Trust Board Paper M

University Hospitals of Leicester NHS
NHS Trust

To:	**Trust Board**
From:	**MEDICAL DIRECTOR**
Date:	**28 JUNE 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 to provide UHL with a fully revised 2012/13 version. An externally facilitated Board development session is in the process of being arranged for this purpose.
- Action owners who are not executive directors have been removed and replaced by the relevant executive in order to demonstrate executive level accountability for the strategic management of these issues.
- No current risk scores have altered since the previous report to the Board.
- A total of nine actions have been completed during this reporting period and one action has slipped against its original deadline.
- Consolidation of risks two, three and four and the criticality of achieving FT status being made more explicit through the SRR/BAF as a whole (and included specifically within risk 4) will be considered during the refresh of the 2012/13 SRR/BAF

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

<table>
<tr><td colspan="2">'significant control issues' to provide assurance on the Trust meeting its principal objectives.</td></tr>
<tr><td colspan="2">Previously considered at another corporate UHL Committee?
Yes – Executive Team</td></tr>
<tr><td>Strategic Risk Register
Yes</td><td>Performance KPIs year to date
No</td></tr>
<tr><td colspan="2">Resource Implications (e.g. Financial, HR)
N/A</td></tr>
<tr><td colspan="2">Assurance Implications
Yes</td></tr>
<tr><td colspan="2">Patient and Public Involvement (PPI) Implications
Yes.</td></tr>
<tr><td colspan="2">Equality Impact
N/A</td></tr>
<tr><td colspan="2">Information exempt from Disclosure
No</td></tr>
<tr><td colspan="2">Requirement for further review?
Yes. Monthly at Executive Team meeting and Board meeting</td></tr>
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UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: TRUST BOARD

DATE: 28 JUNE 2012

REPORT BY: MEDICAL DIRECTOR

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

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1. INTRODUCTION

1.1 This report provides the Board with:-

a) A copy of the SRR / BAF as of 31 May 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 areas for scrutiny of the SRR/BAF (appendix four).

1.2 There will be a refresh of the SRR/BAF in conjunction with the Board to provide UHL with a fully revised 2012/13 version. An externally facilitated Board development session is in the process of being arranged for this purpose. Upon receipt of an appropriate range of dates from the Medical Director and the Director of Safety and Risk, the Director of Corporate and Legal Affairs will work with the Chairman and Board members to set a date in the diary.

2. SRR/BAF 2012/13: POSITION AS OF 31 MAY 2012

2.1 The SRR/BAF is updated by the risk owners and is presented to the Board on a monthly basis. Changes are highlighted in red in appendix one.

2.2 Action owners who are not executive directors have been removed and replaced by the relevant executive in order to demonstrate executive level accountability for the strategic management of these issues. It is however recognised that some of these actions may be delegated to others.

2.3 There is one risk listed below where the target date has been reached but the risk has not yet moved to its target score.

- Risk 17 – Organisation may be overwhelmed by unplanned events

All actions to mitigate the risk have been taken which effectively means that the risk has reached its target level. In this instance the COO has identified the need to maintain the current risk score whilst the issues regarding ED patient inflows are causing concern. This situation will continue to be monitored and the risk score downgraded when appropriate.

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

2.5 A total of nine actions have been completed during this reporting period and one action has slipped against its original deadline. The risk score has not varied due to this slippage. A summary of changes to actions is attached at appendix three.

2.6 In response to a request at the previous Board meeting ongoing actions listed in appendix three are highlighted in bold for ease of reference.

2.7 Consolidation of risks two, three and four and the criticality of achieving FT status being made more explicit through the SRR/BAF as a whole (and included specifically within risk 4) will be considered during the refresh of the 2012/13 SRR/BAF at a future Board development session currently being arranged (see para. 1.2).

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

- Risk One - Overheating of the emergency care system. (Previously presented Sept '11).

- Risk Five – Lack of appropriate PbR income. (Previously presented Oct '11).

- Risk Ten - Readmission rates don't reduce (Previously presented Sept '11).

3. RECOMMENDATIONS

3.1 Taking into account the contents of this report and its appendices, and the presentation by the Chief Executive and the Director Finance and Procurement in respect of risks one, five and ten 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
21 June 2012

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

PERIOD: 1 MAY 2012 – 31 MAY 2012

Appendix 1

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

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	Creation of emergency flow steering group Summit on emergency care (to include Execs/Divisional Directors and CCGs) External review of emergency care processes (Kings College) Increased flexibility plans to be developed Winter Planning and Strategy Group Completion of capital expansion (as agreed by PCT) New Pathway projects in development	4x5=20	Jul 2012 Jun 2012 Jul 2012 Nov 2012 Jun 2012 2013 2012/13	Chief Executive Chief Executive Chief Executive Chief Executive Chief Executive Chief Executive

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

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. 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.	Clinical Vision completed, draft clinical Strategy will be completed by 3rd July and following engagement will be signed off by the Trust Board in August. Respond to ITT for Elective Care Tender.	3x2=6	August 2012 August 2012.	Director of Strategy Director of F&P.

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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.	GP temperature Check part 2 +ve	Temperature check (part 3) results in June 12	Empirical feedback on new initiatives		Jun / Jul 12	Director of Comms
					Informal feedback from GPs re: Guide / hotline / letters		Anecdotal feedback on new initiatives	Fully developed plan for ICE / Transcription interface		30th Sep 12	Director of Comms
					CCG funding = £285k for letters & GP hotline	20 services now transmitting	All letters transmitted electronically	Analyse and plan intervention to restore share.		Jul 12	Director of Comms
					1/4rly Market share analysis to F&P	Market share stable across most services	Ophthalmology first GP referral –ve 9% ENT –ve 12%	Be the successful bidder for the East Leicestershire & Rutland CCG.		Dec 12	Director of F&P
		Consequence 2. 2. Breakdown in key relationships with commissioning decision makers. > Integration / pathway redesign harder > Contract negotiation over 'transformation' > Reputation	Re-alignment of senior clinicians and executive directors to clinical commissioning groups		CCIG monthly meeting	CCG sign off of 12/13 AOP CCIG minutes		Shared understanding and monthly measurement of key metrics between CCGs and UHL		July 12	COO
			Involvement of UHL clinicians in contracting round to provide consistency and expertise		LLR Reconfiguration Board	CCG (agreement to 12/13 contract and C&C changes)					
			Joint working groups to develop key strategies			Agreement of LLR Reconfig' joint vision and principles					
			Event to welcome CCG Lay board members								

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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 12	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)**	Cause National Reviews of specialist services. Sustainability. 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. 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.	4x4=16 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 Leicester in highest scoring option for Safe & Sustainable	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.	3x3=9	Review Jul 2012 Oct 2012 April 2013	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 **Consequence:** 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 Increased team resources needed in PLICs team Focussed resource on strategic alignment	4X3=12	Sep 2012 Jul 2012 Q2 2012	Director of F&P Director of F&P Director of Strategy

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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 applicatio n July 2012	Director of F & P Director of F & P

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

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

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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.	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.	5x5=25 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 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 Benchmark Net Promoter Scores with other trusts within SHA Cluster Identify Action Plans within Divisions to address performance for wards not in top quartile for Net Promoter Scores Undertake review of Divisional Patient Experience Projects for GRMC/TB Staff attitude and opinion survey results (that ultimately link to patient experience) to be reported to the UHL Workforce and OD group Internal Waits Group to be established with key metrics Additional critical care capacity to be introduced	5x4=20	Quarterly Jun 2012 Jun 2012 Jul 2012 Jun 2012 Monthly/ In progress Jul 2012	COO COO COO COO Director of HR COO COO

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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 Strategy

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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	Clinically based audit in Q1 to establish baselines from which appropriate work streams will be determined for 2012/13.	4x2=8	Jul 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 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 Issue of Invitation to Tender Award Contract to Partner	3x3=9	Next review Sep 2012 Jun 2012 Sept 2012 June 2012 Sept 2012	Director of Strategy Director of Strategy Director of Strategy Director of Strategy Director of Strategy

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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	**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 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 (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 UHL review of bowel screening referrals. UHL plan to be crafted for Breast Screening implementation. Identify milestones for Breast Screening Target delivery through meeting with commissioners, EMQA, Public Health, UHL Agree 2012 IP strategic objectives with quarterly monitoring at QPMG LLR review of surgical capacity and demand to be undertaken	3x2=6	Quarterly July 2012 Sep 2012 July 2012 June 2012 July 2012 July 2012 Jun 2012	COO COO COO COO COO COO COO COO

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 Proactive steps being taken to address gaps in training for August, over recruit where required and take steps to make middle grade rotas more attractive Work with Deanery/SHA Workforce Team to improve fill rates – project scope agreed now proceeding to implementation Workforce/OD Committee to receive update on Branding Project and to discuss the ongoing work re: strengthening of a UHL brand/ ethos	2x4=8	Dec 2012 Quarterly update Review Aug 2012 Review Aug 2012 Jun 2012	Director of HR Director of HR Director of HR Director of HR Director of HR

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

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
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	4x 3=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) Releasing time for clinical leaders to engage constructively with CCGs	4x2=8 Business	Review of progress Jun 2012 Aug 2012	Medical Director Medical Director

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	**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 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 Review of divisional structures to identify areas for development/ improvement Appraisal and setting of stretching objectives aligned to the UHL Strategy IMT strategy to support clinical service redesign	5x4=20 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 Review of leadership and talent management strategy as part of Organisational development plan refresh	4x4=16	Review Oct 2012 Six monthly results Review Oct 2012 Review Jul 2012 Dec 2012 Oct 2012 Sept 2012	Director of HR Director of HR Director of HR Director of HR Director of HR Chief Executive Director of HR

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
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	April 2013 Nov 2012	Director of Strategy Director of Strategy

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
	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. Annual Emergency planning Report identifying practice 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		3x3=9		

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 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	Revision and implementation of the staff engagement strategy and Leadership and Talent Management Strategy Review and revise 2011 Staff Engagement 8 point plan incorporating values and behaviours Creation and development of organisational development plan to support new strategy Development of comprehensive leadership and development programme	3x4=12	Sept 2012 Review Jul 2012 Sept 2012 Sept 2012	Director of HR Director of HR Director of HR Director of HR / Director of CALA

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
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 Jun 2012 Jun 2012 Jun 2012	Director of Strategy Director of Strategy Director of Strategy Director of Strategy

APPENDIX TWO

UHL STRATEGIC RISKS SUMMARY REPORT – MAY 2012

Risk No	Risk Title	Current Risk Exp (May 12)	Previous Risk (Apr 12)	Target Risk Score and Final Action Date	Risk Owner	Comment
1	Continued overheating of emergency care system	25	25	20 - 2013	Chief Executive	
8	Deteriorating patient experience	25	25	20 – Jul 12	COO	
9	CIP Delivery	20	20	16 – Quarter 2 12	Director of F&P	Deadline extended reflecting continual development of 2012/12 CIPs. No increased risk associated with delays.
6	Loss of Liquidity	20	20	16 – Linked to timescale for FT application	Director of F&P	Target date extended to align to timescale for FT application. No increased risk associated with delays
15	Management Capability / stretch	20	20	16 – Dec 12	Director of HR	
18	Inadequate organisational development	16	16	12 – Sep 12	Director of HR	
3	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 – Mar 13	Director of Strategy	Deadline for completion extended. No increased risk associated with delays
4	Failure to acquire and retain critical clinical services	16	16	9 – Apr 13	Director of Strategy	
19	Inadequate data protection and confidentiality standards	16	16	12 – Jun 12	Director of Strategy/ IG Manager	
14	Ineffective Clinical Leadership	12	12	8 – Aug 12	Medical Director	
5	Lack of appropriate PbR income (previously Loss making services)	12	12	12 – Sept 12	Director of F&P	
11	IM&T Lack of IT strategy and exploitation	12	12	9 – Sep 12	Director of Strategy	
2	New entrants to market (AWP/TCS	12	12	6 – Aug 12	Director of Strategy	Date updated to reflect agreed programme plan for Clinical Strategy. Draft plan will still be available by end of June. No increased risk associated with delays
17	Organisation may be overwhelmed by unplanned events	12	12	9 – May 12	COO	All actions taken to mitigate risk however risk owner monitoring current position in light of ED patient inflows before closing risk.
13	Skill shortages	12	12	8 – Dec 12	Director of	

APPENDIX TWO

UHL STRATEGIC RISKS SUMMARY REPORT – MAY 2012

					HR	
12	Non- delivery of operating framework targets	**12**	**12**	**6** – Sep 12	COO	
16	Lack of innovation culture	**12**	**12**	**6** – Apr 13	Director of Strategy	
10	Readmission rates don't reduce	**8**	**8**	**8** – July 12	Director of F&P	Date for completion extended to align to expected date for results of clinical audit). No increased risk associated with delays

APPENDIX THREE

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

Risk No.	Action Description	Action Owner	Comment
1	Workshop to be held to review strategy development/ capacity planning if ECN does not meet metrics	Chief Executive	Complete
8	Board reports with Net Promoter scores broken down to specialty and ward level	Chief Operating Officer	Complete
10	Focussed action plans to agree counting and coding of readmissions / new pathways and to isolate the cohort of patients receiving sub-optimal acute care.	Director of Finance and Procurement	Complete. The action plan for delivery of the readmission reduction programme was completed to Plan along with the mitigation of the financial penalty to minimum levels for '11/12 (20%). As part of the "mainstreaming" of the reduction of readmissions, a best practice check sheet is being introduced, supported by tailored data provision to Heads of Service. The independent clinical review is underway, led by Dr Ron Hsu from the University of Leicester. The results of this review will not only inform the ongoing penalty, but will also identify the key services required to avoid those readmissions and therefore where the penalty should be invested by commissioners."
10	Transformation scheme plans for 2012/13 to be developed	Director of Finance and Procurement	Complete
11	**Procure IM&T Strategic Partner to increase capacity and capability**	**Director of Strategy**	**Ongoing.** The programme of activities to procure the Strategic partner has changed from our original estimates. This programme is highly complex with a significant level of interactions. Due to the restricted nature of this procurement we had to ensure that the requirements are correct and the contract is sound.

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

			We are now in the final stages of producing a robust suite of tender and contract documents. Indications from the bidders (HP/BT, Accenture, IBM, CSC and Atos) have indicated that they believe they can provide the required services to UHL. To ensure that we have a strong commercial and financial model we have secured the services of KPMG who have been providing advice and guidance. This has been done in line with their agreed position with the Audit Commission to ensure there is no conflict of interest with regard to their external audit role." To ensure we have a robust and legal procurement, as well as a good foundation contract for delivering the new service, we have been utilising Mills & Reeve LLP. We have where possible used standard OGC contracts and procedures to ensure a high level of support from our bidders. We have been involving the bidders as much as is practicable in the design and execution of the tender. Importantly we held commercial sessions with all the bidders to ensure we would have no "show stoppers" at the bid stage. The tender documents are nearing finalisation and will be issued to the bidders in June. We will be following the trusts governance processes with a view to bringing the full business case and recommendations to the Trust board in September.
13	Appropriate Lead Executive Directors to discuss the ongoing work re strengthening of a UHL brand/ ethos	Chief Executive (in lieu of Executive Team)	Complete. Workforce/OD Committee to receive update on Branding Project and to discuss the ongoing work re: strengthening of a UHL brand/ ethos

APPENDIX THREE

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

15	Increased Executive and Non-Executive Director accountability	Chief Executive	Complete. Executive accountability strengthened via Executive steering group reporting into Executive Team. Divisional Director accountability strengthened via the Emergency Care Strategy Group. NED accountability strengthened via Emergency Care service and Delivery reporting to Board.
17	UHL major incident plan to be updated following 'exercise marble'	Chief Operating Officer	Complete
17	Annual emergency planning report identifying practice	Chief Operating Officer	Complete. Report to be submitted to QPMG
18	Define organisational approach in embedding UHL values and behaviours	Director of HR	Complete.

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?