To:	**Trust Board**
From:	**Chief Nurse/ Deputy Chief Executive**
Date:	**28 March 2013**
CQC regulation:	Outcome 16 – Assessing and Monitoring the Quality of Service Provision

Trust Board Paper CC

Title:	**UHL STRATEGIC RISK REGISTER AND THE BOARD ASSURANCE FRAMEWORK (SRR/BAF) 2012/13**

Author/Responsible Director: Chief Nurse/Deputy Chief Executive

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

The Report is provided to the Board for:

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

Summary / Key Points:

- Six actions were due for completion in February 2013 and of these, five have been completed and one action has a deadline that is extended to December 2013.
- There have been no changes to strategic risk scores since the previous month.
- The recent governance review by RSM Tenon asks the Trust to consider renaming the SRR/BAF as simply the Board Assurance Framework (BAF).
- Board members are invited to review the following risks:
  Risk 1: Reducing avoidable harms.
  Risk 5: Patient experience/ satisfaction.
  Risk 9: Failure to achieve and sustain operational targets.

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

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

(b) note the actions identified within the framework to address any gaps in either controls or assurances (or both);

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

(d) identify any gaps in assurances about the effectiveness of the controls in place to manage the principal risks; and consider the nature of, and timescale for, any further assurances to be obtained, in consequence;

(e) identify any other actions which it feels need to be taken to address any 'significant control issues' to provide assurance on the Trust meeting its principal objectives;

(f) Consider and approve the change in name from SRR/BAF to Board Assurance Framework (BAF).

Previously considered at another corporate UHL Committee? **Yes – Executive Team 19 March 2013**	
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: **28 MARCH 2013**

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

SUBJECT: **UHL 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 28 February 2013.
b) A heat map of risk movements from the previous month.
c) A summary of progress of actions due for completion in the reporting period.
d) Suggested parameters for scrutiny of the SRR/BAF.

2. POSITION AS OF 28 FEBRUARY 2013

2.1 An updated version of the SRR/BAF is attached at appendix one with changes from the previous report highlighted in red text.

2.2 A heat map to show the trend of strategic risk scores from the previous month is attached at appendix two.

2.3 Six actions were due for completion in February 2013 and of these, five have been completed and one action has a deadline extended to December 2013. (See appendix three for further detail).

2.4 Following discussion at the February Board meeting and subsequently the Executive Team meeting of 19 March 2013 the Board's attention is drawn to:

a. Risk 4 (Failure to transform the emergency care system). The current score has been amended from impact (5) x likelihood (4) = 20 to impact (4) x likelihood (5) = 20. A timeline for achieving the target score is yet to be advised.

b. Risk 6 (Failure to achieve FT status). The revised timeline for achievement of FT status will be agreed with the NHS Trust Development Authority as part of the Annual Operating Plan approval scheduled for April 2013 and the SRR/BAF will be updated to reflect this timeline.

c. Risk 7 (Ineffective organisational transformation) now includes reference to a paper from the Chief Executive Officer is to be presented to the Finance and Performance Committee outlining the future approach to transformation and CIP management within UHL.

d. Risk 11 (failure to maintain productive relationships). Results of GP polling are not yet available and will be added to the SRR/BAF once known.

2.5 A key element of the SRR/BAF to assure the Board that controls are effective and the assurances provided within the SRR/BAF are designed to demonstrate this. Many of the current assurances are sourced from monitoring of key internal metrics and the Board is asked to consider whether there are any external sources of assurance that might be used to further strengthen these assurances on future iterations of the SRR/BAF. Examples of these include may include reports from external reviews (e.g. CQC, NHSLA, HSE, etc) and external audit findings.

2.6 A recent governance review by RSM Tenon asks the Trust to consider renaming the SRR/BAF as simply the Board Assurance Framework (BAF). The Risk and Assurance manager has considered this request and proposes that the suggested change of name is implemented subject to agreement by the Board.

2.7 To provide scrutiny of strategic risks on a cyclical basis, Board members are invited to review the following risks against the parameters listed in appendix four. The selection of these risks is based on current risk score beginning with the highest scoring risks.

Risk 1:	Reducing avoidable harms.
Risk 5:	Patient experience/ satisfaction.
Risk 9:	Failure to achieve and sustain operational targets.

3. RECOMMENDATIONS

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

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

(b) note the actions identified within the framework to address any gaps in either controls or assurances (or both);

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

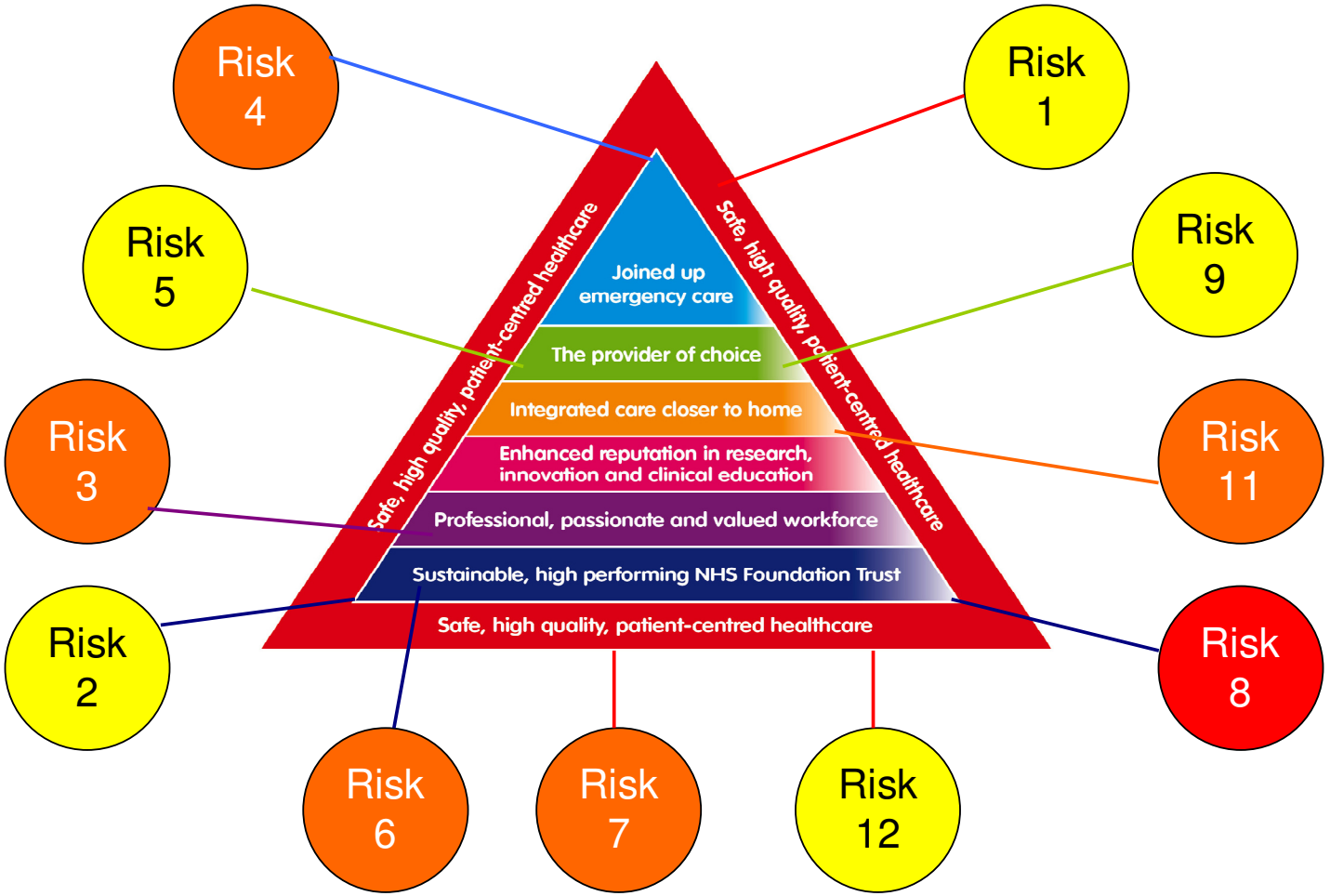
(d) identify any gaps in assurances about the effectiveness of the controls in place to manage the principal risks; and consider the nature of, and timescale for, any further assurances to be obtained, in consequence;

(e) identify any other actions which it feels need to be taken to address any 'significant control issues' to provide assurance on the Trust meeting its principal objectives;

(f) Consider and approve the change in name from SRR/BAF to Board Assurance Framework (BAF).

Peter Cleaver,
Risk and Assurance Manager,
21 March 2013.

UHL STRATEGIC RISK REGISTER / BOARD ASSURANCE FRAMEWORK FEBRUARY 2013



PERIOD: 1 FEBRUARY 2013 – 28 FEBRUARY 2013

RISK TITLE	STRATEGIC OBJECTIVE	CURRENT SCORE	TARGET SCORE
Risk 8 – failure to achieve financial sustainability	g - To be a sustainable, high performing NHS Foundation Trust	25	12
Risk 4 – failure to transform the emergency care system	b - To enable joined up emergency care	20	12
Risk 3 – inability to recruit, retain, develop and motivate staff	f - To maintain a professional, passionate and valued workforce e - To enjoy an enhanced reputation in research, innovation and clinical education.	16	12
Risk 7 – ineffective organisational transformation	a - To provide safe, high quality patient-centred health care	16	12
Risk 6 – failure to achieve FT status	g - To be a sustainable, high performing NHS Foundation Trust	16	12
Risk 11 – failure to maintain productive relationships	d - To enable integrated care closer to home	15	10
Risk 9 – failure to achieve and sustain operational targets	c - To be the provider of choice	12	12
Risk 12 – inadequate reconfiguration of buildings and services	a - To provide safe, high quality patient-centred health care	12	9
Risk 1 - reducing avoidable harms	a - To provide safe, high quality patient-centred health care	12	6
Risk 5 – patient experience/ satisfaction	c - To be the provider of choice	12	6
Risk 2 – business continuity	g - To be a sustainable, high performing NHS Foundation Trust	9	6

STRATEGIC OBJECTIVES:-

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

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

RISK NUMBER/ TITLE:	**RISK 8 – FAILURE TO ACHIEVE FINANCIAL SUSTAINABILITY**
LINK TO STRATEGIC OBJECTIVE(S)	**To be a sustainable, high performing NHS Foundation Trust.**
EXECUTIVE LEAD:	Director of Finance and Business Services

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to achieve financial sustainability including:	Overarching financial governance processes including PLICS process and expenditure controls	5X5=25	Monthly /weekly financial reporting to Exec Team, F&P Committee and Board Cost centre reporting and monthly PLICS reporting Annual internal and external audit programmes Comparison with PLICS benchmarking against other NHS organisations	(c) Underlying deficit	Recovery plan to be developed and monitored by Executive Team (ET)/ F&P Committee and Board	4x3=12	Mar 2013 Director of Finance and Business Services
Failure to achieve CIP	Strengthened CIP governance structure		Progress in delivery of CIPs is monitored by CIP Programme Board (meeting fortnightly) and reported to ET and Board.	(c) Forecast year end CIP shortfall of £5m.			
Locum expenditure	Workforce plan to identify effective methods to recruit to 'difficult to fill' areas Reinstatement of weekly workforce panel to approve all new posts.		The use of locum staff in 'difficult to fill' areas is reported to the Board on a monthly basis via the Quality and Performance report. A reduction in the use of such staff would be an assurance of our success in recruiting substantive staff to 'difficult to fill' areas. Increase in substantive staff of 200wte to Oct 12	(c) Failure to reduce locum spend – ytd to Jan '13.			
Loss of income due to tariff/tariff changes (including referral rate for emergency admissions – MRET)	Contract meetings with Commissioners Negotiations with Commissioners concluded at a transactional level		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board	(c) Failing to manage marginal activity efficiently and effectively			
Ineffective processes for Counting and Coding	Clinical coding project		Ad-Hoc reports on annual counting and coding process				

Loss of liquidity	Liquidity Plan		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board				
Lack of robust control over non-pay expenditure	Non-pay action plan (agreed by F&P Committee)		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board.	(c) Failing to control adverse trends in non-pay (running ahead of activity growth). Month 10Non-pay expenditure £13.4m adverse to plan	Implementation of catalogue control project		Mar 2013 Director of Finance and Business Services
Commissioner fines against performance targets	Contract meetings with Commissioners Negotiations with Commissioners concluded at a transactional level		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board	(c) Failing to reduce readmission trends. Year to date readmission rate 7.8% (month 10)			
Use of readmission monies	Contract meetings with Commissioners Negotiations with Commissioners concluded at a transactional level		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board	(c) Failing to reduce readmission trends			
Ineffective organisational transformation	See risk 7		See risk 7	See risk 7	See risk 7		

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

RISK NUMBER/ TITLE:	**RISK 4 – FAILURE TO TRANSFORM THE EMERGENCY CARE SYSTEM**
LINK TO STRATEGIC OBJECTIVE(S)	**To enable joined up emergency care.**
EXECUTIVE LEAD:	Director of Operations

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to transform emergency care system leading to demands on ED and admissions units continuing to exceed capacity.	LLR emergency Care Network Project to reduce emergency attendances and ensure maximum use of the Urgent care centre.	4x5=20	Monthly report to Trust Board in relation to Emergency Dept (ED) flow.	ED 4 hour standard (Target 95%): Total time in ED - (UHL + UCC) = 93.2% ytd (Month 10). ED - UHL Type 1 and 2 = 91.5% ytd (month 10). ED – UHL type 1and 2 in month figures 80.9% and 84.9% for Month 10.		4x3=12	
	Increased recruitment of ED Medical and nursing staff.		Monthly Quality and Performance summary report to TB including use of locum staff.	(c) Difficulties are being encountered in filling vacancies within the emergency care pathway. Agency and bank requests continue to increase in response to increasing sickness rates, additional capacity, and vacancies.	Continued fortnightly meetings with HR to highlight delays and solutions in the recruitment process. Continue to advertise for permanent and locum consultant positions.		Review of progress May 2013 Director of Operations Review of progress May 13 Director of Operations
	LLR Emergency Plan to ensure that delays to transfer of care are minimised.		Monthly report to Trust Board in relation to Emergency Dept (ED) flow. 270 delayed episodes of transfer of Care (month 10).	(c) Lack of availability of rehabilitation beds for increasing numbers of patients			
	Implementation of phase 1 of the emergency care pathway redesign 18 Feb 2013. Metrics in place in relation to AMU assessment process.		Monthly report to Trust Board in relation to Emergency Dept (ED) flow. 'Time to see consultant' metric included in National ED quarterly indicator.	No gaps identified	No actions required		

	Emergency Care Pathway Programme to enable a comprehensive and co-ordinated approach to the design and implementation of process improvements across the end-to-end patient flow for our ED attendees and medical non-elective patients.			No gaps identified	Sustainable on-going delivery of ED targets		Mar 2013 Direcor of Operations

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

RISK NUMBER/ TITLE:	**RISK 3 – INABILITY TO RECRUIT, RETAIN, DEVELOP AND MOTIVATE STAFF**
LINK TO STRATEGIC OBJECTIVE(S))	**To maintain a professional, passionate and valued workforce** **To enjoy an enhanced reputation in research, innovation and clinical education**
EXECUTIVE LEAD:	Director of Human Resources

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inability to recruit, retain, develop and motivate suitably qualified staff leading to inadequate organisational capacity and development.	Leadership and talent management programmes to identify and develop 'leaders' within UHL	4x4=16	Development of UHL talent profiles	No gaps identified	No actions required	4x3=12	
			Talent profile update reports to Workforce and OD Committee	No gaps identified	No actions required		
	Substantial work program to strengthen leadership contained within OD Plan			No gaps identified	No actions required		
	Organisational Development (OD) plan			(a) A potential measure of the number of applicants received for advertised posts may be a useful future assurance of the success of the OD plan	To develop a monitoring and reporting process		Jun 2013
	Workforce and OD Committee to monitor progress and oversee implementation of OD plan		Progress reports to Board via Workforce and OD Committee	(c) Executive group required to lead on OD plan	Formation of OD executive group		Mar 2013 Director of HR
	Staff engagement action plan encompassing six integrated elements that shape and enable successful and measurable staff engagement		Results of National staff survey and local patient polling reported to Board via Workforce and OD Committee on a six monthly basis. Improving staff satisfaction position. Staff sickness levels may also provide an indicator of staff satisfaction and targets for staff sickness rates are close to being achieved (4.2% ytd at Month 10)	No gaps identified No gaps identified	No actions required No actions required		

	Appraisal and objective setting in line with UHL strategic direction		Appraisal rates reported monthly to Board via Quality and Performance report. Current rates 90.5% ytd at end of month 10 Results of quality audits to ensure adequacy of appraisals reported to the Board via the Workforce and OD Committee. Quality Assurance Framework to monitor appraisals on an annual cycle (next due March 2013).	No gaps identified No gaps identified No gaps identified	No actions required No actions required No actions required		
	Workforce plan to identify effective methods to recruit to 'difficult to fill areas). Divisions and Directorates 2013/14 Workforce Plans		The use of locum staff in 'difficult to fill' areas is reported to the Board on a monthly basis via the Quality and Performance report. A reduction in the use of such staff would be an assurance of our success in recruiting substantive staff to 'difficult to fill' areas.				
	Reward /recognition strategy and programmes (e.g. salary sacrifice, staff awards, etc)			(a) Reward and recognition strategy requires revision to include how we will provide assurance in the future that reward and recognition programmes are making a difference to staffing recruitment/ retention/ motivation.	Revise strategy		Jun 2013 Director of HR
	UHL Branding – to attract a wider and more capable workforce. Includes development of recruitment literature and website, recruitment events, international recruitment. This includes a recently held nurse recruitment day (Jan 2013)		Evaluate recruitment events and numbers of applicants. Reports issued to Nursing Workforce Group (last report 4 Feb). Report to Workforce and OD Committee in March. Positive feedback from nurse recruitment day on 26 Jan 2013	(a) Better baselining of information to be able to measure improvement. (c) Lack of engagement in production of website material	Take baseline from January and measure progress now that there is a structured plan for bulk recruitment. Identify a lead from each professional group to develop and encourage the production of fresh and up to date material		Dec 2013 Director of HR

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

RISK NUMBER/ TITLE:	**RISK 7 – INEFFECTIVE ORGANISATIONAL TRANSFORMATION**
LINK TO STRATEGIC OBJECTIVE(S)	**To provide safe, high quality patient-centred health care.**
EXECUTIVE LEAD:	Director of Finance and Business Services

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Ineffective organisational transformation preventing the development of safer, more effective and productive services. Among other consequences this will impact on the Trust's FT timeline.	Clinical strategy	4x4=16	CIP Programme Board monitors project plans associated with clinical strategy to ensure achievement of key milestones. Good progress in development of 2013/14 CIP plans (Feb '13).	(c) Shortfall on delivery of projects in 2012/13	Interim transformation resources	4x3=12	Apr 2013 Director of Finance and Business Services
	Transformation Board/ team including Interim Director of Service Development						
	Managed Business Partner for IM&T services to deliver IT that will be a key enabler for our clinical strategy.		MBP programme board monitors defined KPIs for 'Lot 1 services'. Non-compliance with KPIs reported to Board	(c) New systems (lot 2) not yet specified	'Lot 2' systems replacement plan to be developed		2013/14 Director of Finance and Business Services
	Development of lean processes improvement capability to deliver more efficient and effective services and greater patient / staff satisfaction. Head of Process Improvement now in post (Jan '13)		Board monitoring of patient and staff survey results. Improved levels of patient / staff satisfaction are expected when lean processes are embedded	(c) Slow start to process improvement initiatives	Board level sponsorship and Leadership Proposals in relation to taking forward transformation to be presented to Finance and performance Committee on 26/3/13		Apr 2013 Director of Finance and Business Services Chief Executive Mar 2013

	Estates Strategy including award of FM contract to private sector partner to deliver an Estates solution that will be a key enabler for our clinical strategy in relation to clinical adjacencies		Facilities Management Co-operative (FMC) will monitor FM contract against agreed KPIs to provide assurance of successful service		Implement contract		Mar 13 Director of Finance and Business Services

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

RISK NUMBER/ TITLE:	**RISK 6 – FAILURE TO ACHIEVE FT STATUS**
LINK TO STRATEGIC OBJECTIVE(S)	**To be a sustainable, high performing NHS Foundation Trust.**
EXECUTIVE LEAD:	Chief Executive Officer

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to achieve Foundation Trust (FT) Status within specified timescale (April 2014)	FT Application Programme Board to provide strategic direction and monitoring of FT application programme FT Workstream group of Executive and operational Leads to ensure delivery of IBP and evidence to support HDD1 and 2 processes FT application project plan/ team All of the above will ensure that all associated workstreams for FT application will meet key milestones	4x4=16	Monthly progress against project reported to Board to provide oversight. Feedback from external assessment of application progress by SHA (readiness review board-to-board meeting scheduled for 19/12/12 Achievement against the key milestones set out in UHL's TFA is reported to the SHA on a monthly basis through the trust over-sight self certification.	No gaps identified No gaps identified (c) Development of LLR Clinical Strategy and Site and Service Reconfiguration Proposals not fully achieved Confirmation of specific LLR reconfiguration priorities over a 3 year time horizon not fully achieved. (c) Draft pre-consultation Business Case considered by Trust Boards not fully achieved. (c) UHL Clinical Strategy developed but preferred options costs not yet identified	No actions required No actions required LLR wide economic modelling is to commence on the 21st January and conclude by the 31st March 2013 To be determined by the BCT economic modelling Statutory consultation will commence in June 2013 pending the output of the economic modelling and agreement of the resulting LLR wide plans Service developments underpinning the Trust's Clinical Strategy will be costed as further iterations of the IBP / LTFM are Developed.	4x3=12	Chief Executive Mar 2013 Chief Executive Mar 2013 Chief Executive Jun 2013 Chief Executive Review May 2013

				(c) Formal Consultation on LLR Reconfiguration Proposals not fully achieved	BCT Programme Board has agreed that consultation should commence in June 2013		Chief Executive Jun 2013
	Monitoring of KPIs in particular in relation to financial position and ED performance that are crucial for a successful FT application		Monthly Finance and Performance report to Board	(c) significant financial variance from plan (c) Underperformance in relation to ED targets	See actions associated with risk number 8 Transform emergency care system to reduce demand and increase footprint of ED (see risk 4)		During 2013/14 Chief Executive Officer

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

RISK NUMBER/ TITLE:	**RISK 11 – FAILURE TO MAINTAIN PRODUCTIVE RELATIONSHIPS**
LINK TO STRATEGIC OBJECTIVE(S)	**To enable integrated care closer to home.**
EXECUTIVE LEAD:	Director of Communications and External Relations

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to maintain productive relationships with external partners/ stakeholders leading to potential loss of activity and income, poor reputation and failure to retain/ reconfigure clinical services	Stakeholder Engagement Strategy Regular meetings with external stakeholders and Director of Communications and member of Executive Team to identify and resolve concerns Regular stakeholder briefing provided by an e-newsletter to inform stakeholders of UHL news Leicester, Leicestershire and Rutland (LLR) health and social care partners have committed to a collaborative programme of change known as the 'Better Care Together' programme	5X3=15	Twice yearly GP surveys with results reported to UHL Executive Team	(a) No surveys undertaken to identify relationship issues. Anecdotal feedback only.	Productive relationships with CCGs are likely to improve further only if UHL performance around ED improves therefore the target score is dependent upon actions from other risks within this document being taken	5X2=10	Dependant upon actions associated with other risks

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

RISK NUMBER/ TITLE:	**RISK 9 – FAILURE TO ACHIEVE AND SUSTAIN OPERATIONAL TARGETS**
LINK TO STRATEGIC OBJECTIVE(S)	**To be the provider of choice.**
EXECUTIVE LEAD:	Director of Operations

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to achieve and sustain operational targets leading to contractual penalties, patient dissatisfaction and poor reputation.	Backlog plans to recover 18 week referral to treatment (RTT) target	4x3=12	Monthly Q&P report to Trust Board showing 18 week RTT rates. RTT admitted and non-admitted rates favourable against target (92.2% and 97.3% respectively for month 10)	No gaps identified	No actions required	4x3=12	
	Referral pathways to decrease demand and ensure discharge to GP where appropriate			(a) Lack assurance in relation to performance metrics to show activity versus number of patients deferred onto a different care pathway.	Development of key metrics at a local level		**tba**
	Transformational theatre project to improve theatre efficiency to 80 -90%		Monthly theatre utilisation rates	No gaps identified	No actions required		
	Emergency Care process redesign (phase 1) implemented 18 February 2013 to improve and sustain ED performance.		Monthly report to Trust Board in relation to Emergency Dept (ED) flow (including 4 hour breaches)	See risk number 4	See risk number 4		
	Each tumour site has developed processes to achieve targets		Director of Operations receives reports from Cancer Manager and information included within Monthly Q&P report to Trust Board	No gaps identified	No actions required		
	Ongoing monitoring of key performance indicators		Monthly Q&P report to Trust Board	No gaps identified	No actions required		

	Outpatient delivery plan to reduce cancellation rates has been developed and circulated to Divisions for inclusion in their CIP plans			(c) Not reducing cancellation rates for outpatients appointments	Continued monitoring of outpatient delivery plan		Review May 2013 Director of Operations

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

RISK NUMBER/ TITLE:	**RISK 12 – INADEQUATE RECONFIGURATION OF BUILDINGS AND SERVICES**
LINK TO STRATEGIC OBJECTIVE(S)	**To provide safe, high quality patient-centred health care**
EXECUTIVE LEAD:	Chief Executive Officer

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inadequate reconfiguration of buildings and services leading to less effective use of estate and services.	Clinical Strategy	3x4=12		(a) Key measures to demonstrate success of strategy and reporting lines not yet identified	Key measures for gauging success of strategy to be developed by specialties as part of their 'mini-IBPs' and will be monitored via divisional and directorate boards.	3X3=9	December 2013 Medical Director
	Estates Strategy including award of FM contract to private sector partner to deliver an Estates solution that will be a key enabler for our clinical strategy in relation to clinical adjacencies		Facilities Management Co-operative (FMC) will monitor against agreed KPIs to provide assurance of successful outsourced service	(c) Estates plans not fully developed to achieve the strategy. (c) The success of the plans will be dependent upon capital funding and successful FT application	Ensure success of FT Application (see risk 6 for further detail) Secure capital funding		Apr 2014 Chief Executive Officer April 2014 Acting Director of Facilities
	Divisional service development strategies and plans to deliver key developments		Progress of divisional development plans reported to Service Reconfiguration Board.	No gaps identified	No actions required		
	Service Reconfiguration Board						
	Capital expenditure programme to fund developments		Capital expenditure reports reported to the Board via Finance and Performance Committee	No gaps identified	No actions required		
	Managed Business Partner for IM&T services to deliver IT that will be a key enabler for our clinical strategy						

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

RISK NUMBER / TITLE	**RISK 1 - REDUCING AVOIDABLE HARMS**
LINK TO STRATEGIC OBJECTIVE(S)	**To provide safe, high quality patient-centred health care**
EXECUTIVE LEAD:	Deputy Chief Executive/ Chief Nurse

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to reduce avoidable harms and mortality and morbidity leading to decreasing patient experience/ patient satisfaction and loss of reputation	Policies and procedures	4x3=12	Hospital Standardised Mortality Indicators reported monthly to Trust Board via Quality and Performance (Q&P) report. Improving position in relation to (HSMI) and HSMI @within expected' for elective and non-elective activity	(a) Lack of mortality analysis out of hours/weekend (a) absence of community-wide mortality review		3x2=6	
	Relentless attention to 5 Critical Safety Actions (CSA) initiative to lower mortality		Q&P report to Trust Board showing outcomes for 5 CSAs. 5 CSAs form part of local CQUIN monitoring. RAG rated green at end of quarter 2.	(c) Lack of a unified IT system in relation to ordering and receiving results means that many differing processes are being used to acknowledge/respond to results. Potential risk of results not being acted upon in a timely fashion.	Feasibility of a less cumbersome IT platform to be investigated by IBM.		Review May 2013 Dep Chief Executive / Chief Nurse
	Learning lessons from incidents, complaints and claims to reduce the likelihood of recurrence.		Monthly patient safety report to Quality Assurance Committee (QAC) and Quality and Performance management Group (QPMG) Number of formal complaints received reducing (1.6 per 1000 attendances - month 10)	No gaps identified	No actions required		
	Infection prevention plan to ensure hospital acquired infections are reduced		MRSA/C. Difficile rates reported to Trust board via monthly Q&P report. 2 MRSA case reported to end of Jan 13 Target = 6. Last case Jan 13 C. Difficile currently below trajectory. 81 cases to end of Jan 13 against full year target of 113.	No gaps identified	No actions required		

	Monthly patient experience monitoring 'Net Promoter'		Monthly patient experience report to Trust board included within Q&P report. Improving Net Promoter results (61.1% at month 10)	No gaps identified	No actions required		
	Implementation of UHL Quality and Safety Commitment' 2012 – 15 (launched Jan 13) Key priorities: Reducing harm, reducing mortality rates and improving the patient experience		Monitoring of CQUINS outcomes via monthly Q&P report to Trust Board Further reductions in SHMI. Published SHMI = 105 (Nov 11 – Jun 12)	(c) Resource to support the delivery of the 'Quality Ambition' is still to be identified. (c) Need wider engagement of CCG partners for health economy initiatives	Delivery of 3 clinical task groups to identify resource requirements 2013 CQUIN and quality negotiations		Dep CEO/ Chief Nurse Mar 2013 Dep CEO/ Chief Nurse Mar 2013
	NHS Safety thermometer utilised to measure the prevalence of harm and how many patients remain 'harm free' (Monthly point prevalence for '4 Harms')		Monthly outcome report of '4 Harms' is reported to Trust board via Q&P report Trust is seeing an improving 'harm' position (92.98% of UHL patients harm free at month 10. National average for Month 10 = 92.2%). However, new DoH definitions may see an increase in harm attributed to UHL to encourage closer working between primary and secondary care	a) The collection of ST data at ward level is resource intensive. There is also a risk that some data may not be accurate due to complex DoH definitions of each harm in relation to whether it is community or hospital acquired	Ongoing education from the operational leads for each harm during the monthly data collection and validation process Utilisation of CQUIN monies for 2013/14 to invest in data collection posts at ward level to improve data quality and release time of ward managers to focus on reducing harms		Dep CEO / Chief Nurse Apr 2013 Dep CEO / Chief Nurse Apr 2013
	Measurement through clinical audit programme to identify adherence to practice standards and outcomes		Bimonthly reports to UHL Clinical Audit Committee Clinical audit dashboards presented at QAC, QPMG and divisional boards	No gaps identified	No actions required		

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

RISK NUMBER/ TITLE:	**RISK 5 – PATIENT EXPERIENCE/ SATISFACTION**
LINK TO STRATEGIC OBJECTIVE(S)	**To be the provider of choice.**
EXECUTIVE LEAD:	Deputy Chief Executive/ Chief Nurse

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	Current Score I x L	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	Target Score I x L	**Timescale** When will the action be completed?
Levels of patient satisfaction/experience may deteriorate leading to poor reputation and deterioration in Net Promoter scores.	Patient experience plan and associated projects. Patient Experience Strategy incorporated into Goal 3 of the Quality & Safety Commitment 2012 - 2015	4x3=12	Patient experience progress reports to Quality Assurance Committee (QAC). Patient stories presented at Trust Board. Discharge project outcomes (i.e. delayed transfer of care) reported to the Discharge and Transfer of Care (DTOC) Group and monthly to the emergency Care Network and Clinical Quality Review Group (CQRG). Data included in monthly Quality and Performance report to Trust Board.	(c) Trust-wide communications of patient experience learning.		2x3=6	
	Net Promoter scores to identify key areas for focus.		Ongoing Patient Experience surveys Net Promoter scores reported monthly to Trust Board via Q&P report. Improving picture in relation to Net Promoter scores (61.1% at month 10).	No gaps identified.	No actions required.		
	Caring @its best, releasing time to care initiatives and implementation of UHL Quality and Safety commitment (launched Jan 13). Key priorities: Reducing harm, reducing mortality rates and improving the patient experience.		Caring @ its best awards Improving patient experience reports. Improved infection prevention outcomes. 2 MRSA case reported to end of Jan 13 Target = 6. Last case Jan 13 C. Difficile currently below trajectory. 81 cases to end of Jan 13 against full year target of 113	(c) Lack of supervisory headroom for ward managers.	Develop proposal for the ward managers to have rostered supervisory time in line with Francis recommendations.		Apr 2013 Dep CEO/Chief Nurse

	Patient experience programme (across 85 clinical areas to gain feedback from patients relating to their experience of care) and national patient survey.		Ongoing Patient Experience surveys. Net Promoter scores reported monthly to Trust Board via Q&P report. Annual reporting to trust board of national patient survey.	No gaps identified. No gaps identified.	No actions required. No actions required.		
	Trust values instilled within UHL staff.		UHL staff awards demonstrating individuals who demonstrate the values. Ongoing Patient Experience surveys. Net Promoter scores reported monthly to Trust Board via Q&P report.	No gaps identified.	No actions required.		
	Patient Adviser /LINKS engagement at divisional level to ensure consistent involvement in the development of services.			(a) No current mechanism to monitor involvement of patient adviser/ LINKS to provide assurance of involvement/ engagement. (c) Evidence to suggest lack of PPI involvement in early stages of service developments.	Identify monitoring mechanism. PPI strategy to be revised/ rewritten and launched via communication campaign. Develop PPI training programme and toolkit for managers. Review and refresh PPI leads post divisional restructure.		Mar 2013 Director of Comms

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

RISK NUMBER/ TITLE:	**RISK 2 – BUSINESS CONTINUITY**
LINK TO STRATEGIC OBJECTIVE(S))	**To be a sustainable, high performing NHS Foundation Trust**
EXECUTIVE LEAD:	Director of Operations

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inability to react /recover from events that threaten business continuity leading to sustained downtime and inability to provide full range of services	Major incident/business continuity/ disaster recovery and Pandemic plans developed and tested for UHL/ wider health community. This includes UHL staff training in major incident planning/ coordination and multi agency involvement across Leicestershire to effectively manage and recover from any event threatening business continuity.	3x3=9	Annual Emergency planning Report identifying good practice presented to the Governance and Risk Management Committee July 2012. External auditing and assurances to SHA, Business Continuity Self-Assessment, June 2010, completed by Richard Jarvis Completion of the National Capabilities Survey, November 2013 completed by Aaron Vogel. Results will be included in the annual report on Emergency Planning and Business Continuity to the QAC. Audit by Price Waterhouse Coopers LLP Jan 2013. Results being compiled and will be reported to Trust Board (date to be agreed)	(c) On-going continual training of staff to deal with an incident (a) Do not gain assurances from external service providers as to their ability to continue to provide services to the trust in the event of an incident within their organisation or/and within the Trust. (a) Do not consider realistic testing of different failure modes for critical IT systems to ensure IT Disaster Recovery arrangements will be effective during invocation.	Training Needs Analysis to be developed to identify training requirements for staff. Training and education materials to be produced in line with ISO 22301 and National Occupational Standards Ensure that contracts awarded include reference to business continuity commitments and providing assurances to the Trust of their arrangements. The arrangements should be reviewed annually. Determine an approach to delivering a physical testing of the IT Disaster Recovery arrangements which have been identified as a dependency for critical services. Include assessment of the benefits of realistic testing of the IT Disaster Recovery arrangements against the potential disruption of testing to operations.	2x3=6	Director of Operations May 2013 Director of Operations Aug 2013 Director of Operations Apr 2013 Chief Information Officer Sep 2013

	Emergency Planning Officer appointed to oversee the development of business continuity within the Trust		Outcomes from Price Waterhouse Coopers LLP audit identified that there is a programme management system in place through the Emergency Planning Officer to oversee. A year plan for Emergency Planning has been developed. Production/updates of documents/plans relating to Emergency Planning and Business Continuity aligned with national guidance have begun.	(c) Key documentation to ensure critical services are identified and plans to mitigate the impact of an incident are not consistently applied and available across the Trust.	Continue with the work schedule to ensure key documents are produced. Review IT service continuity arrangements against the recovery requirements determined by the BIAs to validate existing arrangements.		Director of Operations Aug 2014 Chief Information Officer Sep 2013
	New policy to identify key roles within the Trust of those responsible for ensuring business continuity planning /learning lessons is undertaken.		Minutes/action plans from Emergency Planning and Business Continuity Committee. Any outstanding risks/issues will be raised through the Director of Operations.	No gaps identified	No actions required		
			New Policy on InSite Emergency Planning and Business Continuity Committee ensures that processes outlined in the Policy are followed, including the production of documents relating to business continuity within the service areas. 3 incidents within the Trust have been investigated and debrief reports written, which include recommendations and actions to consider.	(c) Do not effectively communicate issues/lessons learnt that have been identified in service area disruptions and follow up actions	Issues/lesson will feed into the development of local plans and training and exercising events.		Director of Operations Aug 2014
				(c)Do not always consider the impact on business continuity and resilience when implementing new systems and processes.	Further processes require development, particularly with the new Facilities and IM&T providers to ensure resilience is considered/ developed when implementing new systems, infrastructure and processes.		Director of Operations Jul 2013

				(a) Lack of coordination of plans between different service areas and across the CBUs.	Emergency Planning Officer and Divisional BCM leads will ensure that plans developed are coordinated between service areas/CBUs/Divisions Training and Exercising events to involve multiple CBUs/Divisions to validate plans to ensure consistency and coordination.		Director of Operations Aug 2014 Director of Operations Aug 2014

APPENDIX TWO

UHL STRATEGIC RISKS SUMMARY REPORT – FEBRUARY 2013

Risk No	Risk Title	Current Risk Score (Feb 13)	Previous Risk Score (Jan 13)	Target Risk Score and Final Action Date	Risk Owner	Comment
8	Failure to achieve financial sustainability	25	25	12 – Mar 13	Director of Finance and Business services	
3	Inability to recruit, retain, develop and motivate staff	16	16	12 – Jun 13	Director of HR	
4	Failure to transform the emergency care system	20	20	12 – Review May 13	Director of Operations	Date extended due to longer term issues relating to lack of availability of rehabilitation beds
7	Ineffective organisational transformation	16	16	12 – 2013-14	Director of Finance and Business Services	
6	Failure to achieve FT status	16	16	12 – 2013-14	Chief Executive Officer	
11	Failure to maintain productive relationships	15	15	10	Director of Comms and External Relations	
9	Failure to achieve and sustain operational targets	12	12	12 - tba	Director of Operations	Awaiting completion date from Director of Operations
12	Inadequate reconfiguration of buildings and services	12	12	9 - Apr-14	Chief Executive Officer	
1	Reducing avoidable harms	12	12	6 – Review May 13	Dep. Chief Executive/ Chief Nurse	
5	Patient experience/ satisfaction	12	12	6 – Apr 13	Dep. Chief Executive/ Chief Nurse	
2	Business continuity	9	9	6 – Aug 14	Director of Operations	
10	Loss of reputation			n/a	n/a	This risk has been deleted. Loss of reputation is a consequence of failure to control other risks

APPENDIX THREE

UHL SRR/BAF SUMMARY OF CHANGES TO ACTIONS – FEBRUARY 2013

Risk No.	Action Description	Action Owner	Comment
3	Ratification of Organisational Development plan by incoming Chief Executive Officer	Chief Executive	Complete. Discussions held with Director of HR and OD plan endorsed at Trust Board on 28/2/12.
3	Work being undertaken with Divisions, HR and Finance Colleagues to produce detailed workforce numbers for 2013/14. this will include key transformational projects	Director of HR	Complete. All Divisions and Directorates have now submitted 2013/14 Workforce Plans which are being reviewed with the Workforce Development Manager who commenced in post on 25th February.
5	Final version of Patient Experience Strategy document to be presented at TB	Chief Nurse / Deputy CEO	Complete. It has been agreed that the Patient Experience Strategy will be incorporated into Goal 3 of the Quality & Safety Commitment 2012 - 2015
7	FMC governance structures to be ratified	Director of Finance and Business Services	Complete
8	Reinstate weekly workforce panel to approve all new posts	Director of Finance and Business Services	Complete
12	Confirm key measures for gauging success of clinical strategy and formalise reporting lines	Medical Director	Ongoing. All specialities are defining key deliverables as part of their "mini-IBPs" as part of organisational IBP. All IBPs are required by December 2013. The key deliverables will be monitored via the divisional boards and ET. Deadline extended to December 2013.

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?