Trust Board Paper G

To:	**Trust Board**
From:	**Medical Director**
Date:	**26 April 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/ Acting 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	

Summary / Key Points:

- No changes to the SRR/BAF have been made since the previous report to the Board due to the shortened period of time between meetings in April. A full report highlighting the position to the end of April will be received at the Board meeting in May.
- Ongoing discussions have identified that there may be further changes to current risk scores and/ or target risk scores and dates for the following risks:

  Risk 1 *'Continued overheating of the emergency care system'.* (Previously reviewed in March 2012)
  Risk 8 *'Deteriorating patient experience'.* (Previously reviewed March 2012)
  Risk 15 *'Management capability/ stretch'.* (Previously reviewed November 2011)

  In light of the potential deterioration of the above it is proposed that the Board applies additional scrutiny to these risks.

Recommendations:

(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.	
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: **26TH APRIL 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 is a shortened version of the usual SRR/BAF report in light of the following:

a) The change to Trust Board meeting dates.
b) Short period of time between the previous reports to the Board (i.e. three weeks).
c) Easter break.

1.2 A full report will be provided at the Trust Board meeting scheduled for 28 May 2012 and will reflect the April 2012 position.

2. STRATEGIC RISK REGISTER/ BOARD ASSURANCE FRAMEWORK 2011/12: POSITION AS OF 19 APRIL 2012

2.1 Due to the issues highlighted in section 1.1 there have been no updates to the SRR/BAF by members of the Executive Team, however ongoing discussions have identified that there may be further changes to current risk scores and/ or target risk scores and dates for the following risks:

Risk 1 *'Continued overheating of the emergency care system'.* (Previously reviewed in March 2012)
Risk 8 *'Deteriorating patient experience'.* (Previously reviewed March 2012)
Risk 15 *'Management capability/ stretch'.* (Previously reviewed November 2011)

Although these risks have all recently been reviewed it is proposed that, in light of the potential deterioration, additional scrutiny is required.

3. RECOMMENDATIONS

3.1 Taking into account the contents of this report and the presentation by the Chief Executive, Chief Operating Officer and the Director of Human Resources in relation to risks one, eight and 15 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
19 April 2012

Appendix 1

PERIOD: 23 FEBRUARY 2012 – 31 MARCH 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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – STRATEGIC RISK REGISTER/ BOARD ASSURANCE FRAMEWORK MARCH 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** **(Cross reference to risk 17)**	**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 in particular on AMUs 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 Actions associated with recent trust bed capacity risk assessment	5x 5=25 Patients	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 (c) 'Right Time. Right Place' not effectively controlling all risks (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	Increased flexibility plans to be developed Workshop to be held in May 12 to review strategy development / Capacity planning if ECN does not meet metrics Completion of capital expansion (as agreed by PCT) New Pathway projects in development	4x4=16	Nov 2012 May 2012 2013 2012/13	Chief Executive Chief Executive Chief Executive Chief Executive

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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	**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. 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.	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 Business	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.	Clinical Vision completed, detailed Strategy will be completed as part of the IBP.	3x2=6	Jun 2012	Director of Strategy

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

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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 Business	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	3x3=9	Apr 2012 Apr 2012	Director of Comms Director of Comms

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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	4x4=16 Financial/ reputational	EMCHC reports & minutes (bi-weekly). Campaign response numbers. (Sept 2011). Feedback from public consultation. (Sept 2011) Major Trauma Network minutes & actions (quarterly). 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	(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. Seeking compensation from NSCG for transitional costs following loss of solus adult ECMO designation in December 2011. Achieve FT Status, which is critical for controlling own destiny and retaining / attracting critical services.	3x3=9	Review July 2012 Mar 2012 Mar 2012 Review April 2013	Director of Strategy Director of Strategy Director of F&P Director of Strategy

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a b	**5. Lack of appropriate PbR income** **(**Previously loss making services)	**Causes:** Legacy of old contractual regime (Goodwin terms) Limited clinical engagement in clinical coding Limited clinical engagement in contract negotiation Relatively lean contracting team Failure to achieve key operational ratios defined by commissioners (e.g. New/Follow up OP ratios) Level of penalties for readmissions not based on clinical evidence **Consequence:** Under-reported co-morbidities and procedures distort clinical reporting. Service innovation constrained by contract penalties Services have to be internally cross subsidised 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) Clinical coding project Introduction of coding control sheets Portfolio review in Q3 2011/12 External review of contract terms – by Deloitte on behalf of the SHA Alignment of UHL clinical leads to clinical commissioning consortia (CCGs) and engagement in the contracting process Monitored rollout of PLICS to clinicians across the Trust. 2012/13 CIP targets based on PLICS/ SR position	4x3 =12 Financial	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. (a) No external assurance to date on the value of the counting & coding changes (c) Failure to agree to date the proposed C&C changes	2012/ 13 Counting and coding & contract renewal process	4X3=12	Sept 2012	Director of F&P

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a b c d	**6. Loss of liquidity**	Causes Operating losses ytd. Cumulative impact of 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 Restrictions to the UHL Capital Plan to generate cash Negotiations with suppliers Rolling 3m cash forecast	4x5=20 Financial	Weekly cash reporting Monthly reforecast	Maintaining positive cash balances Improvement in creditor days Deloitte and Finnamore review of cash and liquidity Commissioners' offer to fund strategic transition Discussion at DoH escalation meeting to review TFA confirmed that DoH medium term loan could be provided immediately pre authorisation as FT.	(c) Lack of solution to structural lack of liquidity is incomplete until contractual / I&E position is stabilised.	Remaining action is now to deliver a surplus and positive operating cashflow Ongoing review with Commissioners due to conclude Mar 12	4X4=16	Mar 2012	Director of F & P

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a b	**7. Estates issues** **Estates development strategy**	**Cause** Lack of clear estate strategy since cancellation of Pathway **Consequence** Sub-optimum configuration of services.	UHL Service Reconfiguration Board established, with representation from all Divisions.	4x4=16 Business/Financial	Minutes of Service reconfiguration board reported to Exec Team. Service activity and efficiency performance monitoring reported monthly to FM Board.	LLR Space Utilisation Review All site / estate proposals are reviewed by Site Reconfiguration Board Good PEAT scores	(c) Lack of agreed UHL Estates strategy	Further develop UHL Estates Strategy	3x3=9	Review Oct 2012	Director of Strategy
	Investment in Estate	Over provision of assets across LLR Significant backlog maintenance	Governance for site reconfiguration now expanded to include LLR implications and input.		.		(c) No Integrated LLR Estates strategy (linked to agreed clinical model, capacity and assets)	Develop an LLR Estates Vision in support of the clinical strategy.		Apr 2012	Director of Strategy
					Annual PEAT Scores	Capital Bid evaluation		Agree LLR service configuration /downsizing supported by most efficient use of estate.		Review Sep 2012	Director of Strategy
			£6 million per year allocated to reducing backlog maintenance		UHL risk based replacement programme in place.	Maintenance Performance KPIs reported to FM Board	(c) Backlog will take several years of investment to reduce.	Target backlog to high risk elements on an annual basis, where there are greater consequences from a failure.		Review Apr 2012	Director of Strategy
						Capital / backlog programme of works.	(c) Estates staffing & recruitment and retention issues.	Recruit into vacancies & develop staff		Review Apr 2012	Director of Strategy
	Unplanned utility Service Interruption	Failure of electrical, water, gas, steam, infrastructure	Planned Preventative Maintenance (PPM) schedules in place Emergency Planning & Business Contingency Plans in place for estates infrastructure failures		Testing programmes .		(c) Limited number of Authorised Specialist Services in-house	Develop more staff into key roles		Oct 2012	Director of Strategy
	Delayed implementation of LLR FM	Quality and / or cost	Planned project Progression, risks identified		Regular reviews	External scrutiny and validation	(c) External influences beyond UHL control, Economy, Political initiatives, Activity / Income generation	Maintain a risk log for the project. Gateway Review		Full impleme ntation in Jan 2013	Director of Strategy

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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	**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 Overheating of emergency care system leading over demand for AMU admissions. 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 . Failure to meet CQC requirements.	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 Clinical Audit programme Internal wait group. Trolley monitoring process. FTC flexible labour. Redirection of BB trolley patients. Extra capacity metrics.	5x4=20 Patients	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) Exec and Non Exec safety walkabouts Quarterly theatre reports Divisional reports Specialty Dashboard Clinical Effectiveness minutes Clinical Metric results Q&P and Heat map report GRMC minutes Results from clinical audit Dignity Audit outcomes Metric outcomes	Improving polling scores Increasing patients experience results / feedback Complaints reduction Reducing patient cancelled operations Improving nursing metrics Reduction in bed capacity x 2 wards	(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 (a) No monitoring and reporting system for internal standards	Summary of patient experience feedback Quarterly report on complaint pilot work Staff attitude and opinion survey results (that ultimately link to patient experience) to be reported to the UHL Workforce and OD group A report by the Planned Care Divisional head of Nursing to identify the demonstrable and positive impact of the actions associated with this risk is scheduled to be presented to the G&RMC in March 12 Exec team to agree KPIs and monitoring and reporting system	5x2=10	Quarterly Mar 2012 Jun 12 Mar 12 Mar 2012	COO COO Director of HR COO Medical Director

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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	**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 External financial turnaround support for • W&C division • Cardiology • Imaging • Medicine • Capacity Planning • TSO • Workforce planning	5x5=25 Financial	Internal audit review of sample of schemes Weekly metrics Monthly divisional C&C meetings Monitored monthly through F and P Committee and Confirm and challenge TSO now established	External reports confirmed scrutiny of C&C meetings (process)	(a) Lack of consistent recording (c) Plateau on headcount reduction (c) Lack of headcount reduction in first cut 2012/13 CIPs	External financial turnaround support - Medicine CBU. Phase 2 Deloitte & Finnamore work on financial turnaround Development of transformational CIPs will continue into Q1 2012/13	4X5=20	Mar 2012 Mar 2012 Quarter 1 2012/13	Director of F&P Director of F&P Director of F&P

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

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a b	**10. Readmission rates don't reduce**	Contract penalties – for items other than inappropriate readmissions due to acute failings 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 chaired by Divisional Director W&C 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 Financial/ Patients	Monitoring of clinical project plans Q&P report Community 'flash' scorecard monitored by ECN and Medical Director	Strong clinical engagement Reduction in readmission rates Recent FTN paper on readmissions	(c) Still to agree scope of third clinical readmissions audit with commissioners (c) Heavy dependence on Community Project board	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 Action plans for 2012/13 to be developed and monitored via the TSO Clinically based audit in Q1 to establish baselines from which appropriate workstreams will be determined for 2012/13.	4x2=8	May 2012 May 2012 Mar 12 Jun 12	Director of F&P Director of F&P Director of F&P Director of F&P

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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 UHL rolling programme of system/equipment replacement 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 Some vacant posts filled with short term contracts for essential services	4x3=12 Business	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 New Service Desk Team Leader in post (secondment) – performance increasing Incidence of PACS Failures reduced LLR IM&T Delivery Board Minutes Managed Business Partner procurement moving forward	(a) KPIs not reviewed outside IM&T (c) Vacancies in IM&T operations (a) KPIs not benchmarked with other Trusts.	Outline Business case to be developed for future systems 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 Sep 2012 Mar 2012 May 2012	Director of Strategy Director of Strategy Director of Strategy

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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 Lack of critical care capacity	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 Ongoing review of compliance re medical Hand Hygiene training by CBU boards Plans to deliver maintenance of backlog plan	3x4=12 Patients/ reputational/ financial	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 Increasing numbers of medical staff receiving hand hygiene training (35% Jan 2012)	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	LLR review of surgical capacity and demand to be undertaken	3x2=6	June 2012	COO

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

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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. VITAL results have been collated and priority LBR modules for nursing / AHPs identified Adherence to Divisional and Corporate Training Plans and continued development of alternatives models of training Monitoring temporary staff expenditure	3x4=12 HR /Patients	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 still 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 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) 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	Mar 2012 Quarterly update Review Jun 2012 Review Jun 2012 Review Mar 2012	Director of HR Director of HR Director of HR Director of HR Exec Team

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – STRATEGIC RISK REGISTER/ BOARD ASSURANCE FRAMEWORK MARCH 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 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 Participation in NHS leadership framework scheme Links continue to be developed with organisations with a successful track record.	4x4=16 Business	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)	4x2=8	Review of progress Mar 2012	Medical Director

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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 Service strategy to support clinical service redesign	5x4=20 Business	OD and Workforce Committee Papers and reports Trust Board reports Local Staff Polling results Local staff polling performance provided to Workforce and OD committee by Div Dirs 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 Exec Team 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 Develop effective succession planning for the '100' Skills capability review to be performed at divisional/ CBU level and reported to Workforce and OD Committee Strengthening of corporate directorate/ divisional infrastructure Review of leadership and talent management strategy as part of Organisational development plan refresh	3x4=12	Review Mar 12 Mar 12 Six monthly results Review Mar 2012 Review Jul 2012 Review Feb 2012 Dec 2012 Review Mar 2012 Oct 12 Sept 12	Director of HR Chief Executive Director of HR Director of HR Director of HR Chief Executive Director of HR Director of HR Chief Executive Director of HR

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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 Shared learning with innovative organisations	4x3=12 Business/ Financial	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	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. Initial findings from a review of clinician's perceptions of 'blockers' to innovation to be shared with the ET and April 2012 R&D Committee. Fully implement innovation elements of OD Plan.	3x2=6	Review Apr 2012 Apr 2012 Apr 2012 April 2013	Director of Strategy Director of Strategy Director of Strategy Director of Strategy

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	17. Organisation may be overwhelmed by unplanned events **(Cross reference to risk 1 in the context of major internal incidents)**	**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 Overheating of emergency care process **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 Patients/Financial/ Statutory	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	Exercise 'Olympic Shower' UHL Major Incident Plan to be updated following 'exercise Marble' Annual Emergency planning Report identifying practice	3x3=9	Mar 2012 May 2012 May 2012	COO/BCL COO/BCL COO

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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	4x4=16 Business/ Patients/Reputation	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	Revision and implementation of the staff engagement strategy and Leadership and Talent Management Strategy Implement 2011 staff engagement 8 point plan	3x3=9	Sept 2012 Review Mar 2012	Director of HR Director of HR
		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	Creation and development of organisational development plan to support new strategy Development of comprehensive leadership and development programme Develop and implement medical leadership programme Define organisational approach in embedding UHL values and behaviours		Sept 2012 Sept 2012 Mar 2012 Apr 2012	Director of HR Director of HR / Director of Corp and Legal Affairs Director of HR Director of HR

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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	4x4=16 Statutory/ reputational	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 Report on case studies arising from police investigation into breach of policies	3x4=12	Jun 2012 June 2012 June 2012 Jun 2012	Director of Strategy Director of Strategy Director of Strategy Director of Strategy