

BOARD OF DIRECTORS

Agenda Item	P1/164/17	Date: 5th July 2017						
Subject /title	Board Assurance Framework 2017/18							
Author	Helen Porter, Director of Nursing and Quality							
Responsible Director	All Executive Directors							
Executive summary and key issues for discussion								
<p>The Board Assurance Framework (BAF) sets out the strategic risks against the achievements of the Trusts strategy. It enables the Board to monitor how internal governance arrangements support the achievement and delivery of the Trusts strategic objectives. The BAF is agreed annually by the Trust Board in May. It provides assurance to the Trust Board that strategic risks are being effectively managed and what further actions are required to further mitigate these risks.</p> <p>The Board Assurance Framework contributes to the effectiveness of the system of internal control in the Annual Governance Statement.</p> <p>The BAF contains the nine strategic priorities. Each priority has an identified lead Executive Director. Each priority is aligned to all relevant strategic objectives. Each strategic priority is delegated to a Board Committee by the Board.</p> <p>The BAF identifies the levels of assurance received.</p> <p>L1: Operational management L2: Oversight by Committee L3: Independent assurance (MIAA, inspections, reviews)</p> <p>In reviewing the BAF the Board will note any changes in the dashboard and the narrative in 'red' within each of the Strategic Priorities.</p> <p>The Board is asked to consider:</p> <ul style="list-style-type: none"> • The changes to the risk profiles and the updated assurances – identified in 'red' text. <p>To consider:</p> <ul style="list-style-type: none"> • If all strategic priorities have been identified • Review all controls and assurances and determine if these are sufficient • Are there any concerns? • Is the progress in mitigating the risks sufficient and timely • Is assurance proportionate to the level of risk? <p>Key:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Unchanged since last quarter</td> <td style="width: 50%; text-align: center;"></td> </tr> <tr> <td>Deteriorated since last quarter</td> <td style="text-align: center;"></td> </tr> <tr> <td>Improved since last quarter</td> <td style="text-align: center;"></td> </tr> </table>			Unchanged since last quarter		Deteriorated since last quarter		Improved since last quarter	
Unchanged since last quarter								
Deteriorated since last quarter								
Improved since last quarter								

Board Assurance Framework Dashboard

Board Assurance Framework Dashboard	
Part A: Commentary on Changes to the Strategic Risk Profile During the Last Quarter	Level of assurance
<p>Quality Committee</p> <p>No changes to overall risk scores in strategic priorities 1 and 4.</p> <p>Strategic priority 2 – all workforce risks are under review.</p>	
<p>Finance & Business Development Committee</p> <p>No changes to overall risk scores in strategic priorities 2, 5, 6, 7 and 9.</p> <p>Strategic priority 2 – all workforce risks are under review.</p>	
<p>Trust Board</p> <p>No changes to overall risk scores in strategic priorities 2, 4, 5, 6, 7 and 8</p> <p>Note - Strategic priority 2 – all workforce risks are under review.</p>	

Part B: Highlight report				
Strategic Priority	Current Risk Score	Progress update	Assurance	Page No'
Strategic Priority 1 Ensuring the delivery of high quality patient services (safety, experience and outcomes).	4 x 2 = 8	Safeguarding committee now well established. Annual report on compliance with emergency preparedness complete.		1
Strategic Priority 2 Ensuring the Trust has the appropriate, motivated and engaged workforce in place to deliver its strategy.	4 x 3 = 12	Overall risk score remains the same All workforce risks are under review		3
Strategic Priority 3 Ensuring financial sustainability and delivery of the financial plan	5 x 2 = 10	Overall risk score remains the same		5
Strategic Priority 4 Ensuring regulatory compliance with CQC, Monitor, and other relevant legislation.	4 x 2 = 8	The overall risk profile (Potential or actual risks (from <i>risk register</i>) shows no change in risk		7
Strategic Priority 5 Ensuring effective leadership within the Trust	4 x 3 = 12	Overall risk score remains the same		9
Strategic Priority 6 Ensuring the delivery of strategic transformation	5 x 3 = 15	The overall risk profile (Potential or actual risks (from <i>risk register</i>) shows no change in risk		11
Strategic Priority 7 Ensuring adequate infrastructure e.g. estates and IT	3 x 3 = 9	Overall risk score remains the same		13
Strategic Priority 8 Ensuring the alignment of the Trust's strategy with the strategies of key external stakeholders and responding effectively to the policy and commissioning environment	4 x 3 = 12	Revised assessment of risk due to increased risk associated with STP		15
Strategic Priority 9 Ensuring the Trust responds to the technical challenges of changes to cancer treatment.	4 x 3 = 12	Overall risk score remains the same		17

BAF Heat map (July 2017)

Strategic Priority

1. Ensuring the delivery of high quality patient services (safety, experience and outcomes).
2. Ensuring the Trust has the appropriate, motivated and engaged workforce in place to deliver its strategy.
3. Ensuring financial sustainability and delivery of the financial plan
4. Ensuring regulatory compliance with CQC, NHS Improvement, and other relevant legislation
5. Ensuring effective leadership within the Trust
6. Ensuring the delivery of strategic transformation
7. Ensuring adequate infrastructure e.g. estates and IT
8. Ensuring the alignment of the Trust's strategy with the strategies of key external stakeholders and responding effectively to the policy and commissioning environment
9. Ensuring the Trust responds to the technical challenges of changes to cancer treatment

LIKELIHOOD	Almost Certain	5	10	15	20	25
	Likely	4	8	12	16	20
	Possible	3	6	9	12	15
	Unlikely	2	4	6	8	10
	Rare	1	2	3	4	5
			Insignificant	Minor	Moderate	Major
IMPACT						

Strategic context and background papers (if relevant)

- 5 year Strategy
- Trust Business Plan 2017/18 – 18/19

Recommended Resolution

The Board approves the Board Assurance Framework 2017/18 updates.

Risk and assurance

This document contains the risks associated with the non-delivery of the strategic plan actions.

Link to CQC Regulations

Regulation 17: good governance

Resource Implications

N/A

Key communication points (internal and external)

Freedom of Information Status

<p>FOI exemptions must be applied to specific information within documents, rather than documents as a whole. Only if the redaction renders the rest of the document non-sensical should the document itself be redacted.</p> <p>Application Exemptions:</p> <ul style="list-style-type: none"> • Prejudice to effective conduct of public affairs • Personal Information • Info provided in confidence • Commercial interests • Info intended for future publication 	<p>Please tick the appropriate box below:</p> <table border="1" style="width: 100%;"> <tr> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td>A. This document is for full publication</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td>B. This document includes FOI exempt information</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td>C. This whole document is exempt under FOI</td> </tr> </table> <p>IMPORTANT:</p> <p>If you have chosen B above, highlight the information that is to be redacted within the document, for subsequent removal.</p> <p>Confirm to the Trust Secretary, which applicable exemption(s) apply to the whole document or highlighted sections.</p>	<input checked="" type="checkbox"/>	A. This document is for full publication	<input type="checkbox"/>	B. This document includes FOI exempt information	<input type="checkbox"/>	C. This whole document is exempt under FOI
<input checked="" type="checkbox"/>	A. This document is for full publication						
<input type="checkbox"/>	B. This document includes FOI exempt information						
<input type="checkbox"/>	C. This whole document is exempt under FOI						

Equality & Diversity impact assessment

Are there concerns that the policy/service could have an adverse impact because of:	Yes	No
Age		✓
Disability		✓
Sex (gender)		✓
Race		✓
Sexual Orientation		✓
Gender reassignment		✓
Religion / Belief		✓
Pregnancy and maternity		✓
Civil Partnership & Marriage		✓

If YES to one or more of the above please add further detail and identify if full impact assessment is required.

Next steps
The Assurance Framework will be delegated to the relevant committees
Appendices

Strategic Objectives supported by this report

Improving Quality	✓	Maintaining financial sustainability	✓
Transforming how cancer care is provided across the Network	✓	Continuous improvement and innovation	✓
Research	✓	Generating Intelligence	✓

Link to the NHS Constitution

Patients		Staff	
Access to health care	✓	<i>Working environment</i> Flexible opportunities, healthy and safe working conditions, staff support	✓
Quality of care and environment	✓	<i>Being heard:</i> <ul style="list-style-type: none"> • Involved and represented • Able to raise grievances • Able to make suggestions • Able to raise concerns and complaints 	✓
Nationally approved treatments, drugs and programmes	✓		
Respect, consent and confidentiality	✓		
Informed choice	✓	Fair pay and contracts, clear roles and responsibilities	✓
Involvement in your healthcare and in the NHS	✓	Personal and professional development	✓
Complaint and redress	✓	Treated fairly and equally	✓

Strategic Priority 1: Quality	Initial Risk Score	5 x 2 = 10	Target Risk Score (appetite)	5 x 1 = 5	Current Risk score	4 x 2 = 8
Ref 699	Strategic Priority			Executive Director	Board Committee	
Strategic Priority 1	Ensuring the delivery of high quality patient services (safety, experience and outcomes).			Director of Nursing and Quality	Quality Committee	

Ref	Potential or actual risks (from risk register)	June 16	Aug 16	Oct 16	Jan '17	Apr '17	July 17
728	Staffing levels not adequate to provide a safe service	5x2 = 10	5x2 = 10	5x2 = 10	5x2 = 10	5x2=10	5x2=10
614	Safeguarding compliance	4x1 = 4	2x3 = 6	2x3 = 6	2x3 = 6	2x3=6	2x3=6
724	Emergency planning processes not in place and embedded	4x1 = 4	4x2 = 8	4x2 = 8	4x2 = 8	4x2=8	4x2 = 8
725	Systems not robust to ensure learning and feedback from incident and complaints	4x3 = 12	4x3 = 12	4x3 = 12	4x3 = 12	4x3=12	4x3 = 12
497	Insufficient Radiologist capacity – impacting on reporting capacity, clinical support for radiographers administering contract agents, unable to progress plans for Radiologist input into planning	5x3 = 15	5x3 = 15	5x3 = 15	4x4 = 16	3x4=12	3x4 = 12

Impact on strategic initiatives		Potential consequences of the risk	
Ref	Objective	Owner	Key potential consequences of the risk
	Safety: Focus on falls. Development of a comprehensive falls prevention and management plan	DoN&Q	Patient harm
	Experience: Implementation of the Patient Experience Strategy	DoN&Q	Poor patient experience
	Effective: Improving the Quality of Mortality Review and Serious Incident Investigation and Subsequent Learning and Action	DoN&Q	Patient harm, reputational damage
	Deliver our contracted CQUINS	DoN&Q	Poor patient experience, reputational damage
	Develop a CCC: Living with and beyond cancer programme participating in the Merseyside and Cheshire / Cancer Alliance programme	DoN&Q	Poor patient experience

Positive assurances received (last 12 months)

Report ref	Positive assurance	Level of assurance	Evidence
	Report received		Date reported to committee
	Integrated Performance Report	L2	Monthly (Board) 5.4.17
	Infection Control Quarterly report	L2	21.6.16 – quarterly
	CQC In-Patient Survey	L3	21.6.16
	Security Annual Report	L2	26.4.16
	Emergency Preparedness, Resilience & Response Annual Report	L2	25.4.16
	Workforce reports	L2	26.4.16
	Quality Accounts (External Assurance - KPMG)	L3	20.5.16 – (Audit) & 25.5.16 - (Board)
	Organisation Patient Safety Report (NRLS)	L3	21.6.16
	Quality Strategy Action Plan	L2	21.6.16
	EPRR assurance report	L2	7.9.16 (Board)
	Infection Control Annual Report	L2	7.9.16 (Board)
	Integrated Care Directorate Performance Report	L1	16.8.16 (Executive Team)
	MIAA Medical Devices review: limited assurance	L3	27.7.16 (Audit Committee)
	MIAA Quality Spot Checks review: limited assurance	L3	26.10.16 (Audit Committee)
	MIAA Clinical Coding Audit 2016/17 – Significant Assurance	L3	1.3.17 (Board)
	MIAA Performance Management Review – Briefing note	L3	1.3.17 (Board)
	MIAA Medicines Optimisation Review – Significant Assurance	L3	1.3.17 (Board)
	Quality Strategy Action Plan	L2	18.1.17 (Quality)
	Quality Committee Performance Report	L2	18.1.17 (Quality)
	Safeguarding Adults & Children Annual Report 2016	L1	18.1.17 (Quality)
	Mortality Report	L1	27.2.17 (Management Group)
	MIAA Follow Up Report – Medical Devices Management 2016/17: Limited Assurance	L3	5.4.17 (Board)
	MIAA Follow Up Report – Quality spot check - 2015/16: Significant Assurance	L3	5.4.17 (Board)
	CQC In patient survey	L3	9.5.17 (Board)
	Quality Strategy Action Plan	L2	20.6.17 (Quality)
	Quality Performance Report	L2	20.6.17 (Quality)
	Quality Accounts (External Assurance - KPMG)	L3	23.5.17 (Board)
	Integrated Performance Report	L2	Monthly (Board) 9.6.17

Gaps in control / negative assurances				
Ref	Gap	Action Plan	Deadline	Owner
	Did not achieve Trust target for attributable pressure ulcers in 2016/17 however no lapse in care identified.	Monthly incident review panel chaired by DoN&Q	Ongoing	DoN&Q
	% of patients waiting longer than 30 minutes greater than target	Each directorate to have an action plan to reduce waiting times which is monitored in each performance review meeting.	Quarterly	GMs
	Sub-committee structure not in place	Develop sub-committee structure for approval at October Quality Committee as part of the wider Board committee review	October 2017	DoN&Q

Risk are controlled by	Reported to
------------------------	-------------

Ref	Control	Committee	Frequency	Q1	Q2	Q3	Q4
	Quality and Risk Policies	Audit summary to Quality Committee	Annual				
	Delivery of Quality Strategy	Quality Committee	Bi-monthly				
	Directorate performance reviews	Trust Board	Annually				
	HR policies	Audit summary to Quality Committee	Annual				

Strategic Priority 2: Workforce	Initial Risk Score	4 x 3 = 12	Target Risk Score (appetite)	3 x 2 = 6	Current Risk score	4 x 3 = 12
Ref 700	Strategic Priority			Executive Director	Board Committee	
Strategic Priority 2	Ensuring the Trust has the appropriate, motivated and engaged workforce in place to deliver its strategy.			CEO / Director of Workforce and OD	Finance & Business Development/ *Quality Committee/ ^Trust Board	

Ref	Potential or actual risks (from risk register)	June 16	Aug 16	Oct '16	Jan '17	Apr '17	Jul 17
474	Increased turnover and low retention rates	5x3 = 15	5x3 =15	4x3 = 12	4x2 = 8	4x3=12	4x3= 12
612	Medical workforce resistance to change	4x3 = 12	4x3 =12	4x3 = 12	4x3 = 12	4x3=12	4x3= 12
40	Operational effectiveness reduced due to diversion of management attention due to workload	3x3 = 9	3x3 =9	3x2 = 6	3x2 = 6	3x2=6	2x3= 6
542	Implementation of the Workforce Strategy falls behind the required timescale	5x3 = 15	5x3 =15	4x2 = 8	4x2 = 8	4x2=8	4x2= 8

Impact on strategic initiatives		Potential consequences of the risk	
Ref	Objective	Owner	Key potential consequences of the risk
	*Development of career frameworks	DoN&Q	Inability to optimise the workforce
	Delivery of key elements of the Workforce for the Future components of TCC including: <ul style="list-style-type: none"> Recruitment and retention strategy Training, education and development Strategy Succession planning Talent Management 	DoW&OD	Inability to optimise the workforce
	Implement new roles within CCC based on 'forerunner' pilots	DoW&OD	Inability to optimise the workforce
	Full implementation of new workforce roles to support the Future Clinical Model including development of physician associates, hybrid administrative roles	DoW&OD	Inability to optimise the workforce and deliver Transforming Cancer Care
	▲Development of the organisation culture recipe and programme of OD work to ensure that staff and services are prepared for the move to Liverpool and the CCC workforce brand is recognised.	DoW&OD	Inability to optimise the workforce and deliver Transforming Cancer Care

Positive assurances received (last 12 months)			
Report ref	Positive assurance	Level of assurance	Evidence
	Report received		Date reported to committee
	Staff survey deep dive	L3	26.4.16
	Workforce and OD report	L2	20.6.17 (Quality) 5.6.17 (Management Group) 5.4.17 (Board) - Quarterly
	Safe staffing levels report (nursing)	L2	5.4.16 (Board)
	Staff Friends and Family Test	L2	26.4.16
	Integrated Performance Report	L2	27.2.17 (Management Group) Monthly 1.3.17 (Board)
	Partnership Working Update	L2	9.6.17 - monthly (Board)
	Staff Engagement Event – feedback report	L1	22.04.16 (Executive team)
	Safe staffing report	L2	10.6.16
	Workforce race equality standard	L2	10.6.16
	MIAA Nurse revalidation review: no assurance level assigned	L3	27.7.16 (Audit Committee)
	MIAA Volunteer services review: limited assurance	L3	27.7.16 (Audit Committee)
	6 monthly safe staffing acuity report	L2	5.4.16 (Board)
	Employee Turnover & Retention Report	L1	18.1.17 (Quality)
	Staff Survey Results	L3	27.2.17 (Management Group)
	MIAA Follow Up Report – Volunteer Services 2016/17: Significant Assurance	L3	5.4.17 (Board)
	Workforce & OD Report – Quarterly report	L2	5.4.17 (Board)
	Workforce & OD Report	L2	24.04.17 (Management Group) 25.04.17(Quality)
	Staff Survey Deep dive	L2	25.04.17(Quality)

Gaps in control / negative assurances				
Ref	Gap	Action Plan	Deadline	Owner
	Increase in absence rates. Currently 4.14% (March 2017)	HR surgeries between HR Advisors and Managers	On-going	DoWOD
	Increase in staff turnover above target throughout 2016/17	Analysis of exit interviews and PADR process to include career planning questions re Liverpool	April 2016	DoWOD
	Agency spend breached cap for 2016/17 and projections for 2017/18 are high due to medical locum cover	Workforce Redesign Group implemented	Jan 2017	DoWOD
	Staff results relating to PADR, staffing levels and conflicting priorities, stress related absence and pressure to come to work, and reporting of incidents relating to bullying and harassment,	Staff survey action plan in development and team working closely with directorates and corporate depts to address areas for improvement.	April 2017	DoWOD

Risk are controlled by		Reported to					
Ref	Control	Committee	Frequency	Q1	Q2	Q3	Q4
	HR Policies	Audit summary to Quality Committee	Annual				
	Delivery of Workforce and OD Strategy	Quality Committee and Board	Quarterly				
	Workforce plans	Finance and Business Development committee	Annually				

Directorate performance reviews	Trust Board	Annually			
---------------------------------	-------------	----------	--	--	--

Strategic Priority 3: Finance	Initial Risk Score	5 x 3 = 15	Target Risk Score (appetite)	3 x 3 = 9	Current Risk score	5 x 2 = 10
Ref 701	Strategic Priority			Executive Director	Board Committee	
Strategic Priority 3	Ensuring financial sustainability and delivery of the financial plan			Deputy CEO / Director of Finance	Finance & Business Development	

Ref	Potential or actual risks (from risk register)	June 16	Aug 16	Sep 16	Nov 16	Jan 17	Apr '17	June 17
752	Commissioners do not honour the £12m	5 x 2 = 10	4x4=16	REMOVE				
	Non-compliance with Continuity of Service rating	5 x 1 = 5	5 x 1 = 5	5 x 1 = 5	5 x 1 = 5	5 x 1 = 5	5x1=5	5x1 = 5
169	Income plan from PPJV not reached	3 x 3 = 9	3 x 3 = 9	3 x 3 = 9	3 x 3 = 9	3 x 3 = 9	3x3=9	2x2 = 4
27	Non-delivery of CIP	5 x 2 = 10	4 x 3 = 12	4x3=12	4x3 = 12			
34	Loss of activity associated with clinical income	4 x 3 = 12	4X3=12	4X3 = 12				
	Capital programme overspends	4 x 2 = 8	3 x 5 = 15	4 x 2 = 8	4 x 2 = 8	4 x 2 = 8	4X2=8	4X2 = 8
738	Difficulties with accurate data collection post Meditech implementation impacting on cancer waiting time and performance data				5 x 3 = 15	3 x 4 = 12	3x4=12	2x3 = 6
745	Organisation culture not fit for purpose to develop and deliver the Trust's business plan				4 x 3 = 12	4 x 3 = 12	4x3=12	4x3 = 12

Impact on strategic initiatives		Potential consequences of the risk	
Ref	Objective	Owner	Key potential consequences of the risk
	Embed new commissioning arrangements e.g. CCG commissioning	Deputy CEO / DoF	Inability to meet financial obligations
	Deliver the CIP programme	DoT&I	Business case not deliverable.
	Ensure achievement of the agency cap through a system of agency control	DoW&OD	Inability to meet financial obligations Risk to compliance with the Trust Licence
	Achieve an underlying annual surplus of a minimum of 1% of turnover	Deputy CEO / DoF	Inability to meet financial obligations
	Deliver the Trust's Capital Programme	Deputy CEO / DoF	Poor estate
	Deliver the Trust's financial control totals	Deputy CEO / DoF	Inability to meet financial obligations
	Ensure the new H-O service delivers planned surplus	DoT&I	Inability to meet financial obligations
	Ensure a 'Use of Resources' rating of at least 2	Deputy CEO / DoF	Inability to meet financial obligations Risk to compliance with the Trust Licence

Impact on strategic initiatives		Potential consequences of the risk	
Ref	Objective	Owner	Key potential consequences of the risk
	Review and identify other business /entrepreneurial opportunities , for the Trust	Deputy CEO / DoF	Inability to meet financial obligations
	Ensure each of the Trust's subsidiary companies are on trajectory to deliver agreed dividends.	Deputy CEO / DoF	Inability to meet financial obligations

Positive assurances received (last 12 months)			
Report ref	Positive assurance	Level of assurance	Evidence
	Report received		Date reported to committee
	Annual audit of accounts	L3	19.5.17 (Audit Committee)
	Finance report	L2	31.5.17 (Finance & Business)
	Finance report	L2	9.6.17 (Trust Board)
	Integrated Performance Report	L2	Monthly (Management Group) 5.6.17 Monthly (Board) 9.6.17
	Directorate Performance Reports	L1	May 16 (Executive team)
	Monitor risk rating	L3	30.3.16 quarterly (Board)
	Clatterbridge Pharmacy Report (CPL)	L2	25.1.17 quarterly (F&BD)
	Clatterbridge Private Clinic – Financial Sustainability Review	L2	10.6.16 (Trust Board)
	Cost Improvement Programme review (MIAA)	L3	27.4.16 (Audit)
	HR Payroll Review (MIAA)	L3	27.4.16 (Audit)
	Capital Programme Management	L3	27.4.16 (Audit)
	Integrated Care Directorate Performance Report	L1	16.8.16 (executive Team)
	FBC Approval received, confirmation of Green risk rating (NHSI)	L3	6.7.16 (Trust Board)
	NHS Improvement – Q1 Feedback	L3	2.11.16 (Trust Board)
	CIP Review (MIAA) – Significant Assurance	L3	25.1.17 (Audit)
	Reference Costs & Service Line Reporting	L1	30.1.17 (Management Group)
	Clatterbridge Private Clinic	L2	9.6.17 quarterly (Board)
	17/18 CIP programme approval	L2	1.3.17 (Board)
	Two Year Financial Plan 2017/18 – 2018/19	L2	1.3.17 (Board)
	Finance report	L2	monthly (Management Group) 27.2.17 1.3.17 monthly (Board) 29.3.17 monthly (F&BD)
	MIAA Follow Up Report – CIP 2016/17: Significant Assurance	L3	5.4.17 (Board)
	MIAA Follow Up Report – SLA Contract Management 2015/16: Significant Assurance	L3	5.4.17 (Board)

Gaps in control / negative assurances				
Ref	Gap	Action Plan	Deadline	Owner
	Monitor approval of FBC not completed – Verbal Approval received. Awaiting formal confirmation of Green Risk Rating	Monitor review completed	June 2016	Dep CEO/ DoF

Risk are controlled by		Reported to					
Ref	Control	Committee	Frequency	Q1	Q2	Q3	Q4
	Finance Policies						
	Delivery of Workforce and OD Strategy	Quality Committee	Quarterly				
	Workforce plans	Finance and Business Development committee	Annually				
	Directorate performance reviews	Trust Board	Annually				
	Block contract with Commissioners						
	Cost Improvement Programme 2016/17	Finance and Business Development	Bi-monthly				

Strategic Priority 4: Compliance	Initial Risk Score	4 x 3 = 12	Target Risk Score (appetite)	3 x 2 = 6	Current Risk score	4 x 2 = 8
Ref 702	Strategic Priority			Executive Director	Board Committee	
Strategic Priority 4	Ensuring regulatory compliance with CQC, NHS Improvement, and other relevant legislation.			Director of Nursing and Quality	Quality Committee/ ^Trust Board	

Ref	Potential or actual risks (from risk register)	June 16	Aug 16	Oct '16	Jan '17	Apr '17	Jul '17
143	Failure to comply with IRR and IR(me)R	5 x 2 = 10	3x2 = 6	3x2 = 6	3x3 = 9	3x3 = 9	3x3 = 9
726	Ineffective health and safety processes	5 x 2 = 10	5 x 2 = 10	5x2 = 10	5x2 = 10	5x2 = 10	5x2 = 10
763	Failure to comply with NHS Improvement licence conditions	4 x 2 = 8	4 x 2 = 8	4x2 = 8	4x2 = 8	4x2 = 8	4x2 = 8
702	Failure to comply with CQC fundamental standards	5 x 1 = 5	5 x 1 = 5	5x1 = 5	4x2 = 8	4x2 = 8	4x2 = 8
392 & 62	Failure to comply with other legislation	4 x 2 = 8	4 x 2 = 8	4x2 = 8	3x2 = 6	3x2 = 6	3x2 = 6
505	Breach of C diff target of no more than 1 (Monitor de-minimus is 12)	4 x 4 = 16	4 x 4 = 16	4x3 = 12	4x3 = 12	4x3 = 12	3x3 = 9
	Failure to comply with MHRA regulations	4 x 3 = 12	4 x 3 = 12	4x3 = 12			

Impact on strategic initiatives		Potential consequences of the risk	
Ref	Objective	Owner	Key potential consequences of the risk
	▲ Deliver the CQC inspection mandated action plan and report progress to the CQC	DoN&Q	Regulatory intervention Impact on quality and safety of patient care Reputational damage
	Deliver the overall CQC inspection action plan	DoN&Q	Impact on quality and safety of patient care
	Prepare for the new CQC and NHSI assessment and inspection regimes to maintain and enhance Outstanding rating	DoN&Q	Regulatory intervention
	Ensure processes are in place to ensure compliance with the new IR(me)R / IRR regulations	DoN&Q	Regulatory intervention

Positive assurances received (within last year)

Report ref	Positive assurance	Level of assurance	Evidence
	Report received		Date reported to committee
	6 monthly CQC compliance	L2	30.9.16
	Health and Safety Annual report	L2	26.4.16
	IR(ME)R / Radiation Protection Annual Report	L1	23.4.16 (Radiation Protection Committee)
	Integrated Performance Report	L2	Monthly (Management Group) 27.2.17 Monthly (Board) 1.3.17
	Monitor Quarterly Report - Feedback	L3	30.3.16 (Board)
	Annual Report & Accounts (inc Quality Report) – KPMG	L2, L3	20.5.16 – (Audit Committee) 27.5.16 - (Board)
	Well-led Governance Review – Deloitte	L3	4.5.16 (Board)
	Emergency Preparedness, Resilience and Response Annual report	L2	21.6.16
	Well led governance review action plan update	L2	2.11.16 (Board)
	Verbal report to Health and Safety Committee on new Electromagnetic fields at work regulations	L1	9.8.16 (Health and Safety Committee)
	NHS Improvement – Q1 Feedback	L3	2.11.16 (Trust Board)
	MIAA Assurance Framework Review	L3	17.3.17 (Audit – 26.4.17)
	MIAA Information Governance Toolkit Assurance Report	L3	25.4.17 (Quality)
	Health and Safety Annual report	L2	25.4.17
	IR(ME)R / Radiation Protection Annual Report	L1	27.4.17 (Radiation Protection Committee)
	Annual Report & Accounts (inc Quality Report) – KPMG	L2, L3	23.5.17 - (Board)

Gaps in control / negative assurances				
Ref	Gap	Action Plan	Deadline	Owner
	CQC inspection mandated action plan.	Progress monitored through Quality Committee	July 2017	DoN&Q
	New IR(me)R / IRR regulations not yet published	Review of consultation documents	TBC	DoN&Q

Risk are controlled by		Reported to					
Ref	Control	Committee	Frequency	Q1	Q2	Q3	Q4
	CQC Fundamental Standards Policy	Quality Committee	Annually				
	Directorate performance reviews	Trust Board	Annually				
	Health and Safety Policies	Quality Committee	Annual report				
	IR(me)R and IRR policies and procedures	Quality Committee	Annual report				
	Emergency preparedness policies	Quality Committee	Annual report				

Strategic Priority 5: Leadership	Initial risk score	4 x 3 = 12	Target Risk Score (appetite)	4 x 2 = 10	Current Risk score	4 x 3 = 12
	Ref 703	Strategic Priority			Executive Director	Board Committee
Strategic Priority 5	Ensuring effective leadership within the Trust			CEO / Director of Workforce and OD	Trust Board / Finance & Business Development	

Ref	Potential or actual risks (from risk register)	June 16	Aug 16	Oct '16	Jan '17	Apr '17	June 17
	Lack of clarity on accountability and delegated authority	4 x 2 = 8	4x2 =8	4x2 =8	4 x 2 = 8		3 x 2 = 6
	Lack of leadership skills, knowledge and capacity	4 x 2 = 8	4x2 =8	4x2 =8	4 x 2 = 8		4 x 2 = 8
	Inadequate execution of development plans and delivery against operational targets	5 x 2 = 10	5x2 =10	5x2 =10	5 x 2 = 10		5 x 2 = 10
	Lack of effective succession planning for Executive Directors, Senior Managers (including clinical leaders) and subject matter experts (including clinical staff)	4 x 3 = 12	4x3 =12	4x3 =12	4x3 = 12		3 x 3 = 9

Impact on strategic initiatives		Potential consequences of the risk	
Ref	Objective	Owner	Key potential consequences of the risk
	Develop: <ul style="list-style-type: none"> A Corporate Strategy process A new trust multi- year Corporate Strategy to inform and be informed by relevant supporting strategies and wider context e.g. C&M 5YFV, C&M Cancer Strategy, Cancer Alliance and Commissioner strategies as appropriate 	CEO	Sub optimal governance
	Prepare for the new Well-Led annual inspections including a self-assessment against the new CQC KLOEs as part of the Trusts annual governance self-assessment and revision of the Well led review action plan	DoN&Q	Negative impact on ability to take a leadership role in the health economy.
	^o Delivery of key elements of the Workforce for the Future components of TCC including: <ul style="list-style-type: none"> Leadership development strategy 	DoW&OD	Inability to optimise the workforce

Positive assurances received

Report ref	Positive assurance	Level of assurance	Evidence
	Report received		Date reported to committee
	Well-led Governance Review – Deloitte	L3	11.3.16 (Board Development)
	CEO report: Cheshire and Merseyside Sustainability and Transformation Plan	L2	30.3.16
	CEO report: sustainability and transformation plan footprint	L2	24.2.16
	Summary clinical model	L2	24.2.16 (part 2)
	Research strategy update	L2	21.6.16
	CEO Report: Sustainability and transformation plan update	L2	10.6.06
	CEO Report: STP (5YFV) update	L2	1.2.17 (Part 1)
	CEO Report: Cancer Alliance update	L2	1.2.17 (Part 1)
	Building the Trust Strategy (Board Development)	L1, L3	1.2.17 & 10.3.17
	Developing our Strategy	L1	13.2.17 (Management Group)
	Developing our Strategy (Board Development)	L1	9.6.17

Gaps in control / negative assurances				
Ref	Gap	Action Plan	Deadline	Owner
	MC Lung cancer report	Fund the appointment of a Consultant Medical Oncologist and lung cancer research nurse.	July 2016 Completed	MD
	Lack of reporting on internal leadership capacity or capability	For review	July 2017	CEO
	Comprehensive succession planning	Undertake a baseline review	September 2017	CEO

Risk are controlled by		Reported to					
Ref	Control	Committee	Frequency	Q1	Q2	Q3	Q4
	Research Strategy	Quality Committee					
	Transformation Programme	Finance and Business Development Committee					
	Workforce and Organisation Development Strategy	Quality Committee					
	Transformation Programme (Workforce for the Future pillar)	Finance and Business Development Committee					

Strategic Priority 6: Transformation	Initial Risk Score	4 x 4 = 16	Target Risk Score (appetite)	4 x 3 = 12	Current Risk score	5 x 4 = 20
Ref 704	Strategic Priority			Executive Director	Board Committee	
Strategic Priority 6	Ensuring the delivery of transformation			Director of Transformation and Innovation	Finance & Business Development / ^Trust Board	

Ref	Potential or actual risks (from risk register)	June 16	Aug 16	Sep 16	Nov 16	Jan 17	Apr '17	June 17
23,482	TCC: Scheme affordability – escalating costs	5 x 2 = 10	5 x 3 = 15	5 x 5 = 25	4x3 = 12			
27	TCC: Scheme affordability – The required annual CIP savings are not fully delivered	4 x 3 = 12	4x3 = 12					
601	Slippage on the programme to construction commencement	5 x 3 = 15	5x3 = 15					
543	Failure to deliver effective integration of haemato-oncology services causes clinical, performance and financial risks to CCC	4 x 3 = 12	4 x 2 = 8	4 x 2 = 8	4x1 = 4			
721	Integrating HO Services into CCC Meditech / E-prescribing	2 x 5 = 10	2 x 5 = 10	4 x 4 = 16	3 x 3 = 9	3 x 3 = 9	3 x 3 = 9	3x5 = 15
741	Transformation programme fails to deliver required service delivery models, creating clinical, performance, financial and reputational risks	3 x 5 = 15	3 x 4 = 12	3 x 4 = 12	4x3 = 12			
693	Risk of loss of key staff due to changes to working practices				5 x 3 = 15	5 x 3 = 15	4 x 3 = 12	4x3 = 12

Impact on strategic initiatives		Potential consequences of the risk	
Ref	Objective	Owner	Key potential consequences of the risk
	▲ Ensure the construction of the new Clatterbridge Cancer Centre – Liverpool remains on track	Deputy CEO / DoF	Inability to deliver the whole transformation programme.
	▲ Agree detailed move plans to safely transfer staff and services into new CCC-Liverpool	Deputy CEO/FD	Inability to deliver the whole transformation programme.
	Complete the safe and effective management transfer of haemato-oncology services from Royal Liverpool into CCC	DoT&I	Inability to deliver the whole transformation programme.
	Develop a Case for Change for the integration of Aintree and Southport Haemato-oncology services	DoTI	Inability to deliver the whole transformation programme.
	Finalise and begin the implementation of the new CCC Clinical Model	MD	Inability to deliver the whole transformation programme.

Positive assurances received (within last 12 months)			
Report ref	Positive assurance	Level of assurance	Evidence
	Report received		Date reported to committee
	Haemato – Oncology Integration - Project Assurance (MIAA) – Significant Assurance	L3	25.1.17 (Audit)
	Haemato-oncology Transfer Due Diligence Report	L3	7.12.16 (Board – Part 2)
	TCC Borrowing Approval Submission	L2	7.12.16
	Cancer Pathways (Deep Dive Presentation)	L1	18.1.17 (Quality)
	CEO Report: STP (5YFV) update	L2	1.2.17 (Board - Part 1)
	TCC: Build for the Future	L2	Monthly (Board – Part 2) 1.3.17
	TCC: Integrated Performance Review	L2	22.2.17 (F&BD)
	Haemato-oncology draft Heads of Agreement	L3	1.3.17 Board
	Haemato-oncology Head of Agreement	L1,L3	29.3.17

Gaps in control / negative assurances				
Ref	Gap	Action Plan	Deadline	Owner

Risk are controlled by		Reported to					
Ref	Control	Committee	Frequency	Q1	Q2	Q3	Q4
	Transformation Programme	Finance and Business Development committee	Quarterly				
	Workforce plans	Finance and Business Development committee	Annually				

Strategic Priority 7: Infrastructure	Initial Risk Score	3 x 3 = 9	Target Risk Score (appetite)	3 x 2 = 6	Current Risk score	3 x 3 = 9
Ref 705	Strategic Priority			Executive Director	Board Committee	
Strategic Priority 7	Ensuring adequate infrastructure e.g. Estates and IT			Dep CEO / Director of Finance	Finance & Business Development / ^Trust Board	

Ref	Potential or actual risks (from risk register)	June 16	Aug 16	Sep 16	Nov 16	Jan 17	Apr '17	June 17
729	Poor maintenance of medical equipment	5 x 2 = 10	4 x 2 = 8	4 x 2 = 8	4 x 2 = 8	4 x 2 = 8	4 x 2 = 8	4 x 2 = 8
	Ineffective delivery of facilities services	3 x 2 = 6	3 x 2 = 6	3 x 2 = 6	3 x 2 = 6	3 x 2 = 6		Remove
361	Risks to clinical operations in the event of unavailability of the EPR. Most likely at 'go-live' (May 2016) but also at other times due to connectivity issues at other Trusts	5 x 2 = 10	5 x 2 = 10	4 x 3 = 12				
162	Capital programme not delivered	3 x 2 = 6	3 x 2 = 6	3 x 3 = 9	3 x 3 = 9	3 x 3 = 9	3 x 3 = 9	3 x 3 = 9
556	Risks associated with the implementation of EPR	5 x 2 = 10						
372	Safe systems not in place for water safety	3x3 = 9	3 x 3 = 9	3 x 3 = 9	3 x 3 = 9	3 x 3 = 9	3 x 3 = 9	3 x 3 = 9
705	Lack of adequate IT infrastructure	4 x 2 = 8	4 x 2 = 8	4 x 2 = 8	3 x 3 = 9	3 x 3 = 9	3 x 3 = 9	3 x 3 = 9

Impact on strategic initiatives		Potential consequences of the risk	
Ref	Objective	Owner	Key potential consequences of the risk
	Review and refresh the IM+T strategy including full EPR implementation.	Deputy CEO / DoF	Ineffective patient management.
	Implement Meditech and E-prescribe into HO service	Deputy CEO / DoF	Non-compliance with contractual obligations
	Development of high speed 4G connectivity for clinicians and staff on the move,	Deputy CEO / DoF	Ineffective patient management.
	▲ Extend the scope of PropCare	Deputy CEO / DoF	Sub optimal utilisation of PropCare
	▲ Commence detailed planning work for investment into CCC-Wirral site	Deputy CEO/DoF	Inability to deliver the whole transformation programme.

Positive assurances received			
Report ref	Positive assurance	Level of assurance	Evidence
	Report received		Date reported to committee
	Post Implementation EPR briefing (verbal)	L2	10.6.16 (Board)
	Establishment of PropCare	L2	27.5.16 (Board)
	PropCare Project Steering Group	L1	Bi-weekly
	PropCare Board Meeting (1 st Meeting)	L2	13.6.16
	Health and Safety Annual Report	L2	26.4.16
	Integrated Performance Report	L2	Monthly (Management Group) 27.2.17 Monthly (Board) 1.3.17
	Emergency Preparedness, Resilience and Response (EPRR) assurance process (LHRP)	L3	7.9.16 (Board)
	IT Asset Management Review – Limited Assurance (MIAA)	L3	26.10.16 (Audit)
	IT Service Desk Review – Limited Assurance (MIAA)	L3	26.10.16 (Audit)
	MIAA Cyber Security maturity baseline - Assurance not applicable	L3	25.1.17 (Audit)
	EPR Residual Issues Update	L2	22.2.17 (F&BD)
	Capital Programme 2017/18 – 2018/19	L1	22.2.17 (F&BD) 1.3.17 (Board)
	Estates Annual Compliance Statement	L1	18.1.17 (Quality)
	MIAA Information Governance Toolkit Assurance Report	L3	25.4.17 (Quality)
	MIAA Follow Up Report – Energy Management 2014/15: Significant Assurance	L3	5.4.17 (Board)
	Cyber Security briefing	L1	31.3.17 (Board)
	PropCare – Partnership Agreement	L1,L3	31.5.17 (Board)

Gaps in control / negative assurances				
Ref	Gap	Action Plan	Deadline	Owner
	Low levels pseudomonas in the ward water supply	Implement of copper and silver in water system – Now installed	June 2016	Head of Estates.

Risk are controlled by		Reported to					
Ref	Control	Committee	Frequency	Q1	Q2	Q3	Q4
	Health and Safety Policies		Annual				
	Security policies						
	Delivery of Estates Strategy		Quarterly				
	Workforce plans	Finance and Business Development committee	Annually				
	Directorate performance reviews	Trust Board	Annually				
	Business continuity policies						
	Capital programme						
	IM&T strategy						

Strategic Priority 8: External	Initial Risk Score	5 x 2 = 10	Target Risk Score (appetite)	5 x 2 = 10	Current Risk score	4 x 3 = 12
Ref 706	Strategic Priority			Executive Director	Board Committee	
Strategic Priority 8	Ensuring the alignment of the Trust's strategy with the strategies of key external stakeholders and responding effectively to the policy and commissioning environment			CEO	Trust Board	

Ref	Potential or actual risks (from risk register)	June 16	Aug 16	Sep 16	Nov 16	Jan 17	Apr '17	June '17
732	Lack of influence in the local health economy and the development of the STPs	5 x 2 = 10	4 x 3 = 12					
733	Poor engagement with external stakeholders	5 x 2 = 10						
734	Poor operational performance in peripheral clinics impacting adversely on host organisations	4 x 2 = 8	2 x 5 = 10	2 x 3 = 6				
735	The Trust's current/future clinical model is not supported by all key stakeholders	5 x 3 = 15						

Impact on strategic initiatives		Potential consequences of the risk	
Ref	Objective	Owner	Key potential consequences of the risk
	Fully participate in the C&M 5YFV and LDS structures to promote cancer as a priority and monitor alignment with CCC's developing Corporate Strategy	CEO	Negative impact on ability to take a leadership role in the health economy.
	Fully participate in the Cancer Alliance (including CEO role as SRO) monitoring alignment with CCC's developing Corporate Strategy	CEO	Negative impact on ability to take a leadership role in the health economy.
	Develop the partnerships required to deliver the revised corporate strategy, e.g. <ul style="list-style-type: none"> Other providers Research collaborations 	CEO	Negative impact on ability to take a leadership role in the health economy. Risk to current business model
	Respond to recommendations of University of Liverpool Clinical Research Review	MD	Negative impact on ability to take a leadership role in the health economy.

Positive assurances received			
Report ref	Positive assurance	Level of assurance	Evidence
	Report received		Date reported to committee
	CEO report: sustainability and transformation plan footprint	L2	24.2.16
	Summary clinical model	L2	24.2.16 (part 2)
	Review of external environment for strategic planning	L2	10.6.16 (Board)
	Deloitte Well-Led Review	L3	04.05.16 (Board)
	Full Business Case (includes Commissioner support)	L3	30.03.16 (Board)
	FBC Approval received, confirmation of Green risk rating (NHSI)	L3	6.7.16 (Trust Board)
	CEO Report: STP (5YFV) update	L2	1.2.17 (Part 1)
	CEO Report: Cancer Alliance update	L2	1.2.17 (Part 1)
	Building the Trust Strategy (Board Development)	L1, L3	1.2.17 & 10.3.17
	Cancer Pathways (Deep Dive Presentation)	L1	18.1.17 (Quality)
	Developing our Strategy	L1	13.2.17 (Management Group)
	Developing our Strategy (Board Development)	L1	9.6.17

Gaps in control / negative assurances				
Ref	Gap	Action Plan	Deadline	Owner
	National/Regional model of governance to oversee the delivery of the Achieving World Class Cancer Outcomes Strategy (e.g. Cancer Alliances?)b and CCC role	CCC in dialogue with the Specialised Commissioning and the Strategic Clinical Network Still Work in progress CCC CEO taking the SRO role for Cancer cross cutting theme for Cheshire & Merseyside STP – complete	Autumn 2016	CEO

Risk are controlled by		Reported to					
Ref	Control	Committee	Frequency	Q1	Q2	Q3	Q4
	5 year strategy	Trust Board	Annual				
	Clinical Services Contract	Finance and Business Development Committee	Annual				
	Cheshire & Merseyside STP and 4 Local Delivery System Plans	Trust Board	Ad hoc as required				

Strategic Priority 9: External	Initial Risk Score	4 x 3 = 12	Target Risk Score (appetite)	4 x 2 = 8	Current Risk score	4 x 3 = 12
Ref 707	Strategic Priority			Executive Director	Board Committee	
Strategic Priority 9	Ensuring the Trust responds to the technical challenges of changes to cancer treatment			MD	Finance and Business Development	

Ref	Potential or actual risks (from <i>risk register</i>)	June 16	Aug 16	Sep 16	Nov 16	Jan 17	Apr '17	June 17
	Inability to resource new technical development	4 x 3 = 12						
	Unaware of new technical developments	4 x 3 = 12	4 x 2 = 9					

Impact on strategic initiatives		Potential consequences of the risk	
Ref	Objective	Owner	Key potential consequences of the risk
	Develop and implement the new clinical model	MD	Clinical services not cost effective or clinically sustainable
	Transfer and integrate the haemato-oncology services from the Royal Liverpool and Aintree hospitals	DoT&I	Unable to develop an integrated cancer centre
	Sustainability and Transformation Plan	CEO	Negative impact on ability to take a leadership role in the health economy. Risk to current business model

Positive assurances received			
Report ref	Positive assurance	Level of assurance	Evidence
	Report received		Date reported to committee
	Summary clinical model	L2	24.2.16 (part 2)
	CCC Future Clinical Model	L1	3.5.17 (Board Development)

Gaps in control / negative assurances				
Ref	Gap	Action Plan	Deadline	Owner
	Receipt of information on developments from national CRGs	Annual reports to F&B from CRG reps	End 2017	MD

Risk are controlled by		Reported to					
Ref	Control	Committee	Frequency	Q1	Q2	Q3	Q4
	5 year strategy	Trust Board	Annual				