To:	TRUST BOARD
From:	MEDICAL DIRECTOR
Date:	7 APRIL 2011
Healthcare standard:	Outcome 16 – Assessing and Monitoring the Quality of Service Provision

Title:	**UHL STRATEGIC RISK REGISTER AND THE BOARD ASSURANCE FRAMEWORK (SRR/BAF)**

Author/Responsible Director:
Risk and Assurance Manager/ Medical Director

Purpose of the Report:
To provide the Board with an updated SRR/BAF for assurance and scrutiny.

The Report is provided to the Board for:

Decision	**X**	Discussion	**X**
Assurance	**X**	Endorsement	

Summary / Key Points:

- The report concludes the review cycle for 2010/11.
- The 2010/11 SRR/BAF has been updated to reflect changes made by the risk owners.
- 17 actions have been completed and 7 actions have had timescales extended.
- There are no risks scoring 25 (extreme) identified from the organisational risk register for the attention of the Board.
- Strategic risks for 2011/12 have been identified and assessed by the UHL Executive Team prior to review by the Board.
- A new SRR/BAF reporting frequency is proposed for consideration.

RECOMMENDATIONS:

The Trust Board is invited to:

(a) review and comment upon this iteration of the SRR/BAF, as it deems appropriate, with particular reference to risk No's 16, 17, and 20.

(b) note the actions identified within the framework to address any gaps in either controls or assurances (or both);

(c) identify any areas in respect of which it feels that the Trust's controls are inadequate and do not, therefore, effectively manage the principal risks to the organisation meeting its objectives;

(d) identify any gaps in assurances about the effectiveness of the controls in place to manage the principal risks; and consider the nature of, and timescale for, any further assurances to be obtained, in consequence;

(e) identify any other actions which it feels need to be taken to address any 'significant control issues' to provide assurance that the Trust is meeting its principal objectives.

(f) Advise whether quarterly reporting of the SRR/BAF is considered to be adequate in the future (para. 3.4).

Strategic Risk Register Yes	**Performance KPIs year to date** **N/A**
Resource Implications (eg Financial, HR) None	
Assurance Implications This report provides Board assurance that the Trust's strategic risks:- Are an accurate reflection of the principal risks to the achievement of the strategic objectives; Are appropriately controlled; That controls in place are effective; Any actions for further control are implemented.	
Patient and Public Involvement (PPI) Implications N/A	
Equality Impact N/A	
Information exempt from Disclosure No	
Requirement for further review ? Yes.	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **7 APRIL 2011**

REPORT BY: **MEDICAL DIRECTOR**

SUBJECT: **UHL STRATEGIC RISK REGISTER AND THE BOARD ASSURANCE FRAMEWORK (SRR/BAF) 2010/11**

1. INTRODUCTION

1.1 This report provides the Board with :-

a) A copy of the SRR / BAF as of 31 March 2011 (attached at appendix 1).

b) A summary of changes to actions (attached at appendix 2).

c) Suggested areas for scrutiny of the SRR/BAF (attached at appendix 3).

2. ASSURANCE FRAMEWORK 2010/11: POSITION AS OF 31 MARCH 2011

2.1 The Trust's Risk and Assurance Manager has amended the content of the SRR/BAF to reflect information made available from Executive Directors. Changes since the previous report are highlighted in red.

2.2 A further 17 actions have been completed since the previous report to the Board and 7 actions are ongoing and have been granted extended timescales for completion. Where deadlines have been extended an explanation is recorded in the summary of changes to actions attached at appendix 2.

2.3 There are no risks scoring 25 (extreme) identified from the operational risk register for the attention of the Board.

2.4 Each SRR/BAF entry will be scrutinised in detail on a twice yearly basis and to enable this, three risks are presented by their owners at each meeting. The following risks will be presented by the Director of Human Resources and Chief Operating Officer respectively:-

Risk No. 16 – *'Inability to maintain competence of staff'*
Risk No. 17 – *'Inadequate organisational development'*
Risk No. 20 – *'Failure to comply with the Health and Social Care Act 2008 (Hygiene Code)'*

Scrutiny of the above risks concludes the second cycle of review for all the risks on the 2010/11 SRR/BAF prior to the development of the 2011/12 version.

3. 2011/12 SRR/BAF DEVELOPMENT

3.1 We have recognised that as the existing UHL SRR/BAF has developed it has perhaps become too detailed and might obscure real risks facing the Trust. It is natural as the SRR/BAF matures it can be expected to vary in style, format and reporting frequency to suit the needs of the Trust (whilst meeting the minimum criteria laid down by the Dept of Health). The development of new strategic objectives in line with the Trust's 'Good to Great' strategy and the development of key risks /actions in the creation of the Integrated Business Plan (IBP) risk chapter provide an opportunity for review of the SRR/BAF.

3.2 The Trust's strategic risks for 2011/12 have been identified and agreed by the Executive Team drawing upon the 2010/11 SRR/BAF and also the 2011/12 business planning process. These risks have been assessed to identify their consequences, risk scores and any mitigating actions required, culminating in a review by the Board on 7 April 2011.

3.3 During the transition to the 2011/12 SRR/BAF we must ensure that risks from the previous SRR/BAF are either:

a. Encapsulated within the content of the new version;

b. Confirmed as closed by the risk owner (i.e. all mitigating actions completed or the risk identified as no longer relevant);

c. Be transferred to the operational risk register under the relevant corporate directorate.

3.4 With a greater strategic emphasis within the revised SRR/BAF the Board is asked to consider whether a quarterly reporting frequency would be more appropriate, thereby receiving the first SRR/BAF report in July (covering the period April to June).

4. Taking into account the contents of this report and its appendices, and the presentation by the Director of Human Resources and the Chief Operating Officer, in relation to risk No's. 16, 17, and 20 the Board is invited to:-

(a) review and comment upon this iteration of the SRR/BAF, as it deems appropriate, with particular reference to the risks above.

(b) note the actions identified within the framework to address any gaps in either controls or assurances (or both);

(c) identify any areas in respect of which it feels that the Trust's controls are inadequate and do not, therefore, effectively manage the principal risks to the organisation meeting its objectives;

(d) identify any gaps in assurances about the effectiveness of the controls in place to manage the principal risks; and consider the nature of, and timescale for, any further assurances to be obtained, in consequence;

(e) identify any other actions which it feels need to be taken to address any identified 'significant control issues' to provide assurance on the Trust meeting its principal objectives;

(f) Advise whether quarterly reporting of the SRR/BAF is considered to be adequate (para. 3.4).

P Cleaver
Risk and Assurance Manager
31 March 2011

UHL Strategic Risk Register / Assurance Framework 31 March 2011

Corporate Objective	Risk No.	Risk Description	Risk Cause	Risk Consequence	Risk Owner	Gross Risk I	Gross Risk L	Gross Risk I x L	Existing Controls	Net Risk I	Net Risk L	Net Risk I x L	Assurances on Controls (Where can we gain evidence that our controls / systems, on which we are placing reliance, are effective)?	Positive Assurances (What evidence shows we are reasonably managing our risks and objectives are being delivered)?	Gaps in Assurance (Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective)?	Gaps in Control (Where are we failing to put controls/systems in place, where are we failing to make them effective)?	Actions for further control	Target Risk I	Target Risk L	Target Risk I x L	Due Date	Action Owner
Deliver excellent patient experience so that UHL is recognised as the No.1 provider of emergency and specialised	**1**	**Patient safety being significantly compromised**	Pressure of emergency demand Increasing demand in Maternity and neonatal services Medication errors Staff shortage / fatigue Failure to meet the requirements of Caring@its Best or other external standards (e.g. Hygiene Code CQC standards, etc) Failure to comply with DH Central Alerting System (CAS) alerts CIP schemes for 2010/11 implemented without robust analysis of potential outcomes of patient safety Balance of organisational priorities	Harm to patient Poor Trust reputation Increased patient/ family/carer dissatisfaction Potential for litigation	Medical Director	5	5	25	Medical cover rearranged in ED to provide more comprehensive cover Job plans for medical consultants	5	3	15	Access target data reported to TB/Q&PMG and F&PC Weekly monitoring @ Emergency Care Delivery Group	4 hour wait performance for ED = 96.5% (year to date)		Demand for ED services		5	2	10		
									LLR Emergency Plan													
									Mortality / morbidity policy				Clinical Effectiveness Committee									
									Maternity and Children's Programme Board and UHL Specialty Boards													
									Maternity metrics				Maternity metrics and neonatal closures reported to G&RMC									
									Escalation / contingency plans in place for Maternity / neonatal closures in times of peak demand				Maternity metrics and neonatal closures reported to G&RMC									
									Medicines Management				Medicines Management Board minutes	Medicines Management action plan - Reduction in serious errors								
									Caring @ its best' initiative													
									Patient Safety Strategy and associated action plans UHL Quality Improvement Strategy				Reports to G&RMC	**Positive outcome from CQC visit (LRI & GH) Dec 10 / Jan 11.**								
									Nursing metrics				Performance report including quality metrics reported to TB/Q&PMG/NME									
									Clinical Skills training and Statutory / Mandatory training				See assurances for risk No 16									
									Policies and procedural documents				**HCC Hygiene Code inspection report (Dec 2008)** **CNST / ARMS assessments** **CQC self-assessment for outcome 16** **HTA inspections** Clinical audit	**No breaches of hygiene code noted at previous inspection (Dec 2008)** **Compliance at level 2 for Maternity CNST and ARMS (awarded Oct and Dec 2008 respectively)** **Compliance with CQC outcome 16 for 2009/10** Below C Diff. trajectory Improved nursing metrics	Staff recruitment to 'hard to fill' posts		Implementation of DoH '10 for 2010' programme Development of Safety and Quality Board compliance statements for FT application Standardisation of 'high risk' medical equipment Consent policy to be updated to reflect the minimum requirements within the NHSLA 'ARMS 2011/12 standards				April 2011 May 2011 March 2012 May 2011	Director of Safety and Risk Director of Clinical Quality Medical Director Planned Care Divisional Director and Q&S Manager
									Robust Discharge process Ongoing monitoring / audit of discharge process				Results of ongoing monitoring / audit reported to G&RMC, PCT and regular agenda item on Collaborative Clinical Interface Group (CCIG)									

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									WHO surgical safety checklist				Quarterly incident reports to G&RMC Monitoring of use / completion of WHO checklist via theatre 'metrics'									
									Tissue Viability Team Updated central guidance to denote avoidability				Quarterly Incident reports / complaints reports to G&RMC									
									Management infrastructure for CAS process Robust CAS process				CAS deadline compliance data reported via G&RMC/ Medical Device Alert group. Annual audit /review of Divisional CAS processes National performance data from NPSA (from January 2011)	CAS compliance rate of 90% for 4th quarter of 2010. Annual compliance rate 86% (1 percentage point higher than 2009) CQC QRP report (Feb 2010) showed improved performance for CAS alert indicator (moving from 'worse than expected' to 'similar to expected')								
									Risk assessment process for 2010/11CIP schemes Monitoring of key patient safety indicators CIP safety indicators Nursing scorecard				Executive safety walkabouts Incidents and complaints data reported to G&RMC, and Quality Schedule meetings Staff concerns reporting line Nursing Metrics		No process for regular audit of 'unclosed' incidents on Datix							
									Executive Director Leadership				**CHKS results** reported to G&RMC and COG COG review and require actions for improvement from Divisions Actions monitored via G&RMC Monthly Clinical Quality Review Group meeting CQUIN data reported to G&RMC LLR 'Excellence for all' minutes of LLR Board Patient Safety Quality Account information UHL quarterly Patient Safety Report Confirm and Challenge group Q&PMG	**Patient Safety First certificate (NPSA)** **Dr Foster Hospital Guide 2008/09 (84.25 patient safety score)** **CHKS data**							

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	2	**Poor outcomes of clinical care**	Optimal clinical pathways not fully resourced e.g. #NOF/ VTE/head injury/Stroke Shortfalls in clinical staffing to meet peak demand	Patient harm Poor Trust reputation Increased patient/ family/carer dissatisfaction Loss of income related to quality contract/CQUIN Potential for litigation Increased No of incidents relating to deteriorating patients Increase in avoidable mortality and morbidity	Medical Director	4	5	20	Regular workforce review Workforce and OD Group	4	4	16	No of staffing level issues reported as incidents reported to TB and Q&PMG via divisional heat map Reports from Clinical Effectiveness Committee to Q&PMG and G&RMC **CHKS/HMSR reported to CEC** Exception reports to private section of TB re standards of clinical practice Reports from national registries	**Majority of UHL CHKS /HSMR data favourable. (However there are issues around 30 day mortality figures) UHL named as one of the CHKS 'top 40' hospitals for 2010** **Dr Foster Hospital Guide 2008/09 satisfactory overall for clinical effectiveness**	Uncertainty around the accuracy of HSMR data (possible clinical coding issue)	CQC alert for perinatal mortality and neonatal readmissions UHL red rated in CHKS patient safety report re 30 day mortality for elective procedures	To perform detailed review of 30 day mortality rates for elective surgery	4	2	8		
									Staff sickness absence monitoring				Sickness absence rates reported to TB and Q&PMG via divisional heat map	Sickness absence rates reducing (2.8% Sept 2010)								
			Failure to act on results						Local standard operating procedures				Complaints and incidents data reported monthly /quarterly to G&RMC and Q&PMG	Very low numbers of SUI's related to failure to act on results **Dr Foster Hospital Guide 2008/09 satisfactory overall for clinical effectiveness**		Local SOP's not available in all areas	Local SOP's to be developed in all CBU's					
									Strengthened IT facilities for results													
			#NOF delays						Increased operating sessions available for #NOF				No of #NOF's to theatres in 36 hrs reported to TB and Q&PMG via divisional heat map Reports from national registries	74% of # NOF operated on within 36 hrs (YTD Sept 2010) **Dr Foster Hospital Guide 2008/09 satisfactory overall for clinical effectiveness**		Latest SHA data shows UHL in bottom quartile						
									Productive theatre project (TPOT)				Theatre utilisation rates									
			Lack of recognition of deteriorating patients						Early Warning Scores and deteriorating patients care pathways				Acute deteriorating patient reports to G&RMC from 8/6/10 SUI's reported via monthly Quality and Performance report to Trust Committees	**Dr Foster Hospital Guide 2008/09 satisfactory overall for clinical effectiveness**	Lack of consistent indicators to monitor quality / safety elements of CIP		Minimum standards for clinical handover being developed				July 11	Dr S Agrawal
									Implementation of 24/7 critical care outreach at LRI													
									'ALERT' course													
									Deteriorating Patients Steering Group													

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			Insufficient staff training						Clinical training and development ALERT Course				Clinical Audits reported to Clinical Audit Committee		Lack of monitoring by senior committees of actions associated with clinical audit into outcomes of clinical care	Limited assurance from Internal Audit with regard to effectiveness of clinical audits	Effectiveness of clinical audits to be built into Internal Audit annual work plan					
									Staff appraisal				Appraisal rates reported to TB and Q&PMG via divisional heat map	Increasing rate of appraisal (92% Dec 2010)								
			Venous Thrombo-Embolism (VTE)						VTE checklist/ risk assessment				Nursing metrics reported to TB and Q&PMG via divisional heat map	**Exemplar status for VTE prevention**		Required level for metrics and CQUIN not being achieved						
									UHL Adult Anticoagulation, Thrombosis and Thromboprophylaxis Policy													
			MRSA bacteraemia and C Diff infection						Infection Prevention policies and procedures				Infection rates reported to TB and Q&PMG via divisional heat map	**Dr Foster Hospital Guide 2008/09 satisfactory overall for clinical effectiveness**								
									Infection Prevention audits				Reports of audits to Infection Prevention Committee									
									Safety Express Programme (QIPP Safer care work stream)				Frequent reports from Director of Safety and Risk to G&RMC and Q&PMG									
			Use of IT not fully developed						External report recommendations (NICHE-TAVI report)				Monthly report to G&RMC				Implementation of NICHE-TAVI action plan				Apr 2011	Director of Safety and Risk

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	3	**Failure to deliver a high quality patient experience**	Absence of measurement system to gauge performance Medical / Nursing staff shortages Lack of engagement with patient / family/ carers when things go wrong Lack of development of a patient focussed culture /training	Increased level of complaints Adverse media attention / reputational issues Loss of patient income Poor national patient survey results Litigation Reducing levels of care	Medical Director (supported by COO and Director of Comms)	4	5	20	Observational audits Executive safety walk around Executive sponsors for ward areas	4	3	12	Patient Experience Group Public Involvement Group Patient experience dashboard	100% same sex accommodation in relevant wards achieving 18 week RTT				3	2	6		
									Increased complaints meetings and sharing of RCA reports with families												
									Customer care' training Patient experience polling NHS Choices website for patient views Patient Experience Plan Patient Experience module				Patient experience reporting incorporated into Quality and Performance reports to Q&PMG and G&RMC Divisional patient experience performance monitored at Q&PMG	Some improvement in satisfaction scores for patient polling			Introduction of value cards				tba	DCER
									CQC National Patient Survey				Report to TB 2009/10 on **results of National Patient Survey**	**Improved CQC National patient satisfaction score**								
									Divisional trajectories for 100% appraisal rate (by December 2010) Divisional action plans to deliver 100%				Confirm and challenge monthly assurance								
									Caring at its best				Quality metrics Nursing Strategy plans Nursing Scorecard Health check report	Quality metrics improving rapidly			Continued roll-out of 'releasing Time to Care' (completion of phases 1 and 2) Increased number of metrics Introduction of Nursing Strategy Introduction of electronic metrics monitoring				May 2011	Chief Operating Officer
									Complaints analysis				UHL Complaints Annual report 2008/09 reported to G&RMC in 2009/10	'Story telling' to TB								
													Dr Foster Hospital Guide **CHKS benchmarks**	**Dr Foster Hospital guide 2008/09 satisfactory overall (exception - lack of 24/7 palliative care team)**								
			Poor 'end of life' experience						LLR/UHL End of Life Strategy End of life Board				LLR End of Life Board	End of Life fast track								
	20	**Failure to comply with The Health and Social Care Act 2008 (Hygiene Code)**	Failure to comply with the 10 criteria detailed in the act, against which a registered provider will be judged by the Care Quality Commission	Failure to comply would result in the CQC using enforcement powers to ensure the trust meets its legal obligations. Potential for prosecution of senior trust board members and/or enforcement notices against UHL with financial penalties.	COO/ Chief Nurse				Hygiene Code of Practice													
									Quarterly self assessment against the Hygiene Code of Practise .				Results of quarterly self assessments reported to the UHL Infection Prevention Committee and PCT commissioners through the Quality Schedule.	Evidence of roll-out of ANTT training and introduction of intravenous cannulation packs containing a skin disinfectant using a 'hands free' method of delivery.								

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				Loss of trust reputation. Loss of confidence from potential patients within LLR and surrounding counties. Loss of reputation and confidence within LLR GP consortia		5	4	20	LLR Infection Prevention Strategy	5	2	10	LLR DIPAC meeting includes review of LLR progress embracing LLR Strategy, work plan and communications plan					3	3	9		
									UHL Infection Prevention Plan				Monthly ward hygiene reviews	Improving IP incidence position								
									CQC-Provider Compliance Assessment against Outcome 8 (Regulation 12-Cleanliness and infection control).				Nursing Metrics include Infection Prevention monitoring on all wards Quarterly meetings with SHA	UHL has declared compliance with Outcome 8 (Regulation 12) Positive monthly IP metrics								
									The Infection Prevention team have undertaken a review of the policy, procedure and audit requirements of the Act to ensure that UHL meets the requirements detailed.												
									Infection Prevention groups formed at Divisional and CBU level				Evidence and assurance against the Infection Prevention 'Toolkit' can be provided to the trust board and external monitoring bodies.		Lack of consistent format for the IP meetings at divisional/ CBU level. Lack of assurance/evidence available.		Monthly monitoring of CBU and Divisional progress at relevant boards (next review Jan 2010)				ongoing	COO/CN
Prove we value our staff and improve satisfaction, motivation and performance	4	**Failure to offer staff suitable development opportunities**	Lack of the development of a learning and development organisational culture Lack of resource to invest in development opportunities Shortage of staff to support protected time for development	Poor staff morale Staff with Inadequate skill set to appropriately deliver patient care and service delivery High staff turnover rates so lack of continuity Non-compliance with CQC regulation 23 (outcome 14a)	Director of HR	5	4	20	Implementation of the Leadership and Talent Management Strategy Use of EMSHA talent profile Incorporation of Talent profile into UHL appraisal documentation	5	2	10	Reviewed by Learning and Development Strategy Group. Submission of profiles to EMSHA Quality monitoring of Appraisals	Provision and take up of leadership programmes and activities internally and externally	Lack of scrutiny at Executive level	Executive Monitoring of implementation of strategy		3	3	9		
									National /local Staff survey Staff engagement Group Workforce & OD group				**Staff survey results** Reports to Staff Engagement Group		Although staff surveys take place there has been poor uptake from staff (18% return from Jan 11 survey)	High volumes of complaints about staff attitudes/ behaviours	Implement local staff polling and survey whole organisation within first six months of implementation Define the organisation-wide intervention to support the embedding of values and behaviours				July 2011 Apr 2011	Director of HR Director of HR/DCER/ Director of Nursing
									Appraisal process Training and Development plans				Monitoring appraisal rates via performance scorecard Audit of quality of appraisals (March 2011) results to be reported to Workforce and OD committee Reports to Q&PMG Training and Development plans monitored via TED group	Appraisal performance of 92% (Jan 2011) Low/no numbers of SUI involving competence issues	Lack of a robust mechanism to monitor quality of appraisal							

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									Learning and Development Strategy eLearning products for UHL Study Leave Policy				Learning and development strategy Group.		Baseline Statutory and Mandatory Training Requirements with National Requirements / other comparative Trusts Lack of compliance monitoring for Statutory and Mandatory training		Review delivery of Statutory and Mandatory Training Requirements and make recommendations to Learning and Development Strategy Group and Workforce and OD Committee				Apr 2011	Director of HR
													External reviews and inspections	**Third party reports Compliant at NHSLA ARMS level 2 (Dec 2008) related to training** Compliant with Regulation 23 outcome 14a)								
													Training plans reported to G&RMC, Workforce and OD group			Workforce and Organisational Development Committee monitoring of compliance against Statutory and Mandatory training requirements .	Divisions to sign off and monitor training plans Divisions to report bi annually on achievement of training plans Review Statutory and Mandatory Training Performance and update Workforce and OD Committee				May 2011 Apr 2011 May 2011	Director of HR Director of HR Director of HR
													Medical staff study leave information									
	5	**Inability to recruit and retain appropriately skilled staff**	Not knowing what we need Systems to recruit/train Poor consultant/doctor capabilities (new and experienced) No appropriate staff engagement to ensure motivation Lack of staff satisfaction	Limited choice of recruitment Poor management of clinical performance Poor service delivery/ clinical outcomes Poor management performance High turnover rate of staff	Director of HR				Development and implementation of Organisational Development Plan 'Bridging the Gap' Strategy Strategic Workforce Plan Recruitment and selection policy Recruitment and selection training				**Internal /external reviews/ assessments (e.g. NHSLA ARMS, CNST, CQC)**	**Compliant with CNST and NHSLA ARMS level 2 (Oct and Dec 2008 respectively) related to training** Specific recruitment programmes with appropriate testing (e.g. nurse clearing house, HCA's/ trainee Drs)								
									Comprehensive selection process Recruitment and retention Strategy				Turnover rate monitored via quality and performance report	Turnover rate at 7% (Dec 10)								
									Comprehensive sickness absence and well-being action plan				HR performance scorecard Quarterly monitoring of action plan	Low Turnover rate Low sickness absence rate compared with other East Midlands Trusts		Not yet at 3% sickness absence rate						

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						4	4	16	Ongoing analysis of recruitment hot-spots	4	3	12		Proactive action for recruitment hot-spots e.g. Emergency Medicine fortnightly reminder meetings Within other specialist areas, such as Embryology and Cardio-Respiratory, the Trust has developed ways to train its own staff, where they are not available nationally.				4	2	8		
									Staff Engagement Programme				**Staff Survey Results** Staff polling									
									Appraisal process Enhanced consultant appraisal leading to revalidation Plan in place for medical staff non-engagers in revalidation appraisal				Monitoring of appraisal rates via quality and performance reports Appraisal documentation for medical staff			Consultant appraisal roll-out programme shows less than 100% compliance					
									Development plan for senior managers Personal Development Plans				Monitoring of appraisal rates via quality and performance reports		Requirement for increased scrutiny of training and development activities and compliance rates		Implement level 4 Clinical Leadership Programme				Dec 2011	Director of HR
Build a world class reputation by developing research , education and training which is relevant to our diverse population	6	**Inability to achieve academic expectations and integrate R&D into the work of the Trust**	Failure to engage with cooperative and well performing partners Insufficient resource to solve existing problems External influences that are not within UHL's control Lack of international quality of research Insufficient priority given by the Trust to the achievement the integration of R&D into work processes 2011 NIHR process for renewal of Biomedical Research Units and Biomedical Research Centres	Trust will not be seen as 'best in class' for R&D Inability to attract innovative clinicians Inability to attract world class academics reduction in patient numbers Loss of R&D income Loss of education income Loss of key tertiary services	CEO				UHL R&D Strategy communicated across UHL R&D Business Plan Agreed divisional strategy for R&D Divisional R&D plans Strategy for Phase 2 NIHR commercial trials				TB approval of UHL R&D Strategy	Successful HIEC bid Jan 2010 CLAHRC review BRU approval Implementation of 1st wave of HIEC projects	Post RAE plan not clear to UHL R&D Committee R&D Directorate needs to scope R&D potential	Lack of a robust financial model of R&D PLICs view exposes R&D financing	Develop strategy to ensure NIHR funding Additional BRU applications				Apr 2011 Apr 2011	Director of R&D CEO
									Director Leadership: Director of R&D Internal peer review system for grant applications R&D Committee				Development of R&D metrics	Good performance on R&D metrics	R&D office capability and Performance	Build senior R&D management capacity and capability;	Performance of R&D office to national research administration requirements from NIHR Review of R&D office function				Jul 2011 Jun 2011	Director of R&D Director of R&D

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						4	4	16	R&D Committee reports on progress of Trust against AHSC concept Regular meetings with partners	3	4	12	Agendas and Minutes of meetings of R&D Committee 2009/10		No evidence of effective preparation for Research Excellence Framework (REF) Need to see University of Leicester strategy for Health Sciences No assurance that NHS involvement in the above is providing value for money		UHL R&D Committee to develop its shareholder role	3	2	6	Apr 2011	Director of R&D
									Assessment of research capacity and capability as part of planning assurance process for 2009/10 Divisional representation included in R&D Committee Management information systems for capturing research activity				CQC self assessment Divisional R&D performance indicators / measures reported to R&D committee every quarter	Compliance with CQC core standard C12 for 2009/10 Performance of R&D office strengthening MHRA inspections - absence of critical findings		Divisional appraisal skills				
									R&D clinical divisions 'Lead Group'				R&D component of IBP and LTFM									
									Joint UHL/University of Leicester R&D partnership group which meets bi-monthly Joint R&D office function East Midlands cluster developed. Collaborative monitored by CEO's of Trust's, VC's of universities and Deans of Med Schools					Growth of links to Loughborough University Launch of EMHSC Jan 10 Progress review of EMHSC and identification of next steps							
									R&D Committee UHL-University Leicester Standing Committee				Director of R&D monthly report to R&D committee									
In a challenging financial environment, develop capacity, capability and credibility to ensure UHL is fit for purpose	8	**Non-human resource (e.g. buildings, IT systems, medical equipment) not being 'fit for purpose'**	Concerns about future IT Strategy after LLR Health Economy chose to opt out of Lorenzo, and the National Programme for IT has been significantly scaled down. Uncoordinated approach for the purchase of IT systems and medical equipment below capital threshold. Business continuity plan for all IT systems not yet finalised. Fragmented approach for capital planning and developments. Condition of Estates with significant back log maintenance.	IT systems do not support the health system, and instead function in individual organisations. IT systems not fit for purpose to support 21st Century patient care. IT systems do not enable clinical transformation and support the delivery of more efficient care. IT continues to develop as sporadic and point solutions rather than as an enterprise wide approach - this makes the system more complex, fragile and the maintainence more expensive.	Director of Strategy				Corporate Business Continuity plans.				Draft IT Strategy.	Copy of draft IT strategy, and actions from Board Development Session where Strategy was discussed and agreed.	Robust business continuity plans for all systems and assets.	Copies of all business continuity plans.	Development of clear SLAs with Clinical Divisions so encourage customer service and ensure transparent costs regarding IT and Estates (this will be achieved as part of the development of shared services).				Sept 2011	Director of Strategy (Facilities and IT)
									Service Impact Assessment being undertaken by IT and Estates to scope the prioritisation of investment needs, & inform future strategies.				Medical equipment register. Asset register Incident reports	Robust procurement and contracts in place and reviewed. Technical specifications reflect needs of the Trust and services.	Cohesive systems not in place across the Trust. Various different processes and not effective joined up thinking.	Silo working within Trust which requires effective communication regarding business planning, training and updating of equipment	Estates and IT Strategies to compliment Clinical Strategy, incorporating clear Models of Care, efficiencies, clinical adjacencies, & robust funding streams for capital and non-capital equipment to be agreed by Trust Board as part of the 5 Year Business Plan in March.				March 2011	Director of Strategy Director of Facilities Head of IT

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			Lack of robust medical equipment repair / maintenance strategy. Lack of standardised approach to hard FM provision across 3 sites.	Inefficiencies at operational level due to inadequacies of medical equipment below capital threshold. Ability to right-size estate is limited (even more so with Lansley's 5 tests) creating potentially abortive or compromising partial or interim investments. Physical environment not fit to support excellent patient staff and staff motivation. condition, with high maintenance costs and ineffective clinical adjacencies. Backlog maintenance is not addressed systematically and with a consistent approach to managing risk.		4	4	16	Estates Capital Investment prioritised to off set anticipated key infrastructure equipment failures, & on going partial upgrades of patient orientated areas.	4	3	12	Capital Programme report. Revised process for business cases agreed by F&P Committee.	TB capital programme report		Non cohesive capital plans Business planning which reflects non human resource requirements and is aligned to clear clinical priorities and strategic objectives.	Need to link development of Capital plans to service development plans and priorities much more clearly for 2011/12 and also develop medium term plan.	4	2	8	March 2011	Director of Strategy
									Capital Group TOR have been revised and governance processes strengthened. Key will be ensuring capital plans link with service plans.													
									Agreed process for developing Estates and IT Strategies (as part of Integrated Business Planning).				Draft Estates and IT Strategy	Copy of draft estates strategy and IT Strategy , and actions from Board Development Session where Strategy was discussed and agreed.	Estates Strategy Annual Review						
									Planned maintenance schedules incorporating service contracts for key items of equipment. Managed Equipment Services (MES) Restructured Medical Equipment Executive, with revised terms of reference. Medical Equipment library at Glenfield				Complaints data Monthly risk register reports to G&RMC Maintenance records Incident reports		No corporate reporting of equipment downtime No corporate reporting of equipment maintenance costs						
													CQC self assessment	Compliance with CQC standard 11 reported to Trust Board (Jan 2010)								
													NHSLA ARMS assessment	**Level 2 NHSLA compliance (criterion 2.7 and 3.6) Dec 2008**								
	9	**Failure to meet financial obligations**	Non-standard contract with PCT and no clear understanding at Divisional / CBU level of nature of commissioning contract	Financially sub-optimal actions	Director of Finance				Commissioning team working with divisions / CBUs to develop understanding.				Variance analysis in divisional / CBU results									
			Inaccuracies in coding not tested via PbR disciplines						Action plan to improve metrics on process and accuracy of coding data				**Annual National review by Audit Commission**	Trust rated poor on #1/ #2 diagnoses in 2009/10 audit			Actions moved to risk number 19					
			Financially challenged NHS position reflected in future tariff with inbuilt levels of assumed efficiency	Substantial CIP challenge with risk of compromising patient safety and service delivery					'Bottom-up' plans, clinically led.				Monthly Confirm and Challenge sessions with divisions have started. Monthly QPMG held with Divisions. Additional C+C in place for areas underperforming	Monthly achievement of CIP across most areas. Processes for 11/12 CIP development commenced.		'Cost overruns in Acute and Planned Care divisions.					
									Separate risk assessment of impact on patient safety and quality of care				CIP risk report to TB 26/3/10 Review by audit - satisfactory.	PCT assured on patient safety and has funded Q1/Q2 monies (£6m)			Need to develop sharper means of tracking non-pay CIP delivery.			tba	DFP

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			Loss of financial control through the process of organisational change	Failure to achieve FT status Organisation required to downsize Inability to develop services and estate Change of Accountable Officers		5	4	20	Executive Director leadership Standing Financial Instructions Financial Management Risk Disclosure report Internal audit Operational Plan: Financial Systems Reviews Governance and accountability structures (e.g. TB, Q&PMG, F&P Committee, Audit Committee, etc) Appropriate staff training and recruitment Confirm and challenge meetings for Divisions Quality & Performance Management Group for divisions QIPP focus by Director of Strategy CQUINS focus by Chief Operating Officer	5	3	15	Quality and Performance reports by Director of Finance and Procurement to Executive Team, F&P Committee, Audit Committee, and TB **Internal Audit's assessment of UHL's financial systems continue to be reported to Audit Committee**	Delivery of 2009/10 financial plan New divisional finance & performance teams in place - May 2010.		Continuing lack of robust, integrated forecasts Lack of clear understanding of contract terms & conditions at CBU level.		4	2	8		
			Likely that NHS policy for vertical integration of provider services will result in changes across health						Working with other parties in LLR through 'Excellence for All' to jointly manage transition													
			Non-delivery of CIP schemes						Monthly financial performance reporting				LTFM/CIP plans Confirm and challenge meetings									
									All CIP plans for 2010/11established at a high level of granularity with													
									Engagement of new divisional management with CIP for 2010/11 and beyond													

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	10	**Failure to achieve and maintain compliance with external standards**	Absent policies / procedural documents Failure to follow policies / procedural documents Increasing demands of external standards Lack of appropriate human resources to manage projects Ageing estates infrastructure Lack of understanding of requirements	Reduction in discounts to NHSLA contributions Reduction in HCC performance rating Improvement notices served and/ or cessation of specific services Trust reputation Loss of business/income Potential external interference Failure to deliver specific services Lack of neonatal network accreditation	Medical Director	5	5	25	Policies / procedural documents Education and training Internal/ external reviews Self assessments of compliance Assessment criteria for NHSLA 'ARMS'/ CNST/ CQC/ HTA / Information Governance Actions in place for improved compliance with Products of conception guidance	4	3	12	**Results from external inspections (e.g. NHSLA, CNST, CPA, HTA, HSE, etc)** Reports to G&RMC re Products of Conception Actions monitored by Divisional Lead Nurses for Women's and Children's and SD	**Compliant at NHSLA ARMS level 2 (Dec 2008)** **Compliant at CNST level 2 (Oct 2008)** **Confirmation of CQC registration (without conditions) 5/4/10** **HTA licence renewed (with 1 condition and 13 advisories -May 2010)** **Mortuary licence confirmed with no conditions** **Positive outcome from CQC visit (LRI & GH) Dec 10 / Jan 11.**	Insufficient assurance regarding retention of retained products of conception (RPOC)			3	2	6		
													CQC bi-annual returns from divisions	Currently compliant with Healthcare standards. CQC submission for 2009/10 - overall compliance (except for partial compliance with Regulation 23 outcome 14a) There is now significant evidence to suggest compliance with the above	Application made to CQC 29/9/10 to register Renal Satellite units (CQC decision awaited)	The need to provide outcome evidence for CQC is new and may lead to gaps						
									Performance Monitoring via Q&PMG /GRMC				Reports of self assessments and areas of non-compliance to G&RMC and Q&PMG									
									Appropriate project management arrangements and accountability frameworks													
									NICE Quality Standards				Reviewed by Clinical Effectiveness Committee at every meeting									

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	11	**Inability to maintain productive relationships with Commissioners**	Failure to work together to achieve areas of common purpose. Either as a result of disagreement over priorities or poor understanding of one another's' agendas. White paper and decision to abolish PCTs results in a turbulent environment. Differing views regarding the impact of the Goodwin formula - this has been partly addressed in 2011/12 contracting round. Historical Relationships with future commissioners = GPs	Arbitration on contract. Failure to achieve FT as UHL's Business Plan must converge with the PCT plans and the plans for the Health Economy. Failure to deliver best services for patients. Failure to achieve financial sustainability as a economy.	Director of Strategy /Finance Chief Nurse	5	5	25	Governance arrangements for the LLR QIPP Programme have been revised. Provider CIPs will now be managed through the contracts. The remaining CIPs will be Commissioner led programmes. Governance arrangements for contract monitoring. LLR QIPP Plan has been agreed through 2011/12 contracting round. Monthly CORG meeting Agreed CQUIN and Quality Schedule	5	4	20	Weekly telephone contact with commissioners COO/CN is a member of regional QIPP group ECDG Monthly	Positive review of QIPP plan completed by SHA. LLR was assessed as being one of the most advanced integrated plans in East Midlands. But significant concerns highlighted regarded delivery and implementation. No significant evidence that the delivery and implementation has improved since this review. Director of Quality attends UHL G&RMC	Monitoring of contract between PCT's/UHL	Yet to finalise resourcing structure, and secure transformation funding.		4	3	12		
									Planning framework is in the process of being developed an agreed for 2011/12. An agreement on the size and shape of the 'Goodwin' agreed through contracting round.				Minutes of LLR Chief Exec Meetings. CCIG minutes Monthly DIPAC meeting	Agreement to a flat cash scenario for Health Economy Draft planning framework for 2011/12 Agreement and documentation of a set of values by LLR Chief Executives Agreement across whole health economy on work streams	Plans to reduce clinical variation are not having the necessary impact.	The plans are not yet reducing demand for Acute Care.	Continue work with Commissioners to develop plans to reduce clinical variation and planning framework for 2011/12. Work with Commissioners to ensure convergence with Commissioner plans and UHL IBP Build meaningful clinical engagement into the 2011/12 contracting process				Ongoing.	Directors of Finance /Strategy.
									Continue to build and maintain relationships with Exec Teams and emerging GP Consortia across Health Economy. Includes regular meetings between Divisional Directors and GP leaders.												
									Ongoing dialogue with Joint Health Overview and Scrutiny Committee (JHOSC).												
									Refreshed contract negotiating team agreed for 2011/12				Contract Meeting Minutes								
	12	**Inability to maintain productive**	Failure to work together to achieve areas of common purpose. Either as a result	The health and social care community fails to function as a system and	Director of Strategy/ Director of				Ongoing dialogue with JHOSC, and good relationships with officers.				JOSC minutes	Joint projects and action plans have been developed for	Plans to reduce inappropriate demand are not yet having the						

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		relationships with other stakeholders	of disagreement over priorities or poor understanding of one another's' agendas. Cost shunting as a result of the significant efficiencies required from Local Authorities e.g. increased in delayed discharges as a result of reduction in provision in the community.	ultimately services and patients suffer Failure to achieve FT status Failure to engage effectively with Local Authorities, who will have public health and health strategy responsibility after PCTs have been abolished. GPs will be the commissioners and providers of services within 2 1/2 years. If we don't improve and then maintain a productive relationship, the risks are significant, including ultimately an ineffective health system.	Comms	5	3	15	Health Summit established with all public sector partners represented at Chief Executive and Director level. PCT Medical Director appointed to lead integrated approach to improving urgent care system.	4	3	12	Health Summit Action Notes Trust Board Transformation Report	redesigning specific care pathways that require whole system involvement e.g. frail and elderly. A whole systems approach to managing a surge in demand within the whole urgent care system is being implemented. This will involve ensuring whole system capacity is utilised to alleviate areas of pressure within the acute system. This will be delivered through the ongoing effective planning and implementation of the LLR Resilience Plan as required. Project plan developed embracing health and social care partners to respond to both demand, changing pathways of care and an integrated approach to change. The monthly Health Summit will support and monitor the implementation of plans.	required impact.			4	2	8		
									Joint programme boards to manage projects				NSR Board Minutes; Governance arrangements for NSR								
									Joint board for Acute Care.												
									Account management for key stakeholders.						Key Accounts (for example PCTs / Social Services / Universities / Seldom heard groups		Construction of the Trust IBP to form the basis of discussions between exec' team and key stakeholders. Stakeholder engagement sessions to be set up for Feb / Mar 11. Completed - first meeting took place in March			DCER / Trust Equalities Manager / DS
									Measurement of quality and frequency of stakeholder interactions survey												
									The Account management strategy, PPI / Engagement strategy;					Directorate PPI / engagement plans;		Engagement strategy for BME and other hard to reach groups	Ideas collated from BME/ Seldom heard symposium and will be shared at a workshop on 7/12/10 with symposium attendees. 'Co-created' action plan will follow 7/12 event		Feb 2011	DCER
									Strategy being formulated to improve relationships with GPs.				KPIs that matter to GPs are being monitored through the Quality and Performance Report - e.g. quality and timeliness of discharge letters.	Development of GP engagement strategy.		Regular monitoring of quality of relationship with GPs.	Hold a GP 'Summit'			Apr 2011	Medical Director/ DCER
	13	**External threat to portfolio of services from**	White paper and the GP Commissioning Policy has the potential to change the	UHL becomes a large district general rather than a specialised teaching	Director of Strategy				Performance framework to ensure high quality services				Action notes from IBP Development Sessions at Trust Board	First draft IBP presented to Board on 3rd December 09	Reviews not clearly linked with business unit planning.		.					

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		external market and Dept of Health (e.g. TCS)	LLR market structure significantly. Failure to provide high quality and efficient services that patients choose and that regional and national commissioners purchase over and above alternative providers. Day to day operational pressures prevent UHL from focusing on long term aspirations. TCS Policy National service reviews.	hospital. UHL loses market share in general (e.g. TCS) and specialised services (e.g. national reviews)		4	4	16	FT Application process IBP Process includes analysis of market share and markets where we want to / need to compete. Joint plan with local and specialised commissioners	4	3	12	Action notes from Strategic and Finance Workshops with Clinical Teams	Market Assessments completed by Directorates				4	2	8		
									Market Share data now being presented and discussed by the Finance & Performance Committee.												
									Impact of TCS being reviewed through due diligence and as part of the 5 year business plan.							Continue to engage with TCS Board to ensure Due Diligence is forthcoming and the review process is robust				Ongoing	Director of Strategy
									Strategic plans in place to respond to national reviews (e.g. Children's Cardio agreed, Renal Transplant to be developed). Need to ensure we are more proactive in planning for these reviews.				Joint working with clinical directorates to develop robust service plans	Strategic plan in place for Children's Cardio. Plan being developed for Renal Services and other reviews. UHL contributing to discussions with EMSCG on future service configuration.								
	14	**Failure to achieve FT status**	Generating cash / sustaining our liquidity rating. Generating sufficient CIPs to match tariff declines – 5% pa minimum. Sustaining financial balance across the LLR health economy. Shifting to a sustainable post Goodwin PbR contract - Relationship with commissioners (current and	All Trusts to become Foundation trusts by 2013 - there will not be an option for organisations to decide to remain an NHS Trust Reputational impact and subsequent potential loss of patient numbers / income. Less freedoms to develop services. Less financial freedoms.	Director of Strategy				ET meetings serving as the FT application Programme Board FT application governance arrangements reviewed and revised. Three work streams established with Exec Leads and Programme Leads. Programme Leads producing and programme managing detailed work stream plans. Programme Leads producing				Minutes of / papers to: TB; Exec Team; Finance & Performance Committee; GRMC; QPMG; Workforce & OD Committee; R&D Committee. ET / TB FT application progress reports. Notes of the work stream project team meetings.	Draft report of the Internal Audit of the CIP process. CBU / divisional presentations to ET / TB development sessions, inc Market Assessments, Service Improvements, IBP's. FT Application Risk Log. Exec Team risk assessment for the SHA confirm & challenge.	SHA assurance framework revised by the SHA following comments from trusts. First UHL submission highlights gaps in assurance / evidence.					
															Recommendations from the Deloitte, PricewaterhouseCoopers and KPMG reviews yet to be actioned.		Recommendations from the Deloitte Quality Governance Review, PricewaterhouseCoopers review in preparation for the signing of the Tripartite Formal Agreement and the KPMG review of the draft IBP to be embedded into the FT			May 2011	Director of Strategy

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			new). Management capacity and headroom to deliver a robust IBP within challenging timescales. Lack of robust longer term cost improvement plans (detailed for 3 years , outline for 3 years). Identification of top clinical & business risks and modelling of downside scenarios to inform 2 – 5 year plans. Sustaining continuous achievement of and longer term improvement in, our 4 hour A&E performance. Staff side objection to FT status. Staff / clinical engagement.	Potential take over of UHL by other FTs.		5	5	25	Programme Leads producing weekly progress reports. Regular work stream project team meetings to ensure interdependencies are identified and managed. Weekly finance and business planning project team meetings are taking place. Fortnightly CBU business planning meetings continuing into the New Year.	5	4	20	SHA Assurance framework. Outputs from the CBU / divisional business planning meetings inc presentations to ET. High level FT application project plan (inc critical path) underpinned by detailed work stream project plans FT Application Risk Log	Work Stream Programme Lead in place for all three work streams. SHA Assurance Framework, supporting evidence and SHA feedback. ET review of key business risks / development of mitigating actions. Outputs from the: Deloitte Quality Governance Review - March 2011 PricewaterhouseCoopers review in preparation for the signing of the Tripartite Formal Agreement - March 2011 KPMG review of the draft IBP - March 2011.	Mitigating actions developed through the ET review of key business risks yet to be actioned.		Action the mitigating actions developed through the ET review of the key business risks.	5	4	20	Sept 2011	Director of Strategy
	15	**Organisation may be overwhelmed by unplanned events**	Lack of sufficient capacity to deal with incidents causing a significant increase in admissions (e.g. major disaster, pandemic, etc)	Poor patient experience. Trust reputation affected Inability to deliver required level of service Patient safety may be compromised Loss of income Failure to meet duties under the Civil Contingencies Act	COO/ Chief Nurse Director of Facilities				Local Resilience Forum Preparedness scenario . Corporate Policy. Multi agency working across Leicestershire. Silver/gold command training for managers and clinicians. Major incident and Pandemic plans for UHL and the wider health community. Counter Terrorist Awareness training (November 2010)				**External review of plans and capabilities by East Mids SHA, LLR resilience forum, Leics City PCT, local clinical networks. National Capabilities Survey August 2010.**	Contingency plans for directorates and Trust and multi-agency meetings at director level. Assurance matrix for winter planning to be presented to Trust Board September 2010. Agreed Service Level Agreement with the Local Resilience Forum.	Plans not been fully tested in real situations. The UHL Major Incident Plan hasn't been fully tested.		Continue work to develop UHL MIP and appendices via the Emergency Planning Committee				Jun 2011	Emergency Planning / Business continuity Lead
									Daily Sitrep Dedicated project managers/leads for major incident planning.				UHL self-assessment against core standard C24 (emergency preparedness) External audit	Compliance with C24 **CBRNE audit results by SHA in Mar 2010**.							
			Industrial action						Industrial action contingency planning				External audit	**CBRN Audit February 2011 undertaken by SHA**							

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			Business continuity / disaster recovery plans not robust	Delays to treatment of patients Loss of income Breaches of national targets		5	4	20	UHL Business Continuity Group Business continuity/ disaster recovery plans. UHL Winter fuel lead LLR Winter resilience plan Road Fuel Shortage Plan Staff capacity plan	3	3	9	**Internal Audit assessment of UHL's Business Continuity arrangements (2009/10)** **SHA Critical Care surge plan review June 2010** **SHA BCM review in 2010/11.**					3	3	9		
									Temporary post-holder for full time EP / BCM project role							Proposals for health economy approach to support organisations to be identified.				Feb 2011	Chief Operating Officer
			Failure of business critical systems (e.g. PACS)						Regular systems maintenance programmes Business continuity / disaster recovery plans IT systems redundancies and multiple backup servers Support from manufacturers of equipment													
			UHL Major Incident Plan becomes outdated and is not tested annually						National guidance in place.				Major incident exercises (Operation Earthquake and Operation Greystoke) undertaken with multi agency representation.	The CBRNe Plan has been tested in a real situation. The Trust responded positively to the H1N1 outbreak. Results from table-top exercises reported to G&RMC.								
									Emergency planning and Business Continuity committee meeting reports to G&RMC and Board SHA review of Major Incident Plans (MIPs) in 2010/11.						SHA review of UHL MIP identified areas of improvement (This was not a formal review and it was recognised that the areas of improvement may be in other areas of the plan i.e. CBRNe, Communications plan).	Develop Training needs analysis via UHL Emergency Planning Committee. Develop E-Learning package for Emergency Preparedness training			Jun 2011 July 2011	Emergency Planning Officer Emergency Planning Officer
									UHL Pandemic Working Group				H1N1pandemic reports to UHL Infection Prevention & Control Committee	Look-back exercise into H1N1 - ('Swine 'flu) contingency planning reported to Board - Sept 09								
	16	**Inability to maintain competence of staff**	Inadequate time and resource for developing and updating staff	Delivery of poor quality patient care and service delivery Inadequate performance management	Director of HR				Learning and Development Strategy Staff polling				Staff Attitude Survey results Divisional returns and evidence for relevant CQC regulation outcomes.	Investment made in specific training and development Learning Management system pilot implementation. 2009 SAOS improved position on a range of related key findings.								

Corporate Objective	Risk No.	Risk Description	Risk Cause	Risk Consequence	Risk Owner	Gross Risk I	Gross Risk L	Gross Risk I x L	Existing Controls	Net Risk I	Net Risk L	Net Risk I x L	Assurances on Controls (Where can we gain evidence that our controls / systems, on which we are placing reliance, are effective)?	Positive Assurances (What evidence shows we are reasonably managing our risks and objectives are being delivered)?	Gaps in Assurance (Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective)?	Gaps in Control (Where are we failing to put controls/systems in place, where are we failing to make them effective)?	Actions for further control	Target Risk I	Target Risk L	Target Risk I x L	Due Date	Action Owner
						4	4	16	Learning and Development Strategy Group	3	3	9	Ad hoc reports to TB through Chair of Learning and Development Strategy Group (Director of HR)					3	2	6		
									Range of eLearning products for UHL through eUHL to provide flexible delivery options.				Training records from OLM /ESP	Number, range and use of eLearning available through eUHL and ESP. Training records held on Electronic Skills Passport and OLM.								
									Clinical Education. Study Leave Policy				Collation of medical staff study leave information from ESP									
									Appraisal process Continuing Professional Development				Appraisal Rates recorded through HR Scorecard. Training records from Electronic Skills Passport and OLM. Bi annual Divisional reports on progress against training plans. Monitoring of T&D funding stream spend.	Appraisal rates 92% (Dec 10) Investment made in specific training and development	Lack of high level scrutiny of training and development outcomes from appraisal process	Lack of high level scrutiny of training and development outcomes from appraisal process	Extended use of ESR OLM as per HR systems strategy				2010/13	Director of HR
									Medical appraisal and revalidation pilot Plan in place for medical staff non-engagers in revalidation appraisal				Steering Committee	Strengthened UHL appraisal system is live and meets criteria for revalidation								
									HR discuss monthly Scorecard results with divisional teams.				Quality and Performance Management Group									
									Confidential phone line for staff concerns (including concerns around competency issues)				Review of all calls and actions taken									
									Performance Excellence programme for L2, L3 and L4 Leaders.				Staff survey Staff polling	Programme complete for level 2 and 3								
									Revised Capability / Disciplinary Procedure				HR scorecard monitors action taken									
	17	**Inadequate organisational development**	Lack of specific development programme for change management. Board development knowledge based rather than skills based. Financial climate Low levels of Staff Engagement. Inadequate equipping of managers, leaders, staff for	Poor quality and efficiency of service to patients and service delivery Fail to achieve FT status Poor Trust reputation Poor service delivery Low staff morale	Director of HR				Organisational development plan				Range of measurable success criteria for Organisational Development Plan (RAG rated) reported to Executive Team, Q&PMG and TB L&D Strategy group receive feedback on Leadership development and Academy progress and monitor against Leadership elements of OD plan.	Progress against these indicators is measured and assessed through Quality and performance report and up dates on specific elements								

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			change. Inadequate recognition of changes required to organisational culture and correlation between actions and effects on organisational culture.			4	4	16	Staff engagement Strategy Exec led Workforce & OD group Staff polling				**National / local Staff Survey Results**		Although staff surveys take place there has been poor uptake from staff (18% return from Jan 11 survey)	High volumes of complaints about staff attitudes/ behaviours	Implement local staff polling and survey whole organisation within first six months of implementation Review phase 1 results and recommend interventions and further phase 2 implementation requirements Define the organisation-wide intervention to support the embedding of values and behaviours					
									Performance monitoring via Trust Committees and intervention when necessary Divisional quality and performance meetings	4	3	12	Reports to Q&PMG and Workforce and OD committee		Lack of performance monitoring at divisional level Inadequate evidence of change in behaviours.	Performance culture not strong enough	Implementation of the Staff engagement strategy and Leadership and talent management strategy	3	3	9	Mar 2012	Director of HR
									Performance Excellence programme to assist managers to manage performance of staff.				Monitoring of attendance on programmes									
									Board development programme													
									Recruitment process for Exec and non- exec directors													
									Talent management / Leadership programme Clinical Leadership programme targeted at Ward Managers				Reporting of projects and interventions as part of Leadership programme			Inadequate succession planning	Implement talent management succession planning processes for L1 an L2 leaders and then subsequently over the organisation as a whole Develop and implement medical leadership development programme				Mar 2012 Mar 2012	Director of HR Director of HR
									8 Work streams identified to embed UHL values at work.								Define organisational-wide approach in embedding UHL values and behaviours Review 8 work streams and update staff engagement strategy				Apr 2011 June 2011	Director of HR Director of HR

Corporate Objective	Risk No.	Risk Description	Risk Cause	Risk Consequence	Risk Owner	Gross Risk I	Gross Risk L	Gross Risk I x L	Existing Controls	Net Risk I	Net Risk L	Net Risk I x L	Assurances on Controls (Where can we gain evidence that our controls / systems, on which we are placing reliance, are effective)?	Positive Assurances (What evidence shows we are reasonably managing our risks and objectives are being delivered)?	Gaps in Assurance (Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective)?	Gaps in Control (Where are we failing to put controls/systems in place, where are we failing to make them effective)?	Actions for further control	Target Risk I	Target Risk L	Target Risk I x L	Due Date	Action Owner
	18	**Instability during organisational change (internal and external)**	Management arrangements not able to sustain demand pressures/ variation Increased staff turnover Distraction risk for staff during uncertainty period Executive over commitment Gaps in performance SHA/ PCT transition may adversely affect the commissioning process 2011/12 CIP delivery National moves (e.g. agenda for change)	Low morale / disaffected/ demotivated staff Public concerns regarding services Lack of financial control Lack of 'ownership' of CIP schemes leading to non-delivery Possible service failures Loss of trust reputation Failure to maintain compliance with external standards	CEO	5	5	25	Regular updates of changes to 'Back Office' management arrangements Governance and accountability structures Performance scorecard to monitor 'hotspots' Management of change process G&RMC / Q&PMG and F&P Committee New Workforce and OD Committee	5	3	15	Performance reports to Q&PMG / F&PC/ G&RMC Sickness absence rates Specific performance 'hotspot' reports to F&P Committee and Q&PMG Staff turnover rates Statement of Internal Control (SIC) Executive safety walkabouts Staff Polling	Divisional / CBU arrangements complete Staff turnover stable CIP return rate high to 31/7/10 (90%+) Meeting most national targets Management of change process largely complete	Metrics and Executive walkabouts under-identify risks	Management acumen in key areas Management visibility	Review management capacity and capability in key areas Review escalation plans	5	3	15	Jun 2011 Jun 2011	COO
	19	**Inaccuracies in clinical coding**	HISS constraints	Loss of income (PbR) Outlier for CHKS/HSMR data Non- optimisation of HRG Loss of Trust reputation	COO/ Chief Nurse	4	5	20	Short (next 2 - 6 months) and medium term (6 - 12 months) action plans to improve metrics on process and accuracy of coding data	4	3	12	Verbal updates to F&P Committee by COO		Documented progress reports to F&P		Develop fully documented reporting process to F&P	4	2	8	Mar 2011	Asst Director of Information
			High workload (coding per person above national						Access to bank staff and overtime													
									Analysis of HISS/ORMIS procedure data				Data quality reports scrutinised by coding manager on a daily basis to identify errors Comparison of clinical coding against information held in other clinical audit systems Annual National review by accredited auditors and reported to CEC Orthopaedic coding audit (commencing end of Feb 11)	Trust rated poor on #1/ #2 diagnoses in 2009/10 audit	Benchmarking against other comparable Trusts via 'PerL' software Regular internal audit		Scoping exercise to identify future business/resource need Clinical coding dashboard bringing a range of published metrics together (including internal and external audit results) will be developed early in the New Year At specialty level implementation of a manual process for the capture of I/P coding to be rolled out Trust-wide Internal audit programme to be developed complimented with an annual external audit.				June 2011 Feb 2011 Apr 2011 June 2011	Asst Director of Information Asst Director of Information Asst Director of Information Asst Director of Information
									Involvement with consultants to become 'coding champions'													
			Inaccuracies / omissions in source documentation (e.g. case notes may not include co-morbidities, high cost drugs may not be listed)						Training for smaller numbers of coders arranged on ad-hoc basis rather than large numbers on a programmed basis				Attendance at training monitored by Clinical Coding Manager								
			Inability to provide training to large groups of coders due to lack of time and						Accreditation of coders via national examination				Attendance at training monitored by Clinical Coding Manager								

Please note:

Risk No 7 has been removed from the register following amalgamation with risk No.6

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						I	L	I x L		I	L	I x L						I	L	I x L		

All risks retain their original reference number

UHL SRR/BAF SUMMARY OF CHANGES TO ACTIONS – MARCH 2011

Risk No.	Action Description	Action Owner	Comment
1	Development of Safety and Quality Board compliance statements for FT application	Director of Clinical Quality	Ongoing. A high level self assessment and a number of external reviews by Deloitte, PWC and KPMG have recently been completed and will inform completion of the board assurance statements in due course. Action deadline extended to May 2011
1	Consent policy to be updated to reflect the minimum requirements within the NHSLA 'ARMS' 2011/12 document	Director of Clinical Quality	Ongoing. This action is now under the leadership of A Furlong (Divisional Director and M Wain (Quality and Safety Manager). Draft policy has been developed and is currently in the consultation phase. Anticipated final approval at PGC in May 2011. Action deadline extended to May 2011.
2	Continuing implementation of acutely deteriorating patients indicators	Medical Director	Completed
4	Review phase 1 results and recommend interventions and further phase 2 implementation requirements	Director of HR	Completed. Phase 1 results currently being reviewed. Phase 2 discussions at Workforce/ OD Committee
4	Complete internal audit of appraisal	Director of HR/ EMIAS	Completed. Draft audit report from EMIAS following exit meeting on 9/3/11. final report due to be published 21/22 March and then reported to Workforce /OD Committee on 23 March 2011 and to Audit Committee on 12 April 2011.
4	Internal Audit of Statutory and Mandatory Training Requirements and report findings to Workforce and OD Committee in March 2011.	Director of HR	Completed. As above
4	Divisions to sign off and monitor training plans	Director of HR	Ongoing. Deadline extended to May 2011. Technical difficulties with UHL Electronic Skills Passport (ESP) have not allowed training reports to be generated. Most key technical issues now resolved.
4	Review Statutory and Mandatory Training Performance and update Workforce and OD Committee	Director of HR	Ongoing. As above

UHL SRR/BAF SUMMARY OF CHANGES TO ACTIONS – MARCH 2011

5	Further analysis of recruitment hot-spots to be developed via workforce plan	Director of HR	Completed. The SIPs should address areas of current service need. As part of the development of Assistant and Advanced Practitioners we will be looking to identify gaps Whilst there are currently no gaps in capacity the nursing workforce will need to become more specialist. Whilst recruiting newly qualified nurses is possible there are difficulties in supporting these nurses to obtain appropriate experience levels to fulfil post requirements. There are particular issues in terms of recruiting experienced nurses for most specialities. There age profile of midwives suggests that in the next 10 years we may have recruitment/ retention difficulties. Lack of suitably qualified theatre staff continues to be a real issue.
5	Action programme for roll-out of Consultant appraisal	Medical Director	Completed. Majority of appraisals now complete (appraisal now completed for approximately 600 consultants). > 1apprasial per day Plan in place for the non engagers (<5%) who have all been contacted personally.
6	Development of Cancer clinical trials facility to be submitted to commercial executive	CEO	Completed.
6	Review of R&D office function	Director of R&D	Ongoing. R&D have recently (week beginning 14th March) been inspected by the Medicines and Healthcare Products Regulatory Agency (MHRA). This inspection has effectively been a thorough review of many aspects of the R&D Office function and the full formal report is due in the next 3-5 weeks. It would sensible to include the CAPA and any recommendations from the MHRA in the internal review. A response to the inspection report is required

UHL SRR/BAF SUMMARY OF CHANGES TO ACTIONS – MARCH 2011

			within four weeks and the internal review will be completed soon after. Deadline extended to June 2011
8	Estates and IT Strategies to compliment Clinical Strategy, incorporating clear Models of Care, efficiencies, clinical adjacencies, & robust funding streams for capital and non-capital equipment to be agreed by Trust Board as part of the 5 Year Business Plan in March.	Director of Strategy /Director of Facilities/ Head of IM&T	Completed. Draft strategies completed.
8	Need to link development of Capital plans to service development plans and priorities much more clearly for 2011/12 and also develop medium term plan.	Director of Strategy	Completed.
9	Earlier start to CIP planning for 2011/12. Clear leadership of pan-Trust 2011-12 CIPs in process of being established.	Director of Finance and Procurement	Completed. CIP's in process of being established. Corporate CIP identified. SRO to be appointed for each scheme (advertised March and interview end of March). Overall corporate CIP lead to be advertised.
11	Relationships meetings / lead to commence dialogue starting with GP and consortia and appointment of Head of Services for GPs… also involving Div Dir's in commissioning talks.	DCER	Completed. Discussions now taking place on a regular basis. Head of Service for GPs appointed.
12	Construction of the Trust IBP to form the basis of discussions between exec' team and key stakeholders. Stakeholder engagement sessions to be set up for Feb / Mar 11.	DCER / Trust Equalities Manager / Director of Strategy	Completed. First meeting has taken place

UHL SRR/BAF SUMMARY OF CHANGES TO ACTIONS – MARCH 2011

14	SHA feedback to be actioned.	Director of Strategy	Completed. This is part of a monthly feedback process and will continue until UHL FT Application is handed over the Department of Health in September 2011.
15	Continue work to develop UHL MIP and appendices via the Emergency Planning Committee	Emergency Planning Officer / Business Continuity Lead	Ongoing. Initial draft of Major Incident Plan (MIP) developed and comments received back from 'experts'. Second draft including comments in progress. Deadline extended until June 2011.
15	Develop Training Needs Analysis (TNA) via UHL Emergency Planning Committee.	Emergency Planning Officer	Ongoing. TNA cannot be developed until final Major Incident Plan is approved. Deadline extended to June 2011.
16	Action programme for roll-out of Consultant appraisal	Medical Director	Completed. Majority of appraisals now complete (appraisal now completed for approximately 600 consultants). > 1apprasial per day Plan in place for the non engagers (<5%) who have all been contacted personally.
18	Review change management process	CEO	Completed
19	Nominate project manager and review outputs from 'PerL' software	Asst Director of Information	Completed. Corporate scheme to have nominated SRO. Advertised and appointed March 2011 (1 year contract). PerL software uploaded with last full quarter and analysis will commence April 2011.
	Detailed project plan to be developed	Asst Director of Information	Completed. PID developed

SUGGESTED AREAS FOR TRUST BOARD SCRUTINY OF THE UHL INTEGRATED STRATEGIC RISK REGISTER AND BOARD ASSURANCE FRAMEWORK

1) Are the Trust's strategic objectives S.M.A.R.T? i.e. are they :-

- **S**pecific
- **M**easurable
- **A**chievable
- **R**ealistic
- **T**imescaled

2) Have the main risks to the achievement of the objectives been adequately identified?

3) Have the risk owners (i.e. Executive Directors) been actively involved in populating the SRR/BAF?

4) Are there any omissions or inaccuracies in the list of controls?

5) Have all relevant data sources been used to demonstrate assurance on controls and positive assurances?

6) Is the SRR/BAF dynamic? Is there evidence of regular updates to the content?

7) Has the correct 'action owner' been identified?

8) Are the assigned risk scores realistic?

9) Are the timescales for implementation of further actions to control risks realistic?