University Hospitals of Leicester NHS
NHS Trust

To:	**Trust Board**
From:	**Medical Director**
Date:	**2 February 2012**
CQC regulation:	Outcome 16 – Assessing and Monitoring the Quality of Service Provision

Title:	**UHL STRATEGIC RISK REGISTER AND THE BOARD ASSURANCE FRAMEWORK (SRR/BAF) 2011/12**

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

Summary / Key Points:

- Risk 4 *(Failure to acquire and retain critical clinical services)* has increased its current risk score from 12 – 16 to reflect issues in Children's Cardiac Services that may adversely impact upon the preferred option.
- A total of 22 actions have been completed during this reporting period and a further 13 have had their deadlines extended. Information is awaited on one action due to the absence of the Medical Director.
- The following risks are proposed for scrutiny by the Board:
  Risk 8 – *'Deteriorating patient experience'*.
  Risk 11 – *'IM&T – Lack of organisational IT exploitation'*.
  Risk 16 – *'Lack of innovation Culture'.*

Recommendations:

The Trust Board is invited to:

(a) review and comment upon this iteration of the 2011/12 SRR/BAF, as it deems appropriate, with particular reference to risks 8, 11 and 16.

(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.

Paper J

Previously considered at another corporate UHL Committee? **Yes – Executive Team**	
Strategic Risk Register **Yes**	**Performance KPIs year to date** **No**
Resource Implications (eg Financial, HR) **N/A**	
Assurance Implications **Yes**	
Patient and Public Involvement (PPI) Implications **No**	
Equality Impact **N/A**	
Information exempt from Disclosure **No**	
Requirement for further review? **Yes. Monthly at Executive Team meeting and Board meeting**	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **2 FEBRUARY 2012**

REPORT BY: **MEDICAL DIRECTOR**

SUBJECT: **UHL STRATEGIC RISK REGISTER AND BOARD ASSURANCE FRAMEWORK (SRR/BAF) 2011/12**

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1. INTRODUCTION

1.1 This report provides the Board with:-

a) A copy of the SRR / BAF as of 26 January 2012 (appendix 1).
b) A summary of risk movements from the previous month (appendix 2).
b) A summary of changes to actions (appendix 3).
c) Suggested areas for scrutiny of the SRR/BAF (appendix 4).

1.2 Following discussion at the January 2012 Board meeting further amendments have been made to risk 13 (skills shortages) to reflect the content of the discussion. The Board is asked to note that due to the absence of the Medical Director it has not been possible to provide an update to risk 14 in relation to updating the entry to reflect appropriate implications of 'professionalism' issues arising from the Francis Inquiry. This amendment is deferred to the next iteration of the SRR/BAF.

2. STRATEGIC RISK REGISTER/ BOARD ASSURANCE FRAMEWORK 2011/12: POSITION AS OF 26 JANUARY 2012

2.1 The 2011/12 Strategic Risk Register / Board Assurance Framework (SRR/BAF) has been developed using the risks set out by the Director of Finance and Procurement and progressed and extended by members of the Executive Team (ET) as the foundation of the document.

2.2 The SRR/BAF is updated on a monthly basis by the risk owners and is presented to the ET on a monthly basis for consideration prior to submission to the Board. Changes have been agreed by the risk owners and are highlighted in red.

2.3 Risk 4 *(Failure to acquire and retain critical clinical services)* has increased its current risk score from 12 – 16 to reflect issues in Children's Cardiac Services that may adversely impact upon the preferred option.

2.4 Risks 9 and 5 have altered titles that more accurately reflect the risk.

2.5 A total of 22 actions have been completed during this reporting period and a further 13 have had their deadlines extended. Information is awaited on one action due to the absence of the Medical Director. A summary of changes to actions including explanations for slippage is shown at appendix 3.

2.6 To provide regular scrutiny of risks on a cyclical basis a small number of risks will be selected at each meeting for Board members to review against the parameters listed in appendix 4. The following risks are proposed for review:

Risk 8 – *'Deteriorating patient experience'*. Chief Operating Officer.
Risk 11 – *'IM&T – Lack of organisational IT exploitation'*. Director of Strategy.
Risk 16 – *'Lack of innovation Culture'.* Director of Strategy.

3. Taking into account the contents of this report and its appendices, and the presentation by the Chief Operating Officer, and the Director of Strategy respectively in relation to risks 8, 11 and 16, 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);

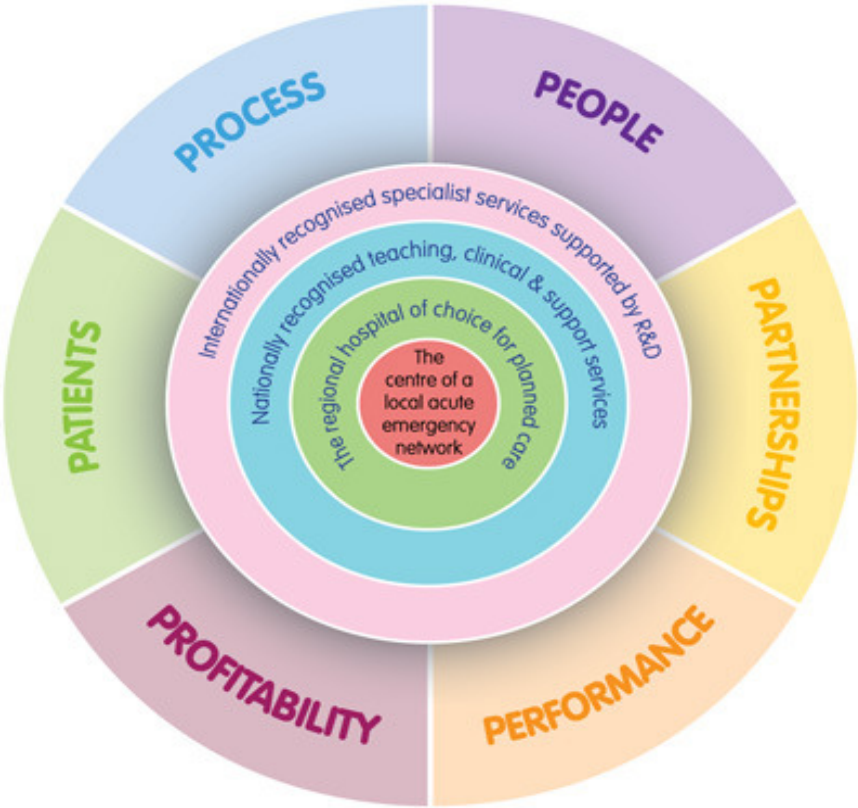
(c) identify any areas in respect of which it feels that the Trust's controls are inadequate and do not, therefore, effectively manage the principal risks to the organisation meeting its objectives;

(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 'significant control issues' to provide assurance on the Trust meeting its principal objectives.

P Cleaver
Risk and Assurance Manager
26 January 2012

PERIOD: 23 DECEMBER 2011 – 26 JANUARY 2012



STRATEGIC GOALS

a. Centre of a local acute emergency network
b. The regional hospital of choice for planned care
c. Nationally recognised for teaching, clinical and support services
d. Internationally recognised specialist services supported by Research and Development

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – STRATEGIC RISK REGISTER/ BOARD ASSURANCE FRAMEWORK 26 JANUARY 2012

Objective	Risk	Cause /Consequence	Controls	Current Risk	Assurance On Controls	Positive Assurance	Gaps in Assurance (a) / Control (c)	Actions for Further Control	Target Risk	Due Date	Risk / Action Owner
a c	**1. Continued overheating of emergency care system**	**Causes:** Lack of middle grade/senior decision makers Behaviour of new clinical commissioning groups Small footprint Delays in discharge efficiency Re-beds Delays in discharge to community beds Late evening bed bureau arrivals **Consequences** Clinical risk within ED Major operational distraction to whole of UHL Financial loss (30% marginal rate) Poor winter planning – inefficient/sub-optimal care Insufficient bed capacity Poor patient experience	Increased recruitment of revised workforce (including ED consultants / middle grade Drs) Frail elderly project in place 'Right Time, Right Place' initiative LLR emergency Plan LLR ECN Project Ward Discharge metrics Common metrics for reporting across all stakeholders CQUIN linked to in patient flow efficiency Emergency Care is a key theme for regular discussion at ET Representatives from Clinical Commissioning Groups attend ET bi-monthly re emergency care	5x4=20	Task Force minutes Daily /weekly ED performance Trust Board ECN Report Monthly Trust Board UHL report Q & P report ESIST report	Workforce changes progressing and new starters commenced Significantly improved ED 4 hour performance (since 22/11/11) Improving position for: EDD Discharge before 13.00 Ward/board rounds	(c) Absence of an agreed action plan at present to divert attendances (c) fragility in ED performance (a) absence of assurance from partner agencies re: metric outcome (a) No clear metrics or accountabilities for EMAS performance c) No integrated strategy for UHL/LPT discharge and use of Community hospitals (c) ED capital expansion	Capacity plan B if ECN does not meet metrics (ECN 'Lock-in' session scheduled for 22/11/11) Develop strategy via ECN Completion of capital expansion (as agreed by PCT) New Pathway projects in development	4x4=16	01/12 2013 2012/13	CEO CEO CEO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – STRATEGIC RISK REGISTER/ BOARD ASSURANCE FRAMEWORK 26 JANUARY 2012

Objective	Risk	Cause /Consequence	Controls	Current Risk	Assurance On Controls	Positive Assurance	Gaps in Assurance (a) / Control (c)	Actions for Further Control	Target Risk	Due Date	Risk / Action Owner
a b	**2. New entrants to market (AWP/TCS**	Cause TCS agenda. (Elective care bundle/UCC). Impact of Health and Social Care Bill. – 'Any willing provider Financial climate.	GP Head of Service to help secure referrals and improve service quality. Review of market analysis – quarterly at F&P Committee. Rigorous market assessment to clearly identify opportunities to create new markets Market share analysis and quarterly report, linked to SLR / PLICS Clinical involvement in Commissioning. Tendering process for services (elective care bundle & UCC). Links established with PCT Cluster regarding Elective care Bundle Tendering expertise reviewed for major procurements. Programme team with relevant resources agreed established to support Elective Care Bundle; external support agreed for other major procurements as required.	4x3=12	GP Temperature Check. Completed in May 2011. F&P and Exec Team minutes on a quarterly basis where market share analysis has been discussed. Divisional and CBU market assessments and competitor analysis. Completed on an annual basis as part of the annual planning process. Market share analysis reported to F&P Quarterly. Commissioning meetings. Tendering meetings. Monthly meetings between CCGs and Exec Team	Improved services in areas that are important to our customers. Commissioner e.g. discharge letters	(a) Quarterly monitoring market gain/loss at Trust Board level. (a) Further development of market share vs quality vs profitability analysis. (c) Systematic analysis of market share at Divisional and CBU Boards.	Implement Quarterly market share reporting and impact analysis on Strategy at CBU, Divisional and Trust wide level. Develop a training plan for CBUs and contract leads for utilising market share data to inform strategy Clinical Vision completed, detailed Strategy will be completed as part of the IBP.	3x2=6	01/12 01/12 06/12	DoC DoC DoS
		Insufficient expertise for tendering at CBU or corporate level. Consequence Downside: Loss of market share, business, services and revenue. Increased competition from competitors Upside: Opportunities to develop partnerships and grow income streams.									

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – STRATEGIC RISK REGISTER/ BOARD ASSURANCE FRAMEWORK 26 JANUARY 2012

Objective	Risk	Cause /Consequence	Controls	Current Risk	Assurance On Controls	Positive Assurance	Gaps in Assurance (a) / Control (c)	Actions for Further Control	Target Risk	Due Date	Risk / Action Owner
a b c	**3 Relationships with Clinical commissioning groups**	**Cause** NHS reforms Requirement for clinical input into commissioning Weak relationships with GPs as result of historical lack of engagement by UHL **Consequence** Lack of certainty/ continuity of commissioning through transition CCG management capacity and capability during the transition Loss of revenue Lack of GP support for UHL strategy	GP Head of Service GP relationships action plan part 2 'LLR Clinical Senate' LLR Strategy Alignment of senior clinicians and executive directors to clinical commissioning groups Involvement of UHL clinicians in contracting round to provide consistency and expertise Joint working groups to develop key strategies	4x4=16	GP temperature check completed in May 2011. Minutes from Clinical Senate (monthly) Notes from Account management structure with DDs and Execs (at least quarterly). Quarterly reports of market share to UHL Finance and Performance Committee Monthly Q&P reports monitoring discharge letter turnaround	Building clinician to clinician relationships through the LLR senate Proactive approach from GP consortia Clinical engagement with CCG chairs Improving customer care (e.g. OP letters project) Attendance of ET members at the Collaborative Commissioning Board GP input into readmissions and clinical coding projects 2nd GP survey shows increased satisfaction with 'communications' and 'business relationships'	(a) Few examples we can point to of redesigned pathways (a) Difficult feedback through DeLoitte from CGCs and Cluster	Agree 1 or 2 services for rapid pathway redesign Obtain PCT and CCG convergence with annual plan and IBP Paper setting out draft terms of engagement to be considered by ET on 10/1/12 Proposal to ET Jan 12 On resource required to deliver these elements more quickly.	3x3=9	04/12 04/12 01/12 01/12	DoC DoC DoC DoC

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c d	**4. Failure to acquire and retain critical clinical services (e.g. loss of services through specialist services designation including ECMO, Paediatric Cardiac Services, NUH as a level 1 major trauma centre)**	Cause National Reviews of specialist services Potential 'snowball effect' Cost Effectiveness. Consequence Loss of key clinicians Inability to attract best quality staff Inability to achieve academic expectations Adverse outcome of further tertiary reviews Significant loss of income Upside: Retain local, regional and national profile, potential to grow services, improved recruitment and retention, increased R&D potential.	EMCHC Strategy and Programme Boards. Risks identified through business plans. Campaign to support paediatric cardiac services/repatriate services. Commissioner support and engagement. Major Trauma Network group established. Participation of key UHL clinicians. ECMO NCG/Board engagement. Regular review by Exec Team & Trust Board. Strong academic recognition Joint planning with NUH re tertiary services Ongoing dialogue with other children's cardiac centres to ensure strong proposal on sustainable network Business planning underpinned by SLR Analysis	4x4=16	EMCHC reports & minutes (bi-weekly). Campaign response numbers. (Sept 2011). Feedback from public consultation. (Sept 2011) Major Trauma Network minutes & actions (quarterly). ECMO costing analysis TB and Exec Team papers (monthly & weekly). Quarterly Network Meetings SLR Data in Business Plans	ECMO contract in place. Campaign response results Lead co-coordinating centre/national training for ECMO. 3 BRUS achieved in Sept 2011 Leicester in highest scoring option for Safe & Sustainable Minutes of confirm and challenges demonstrating engagement in SLR data. Increase use of PLICs at CBU and Speciality level.	(c) Do not have an agreed service profile for tertiary services (c) Identified gaps in Children's Cardiac Service (e.g. co-location of ENT) could impact on final score and preferred option.	Marketing strategy for focus services we agree to develop identified in Annual Plans Develop plan for co-location of ENT (specifically outpatient clinics 9-5) with Children's Cardiac Services.	3x3=9	Rev 03/12 03/12	DoS Do S

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – STRATEGIC RISK REGISTER/ BOARD ASSURANCE FRAMEWORK 26 JANUARY 2012

Objective	Risk	Cause /Consequence	Controls	Current Risk	Assurance On Controls	Positive Assurance	Gaps in Assurance (a) / Control (c)	Actions for Further Control	Target Risk	Due Date	Risk / Action Owner
a b	5. **Lack of appropriate PbR income** (Previously loss making services)	**Causes:** Lack of productivity Poor use of clinical capacity Poor controls on premium pay Lack of innovation Lack of full PbR income **Consequence:** Services have to be internally cross subsidised Risk of increasing clinical risk through pursuit of inappropriate cost reductions Impact on Trust's ability to deliver statutory targets (i.e. breakeven).	High level SLR analysis of service profitability External benchmarking Targeted turnaround support introduced to focus on main loss making CBUs (Medicine, Cardiothoracic Surgery, Planned Care) CIP programme Monthly pay expenditure reports Portfolio review in Q3 2011/12 External financial turnaround support for - W&C division - Cardio External review of contract terms –by SHA	5x5=25	Monthly SLR/PLICS data SLR/PLICS presentations Monthly financial reporting	Counting and coding changes Usage of PLICS (but uneven) Positive Internal audit review of annual RCI (PLICS) cost attribution methodology	(a) Still some underlying issues in data robustness (c) Major deterioration in 2011/12 forecast outturn due to losses in key CBUs. (a) Failure to deliver the forecast to date	Counting and coding & contract renewal process Set 2012/13 CIP targets based on PLICS/ SR position Transactional changes to incentivise behaviour External financial turnaround support - Medicine CBU. Phase 2 Deloitte & Finnamore work on financial turnaround Establish PMO / TSO process	4X4=16	03/12 03/12 03/12 01/12 03/12 First meeting held in 12/11	DoF&P DoF&P DoF&P DoF&P DoF&P CEO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – STRATEGIC RISK REGISTER/ BOARD ASSURANCE FRAMEWORK 26 JANUARY 2012

Objective	Risk	Cause /Consequence	Controls	Current Risk	Assurance On Controls	Positive Assurance	Gaps in Assurance (a) / Control (c)	Actions for Further Control	Target Risk	Due Date	Risk / Action Owner
a b c d	**6. Loss of liquidity**	Causes Operating losses ytd Non standard contract Consequences Unable to invest in core services or develop new services Failure to deliver EFL statutory target	Updated internal liquidity plan Daily cash monitoring 12 month cash forecast SHA assistance in securing loan from NHS partners Internal liquidity plan Restrictions to the UHL Capital Plan to generate cash Negotiations with suppliers Rolling 3m cash forecast	5x5=25	Weekly cash reporting Monthly reforecast	Maintaining positive cash balances Improvement in creditor days Deloitte and Finnamore review of cash and liquidity	(c) Lack of solution to structural lack of liquidity	Response needed following Nov '11 pronouncement by Secretary of State re new criteria for financial assistance for pipeline FTs. Follow up with Director of provider element	4X4=16	01/12	CEO

Objective	Risk	Cause /Consequence	Controls	Current Risk	Assurance On Controls	Positive Assurance	Gaps in Assurance (a) / Control (c)	Actions for Further Control	Target Risk	Due Date	Risk / Action Owner
a b	**7. Estates issues** **Under utilisation and investment in Estates**	**Cause** Lack of clear estate strategy since cancellation of Pathway **Consequence** Sub-optimum configuration of services. The efficient provision of services in many areas is restricted by the physical limitations of the buildings and by less than optimum clinical adjacencies. Over provision of assets across LLR	**UHL** Service Reconfiguration Board established, with representation from all Divisions. Governance for site reconfiguration now expanded to include LLR implications and input.	4x4=16	Minutes of Service reconfiguration board reported to Exec Team. All site / estate proposals are reviewed monthly by Site reconfiguration Board. Service activity and efficiency performance monitoring reported monthly to FM Board. . External audit of Estate by CAPITA reported to ET. Annual PEAT Scores	LLR Space Utilisation Review Good PEAT scores	(c) Lack of agreed UHL Estates strategy (c) No Integrated LLR Estates strategy (linked to agreed clinical model, capacity and assets)	Further develop UHL Estates Strategy Develop an LLR Estates Vision in support of the clinical strategy. Agree LLR service configuration /downsizing supported by most efficient use of estate.	3x3=9	04/12 Review 04/12 Review 04/12	DoS DoS DoS
		Significant backlog maintenance Upside – Potential for asset disposal in medium to long term Downside scenario example – failure of electrical infrastructure	£6 million per year allocated to reducing backlog maintenance Planned Preventative Maintenance (PPM) schedules in place Emergency Planning & Business Contingency Plans in place for estates infrastructure failures		Capital meeting notes & Capital Bids progress. UHL risk based replacement programme in place. PPM Performance reported to FM Board. Testing programmes .	Estates infrastructure failures dealt with effectively	Backlog will take several years of investment to reduce. (c) Estates staffing & recruitment and retention issues.	Target backlog to high risk elements on an annual basis, where there are greater consequences from a failure Recruit into vacancies where affordable & develop staff.		Review 04/12 Review 04/12	Head of Est & Fac DoS

Objective	Risk	Cause /Consequence	Controls	Current Risk	Assurance On Controls	Positive Assurance	Gaps in Assurance (a) / Control (c)	Actions for Further Control	Target Risk	Due Date	Risk / Action Owner
b	**8.Deteriorating patient experience**	**Causes:** Cancelled operations Poor communications Increased waiting times for elective and emergency patients Poor clinical outcomes Lack of patient information Poor customer service Lack of engagement or consultation **Consequences** Patients not recommending or choosing UHL leading to reduced activity Contract penalties Reduced income from CQUIN monies Increased complaints Reputation impact	Monthly patient polling Patient Experience plan and projects Local awareness of LLR Emergency Care communication plan Caring @ its Best Divisional projects and dashboard National Patient Survey Engagement of Age UK, LINKS 10 point plan Introduction of emergency co-ordinator Introduction of escalation thresholds Theatre and out-patient transformation project Cancellation validation process Clinical quality and OPD/ED metrics Improved data analysis illustrating trends and prediction of key risk areas. Engagement of consortia members and ECN for campaign Draft internal standards developed by working group	5x3=15	Patient experience minutes Monthly Trust Board report Real time patient feedback Patient Stories Patient Experience data presented with patient safety and outcome measures Outcomes of 10 point plan reported to G&RMC (Sept 11) Quarterly theatre reports Divisional reports Specialty Dashboard Clinical Effectiveness minutes Clinical Metric results Q&P and Heat map report GRMC minutes	Improving polling scores Increasing patients experience results / feedback Complaints reduction Reducing patient cancelled operations Improving nursing metrics	(c) Lack of assurance regarding patient experience feedback processes c) Expectations of patients regarding care not being met (c) Increasing waiting time for treatment of surgical emergencies No monitoring and reporting system for internal standards	Summary of patient experience feedback Quarterly report on complaint pilot work Develop Correspondence to meet patient experience in the emergency pathway Exec team to agree KPIs and monitoring and reporting system	5x2=10	Quarterly 03/12 02/12 03/12	COO DoN COO COO MD

Objective	Risk	Cause /Consequence	Controls	Current Risk	Assurance On Controls	Positive Assurance	Gaps in Assurance (a) / Control (c)	Actions for Further Control	Target Risk	Due Date	Risk / Action Owner
b c	9. **CIP Delivery** (previously CIP requirement)	Risk of Quality being compromised, increased clinical risk Failure to achieve statutory breakeven duties Risk of delay/failure of FT project with uncertain consequences thereafter	CIP plan for 2011/12 CIPs assessed for impact on quality of care Pan-LLR QIPP plan Transformation board Head of Transformation and project managers for pan-Trust CIP schemes External turnaround support (to Dec 12) Planned reduction in WTE for 2011/12	5x5=25	Internal audit review of sample of schemes Weekly metrics Monthly divisional C&C meetings Monitored monthly through F and P & Confirm and challenge	External reports confirmed scrutiny of C&C meetings (process)	(a) Lack of Project Management Office (a) Lack of consistent recording	Introduce TSO Introduce weekly meetings incorporating D&F	4X5=20	01/12 01/12	CEO DoF&P
a b	10. **Readmission rates don't reduce**	Contract penalties Leakage of money from NHS to LAs if no agreement on reablement Opportunity cost of readmissions e.g. less capacity Continuing risk of sub-optimal patient care	Project board with divisional representation Readmission action plans across all specialties Regular reporting of readmission trajectory Community readmission Project LPT implemented support for ED Working relationships between admissions board and community workstreams Interim agreement with commissioners on 2011/12 readmissions penalty	4x3=12	Monitoring of clinical project plans Q&P report Community 'flash' scorecard monitored by ECN and Medical Director	Strong clinical engagement Reduction in readmission rates	(c) Heavy dependence on Community Project board	Discussion with Commissioners on in-year use of reablement money Third clinical audit on underlying causes of readmissions Focussed action plans to agree counting and coding of readmissions / new pathways and to isolate the cohort of patients receiving sub-optimal acute care	4x2=8	02/12 02/12 02/12	DoF&P DoF&P DoF&P

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – STRATEGIC RISK REGISTER/ BOARD ASSURANCE FRAMEWORK 26 JANUARY 2012

Objective	Risk	Cause /Consequence	Controls	Current Risk	Assurance On Controls	Positive Assurance	Gaps in Assurance (a) / Control (c)	Actions for Further Control	Target Risk	Due Date	Risk / Action Owner
a b	**11. IM&T** **Lack of organisational IT exploitation**	**Causes** Insufficient capacity and capability in IM&T Failure of NPfIT to deliver an integrated IT solution Organisational development has not focused on key IT skills and capabilities Lack of confidence in the delivery of benefits from IT systems **Consequences** Current systems complicated and disjointed leading to significant performance risk Majority of systems become obsolete or no longer supported by 2013/14 Major disruption to service if changeover not managed well Communications with partners is compromised IM&T unable to support transformation of UHL processes Poor customer service from IM&T Insufficient commitment from clinical teams, with regard to training, to major IT projects causing delay to the projects and the delivery of the identified benefits	Chief Information Officer Communications with internal and external stakeholders New structure and operating model for IM&T Programme and project plan discipline including benefits realisation. IM&T KPIs IT implementation plan IM&T Strategy Group Managed Service contract for PACS approved and in place. LLR IM&T delivery Board Business partners to work with the divisions and clinicians to improve communications and involvement	4x3=12	CIO in post. IT strategy agreed by TB Nov 2011 implementation plan in place Project management documentation KPIs reviewed monthly by IM&T Board Minutes of IM&T strategy Group (quarterly) Daily Monitoring of help desk calls (reported monthly to IM&T Board) PACS performance metrics (reported monthly to IM&T Board) Delivery Board minutes (quarterly)	MOC Completed LLR IM&T Delivery Board Minutes Incidence of PACS Failures reduced	(a) KPIs not reviewed outside IM&T (c) Vacancies in IM&T operations (a) KPIs not benchmarked with other Trusts. (a) Help desk performance deteriorated due to increased vacancies	Outline Business case to be developed for future systems Temporary recruitment to vacant posts with contractors, need for review in March Review KPIs quarterly through Q&P and ensure this includes benchmarking Procure IM&T Strategic Partner to increase capacity and capability	3x3=9	Next review 09/12 03/12 03/12 05/12	DoS DoS DoS DoS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – STRATEGIC RISK REGISTER/ BOARD ASSURANCE FRAMEWORK 26 JANUARY 2012

Objective	Risk	Cause /Consequence	Controls	Current Risk	Assurance On Controls	Positive Assurance	Gaps in Assurance (a) / Control (c)	Actions for Further Control	Target Risk	Due Date	Risk / Action Owner
a b	**12. Non-delivery of operating framework targets**	**Causes:** External factors i.e. Pandemic Poor system management Demand greater than supply ability Inefficient administrative procedures Lack of clinician availability **Consequences** Patient care at risk Reduced choice – reduced activity Risk of Contract penalties Reduced income stream Poor patient experience Increased waiting times Failure to achieve FT Failure to meet MONITOR and CQC targets Deteriorating infection prevention measures	Backlog plan Agreed referral guidance Identified clinician capacity Increased provision of capacity Access target monitoring as CIP's are implemented to ensure no impact. Review of bed allocation Staff recruited to support activity Transformational theatre project established Ensuring efficient utilisation of theatres Transformational Outpatient project established Review of Out-patient management to support delivery of plan UHL Winter Plan UHL Infection Prevention Plan	3x4=12	Monthly 18/52 minutes RTT performance reports Monthly heat map report Monthly Q&P report HII reports Quality schedule/CQUIN reports Theatre Board progress report Monthly monitoring of theatre utilisation to theatre project Board OP project PID and minutes reported to Monthly contract meeting Daily / weekly sitrep reporting Quarterly self assessment results reported to UHL IPC and PCT	Reducing patient waiting times evident Delivery of quality Schedule and CQUIN Achievement of RTT targets Improving theatre efficiency and performance Reducing level of CDT	(c) Plans to deliver maintenance of backlog plan (Gen surg, ENT, Ophthalmic) (c) Diagnostic capacity for target maintenance c) Impact of new target delivery with network trusts (a)Capacity and capability for continued delivery (c) impact of new operating framework targets for 12/13 a) Lack of evidence to demonstrate attendance of stat / Man training (requirement for NHSLA L2 compliance)	Plan identified awaiting decision from Commissioners Review diagnostic capacity for Operating Framework delivery (Bowel screening) Bid submitted for 18 week activity and awaiting Commissioner response Review compliance re medical Hand Hygiene training.	3x2=6	Review 02/12 04/12 Review 02/12 12/11	COO COO/CN /Div Man CSD COO/CN MD/ CBU Leads

N.B. Action dates are end of month unless otherwise stated

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – STRATEGIC RISK REGISTER/ BOARD ASSURANCE FRAMEWORK 26 JANUARY 2012

Objective	Risk	Cause /Consequence	Controls	Current Risk	Assurance On Controls	Positive Assurance	Gaps in Assurance (a) / Control (c)	Actions for Further Control	Target Risk	Due Date	Risk / Action Owner
a b c d	**13. Skill shortages**	**Cause** No development of a learning and development culture No resource to invest in development opportunities Inability to release staff for education / training Inability to recruit and retain appropriately skilled staff **Consequence** Lack of sustainability of some middle grade rotas Quality compromised, increased clinical risk Compliance with external standards may be affected Additional expenditure on agency staff High staff turnover rates	Use of EMSHA talent profile and incorporation into appraisal documentation Leadership and Talent Management Strategy Compliance with mandatory and statutory training requirements being monitored by Education leads Associate Medical Director for Clinical Education Productive strategic relationships and joint working with training partners Adherence to Divisional and Corporate Training Plans and continued development of alternatives models of training Monitoring temporary staff expenditure	3x4=12	Monthly reporting of appraisal rates to TB OD and Workforce Committee Reports Specific reports to highlight shortage Analysis of reasons for joining/ leaving UHL Gaps and rota monitoring is reviewed by the Trust Medical Workforce Groups and services Training and Development plans monitored via TED group and education leads Monthly budget reports Monthly TB report on turnover rates Local Staff Polling /National staff survey	Increased appraisal rate compliance Recruitment of advanced nurse practitioners Increase in midwife numbers Nurse: bed ratio meets national compliance Recruitment of post-graduate workforce Improvements in junior medical staff fill rates Partnership working between HEI / UHL commended by NMC Reduction in premium workforce Consistently good turnover rate Improving national staff attitude and opinion results	(a) Lack of regularised reporting on work to address targeted recruitment gaps (a)Succession plan in development (c) Lack of engagement of clinicians. (a) Need to understand the detail beneath the organisational figures	Review of frequency/reporting lines for the work to address targeted recruitment gaps to ensure regular reporting Review of post-reg LBR modules at DMU and University of Leicester commencing Dec 2011 – identifying priorities for workforce development Link workforce redesign to the development of effective patient pathways, to reduce requirement on difficult to recruit posts and / or make the posts more attractive Work with partners to address gaps in training plans, over recruit where required and take steps to make middle grade rotas more attractive (Finnamore and Deloitte) Triangulate VITAL results with Caring at its Best Dashboards to prioritise training for clinical areas or individuals with poor VITAL scores or metric results Work with Deanery to improve fill rates Appropriate lead Exec Directors to discuss the ongoing work re: strengthening of a UHL brand/ ethos	2x4=8	03/12 02/12 Quarterly update Review 01/12 02/12 Review 01/12 Review 03/12	DoHR ADNS DoHR DoHR ADNS DoHR DoHR

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – STRATEGIC RISK REGISTER/ BOARD ASSURANCE FRAMEWORK 26 JANUARY 2012

Objective	Risk	Cause /Consequence	Controls	Current Risk	Assurance On Controls	Positive Assurance	Gaps in Assurance (a) / Control (c)	Actions for Further Control	Target Risk	Due Date	Risk / Action Owner
b c	**14. Ineffective Clinical Leadership**	**Cause** Inability to effectively implement Organisational Development Strategy **Consequence** Inability to responsively change service model to meet changing healthcare needs	Assistant Medical Director with responsibility for clinical engagement Contracts for CBU Medical Leads Medical Engagement strategy UHL Leadership Academy Adoption of NHS leadership framework Work with Warwick University on medical engagement Monthly CBU Medical Lead meetings GP engagement strategy Secondary care representation on medical groups Process for ongoing assessment of ME	4x4=16	Medical Engagement survey (Warwick University) Review of Clinical Engagement Strategies at OD and Workforce Committee Reports to LLR 'Senate'	Well attended Medical Staff Committee meetings Structured New consultant program Strong clinical engagement with Transform-ation workstream Positive feedback from GP's	c) ME scale not yet repeated (c) Problematic communications with clinical staff (a) No strong track record of confidence and experience of success in our medical leaders (c) No formal links with CGC agreed	Implementation of plan to improve communication with our consultant body (consultant web-site, web accessible e mail) Develop links with organisations with successful track record. Participation in NHS leadership framework scheme	4x2=8	Review 03/12 02/12 02/12	MD MD DoHR

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Objective	Risk	Cause /Consequence	Controls	Current Risk	Assurance On Controls	Positive Assurance	Gaps in Assurance (a) / Control (c)	Actions for Further Control	Target Risk	Due Date	Risk / Action Owner
a b c d	**15. Management Capability / stretch**	**Causes** Lack of development opportunities Lack of experience and skills Staff do not understand the environment we are transitioning into Size of the challenge Environment **Consequences** Inability to support changes to service model Lack of focus on key metrics and service delivery Gaps in middle management leadership Inadequate organisational development	Leadership development and interventions Development and building of organisational capacity and capability on processes to support service redesign Organisational development plan Exec led Workforce & OD group Mentoring and coaching training for Medical Leaders Annual business planning template including capacity and capability and leadership and governance 8 point Staff Engagement action plan Review of divisional structures to identify areas for development/ improvement Appraisal and setting of stretching objectives aligned to the UHL Strategy IMT strategy to support clinical service redesign	5x4=20	OD and Workforce Committee Papers and reports Trust Board reports Local Staff Polling results Monthly monitoring of appraisal levels in Q&P report Monthly confirm and challenge exercise with divisions	Implementation of CBU structural changes Improving Staff polling results Appraisal rates good	(a) Areas that are not improving based on survey results (a) lack of Corporate alignment re: objectives (a) Staff responses still poor (c) Ineffective succession planning (c) Lack of challenge and scrutiny of performance and quality at divisional level	Supplement internal resource with external capability where required Core objectives for 2012 /13 to be agreed Ensure the right people in the right post with the right level of support Ensure managers have the right training to fulfil their roles. Integration of NHS Leadership framework within UHL Increased Executive and NED accountability Consider ways to increase participation in staff polling including divisional targets on participation Develop effective succession planning for the '100' Skills capability review to be performed at divisional/ CBU level and reported to Workforce and OD Committee Defines SMART objectives at team and individual level Develop a common definition for 'capability' and reflect in talent management profile	3x2=6	Review 03/12 03/12 Six monthly results Review 03/12 Review 07/12 Review 02/12 01/12 03/12 Review 03/12 Review 03/12 01/12	DoHR DoHR DoHR DoHR DoHR CEO DoHR DoHR DoHR DoHR DoHR

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Objective	Risk	Cause /Consequence	Controls	Current Risk	Assurance On Controls	Positive Assurance	Gaps in Assurance (a) / Control (c)	Actions for Further Control	Target Risk	Due Date	Risk / Action Owner
b c d	**16. Lack of innovation culture**	**Cause** Lack an innovation culture. Innovation seen as optional 'if we have time to spare' Lack of support when developing new models Too focussed on immediate operational issues (firefighting) **Consequence** Low staff morale Downside Outmoded models of delivery increasingly expensive and vulnerable Upside A health system that supports the spread and adoption of evidence-based innovative systems, products, practices and technologies.	Board level lead for innovation working with the SHA to further develop the NHS East Midlands Innovation Strategy UHL Transformation Programme to stimulate and drive an innovation culture within the organisation Deloitte and Finnamore to help identify areas of innovation Commercial Executive R&D Committee/ strategy PhD sponsored to examine how to successfully foster an entrepreneurial culture	4x3=12	CBU & Divisional Business Plans. UHL projects funded through the Regional Innovation Fund. Minutes of Commercial Executive (monthly) Minutes of R&D Committee (monthly) Transformation Programme project plans and highlight reports (Bi-weekly Transformation Board) Ideas forum on InSite	Success in last round of 2010/11 Regional Innovation Fund 3 successful BRU applications Good clinical engagement with R&D Committee Increasing number of ideas generated	(a) Lack of a clear base line of current culture and future desired state. (a) Unclear uptake on others innovation. (c) Innovation not incentivised. (c) Lack of clinical engagement (c) Inability to learn from others due to lack of opportunity to spend time outside of current issues	Initial findings from research to understand the factors blocking innovation to be presented to the R&D Committee in April. Early findings will be fed into the Annual Planning process. Establish clear mechanisms for incentivising innovation. Continue to invite innovative organisations to share learning	3x2=6	Review 04/12 03/12 01/12	DoS DoS DoS

Objective	Risk	Cause /Consequence	Controls	Current Risk	Assurance On Controls	Positive Assurance	Gaps in Assurance (a) / Control (c)	Actions for Further Control	Target Risk	Due Date	Risk / Action Owner
	17. Organisation may be overwhelmed by unplanned events	**Cause** Lack of sufficient capacity to deal with incidents causing a significant increase in admissions (e.g. major disaster, pandemic, etc) Industrial action Business continuity / disaster recovery plans not robust Failure of business critical systems (e.g. PACS) UHL Major Incident Plan becomes outdated and is not tested annually **Consequences** 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 Delays to treatment of patients Loss of income Breaches of national targets	Local Resilience Forum Corporate Policy. Multi agency working across Leicestershire. Major incident/business continuity/ disaster recovery and Pandemic plans for UHL/ wider health community. Dedicated project managers/leads for major incident planning. Incident command training for managers and clinicians. Counter Terrorist Awareness training Winter plan review 'Exercise Cameron' table top UHL Pandemic Working Group UHL Business Continuity Group Industrial action contingency planning Regular systems maintenance programmes IT systems redundancies and multiple backup servers Support from manufacturers of equipment	4x3=12	Review of MIPs and capabilities by EMSHA, LLR resilience forum, Leics City PCT, local clinical networks during 2011/12. SHA Critical Care surge plan review July 2011 SHA BCM review in 2010/11. Feedback from major incident exercises UHL self-assessment against core standard C24 Emergency planning and Business Continuity committee meeting minutes	Majax (fire) feedback from partner agencies SHA using UHL winter plan as an exemplar Feedback from Trust Decontamination Incident Compliance with C24	(a)Plans not all fully tested in real situations. (a)The UHL Major Incident Plan not fully tested. (a) Testing of Winter Plan (c) Update plan in relation to CBRN	Olympics preparedness exercise CBRN audit to be undertaken	3x3=9	01/12 02/12	COO/BCL Head of Ops

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Objective	Risk	Cause /Consequence	Controls	Current Risk	Assurance On Controls	Positive Assurance	Gaps in Assurance (a) / Control (c)	Actions for Further Control	Target Risk	Due Date	Risk / Action Owner
abcd	**18 Inadequate organisational development**	**Cause** Lack of specific development programme for change management. Inadequate recognition of changes required to organisational culture and correlation between actions and effects on organisational culture. Low levels of Staff Engagement.	Organisational development plan Non- Exec led Workforce & OD group Staff engagement Strategy, local staff polling and national staff survey	4x3=12	Range of measurable success criteria reported to ET, Q&PMG and TB National / local Staff Survey Results	Increased % of staff satisfied in certain elements	(a) Larger no. of staff responses required. (c) 2011 staff engagement 8 point plan not yet implemented	Implementation of the staff engagement strategy and Leadership and Talent Management Strategy Implement 2011 staff engagement 8 point plan	3x3=9	03/12 Review 03/12	DoHR DoHR
		Board development knowledge based rather than skills based. Inadequate equipping of managers, leaders, staff for change. **Consequences** Poor quality and efficiency of service to patients and service delivery Poor Trust reputation Inconsistent behaviour against trust values Low staff morale	Board development programme Talent management / Leadership programme/ Clinical Leadership programme Performance monitoring via Trust Committees and intervention when necessary Divisional quality and performance meetings Performance Excellence programme . Greater reward / recognition (e.g. Caring at its Best Awards)		Reports to Q&PMG, Workforce and OD Committee, and TB Reporting of projects and interventions as part of leadership programme National survey and local polling results	Increased No of staff performance managed. Increased No of staff reporting a positive and valued appraisal	(c) Board development content /structure requires revision (a) '100' talent profile not adequately discussed at appraisal (c) Lack of performance monitoring / management at divisional levels (a) Inadequate evidence of change in behaviours (c) High volumes of complaints about staff attitudes/ behaviour c) Lack of clinical leadership development (c) Organisational values and behaviours not embedded (c) Lack of clinical	Develop and implement medical leadership programme Define organisational approach in embedding UHL values and behaviours		03/12 03/12	DoHR DoHR

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Objective	Risk	Cause /Consequence	Controls	Current Risk	Assurance On Controls	Positive Assurance	Gaps in Assurance (a) / Control (c)	Actions for Further Control	Target Risk	Due Date	Risk / Action Owner
abcd	**19 Inadequate data protection and confidentiality standards**	**Cause** Lack of compliance with existing data protection and confidentiality standards. Inadequate recognition of minimum standards required to protect patient and key corporate information. Limited levels of Staff Engagement and understanding despite previous training approaches. Board compliance requirements knowledge based rather than skills based. Inadequate updating of managers, leaders, staff for managing personal information to compliance standard. **Consequences** Poor protection of highly sensitive personal data relating to patients and staff Damage to corporate reputation from data breaches Inconsistent behaviour against trust values Limited staff understanding	Information Governance Steering Group and associated strategy work programme SIRO assessment as part of monthly performance review Caldicott updates for monthly performance plan Annual Information Governance(IG) Toolkit compliance assessment in March Staff IG training strategy, local staff cascade sessions and online resources Integrated IG training programme Performance monitoring via IG Steering Group and intervention when necessary Divisional quality and performance meetings to include IG items	3x3=9	Range of measurable success criteria including new KPIs reported to SIRO and ET, Q&PMG and IG Steering Group National / local IG Compliance Audit Results reported to appropriate committees Reports to Q&PMG, IG Steering Group, and SIRO reporting of projects and interventions as part of leadership programme	Increased % of staff trained in IG to required standards Increased no of audits highlighting sound compliance Decreased no of data breaches and other information incidents	(c) Large no. of staff not trained to updated DoH standards in IG (c) IG spot-checks audit plans not fully tested in real situations. (c) Limited clinical engagement	Implementation of the updated IG training strategy Implement IG spot-checks for clinical and non clinical areas Clarify what is expected in terms of performance and compliance via improved marketing internally aimed at clinical staff	2x2=4	06/12 06/12 06/12	DoS/IG Man DoS/IG Man DoS/IG Man

Appendix 2

UHL STRATEGIC RISKS SUMMARY REPORT – JANUARY 2012

Risk No	Risk Title	Current Risk Exp (Jan 12)	Prev Month Risk Exp (Dec 2011)	Target Risk Score and Final Action Date	Risk Owner	Comment
9	CIP Delivery	**25**	**25**	**20** – Jan 12	Director of F&P	Previous title 'CIP Requirement'
5	Lack of appropriate PbR income	**25**	**25**	**16** – Mar 12	Director of F&P	Previous title 'Loss Making Services'.
6	Loss of Liquidity	**25**	**25**	**16** – Jan 12	Director of F&P	
1	Continued overheating of emergency care system	**20**	**20**	**16** - 2013	Chief Executive	
15	Management Capability / stretch	**20**	**20**	**6** – Mar 12	Director of HR	
3	Relationships with Clinical commissioning groups	**16**	**16**	**9** – Apr 12	Director of Comms	
7	Estates issues Under utilisation and investment in Estates	**16**	**16**	**9** – Sep 12	Director of Strategy	
14	Ineffective Clinical Leadership	**16**	**16**	**8** – Mar 12	Medical Director	Current risk score increased reflecting issues in Children's Cardiac Services that may impact upon final score and preferred option.
4	Failure to acquire and retain critical clinical services	**16**	**12**	**9** – Mar 12	Director of Strategy	
8	Deteriorating patient experience	**15**	**15**	**10** – Dec 12	COO	
11	IM&T Lack of IT strategy and exploitation	**12**	**12**	**9** – May 12	Director of Strategy	
2	New entrants to market (AWP/TCS	**12**	**12**	**6** – Jun12	Director of Strategy	
17	Organisation may be overwhelmed by unplanned events	**12**	**12**	**9** – Feb 12	COO	
18	Inadequate organisational development	**12**	**12**	**9** – Mar 12	Director of HR	
10	Readmission rates don't reduce	**12**	**12**	**8** – Feb 12	Director of F&P	
13	Skill shortages	**12**	**12**	**8** – Feb 12	Director of HR	
12	Non- delivery of operating framework targets	**12**	**12**	**6** – Apr 12	COO	
16	Lack of innovation culture	**12**	**12**	**6** – Apr 12	Director of Strategy	
19	Inadequate data protection and confidentiality standards	**9**	**9**	**4** – Jun 12	Director of Strategy/ IG Manager	

Appendix 3

UHL SRR/BAF SUMMARY OF CHANGES TO ACTIONS – JANUARY 2012

Risk No.	Action Description	Action Owner	Comment
1	LLR emergency plan to be implemented	Chief Executive	Completed. Now a control.
1	Identification of additional capacity if partner metrics do not achieve	Chief Executive	Completed. Additional capacity opened.
2	Complete rigorous market assessment to clearly identify opportunities to create new markets and be the new entrants wherever possible	Director of Strategy	Completed. Now a control.
2	Develop clinical strategy that effectively responds to market analysis	Director of Strategy	Action reworded to provide more clarity and links to gaps in controls and assurances. Deadline extended to June 2012
2	Review tendering expertise and ensure sufficient resource aligned to qualified opportunities identified in the market	Director of Strategy	Completed. Now a control.
4	Marketing strategy for focus services we agree to develop	Director of Strategy	Ongoing. This is work in progress and first draft proposals were completed in January. Next key milestone is finalising Annual Plan by end of March.
4	Rigorous SLR analysis and business planning	Director of Strategy	Complete. Now a control.
5	Portfolio review in Q3 2011/12	Director of Finance and Procurement	Completed, now a control.
5	External review of contract terms	Director of Finance and Procurement	Completed, now a control
5	Root cause analysis of systems	Director of Finance and	Completed. Coding procedure identified with key action areas.

UHL SRR/BAF SUMMARY OF CHANGES TO ACTIONS – JANUARY 2012

	issues causing data 'breakage'	Procurement	
5	External financial turnaround support	Director of Finance and Procurement	Partially complete financial turnaround awaited for Medicine CBU. Expected January 12.
6	Implementing rolling 3m cash forecast	Director of Finance and Procurement	Completed, now a control.
7	Develop an LLR Estates Vision in support of the clinical strategy.	Director of Strategy	First draft completed and presented to SHA. Next Review April 2012.
7	Agree LLR service configuration supported by most efficient use of estate	Director of Strategy	Ongoing. Action reworded to amalgamate two previously separate actions. Next review September 2012.
7	Agree downsizing plans as part of LLR Estates Strategy.	Director of Strategy	See above.
8	Pilot of focussed patient support and information to be introduced	Chief Operating Officer	Completed. Pilot commenced.
8	Audit to be undertaken (PWC) on patient experience feedback processes. Report will be provided	Director of Nursing	Completed. Audit report finalised
8	Implementation of Trust working group (led by Rob Sayer)	Medical Director	Completed, now a control.
8	Introduction of emergency co-ordinator	Chief Operating Officer	Completed. Now a control.
8	Introduction of escalation thresholds	Clinical Director (Planned Care)	Completed. Now a control.
8	Introduction of Trust-wide cancellation validation process	Chief Operating Officer	Completed. Now a control.
9	Quality assess all CIPs for impact on quality of care	Divisional Directors	Completed

Appendix 3

UHL SRR/BAF SUMMARY OF CHANGES TO ACTIONS – JANUARY 2012

9	Deloitte and Finnamore supported review of 11/12 CIP schemes and M7 reforecast. Bridges into 12/13 planning	Director of Finance and Procurement	Completed.
10	Discussion with Commissioners on in-year use of re-ablement money	Director of Finance and Procurement	Deadline extended to February 2012.
11	Outline Business case to be developed for future systems	Director of Strategy	Completed for 2012/13. Next review September 2012.
12	Proposed plan for contract meetings and work with commissioners to provide a solution	Chief Operating Officer	Ongoing. Plan has been identified but currently awaiting decision from commissioners. Review in February 2012.
12	Discussions ongoing with Commissioners for additional activity to meet specialty specific 18 week targets	Chief Operating Officer	Ongoing. Bid submitted for 18 week activity and now awaiting Commissioner response. Review in February 2012.
12	Review compliance re medical Hand Hygiene training.	Medical Director	Information awaited.
14	Implementation of plan to improve communication with our consultant body (consultant web-site, web accessible e mail)	Medical Director	Reviewed. Structure of website agreed and content of being developed. Awaiting IMT decision of best technical approach to web accessible email. Next review date March 2012.
14	Ensure secondary care representation on medical groups	Medical Director	Completed, now a control
14	Process for ongoing assessment of ME	Medical Director	Completed, now a control
15	Supplement internal resource with	Director of HR	Ongoing. Acute divisional manager commenced 16/1/12 and

UHL SRR/BAF SUMMARY OF CHANGES TO ACTIONS – JANUARY 2012

	external capability where required		Deloitte and Finnamores working with UHL. Additional capacity for transformation and to support CBUs is currently being sourced. Review in March 2012.
15	Clarify what is expected in terms of performance.	Director of HR	Completed.
15	Ensure managers have the right training to fulfil their roles.	Director of HR	Ongoing. Further development of the performance management processes will be disseminated across the management population. Leadership programme for senior management (i.e. Levels one, two, and three) developed. Clinical leadership programme for level four completed for cohorts one and two and initiated for cohorts three and four. Review in March 2012.
15	Increased Executive and NED accountability	Chief Executive	Ongoing. Currently under review in relation to Assurance Framework for Aspiring Foundation Trusts. Executive Team Away Day on 7 February to agree accountability and objectives for 2012/13. Review in February 2011
15	Skills capability review to be performed at divisional/ CBU level and reported to Workforce and OD Committee	Director of HR	Ongoing. Prior to this action being completed there needs to be further work around defining SMART objectives at both a team and individual level. Review March 2012
16	Understand and remedy the factors that currently block innovation.	Director of Strategy	Complete. Initial findings from research completed and will be presented to the R&D Committee in April. Early findings will be fed into the Annual Planning process.
16	Develop a systematic process for sharing, diffusion and adoption.	Director of Strategy	Action removed. Best practice within UHL and outside UHL being identified as part of the strategic planning process and the Transformation Programmes. Further work required to ensure it is fully embedded. Recommend remove as a specific action.

AREAS OF SCRUTINY FOR 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 key 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?