To:	**Trust Board**
From:	**MEDICAL DIRECTOR**
Date:	**27 SEPTEMBER 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: Medical Director

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

The Report is provided to the Board for:

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

Summary / Key Points:

- There will be a refresh of the SRR/BAF in conjunction with the Board on 1 October 2012 in order to provide UHL with a fully revised 2012/13 version.
- Six actions due for completion in August have been completed. There are four actions where the deadline has slipped to a later date.
- No current risk scores have altered since the previous report.
- Risk 10 and risk 5 have both reached their target scores and TB is asked to consider whether these can be closed.

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, 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: **27 SEPTEMBER 2012**

REPORT BY: **MEDICAL DIRECTOR**

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

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1. INTRODUCTION

1.1 This report provides the Board with:-

a) A copy of the SRR/BAF as of 31 August 2012 (appendix one).
b) A summary of risk movements from the previous month (appendix two).
b) A summary of changes to actions (appendix three).
c) Suggested parameters for scrutiny of the SRR/BAF (appendix four).

1.2 There will be a refresh of the SRR/BAF in conjunction with the Trust Board to provide UHL with a revised version and an externally facilitated Trust Board Development Session has been arranged for 1 October 2012 to achieve this. Trust Board members will receive a pack ahead of the day including the session agenda, aims and objectives as well as useful guidance documents.

1.3 The current BAF/SRR is reviewed by Executive Team and Trust Board each month. Some weaknesses have been:-

- Too much detail and too operational rather than strategic;
- Critical controls and assurances difficult to pick out in the document and therefore not user friendly for Audit Committee;
- Reluctance to close risks;
- No clear trajectory of risk reduction until target score is reached.

1.4 Improvements to the refreshed document should result in:-

- Better integration with operational risk register (link risks);
- Risks built with SMART strategic objectives for Trust Board, Executive Team and Audit Committee;
- Focus on strategic risks not operational detail.

1.5 In addition, the Board needs to be able to articulate its risk appetite and to be assured that the BAF is congruent with the Trust's Strategic Direction document and the refreshed Integrated Business Plan (IBP).

2. SRR/BAF 2012: POSITION AS OF 31 AUGUST 2012

2.1 An updated version is attached at appendix one with amendments from the previous report highlighted in red text.

2.2 Six actions due for completion in August have been completed. There are four actions where the deadline has slipped to a later date (see appendix three for details). The risk scores have not varied due to these slippages.

2.3 No current risk scores have altered since the previous report to the Board.

2.4 Risk 10 ('readmission rates don't reduce') and risk 5 ('lack of appropriate PbR income') have both now reached their target scores and a moderate level of residual risk. These cases were reviewed at August ET where it was suggested they could now be closed. The Trust Board is asked to consider whether further reductions would provide benefits that would justify any additional time, effort and cost or to accept the risks at their existing levels.

2.5 In the absence of the Director of Strategy and in conjunction with recent changes to Director Portfolios, to ensure the Strategic Risks are continually monitored, new risk owners will be appointed at the Trust Board Development Session on the 1 October.

2.6 To provide regular scrutiny of strategic risks on a cyclical basis, Trust Board members are invited to review the following risks against the parameters listed in appendix four.

- **Risk 7:** 'Under utilisation and investment in Estates' – Previously presented March 2012.
- **Risk 8:** 'Deteriorating patient experience' - Previously presented January 2012.
- **Risk 9:** 'CIP Delivery' – Previously presented March 2012.

3. RECOMMENDATIONS

3.1 Taking into account the contents of this report and its appendices, and the presentations by the Acting Director of Estates & Facilities, Chief Operating Officer and Director of Finance & Procurement in respect of risks 7, 8 and 9, the Trust Board is invited to:

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

Richard Manton, on behalf of
Peter Cleaver,
Risk and Assurance Manager
20 September 2012

PERIOD: 1 AUGUST 2012 – 31 AUGUST 2012

STRATEGIC GOALS

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

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

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 Effectiveness in reducing the numbers presenting at ED Lack of bed capacity and critical care capacity 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 and penalty costs) 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 ED referral pathway to next day clinics 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	4x4=16 Business/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 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	External review of emergency care processes to commence 14 Sept 2012 Increased flexibility plans to be developed Respond to recommendations of the July ECIST report Completion of staged capital expansion (as agreed by PCT) New Pathway projects in development	3x4=12	Oct 2012 Nov 2012 Sep 2012 2013 2012/13	Chief Executive Chief Executive COO Chief Executive Chief Executive

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

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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. Cause: 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 Project team established to lead response to Elective Care Tender.	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.	Strategic Direction Document complete. Clinical strategy to be completed as part of IBP by end of October 2012. Respond to next steps regarding Elective Care Tender.	3x2=6	Oct 2012 Oct 2012.	Director of Strategy Director of F&P.

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

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a b c	**3 Deteriorating relationships with Clinical Commissioning Groups**	**Context** New Health act; competition/ collaboration &partnership contract **Cause** 1. Weak relationships with GPs as result of historical lack of engagement by UHL 2. Lack of understanding / trust between UHL leaders and CCG leaders 3. Lack of evidence of pathway redesign		4x4=16 Business					3x3=9		
		Consequence 1. High levels of GP (customer) dissatisfaction with UHL services. > loss of market share / revenue > lower hurdles for competition > No grass root support from GPs regardless of strength of CCG leader relationships.	GP Head of Service GP relationships action plan part 2 GP value added > training / Podcasts Getting the basics right > GP Hotline GP Referrers Guide OP letters 20+ services now transmitting electronically Discharge letters within 24 hours GP newsletter		GP temperature check (part 3) in May 2012. Informal feedback from GPs re: Guide / hotline / letters CCG funding = £285k for letters & GP hotline 1/4rly Market share analysis to F&P	GP temperature Check part 2 +ve 20 services now transmitting Market share stable across <u>most</u> services	Temperature check (part 3) results in June 12 Anecdotal feedback on new initiatives <u>All</u> letters transmitted electronically Ophthalmology first GP referral –ve 9% ENT –ve 12%	Fully developed plan for ICE / Transcription interface Analyse and plan intervention to restore share. Be the successful bidder for the East Leicestershire & Rutland CCG. Shared understanding and monthly measurement of key metrics between CCGs and UHL	Sep 2012 Sep 2012 Dec 2012 Sep 2012	Director of Comms Director of Comms Director of F&P COO
		Consequence 2. 2. Breakdown in key relationships with commissioning decision makers. > Integration / pathway redesign harder > Contract negotiation over 'transformation' > Reputation	<u>Re-alignment</u> 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 Event to welcome CCG Lay board members		CCIG monthly meeting LLR Reconfiguration Board	CCG sign off of 12/13 AOP CCIG minutes CCG (agreement to 12/13 contract and C&C changes) Agreement of LLR Reconfig' joint vision and principles					

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	3 (continued)		CCIG Right care Transformation			Emergency Gynae pathway Urgent medical clinics/ admission avoidance	Still few examples we can point to of redesigned pathways	Agree more services for rapid pathway redesign		Oct 2012	Director of Strategy

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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, Elective Care Bundle)**	<u>Cause</u> National Reviews of specialist services. Sustainability. Cost Effectiveness. Recommendation made by JCPCT to not designate Leicester's Paediatric Cardiac Surgery <u>Consequence</u> 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 Patient safety impacted in the short term. Impact on ECMO. <u>Upside:</u> 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. ECMO NCG/Board engagement. Regular review of key service reviews by Exec Team & Trust Board. Strong academic recognition Ongoing dialogue with other children's cardiac centres to ensure strong proposal on sustainable network Co-location of ENT with Children's Cardiac Services completed. Initial response strategy agreed for Children's Cardiac Services	4x5=20 Financial/ reputation	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	Do not have an IBP with an agreed service profile for tertiary services.	Draft Clinical Strategy Draft IBP Achieve FT Status, which is critical for controlling own destiny and retaining / attracting critical services. Undertake lessons learnt review on Paediatric Cardiac Surgery Review – in progress Review all other services due to be reviewed nationally and ensure lessons learnt are applied	3x3=9	Review Sep 2012 Oct 2012 April 2014 Oct 2012 Apr 2013	Director of Strategy Director of Strategy Director of Strategy Director of Strategy Director of Strategy

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a b	**5. Lack of appropriate PbR income** **(**Previously loss making services)	**Causes:** Limited clinical engagement in clinical coding 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 Risk of new CCGs pursuing a "competition-based" agenda Sub-tariff commissioning **Consequences:** Service innovation constrained by contract penalties 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 Clinical coding project Introduction of coding control sheets 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 New PLICS licences secured Monthly financial reporting	Counting and coding changes agreed for 2012/13 contracting round Positive Internal audit review of annual RCI (PLICS) cost attribution methodology	(a) Still some underlying issues in data robustness	2012/ 13 Counting and coding & contract renewal process Focussed resource on strategic alignment	4X3=12	Sep 2012 Q2 2012	Director of F&P 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 Negotiations with suppliers Rolling 3m cash forecast	4x5=20 Financial	Weekly cash reporting Monthly reforecast	Maintaining positive cash balances 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.	Strategic funding request to M&E SHA to be linked to the FT application. Strategic bid for transition funding being prepared with LLR commissioners.	4X4=16	Linked to FT application Oct 2012	Director of F&P Director of F&P

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

Objective	Risk	Cause /Consequence	Controls	Current Risk	Assurance On Controls	Positive Assurance	Gaps in Assurance (a) / Control (c)	Actions for Further Control	Target Risk	Due Date	Risk / Action Owner
a b	**7. Estates** **Estates development strategy**	**Cause** Lack of clear estate strategy since cancellation of Pathway **Consequence** Sub-optimum configuration of services.	Service Reconfiguration Board established, with representation from all Divisions.	4x4=16 Business/ Financial	Minutes of Service reconfiguration board reported to Exec Team.	LLR Space Utilisation Review All proposals are reviewed by Site Reconfiguration Board	(c) Lack of agreed Estates strategy	Further develop UHL Estates Strategy	3x3=9	Review Oct 2012	Acting Director of Estates & Facilities
	Investment in Estate	Cause: Over provision of assets across LLR Consequence: Significant backlog maintenance	PEAT inspections Governance for site reconfiguration now expanded to include LLR implications and input. £8 million per year allocated to reducing backlog maintenance		Annual PEAT Scores Service activity and efficiency performance monitoring reported monthly to FM Board. Risk based replacement programme in place.	Good PEAT scores Capital Bid evaluation / backlog programme of works Maintenance Performance KPIs reported to FM Board	(c) No Integrated LLR Estates strategy (linked to agreed clinical model, capacity and assets) (c) Backlog will take several years of investment to reduce.	Agree LLR service configuration /downsizing supported by most efficient use of estate. Lot 2 Estates & Facilities outsourcing opportunities for investment / development Target backlog to high risk elements on an annual basis, where there are greater consequences from a failure.		Review Sep 2012	Acting Director of Estates & Facilities
	Unplanned utility Service Interruption	Cause: Failure of electrical, water, gas, steam, infrastructure **Consequences** Service disruption, clinical/ quality/safety operational risk increased.	Planned Preventative Maintenance (PPM) schedules in place Emergency Planning & Business Contingency Plans in place for estates infrastructure failures		Frequent testing programmes.	Estates infrastructure failures dealt with effectively	(c) Limited number of Authorised Specialist Services in-house	Authorised person appointment letters to be reviewed/updated.		Oct 2012	Acting Director of Estates & Facilities
	Delayed implementation of LLR FM	Cause: Quality and / or cost issues **Consequences** Financial & operational. Potential efficiency losses.	Planned project Progression, risks identified Estates Vision in support of the clinical strategy.		Regular reviews of risk log Positive Gateway Review at level 3 completed.	External scrutiny and validation	(c) External influences beyond UHL control, Economy, Political initiatives, Activity / Income generation	Gateway Review at Level 5 scheduled for FBC and contract award.		Dec 2012	Acting Director of Estates & Facilities

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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.	Patient Experience plan and projects Local awareness of LLR Emergency Care communication plan Caring @ its Best National Patient Survey Engagement of Age UK, LINKS 10 point plan Net Promoter Scores reviewed identifying key areas & ranking of scores for focus Emergency co-ordinator Escalation thresholds Theatre and out-patient transformation project Cancellation validation Clinical quality and OPD/ED metrics Improved data analysis Engagement of consortia members and ECN for campaign Clinical Audit programme Internal wait group. Trolley monitoring process. FTC flexible labour. Redirection of BB trolley patients. Extra capacity metrics.	4x3=12 Patients	Monthly patient polling Monthly Trust Board report Real time patient feedback Patient Stories Patient Experience data presented with patient safety and outcome measures Net Promoter scores benchmarked with other trusts within SHA Cluster 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 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 Successful Patient Experience Conference May 2012 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 Review volunteer roles within OP and ward areas Review patient information relating to consent Internal Waits Group to be established with key metrics Additional critical care capacity to be introduced	2x3=6	Quarterly Sep 2012 Sep 2012 Monthly/ In progress Review Oct 2012	COO DNS DNS COO COO

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

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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 2012/13 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	5x4=20 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) Further headcount reductions delivered	(a) Lack of consistent recording (c) Lack of headcount reduction in first cut 2012/13 CIPs Executive leadership on Transformation now assigned to Director of Strategy (June '12)	Development of transformational CIPs will continue into Q2 2012/13	4x4=16	Quarter 2 2012/13	Director of F&P

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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 work streams Interim agreement with commissioners on 2011/12 readmissions penalty Third clinical audit on underlying causes of readmissions	4x2=8 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) project manager has resigned – to be replaced (June '12) (c) Heavy dependence on Community Project board		4x2=8	Sept 2012	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 reviewed as required via Q&PMG 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 Award contract to IM&T strategic partner	3x3=9	Next review Sep 2012 Dec 2012	Acting Director of IM&T Acting Director of IM&T

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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/ reputation/ 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 Increase in 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 (c) impact of national bowel screening targets (c) impact of national breast screening targets (c) IP plan for 2012	Quarterly contract with referring Trust Recruitment of CBU Manager vacancies External audit overview of cancer pathway Roll-out of capacity plan across specialities	3x2=6	Quarterly Review Sep 2012 Sep 2012 Jan 2013	COO COO COO DS

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

Objective	Risk	Cause /Consequence	Controls	Current Risk	Assurance On Controls	Positive Assurance	Gaps in Assurance (a) / Control (c)	Actions for Further Control	Target Risk	Due Date	Risk / Action Owner
a b c d	**13. Skill shortages**	**Cause** No development of a learning and development culture No resource to invest in development opportunities Inability to release staff for education / training Inability to recruit and retain appropriately skilled staff **Consequence** Lack of sustainability of some middle grade rotas Quality compromised, increased clinical risk Compliance with external standards may be affected Additional expenditure on agency staff High staff turnover rates	Use of EMSHA talent profile and incorporation into appraisal documentation Leadership and Talent Management Strategy Compliance with mandatory and statutory training requirements being monitored by Education leads Associate Medical Director for Clinical Education Productive strategic relationships and joint working with training partners. 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 Review of Deanery/ Trust funding of trainee doctor positions being reviewed at specialty level.	2x4=8	Dec 2012 Quarterly update Review Oct 2012	Director of HR Director of HR Director of HR

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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	Medical Engagement strategy UHL Leadership Academy Work with Warwick University on medical engagement GP engagement strategy Secondary care representation on CCG Participation in NHS leadership framework scheme Links continue to be developed with organisations with a successful track record. CCG commitment to develop clinical leadership within UHL	4x3=12 Business	Medical Engagement survey (Warwick University) Review of Clinical Engagement Strategies at OD and Workforce Committee Joint multi organisation clinically led working with LLR CCIG	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) Pilot of web based access Roll-out of technical solution if pilot is successful Releasing time for clinical leaders to engage constructively with CCGs – awaiting approval for funding from commissioners before implementing changes	4x2=8 Business	Review of progress Sep 2012 Review Sep 2012 Dec 2012 Sept 2012	Medical Director Medical Director Medical Director 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
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 programme in place and communicated Engagement with Leadership Academy programmes Talent management guidance Development and building of organisational capacity and capability on processes to support service redesign Organisational development plan Exec led Workforce & OD group Skills capability review 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 UHL has joined cohort 1 of Midlands and East Talent management champions Review of divisional structures to identify areas for development/ improvement Appraisal and setting of stretching objectives aligned to the UHL Strategy	4x4=16 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 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 Develop effective succession planning for the '100' Strengthening of corporate directorate/ divisional infrastructure Leadership and talent management strategy, reviewed, as part of organisational development plan refresh, and to be disseminated through OD plan	4x3=12	Review Oct 2012 Six monthly results Review Oct 2012 Review Oct 2012 Dec 2012 Oct 2012 Oct 2012	Director of HR Director of HR Director of HR Director of HR Director of HR Chief Executive Director of HR

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Objective	Risk	Cause /Consequence	Controls	Current Risk	Assurance On Controls	Positive Assurance	Gaps in Assurance (a) / Control (c)	Actions for Further Control	Target Risk	Due Date	Risk / Action Owner
b c d	**16. Lack of innovation culture**	**Cause** Lack an innovation culture. Innovation seen as optional 'if we have time to spare' Lack of support when developing new models Too focussed on immediate operational issues (firefighting) **Consequence** Low staff morale Downside Outmoded models of delivery increasingly expensive and vulnerable Upside A health system that supports the spread and adoption of evidence-based innovative systems, products, practices and technologies.	Board level lead for innovation working with the SHA to further develop the NHS East Midlands Innovation Strategy UHL Transformation Programme to stimulate and drive an innovation culture within the organisation Deloitte and Finnamore to help identify areas of innovation Commercial Executive R&D Committee/ strategy PhD sponsored to examine how to successfully foster an entrepreneurial culture 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 Successful Experimental Cancer Medicine Centre application Opening of 3 new patient centred research facilities Successful application for BRU capital funding 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	Fully implement innovation elements of OD Plan. Establish clear mechanisms for incentivising innovation.	3x2=6	Apr 2013 Nov 2012	Director of Strategy 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
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. 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	Organisational development plan Non- Exec led Workforce & OD group Staff engagement Strategy, local staff polling and national staff survey Board development programme Talent management / Leadership programme/ Clinical Leadership programme UHL has joined cohort 1 of Midlands and East Talent management champions 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)	4x4=16 Business/ Patients/Reputation	Range of measurable success criteria reported to ET, Q&PMG and TB National / local Staff Survey Results 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 % of staff satisfied in certain elements Increased No of staff performance managed. Increased No of staff reporting a positive and valued appraisal	(a) Larger no. of staff responses required. (c) 2011 staff engagement 8 point plan not yet implemented (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	Staff engagement strategy and Leadership and Talent Management Strategy to be disseminated through OD plan Creation and development of organisational development plan to support new strategy. OD plan to be implemented after approval from Executive Team Development of comprehensive leadership and development programmes: Medical development programme for HOS /CBU due to commence November 2012	3x4=12	Oct 2012 Oct 2012 Nov 2012	Director of HR Director of HR Director of HR / Director of CALA

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Objective	Risk	Cause /Consequence	Controls	Current Risk	Assurance On Controls	Positive Assurance	Gaps in Assurance (a) / Control (c)	Actions for Further Control	Target Risk	Due Date	Risk / Action Owner
abcd	**19 Inadequate data protection and confidentiality standards**	**Cause** Lack of compliance with existing data protection and confidentiality standards. Inadequate recognition of minimum standards required to protect patient and key corporate information. Limited levels of Staff Engagement and understanding despite previous training approaches. Board compliance requirements knowledge based rather than skills based. Inadequate updating of managers, leaders, staff for managing personal information to compliance standard. **Consequences** Poor protection of highly sensitive personal data relating to patients and staff Damage to corporate reputation from data breaches Inconsistent behaviour against trust values Limited staff understanding	Information Governance Steering Group and associated strategy work programme SIRO assessment as part of monthly performance review Caldicott updates for monthly performance plan Annual Information Governance(IG) Toolkit compliance assessment in March Staff IG training strategy, local staff cascade sessions and online resources Integrated IG training programme Performance monitoring via IG Steering Group and intervention when necessary Divisional quality and performance meetings to include IG items IG spot-checks for clinical and non clinical areas	4x3=12 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	Ensure staff have updated methods for undertaking IG training to fulfil their roles. Strengthening of corporate directorate/ divisional information governance infrastructure Improve IG audit and performance reporting via IG Programme Board	4x2=8	Oct 2012 Nov 2012 Nov 2012	Director of Strategy (SIRO) Director of Strategy (SIRO) Director of Strategy (SIRO)

APPENDIX TWO

UHL STRATEGIC RISKS SUMMARY REPORT – AUGUST 2012

Risk No	Risk Title	Current Risk Score (August 12)	Previous Risk Score (July 12)	Target Risk Score and Final Action Date	Risk Owner	Comment
9	CIP Delivery	**20**	**20**	**16** – Quarter 2 12	Director of F&P	
6	Loss of Liquidity	**20**	**20**	**16** – Linked to timescale for FT application	Director of F&P	
4	Failure to acquire and retain critical clinical services	**20**	**20**	**9** – Apr 14	Director of Strategy	
15	Management capability / stretch	**16**	**16**	**12** – Dec 12	Director of HR	
1	Continued overheating of emergency care system	**16**	**16**	**12** - 2013	Chief Executive	
18	Inadequate organisational development	**16**	**16**	**12** – Sep 12	Director of HR	
3	Deteriorating relationships with Clinical commissioning groups	**16**	**16**	**9** – Dec 12	Director of Comms	
7	Estates issues Under utilisation and investment in Estates	**16**	**16**	**9** – Dec 12	Acting Director of Estates & Facilities	
8	Deteriorating patient experience	**12**	**12**	**6** – Oct 12	COO	
19	Inadequate data protection and confidentiality standards	**12**	**12**	**8 –** Nov 12	Director of Strategy/ IG Manager	
14	Ineffective Clinical Leadership	**12**	**12**	**8** – Dec 12	Medical Director	
11	IM&T Lack of IT strategy and exploitation	**12**	**12**	**9** – Dec 12	Acting Director of IM&T	
2	New entrants to market (AWP/TCS	**12**	**12**	**6** – Oct 12	Director of Strategy	
13	Skill shortages	**12**	**12**	**8** – Dec 12	Director of HR	
12	Non- delivery of operating framework targets	**12**	**12**	**6** – Jan 13	COO	
16	Lack of innovation culture	**12**	**12**	**6** – Apr 13	Director of Strategy	
10	Readmission rates don't reduce	**8**	**8**	**8 –** Sept 12	Director of F&P	Risk has achieved target score. Risk remains open following discussion at August TB and deadline extended accordingly.

APPENDIX THREE

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

Risk No.	Action Description	Action Owner	Comment
1	External review of emergency care process (Kings College)	Chief Executive	The external review by Kings was cancelled due to their non-availability. A company has been commissioned to undertake this work which will commence on September 14th and be complete by mid-October 2012. Action deadline extended to October 2012.
1	Job plan review to be undertaken	Chief Operating Officer/ Medical Director	**Complete**
1	Introduce ED referral pathway to next day clinics	Chief Operating Officer	**Complete**
2	Draft clinical strategy completed and further work identified to be completed and signed off by Trust Board in August	Director of Strategy	Strategic Direction Document complete. Draft clinical strategy to be completed as part of IBP by end of October 2012.
4	Complete clinical and legal review of JCPTC decision on Paediatric Cardiac Surgery	Director of Strategy	**Complete**
4	Undertake lessons learnt review on Paediatric Cardiac Surgery review	Director of Strategy	In progress. Action deadline extended to October 2012.
8	Review Net Promoter results identifying key areas and ranking of scores for focus	Chief Operating Officer	**Complete**
12	Identify and implement revised LOGI pathway	Chief Operating Officer	**Complete**
12	Relaunch cancelled operations guidance with RCA for non-compliance	Chief Operating Officer	**Complete**
14	Releasing time for clinical leaders to engage constructively with CCGs	Medical Director	Bid submitted for transformation funding. Awaiting formal approval from commissioners that this will be funded before changes can be implemented (action due date extended to September 2012).

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

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

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

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

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

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

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

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

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

8) Are the assigned risk scores realistic?

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