United Lincolnshire Hospitals NHS Trust

Risk Register									Board Assurrance Framework							
Ref	Strategic Outcome	Strategic Risk	Potential Cause and Impact	Grade (including change in risk) L	S	Rating	Target score	Key Controls	Mitigating actions	Three Lines of Defence First	Second	Third	Gaps in control assurance	Completion Date for Actions	Responsible Executive	Board Committee	Escalation
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 ✓Inadequate staffing levels **Impact** ✓Poor patient experience and standards of care ✓Loss of reputation ✓Financial penalties ✓Regulatory intervention/action • Increase in complaints • Failure to achieve Friends & Family Test percentage recommends targets	4	4	**16 Very High Risk** ⟷	**12**	QIA for all efficiency programme schemes Bi Annual Establishment Review to Trust Board Daily Operational Process for safe staffing A&E Delivery Board	Golden Hour • Clinical Cabinets • Ward Health Checks • Daily review of nurse staffing • Falls reduction plan • Sepsis reduction plan • Specialty governance reviews • Hygiene improvement plan • 7 day service plan • Patient safety walk rounds • Whistleblowing policy • Nursing workforce plan • Urgent care delivery plan including beds • Clinical Audit Plan • Ward Assurance through accreditation • FFT feedback • Complaints & PALS themes • Care Opinion feedback • National survey	Quality metrics in monthly business unit reviews • Quality Strategy //People Strategy agreed (as part of 2021) with five year focus on right numbers of people with right skills, motivated and managed to perform at their best. focus on clinical quality with daily, weekly monthly monitoring, corrective action and accountibility to through identified mitigations. focus on reduction in patient harm and best patient experience KPIs to be further developed. Engagement around quality strategy within 2021 is central to delivery of objective. Reviewing and seeking additional resources to drive forward key pieces of	• 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	• Regulator & partner oversightthrough SIB • CQC • 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	Quality Governance Committee	**No change**
S02	**Strategic Objective: A clinically responsive organisation**																
S02:2.1	Openness and transparency	Failure to provide clinically responsive organisation	**Cause** ✓Failure to meet quality 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 loss of staff	3	4	**12 High Risk** ⟷	**9**	Clinical Governance	• Compliance targets Specialty governance, Medical recruitment and retention plans, medical engagement work, ward accreditation, SI management and learning, Clincal service reviews, 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	Specialty governances, Local and national audits, best practice workstreams, SI monitoring and learning, Performance reporting, Patient Safety committee reviews and Clinical Effectiveness Assurance Report. Medicines Safety Report.	• Reports from QG Committee • Reports from FSID • HR/OD report	CQC, NHSI, NHSE reports and reviews • 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.	Medical Director and Director of Nursing	Quality Governance Committee	**No change**
S03	**Strategic Objective: Services shaped around patients' needs**																
S03:3.1	Efficient and effective services	Service delivery failure	**Cause** ✓Failure to recognise and implement change ✓Failure of clinical services to plan for the future and failure to modernise major care pathways ✓Failure to recognise and manage the resistance to change ✓ Failure to recruit to high levels of skilled medical staff ✓Failure to change and implement new and emerging medical technology ✓Failure to communicate change **Impact** ✓Unsustainable services ✓Poor patient experience ✓Poor delivery of performance standards ✓Failure to take account of what patients want ✓Failure to plan for the changing demand of services for increasing morbitity and ageing services	4	4	**16 Very High Risk** ⟷	**12**	Maintaining service delivery	• Quality Governance Compliance • Clinical Governance arrangements • Periodically review fragile services • Develop service review programme (GIRFT) with supporting action plans • Strengthening clinical governance arrangements, strengthening clinical engagement and leadership, • Patient Experience reviews • Developing and implementing Speciality Governance, Clinical Strategy and clinical service reviews, CESR. Pathway reviews, DTC & PACEFF, NICE Guidance implementation and audits • Developing the Engagement Strategy for the 2021 • Analysis of complaints and incidents • Performance clinics/reviews • Report to Regulators • Working with the STPs to align and integrate services • Workforce recruitment and training • Developing staff succession plans	Clinical Governance Reviews • Performance Reviews • Service Reviews, CESC, Pathway reviews, NICE Guidance implementation	2021 programme, Clinical Service Reviews, Trust Board Committees - FSID, QGC, WF&OD • CMB / CEC / ET • Medical Utilisation Group • CSIG • Contracting Assurance • CCG Reporting Assurance	• SET • LCB • NHS I / NHS E	Gaps in control • Detecting rogue practice, Not having an holistic review of services • Integrated information to provide a joined up picture at service line level Gaps in assurance • Local governance • Not having an agreed Clinical Strategy	Completion of Clinical Redesign by milestones for the 2021 Programme highlighted in the 2021 Strategy in October 2017	Medical Director	Finance, Service Improvement and Delivery Committee	**No change**
S03:3.2	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	**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	4	4	**16 Very High Risk** ⟷	**12**	1. Backlog/ Maintenance Capital and Revenue Investment 2. Estates Strategy 3. Safety Governance	• Delivery of 17/18 capital backlog investment programme. • Development of 5 and 10 year capital backlog investment programmes. • Delivery of 17/18 revenue maintenance resources. • Development of medium term on-going revenue resources plans. • Finalisation of Technical Estates Strategy from draft status. • Estates Strategy alignment with Clinical Strategy, including input to STP requirements. • Sale of land to release resources. • Re-quantification of backlog maintenance scale to support investment planning.	1, 2, 3 & 4. Progress monitored through estates program governance and Estates Environment and Infrastructure Committee reporting to FSID.	1. Estates Capital Progress reporting to Trust CRIB. 2. Progress Reporting to Estates Environment Committee 3. Reporting to governance committees, H&S Committee and IPC	1,2,3 & 4 Estates Infrastructure and Environment 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 to quickly resolve significant risks and high levels of backlog. • Estates Strategy not complete • Clinical strategy finalisation informing estates plan • Re quantification of backlog maintenance not yet fully completed Insufficient staff resources to manage	1. Medium term extended backlog plan 18/19 financial year 2. Estates Strategy finalisation 2018/19, 17/18, backlog re quantification 18/19 Q2. 3. Revenue Compliance Plan 17/18 and on-going 4. EFM Quality 18/19 & on-going Energy and Sustainability 18/19 & on-going plan.	Director of Estates and Facilities	Finance, Service Improvement and Delivery Committee	**No change**

		other statutory legal duties.	**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.					Assurance Delivery of Revenue Compliance Plan 4. Quality Governance Assurance	• Electrical Infrastructure. • Mechanical Infrastructure. • Water Safety. • Asbestos Management. • Fire Safety. • EFM Quality Patient Environment - food/ cleaning/ physical environment • Energy and Sustainability				EFM agenda. Workforce Planning insufficiently developed to maintain adequate EFM op resources **Gaps in assurance** • Programme management resources • Compliance evidence capture limited by revenue availability				
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	5	**20** **Very High Risk** ↔	**12**	People Strategy + Workforce Plans	• Appraisal system • Core learning • Revised approached to medical and nurse recruitment - key priority for Trust in 2017/18 • Engagement programme • Leadership charter • Leadership development programme • Engagement plan for medical staff • Job plans • Collective action in the East Midlands and continued efforts to turn locums into permanent members of staff to mitigate IR35	People Strategy developed with five year focus on right numbers of people with right skills. People Strategy Work Programme) sets out the actions to deliver the Strategy. KPIs have been identified to reflect priority areas (of which recruitment is one), monitored by Board through performance report. Workforce Plans will address one-year priorities around recruiting and retaining staff. Use of apprentices and development of new roles, plus review of skill mix within pathways will all, in longer term, help address issue Additional temporary resources to be allocated to HR to take forward recruitment work. being developed.	• Integrated Performance Report to Board & Workforce KPIs • Workforce and OD Committee Workforce Report Updates on progress on People Strategy • Annual nurse establishment review • Pulse check review by ET Work of Medical and Nursing Workforce Utilisation Groups - reviewed 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 & OD	Workforce and Organisational Development Committee	**No change**
S05	Strategic Objective: Performance Improvement																
S05:5.1	Continuous improvement	Failure to sustain an 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 ✓challenges caused by changes to tax arrangements for personal companies (IR35) **Impact** ✓Poor patient experience and outcomes ✓Loss of reputation ✓Poor recruitment and retention prospects ✓Poor CQC results	4	5	**20** **Very High Risk** ↔	**9**	Staff Engagement Plans within People Strategy	• Promoting core narrative around 2021 - vision for each site • Creating opportunities to listen to staff - Big Conversations/response to staff surveys • Leadership development • Recognition strategies • Effective appraisals • Well-being approach	People Strategy agreed (as part of 2021) with five year focus on right numbers of people with right skills, motivated and managed to perform at their best. Five year milestones in the People Strategy, which itself is part of 2021 programme, Output from staff survey will drive strategy and actions. KPis agreed and engagement index will feature in it. Engagement around 2021 vision and values a priority. Annual Workforce Operational Plan supports this. Priority for the Board and additional resources should be in place in Spring to drive forward initiatives.	•KPIs in Integrated Performance Report to Board • Workforce Report to Workforce and OD Committee • Regular staff surveys - national and local pulse checks • Senior Leadership Forum • Staff engagement group meets regularly to review our approach	• CQC • NHS Oversight • Internal Audit	**Gaps in control** • Programme of activity needs to be prioritised to reflect resources available. **Gaps in assurance** • Current staff survey scores show a workforce becoming less engaged. Variation too between Directorates and sites that needs to be addressed	People Strategy to be revised by May, with clear milestones and prioritised actions, linked to overall ULHT Operational Plan	Director of HR &OD	Workforce and Organisational Development Committee	**Risk increased**
S05:5.2	Continuous improvement	Failure to maintain operational performance	**Cause** ✓Failure to deliver contractual/national performance targets ✓Failure to collect and report accurate data ✓Insufficient workforce to meet demand ✓Demand exceeds available capacity **Impact** ✓Poor quality and patient experience ✓Loss of reputation ✓Failure to meet contractual obligations ✓Loss of STF and/or fines/penalties ✓Intervention	5	4	**20** **Very High Risk** ↑	**12**	Performance Management	• 2021 Improvement Worstreams for Theatres and Outpaitents Performance Management Framework • Constitutional Standards • Data Quality Strategy **RTT** • Demand and Capacity Review • Workforce Planning • Agency workforce ready review • Contract Delivery Plan • RTT Recovery and Delivery Group • Speciality Recovery Action Plans **Cancer** • Cancer Improvement Plan • Cancer Operational Committee • Cancer Recovery and Delivery Group **Urgent Care** • Urgent Care Improvement Plan • Bed Capacity Plan • Urgent Care Recovery and Delivery Group	• x2 weekly cancer and RTT meeting Project governance for outpatients and theatres Weekly urgent care oversight meeting Clinical Directorate Performance Reviews	• Integrated Performance Report to Trust Board Contract Assurance Board Performance Review • FSID report to Board	Monthly NHSI Performance Review Meetings A&E Delivery Board	**Gaps in control** • Insufficient workforce to meet demand • Insufficient investment to match resources to demand • Insufficient bed capacity • Appropriate Clinical Leadership **Gaps in assurance** • Data Quality reporting	• RTT Recovery more than 90% Nov 2018 • 4 hr recovery more than 90% Dec 2018 • Cancer 62 day more than 80% Dec 2018	Chief Operating Officer	Finance, Service Improvement and Delivery Committee	**No change**
S06	**Strategic Objective: Financial stability and recovery**																
S06:6.1	Value for money	Failure to achieve financial sustainability	**Cause** • Failure to deliver the long term 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 • Loss of financial control • Failure to plan for unforeseen events - e.g. fire • Failure to gain clinical engagement	5	4	**20** **Very High Risk** ↔	**12**	Long Term Financial Plan (2021 and STP) 2017/18 Financial Recovery Plan 3 Year Financial Recovery Plan Two-year Operational and Financial Plan Performance Accountability Framework	• Working Capital Plan • Agreement of long term financial model - Financial Recovery Plan • Lines of financial accountability • Financial reporting to CEC, CMB, FSID and TB • Contract delivery plan • Urgent care delivery plan • Cancer, A&E plans • Efficiency programme • Service Review Programme • Agency reduction plan	• Performance Accountability Management Reporting • Financial Performance Report • Financial Recovery Plan • Financial Turnaround Group • Finance Grip and Control	• FSID report to Board • Contract Assurance Board • Agency spend performance review by ET • Financial Recovery Plan overview by ET, CEC and CMB • Regular financial input to CMB / CEC • Financial Strategy Group • External Partners	• FIMS return to NHSI • CCGs • STP Financial Bridge • PerformanceReview Meeting (NHSI) • System Improvement Board (NHSI) • IDM (NHSI)	**Gaps in control** • Financial Management support to Directorates • Gaps in delivery of Finance Recovery Plan • Long term efficiency programme not identified • Agency costs off trajectory • No market repatriation strategy **Gaps in assurance**	2017/20 Financial Recovery Plan to October Board and NHSI submission 31st October Implementation of 2017/18 Financial Recovery Plan 30th November	Director of Finance	Finance, Service Improvement and Delivery Committee	**No change**

			Impact • Organisational continuity of services • Trust goes into financial special measures with external intervention and regulatory action • Insufficient cash to meet liabilities and impact on operational services • Individual services not sustainable with potential for closing services with detrimental impact on patients • Loss of reputation				Framework						• Financial Governance in development				

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 identified 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 version of assurance framework

Risk rating has been increased from previous version of assurance framework

Red Changes to risks since last reporting period

Response received
No changes made

Response received
Amendments made