Borders NHS Board

STRATEGIC RISK REGISTER 2014/15

Aim

To update the Health Board on the strategic risk register and the future plans to identify additional risks to the organisation.

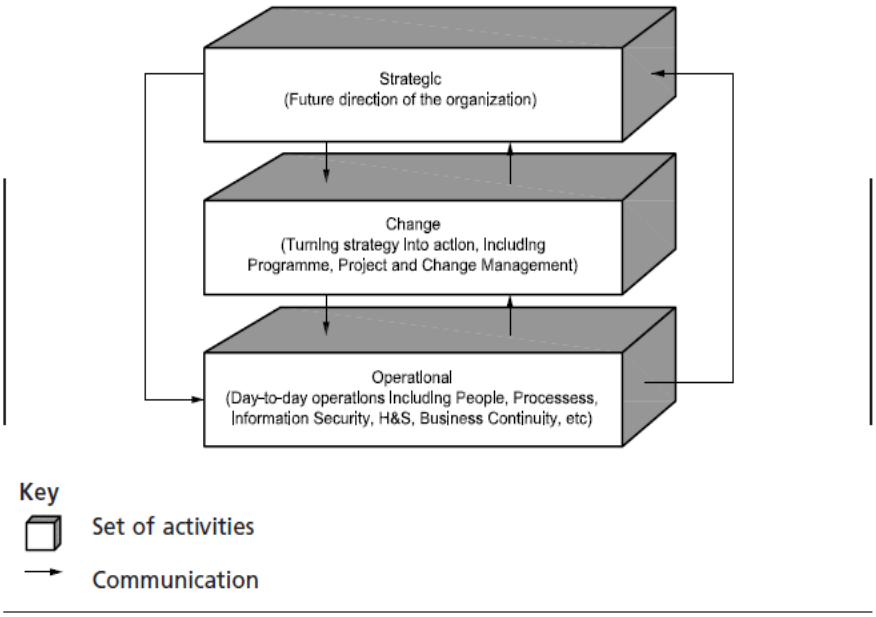
Background

Understanding strategic risk forms a component part of ensuring that corporate values and objectives are attained.

Strategic risk is defined as:

"*risk concerned with where the organisation wants to go, how it plans to get there, and how it can ensure survival" (British Standards Institute Risk Management BS 31100:2011).*

Figure 1 Risk management perspectives



British Standards Institute Risk Management BS 31100:2011

The Strategic Risk Register format was adjusted to meet the PricewaterhouseCoopers Internal Audit recommendations and presented to the Board Executive Team (BET) in October 2014. At this meeting there was a discussion regarding any new strategic risk that should be considered and it was identified that the recently agreed NHS Borders Clinical Strategy should be assessed for potential new strategic risk. Also that risk owners

undertook to individually review their current strategic risks to ensure they were still relevant, mitigation actions up to date and risk levels correct. The reviewed strategic risk register was again discussed at BET Jan 2015 and approved (with some minor amendments). It was also agreed at this meeting that the strategic risks should be reviewed by the Clinical Executive Strategy Group; this was completed at the Strategy Group 12th March 2015.

The Datix Risk Register facilitates managers identifying strategic risks; these must be agreed by the clinical board/directorate managers. It was agreed at the Strategy Group that strategic risks identified by clinical boards would be owned by the senior leadership and would be presented to the Strategy Group for oversight before being accepted onto the strategic risk register.

BET has responsibility for identifying and managing strategic risks that are identified with regard to the overall strategic direction of the organisation. By facilitating clinical board managers to also identify strategic risks widens the scope to include potential strategic risks arising from the delivery of operational healthcare services. The BET and the Strategy Group will have joint responsibility for agreeing the register.

Summary

The BET have reviewed the current Strategic Risk Register October 2014 and again January 2015 with the addition of one new strategic risk: failure to meaningfully implement the Clinical Strategy. The Strategy Group had oversight of the strategic risk register in March 2015 to ensure there were no gaps, strategic risks were relevant and that they were being managed to acceptable levels. The introduction of the Datix risk register facilitates strategic risks being identified within clinical boards; any strategic risks identified through Datix will be owned by the clinical board leadership and presented to the Strategy Group for oversight prior to acceptance onto the strategic risk register.

This approach ensures that the scope to identify potential strategic risks is widened to include any potential strategic risks arising from the delivery of operational healthcare services.

Recommendation

The Board is asked to **note** the revised Strategic Risk register and the ongoing actions to identify additional strategic risks moving into 2015/16.

Policy/Strategy Implications	Implementing of policies/strategies and risks arising would be included in risk management process
Consultation	Process inclusive of senior risk owners
Consultation with Professional Committees	Clinical Executive Strategy Group and BET have been consulted.
Risk Assessment	Strategic risks may exist that have not been identified.
Compliance with Board Policy requirements on Equality and Diversity	Compliant

	NHSB EQIA Health BOard Paper March 2
Resource/Staffing Implications	Risk management is included in existing managerial duties.

Approved by

Name	Designation	Name	Designation
Evelyn Rodger	Director of Nursing & Midwifery, Interim Director of Acute Services		

Author(s)

Name	Designation	Name	Designation
Sheila MacDougall	Risk & Safety Manager		

NHS BORDERS STRATEGIC RISK REGISTER

2013-16
Version 7

Board Executive Team

Risk Management Activity

Responsible Group	Date	Updated Version	Risk Register approved	Comments
Strategic & Performance Committee	**Sept 2011**	**V1**		**Initial identification of strategic risk**
BET	**28/08/2012**	**V2**	**Approved by BET**	**Agreed strategic risk register**
Strategic & Performance Committee	**Sept 2012**	**V2**		**Reviewed**
NHS Borders Health Board				**Introduction of new Corporate Objectives 2013-16**
BET	**22/10/2013**	**V2**		**V2 Reviewed risks & updated, resulted in V3**
BET	**22/10 to 19/11/2013**	**V3**		**V3 reviewed over a period of time by risk owners and updated resulting in V4**
BET	**19/11/2013**	**V4**	**Approved by BET**	**V4 agreed**
Strategic & Performance Committee	**05/12/2013**	**V4**		**Reviewed**
Risk, Health and Safety Team	**09/10/2014**	**V5**		**V5 register format changed in accordance with Internal Audit Report**
BET	**12/10/2014**	**V5**		**For review & addition to Datix Risk Register**
BET updates from risk owners	**12/10/2014 – 14/01/2014**	**V6**		**1 new risk (no. 8), 1 risk down graded (no.2), some actions implemented and now an implemented control measure.**
BET	**26/01/2015**	**V6.1**	**For discussion**	**Submitted for BET meeting 10.02.2015**
BET	**10.02.2015**	**V7**	**Approved by BET**	**Risk 7 was agreed at high, risk 8 modified risk source regarding lack of IT strategy remain very high. With these changes BET approved v7**
Clinical Executive- Strategy Group	**10.03.2015**	**V7**	**Register content reviewed for any gaps.**	**Discussed whether any gaps in register, specific discussion re risk no. 8, agreed Datix strategic risk to be brought to Groups attention and agreement before being entered on the Strategic Risk Register.**

NHS Borders Strategic Risk Register 2013-16

Source of risk	Risk	Linked to Corporate Objective	Managed by (key systems / processes):	Likeli-hood	Impact	Risk Level after Mitigation	Further Actions Required	Risk Owner Lead Executive	Review Time-scale
Risk No 1 : Failure of multi agency working									
Poor interagency communication Differing organisational cultures Political interdependence Failure of collaboration with SBC and other partners in delivering services	Patients inappropriately admitted to Hospital- with further exposure to clinical risk Independence of patients is reduced and has more reliance on service support. Strategic aims misaligned and patients do not receive appropriate care. Public Health risks if beds are not available due to hospital closure Long-term negative impact on health and well-being increases demand on NHS services Decreased preventative services resulting in increased demand for NHS Services Closure of some voluntary sector providers	Processes and Structures	1. Strategic interagency leads meeting twice per month to: -service plan -ensure robust communication -ensure organisational collaboration 2. Strategic direction reviewed is increasingly co-dependent- managed through operational systems 3. Progression a of National Policy on Health and Social Care- implementation plans 4. Joint performance review of Mental Health & LD reported on quarterly basis 5. Change Fund (adult & children) facilitates sustained collaboration 6. Jointly managed services in Mental Health & Learning Disabilities and Public Health.	Unlikely	Major	Medium	1. Change fund monitored by CHCP, ongoing reporting on performance required 2. Joint performance review framework developed and sustained	Chief Executive	Annually

Source of risk	Risk	Linked to Corporate Objective	Managed by (key systems / processes):	Likeli-hood	Impact	Risk Level after Mitigation	Further Actions Required	Risk Owner Lead Executive	Review Time-scale
Risk No 2 : Financial decision-making in partner organisations' budgets forces an increase in NHS expenditure									
Loss of income or reduction to service being provided to or by partner organisations such as • SBC • Other Healthcare Partners • Voluntary Sector • SG - National funding	Reduced capacity for joint working leading to either increased expenditure for NHS Borders to make up the capacity, increased demand on NHS servces or a reduced provision for service users. Wider impact on partnership working Negative impact on the health of the Borders population	Performance and Delivery Health Improvement and Inequalities	1. Integrated Clinical Boards 2. Appointment of a Chief Officer 3. The development of health and social care integration. 4. Creation of a Shadow Board 5. Regular joint reporting to the Planning & Delivery Committee and Shadow Board. 6. Regular meetings between NHS Borders and SBC Finance departments 7. Share information on financial outlook and financial plan to promote better understanding of financial challenges and impact of decisions 8. Alignment of budget timetables 9. Quarterly meetings with SG finance	Possible	Moderate	Medium	1. Integrated budget to be developed 2. Integrated working/services 3. Integrated management structures	Director of Finance	31st March 2016

Source of risk	Risk	Linked to Corporate Objective	Managed by (key systems / processes):	Likeli-hood	Impact	Risk Level after Mitigation	Further Actions Required	Risk Owner Lead Executive	Review Time-scale
Risk No 3 : Industrial Action									
UK National NHS Policy	Service interruption to clinical and support services Inability to meet waiting times targets Critical services (clinical, payroll, laundry, IM&T, catering) unable to deliver during industrial action Financial impact on organisation Political impacts on SBC/healthcare partners Environmental impacts on premises Adverse impact on organisational culture/ performance/ workforce	Performance and Delivery	1. Staff Governance framework 2. Business Continuity Plans 3. Local guidance re Industrial Action for managers and staff developed in Partnership and issued to managers and staff 4. NHS Borders / TU negotiation group to be re-established as required (reporting through to APF)	Possible	Major	High	1. Awareness of any ongoing national / UK wide activities through HRD and CE networks	Director of Work-force and Planning	30 Sept 2014

Source of risk	Risk	Linked to Corporate Objective	Managed by (key systems / processes):	Likeli-hood	Impact	Risk Level after Mitigation	Further Actions Required	Risk Owner Lead Executive	Review Time-scale
Risk No 4: Unacceptable Clinical Performance									
Unacceptable performance by: **-Doctors** **-Nursing and midwifery** **-AHP, Dentist, Pharmacy, Optometrists and other supporting clinical professions** **<u>Doctors</u>** Doctors fail to deliver good medical practice as defined in GMC 4 domains: -knowledge, skills & performance -Safety & quality -Communication, partnership & Team working -Trust Internal processes fail to consistently identify Doctors poor performance in the 4 domains Organisational tolerance of basic procedural deficiencies impacts adversely on care outcomes **<u>Nurses & Midwives, AHP, Dentists etc</u>** Fail to adhere to -safe guard patient well being -maintain knowledge, skills -protect & promote health and well being of pts& wider community -provide high standard of practice & care -Open & honest -promote trust	Patient safety compromised Increased financial pressures Overall organisational performance to achieve LDP adversely affected Litigation Increase in: -complaints -compensation Non compliance with relevant legislation Operational impacts on service delivery	Patient Safety	1. Training & Induction, 2. policy for introduction of new procedures and treatments (ADTC, Clinical Gov Committee), GMC/NMC professional standards and so on. 3. HPC 4. Strong focus on SPSP and strict adherence to procedures enforced. 5. HSMR and other clinical outcomes measures are monitored closely eg mortality review, HAI 6. Appraisal & revalidation for all Doctors 7. Clinical Governance framework 8. Healthcare governance systems 9. Significant Adverse Event Review process with Adverse Event Management Policy	Unlikely	Major	Medium	1. Investigations process to be developed for claims 2. Learning from complaints 3. Developing clinical leadership to support good practice 4. Expand clinical outcomes measures to all NHS Borders locations 5. Review of Doctor recruitment process	Medical Director Director of Nursing & Midwifery	April 2014 Annually

Source of risk	Risk	Linked to Corporate Objective	Managed by (key systems / processes):	Likeli-hood	Impact	Risk Level after Mitigation	Further Actions Required	Risk Owner Lead Executive	Review Time-scale
Risk No 5: Non-achievement of Financial Targets (RRL and CRL)									
`Reduction in the level of income or increases in the level of expenditure Requirement to achieve non financial targets Unplanned event	Statutory targets are not achieved. Significant increase in Scottish Government involvement in the organisation Adverse impact on service delivery & workforce Detrimental impact on quality of services and patient safety Increased complexity of patient care needs not met Reputational risk of the organisation and board members	Deliver safe, effective and high quality services	1. Local Delivery Plan Process 2. . 3. Ongoing review and update of the financial plan. 4. Maintain strong links with SG – quarterly meetings. 5. Medium and longer term planning 6. Horizon scanning and networking. 7. Organisational awareness of the financial environment. 8. Financial management systems and controls. 9. Ensure management information and reporting is timely, accurate, understood and acted upon. 10. Establishment of the Quality and Efficiency Board. 11. Robust project management. 12. Focus on quality 13. Senior Clinical input into decision making .	Possible	Major	High	1. Organisational engagement 2. Wider clinical input to develop plans and strategies 3. Review of all services	Director of Finance	31st March 2016

Source of risk	Risk	Linked to Corporate Objective	Managed by (key systems / processes):	Likeli-hood	Impact	Risk Level after Mitigation	Further Actions Required	Risk Owner Lead Executive	Review Time-scale
Risk 6 : Destabilisation of BGH as a full District General Hospital									
Key services are unsustainable due to a range of pressures Reduction of medical trainees in key specialities (Paeds/obstetrics/neonates) 24/7 cover not sustainable Reduced volume of patients requiring core clinical activities	Patients do not all receive appropriate care within NHS Borders Hospital closure Workforce issues Legal issues	Patient Safety	1. Work ongoing to ensure Borders residents are not referred out of the Borders unless clinically necessary. 2. Catchment population increasing through services to neighbouring Boards being offered / encouraged 3. GP not to refer out of Health Board unless clinical need requires 4. Increased profile of services available to external patient communities 5. Increased de-commissioning /repatriation 6. Increased training/development in advance for Neonate Nurse Practitioner 7. Joint working with Lothian. Joint appointments for sustainability of service. 8. Improved monitoring of Board referrals by GP practice / consultants – monthly via Commissioning Team 9. Role Development Framework agreed and in place	Possible	Extreme	**High**	1. New service models,- to be developed 2. Training up skilling non-medical staff, advanced practitioners 3. CE Opes: receiving quarterly reports plus exception reporting 4. Workforce planning to meet service needs continually reviewed. 5. Strategic approach to advanced nurse/midwife / 6. AHP practice	Chief Executive	Annually

Source of risk	Risk	Linked to Corporate Objective	Managed by (key systems / processes):	Likeli-hood	Impact	Risk Level after Mitigation	Further Actions Required	Risk Owner Lead Executive	Review Time-scale
Risk No 7 : Failure of Resilience									
Failure to have adequate and tested business continuity plans Resilience to have human resource to respond Sufficient capacity to deal with crisis Significant dependence on technology to deliver healthcare	Collapse of critical services. Significant impact on patient safety	Deliver safe, effective & high quality services Patient Safety Improve health of population	1. Training and exercising business continuity plans overseen by Resilience Committee 2. Monitoring that adequate plans exist & are relevant 3. Continue to implement actions coming out of internal audit, including exercise plan, e-learning for selected groups, and awareness raising	Possible	Extreme	High	1. Complete IT disaster recovery plans 2. Internal audit PWC Feb 2015- revise risk based on audit findings	Director of Public Health	Quarterly June Sept Dec March
GP Practices resign from contract to provide medical cover to Community Hospitals. Hawick Community Hospital cover ceases 1st February 2014.	Interruption of medical provision to Community Hospitals- lack of medical cover for patient care , patient flow across system disrupted, potential patient safety issues Financial costs of alternative medical cover unsustainable Adverse publicity	Deliver safe, effective & high quality services Patient Safety Improve health of population	1. Current operational processes	Almost certain	Moderate	High	1. Development of an action plan is underway and will be agreed by January 2014	Director of Public Health Chief Operating Officer	Monthly basis

Source of risk	Risk	Linked to Corporate Objective	Managed by (key systems / processes):	Likeli-hood	Impact	Risk Level after Mitigation	Further Actions Required	Risk Owner Lead Executive	Review Time-scale
Risk 8 : Failure to meaningfully implement clinical strategy									
Change of government brings change in focus of 20/20 vision. Political influence (local & national) not aligned with local strategy Funding from Government based on % inflation is withdrawn with reduction in funding. Population increase is greater than anticipated. Population health has no improvement through lack of "mutuality" and ownership by Borders community. Under estimate of future disease profile e.g. increasing antibiotic resistance Capacity of human resources to embed the key strategic principles is not timeously available. Integration agenda will adversely affect the implementation of the strategic way forward. The community based clinical & social care infrastructure is not developed to timescales or insufficient volume to meet needs. Organisational change is too widespread affecting moral and therefore productivity. Cont'd	Clinical strategy not aligned to change in political direction and therefore undeliverable. Healthcare Service will not be delivered within available means. Financial budgets exceeded. Patient safety & quality are adversely affected for short periods during transition periods or for longer term. Reputation of the Health Board diminishes within Borders community. With consistent poor publicity. Borders General Hospital does not function at efficient level due to lack of appropriate community care infrastructure for patient flow. Meaningful public engagement slows impacting on the achievement of person centred care. Staff morale adversely affected, productivity slows, patient safety, service delivery adversely affected Demands on healthcare delivery are greater than planned capacity.	Deliver safe, effective & high quality services Patient Safety & Quality Improve health of population Promote excellence in organisational behaviour	1. Fiscal Financial control 2. Public engagement process. 3. Public Health strategy and monitoring of population health 4. Staff engagement processes underpinned by principles of partnership working. 5. Scheme of Integration & strategic plan in development. 6. Proactive contact with political and media stakeholders.	possible	major	**High**	1. Chair & CE to participate in a programme of staff engagement regarding the clinical strategy. 2. Board Executives & Non Executives to attend the SBC area forum network. 3. Further develop community services to support people in their own homes. 4. Further develop public health and community asset approaches to improve health	Medical Director	July 2015

Source of risk	Risk	Linked to Corporate Objective	Managed by (key systems / processes):	Likeli-hood	Impact	Risk Level after Mitigation	Further Actions Required	Risk Owner Lead Executive	Review Time-scale
Risk 8 : Failure to meaningfully implement clinical strategy – cont'd									
Public engagement is over stretched by volume of consultations. Public no longer engage. Positive staff engagement not attained. Workforce challenges in terms of recruitment & retention in all disciplines						**High**			
Technology: lack of comprehensive IT Strategy identifying business needs and core gaps, impacts of e-health strategy, Staffing costs are greater than funding levels.	Technical solutions are not adopted and clinical strategy not fully implemented. Opportunities for efficiencies missed.	Deliver safe, effective & high quality services Patient Safety & Quality	1. Bid to national funding streams. 2. Participation in IHI programme to identify prioritised investment for best value	Almost certain	Major	**Very High**	1. Explore future strategic options 2. Develop IT Strategy	Medical Director	July 2015