is now on securing additional capacity to meet national expectations for 2019/20. A 19/20 commissioning options paper is being presented to CAG and Health & Care Committee in May.	3 x 5 = 15	Last review date: **May 2019** Projected closure date: {03/20} 

Risk ref + date added to register + responsible committee + corresponding Strategic Objective	Risk description and categories	Current controls	Impact	Likelihood	Current risk rating (I x L)	Future or additional controls / actions planned to mitigate risk including costs + benefit	In year target risk rating (I x L)	Last review date + projected closure date
W221 July 2017 Quality Committee SO1	Risk description: Lack of assurance of safe care at Princess Alexandra Hospital with overall HSMR rates higher than expected, standardised mortality rate for latest reported period 04/16 – 03/17. 2 main areas of concern are mortality from fractured neck of femur (#NOF) and sepsis diagnosis. National reporting for mortality is SMHI which reports 6 months later than HSMR and is also higher than expected range. Risk categories: Clinical Financial Reputational Safety	07/17> All areas flagging as higher than expected mortality are subject to internal audit. 07/17> #NOF investigated in-depth. 08/17> No longer an outlier. 09/17> Sustained for 3 months. 07/17> Subject to Chief Executive scrutiny panel which WECCG's Chief Medical Officer is present at. Key determinant of survival is time to theatre – with a target of 48 hours. 08/18> Mortality Surveillance Group now meeting monthly at PAH to review wider number of deaths in line with national policy. 02/19> There is a new mortality oversight group where mortality examiners provide information and oversight. 11/18> PAH Board requested a detailed review of all deaths in September 2018. 02/19> The Trust has a detailed action plan to address mortality. This focuses on flow throughout the hospital, adherence to best practice pathways and rapid identification and escalation for individual patients as needed. Oversight by Trust Board & Mortality Surveillance Group which is attended by NHS Improvement, West Essex CCG & East & North Herts CCG.	4	4	16	*11/18 Previous controls / actions archived.*	4 x 1 = 4	Last review date: **May 2019** Projected closure date: {ongoing} 

Risk ref + date added to register + responsible committee + corresponding Strategic Objective	Risk description and categories	Current controls	Impact	Likelihood	Current risk rating (I x L)	Future or additional controls / actions planned to mitigate risk	In year target risk rating (I x L)	Last review date + projected closure date
W230 October 2017 Responsible committee: Local Delivery Board SO.1	Risk description: Ambulance response times affected by ARP and PAH handover performance Risk categories: Clinical Corporate Operational Reputational Safety	04/18> EEAST Risk Summit Jan 18 has resulted in new Ambulance Handover protocol and action plan to address poor performance implemented 25th February Handover performance continues to be monitored daily Fit2Sit handover now operational New paramedic roles support ED operational Ambulance conveyance audit repeated in July – appropriateness of conveyances sustained and therefore CCG not considering alternative transport offer for HCP heralded journeys 02/19 EEAST have contributed to plan, regular meetings in place.	4	4	16	09/18> Ambulance conveyance audit to be repeated in November. LDB meeting in September focused on reduction of ambulance conveyances through increased use of community pathways. 11/18 Refresh of Ambulance Handover protocol and action plan with PAH to be agreed at LDG in November 12/18 Ambulance Handover plan now refreshed and progress reported to NHSI on a weekly basis. Agenda item on next LDOG and reviewed via LDB. Meeting planned between Head of Ops, EEAST and CCG early January to ascertain progress made. 01/19 Further refresh to take place by end of January. ED surge policy produced including actions when ambulance turnaround times are challenged. 04/19 ECIST ED review underway including ambulance Handover, ECIST Plan to merge with local AHP **05/19 Bi weekly meetings established with CCG/EEAST/PAH. HALO now agreed. March performance showing improvement in handover times may be attributable to HALO, need to review April and May performance to understand impact.**	3x3=9	Last review date: **May 2019** Projected closure date: {Ongoing}

Risk ref + date added to register + responsible committee + corresponding Strategic Objective	Risk description and categories	Current controls	Impact	Likelihood	Current risk rating (I x L)	Future or additional controls / actions planned to mitigate risk	In year target risk rating (I x L)	Last review date + projected closure date
W249 (Revised risk) November 2018 Responsible committee: Corresponding SO:	Risk description: Lack of bedded and non bedded capacity over the winter period, including the availability of D2A and community beds. This could lead to limited patients flow out of hospital. Risk categories: Clinical Corporate Financial Operational Reputational Safety	Winter Plan detailing all planned capacity Daily review of bedded and non bedded capacity via SHREWD Maximise use of all available bedded capacity Flexible criteria in operation at all status levels into beds Current provision : 12/18 2 beds at HEH now open. Ashlyn bed pilot (4 beds) Forest Place provision (4 beds) ESC and HSC - 48 hr home 1-1 support Nightingale medical escalation - 18 beds **04/19 Nightingale medical ward opened late April as medical escalation capacity in periods of surge. Stepped up and staffed and stepped down as needed to support periods of surge.**	4	4	16	Additional bedded capacity early January - 27 beds at PAH (10 commissioned by CCG) 2 beds at SWCH, 8 beds planned at HEH and 10 D2A beds – flexible use of beds needed. 01/19 Additional community hospital beds at Saffron Walden Community Hospital and Herts & Essex hospital, 6 in total. Additional community support to existing D2A capacity to maximise utilisation – with additional therapy support to be implemented in January 02/19 4 additional residential beds at Ashlyns, pilot scheme to inform future commissioning. 21 Further IC beds to be commissioned. D2A home 1-1 support commissioned. **05/19> Scoping and financial modelling underway for 21 further IC beds. Additional beds at Ashlyn pilot still underway** **Winter Review Event in May - feedback will help to shape 2019/20 provision.** **SHREWD daily review in place (June 2019) to ascertain available system capacity.** **Scoping and financial modelling complete for 21 IC beds July/August timescale.** **Preparation of Winter Plan commences August 2019 including additional capacity.**	2 x 2 = 4	Last review date: **May 2019** Projected closure date: **Ongoing** 

Risk ref + date added to register + responsible committee + corresponding Strategic Objective	Risk description and categories	Current controls	Impact	Likelihood	Current risk rating (I x L)	Future or additional controls / actions planned to mitigate risk	In year target risk rating (I x L)	Last review date + projected closure date
Revised and combined W242 and W243 **May 2019** Finance & Performance Committee SO5	**Failure of WECCG and system to achieve the NHSE Quality premium targets for:** **1. < 15% of decision support tool (DST) assessments to be undertaken in an acute hospital.- discharge to assess (D2A) pathway** 2. **>80% of all new DST assessments to be undertaken within the 28 day framework.** **Risk categories:** **Financial** **Operational** **Reputational** **Safety**	**Weekly monitoring with system partners to establish ongoing position.** **EPUT has a pilot in place in the Harlow locality for an administrator / to co-ordinate and write each DST with the clinical MDT which supports delivery of the >80% target.** **Weekly teleconference with NHSE & I to discuss current backlog position in WECCG and question/challenge current and future controls.** **CHC Team receives and ratifies all positive checklists from acute trusts. CHC Team informs the acute trust to contact the lead (Essex social care) for admission to the D2A beds in West Essex. If there are no D2A beds available, Head of CHC/Professional lead will confirm if DST can be undertaken in the acute setting on a case by case basis.** **CCG monitor performance at Finance and Performance Committee, CHC internal assurance meeting and Quality committee** **Engagement with all partners including neighbouring acute trusts Addenbrookes, Whipps Cross and hospices.**	3	5	15	11/18 Proposing escalation to ICP requires system discussion – to be agreed by Exec Team. **05/19> June 2019 Head of CHC due to meet with EPUT lead to discuss outcome of Admin review DST activity scoping to agree next steps on completion of the pilot period and D2A audit.**	3 x **4** = **12**	Last review date: **May 2019** Projected closure date: {**Ongoing**}

Risk ref + date added to register + responsible committee + corresponding Strategic Objective	Risk description and categories	Current controls	Impact	Likelihood	Current risk rating (I x L)	Future or additional controls / actions planned to mitigate risk	In year target risk rating (I x L)	Last review date + projected closure date
W227 September 2017 SO.1	Risk description: Essex wide health systems ability to manage any mass casualty event (including transport incidents, acts of terrorism, infectious diseases, CBRN) where number, type and severity of casualties could overwhelm the local health provision. Potential for associated risks includes: > distances of transfer times > ability to create space for admissions in specialist areas such as paediatrics, burns, trauma > ability to discharge / transfer patients to create space in specialisms > transport - the need to find alternative transport to EAST / the need to increase PTS provisions / availability > capacity concern regarding the ability of the acute trusts to take the recommended amount of P1 (priority one) casualties in the 1st 60 minutes **Risk categories: to be determined at next quarterly review (June 2019).**	Emergency Planning Team in place to support Essex CCGs. NHS England monitors UK terrorism threat level as health services are part of the response. CCGs assist with maintaining continuity and resilience within our health and social care system and providing mutual aid to our system partners. Core standards assurance process in place with NHS England Integrated Strategic Management for health training in place for acute, community and ccg on call directors (180 trained and assessed to date). Trained loggists (approximately 50) across Essex CCGs. Incident response and business continuity plans in place across system.	5	3	15	*Previous actions / comments archived.* 10/18 3rd draft of NE plan in place. Mid and South Essex workshop has taken place, report to be finalised with action plan and plan will be developed by end March 2019. CCG to now work with the EPT to arranged a workshop date in West Essex. **01/19> West Essex via the EPRR lead from PAH has set up a local EPRR forum; at the first meeting in January the requirement for West Essex to hold a non-acute mass casualty workshop was discussed . This will take place summer 2019** **NE and Mid and South Essex Plan is in development, NE plan in final draft due for completion and testing in June and Mid and South Essex Plan due for completion during 2019**	5 x 2 =10	**Subject to quarterly review** Last review date: **March 2019** Projected closure date: {Ongoing}