To:	**Trust Board**
From:	**Deputy Chief Executive/ Chief Nurse**
Date:	**20 December 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) 2012/13**

Author/Responsible Director: Medical Director

Purpose of the Report:
To provide the Board with an updated SRR/BAF for assurance and scrutiny.
To propose changes to existing risk reporting process.

The Report is provided to the Board for:

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

Summary / Key Points:

- The UHL SRR/BAF has undergone a full revision to ensure its accuracy in relation to the strategic risks facing UHL for the remainder of 2012/13.
- This version of the SRR/BAF was presented to and ratified by the Executive Team on 11 December 2012.
- During the final quarter of 2012/13 work must begin to develop the 2013/14 SRR/BAF.
- Changes to the existing risk reporting process are proposed to achieve increased levels of accountability and improved 'line of sight' for risks from 'Ward to Board'.

Recommendations

Taking into account the contents of this report and its appendices the Board is invited to:

(a) review and comment upon this iteration of the SRR/BAF, as it deems appropriate:

(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; (f) Endorse the proposals to improve accountability and oversight of risks outlined in section 4.1 a –e of this report.	
Previously considered at another corporate UHL Committee? **Yes – Executive Team**	
Strategic Risk Register **Yes**	**Performance KPIs year to date** **No**
Resource Implications (e.g. Financial, HR) **N/A**	
Assurance Implications **Yes**	
Patient and Public Involvement (PPI) Implications **Yes.**	
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: **20 DECEMBER 2012**

REPORT BY: **DEPUTY CHIEF EXECUTIVE/ CHIEF NURSE**

SUBJECT: **UHL INTEGRATED STRATEGIC RISK REGISTER / BOARD ASSURANCE FRAMEWORK (SRR/BAF) 2012/13**

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1. INTRODUCTION

1.1 The UHL SRR/BAF has undergone a full revision to ensure its accuracy in relation to the strategic risks facing UHL for the remainder of 2012/13. A commitment was made to provide a fully revised SRR/BAF to the Board meeting on 20 December 2012.

1.2 The revision is a culmination of outputs from an externally facilitated Board development session on the 1 October 2012 and a further refinement of these outputs by the Chief Executive Officer and Executive Directors at a meeting on 13 November 2012.

1.3 This process has taken account of both the high level risks to the achievement of our strategic objectives and the key risk themes from the UHL operational register with risk owners providing the narrative for each risk entry.

1.4 This version of the SRR/BAF was presented to and ratified by the Executive Team on 11 December 2012.

1.5 A mapping exercise has been performed in order to identify links between the previous version and the current version of the SRR/BAF. The results of the mapping exercise are shown at appendix one.

2. CURRENT POSITION AS OF 30 NOVEMBER 2012

2.1 A copy of the revised SRR/BAF is attached at appendix two for information and scrutiny.

2.2 The mapping exercise has identified two risks from the previous version that do not robustly link with the revised SRR/BAF. These are:

a. Inadequate data protection and confidentiality standards.

b. Compliance with external standards (e.g. NHSLA, CQC, HSE, etc).

It is expected that risks will move from the SRR/BAF to the operational register and vice verse and it is proposed that the above risks are maintained under the stewardship of an Executive Director and captured on the Corporate Nursing operational risk register to ensure continuity of associated mitigations.

3. NEXT STEPS

3.1 During the final quarter of 2012/13 work must begin to develop the 2013/14 SRR/BAF taking account of:-

a. Short and medium term risks in relation to the 2013/14 annual operating plan.
b. Longer term risks to the achievement of the 2013- 2018 integrated business plan.

3.2 The SRR/BAF will continue to be presented to the Board on a monthly basis until such time that the Board agree to a less frequent review of the SRR/BAF**.**

4. FUTURE RISK REPORTING PROPOSALS

4.1 Successful management of risk within UHL requires formal accountability for the management of risk at all levels of the Trust and a clear 'line of sight' of risks from 'ward to Board'. This flow of risk information needs to be balanced to ensure there is no information overload at senior levels which may lead to risks not being given appropriate airtime or attention at senior Trust committees. The following changes to the existing risk reporting process are proposed to achieve increased levels of accountability and improved 'line of sight' for risks:

a. All divisional and operational risks will be linked to an executive or corporate director in addition to the respective clinical director.

b. In addition to a monthly SRR/BSAF report the Executive Team will receive a monthly report of all high risks and a bi-annual report of all moderate risks from the UHL operational risk register.

c. The appropriate executive or corporate director will be responsible for holding divisional directors to account in relation to the effective management of risks and mitigations and this will replace the current function of the QPMG in respect of this process.

d. The ET will identify risks of strategic significance and decide whether the risk(s) should be reflected in the Trusts SRR/BAF.

e. To provide a 'line of sight' for risks 'from ward to Board' the Board will receive a quarterly report showing all high risks recorded on the operational risk register.

4.2 A paper providing further detail of the above was submitted for consideration to the Executive Team meeting on 11 December. The Board's attention is drawn to the content of the paper which is attached at appendix three.

5. RECOMMENDATIONS

5.1 Taking into account the contents of this report and its appendices the Board is invited to:

(a) review and comment upon this iteration of the SRR/BAF, as it deems appropriate:

(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;

(f) Endorse the proposals to improve accountability and oversight of risks outlined in section 4.1 a –e of this report.

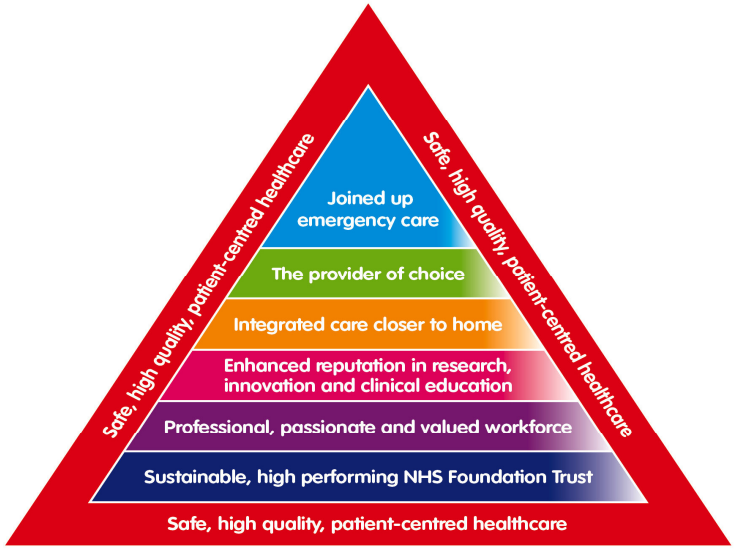
Peter Cleaver,
Risk and Assurance Manager
13 December 2012

REVISED BAF 2012/13 MAPPING EXERCISE

New risk	Mapped to old risk
1. Failure to transform the emergency care system	Continued overheating of the emergency care system
2. Ineffective organisational transformation	Inadequate organisational development
3. Failure to achieve financial sustainability	CIP delivery Lack of appropriate PbR income Loss of liquidity
4. Failure to achieve FT status	N/A
5. Failure to maintain productive relationships	Deteriorating relationships with CCGs Failure to acquire and retain clinical services
6. Reducing avoidable harms	Deteriorating patient experience
7. Business continuity	Organisation may be overwhelmed by unplanned events
8. Inability to recruit, retain, develop and motivate staff	Skills shortages Ineffective clinical leadership Management capability/ stretch Lack of innovation culture Inadequate organisational development
9 Patient experience/ satisfaction	Deteriorating patient experience
10. Failure to achieve and sustain operational targets	Readmission rates don't reduce Non-delivery of operating framework targets
11. Loss of reputation	New entrants to market Failure to acquire and retain clinical services
12. Inadequate reconfiguration of buildings and services	Estates IM&T
Not linked in new SRR/BAF but to become part of operational register (Corp. Nursing)	Inadequate data protection and confidentiality standards
	Risks in relation to compliance with external standards (e.g. NHSLA, CQC, HSE, etc)

PERIOD: 1 NOVEMBER – 30 NOVEMBER 2012

Appendix 2



STRATEGIC OBJECTIVES

a. To provide safe, high quality patient-centred health care.
b. To enable joined up emergency care.
c. To be the provider of choice.
d. To enable integrated care closer to home.
e. To enjoy an enhanced reputation in research, innovation and clinical education
f. To maintain a professional, passionate and valued workforce
g. To be a sustainable, high performing NHS Foundation Trust.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – STRATEGIC RISK REGISTER/ BOARD ASSURANCE FRAMEWORK - DRAFT

RISK NUMBER/ TITLE:	**RISK 1 – FAILURE TO TRANSFORM THE EMERGENCY CARE SYSTEM**						
LINK TO STRATEGIC OBJECTIVE(S)	a, b, c, g						
EXECUTIVE LEAD:	Director of Operations						
Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives are discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale/ Action Owner** When will the action be completed?
Failure to transform emergency care system leading to demands on ED and admissions units continuing to exceed capacity	LLR emergency Care Network Project to reduce emergency attendances and ensure maximum use of the Urgent care centre.	4x4=16	Monthly report to Trust Board in relation to Emergency Dept (ED) flow			4x3=12	
	Increased recruitment of ED Medical and nursing staff		Monthly Quality and Performance summary report to TB including use of agency staff				
	LLR Emergency Plan to ensure that delays to transfer of care are minimised.		Monthly report to Trust Board in relation to Emergency Dept (ED) flow				
	'Right time, right place' initiative to ensure ED process provides timely assessment in Ed to facilitate transfer to AMU or discharge		'Time to see consultant' metric included in National ED quarterly indicator	(a) Lack of assurance in relation to metrics to identify appropriateness of AMU assessment process	Right Place consulting to be appointed to identify performance metrics in relation to AMU assessment process		Jan 2013 Director of Operations

	Emergency Care Pathway (ECP) Programme to enable a comprehensive and co-ordinated approach to the design and implementation of process improvements across the end-to-end patient flow for our ED attendees and medical non-elective patients.		Executive led programme board will provide regular progress reports in relation to ECP programme to senior Trust committees. Monthly report to Trust Board in relation to Emergency Dept (ED) flow	(c) Lack of single point of access to stream patients attending ED	Develop ED Processes to provide single Point of Access streaming patients to the most appropriate care setting and development of systems in ED that enable delivery of high quality processes.		Mar 2013 Director of Operations
				(c) Ineffective model of care	Develop an Acute Model of Care enabling medically referred patients to be assessed with a treatment plan developed within 6-14 hours of admission supported by clinicians with the right skill mix to manage the case mix and internal support services.		Mar 2013 Director of Operations
				(c) Lack of sustainable consultant led ward processes	Implement consistently applied consultant led ward processes that enable optimal length of stay to be achieved for all patients based on their clinical need within right-sized bed base.		Mar 2013 Director of Operations
				(c) Capacity management function requires strengthening	Develop robust capacity management function underpinned by accurate and timely information, a competent team with clear roles and responsibilities and Trust wide focus on the efficient use of capacity to deliver services.		Mar 2013 Director of Operations
				(c) Unacceptable level of Delayed Transfers of Care (DTOC)	Sustained reduction in delayed transfers of care to 20 by working with other health providers and social services.		Mar 2013 Director of Operations

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – STRATEGIC RISK REGISTER/ BOARD ASSURANCE FRAMEWORK - DRAFT

RISK NUMBER/ TITLE:	**RISK 2 – INEFFECTIVE ORGANISATIONAL TRANSFORMATION**
LINK TO STRATEGIC OBJECTIVE(S)	b, c, g
EXECUTIVE LEAD:	Director of Finance and Business Services

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives are discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale/ Action Owner** When will the action be completed?
Ineffective organisational transformation preventing the development of safer, more effective and productive services	Clinical strategy	4x4=16	CIP Programme Board monitors project plans associated with clinical strategy to ensure achievement of key milestones.	(c) Shortfall on delivery of projects in 2012/13	Interim transformation resources	4x3=12	Apr 2013 Director of Finance and Business Services
	Transformation Board/ team including Interim Director of Service Development						
	Managed Business Partner for IM&T services to deliver IT that will be a key enabler for our clinical strategy.		MBP programme board monitors defined KPIs for 'Lot 1 services'. Non-compliance with KPIs reported to Board	(c) New systems (lot 2) not yet specified	'Lot 2' systems replacement plan to be developed		2013/14 Director of Finance and Business Services
	Development of lean processes improvement capability to deliver more efficient and effective services and greater patient / staff satisfaction		Board monitoring of patient and staff survey results. Improved levels of patient / staff satisfaction are expected when lean processes are embedded	(c) Slow start to process improvement initiatives	Board level sponsorship and Leadership		Apr 2013 Director of Finance and Business Services
	Facilities outsourcing		Facilities Management Co-operative (FMC) will monitor against agreed KPIs to provide assurance of successful service	(c) FM contract not yet implemented	Implement contract		Feb 2013 Director of Finance and Business Services

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – STRATEGIC RISK REGISTER/ BOARD ASSURANCE FRAMEWORK - DRAFT

RISK NUMBER/ TITLE:	**RISK 3 – FAILURE TO ACHIEVE FINANCIAL SUSTAINABILITY**
LINK TO STRATEGIC OBJECTIVE(S)	c, e, f, g
EXECUTIVE LEAD:	Director of Finance and Business Services

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	Current Score I x L	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives are discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	Target Score I x L	**Timescale/ Action Owner** When will the action be completed?
Failure to achieve financial sustainability including:	Overarching financial governance processes including PLICS process and expenditure controls	4X4=16	Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board Cost centre reporting and monthly PLICS reporting Annual internal and external audit programmes Comparison with PLICS benchmarking against other NHS organisations	(c) Underlying deficit	Recovery plan to be developed and monitored by Executive Team (ET)/ F&P Committee and Board	4x3=12	Mar 2013 Director of Finance and Business Services
Failure to achieve CIP	CIP governance structure		Progress in delivery of CIPs is monitored by CIP Programme Board and reported to ET and Board	(c) Failing to effectively manage/ monitor CIP leading to failure of 3 clinical divisions to deliver on their CIP.	Strengthened CIP governance structure to enhance management/ monitoring arrangements		Dec 2012 Director of Finance and Business Services
Locum expenditure	Workforce plan to identify effective methods to recruit to 'difficult to fill areas)		The use of locum staff in 'difficult to fill' areas is reported to the Board on a monthly basis via the Quality and Performance report. A reduction in the use of such staff would be an assurance of our success in recruiting substantive staff to 'difficult to fill' areas.				
Loss of income due to tariff/tariff changes (including referral rate for emergency admissions – MRET)	Contract meetings with Commissioners		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board	(c) Failing to manage marginal activity efficiently and effectively	Ongoing negotiations with Commissioners		Jan 2013 Director of Finance and Business Services
Ineffective processes for Counting and Coding	Clinical coding project		Ad-Hoc reports on annual counting and coding process				

loss of liquidity	Liquidity Plan		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board				
Lack of robust control over non-pay expenditure	Non-pay action plan (agreed by F&P Committee)		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board	(c) Failing to control adverse trends in non-pay (running ahead of activity growth			
Commissioner fines against performance targets	Contract meetings with Commissioners		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board	(c) Failing to reduce readmission trends	Ongoing negotiations with Commissioners		Jan 2013 Director of Finance and Business Services
Use of readmission monies	Contract meetings with Commissioners		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board	(c) Failing to reduce readmission trends	Ongoing negotiations with Commissioners		Jan 2013 Director of Finance and Business Services

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – STRATEGIC RISK REGISTER/ BOARD ASSURANCE FRAMEWORK - DRAFT

RISK NUMBER/ TITLE:	**RISK 4 – FAILURE TO ACHIEVE FT STATUS**
LINK TO STRATEGIC OBJECTIVE(S)	a, b, c, d, e, f, g
EXECUTIVE LEAD:	Chief Executive Officer

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	Current Score I x L	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives are discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	Target Score I x L	**Timescale/ Action Owner** When will the action be completed?
Failure to achieve Foundation Trust (FT) Status within specified timescale (April 2014)	FT Application Programme Board to provide strategic direction and monitoring of FT application programme FT Workstream group of Executive and operational Leads to ensure delivery of IBP and evidence to support HDD1 and 2 processes FT application project plan/ team	5x3=15	Monthly progress against project reported to Board to provide oversight. Feedback from external assessment of application progress by SHA (readiness review board-to-board meeting scheduled for 19/12/12			4x2=8	
	Monitoring of KPIs in particular in relation to financial position and ED performance that are crucial for a successful FT application		Monthly Finance and Performance report to Board	(c) significant financial variance from plan (c) Underperformance in relation to ED targets	See actions associated with risk number 8 Transform emergency care system to reduce demand and increase footprint of ED		During 2013/14 Chief Executive Officer

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – STRATEGIC RISK REGISTER/ BOARD ASSURANCE FRAMEWORK - DRAFT

RISK NUMBER/ TITLE:	**RISK 5 – FAILURE TO MAINTAIN PRODUCTIVE RELATIONSHIPS**
LINK TO STRATEGIC OBJECTIVE(S)	a, b, c, d, e, g
EXECUTIVE LEAD:	Director of Communications and External Relations

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives are discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale/ Action Owner** When will the action be completed?
Failure to maintain productive relationships with external partners/ stakeholders leading to potential loss of activity and income and failure to retain clinical services	Stakeholder Engagement Strategy Regular meetings with external stakeholders and Director of Communications and member of Executive Team to identify and resolve concerns Regular stakeholder briefing provided by an e-newsletter to inform stakeholders of UHL news	4X3=12	Twice yearly GP surveys with results reported to UHL Executive Team	(a) No surveys undertaken to identify relationship issues. Anecdotal feedback only.	Productive relationships with CCGs are likely to improve further only if UHL performance around ED improves therefore the target score is dependent upon actions from other risks within this document being taken	4X2=8	

RISK NUMBER / TITLE	**RISK 6 - REDUCING AVOIDABLE HARMS**						
LINK TO STRATEGIC OBJECTIVE(S)	a, c, g						
EXECUTIVE LEAD:	Deputy Chief Executive/ Chief Nurse						
Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives are discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale/ Action Owner** When will the action be completed?
Failure to reduce avoidable harms and mortality and morbidity leading to decreasing patient experience/ patient satisfaction and loss of reputation	Policies and procedures	4x3=12	Hospital Standardised Mortality Indicators reported monthly to Trust Board via Quality and Performance (Q&P) report. Improving position in relation to (HSMI) and HSMI @within expected' for elective and non-elective activity			3x2=6	
	Relentless attention to 5 Critical Safety Actions (CSA) initiative to lower mortality		Q&P report to Trust Board showing outcomes for 5 CSAs. 5 CSAs form part of local CQUIN monitoring. RAG rated green at end of quarter 2.	(c)Lack of clarity in relation to lines of accountability	Development of divisional accountability lines document		CEO Dec 2012
	Learning lessons from incidents, complaints and claims to reduce the likelihood of recurrence.		Monthly patient safety report to Governance and risk Management Committee (GRMC) and Quality and Performance management Group (GRMC) Number of formal complaints received reducing				
	Infection prevention plan to ensure hospital acquired infections are reduced		MRSA/ C. Difficile rates reported to Trust board via monthly Q&P report. 1MRSA case reported to end of Sept. 2012/13 Target = 6 C. Difficile currently below trajectory. 41 cases to end of Sept. against target of 54.				
	Monthly patient experience monitoring 'Net Promoter'		Monthly patient experience report to Trust board included within Q&P report. Improving Net Promoter results.				

	'Quality Ambition' 2012 – 15		Monitoring of CQUINS outcomes via monthly Q&P report to Trust Board Further reductions in SHMI.	(c)Lack of staff awareness of 'Quality Ambition'. (c) Resource to support the delivery of the 'Quality Ambition' is still to be identified. (c) Need wider engagement of CCG partners for health economy initiatives	Trust-wide launch of 'Quality and Safety Ambition' Delivery of 3 clinical task groups to identify resource requirements 2013 CQUIN and quality negotiations		Dep CEO/ Chief Nurse Jan 2013 Dep CEO/ Chief Nurse Mar 2013 Dep CEO/ Chief Nurse Mar 2013
	NHS Safety thermometer utilised to measure the prevalence of harm and how many patients remain 'harm free' (Monthly point prevalence for '4 Harms')		Monthly outcome report of '4 Harms' is reported to Trust board via Q&P report Trust is seeing an improving 'harm' position				

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – STRATEGIC RISK REGISTER/ BOARD ASSURANCE FRAMEWORK - DRAFT

RISK NUMBER/ TITLE:	**RISK 7 – BUSINESS CONTINUITY**
LINK TO STRATEGIC OBJECTIVE(S)	a
EXECUTIVE LEAD:	Director of Operations

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives are discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale/ Action Owner** When will the action be completed?
Inability to react /recover from events that threaten business continuity leading to sustained downtime and inability to provide full range of services	Major incident/business continuity/ disaster recovery and Pandemic plans developed and tested for UHL/ wider health community. This includes UHL staff training in major incident planning/ coordination and multi agency involvement across Leicestershire to effectively manage and recover from any event threatening business continuity. Emergency Planning Officer appointed to oversee the development of business continuity within the Trust	3x4=12	Annual Emergency planning Report identifying good practice presented to the Governance and Risk Management Committee December 2011 External auditing and assurances to SHA, Business Continuity Self-Assessment, June 2010, completed by Richard Jarvis Completion of the National Capabilities Survey, November 2013 completed by Aaron Vogel. Results will be included in the annual report on Emergency Planning and Business Continuity to the GRMC. Audit by Price Waterhouse Coopers LLP Jan 2013 results will be reported to Trust Board (date to be agreed)	(c) Lack of coordination of plans between different service areas and across the CBUs. (c) On-going continual training of staff to deal with an incident (c) Do not effectively Identify, report and communicate issues/lessons learnt that have been identified in service area disruptions and follow up actions. (c)Do not always consider the impact on business continuity and resilience when implementing new systems and processes. (a) Do not gain assurances from external service providers as to their ability to continue to provide services to the trust in the event of an incident within their organisation or/and within the Trust.	New terms of reference and membership of the Emergency Planning and Business Continuity Committee to oversee and provide strategic oversight and commitment to business continuity. New policy to identify key roles within the Trust of those responsible for ensuring business continuity planning /learning lessons is undertaken.	2x3=6	Jan 2013 Jan 2013

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – STRATEGIC RISK REGISTER/ BOARD ASSURANCE FRAMEWORK - DRAFT

RISK NUMBER/ TITLE:	**RISK 8 – INABILITY TO RECRUIT, RETAIN,DEVELOP AND MOTIVATE STAFF**
LINK TO STRATEGIC OBJECTIVE(S)	a, b, c, d, e, f, g
EXECUTIVE LEAD:	Director of Human Resources

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives are discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale/ Action Owner** When will the action be completed?
Inability to recruit, retain, develop and motivate suitably qualified staff leading to inadequate organisational capacity and development.	Leadership and talent management programmes to identify and develop 'leaders' within UHL	4x3=12	Development of UHL talent profiles			4x2=8	
	Organisational Development (OD) plan			(c) OD plan not ratified (a) A potential measure of the number of applicants received for advertised posts may be a useful future assurance of the success of the OD plan	Ratification by incoming Chief Executive Officer To develop a monitoring and reporting process		Feb 2013 Director of HR Jun 2013 Director of HR
	Workforce and OD Committee to monitor progress and oversee implementation of OD plan		Progress reports to Board via Workforce and OD Committee	(c) Executive group required to lead on OD plan	Formation of OD executive group		Mar 2013 Director of HR
	Staff engagement action plan		Results of National staff survey and local patient polling reported to Board via Workforce and OD Committee on a six monthly basis. Improving staff satisfaction position. Staff sickness levels may also provide an indicator of staff satisfaction and targets for staff sickness rates are close to being achieved				
	Appraisal and objective setting in line with UHL strategic direction		Appraisal rates reported monthly to Board via Quality and Performance report. Current rates near to 100% Results of quality audits to ensure adequacy of appraisals reported to the Board via the Workforce and OD Committee.				

	Workforce plan to identify effective methods to recruit to 'difficult to fill areas)		The use of locum staff in 'difficult to fill' areas is reported to the Board on a monthly basis via the Quality and Performance report. A reduction in the use of such staff would be an assurance of our success in recruiting substantive staff to 'difficult to fill' areas.				
	Reward /recognition strategy and programmes (e.g. salary sacrifice, staff awards, etc)			(a) Reward and recognition strategy requires revision to include how we will provide assurance in the future that reward and recognition programmes are making a difference to staffing recruitment/ retention/ motivation.	Revise strategy		Jun 2013 Director of HR

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – STRATEGIC RISK REGISTER/ BOARD ASSURANCE FRAMEWORK - DRAFT

RISK NUMBER/ TITLE:	**RISK 9 – PATIENT EXPERIENCE/ SATISFACTION**
LINK TO STRATEGIC OBJECTIVE(S)	c, g
EXECUTIVE LEAD:	Deputy Chief Executive/ Chief Nurse

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives are discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale/ Action Owner** When will the action be completed?
Levels of patient satisfaction/experience may deteriorate	Patient experience plan and associated projects	4x3=12	Patient experience progress reports to Governance and Risk Management Committee (GRMC) Patient stories presented at Trust Board Discharge project outcomes (i.e. delayed transfer of care) reported to the Discharge and Transfer of Care (DTOC) Group and monthly to the emergency Care Network and Clinical Quality Review Group (CQRG). Data included in monthly Quality and Performance report to Trust Board.	(c) Lack of patient experience strategy including: • Improving services for older people • Improve services for patients with dementia • Improve services for 'End of Life' (c) Trust-wide communications of patient experience learning	Development and ratification of patient experience strategy	2x3=6	Dec 2012 Dep CEO/Chief Nurse
	Net Promoter scores to identify key areas for focus		Ongoing Patient Experience surveys Net Promoter scores reported monthly to Trust Board via Q&P report. Improving picture in relation to Net Promoter scores (57.5% at the end of September)	(c) Not reducing cancellation rates for outpatients appointments	Outpatient project delivery plan to be developed		Jan 2013 Director of Operations
	Caring @its best and releasing time to care initiatives		Caring @ its best awards Improving patient experience reports Improved infection prevention outcomes	(c) Lack of supervisory headroom for ward managers	Develop proposal for the ward managers to have rostered supervisory time in line with Francis recommendations		Jan 2013 Dep CEO/Chief Nurse
	Patient experience programme (across 85 clinical areas to gain feedback from patients relating to their experience of care) and national patient survey		Ongoing Patient Experience surveys Net Promoter scores reported monthly to Trust Board via Q&P report. Annual reporting to trust board of national patient survey				

	Trust values instilled within UHL staff.		UHL staff awards demonstrating individuals who demonstrate the values. Ongoing Patient Experience surveys. Net Promoter scores reported monthly to Trust Board via Q&P report.				
	Patient Adviser /LINKS engagement at divisional level to ensure consistent involvement in the development of services			(a) No current mechanism to monitor involvement of patient adviser/ LINKS to provide assurance of involvement/ engagement	Identify monitoring mechanism		Mar 2013 Director of Comms and External Relations

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – STRATEGIC RISK REGISTER/ BOARD ASSURANCE FRAMEWORK - DRAFT

RISK NUMBER/ TITLE:	**RISK 10 – FAILURE TO ACHIEVE AND SUSTAIN OPERATIONAL TARGETS**
LINK TO STRATEGIC OBJECTIVE(S)	a, c, e, f, g
EXECUTIVE LEAD:	Director of Operations

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives are discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale/ Action Owner** When will the action be completed?
Failure to achieve and sustain operational targets	Backlog plans to recover 18 week referral to treatment (RTT) target	4x3=12	Monthly Q&P report to Trust Board showing 18 week RTT rates			4x2=8	
	Referral pathways to decrease demand and ensure discharge to GP where appropriate			(a) Lack assurance in relation to performance metrics to show activity versus number of patients deferred onto a different care pathway.	Development of key metrics at a local level		
	Transformational theatre project to improve theatre efficiency to 80 -90%		Monthly theatre utilisation rates included in divisional heat map presented to Trust Board on a monthly basis. Target utilisation is 86%; month 7 position is 81.4% (I/P) and 74.6% (O/P).				
	'Right place, right time' initiative		Monthly report to Trust Board in relation to Emergency Dept (ED) flow (including 4 hour breaches)				
	Each tumour site has developed processes to achieve targets		Director of Operations receives reports from Cancer Manager and information included within Monthly Q&P report to Trust Board				
	Ongoing monitoring of key performance indicators		Monthly Q&P report to Trust Board				

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – STRATEGIC RISK REGISTER/ BOARD ASSURANCE FRAMEWORK - DRAFT

RISK NUMBER/ TITLE:	**RISK 11 – LOSS OF REPUTATION**
LINK TO STRATEGIC OBJECTIVE(S)	c, e, f
EXECUTIVE LEAD:	Director of Communications and External Relations

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives are discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale/ Action Owner** When will the action be completed?
Loss of favourable reputation leading to difficulties in recruitment of high quality staff and potential for reduced market share.	Reputation is maintained proactively and reactively. Proactively by the hospital achieving its performance targets and providing safe, high quality care for patients. This in turn can only be achieved by mitigating many of the other risks contained within this document.	3X3=9	Assurances that the Trust is achieving its targets and providing high quality care are included in other risks within this document			3x2=6	
	On a reactive basis our major control is the Communications Team who will strive to form good relationships with our critics to provide a positive image of UHL, changing the critical foe to a 'critical friend'		The percentage of positive and negative news stories about UHL (local and national) is monitored by the Communications team on a daily basis and a deteriorating position would be reported to the Board by the Director of Communications GP polling used as an external mirror. Net Promoter scores monitored and reported to Board on a monthly basis via Quality and Performance report Patient polling and staff survey results reported to trust Board During the FT application process reputation is also gauged by external assurance from DeLoittes, etc	(a) After the FT application process has completed There will be no 'reputation polling' of other external stakeholders. To continue with polling would require additional resource within the Communications Team to achieve and would be of questionable value in reducing the risk score further.	Explore feasibility of future 'reputation polling'		Mar 2013 Director of Comms and External Relations

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – STRATEGIC RISK REGISTER/ BOARD ASSURANCE FRAMEWORK - DRAFT

RISK NUMBER/ TITLE:	**RISK 12 – INADEQUATE RECONFIGURATION OF BUILDINGS AND SERVICES**
LINK TO STRATEGIC OBJECTIVE(S)	b, c, d, g
EXECUTIVE LEAD:	Chief Executive Officer

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives are discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale/ Action Owner** When will the action be completed?
Inadequate reconfiguration of buildings and services leading to less effective use of estate and services	Clinical Strategy	3x3=9		(c) Clinical Strategy not yet finalised/ ratified (a) Key measures to demonstrate success of strategy and reporting lines not yet identified	Finalise and ratify clinical strategy Confirm key measures for gauging success of strategy and formalise reporting lines	3X2=6	Jan 2013 Medical Director Feb 2013 Medical Director
	Estates strategy including award of FM contract to private sector partner.		Facilities Management Co-operative (FMC) will monitor against agreed KPIs to provide assurance of successful outsourced service	(c) Estates plans not fully developed to achieve the strategy. (c) The success of the plans will be dependent upon capital funding and successful FT application	Ensure success of FT Application (see risk 6 for further detail) Secure capital funding		April 2014 Chief Executive Officer Acting Director of Facilities April 2014
	Divisional service development strategies and plans to deliver key developments		Progress of divisional development plans reported to Service Reconfiguration Board.				
	Service Reconfiguration Board						
	Capital expenditure programme to fund developments		Capital expenditure reports reported to the Board via Finance and Performance Committee				

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **UHL EXECUTIVE TEAM**

DATE: **11 DECEMBER 2012**

REPORT BY: **DEPUTY CHIEF EXECUTIVE/ CHIEF NURSE**

SUBJECT: **UHL RISK ESCALATION AND REPORTING PROCEDURE**

1. INTRODUCTION

1.1 Successful management of risk within UHL requires formal accountability for the management of risk at all levels of the Trust and a clear 'line of sight' of risks from 'ward to Board'. This flow of risk information needs to be balanced to ensure there is no information overload at senior levels which may lead to risks not being given appropriate airtime at high level Trust committees. The existing process is outlined in detail in the UHL Risk Management Strategy and is summarised in this paper

1.2 The current process (developed in conjunction with KPMG) is some three years old and as risk management has evolved at UHL it has been recognised that there are some areas for development in both the mechanism for ensuring accountability for the management of risks and mitigations and the 'line of sight' reporting of risks.

1.3 This paper proposes changes to the current processes to resolve the issues outlined above.

2. CURRENT POSITION

2.1 The UHL risk reporting and accountability structure is summarised in a flowchart attached at paper A. Risks are identified at CBU and department level and placed on the UHL operational risk register. Risks are managed locally wherever possible and CBUs and departments report their risks to a divisional or directorate board at the following frequency:

Extreme risks – reported immediately
High risks – reported monthly
Moderate risks – reported quarterly
Low risks – reported annually

Divisional and directorate boards are tasked with ensuring that CBU and department managers are held to account in relation to the effective management of the risks and mitigations.

2.2 The Quality and Performance Management Group (QPMG) receives a monthly report detailing the extreme and high risks from the operational risk register. QPMG are required to:

a. Hold divisional and corporate directors to account in relation to the effective management of risks and mitigations.

b. Identify risks from the operational register that may be of strategic significance for onward reporting to the Executive Team for oversight and decision as to whether the risk should be reflected in the Trusts Strategic Risk Register and Board Assurance Framework (SRR/BAF).

2.3 The Executive Team (ET) receive weekly notifications of any new high risks opened during the preceding seven days. In addition the ET receives a monthly update of the SRR/BAF prior to its submission to the Board. The executive risk owners update the entries on the SRR/BAF on a monthly basis.

2.4 The Board receive a monthly report of the strategic risks for oversight and in turn hold Executive Directors to account for the effective management of risks.

2.5 It is apparent that within the current process QPMG the is not the most effective forum for holding clinical divisions and corporate directorates to account as not all corporate divisions are represented. It is also recognised that operational risks are not assigned to Executive/ Corporate Directors for oversight to ensure that risks are being effectively managed.

3. PROPOSAL

3.1 It is proposed that the following changes are made to the current process:

a. All divisional and operational risks will be linked to an executive or corporate director in addition to the respective clinical director.

b. In addition to a monthly SRR/BSAF report the ET will receive a monthly report of all high risks and a bi-annual report of all moderate risks from the UHL operational risk register.

c. The appropriate executive or corporate director will be responsible for holding divisional directors to account in relation to the effective management of risks and mitigations and this will replace the current function of the QPMG in respect of this process.

d. The ET will identify risks of strategic significance and decide whether the risk(s) should be reflected in the Trusts SRR/BAF.

e. To provide a 'line of sight' for risks the Board will receive a quarterly report showing all high risks from the operational risk register.

3.2 A flowchart summarising the proposed process is attached at paper B.

4. FUTURE DEVELOPMENTS

4.1 There is an intention to develop more innovative ways of reporting risks to high level Trust committees and this will include electronic reporting enabling a 'drill-down' facility from the strategic level risks into the operational risks that feed them. This will be dependent upon a technical solution being available. It must, however, be recognised that any risk register is only as good as its source data and it is imperative that good quality risk information is available from clinical divisions and corporate directorates to support this.

5. RECOMMENDATIONS

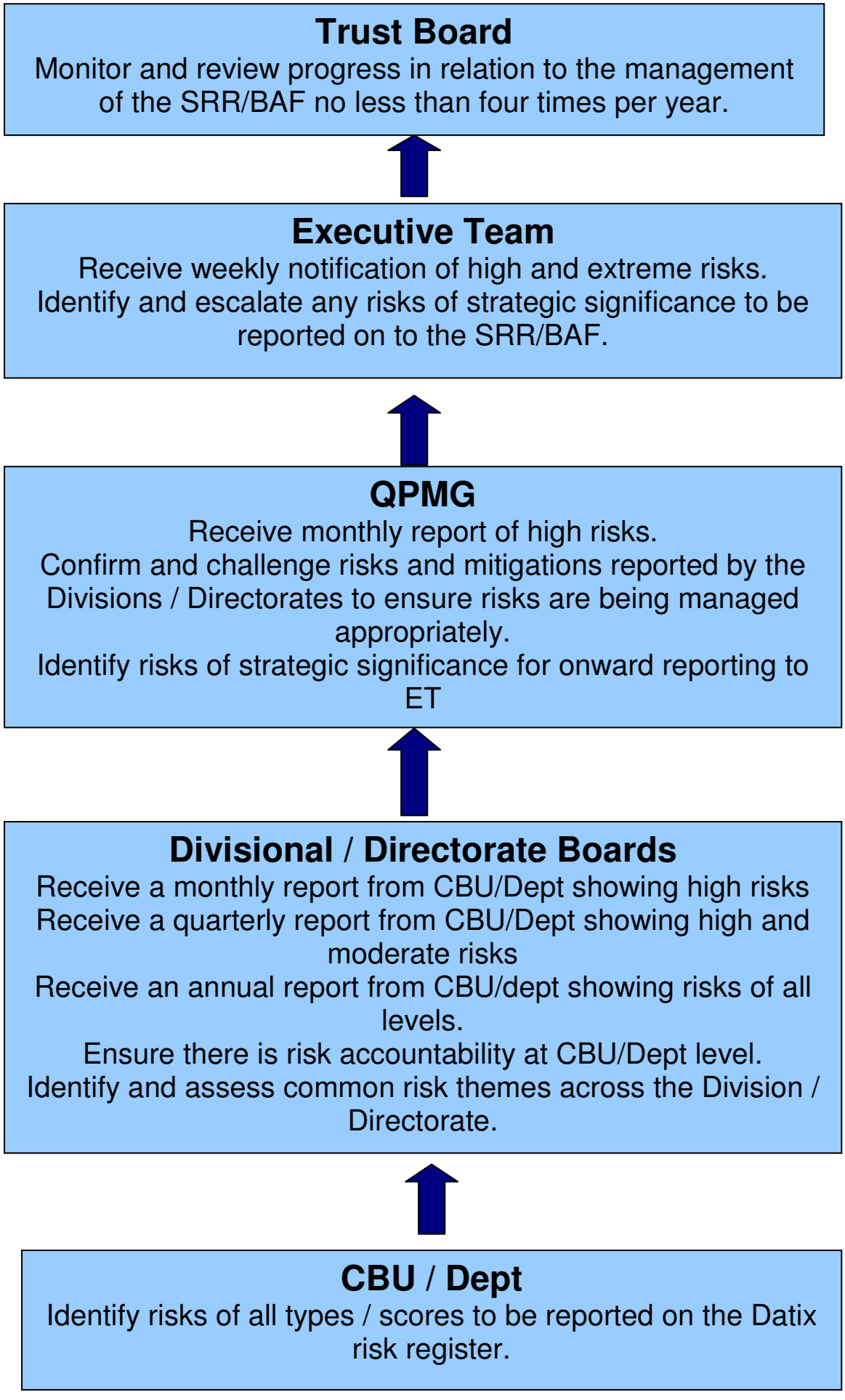
5.1 The ET is invited to:

a. Receive and note this report.

b. Consider and endorse the changes to the reporting process outlined in section 3.1 a – e.

P Cleaver, Risk and Assurance Manager
7 December 2012

Current UHL Risk Escalation Flowchart



Proposed UHL Risk Escalation Flowchart

Trust Board

Monitor and review progress in relation to the management of the SRR/BAF.
Receive monthly notification of extreme risks.
Receive quarterly report of high risks.

Executive Team

Receive weekly notification of high and extreme risks.
Receive a monthly report of high risks.
Receive a bi-annual report of moderate risks.
Confirm and challenge risks and mitigations reported by the Divisions / Directorates to ensure risks are being managed appropriately.
Identify and escalate any risks of strategic significance to be included on the SRR/BAF.

Divisional / Directorate Boards

Receive a monthly report from CBU/Dept showing high risks
Receive a quarterly report from CBU/Dept showing high and moderate risks.
Receive an annual report from CBU/Dept showing all levels of risks
Ensure there is risk accountability at CBU/Dept level.
Identify and assess common risk themes across the Division / Directorate.

CBU / Dept

Identify risks of all types / scores to be reported on the operational risk register.