Appendix A: January 2017 Integrated Strategic Risk Register and Board Assurance Framework

United Lincolnshire Hospitals NHS Trust

2016/17 Assurance Framework: January 2017

Ref	Strategic Outcome	Strategic Risk	Potential Cause and Impact	Grade (including change in risk)			Target score	Key Controls	Mitigating actions	Three Lines of Defence			Gaps in control/assurance	Completion Date for Actions	Responsible Director	Escalation
				L	S	Rating				First	Second	Third				
S01	**Strategic Objective: Consistently high quality and safe patient care**															
S01:1.1	Positive patient experience	Failure to provide good quality and safe service	**Cause** ✓Uncontrolled urgent care demand, exceeding capacity ✓Efficiency programme impact upon safety or reduce patient safety ✓Inadequate staffing levels **Impact** ✓Poor patient experience and standards of care ✓Loss of reputation ✓Financial penalties ✓Regulatory intervention/action	4	4	16 Very High Risk ⟷		Quality Strategy	• SQD/safety thermometer data • RCA of SUIs • Ward triangulation metrics • Daily review of nurse staffing • Falls reduction plan • Sepsis reduction plan • Specialty governance reviews • Hygiene improvement plan • 7 day service plan • Patient safety walkrounds • Whistleblowing policy • Nursing workforce plan • Urgent care delivery plan including beds	• Quality metrics in monthly business unit reviews • Quality Strategy	• Quality report to Board • Audit of Quality Account • Reports from HR and OD Committee • Annual nursing review • Patient experience, safety and mortality committee reports escalating to QGC • Patient Safety Meetings	• Reports from QGC to Board • Reported elsewhere • Quality monitoring with CCG • NHSI external review (IDM) • Contract quality review with CCG	**Gaps in control** • Implementation of hygiene improvement plan, housekeeping resource • QIAs not yet completed **Gaps in assurance** • Insufficient backlog maintenance investment • Absence of investment in 7 day service plan • Unclear role of CEC for accountability	Completion of Quality milestones for the 2021 Programme to be monitored through the 2021 Programme Board.	Director of Nursing	**No change** **Reviewed by Quality Governance:note compliance and culture to be escalated**
S02	Strategic Objective: A clinically responsive organisation															
S02:2.1	Openness and transparency	Failure to provide good quality and safe service	**Cause** ✓Failure to meet quality strategy standards ✓Inadequately maintained or obsolete infrastructure ✓Harm or error resulting from a failure to meet safe and responsive standards **Impact** ✓Poor CQC rating ✓Loss of reputation ✓Regulatory intervention/action ✓Significant failure of services due to prolonged loss of infrastructure	3	4	12 High Risk ⟷		Clinical Governance	• Clinical Strategy/LHAC/STP • Nurse recruitment and retention plans • Service review programme • Patient experience strategy • Patient experience committee • Staff engagement plan • Leadership programme • Job planning • Appraisals • Service improvement programme	Patient Safety and Clincial Effectiveness Assurance Report. Quality Report. Medicines Safety Report.	• STP/LHAC/MTP update • Reports from HR and OD Committee • Reports from FSID • HR/OD report	Reported elsewhere • LHAC Programme Board • Patient experience committee reports to QGC	**Gaps in control** • LHAC implementation delayed • Service review programme just initiated • Key care pathways not yet identified for review (STP) • Developing performance framework **Gaps in assurance** • STP governance structure • Clinical Strategy implementation governance arranged	Completion of Hospital delivery and market share milestones for the 2021 Programme to be monitored through the 2021 Programme Board.	Director of Operations	**No change** **Reviewed by Quality Governance:note compliance and culture to be escalated**
S03	Strategic Objective: Services shaped around patients needs															
S03:3.1	Efficient and effective services	Failure to deliver change / transformation	**Cause** ✓Failure to deliver the Trust's clinical strategy/LHAC ✓Failure of clinical services to plan for the future and failure to modernise major care pathways **Impact** ✓Unsustainable services ✓Poor patient experience ✓Poor delivery of performance standards	4	4	16 Very High Risk ⟷		Clinical Strategy	• Clinical Strategy/LHAC/STP • Nurse recruitment and retention plans • Service review programme • Patient experience strategy • Patient experience committee • Staff engagement plan • Leadership programme • Job planning • Appraisals • Service improvement programme	• LHAC Programme Board • Patient experience committee reports to QGC CSIG	• STP/LHAC/MTP update • Reports from HR and OD Committee • Reports from FSID • HR/OD report • CSIG	• Reported elsewhere • LHAC Programme Board • Patient experience committee reports to QGC	**Gaps in control** • LHAC implementation delayed • Trust's medium term plan not yet finalised • Service review programme just initiated • Key care pathways not yet identified for review (STP) **Gaps in assurance** • STP governance structure • Clinical Strategy implementation governance arranged	Completion of Clinical Strategy milestones for the 2021 Programme to be monitored through the 2021 Programme Board.	Medical Director	**No change** **Reviewed by Quality Governance:note compliance and culture to be escalated**
S03:3.2	Efficient and effective services	Failure to mainain effective partnerships	**Cause** ✓Failure to plan collectively with local CCGs, Providers and Network providers ✓Failure to secure collaborative provision of service ✓Failure to provide adequate support for education ✓Failure to foster good potential relationships **Impact** ✓Unsustainable services in Lincolnshire ✓Loss of income ✓Loss of reputation	3	4	12 High Risk ⟷		Communication Strategy	• Developing partnership working. • Stakeholder management	• STP meetings • Governance Framework	Monthly updates to the Trust Board including progress against key controls.	• Reported through the 2 Year Operational Plan	**Gaps in control** • Need to align to the wider STP communication plan • Alignment to the Trust's 2 Year Opreational Plan adn 5 Year Strategy **Gaps in assurance** • Part of a wider Communication Plan for the 2021 Programme	Completion of Communication Plan milestones for the 2021 Programme which will outline each of theworkstream communication milestones to be monitored through the 2021 Programme Board.	Medical Director	**No change**

S03:3.3	Efficient and effective services	Failure to provide and maintain as statutorily required, premises where care and treatment are delivered from that are clean, suitable for the intended purpose, maintained and where required, appropriately located, in accordance with the NHS Constitution, CQC regulations and other statutory legal duties.	**Cause** ✓ Failure to plan effectively to deliver the built environment required for modern services ✓Failure to meet built environment statutory standards and best practice guidance ✓Failure to deliver a rolling programme of improvements ✓Failure to align current estates model to future clinical redesign Failure to invest in the built environment infrastructure to a sufficient level in both capital replacement and revenue maintenance over a prolonged period to ensure safety and reliability is assured **Impact** ✓Unsustainable services in Lincolnshire ✓Loss of income ✓Loss of reputation Potential to harm patients, Staff and Visitors, including prolonged outage and loss of clinical facility impacting on patient safety Failure to comply with legal requirements leading to prosecution	4	4	**16** **Very High Risk** ⟷		1. Backlog/ Maintenance Capital and Revenue Investment 2. Estates Strategy 3. Safety Governance Assurance Delivery of Revenue Compliance Plan 4. Quality Governance Assurance	• Delivery of 16/17 capital backlog investment programme. • Development of 17/18 and 5 year capital backlog investment programmes. • Delivery of 16/17 revenue maintenance resources. • Development of 17/18 and on-going revenue resources plans. • Delivery of Draft Technical Estates Strategy. • Estates Strategy alignment with Clinical Strategy, including input to LHAC. • Sale of land to release resources. • Re-quantification of backlog maintenance scale to support investment planning. • Electrical Infrastructure. • Mechanical Infrastructure. • Water Safety. • Asbestos Management. • Fire Safety. • EFM Quality Patient Environment - food/ cleaning/ physical environment • Energy and Sustainability	1, 2, 3 & 4. Progress monitored through estates program governance reporting to Director of Estates and Facilities.	1. Estates Capital Progress reporting to Trust IPB. 2. Progress Reporting to Estates Environment Committee & LHAC Estates Programme Board. 3. Progress Reporting to Estates Environment Committee, Trust IPC and Trust HSC. 4. Progress Reporting to Estates Environment Committee & Trusts Sustainable Development Committee.	1,2,3 &4 Estates Committee report to FSID. 1,2,3 &4 Estates National Reporting requirements through NHS PAM – for Trust Board Governance, National Estates performance data submissions (ERIC) and Lord Carter estates productivity and efficiency.	**Gaps in control** • Inadequate backlog maintenance funding capital/ revenue • Estates Strategy not complete • LHAC implementation/ clinical strategy delayed • Re quantification of backlog maintenance not yet complete **Gaps in assurance** • Programme management resources • Compliance evidence capture limited by revenue availability	1. 16/17 financial year 2. draft 2016/17, Land Sales 16/17, 17/18, backlog re quantification 16/17 fin year 3. Revenue Compliance Plan 16/17 and on-going 4. EFM Quality 16/17 & on-going Energy and Sustainability 16/17 & On-going	Director of Estates and Facilities	**No change** **Reviewed by FSID**
S04	Strategic Objective: Skilled, competent and motivated workforce															
S04:4.1	Sustainable service delivery	Failure to sustain adequate workforce	**Cause** ✓Poor workforce planning ✓Poor workforce intelligence systems ✓Recruitment and retention difficulties in "hard to get" skills ✓Poor recognition and reward mechanisms ✓Absence of new ways of working **Impact** ✓Failure to deliver sufficient capacity to meet contracted obligation ✓Poor patient experience and outcomes ✓Poor CQC rating, regulatory action ✓Loss of reputation	4	4	**16** **Very High Risk** ⟷		Workforce planning	• Appraisal system • Core learning • Nursing recruitment and retention plan (including agency reduction) • Engagement programme • Leadership charter • Leadership development programme • Medical staff improvement programme • Job plans	People Strategy in development with five year focus on right numbers of poepl with right skills. People Strategy Work Programme (Workforce Plan) with two year focus to reflect Operational Plan. KPIs have been identified to reflect priority areas, monitored by Board through performance report. Additional temporary resources allocated to HR. New HR structure being developed.	• HR and OD report to Board • HR and OD Committee report • Staff survey action plan • Annual nurse establishment review • Pulse check review by ET	• CQC • NHS Oversight • Internal Audit	**Gaps in control** • Low appraisal and core learning compliance **Gaps in assurance** • Lack of assurance and compliance with Trust values and behaviours • Medical staff improvement programme	Completion of Workforce Planning milestones for the 2021 Programme to be monitored through the 2021 Programme Board.	Director of HR	**Response received Amendments made**
S05	Strategic Objective: Performance Improvement															
S05:5.1	Continuous improvement	Failure to sustainan engaged workforce	**Cause** ✓Low levels of engagement, health and well being and satisfaction ✓Inadequate training, appraisals and development ✓Inadequate recognition of staff ✓Non adherence to Trust values and behaviours ✓Inconsistent leadership **Impact** ✓Poor patient experience and outcomes ✓Loss of reputation ✓Poor recruitment and retention prospects ✓Poor CQC results	3	4	**12** **High Risk** ⟷		Staff Engagement	• Engaging staff • Leadership development • Recognition strategies • Effective appraisals • Embedding values and behaviours	People Strategy in development with five year focus on right numbers of poepl with right skills. People Strategy Work Programme (Workforce Plan) with two year focus to reflect Operational Plan. KPIs have been identified to reflect priority areas, monitored by Board through performance report. Additional temporary resources allocated to HR. New HR structure being developed.	• HR and OD report to Board • HR and OD Committee report • Staff survey action plan • Annual nurse establishment review • Pulse check review by ET	• CQC • NHS Oversight • Internal Audit	**Gaps in control** • Currently shaping and setting up the 2021 Programme to deliver the MTP priorities. **Gaps in assurance** •	Completion of Staff Engagement milestones for the 2021 Programme to be monitored through the 2021 Programme Board.	Director of HR	**Response received Amendments made**
S05:5.2	Continuous improvement	Failure to maintain operational performance	**Cause** ✓Failure to deliver contractual/national performance targets ✓Failure to reduce delayed transfers of care ✓Failure to collect and report accurate data **Impact** ✓Intervention ✓Loss of STF and/or fines/penalties ✓Loss of reputation ✓Poor quality and patient experience ✓Failure to meet contractual obligations	4	4	**16** **Very High Risk** ⟷		Performance Management	• Urgent care plan (including bed capacity) • Lincolnshire SRG • Performance targets for CCGs/other providers in 2016/17 contract • Contract delivery plan • Winter plan • Urgent care improvement programme (including beds and QF3) • Cancer improvement plan • Performance Management Framework • Agreed local trajectories in contract with dependent target for CCSs/other trusts • SRG recovery plans • Data Quality Strategy	Performance Framework • Contract Assurance Board • Business Unit business review meetings • SRG minutes • Planned Care Board	• Performance Review • FSID report to Board	CCGs Contracting	**Gaps in control** • Insufficient bed capacity • No market repatriation plan • Unclear lines of accountability for CDs • Below trajectory perf in Q2 for cancer, A&E and Diagnostics. High risk of non delivery of RTT in July **Gaps in assurance** • Data Quality reporting	2016/17 urgent delivery plan agreed and resolved including bed plans. CMG/CEC role dfinition to be considered by TB Revised opening hours for GDH A&E to release Med staff	Director of Operations	**No change** **Reviewed by FSID**
S06	Strategic Objective: Financial stability and recovery															

S06:6.1	Value for money	Failure to achieve financial sustainability	**Cause** • Failure to deliver the financial plan • Failure to manage historic debt • Failure to deliver required levels of efficiency gain • Loss of market share/failure to regain market share • Failure to deliver contract with CCGs including application of financial penalties • Failure to control agency costs • Failure to deliver the STF **Impact** • Trust goes into administration, external intervention, regulatory action • Individual services not sustainable • Loss of reputation • Insufficient cash to be a going concern • Continual failure to deliver control total	4	4	**16** **Very High Risk** ⟷		Two-year Operational and Financial Plan	• Agreement of long term financial model. • Financial Strategy • Lines of financial accountability • Financial reporting to CEC, FSID and TB • Contract delivery plan • Urgent care delivery plan • Cancer, A&E plans • Efficiency programme • Business Unit review programme • Agency reduction plan • Liquidity plans agreed • FIP • Nursing recruitment strategy • Medical staff strategy	• Financial performance report • FSID report to Board • Efficiency programme update • Performance report • FIP	• Contract Assurance Board • Agency spend performance review by ET • FIMS return to NHSI • Efficiency programme overview by ET, CEC and CMB • Financial report to ET • IDM (NHSI) • Regular financial input to CMB • STF mitigation plan required	CCGs	Gaps in control • Gaps in delivery of efficiency programme • Long term efficiency programme not identified • Agency costs off trajectory for nursing • No market repatriation strategy Gaps in assurance • I &E forecast 2016/17 • Failure to achieve STF Funding	2017-19 Operational and Financial Plan outline report to November Board.	Director of Finance	**No change** **Reviewed by FSID**

Key

Risk Rating Key / Source - Risk Management Policy

Likelihood					
Almost Certain - 5	*Low risk 5*	*Moderate risk 10*	*Very high risk 15*	**Very high risk 20**	**Very high risk 25**
Likely – 4	*Low risk 4*	*Moderate risk 8*	*Moderate risk 12*	**Very high risk 16**	**Very high risk 20**
Possible – 3	*Low risk 3*	*Low risk 6*	*Moderate risk 9*	**High risk 12**	**Very high risk 15**
Unlikely – 2	*Low risk 2*	*Low risk 4*	*Low risk 6*	**High risk 8**	**High risk 10**
Rare – 1	*Low risk 1*	*Low risk 2*	*Low risk 3*	*Low risk 4*	*Low risk 5*
	Negligible – 1	**Minor – 2**	**Moderate – 3**	**Major – 4**	**Catastrophic – 5**
	Severity				

Lead officers will be asked to verify the status of each risk identfied within the Assurance Framework and the following colours will identify whether a risk has been updated.

Rating Change

⟷ No change in risk rating from previous version of assurance framework

↓ Risk rating has been downgraded from previous vesion of assurance framework

↑ Risk rating has been increased from previous version of assurance framework

Response received
No changes made

Response received
Amendments made