

## GOVERNANCE & COMPLIANCE SUB-COMMITTEE

Agenda Item	P1-078-18	Date: 15 <sup>th</sup> May 2018
Subject /title	End of Year Board Assurance Framework (BAF) 2017/18	
Author	Ann Farrar, Interim Chief Executive	
Responsible Director	All Executive Directors	
Executive summary and key issues for discussion		
<p>The Board of Directors in April reviewed current and emerging risks as a result of the recent changes to the Executive Team. It is recognised that the Board Assurance Framework (BAF) needs strengthening and whilst internal audit rate the BAF as substantial assurance it also recognises the need for continuous improvement.</p> <p>Following this the Executive Team undertook a further review of existing and emerging risks, and agreed the overall risk ratings across the strategic priorities based on current intelligence.</p> <p>As a consequence of these discussions this report maps the outcomes against the Trust's strategic priorities in the BAF attached at appendix 1.</p> <p>The Governance &amp; Compliance Sub-Committee received the final report on the BAF for 2017/18 at its meeting on 15<sup>th</sup> May 2018 and made a recommendation for the Board to approve the document, subject to minor amendments which have now been incorporated.</p> <p>The 2018/19 BAF will be strengthened and developed to reflect best practice at a forthcoming Executive Team meeting (from June) when the Directors will identify risks against the new strategic priorities. The outcome of these discussions will inform the 2018/19 BAF for presentation to Board in July 2018.</p>		
<b>Context</b>		
<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 BAF 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>		
L1: Operational management		
L2: Oversight by Committee		




**L3: Independent assurance (MIAA, inspections, reviews)**

In reviewing the BAF the Board will be requested to note any changes in the dashboard and the narrative in 'red' within each of the Strategic Priorities.






To consider:

- 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?

**Key:**

<b>Unchanged since last quarter</b>	
<b>Deteriorated since last quarter</b>	
<b>Improved since last quarter</b>	

## Board Assurance Framework Dashboard

Highlight report				
Strategic Priority	Current Risk Score	Progress update	Assurance	Page No'
<b>Strategic Priority 1</b> Ensuring the delivery of high quality patient services (safety, experience and outcomes).	5 x 3 = 15	Revised assessment of overall risk score reflects increased risk profile: <ul style="list-style-type: none"> <li>Issues in relation to PET CT SUV since December 2016</li> <li>Consistent deterioration in VTE assessment and Sepsis to ATB therapy within 1 hour</li> <li>Failure to deliver elements of the PLACE action plan in year</li> <li>Failure to comply with elements of good Safeguarding practices</li> <li>Limited assurance for two consecutive years for Medical Devices</li> <li>Limited compliance to NICE guidance</li> </ul>		1
<b>Strategic Priority 2</b> 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		4
<b>Strategic Priority 3</b> Ensuring financial sustainability and delivery of the financial plan	5 x 2 = 10	Overall risk score remains the same		6
<b>Strategic Priority 4</b> Ensuring regulatory compliance with CQC, Monitor, and other relevant legislation.	4 x 3 = 12	Revised assessment of overall risk score reflects increased risk profile: <ul style="list-style-type: none"> <li>Process for Well-led review not identified</li> <li>No single IPR to reflect proactive management of strategic objectives however there are a range of reports but they do not comprehensively cover the new CQC standards</li> <li>Lack of assessment to understand requirements to retain CQC 'Outstanding' rating</li> </ul>		8
<b>Strategic Priority 5</b> Ensuring effective leadership within the Trust	4 x 3 = 12	Revised assessment of overall risk score reflects increased risk profile primarily in relation to changes in the Executive Leadership team		10

<b>Strategic Priority 6</b> Ensuring the delivery of strategic transformation	<b>4 x 4 = 16</b>	Revised assessment of overall risk score reflects increased risk profile: <ul style="list-style-type: none"> <li>Lack of comprehensive assurance across the TCC programme – 4 pillars: Care, Workforce, Build and Connectivity</li> </ul>		<b>12</b>
<b>Strategic Priority 7</b> Ensuring adequate infrastructure e.g. estates and IT	<b>4 x 3 = 12</b>	Revised assessment of overall risk score reflects increased risk profile: <ul style="list-style-type: none"> <li>Multiple risks identified on risk register relating to various matters regarding Meditech</li> <li>Lack of service standards for Hard &amp; Soft FM services provided via PropCare</li> </ul> <p>Several work streams underway to review all risks relating to Meditech, these will suggest solutions which should solve/ mitigate risks quickly</p>		<b>14</b>
<b>Strategic Priority 8</b> Ensuring the alignment of the Trust's strategy with the strategies of key external stakeholders and responding effectively to the policy and commissioning environment	<b>3 x 3 = 9</b>	Overall risk score remains the same		<b>16</b>
<b>Strategic Priority 9</b> Ensuring the Trust responds to the technical challenges of changes to cancer treatment.	<b>3 x 3 = 9</b>	Revised assessment of overall risk score reflects reduced risk		<b>18</b>

## BAF Heat map (May 2018)

### 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	6 16	20
	Possible	3	6	8 9	2 12 5 7	1 15
	Unlikely	2	4	6	8	3 10
	Rare	1	2	3	4	5
		Insignificant	Minor	Moderate	Major	Catastrophic
IMPACT						

Strategic context and background papers (if relevant)								
<ul style="list-style-type: none"> <li>• 5 year Strategy</li> <li>• Trust Business Plan 2017/18 – 18/19</li> </ul>								
Recommended Resolution								
The Board is asked to <b>APPROVE</b> the final report on the Board Assurance Framework (BAF) 2017/18								
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><b>Application Exemptions:</b></p> <ul style="list-style-type: none"> <li>• <b>Prejudice to effective conduct of public affairs</b></li> <li>• <b>Personal Information</b></li> <li>• <b>Info provided in confidence</b></li> <li>• <b>Commercial interests</b></li> <li>• <b>Info intended for future publication</b></li> </ul>	<p>Please tick the appropriate box below:</p> <table border="1"> <tr> <td><input checked="" type="checkbox"/></td> <td><b>A. This document is for full publication</b></td> </tr> <tr> <td><input type="checkbox"/></td> <td><b>B. This document includes FOI exempt information</b></td> </tr> <tr> <td><input type="checkbox"/></td> <td><b>C. This whole document is exempt under FOI</b></td> </tr> </table> <p><b>IMPORTANT:</b></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"/>	<b>A. This document is for full publication</b>	<input type="checkbox"/>	<b>B. This document includes FOI exempt information</b>	<input type="checkbox"/>	<b>C. This whole document is exempt under FOI</b>
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<input type="checkbox"/>	<b>C. This whole document is exempt under FOI</b>							
Equality & Diversity impact assessment								
Are there concerns that the policy/service could have an adverse impact because of:	<b>Yes</b>	<b>No</b>						
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.								

<b>Next steps</b>
The Assurance Framework will be delegated to the relevant committees
<b>Appendices</b>
Appendix 1 – Board Assurance Framework Report Appendix 2 – Risk Matrix

### 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

<b>Patients</b>		<b>Staff</b>	
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"> <li>• Involved and represented</li> <li>• Able to raise grievances</li> <li>• Able to make suggestions</li> <li>• Able to raise concerns and complaints</li> </ul>	✓
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	✓

<b>Strategic Priority 1: Quality</b>	<b>Initial Risk Score</b>	<b>5 x 2 = 10</b>	<b>Target Risk Score (appetite)</b>	<b>5 x 1 = 5</b>	<b>Current Risk score</b>	<b>5 x 3 = 15</b>
Ref 699	<b>Strategic Priority</b>			<b>Executive Director</b>		<b>Board Committee</b>
Strategic Priority 1	<b>Ensuring the delivery of high quality patient services (safety, experience and outcomes).</b>			<b>Director of Nursing and Quality</b>		<b>Quality Committee</b>

Ref	Potential or actual risks (from <i>risk register</i> )	July 17	Oct '17	Jan '18	Mar '18	April '18
New	Insufficient resilience to deliver quality standards eg VTE / Sepsis					
New	Medical devices assurance is limited for two consecutive years					
New	Limited compliance to NICE guidance					
728	Staffing levels not adequate to provide a safe service	5x2 = 10	5x2 = 10	5x2 = 10		
614	Safeguarding compliance	2x3 = 6	2x3 = 6	2x3 = 6	3x3 = 9	
724	Emergency planning processes not in place and embedded	4x2 = 8	4x2 = 8	4x2 = 8	3x2 = 6	
725	Systems not robust to ensure learning and feedback from incident and complaints	4x3 = 12	4x3 = 12	4x2 = 8		
497	Insufficient Radiologist capacity – impacting on reporting capacity, clinical support for radiographers administering contract agents, unable to progress plans for Radiologist input into planning	3x4 = 12	3x4 = 12	3x4 = 12		
New	Insufficient understanding re escalation processes for incidents eg PET-CT				2 x 3	
New	System not robust – learning and feedback from deaths					

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
	<b>Report received</b>		<b>Date reported to committee</b>
	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) 1.11.17
	EPRR assurance	L2	6.9.17 (Board)
	Infection control annual report	L2	5.7.17 (Board)
	Quality report	L2	9.6.17 (Board)
	Quality committee performance report	L1	20.6.17 (Quality)
	In patient survey report	L3	20.6.17 (Quality)
	Quality strategy update	L1	20.6.17 (Quality)
	Communications at end of life	L1	20.6.17 (Quality)
	Mortality review	L1	1.11.17
	Quality Committee performance report	L1	24.1.18 (QC)
	Assurance from the Quality and Safety Sub-Committee	L1	24.1.18 (QC)
	Quality Spot Checks (Part 2) (MIAA) – Limited Assurance	L3	31.1.18 (Audit)
	Mortality Report	L1	25.4.18 (Board)

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
New	Lack of understanding of risk escalation process	Independent review to be undertaken (PET-CT) – consider events / culture of organisation that prevent incidents not being identified a SUI.	June '18	MD
New	Lack of appropriate data collection to inform delivery of quality standards	Implement effective local data collection process for Sepsis and VTE standards, detailed plan in place with immediate actions and monitored daily through Integrated Care directorate and monthly through Integrated performance and quality report.	July '18	DepCEO/ DoO&T
New	Insufficient learning and feedback opportunity in relation to mortality	Mortality lead to be identified, additional SPA to be funded	July '18	MD
		Introduce programme to provide opportunity to cascade learning and ensure appropriate system is embedded	June '18	DoN&Q

		into the culture of the organisation whilst understanding the escalation of risks and actions to be undertaken		
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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				

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

Ref	Potential or actual risks (from <i>risk register</i> )	Jul '17	Oct '17	Jan '18	Mar '18	April '18
612	Workforce resistance to change	4x3= 12	4x3 = 12	4x3 = 12		No new risk's identified at April Board meeting
542	Implementation of the Workforce Strategy falls behind the required timescale	4x2= 8	4x2 = 8	4x2 = 8		
766	Recruitment & Retention: Potential loss of staff in relation of the move to Liverpool			4x3 = 12		
728	Staffing levels not adequate to provide a safe service			5x2 = 10		
201	Failure to provide adequate support for employee stress leading to increased absence from work			3x3 = 9		
New	Insufficient capacity in the Finance team – contributing to loss of financial control				4x2 = 8	
New	Negative perception of timing/scale/appropriateness of CCC 60 <sup>th</sup> birthday celebrations affects relationship with staff, patients or stakeholders				2x2 = 4	

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"> <li>Recruitment and retention strategy</li> <li>Training, education and development</li> <li>Strategy</li> <li>Succession planning</li> <li>Talent Management</li> </ul>	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
	<b>Report received</b>		<b>Date reported to committee</b>
	Integrated Performance Report	L2	Board 9.6.17, 5.7.17 and 6.9.17
	Partnership Working Update	L2	9.6.17 - monthly (Board)
	6 monthly safe staffing acuity report	L2	6.9.17 (Board)
	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)
	Revalidation statement of compliance	L2	6.9.17 (Board)
	Workforce and OD strategy update	L2	5.7.17 (Board)
	Medical director update	L2	9.6.17 (Board)
	Staff survey	L3	20.6.17 (Quality)
	Workforce Race Equality Standard	L2	5.7.17 (Board)
	Bi-annual safe staffing report	L1	1.11.17 (Board)
	Raising concerns bi-annual report	L1	24.1.18 (QC)
	Assurance from the Workforce Sub-Committee	L1	24.1.18 (QC)

Gaps in control / negative assurances				
Ref	Gap	Action Plan	Deadline	Owner
	Absent rate remains consistently between 0.5% and 1% above the trust target of 3.5%	HR surgeries between HR Advisors and Managers and policy reviewed during 2017	On-going	DoWOD
	Increase in staff turnover above target throughout 2017/18	Analysis of exit interviews and PADR process to include career planning questions re Liverpool	April 2018	DoWOD
	Agency spend breached cap for 2016/17 and projections for 2017/18 are high due to medical locum cover – Agency spend now under control and within cap.	Workforce Redesign Group implemented	Completed	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. Initial results of the 2017 staff survey indicate consistent levels of stress with 2016.	April 2018	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				

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

Ref	Potential or actual risks (from risk register)	June '17	Oct '17	Jan '18	Mar '18	April '18
779	Non-compliance with Continuity of Service rating	5x1 = 5	5x1 = 5	5x2 = 10		No new risk's identified at April Board meeting
169	Income plan from PPJV not reached	2x2 = 4	2x2 = 4	2x2 = 4	4x3 = 12	
27	Non-delivery of CIP	4x3 = 12	4x3 = 12	4x3 = 12		
34	Loss of activity associated with clinical income	4X3 = 12	4x3 = 12	4x3 = 12	2x5 = 10	
780	Capital programme overspends	4X2 = 8	4x2 = 8	4x2 = 8	5x3 = 15	
738	Difficulties with accurate data collection post Meditech implementation impacting on cancer waiting time and performance data	2x3 = 6	2x3 = 6	2x3 = 6		
745	Organisation culture not fit for purpose to develop and deliver the Trust's business plan	4x3 = 12	4x3 = 12	4x3 = 12		
New	Costs of interim management requirements exceed affordability within the financial plan				4x3 = 12	
New	Loss of additional financial contribution of subsidiaries, Joint Venture and R&I to Trust financial plans 2018/19.				2x3 = 6	

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
	<b>Report received</b>		<b>Date reported to committee</b>
	Integrated Performance Report	L2	Monthly (Management Group) 5.6.17 Monthly (Board) 1.11.17
	Clatterbridge Pharmacy Report (CPL)	L2	9.6.17 & 1.11.17quarterly (F&BD)
	Clatterbridge Private Clinic	L2	9.6.17 & 1.11.17quarterly (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	6.9.17 (Board) 27.9.17 (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)
	Annual Report & Accounts 2016/17	L3	19.5.17 (Audit), 23.5.17 (Board)
	Monthly Finance submission – NHSI (Segment 1)	L3	1.11.17 (Board) Monthly information pack to Board members
	Finance Systems Review (MIAA) - Significant Assurance	L3	31.1.18 (Audit)
	Cancer Waiting Times process review (MIAA) – Significant Assurance	L3	31.1.18 (Audit)

Gaps in control / negative assurances				
Ref	Gap	Action Plan	Deadline	Owner
	No gaps to report			

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	x	x		
	Block contract with Commissioners						
	Cost Improvement Programme 2016/17	Finance and Business Development	Bi-monthly	x	x		

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

Ref	Potential or actual risks (from risk register)	Jul '17	Oct '17	Jan '18	Mar '18	April '18
New	To deliver the 'must do's' to retain CQC 'Outstanding' rating					
New	Potential risk to 'outstanding' Well-Led Review rating by the CQC for 2018/19 inspection					
New	No single integrated performance report to reflect the new CQC standards					
143	Failure to comply with IRR and IR(me)R	3x3 = 9	3x3 = 9	3x3 = 9		
726	Ineffective health and safety processes	5x2 = 10	5x2 = 10	5x2 = 10		
763	Failure to comply with NHS Improvement licence conditions	4x2 = 8	4x2 = 8	4x2 = 8		
702	Failure to comply with CQC fundamental standards	4x2 = 8	4x2 = 8	4x2 = 8		
392 & 62	Failure to comply with other legislation	3x2 = 6	3x2 = 6	3x2 = 6		
505	Breach of C diff target of no more than 5	3x3 = 9	3x4 = 12	3x4 = 12		
New	Potential for unannounced CQC inspection due to unplanned changes in the Trust leadership structure resulting in enhanced regulatory scrutiny.				4x3 = 12	
New	Reputational damage and staff/stakeholder concern regarding the reasons behind any unannounced/planned CQC inspection and the resulting feedback				4x3 = 12	
New	The loss of corporate memory due to changes to the executive team could present challenges to the production of the Quality Report (Accounts) and the Annual Governance Statement				3x2 = 6	

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
	<b>Report received</b>		<b>Date reported to committee</b>
	Integrated Performance Report	L2	Board 6.9.17, 5.7.17, 9.6.17
	Annual Report & Accounts (inc Quality Report) – KPMG	L2, L3	23.5.17 - (Board)
	HSE notification of IRR breach	L2	6.9.17 (Board)
	EPRR assurance	L2	6.9.17 (Board)
	Executive leads for all KLOE's identified	L1	1.5.18 (Well-led mtg)

Gaps in control / negative assurances				
Ref	Gap	Action Plan	Deadline	Owner
	CQC inspection mandated action plan.	Mandated action plan completed	Oct 2017	DoN&Q
	New IR(me)R / IRR regulations not yet published	Response sent to IRR consultation	Sept 2017	DoN&Q
New	Lack of assessment to understand requirements to retain CQC 'Outstanding' rating	Undertake a base line assessment of work that is required to achieve 'Outstanding' including timeframe – topic for Board Development session	June '18	DoN&Q
New	Process for Well-led review not identified	Engagement of additional expert support to close gaps in assurance Progress report to Board Board self assessment to be undertaken Additional capacity and capability to be commissioned within resources	July '18	CEO
New	No single IPR to reflect proactive management of strategic objectives however there are a range of reports but they do not comprehensively cover the new CQC standards	To develop a revised IPR which is comprehensive with month on month improvements – external support to be commissioned if necessary	July '18	Acting Deputy CEO/DoO&T

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				
	Bi-weekly Well-led Executive meeting	Governance & Compliance Sub-Committee					



<b>Strategic Priority 5: Leadership</b>	<b>Initial risk score</b>	<b>4 x 3 = 12</b>	<b>Target Risk Score (appetite)</b>	<b>4 x 2 = 8</b>	<b>Current Risk score</b>	<b>4 x 3 = 12</b>
Ref 703	<b>Strategic Priority</b>			<b>Executive Director</b>	<b>Board Committee</b>	
Strategic Priority 5	<b>Ensuring effective leadership within the Trust</b>			<b>CEO / Director of Workforce and OD</b>	<b>Trust Board / °Finance &amp; Business Development</b>	

Ref	Potential or actual risks (from risk register)	June 17	Oct '17	Jan '18	Mar '18	April '18
	Lack of clarity on accountability and delegated authority	3x2 = 6	3x2 = 6	3x2 = 6		No new risk's identified at April Board meeting
	Lack of leadership skills, knowledge and capacity	4x2 = 8	4x2 = 8	4x2 = 8		
	Inadequate execution of development plans and delivery against operational targets	5x2 = 10	5x2 = 10	5x2 = 10	4x2 = 8	
	Lack of effective succession planning for Executive Directors, Senior Managers (including clinical leaders) and subject matter experts (including clinical staff)	3x3 = 9	3x3 = 9	3x3 = 9		
New	Change in Executive leadership Team could adversely affect the effective leadership within the Trust.				4x2 = 8	
New	Loss of SIRO corporate memory presents risk in failure to execute ratification & publication process re DH Information Governance Toolkit submission. Also required to meet GDPR requirements				3x2 = 6	
New	Change in leadership and current CEO capacity could adversely affect the effective management of complaints				3x2 = 6	
New	Lack of leadership capacity and capability through a period of significant change could have an impact on effective decision-making, communications, stakeholder management and staff morale				4x2 = 8	
New	Reduction in strategic influencing capability due to loss of experienced CEO (and vacant SRO Cancer Alliance)				3x5 = 15	
New	Loss of personal influence on potential external opportunities (e.g. Cancer Alliance, UoL, R&I)				3x3 = 9	
New	Insufficient management capacity in the Directorates / Departments – contributing to loss of financial control.				2x2 = 4	

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"> <li>A Corporate Strategy process</li> <li>A new trust multi- year Corporate Strategy to inform and be informed by relevant supporting strategies and wider context e.g. C&amp;M 5YFV, C&amp;M Cancer Strategy, Cancer Alliance and Commissioner strategies as appropriate</li> </ul>	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.
	<sup>o</sup> Delivery of key elements of the Workforce for the Future components of TCC including: <ul style="list-style-type: none"> <li>Leadership development strategy</li> </ul>	DoW&OD	Inability to optimise the workforce

Positive assurances received			
Report ref	Positive assurance	Level of assurance	Evidence
	<b>Report received</b>		<b>Date reported to committee</b>
	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
	MIAA - Research Funding & Governance Review (Limited)	L3	25.10.17 (Audit Committee)
	Leadership Development Programme	L1	21.9.17 (Exec Team)
	Workforce and OD strategy update	L2	5.7.17 (Board)
	NED skills review	L2	6.9.17 (Board)
	Scheme of Reservation & Delegation – proposed revisions	L1, L2	12.1.18 (Exec Team) 16.1.18 (Fin Sub-Com) 17.1.18 (Gov & Com Sub-Com) 31.1.18 (Audit Com) 7.2.18 (Trust Board)
	Standing Financial Instructions / Standing Orders – proposed revisions	L1	16.4.18 (Audit Committee) 25.4.18 (Trust Board)

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					
	New leadership development programme commences October 2017	Workforce					x
	Review of Scheme of Delegation / SFI's					x	

<b>Strategic Priority 6: Transformation</b>	<b>Initial Risk Score</b>	<b>4 x 4 = 16</b>	<b>Target Risk Score (appetite)</b>	<b>4 x 3 = 12</b>	<b>Current Risk score</b>	<b>4 x 4 = 16</b>
Ref 704	<b>Strategic Priority</b>			<b>Executive Director</b>	<b>Board Committee</b>	
Strategic Priority 6	<b>Ensuring the delivery of transformation</b>			<b>Acting Deputy CEO /Director of Operations &amp; Transformation</b>	<b>Finance &amp; Business Development / ^Trust Board</b>	

Ref	Potential or actual risks (from risk register)	June 17	Oct '17	Jan '18	Mar '18	April '18
741	Transformation programme fails to deliver required service delivery models, creating clinical, performance, financial and reputational risks due to overall complexity of the four pillars that are the substance of the transformation programme.	4x3 = 12	4x3 = 12	4x2 =8		
23,482	TCC: Scheme affordability – escalating costs	4x3 = 12	4x3 = 12	4x3 =12		
27	TCC: Scheme affordability – The required annual CIP savings are not fully delivered	4x3 = 12	4x3 = 12	4x3 =12		
543	Failure to deliver effective integration of haemato-oncology services causes clinical, performance and financial risks to CCC	4x1 = 4	4x1 = 4	4x1 =4	4 x 2 = 8	
721	Integrating HO Services into CCC Meditech / E-prescribing	3x5 = 15	3x4 = 12	4x3 = 12		
693	Risk of loss of key staff due to changes to working practices	4x3 = 12	4x3 = 12	4x3 = 12		
691	Stakeholder concern causes opposition / delay to consultation / implementation of new clinical model (particularly in the Eastern sector)				4x3 = 12	
New	Loss of stakeholder confidence in future of/progression of capital build programme				3x3 = 9	
New	Loss of corporate memory and inability to drive entrepreneurship may lead to failure to develop and implement a comprehensive research strategy and will reduce opportunities to increase patient access to clinical trials; reduce ability to attract and/or retain outstanding cancer workforce; impact on organisation reputation				3x3 = 9	
New	Loss of stakeholder confidence leading to negative impact on charity appeal in relation to new build – from the public or withdrawal of support from high profile patrons				2x3 = 6	

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
	<b>Report received</b>		<b>Date reported to committee</b>
	Haemato – Oncology Integration - Project Assurance (MIAA) – Significant Assurance	L3	25.1.17 (Audit)
	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	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
	PropCare – Partnership Agreement	L1,L3	31.5.17 (Board)
	Haemato-oncology – Service Transfer Agreement	L1, L3	28.6.17 (Board)
	Haemato-oncology – progress report	L1	5.7.17 (Board)
	PropCare Quarterly Report – Build	L1	17.1.18 (Infrastructure Sub-Com)

Gaps in control / negative assurances				
Ref	Gap	Action Plan	Deadline	Owner
741	Comprehensive assurance across the TCC Programme - 4 pillars: Care, Workforce, Build and Connectivity	Produce an assurance report to the Trust, recognising the substantial work in progress	Jul '18	Acting Deputy CEO/DoO&T

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				
	Executive nominated lead for PropCare in place	Board (6.9.17)					
741	Transformation programme assurance report	Board	Bi-monthly				

<b>Strategic Priority 7: Infrastructure</b>	<b>Initial Risk Score</b>	<b>3 x 3 = 9</b>	<b>Target Risk Score (appetite)</b>	<b>3 x 2 = 6</b>	<b>Current Risk score</b>	<b>4 x 3 = 12</b>
Ref 705	<b>Strategic Priority</b>			<b>Executive Director</b>	<b>Board Committee</b>	
Strategic Priority 7	<b>Ensuring adequate Estates and IT infrastructure</b>			<b>Acting Deputy CEO / Director of Operations &amp; Transformation</b>	<b>Finance &amp; Business Development / ^Trust Board</b>	

Ref	Potential or actual risks (from risk register)	June '17	Oct '17	Jan '18	Mar '18	April '18
729	Poor maintenance of medical equipment	4 x 2 = 8	4 x 2 = 8	4 x 2 = 8		No new risk's identified at April Board meeting
361	Risks to clinical operations in the event of unavailability of the EPR (Meditech) – clinical decisions based on data being unavailable in a safe and timely manner	4 x 3 = 12	4 x 3 = 12	4 x 3 = 12		
162	Capital programme not delivered	3 x 3 = 9	3 x 3 = 9	3 x 2 = 6		
556	Risks associated with the implementation of EPR – eg role out to Haemato-oncology service	5 x 2 = 10	5 x 2 = 10	5 x 2 = 10		
372	Safe systems not in place for water safety	3 x 3 = 9	3 x 3 = 9	3 x 3 = 9		
705	Lack of adequate IT infrastructure	3 x 3 = 9	3 x 3 = 9	3 x 3 = 9		
New	Lack of service standards for Hard & Soft FM services provided via PropCare					4 x 3 = 12

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/FD	Inability to deliver the whole transformation programme.

Positive assurances received			
Report ref	Positive assurance	Level of assurance	Evidence
	<b>Report received</b>		<b>Date reported to committee</b>
	Integrated Performance Report	L2	9.6.17, 5.7.17 and 6.9.17, (Board)
	Emergency Preparedness, Resilience and Response (EPRR) assurance process (LHRP)	L3	6.9.17 (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)
	IM&T Strategy 2015-18	L1	3.5.17 (Board)
	IT Service Continuity (MIAA) – Limited Assurance	L3	31.1.18 (Audit)
	Several work streams underway to review all risks relating to Meditech and fix the issues which should be solved/ mitigated against quickly	L1	10.5.18 (Exec Team)

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.
New	No formal KPI's identified with PropCare to monitor performance of Hard and Soft FM services	Development of KPI's to monitor progress to be reported to Operational Delivery Sub-Committee	TBA	Associate Director of Operations

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						
	Executive nominated lead for PropCare in place	Board					

<b>Strategic Priority 8: External</b>	<b>Initial Risk Score</b>	<b>5 x 2 = 10</b>	<b>Target Risk Score (appetite)</b>	<b>5 x 2 = 10</b>	<b>Current Risk score</b>	<b>3 x 3 = 9</b>
Ref 706	<b>Strategic Priority</b>				<b>Executive Director</b>	<b>Board Committee</b>
Strategic Priority 8	<b>Ensuring the alignment of the Trust's strategy with the strategies of key external stakeholders and responding effectively to the policy and commissioning environment</b>				<b>Interim CEO</b>	<b>Trust Board</b>

Ref	Potential or actual risks (from risk register)	June '17	Oct '17	Jan '18	Mar '18	April '18
732	Lack of influence in the local health economy and the development of the STPs	4 x 3 = 12	4 x 3 = 12	3 x 3 = 9		No new risk's identified at April Board meeting
733	Poor engagement with external stakeholders	5 x 2 = 10	5 x 2 = 10	5 x 2 = 10		
735	The Trust's current/future clinical model is not supported by all key stakeholders	5 x 3 = 15	5 x 3 = 15	3 x 3 = 9		
572	Damage to Trust reputation, staff/stakeholder relationships and/or public confidence				3x5 = 15	
New	Negative perception of timing/scale/appropriateness of CCC 60 <sup>th</sup> birthday celebrations affects relationship with staff, patients or stakeholders				2x2 = 4	

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"> <li>Other providers</li> <li>Research collaborations</li> </ul>	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
	<b>Report received</b>		<b>Date reported to committee</b>
	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
	Developing our Strategy (Board, CoG, CD's and Senior Managers)	L1	24.10.17
	Clinical Model - Sefton CCG Governing Body	L3	7.9.17
	Clinical Model – Mid Mersey Cancer Group	L3	28.9.17
	Clinical Model – Eastern Sector	L3	27.11.17
	Clinical Model – sector hubs – West Lancs CCG	L3	16.1.18
	Strategy engagement with University of Liverpool and LHP	L3	22.1.18 and 26.1.18

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				

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

Ref	Potential or actual risks (from risk register)	June 17	Oct '17	Jan '18	Mar '18	April '18
	Inability to resource new technical development	4 x3 =12	4 x3 =12	4 x3 =12		No new risk's identified at April Board meeting
	Unaware of new technical developments	4 x2 = 9	4 x2 = 9	4 x2 = 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
	<b>Report received</b>		<b>Date reported to committee</b>
	Summary clinical model	L2	24.2.16 (part 2)
	CCC Future Clinical Model	L1	3.5.17 (Board Development)
	Setting the Trust Strategy	L1	4.10.17 & 24.10.17 (Board Development)
	Developing the Trust Strategy	L1	6.12.17 (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				

The descriptors and levels of **Impact**.

	1	2	3	4	5
	None	Minor	Moderate	Major	Catastrophic
<b>Patient injury (emotional, physical, psychological, loss of function)</b>	No injury or identifiable damage	Mild injury. Extra observation or minor treatment. Minimal harm.	Significant but not permanent harm. Moderate increase in treatment.	Serious injury with prolonged disability – permanent harm	Unexpected death or significant permanent disability
<b>Staff / visitor injury</b>	No injury or minor injury not requiring first aid	Mild injury requiring first aid	Injuries that last for more than 3 days	Major injuries reportable under RIDDOR	Unexpected death or significant permanent disability
<b>Control of infection</b>	Minor microbiological contamination not coming into contact with patients, staff or public	Contamination or hospital acquired colonisation affecting one or more individuals	Contamination causing hospital acquired infection of one or more individuals	Contamination or hospital acquired infection causing clinical impact to patient / staff or closure of the ward	Contamination or hospital acquired infection causing unexpected death or significant permanent disability or multiple ward or hospital closure
<b>Possibility of complaint or litigation</b>	No possibility of complaint or litigation	Slight possibility of complaint or litigation	Likely complaint or litigation	Claim above excess level. Justified multiple complaints	Multiple claims or single major claim
<b>Objectives / project slipping</b>	Insignificant project slippage, cost increase. Barely noticeable reduction in scope or quality	Minor project slippage. Minor reduction in scope or quality. <5% over budget	Serious over run on project Reduction in scope or quality 5-10% over budget	Project in danger of not being delivered. Failure to meet secondary objectives 10-25% over budget	Unable to deliver project Failure to meet primary objectives >25% over budget.
<b>Service / business interruption</b>	Loss / interruption up to 1 hour	Loss / interruption up to 4 hours	Loss / interruption up to 8 hours	Loss / interruption up to 2 days	Loss / interruption more than 2 days
<b>Workforce capacity / capability</b>	Service delivery not compromised	Service delivery compromised at a minimum short term level (1 day) Unsatisfactory staffing level (below minimum level and skill mix)	Service delivery compromised / reduced. Ongoing unsafe for 2-5 days	Service delivery compromised / reduced. Ongoing unsafe for 5-10 days	Major service disruption / inability to provide service due to significant lack of staff

<b>Financial</b>	No obvious / small impact.	Financial impact less than (£50K)	Financial impact (£50-<250k)	Financial impact : Capital schemes: (£250k - <£3m) Revenue: (£250K - <£1m)	Financial impact : Capital schemes: (£>3m) Revenue: (£>1m)
<b>External inspections</b>	No adverse comments / non compliances	Recommendations given	Challenging recommendations	Enforcement action / critical report	Severely critical report / improvement notices / removal of licence
<b>Adverse publicity / reputation</b>	Rumours (internal / external) no impact on reputation	Local media attention – short term and retrievable	Local media attention – long term – impact on reputation resulting in detrimental impact upon perception of stakeholders	National adverse publicity or significant negative publicity relating to Trust practice which has impact on business continuity	National adverse publicity resulting in significant detrimental impact on business. Full public enquiry.
<b>Estates infrastructure</b>	Minor service inconvenience. Able to be resolved in 1 day.  Effects small part of hospital	Temporary loss of service in single area.  Safety breach that could lead to injury but risks able to be controlled.	Prolonged loss of service to single areas that would result in area closure. Safety breach that could lead to serious injury and able to be controlled.	Prolonged loss of service to single or multiple areas that would result in area closure. Safety breach that could lead to serious injury and risks not able to be controlled	Hospital wide disruption to clinical services.  External safety warning of major danger to staff / patients.
<b>Compliance</b>	No or minimal breach of guidance / regulatory or statutory duty.	Breach of guidance / regulatory or statutory duty.  Reduced performance but able to resolve. Unresolved.	Breach of guidance / regulatory or statutory duty.  Reduced performance rating if unresolved.	Breach of guidance / regulatory or statutory duty.  Improvement notices. Low performance rating	Breach of guidance / regulatory or statutory duty.  Prosecution.  Complete systems change required.  Severely critical report.

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<b>Information governance</b>	Less than 5 people affected or risk assessed as low e.g. files encrypted	Serious potential breach and risk assessed high e.g. unencrypted clinical records lost. Up to 20 people effected	Serious breach of confidentiality e.g. up to 100 people effected	Serious breach with either particular sensitivity or up to 1000 people effected	Serious breach with potential theft.
<b>Radiation</b>	None or minimally increased dose to staff or patients	Some increase in dose to one or more individual(s) (non-patient) Some increase in patient dose (for <30% of treatment fractions)	Dose Investigation Levels exceeded for one or more individual(s) (non-patient) Impact on dose for many treatment fractions or for several patients Significant increase in patient dose (non-treatment) (>50%)	Annual Dose Limit exceeded for one or more individual(s) (Reportable) >5% impact on treatment dose (full course) Impact on treatment dose for many patients (>5%) Major increase in patient dose (non-treatment) (>3x)	Critical dose to one or more individual(s) >20% impact on treatment dose (single fraction) or 10% (full course) (Reportable) Impact on treatment dose for very many patients (>15%) Reportable increase in patient dose (non-treatment)
<b>Patient experience / outcome</b>	Unsatisfactory patient experience not directly related to patient care	Unsatisfactory patient experience readily resolved	Mismanagement of patient care, short term effects (less than a week)	Serious mismanagement of patients care, long term effects (more than 1 week)	Totally unsatisfactory patient outcome or experience.
<b>Chemotherapy Prescribing</b>	Insufficient information, treatment not prescribed, calculation errors within 10% . Intervention did not affect standard of patient care	Minimal harm/disruption to patient, legal requirements for prescriptions not met, missing signatures, non protocol forms, incorrect number of cycles, Incorrect interval/date/schedule, supportive meds not prescribed, dose calculation error between 10-20%. Late prescriptions.	Moderate toxicity, illegible prescription, Dose calculation error >20%, chemotherapy drugs omitted from protocol	Incorrect route. Major/permanent toxicity. Dose calculation error >30%, wrong drug prescribed	Death or significant permanent disability. Dose calculation error>50%
<b>Omitted Medicines</b>	No omitted doses	Omission of any medicines without a valid reason (minor harm)	Omission of any medicines without a valid reason (moderate harm)	Omission of any medicines without a valid reason (major harm)	Omission of any medicines that leads to patients unexpected death or significant permanent disability

**Likelihood.**

	Descriptor	Proposed description
1	Rare	May occur in exceptional circumstances, not expected to occur.
2	Unlikely	Unlikely to occur, could occur on an infrequent basis
3	Possible	Reasonable chance of occurring. Expected to occur a few times.
4	Likely	Will occur in most circumstances, expected to occur in most circumstances. However, not a persistent issue. No issues of custom and practice
5	Certain	Most likely to occur than not, expected to occur frequently / expected to occur in most circumstances. Is a constant threat, is custom and practice.

**Risk grading matrix:**

Impact→ ↓ Likelihood	None	Minor	Moderate	Major	Catastrophic
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

**Management of Risks**

	<b>High risk (15 and over)</b> Managed by risk owner (usually departmental manager) with oversight by an executive director Immediate action to remove or reduce the risk Highlight action plan contained in risk register with defined timescales and target reduction to reduce or remove the risk with full risk mitigation plan developed by risk owner. Risk reviewed at least monthly. Risks included in departmental reviews. Risks reported monthly to Trust Board with risk mitigation plans and monthly reviews.
	<b>Moderate risk (9-12)</b> Managed by Departmental manager Urgent action to remove or reduce the risk Action plan contained in risk register with defined timescales to reduce or remove the risk Risk reviewed at least quarterly. Risks included in departmental reviews. Risks reported to Integrated Governance (or other relevant Board committee) quarterly.
	<b>Low risk (4-8)</b> Managed by departmental manager Action cost effective in reducing risk Actions contained within risk register, reviewed minimum of 6 monthly
	<b>Very low risk (less than 4)</b> Managed by routine procedures Action if inexpensive / easy to implement Actions contained within risk register, reviewed minimum of annually