To:	**Trust Board**
From:	**Deputy Chief Executive/ Chief Nurse**
Date:	**31 January 2013**
CQC regulation:	Outcome 16 – Assessing and Monitoring the Quality of Service Provision

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

Author/Responsible Director: Medical Director

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

The Report is provided to the Board for:

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

Summary / Key Points:

- The UHL SRR/BAF has undergone a full revision to ensure its accuracy in relation to the strategic risks facing UHL for the remainder of 2012/13 and is presented in a differing format from previous versions.
- This version of the SRR/BAF was presented to and ratified by the Executive Team on 22 January 2013.
- Three actions were due for completion in December 2012 and all have been completed within timescale.
- Changes to the content of the SRR/BAF include an increase in risk associated with the failure of our FT application and removal from the register of the risk associated with 'Loss of Reputation'.

Recommendations

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

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

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

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

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

(e) identify any other actions which it feels need to be taken to address any 'significant control issues' to provide assurance on the Trust meeting its principal objectives; (f) Endorse the proposals to improve accountability and oversight of risks outlined in section 4.1 a –e of this report.
Previously considered at another corporate UHL Committee? **Yes – Executive Team 22 January 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: **31 JANUARY 2013**

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

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

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1. INTRODUCTION

1.1 This report provides the Board with:-

a) A copy of the SRR/BAF as of 31 December 2012 (appendix one).
b) A heatmap of risk movements from the previous month (appendix two).
b) A summary of progress of actions due for completion in the reporting period (appendix three).
c) Suggested parameters for scrutiny of the SRR/BAF (appendix four).

1.2 The SRR/BAF is presented in a differing format from previous versions inasmuch that the title sheet now illustrates each strategic risk linked to the relevant strategic objective and the risk RAG rated to provide an 'at-a-glance' representation of risks and objectives. The inherently imprecise nature of risk means that any given risk may link to more than one strategic objective however an attempt has been made to map each risk to the 'best-fit' objective. The second page shows each strategic risk number, description, current risk score and target risk score linked to the respective objectives. The remainder of the document shows the detail for each strategic risk and is sorted in descending order of risk scores.

2. CURRENT POSITION AS OF 31 DECEMBER 2012

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

2.2 Three actions were due for completion in December 2012 and all have been completed within timescale.

2.3 A heat map to show how the strategic risk scores have changed from the previous month is attached at appendix two. These changes include:

- An increase in risk associated with the failure of our FT application.
- Removal from the register of the risk associated with 'Loss of Reputation'. This risk was identified as a consequence of many of the other risks and the effective management of all other risks would alleviate this. As such it did not sit as a stand-alone item with its own actions

2.4 To provide regular scrutiny of strategic risks on a cyclical basis, Trust Board members are invited to review the following risks against the parameters

listed in appendix four. The selection of these risks will be based on current risk score and beginning with the highest scoring risks.

Risk 3 - Inability to recruit, retain, develop and motivate staff.

Risk 4 - Failure to transform the emergency care system.

Risk 8 - Failure to achieve financial sustainability.

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;

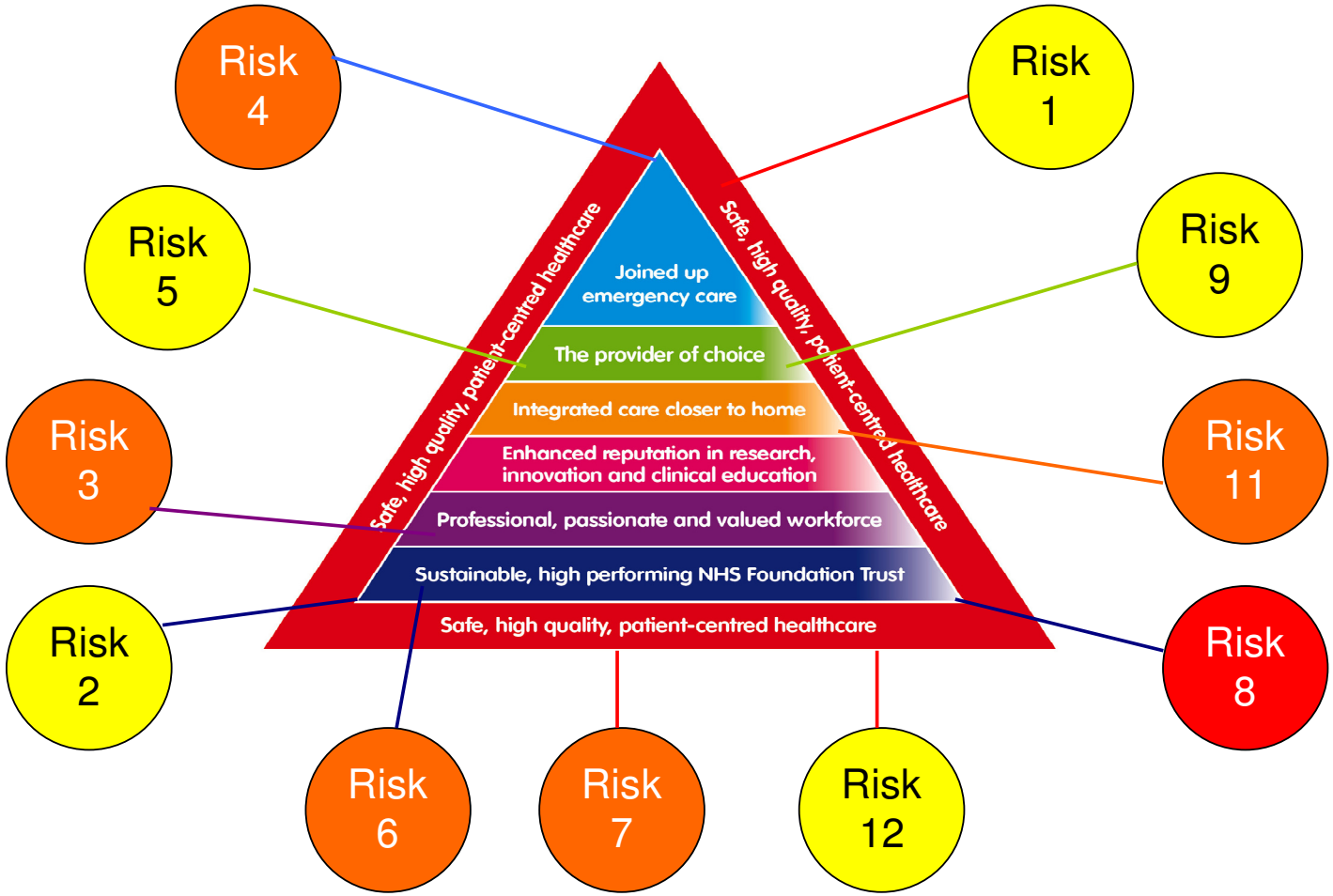
(d) identify any gaps in assurances about the effectiveness of the controls in place to manage the principal risks; and consider the nature of, and timescale for, any further assurances to be obtained, in consequence;

(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;

Peter Cleaver,
Risk and Assurance Manager
24 January 2013

UHL STRATEGIC RISK REGISTER / BOARD ASSURANCE FRAMEWORK DECEMBER 2012

Appendix 1



PERIOD: 1 DECEMBER – 31 DECEMBER 2012

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 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 4 – failure to transform the emergency care system	b - To enable joined up emergency care	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.**

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

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 Finance and Performance (F&P) Committee and Board Cost centre reporting and monthly PLICS reporting Annual internal and external audit programmes Comparison with PLICS benchmarking against other NHS organisations	(c) Underlying deficit	Recovery plan to be developed and monitored by Executive Team (ET)/ F&P Committee and Board	4x3=12	Mar 2013 Director of Finance and Business Services
Failure to achieve CIP	Strengthened CIP governance structure		Progress in delivery of CIPs is monitored by CIP Programme Board and reported to ET and Board				
Locum expenditure	Workforce plan to identify effective methods to recruit to 'difficult to fill areas)		The use of locum staff in 'difficult to fill' areas is reported to the Board on a monthly basis via the Quality and Performance report. A reduction in the use of such staff would be an assurance of our success in recruiting substantive staff to 'difficult to fill' areas.				
Loss of income due to tariff/tariff changes (including referral rate for emergency admissions – MRET)	Contract meetings with Commissioners		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board	(c) Failing to manage marginal activity efficiently and effectively	Ongoing negotiations with Commissioners		Jan 2013 Director of Finance and Business Services
Ineffective processes for Counting and Coding	Clinical coding project		Ad-Hoc reports on annual counting and coding process				

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

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

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			4x3=12	
			Talent profile update reports to Workforce and OD Committee				
	Substantial work program to strengthen leadership contained within OD Plan						
	Organisational Development (OD) plan			(c) OD plan not ratified (a) A potential measure of the number of applicants received for advertised posts may be a useful future assurance of the success of the OD plan	Ratification by incoming Chief Executive Officer To develop a monitoring and reporting process		Feb 2013 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		Results of National staff survey and local patient polling reported to Board via Workforce and OD Committee on a six monthly basis. Improving staff satisfaction position. Staff sickness levels may also provide an indicator of staff satisfaction and targets for staff sickness rates are close to being achieved				

	Appraisal and objective setting in line with UHL strategic direction		Appraisal rates reported monthly to Board via Quality and Performance report. Current rates near to 100% Results of quality audits to ensure adequacy of appraisals reported to the Board via the Workforce and OD Committee. Quality Assurance Framework to monitor appraisals on an annual cycle (next due March 2013).				
	Workforce plan to identify effective methods to recruit to 'difficult to fill areas)		The use of locum staff in 'difficult to fill' areas is reported to the Board on a monthly basis via the Quality and Performance report. A reduction in the use of such staff would be an assurance of our success in recruiting substantive staff to 'difficult to fill' areas.	(c) Detailed workforce plan for 2013/14 required	Work being undertaken with Divisions, HR and Finance Colleagues to produce detailed workforce numbers for 2013/14. this will include key transformational projects		Feb 2013
	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		June 2013

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.	4x4=16	Monthly report to Trust Board in relation to Emergency Dept (ED) flow			4x3=12	
	Increased recruitment of ED Medical and nursing staff		Monthly Quality and Performance summary report to TB including use of agency staff				
	LLR Emergency Plan to ensure that delays to transfer of care are minimised.		Monthly report to Trust Board in relation to Emergency Dept (ED) flow				
	'Right time, right place' initiative to ensure ED process provides timely assessment in Ed to facilitate transfer to AMU or discharge		'Time to see consultant' metric included in National ED quarterly indicator	(a) Lack of assurance in relation to metrics to identify appropriateness of AMU assessment process	Right Place consulting to be appointed to identify performance metrics in relation to AMU assessment process		Jan 2013 Director of Operations
	Emergency Care Pathway 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.						

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	Clinical strategy	4x4=16	CIP Programme Board monitors project plans associated with clinical strategy to ensure achievement of key milestones.	(c) Shortfall on delivery of projects in 2012/13	Interim transformation resources	4x3=12	Apr 2013 Director of Finance and Business Services
	Transformation Board/ team including Interim Director of Service Development						
	Managed Business Partner for IM&T services to deliver IT that will be a key enabler for our clinical strategy.		MBP programme board monitors defined KPIs for 'Lot 1 services'. Non-compliance with KPIs reported to Board	(c) New systems (lot 2) not yet specified	'Lot 2' systems replacement plan to be developed		2013/14 Director of Finance and Business Services
	Development of lean processes improvement capability to deliver more efficient and effective services and greater patient / staff satisfaction		Board monitoring of patient and staff survey results. Improved levels of patient / staff satisfaction are expected when lean processes are embedded	(c) Slow start to process improvement initiatives	Board level sponsorship and Leadership		Apr 2013 Director of Finance and Business Services
	Facilities outsourcing		Facilities Management Co-operative (FMC) will monitor against agreed KPIs to provide assurance of successful service	(c) FM contract not yet implemented	Implement contract		Feb 2013 Director of Finance and Business Services

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

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	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			4x3=12	
	Monitoring of KPIs in particular in relation to financial position and ED performance that are crucial for a successful FT application		Monthly Finance and Performance report to Board	(c) significant financial variance from plan (c) Underperformance in relation to ED targets	See actions associated with risk number 8 Transform emergency care system to reduce demand and increase footprint of ED		During 2013/14 Chief Executive Officer

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

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	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	**tba**

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			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 included in divisional heat map presented to Trust Board on a monthly basis. Target utilisation is 86%; month 7 position is 81.4% (I/P) and 74.6% (O/P).				
	'Right place, right time' initiative		Monthly report to Trust Board in relation to Emergency Dept (ED) flow (including 4 hour breaches)				
	Each tumour site has developed processes to achieve targets		Director of Operations receives reports from Cancer Manager and information included within Monthly Q&P report to Trust Board				
	Ongoing monitoring of key performance indicators		Monthly Q&P report to Trust Board				

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

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		(c) Clinical Strategy not yet finalised/ ratified (a) Key measures to demonstrate success of strategy and reporting lines not yet identified	Finalise and ratify clinical strategy Confirm key measures for gauging success of strategy and formalise reporting lines	3X3=9	Jan 2013 Medical Director Feb 2013 Medical Director
	Estates strategy including award of FM contract to private sector partner.		Facilities Management Co-operative (FMC) will monitor against agreed KPIs to provide assurance of successful outsourced service	(c) Estates plans not fully developed to achieve the strategy. (c) The success of the plans will be dependent upon capital funding and successful FT application	Ensure success of FT Application (see risk 6 for further detail) Secure capital funding		April 2014 Chief Executive Officer Acting Director of Facilities April 2014
	Divisional service development strategies and plans to deliver key developments		Progress of divisional development plans reported to Service Reconfiguration Board.				
	Service Reconfiguration Board						
	Capital expenditure programme to fund developments		Capital expenditure reports reported to the Board via Finance and Performance Committee				

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – 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 are discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to reduce avoidable harms and mortality and morbidity leading to decreasing patient experience/ patient satisfaction and loss of reputation	Policies and procedures	4x3=12	Hospital Standardised Mortality Indicators reported monthly to Trust Board via Quality and Performance (Q&P) report. Improving position in relation to (HSMI) and HSMI @within expected' for elective and non-elective activity			3x2=6	
	Relentless attention to 5 Critical Safety Actions (CSA) initiative to lower mortality		Q&P report to Trust Board showing outcomes for 5 CSAs. 5 CSAs form part of local CQUIN monitoring. RAG rated green at end of quarter 2.				
	Learning lessons from incidents, complaints and claims to reduce the likelihood of recurrence.		Monthly patient safety report to Governance and risk Management Committee (GRMC) and Quality and Performance management Group (GRMC) Number of formal complaints received reducing				
	Infection prevention plan to ensure hospital acquired infections are reduced		MRSA/C. Difficile rates reported to Trust board via monthly Q&P report. 1MRSA case reported to end of Sept. 2012/13 Target = 6 C. Difficile currently below trajectory. 41 cases to end of Sept. against target of 54.				
	Monthly patient experience monitoring 'Net Promoter'		Monthly patient experience report to Trust board included within Q&P report. Improving Net Promoter results.				

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

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

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 provider scores	Patient experience plan and associated projects	4x3=12	Patient experience progress reports to Governance and Risk Management Committee (GRMC) Patient stories presented at Trust Board Discharge project outcomes (i.e. delayed transfer of care) reported to the Discharge and Transfer of Care (DTOC) Group and monthly to the emergency Care Network and Clinical Quality Review Group (CQRG). Data included in monthly Quality and Performance report to Trust Board.	(c) Lack of patient experience strategy including: • Improving services for older people • Improve services for patients with dementia • Improve services for 'End of Life' (c) Trust-wide communications of patient experience learning	Final version of Patient Experience Strategy document to be presented at TB	2x3=6	Feb 13 Dep. CEO/Chief Nurse
	Net Promoter scores to identify key areas for focus		Ongoing Patient Experience surveys Net Promoter scores reported monthly to Trust Board via Q&P report. Improving picture in relation to Net Promoter scores (57.5% at the end of September)	(c) Not reducing cancellation rates for outpatients appointments	Outpatient project delivery plan to be developed		Jan 2013 Director of Operations
	Caring @its best and releasing time to care initiatives		Caring @ its best awards Improving patient experience reports Improved infection prevention outcomes	(c) Lack of supervisory headroom for ward managers	Develop proposal for the ward managers to have rostered supervisory time in line with Francis recommendations		Jan 2013 Dep CEO/Chief Nurse
	Patient experience programme (across 85 clinical areas to gain feedback from patients relating to their experience of care) and national patient survey		Ongoing Patient Experience surveys Net Promoter scores reported monthly to Trust Board via Q&P report. Annual reporting to trust board of national patient survey				

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

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 are discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inability to react /recover from events that threaten business continuity leading to sustained downtime and inability to provide full range of services	Major incident/business continuity/ disaster recovery and Pandemic plans developed and tested for UHL/ wider health community. This includes UHL staff training in major incident planning/ coordination and multi agency involvement across Leicestershire to effectively manage and recover from any event threatening business continuity. Emergency Planning Officer appointed to oversee the development of business continuity within the Trust	3x3=9	Annual Emergency planning Report identifying good practice presented to the Governance and Risk Management Committee December 2011 External auditing and assurances to SHA, Business Continuity Self-Assessment, June 2010, completed by Richard Jarvis Completion of the National Capabilities Survey, November 2013 completed by Aaron Vogel. Results will be included in the annual report on Emergency Planning and Business Continuity to the GRMC. Audit by Price Waterhouse Coopers LLP Jan 2013 results will be reported to Trust Board (date to be agreed)	(c) Lack of coordination of plans between different service areas and across the CBUs. (c) On-going continual training of staff to deal with an incident (c) Do not effectively Identify, report and communicate issues/lessons learnt that have been identified in service area disruptions and follow up actions. (c)Do not always consider the impact on business continuity and resilience when implementing new systems and processes. (a) Do not gain assurances from external service providers as to their ability to continue to provide services to the trust in the event of an incident within their organisation or/and within the Trust.	New terms of reference and membership of the Emergency Planning and Business Continuity Committee to oversee and provide strategic oversight and commitment to business continuity. New policy to identify key roles within the Trust of those responsible for ensuring business continuity planning /learning lessons is undertaken.	2x3=6	Jan 2013 Jan 2013

APPENDIX TWO

UHL STRATEGIC RISKS SUMMARY REPORT – DECEMBER 2012

Risk No	Risk Title	Current Risk Score (Dec 12)	Previous Risk Score (Nov 12)	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	16	16	12 – Jan 13	Director of Operations	
7	Ineffective organisational transformation	16	16	12 – 2013-14	Director of Finance and Business Services	
6	Failure to achieve FT status	16	12	12 – 2013-14	Chief Executive Officer	Score increased following discussions at ET.
11	Failure to maintain productive relationships	15	15	10	Director of Communications and External Relations	Timescale for action to be agreed
9	Failure to achieve and sustain operational targets	12	12	12	Director of Operations	Timescale for single action to be agreed
12	Inadequate reconfiguration of buildings and services	12	12	9 - Apr-14	Chief Executive Officer	
1	Reducing avoidable harms	12	12	6 – Mar 13	Dep. Chief Executive/ Chief Nurse	
5	Patient experience/ satisfaction	12	12	6 – Feb 13	Dep. Chief Executive/ Chief Nurse	
2	Business continuity	9	9	6 – Jan 13	Director of Operations	
10	Loss of reputation	n/a	n/a	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 – DECEMBER 2012

Risk No.	Action Description	Action Owner	Comment
1	Development of divisional accountability lines document	CEO	Completed by J.Birrell December 2012
5	Development and ratification of patient experience strategy	Dep CEO/ Chief Nurse	Framework submitted to Trust Board December 2012
8	Strengthen CIP governance structure to enhance management / monitoring arrangements	Director of Finance and Business Services	New CIP governance framework now in place

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?