To:	**Trust Board**
From:	**Rachel Overfield - Chief Nurse**
Date:	**20 December 2013**
CQC regulation:	Outcome 16 – Assessing and Monitoring the Quality of Service Provision

Title:	**UHL RISK REPORT INCORPORATING THE BOARD ASSURANCE FRAMEWORK (BAF) 2013/14**

Author/Responsible Director: Chief Nurse

Purpose of the Report:
The report provides the Board with an updated BAF and oversight of any new extreme and high risks within the Trust. The report includes:-

a) A copy of the BAF as of 30 November 2013.
b) An action tracker to monitor progress of BAF actions
c) A summary diagram of risk movements from the previous month.
d) New extreme and/ or high risk opened during the reporting period.

The Report is provided to the Board for:

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

Summary :

- There have been six BAF entries that have seen increased scores during the reporting period
- The Board is asked to consider the proposal to remove BAF entry number six (failure to achieve FT status) for future iterations of the BAF.
- Board members are invited to review the following BAF risks.
  Ineffective strategic planning and response to external influences (Director of Strategy).
  Failure to achieve FT status (risk owner – Director of Strategy).
  Failure to maintain productive and effective relationships (risk owner Director of Communications and Marketing).
- One new high risk has opened on the UHL risk register during November 2013.

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

(a) review and comment upon this iteration of the 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 which it feels that the Trust's controls are inadequate and do not, therefore, effectively manage the principal risks to the organisation achieving 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;

(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 endorse the proposal by the Director of Strategy and the UHL Risk and Assurance Manager outlined in section 2.4 of the report (i.e. removal of BAF entry number six).

Strategic Risk Register Yes	**Performance KPIs year to date** N/A
Resource Implications (eg 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 review by the Board	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **20 DECEMBER 2013**

REPORT BY: **RACHEL OVERFIELD - CHIEF NURSE**

SUBJECT: **UHL RISK REPORT INCORPORATING THE BOARD ASSURANCE FRAMEWORK (BAF) 2013/14**

---

1. INTRODUCTION

1.1 This report provides the Board with:-

a) A copy of the BAF as of 30 November 2013.
b) An action tracker to monitor progress of BAF actions.
c) A summary diagram of BAF scores to show any changes from the previous month.
d) Notification of any new extreme or high risks opened during the reporting period.

2. BAF POSITION AS OF 30 NOVEMBER 2013

2.1 A copy of the BAF is attached at appendix one with changes to narrative since the previous version shown in red text.

2.2 The progress of actions associated with the BAF is monitored by reference to the action tracker attached at appendix two. The Board is asked to note the deletion of action numbers 3.6 and 10.2 as both of these are incorporated within other actions.

2.3 Appendix three provides a summary of changes to BAF scores and the Board is asked to note that during this reporting period six scores have increased as described in the table below.

Risk No.	Score (from/ to)	Rationale
3	16 - 20	Reflecting the difficulties being encountered in filling nurse staffing vacancies due to shortages of qualified nurses.
4	12 - 16	Reflecting the current lack of organisational change
5	12 -16	Reflecting the lack of robust strategic planning prior to appointment of Director of Strategy.
9	12 - 20	Reflecting the continuing failure to achieve compliance with RTT targets for admitted and non-admitted patients and ED targets.
10	12 - 15	Reflecting the slow pace of reconfiguration.
11	9 - 12	Reflecting that business continuity plans

		have not yet been received from Interserve.

2.4 Following discussions between the Director of Strategy and the UHL Risk and Assurance Manager the Board is asked to consider a proposal for BAF entry number six (failure to achieve FT status) to be removed from future iterations as the risk is reflecting a consequence of the failure to control other risks in the BAF (e.g. maintenance of quality standards, operational performance, ED, financial sustainability, etc).

2.5 To provide an opportunity for more detailed scrutiny three BAF entries are presented on a monthly basis for Board members to review against the parameters listed in appendix four.

- Ineffective strategic planning and response to external influences (Director of Strategy).
- Failure to achieve FT status (risk owner – Director of Strategy).
- Failure to maintain productive and effective relationships (risk owner Director of Communications and Marketing).

3 EXTREME AND HIGH RISK REPORT.

3.1 The Board is asked to note that one new high risk has opened during November 2013 as described below. The details of this risk are included at appendix five.

Risk ID	Risk Title	Risk Score	CMG/Corporate Directorate
2248	Lack of IR(ME)R training records held across the Trust	16	Clinical Support & Imaging

4. RECOMMENDATIONS

4.1 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 BAF, as it deems appropriate:

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

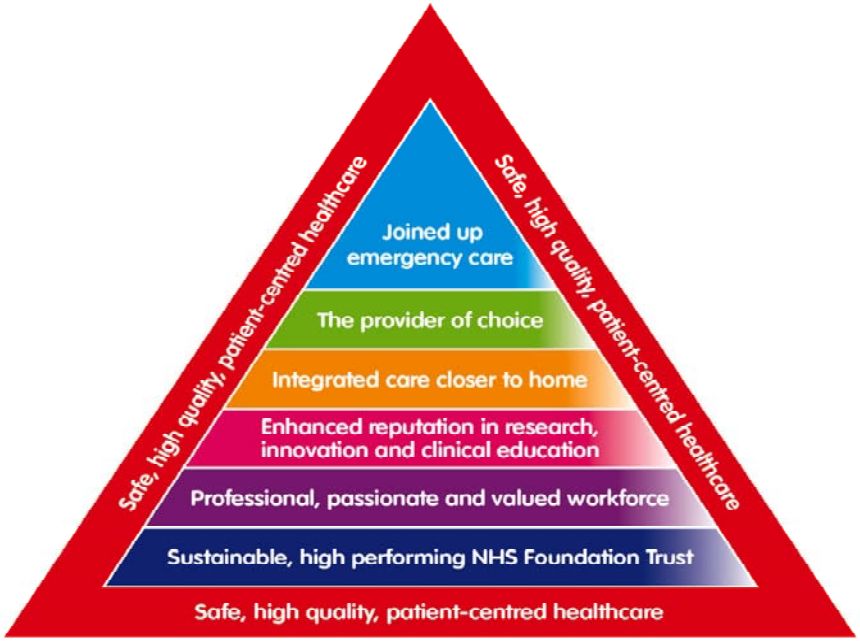
(c) identify any areas which it feels that the Trust's controls are inadequate and do not, therefore, effectively manage the principal risks to the organisation achieving its objectives;

(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;

(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 endorse the proposal by the Director of Strategy and the UHL Risk and Assurance Manager outlined in section 2.4 of this report.

Peter Cleaver,
Risk and Assurance Manager,
12 December 2013.


Safe, high quality, patient-centred healthcare
Safe, high quality, patient-centred healthcare
Joined up emergency care
The provider of choice
Integrated care closer to home
Enhanced reputation in research, innovation and clinical education
Professional, passionate and valued workforce
Sustainable, high performing NHS Foundation Trust
Safe, high quality, patient-centred healthcare

PERIOD: NOVEMBER 2013

RISK TITLE	STRATEGIC OBJECTIVE	CURRENT SCORE	TARGET SCORE
Risk 1 – Failure to achieve financial sustainability	g - To be a sustainable, high performing NHS Foundation Trust	25	12
Risk 2 – Failure to transform the emergency care system	b - To enable joined up emergency care	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.	20	12
Risk 4 – Ineffective organisational transformation	a - To provide safe, high quality patient-centred health care c - To be the provider of choice d - To enable integrated care closer to home	16	12
Risk 5 – Ineffective strategic planning and response to external influences	a - To provide safe, high quality patient-centred health care c - To be the provider of choice g - To be a sustainable, high performing NHS Foundation Trust	16	12
Risk 6 – Failure to achieve FT status	g - To be a sustainable, high performing NHS Foundation Trust	16	12
Risk 7 – Failure to maintain productive and effective relationships	c - To be the provider of choice d - To enable integrated care closer to home f - To maintain a professional, passionate and valued workforce	15	10
Risk 8 – Failure to achieve and sustain quality standards	a - To provide safe, high quality patient-centred health care c - To be the provider of choice	16	12
Risk 9 – Failure to achieve and sustain high standards of operational performance	a - To provide safe, high quality patient-centred health care	20	12
Risk 10 – Inadequate reconfiguration of buildings and services	a - To provide safe, high quality patient-centred health care	15	9
Risk 11– Loss of business continuity	g - To be a sustainable, high performing NHS Foundation Trust	12	6
Risk 12 – Failure to exploit the potential of IM&T	a - To provide safe, high quality patient-centred health care d - To enable integrated care closer to home	9	6
Risk 13 - Failure to enhance education and training culture	e – To enjoy an enhanced reputation in research, innovation and clinical education	12	6

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK NOVEMBER 2013

RISK NUMBER/ TITLE:	**RISK 1 – FAILURE TO ACHIEVE FINANCIAL SUSTAINABILITY**
LINK TO STRATEGIC OBJECTIVE(S)	**g. - 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. Revised variance analysis and reporting metrics especially for the ETPB Self-assessment and SLM baseline exercise completed and project manager identified Finalised SLM Action plan Full information has now been received on UHL allocations from all the no-recurrent funding streams including transformation monies. This information is being incorporated into the financial forecasts.	5X5=25	Monthly /weekly financial reporting to Exec Team Performance Board, F&P Committee and Board. Cost centre reporting and monthly PLICS reporting. Monthly confirm and challenge processes at specialty and CMG level. Annual internal and external audit programmes. Monthly meetings with the NTDA and the CCG Contract Performance Meeting	(c) SLM programme not fully implemented	ESB will continue to meet every 6 weeks to ensure implementation of SLM across the Trust (expected Mar 2014) (1.19)	4x3=12	Mar 2014 DFBS
Failure to achieve CIP.	Strengthened CIP governance structure including appt of Head of CIP programme		Progress in delivery of CIPs is monitored by CIP Programme Board (meeting fortnightly) and reported to ET and Board.	(c) Under-delivery of CIP programme (£0.8m adverse to plan M7)			

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. STAFFflow for medical locums saving £130k of every £1m expenditure Financial Recovery plans developed Non Contractual Payments are discussed at monthly CMG meetings Confirm and Challenge Meetings All CMGs (by specialty) have produced premium spend trajectories and associated plans until March 2014 Weekly Staff Bank data reports are issued for medical and nursing (qualified and unqualified) staff Action plan to increase bank staff capacity and drive down agency nurse expenditure.		The use of locum staff in 'difficult to fill' areas reported monthly to the Board via the Q&P report. A reduction in the use of locums would be an assurance of success in recruiting substantive staff to 'difficult to fill' areas. Increase in contracted staff numbers of medical and nursing professions of 252wte since Mar 12. Saving in excess of £0.6m 5 weeks after 'go live' date Monthly Q&P report to TB Monthly confirm and challenge meetings Non contractual payments (premium spend) are reported monthly to the Finance and Performance Committee A weekly report is presented to ET. Weekly meetings with HoNs and DHR to monitor progress.	(c) Further investigation required as to the increase in Consultant numbers by 41wte (7.7%)			
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. Ongoing discussions with commissioners about planned re-investment of the MRET deductions.		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board.	(c) Failing to manage marginal activity efficiently and effectively. This is being addressed via ongoing discussions with Commissioners			

Ineffective processes for Counting and Coding.	Clinical coding project.		Ad-Hoc reports on annual counting and coding process. PbR clinical coding audit Jan 2013 (final report received 29 May 2013). IG toolkit audit (sample of 200 General Surgery episodes).	(c) Error rates in audit sample could be indicative of underlying process issues (c) Error rates identified as: Primary diagnoses incorrect 8.0% › Secondary diagnoses incorrect 3.6%. › Primary procedure incorrect 6.4% › Secondary procedure incorrect 4.5%.	Submit application for clinical coding to be included as a 2nd wave LIA pioneering team to involve clinicians. (1.20)		Review Jan 2014 DS
Loss of liquidity.	Liquidity Plan.		Monthly /weekly financial reporting to F&P Committee and Board. Detailed cash management plans presented at August 2013 F&P committee				
Lack of robust control over pay and non-pay expenditure.	Pay and Non-pay recovery action plan in place and monitored monthly Catalogue control project.		Monthly /weekly financial reporting to F&P Committee and Board. Non-pay management plan presented at July F&P committee Ongoing Monitoring via F&P Committee.				
Commissioner fines against performance targets.	Contract meetings with Commissioners and negotiations with Commissioners concluded at a transactional level. Plans and trajectories developed to reduce admission rates that are monitored at monthly C&C meetings.		Monthly /weekly monitoring of action plans, key performance target, and financial reporting to F&P Committee and Board.				
Use of readmission monies.	Contract meetings with Commissioners Negotiations with Commissioners concluded at a transactional level Ownership of readmissions work streams in divisions clarified		Monthly /weekly financial reporting to F&P Committee and Board.				
Ineffective organisational transformation.	See risk 4		See risk 4.	See risk 4.	See risk 4.		See risk 4

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK NOVEMBER 2013

RISK NUMBER/ TITLE:	**RISK 2 – FAILURE TO TRANSFORM THE EMERGENCY CARE SYSTEM**
LINK TO STRATEGIC OBJECTIVE(S)	**b. - To enable joined up emergency care.**
EXECUTIVE LEAD:	Chief Operating 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 transform emergency care system leading to demands on ED and admissions units continuing to exceed capacity.	Health Economy has submitted response plan to NHSE requirements for an Emergency Care system under the A&E Performance Gateway Reference 00062.	5x5=25	Once plan agreed with NTDA, it will be circulated to the Board	No gaps	No actions	4x3=12	
	Emergency Care Action Team formed. Chaired by Chief executive to ensure Emergency Care Pathway Programme actions are being undertaken in line with NHSE action plan and any blockages to improvement removed. Development of action plan to address key issues		Action Plan circulated to the Board on a monthly basis as part of the Report on the Emergency Access Target within the Quality and Performance Report	Gaps described below	Actions described below		
	A new plan has been submitted detailing a clear trajectory for performance improvement and includes key themes from plan: Single front door		Project plan developed by CCG project manager Risks from 'single front door' to be escalated via ECAT and raised with CCG Managing Director as required	No gaps	No actions		
	ED assessment process is being operated.		Forms part of Quality Metrics for ED reported daily update and part of monthly board performance report	No gaps	No actions		
	Recruitment campaign for continued recruitment of ED medical and nursing staff including fortnightly meetings with HR to highlight delays and solutions in the recruitment process.		Vacancy rates and bank/agency usage reported to Trust Board on a monthly basis Recruitment plan being led by HR and monitored as part of ECAT	(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. (c) Staffing vacancies for medical and nursing staff remain high.	Continue with substantive appts until funded establishment is achieved (2.7)		Review Jan 2014 COO

	Formation of an EFU and AFU to meet increased demand of elderly patients		'Time to see consultant' metric included in National ED quarterly indicator.	No gaps	No actions		
	Maintenance of AMU discharge rate above 40%		Reported to Operational Board twice monthly and will be included in Emergency Care Update report in Q&P Report.	No gaps	No actions		
	New daily MDT Board Rounds on all medical wards and medical plans within 24hrs of admission		Reported to Operational Board twice monthly and will be included in Emergency Care Update report in Q&P Report.	No gaps	No actions		
	EDDs to be available on all patients within 24 hours of admission. Review built in to daily discharge meetings to check accuracy of EDDs (from 2/09/13).		Monitored and reported to Operational Board twice monthly and will be included in Emergency Care Update report in Q&P report	No gaps	No actions		
	Maintain winter capacity in place to allow new process to embed		All winter capacity beds are to be kept open until the target is consistently met	No gaps	No actions		
	DTOCs to be kept to a minimal level		Forms part of the Report on Emergency Access in the Q&P Report.	(c) Lack of availability of rehabilitation beds for increasing numbers of patients.	CCG/LPT to increase capacity by use of Intermediate Care Services (2.9)		Review Jan 2014 CO O

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK NOVEMBER 2013

RISK NUMBER/ TITLE:	**RISK 3 – INABILITY TO RECRUIT, RETAIN, DEVELOP AND MOTIVATE STAFF**
LINK TO STRATEGIC OBJECTIVE(S))	**e. - To enjoy an enhanced reputation in research, innovation and clinical education** **f. - To maintain a professional, passionate and valued workforce**
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.	4x5=20	Development of UHL talent profiles.	No gaps identified.	No actions required.	4x3=12	
			Talent profile update reports to Remuneration 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 central enabler of delivering against the OD Plan work streams will be adopting, 'Listening into Action' (LiA) and progress reports on the LiA will be presented to the Trust Board on a quarterly basis.	No gaps identified.	No actions required.		
	A central enabler of delivering against the OD Plan work streams will be adopting, 'Listening into Action (LiA). A Sponsor Group personally led by our Chief Executive and including, Executive Leads and other key clinical influencers has been established.		Progress reports on the LiA will be presented to the Trust Board on a quarterly basis.	No gaps identified. No gaps identified.	No actions required. No actions required.		
	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 on a six monthly basis. Improving staff satisfaction position.	No gaps identified.	No actions required.		
			Staff sickness levels may also provide an indicator of staff satisfaction and performance. Staff sickness rate is 3.85% for M7	No gaps identified	No actions required.		

	Appraisal and objective setting in line with UHL strategic direction. Local actions and appraisal performance trajectories agreed with CMGs and Directorates Boards		Appraisal rates reported monthly to Board via Quality and Performance report. Month 6 appraisal rate = 91%	(C) Appraisal rate consistently below target (target =95%)	Implement targeted recovery plans and trajectories for each cost centre		Dec 2013 DHR
	Summary of quality findings communicated across the Trust; to identify how to improve the quality of the appraisal experience for the individual and the quality of appraisal meeting recording.		Results of quality audits to ensure adequacy of appraisals reported to the Board via the quarterly workforce and OD report.	No gaps identified.	No actions required.		
			Appraisal Quality Assurance Findings reported to Trust Board via OD Update Report June 2013 Quality Assurance Framework to monitor appraisals on an annual cycle (next due March 2014).	No gaps identified.	No actions required.		
	Workforce plans to identify effective methods to recruit to 'difficult to fill areas). CMG and Directorates 2013/14 Workforce Plans.		Nursing Workforce Plan reported to the Board in September 2013 highlighting demand and initiatives to reduce gap between supply and demand. The use of locum staff in 'difficult to fill' areas is reported to the Board on a monthly basis via the Q&P report. Reduction in the use of such staff would be an assurance of our success in recruiting substantive staff.	(c) Approximately 500 nursing staff vacancies identified across UHL following nursing staff review. Difficulties in recruitment due to many hospitals within UK looking to recruit in response to Francis report. (c) Risks with employing high number from an International Pool in terms of ensuring competence	Active recruitment strategy including implementation of a dedicated nursing recruitment team. (3.8) Develop an employer brand and maximise use of social media (3.9) Programme of induction and adaptation in development with Nursing education leads, timetabled to ensure capacity to support programme. (3.10)		Dec 2013 CN/ DHR April 2014 DHR April 2014 DHR
	Reward /recognition strategy and programmes (e.g. salary sacrifice, staff awards, etc). Recruitment and Retention Premia for ED medical and nursing staff			(a) Reward and recognition strategy requires revision to include how we will provide assurance that reward and recognition programmes are making a difference to staffing recruitment/ retention/ motivation.	Revise and launch reward and recognition strategy. (3.1) Development of Pay Progression Policy for Agenda for Change staff (3.3)		Jan 2014 DHR Dec 2013 DHR

	UHL Branding – to attract a wider and more capable workforce. Includes development of recruitment literature and website, recruitment events, international recruitment. Reporting and monitoring of posts with 5 or less applicants.		Evaluate recruitment events and numbers of applicants. Reports issued to Nursing Workforce Group (last report 4 Feb). Reporting will be to the Board via the quarterly workforce an OD report. Quarterly report to senior HR team and to Board via quarterly workforce and OD report	(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. (3.2)		Dec 2013 DHR
	Statutory and mandatory training programme for 9 key subject areas in line with National Core Skills Framework		Monthly monitoring of statutory and mandatory training uptake via reports to TB and ESB against 9 key subject areas (currently showing month on month improvements (58% at M7)	(c) Compliance against the 9 key subject areas is 55% (a) Potentially there may be inaccuracies of training data within the e-UHL system	Ensure Statutory and Mandatory training is easy to access and complete with 75% compliance by reviewing delivery mode, access and increasing capacity to deliver against specific subject areas (3.5) Update e-UHL records to ensure accuracy of reporting on a real time basis (3.7)		Mar 2014 DHR Mar 2014 DHR

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK NOVEMBER 2013

RISK NUMBER/ TITLE:	**RISK 4 – INEFFECTIVE ORGANISATIONAL TRANSFORMATION**
LINK TO STRATEGIC OBJECTIVE(S)	**a. - To provide safe, high quality patient-centred health care.** **c. - To be the provider of choice.** **d. - To enable integrated care closer to home**
EXECUTIVE LEAD:	Director of Strategy

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 put in place a robust approach to organisational transformation, adequately linked to related initiatives and financial planning/outputs	Development of Improvement and Innovation Framework (IIF) Outputs from this transformation programme will drive the implementation of the clinical strategy.	4x4=16	Monthly progress reports to Exec Strategy Board and F&P Committee. Approval of framework and operational arrangements due at Trust Board June 2013. Monitoring of overall Framework will be via IIF Board and F&P Ctte and monitoring of financial outputs (CIPs) will be via CIP Delivery Board, Exec Performance Board and F&P Committee. Delivery of whole hospital change programmes requires alignment with the whole local Health Economy change programme – currently described through the Better Care Together programme	(c) Gaps are evident in the alignment of transformational process between UHL and principle partners – this is being raised through the Better Care Together Programme structures	Review outputs from Chief Officers Group and strategic Planning Group to ensure gaps in current processes are being addressed (4.1)	4x3=12	Review Feb 2014 DS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK NOVEMBER 2013

RISK NUMBER / TITLE	**RISK 5 - INEFFECTIVE STRATEGIC PLANNING AND RESPONSE TO EXTERNAL INFLUENCES**
LINK TO STRATEGIC OBJECTIVE(S)	**a. - To provide safe, high quality patient-centred health care.** **c. - To be the provider of choice.** **e. - To enjoy an enhanced reputation in research innovation and clinical education.** **g. - To be a sustainable, high performing NHS Foundation Trust**
EXECUTIVE LEAD:	Director of Strategy

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 put in place appropriate systems to horizon scan and respond appropriately to external drivers. Failure to proactively develop whole organisation and service line clinical strategies	Appointment of Strategy Director	4x4=16	Plan agreed by Remuneration Committee	None identified	Not applicable	4x3=12	N/A
	Allocation of market intelligence responsibility to Director of Marketing and Communications		Agreed by Remuneration Committee	None identified	Not applicable		N/A
	Co-ordinated approach to business intelligence gathering and response via Clinical Management Groups Workshop 'hosted by the Director of Strategy 'delivering our strategic direction' held in November with all CMGs to set the external context within which we will need to develop a LLR Integrated 5-yaer plan, within which our 2-yaer operational plans will sit. CMG Strategy Leads now engaged in the BSST meetings to improve engagement, alignment and teamwork. ESB forward plan reflecting a 12 month programme aligned with: • the development of the IBP/LTFM • the reconfiguration programme • the development of the next AOP • The TB Development Programme The TB formal agenda		Weekly strategic planning meetings in place – cross CMG and corporate team attendance with delivery led through the Strategy Directorate Development of a clear, clinically based 5 year strategic will provide assurance that strategic planning is taking place Reports to ESB Regular reports to TB reflecting progress of 12 month programme	None identified None identified	Not applicable Not applicable		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK NOVEMBER 2013

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

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 meet the requirements of the FT application process in terms of service quality, strategy, financial resilience and governance	FT Programme Board provides strategic direction and monitors the FT application programme.	4x4=16	Monthly progress against the FT programme is reported to the Board to provide oversight.	No gaps identified.	No actions required.	4x3=12	
	FT Workstream group of Executive and operational Leads to ensure delivery of IBP and evidence to support HDD1 and 2 processes.		Feedback from external assessment of application progress by SHA	No gaps identified.	No actions required.		
	FT application project plan / project team in place FT Integrated Development Plan		Reports to FTPB and Trust Board	No gaps identified	Not applicable		N/A
	Progression of Better Care Together Programme which underpins the UHL service strategy and LTFM. Appointment of Director of Strategy as BCT lead Chief Officers have sponsored the establishment of the LLR Strategy Leads Group to support the development of a 5 year Integrated Health and Care Plan. UHL's lead representative on this working group is the Head of Planning and Business Development.		Economic modelling incorporated into the Trust Reconfiguration Strategic Outline Case (SOC) structure and process. Regular reports to Exec Strategy Board and Trust Board Various inputs from Exec Team to BCT work.	No gaps identified No gaps identified	Not applicable Not applicable		
			Feedback and recommendations from the independent reviews against the Quality Governance Framework and the Board Governance Framework.	(c) Independent reports identify a number of recommendations.	Action plans to be developed to address recommendations from independent reviews. (6.11)		Dec 2013 CEO
	Monitoring of KPIs in particular in relation to financial position and key operational performance indicators.		Monthly reports to Executive Performance Board, F&P Committee and Trust Board	None identified.	Not applicable		N/A
			Achievement against the new TDA Accountability Framework is reported to the Trust board and the TDA on a monthly basis.	None identified	Not applicable		N/A

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK NOVEMBER 2013

RISK NUMBER/ TITLE:	**RISK 7– FAILURE TO MAINTAIN PRODUCTIVE AND EFFECTIVE RELATIONSHIPS**
LINK TO STRATEGIC OBJECTIVE(S)	**c. - To be the provider of choice.** **d. - To enable integrated care closer to home.** **f. – To maintain a professional, passionate and valued workforce.**
EXECUTIVE LEAD:	Director of Marketing and Communications

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 ('Better Care Together')	5X3=15	Twice yearly GP surveys with results reported to UHL Executive Team. Latest survey results discussed at the April 2013 Board and showed increasing levels of satisfaction… a trend which has now continued for 18 months. Annual Reputation / Relationship survey to key professional and public stakeholders Nov 13. Anecdotal feedback from partners and soft intelligence indicates that relations with key organisations and individuals are improving under new UHL leadership. However, progress on Better Care Together and discussions re: health economy finances in Nov / Dec 2013 could be contra indicators.	(c) No external and 'dispassionate' professional view of stakeholder / relationship management activity	Invite PWC (Trust's Auditors) to offer opinion on the plan / talk to a selection of stakeholders. (7.3)	5X2=10	Jan 2014 DCM

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK NOVEMBER 2013

RISK NUMBER/ TITLE:	**RISK 8 – FAILURE TO ACHIEVE AND SUSTAIN QUALITY STANDARDS**
LINK TO STRATEGIC OBJECTIVE(S)	**a. – To provide safe, high quality patient-centred health-care**
EXECUTIVE LEAD:	Chief Nurse (with Medical Director)

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 quality standards leading to failure to reduce patient harm with subsequent deterioration in patient experience/ satisfaction/ outcomes, loss of reputation and deterioration of 'friends and family test' score.	Standardised M&M meetings in each speciality.	4x4=16	Routine analysis and monitoring of out of hours/weekend mortality at CMG Boards.	No gaps.	No action needed.	4x3=12	
	Systematic speciality review of "alerts" of deterioration to address cause and agree remedial action by Mortality Review Committee. Reports to Executive Quality Board, QAC, and by exception to ET and TB.		Quality and Performance Report and National Quality dashboard presented to ET and TB. Currently SMHI "within expected" (i.e. 106).	(a) UHL risk adjusted perinatal mortality rate above regional and national average. (c) High HSMR for low risk procedures	Women's CMG to work with Dr Foster and other trusts to better understand risk adjustment model (8.2). Review of all deaths identified in low risk groups. Working with DFI to ensure data has been recorded accurately (8.12)		Jan 2014 MD Dec 2013 MD
	Robust implementation of actions to achieve Quality Commitment (save 1000 extra lives in 3 years).		SHMI remains "within expected" (i.e. 106). Independent analysis of mortality review performed by Public Health. Results reported at November 2013 TB meeting.	No gaps identified.	No action needed.		
	Agreed patient centred care priorities for 2013-14: - Older people's care - Dementia care - Discharge Planning		Quality Action Group meets monthly. Achievement against key objectives and milestones report to Trust board on a monthly basis. A moderate improvement in the older people survey scores has been recorded.	No gaps identified.	No action needed.		
	Multi-professional training in older peoples care and dementia care in line with LLR dementia strategy.		Quality Action Group monitoring of training numbers and location.	No gaps identified.	No action needed.		

	Protected time for matrons and ward sisters to lead on key outcomes.		CMG/ specialty reporting on matron activity and implementation or supervisory practice.	(c) Present vacancy levels prevent adoption of supervisory practice.	Active recruitment to ward nursing establishment so releasing ward sister –for supervisory practice (8.5).		Sep 2014 CN
	To promote and support older peoples champions network and new dementia champions network.		Monthly monitoring of numbers and activity.	No gaps identified.	No action needed.		
	Targeted development activities for key performance indicators - answering call bells - assistance to toilet - involved in care - discharge information		Monthly monitoring and tracking of patient feedback results. Monthly monitoring of Friends and Family Test reported to the TB (66.2% at M7).				
	Quality Commitment 2013 – 2016: • Save 1000 extra lives • Avoid 5000 harm events • Provide patient centred care so that we consistently achieve a 75 point patient recommendation score		Quality Action Groups monitoring action plans and progress against annual priority improvements. A Quality Commitment dashboard has been developed to present updates to the TB on the 3 core metrics for tracking performance against our 3 goals. These metrics will be tracked up to 2015. Impressive drops in fall numbers have been observed in Datix reports and in the Safety Thermometer audit.				
	Relentless attention to 5 Critical Safety Actions (CSA) initiatives to lower mortality.		Q&P report to TB showing outcomes for 5 CSAs. 4CSAs form part of local CQUIN monitoring. RAG rated green at end of quarter 2. M&M CSA removed from CQUIN monitoring due to full implementation For Quarter 1 the CSA programme saw a 50% reduction in SUIs against the same period last year.	(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.	Implementation of Electronic Patient Record (EPR). (8.10)		2015 CIO
	NHS Safety thermometer utilised to measure the prevalence of harm and how many patients remain 'harm free' (Monthly point prevalence for '4 Harms'). Monthly meetings with operational/clinical and managerial leads for each harm in place.		Monthly outcome report of '4 Harms' is reported to Trust board via Q&P report. The percentage of Harm Free Care for M7 was 94.74% reflecting a reduction in the number of patients with newly acquired harms.	(a) Some data may not be accurate due to complex DoH definitions of each harm in relation to whether it is community or hospital acquired.	UHL to be part of the DH review in to the use of the Safety Thermometer tool (8.11)		Review Dec 2013 CN

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK NOVEMBER 2013

RISK NUMBER/ TITLE:	**RISK 9 – FAILURE TO ACHIEVE AND MAINTAIN HIGH STANDARDS OF OPERATIONAL PERFORMANCE**
LINK TO STRATEGIC OBJECTIVE(S)	**a. - To provide safe, high quality patient-centred health-care** **c. - To be the provider of choice.** **g. - To be a sustainable, high performing NHS Foundation Trust.**
EXECUTIVE LEAD:	Chief Operating 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 and sustain operational targets leading to contractual penalties, patient dissatisfaction and poor reputation.	Referral to treatment (RTT) backlog plans (patients over 18 weeks) and operational performance of 90% (for admitted) and 95 % (for non-admitted). Further recovery plans submitted to Commissioners for external assurance	4x5=20	Key specialities will go onto weekly performance meetings with COO Weekly patient level reporting meeting for all key specialties Monthly Q&P report to Trust Board showing 18 week RTT performance Daily RTT performance and prospective reports to inform decision making	(c) 83.5% admitted RTT performance (M7). Backlog plans require further development in line with review of demand and capacity in key specialties. Recovery of the admitted and non admitted standards at Trust and speciality level is not anticipated until the new financial year. (c) Capacity issues created by emergency demand causes cancellations of operations.	Re-configuration of surgical beds to create a 'protected area' for surgical patients or by use of independent sector. (9.2)	4x3=12	Review Jan 2014 COO
	Transformational theatre project to improve theatre efficiency to 80 -90%.		Monthly theatre utilisation rates. Theatre Transformation monthly meeting. Transformation update to Board.	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 2.	See risk number 2.		

	Cancer 62 day performance - Tumour site improvement trajectory agreed and each tumour site has developed action plans to achieve targets. Senior Cancer Manager appointed Lead Cancer Clinician appointed Action plan to resolve Imaging issues implemented.		Cancer action board established and weekly meetings with all tumour sites represented Monthly trajectory agreed and Cancer action plan agreed with CCGs in June 2013 and reported and monitored at Executive Performance board. Chief Operating Officer receives reports from Cancer Manager and 62 day performance included within Monthly Q&P report to Trust Board.				

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK NOVEMBER 2013

RISK NUMBER/ TITLE:	**RISK 10 – INADEQUATE RECONFIGURATION OF BUILDINGS AND SERVICES**
LINK TO STRATEGIC OBJECTIVE(S)	**a. - To provide safe, high quality patient-centred health care**
EXECUTIVE LEAD:	Director of Strategy

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.	3x5=15	Trust Board development session on development of approach to strategic planning and development of SOC. This outlined the methodology being used to ensure any changes in configuration is specifically designed to deliver optimum quality of care Ongoing monitoring of service outcomes by MRC to ensure outcomes improve. Improvement in health outcomes and effective Infection Prevention and Control practices monitored by Executive Quality Board (Q+P report) with escalation to ET, QAC and TB as required.	(a) Service specific KPIs not yet identified for all services	Prioritisation of key areas within the clinical strategy for delivery (10.1) Iterative development of strategic plans with specialities. Monitored by CMG and Executive Boards (10.5)	3X3=9	Dec 2013 MD March 2014 MD
	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. Reconfiguration Programme working with clinicians to develop a 'preferred' way forwards' with regards to the alignment of the future estate with clinical strategy		Facilities Management Collaborative (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 approval by the NTDA.	Reconfiguration programme to develop a strategic outline case which will inform the future estate strategy (10.6) Secure capital funding. (10.3)		Jan 2014 DS Dec 2013 DFBS
	CMG 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.		Monthly ET Strategy session to provide oversight of reconfiguration.	No gaps identified.	No actions required.		

	Capital expenditure programme to fund developments.		Capital expenditure reports reported to the Board via F&P 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. IM&T incorporated into Improvement and Innovation Framework.		IM&T Board in place.	No gaps identified.	No actions required.		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK NOVEMBER 2013

RISK NUMBER/ TITLE:	**RISK 11 – LOSS OF BUSINESS CONTINUITY**
LINK TO STRATEGIC OBJECTIVE(S))	**g. - To be a sustainable, high performing NHS Foundation Trust.**
EXECUTIVE LEAD:	Chief Operating 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?
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. Tailored training packages for service area based staff.	3x4=12	Annual Emergency planning Report identifying good practice presented to the GRMC July 2012. Training Needs Analysis developed to identify training requirements for staff supported by appropriate training packages for Senior Managers on Call 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 included in the annual report on Emergency Planning and Business Continuity to the QAC. Audit by PwC Jan 2013. Results being compiled and will be reported to Trust Board (date to be agreed). Documented evidence from key critical suppliers has been collected to ensure that contracts include business continuity arrangements.	(c) On-going continual training of staff to deal with an incident. (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. (c) No clear definition of what makes a critical supplier and how a loss would impact on the Trust. No plan as to how we would manage a loss.	Training and Exercising events to involve multiple specialties/CMGs to validate plans to ensure consistency and coordination (11.13). 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 arrangements against the potential disruption of testing to operations. (11.2) Develop a plan and a better understanding of how a loss of critical suppliers will affect the Trust (11.12)	2x3=6	Aug 2014 COO Review Dec 2013 CIO Dec 2013 COO

	Emergency Planning Officer appointed to oversee the development of business continuity within the Trust.		Outcomes from PwC 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 developed. Production/updates of documents/plans relating to Emergency Planning and Business Continuity aligned with national guidance have begun. Including Business Impact Assessments for all specialties. Plan templates for specialties now include details/input from Interserve	(c) not all the critical suppliers questioned provided responses (c) contracts aren't assessed for their potential BC risk on the Trust (c) Local plans for loss of critical services not completed due to change over of facilities provider (c) Plans have not been provided by Interserve as to how they would respond or escalate issues to the Trust.	Further work required to develop escalation plans and response plans for Interserve. (11.11)		Dec 2013 COO
	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 COO.	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. Issues/lessons feed into the development of local plans and training and exercising events.				

			Head of Operations and Emergency Planning Officer are consulted on the implementation of new IM&T projects that will disrupt users access to IM&T systems	(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. (11.8)		Review Dec 2013 COO
				(a) Lack of coordination of plans between different service areas and across the specialties.	Training and Exercising events to involve multiple specialties/CMGs to validate plans to ensure consistency and coordination. (11.10)		Aug 2014 COO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK NOVEMBER 2013

RISK NUMBER/ TITLE:	**RISK 12 FAILURE TO EXPLOIT THE POTENTIAL OF IM&T**
LINK TO STRATEGIC OBJECTIVE(S))	**a. - To provide safe, high quality patient-centred health care.** **d. - To enable integrated care closer to home**
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 integrate the IM&T programme into mainstream activities	Managed Business Partner for IM&T services to deliver IT that will be a key enabler for our clinical strategy. IM&T now incorporated into Improvement and Innovation Framework	3x3=9	IM&T Board in place. Quarterly reports to Trust Board	No gaps identified	No actions required	3x2=6	
	Engagement with the wider clinical communities (internal) including formal meetings of the newly created advisory groups/ clinical IT. Improved communications plan incorporating process for feedback of information		CMIO(s) now in place, and active members of the IM&T meetings The joint governance board monitors the level of communications with the organisation	No gaps identified	No actions required		
	Engagement with the wider clinical communities (External). UHL CMIOs are added as invitees to the meetings, as are the clinical (IM&T) leads from each of the CCGs		UHL membership of the wider LLR IM&B board	No gaps identified	No actions required		

Benefits are not well defined or delivered	Appointment of IBM to assist in the development of an incentivised, benefits driven, programme of activities to get the most out of our existing and future IM&T investments Initial engagement with key members of the TDA to ensure there is sufficient understanding of technology roadmap and their involvement. The development of a strategy to ensure we have a consistent approach to delivering benefits Increased engagement and communications with departments to ensure that we capture requirements and communicate benefits Standard benefits reporting methodology in line with trust expectations		Minutes of the joint governance board, the transformation board and the service delivery board Benefits are part of all the projects that are signed off by the relevant groups	(c) the delivery programme is dependent on TDA approvals for some elements (c) ensure that all CMGs/ specialties have the approach to IM&T benefits as part of delivery projects (a) production of a standard report on the delivery of benefits	TDA approvals documentation to be completed (12.8)		Review Jan 2014 CIO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK NOVEMBER 2013

RISK NUMBER/ TITLE:	**RISK 13 – FAILURE TO ENHANCE MEDICAL EDUCATION AND TRAINING CULTURE**
LINK TO STRATEGIC OBJECTIVE(S)	**e - To enjoy an enhanced reputation in research, innovation and clinical education.**
EXECUTIVE LEAD:	Medical Director

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 implement and embed an effective medical training and education culture with subsequent critical reports from commissioners, loss of medical students and junior doctors, impact on reputation and potential loss of teaching status.	Medical Education Strategy and Action Plan	4x3 = 12	Strategy approved by the Trust Board Strategy monitored by Operations Manager and reviewed monthly in Full team Meetings. Favourable Deanery visit in relation to ED Drs training	(c) Lack of engagement/awareness of the Strategy with CMGs.	Meetings to discuss strategy with CMGs (13.1)	3x2 = 6	Dec 2013 MD
	UHL Education Committee 'Doctors in Training' Committee established Education and Patient Safety		Professor Carr reports to the Trust Board Reports submitted to the Education Committee Terms of reference and minutes of meetings	(c) Attendance at the Committee could be improved. (c) Improved trainee representation on Trust wide committees (c) Improve engagement with other patient safety activities/groups	Relevance of the committee to be discussed at specialty/ CMG meetings (13.2) 'Build relationships with CMG Quality Leads. Establish links with LEG/QAC and QPMG. (13.4)		Dec 2013 MD Dec 2013 MD

	Quality Monitoring		Quality dashboard for education and training monitored monthly by Operations Manager, Quality Manager and Education Committee. Education Quality Visits to specialties Monitor progress against the Education Strategy and GMC Training Survey results	(a) Information is from diverse sources – the collation of information needs to be established (a) Lack of engagement with specialties to share findings from the dashboards (a) Do not currently ensure progress against strategic and national benchmarks (c) Inadequate educational resources	Introduce exit surveys for trainees Communicate feedback from the GMC training survey and LETB Visits via the Dashboard. (13.5) Attend CMG management meetings and liaise with specialties. (13.6) Monitor UHL position against other trusts nationally. (13.7) New Library/learning facilities to be developed at the LRI .(13.8)		Dec 2013 MD Dec 2013 MD Review Feb 2014 MD Apr 2014 MD
	Educational project teams to lead on education transformation projects		Project team meets monthly Favourable outcome from Deanery visit in relation to ED Drs training	(c) Implementation of the project within Acute Medicine needs to be improved.	Dr Hooper in post for Acute Medicine to implement project. (13.9)		Feb 2014 MD
	Financial Monitoring		SIFT monitoring plan in place	(c) Poor engagement with specialties in relation to implication of SIFT	Need to engage with the specialties to help them understand the implication of SIFT and their funding streams. (13.10)		Dec 2013 MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

ACTION TRACKER FOR THE 2013/14 BOARD ASSURANCE FRAMEWORK (BAF)

Monitoring body (Internal and/or External):	Executive Team
Reason for action plan:	Board Assurance Framework
Date of this review	**November 2013**
Frequency of review:	Monthly
Date of last review:	October 2013

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
1	**Failure to achieve financial sustainability**					
1.11	Ongoing discussions with commissioners about planned re-investment of the MRET deductions.	DFBS		Review October 2013	**Complete** (confirmed at TB meeting 28/11/13).	5
1.19	ESB will continue to meet every 6 weeks to ensure implementation of SLM across the Trust (expected Mar 2014)	DFBS		March 2014	On track.	4
1.20	Submit application for clinical coding to be included as a 2nd wave LIA pioneering team to involve clinicians.	DS	ADI	Review January 2014	On track. Successful with LIA application and upgraded to a 2nd wave LIA Enabling our People project with a focus on improving coding at the LRI.	4
2	**Failure to transform the emergency care system**					
2.7	Continue with substantive appts until funded establishment within ED is achieved.	COO	HO	Review ~~Sept Nov 2013~~ Jan 2014	Remains on track. Further review of progress Jan 2014.	4

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
2.9	CCG/LPT to increase capacity by use of Intermediate Care Services.	COO	HO	~~August~~ Review ~~October~~ ~~November 2013~~ January 2014	DTOCs reduced but not at level required yet. Additional community beds in City (24) and East (24) have been delayed and are now due to start in Dec 2013. Additional 19 IP beds for LPT also in process of being put in place. Review in January 2014 to ensure additional community beds in	3
3	**Inability to recruit, retain, develop and motivate staff**					
3.1	Revise and re-launch UHL reward and recognition strategy.	DHR	DDHR	~~October 2013~~ January 2014	A draft strategy is in place which has been further developed through 2 LiA events in September. The Recruitment and Retentions Strategy was presented to Executive Team on 5 November 13. There are some further updates to make before presentation to the Trust Board in December. The updated Strategy will be shared with staff side colleagues. The launch of the strategy is anticipated in January 2014. The action completion date has been amended to reflect this.	4

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
3.2	Take baseline from January and measure progress in relation to the success of recruitment events 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.	DHR	DDHR	December 2013	Programme of Trust wide recruitment campaigns for Registered nurses and HCA's during 2013. Key actions have included Development and implementation of a Band 5 registered nurse and Band 2 HCA job swap to limit the number of internal moves from full recruitment processes. Attendance at 3 Registered Nurse jobs fairs in Manchester, London and Glasgow Development to a Nursing recruitment web page. Adverts have appeared on train platforms between Leicester, London and surrounding areas and use of social media as an advertising source has been utilised. LiA will support further development of all of the above for Nursing and other staff groups in UHL. International Recruitment campaigns are continuing to progress. A comprehensive rolling programme of advertising has been proposed for 2014.	4

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
3.3	Development of Pay Progression Policy for Agenda for Change staff.	DHR	DDHR	~~October~~ ~~November~~ December 2013	Presentation of proposal to ESB on 1st October. Work to finalise a Policy for discussion with staff side underway. Initial staff side comments acquired and specific meeting to discuss on 16 December 13. Pay Progression Policy to be considered at ESB on 3 December 2013.	3
3.4	Implementation of Recruitment and Retention Premia for ED staff.	DHR	DDHR	~~September~~ ~~October~~ November 2013	**Complete**. R&R premia approved by the Remuneration Committee for Consultants and Band 5 Nurses in ED, in line with certain qualifying criteria. For Consultants an agreed job plan was required and for the majority has been completed and the payments will be made in December pay. Band 5 Nurses receive their first payment after 6 months and will be reflected in January 2104 pay.	5
3.5	Ensure Statutory and Mandatory training is easy to access and complete with 75% compliance by reviewing delivery mode, access and increasing capacity to deliver against specific subject areas.	DHR	ADLOD	March 2014	Performance improved to 60%. First four newly designed e-learning packages have been completed:- All other e-learning packages will be available from the end of December 2013.	4
3.6	Consult and implement Pay Progression Policy	DHR	DDHR	November 2014	First stage of staff side consultation will take place at the JSCNC on 11.11.13. **NB: This action has been deleted from the BAF and will be deleted from future iterations of the action tracker as the action is incorporated in action 3.3.**	4

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
3.7	Update e-UHL records to ensure accuracy of reporting on a real time basis	DHR		March 2014	Work in progress with designing new system and completion of Project Documentation for review by IMT Project Board on 4 November 2013. Data from other systems has been migrated across to the e-UHL System to support accurate reporting. A Project Brief has been completed to reflect e-UHL System upgrade requirements and a Project Board has been established in taking forward this work.	4
3.8	Active recruitment strategy to recruit to current nurse vacancies including implementation of a dedicated nursing recruitment team	CN/ DHR		December 2013	Team leader appointed and new structure to be implemented from 2 December 2013.	4
3.9	Develop an employer brand and maximise use of social media to describe benefits of working at UHL	DHR		April 2014	First meeting of task and finish group taken place. Use of Linked-In and staff good news stories to describe benefits of working at UHL	4
3.10	Programme of induction and adaptation in development with Nursing education leads, timetabled to ensure capacity to support recruitment programme.	DHR		April 2014	Programme in development which covers induction, interim development and long term development. Includes dedicated older person's training course	4
4	**Ineffective organisational transformation**					

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
4.1	Review outputs from Chief Officers Group and strategic Planning Group to ensure gaps in current processes are being addressed	DS		Review Feb 2014	On track	4
5	**Ineffective strategic planning and response to external influences**					
7	**Failure to maintain productive and effective relationships**					
7.3	Invite PWC (Trust's Auditors) to offer opinion on the plan / talk to a selection of stakeholders.	DMC		January 2014	On track	4
8	**Failure to achieve and sustain quality standards**					
8.2	Women's CMG to work with Dr Foster and other trusts to better understand risk adjustment model related to the national quality dashboard.	MD		January 2014	On track	4
8.5	Active recruitment to ward nursing establishment so releasing ward sister for supervisory practice.	CN		September 2014	On going recruitment process in place and is likely to take 12 -18months. Deadline extended to reflect this.	4
8.10	Implementation of Electronic Patient Record (EPR)	CIO		2015	Currently developing the procurement strategy for the EPR solution	4
8.11	UHL to be involved in the DH review in to the use of the Safety Thermometer tool	CN		Review Dec 2013	Timescale DH dependent	4
8.12	Review of all deaths identified in low risk groups. Working with DFI to ensure data has been recorded accurately.	MD		Dec 2013	On track	4
9	**Failure to achieve and sustain high standards of operational performance**					
9.2	Re-configuration of surgical beds to create a 'protected area' for surgical patients or by use of independent sector.	COO	HO/CMGM Planned	~~November 2013~~ January 2014	Discussions with independent sector regarding sending elective surgical work to them. Paper written and presented to QAC and F&P. RAG rating changed to reflect delays to original completion date. Review progress in January 2014	3

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
9.8	Further development of backlog plans. RTT revised recovery plans to be submitted to commissioners 28/11/13. (Action reworded November 2013)	COO		~~August~~ ~~September~~ End of ~~October~~ November 2013	**Complete.** Formal recovery plan submitted to Commissioners	5
9.10	Outputs from IST initial capacity and demand review to inform recovery plan development	COO		~~November 2013~~	**Complete**	5
10	**Inadequate reconfiguration of buildings and services**					
10.1	Prioritisation of key areas within the clinical strategy for delivery *(Action reworded Nov 2013)*	MD		December 2013	On track.	4
10.2	Ensure success of FT Application (see risk 6 for further detail).	CEO		April 2015	Timetable subject to change due to changes in national approach. **NB: This action has now been deleted from the BAF as it was originally identified as the mechanism of securing funding for the reconfiguration. Capital funding will now be secured in line with action 10.3**	3
10.3	Secure capital funding to implement Estates Strategy.	DFBS		~~May 2013~~ ~~December 2013~~ March 2014	Work underway on capital planning around reconfiguration – SOC due for completion in March 2014 which will be the key vehicle to agree availability of capital funding.	3
10.5	Iterative development of strategic plans with specialities. Monitored by CMG and Executive Boards	MD		March 2014	On track	4
10.6	Reconfiguration programme to develop a strategic outline case which will inform the future estate strategy	DS		January 2014	On track	4
11	**Loss of business continuity**					

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
11.2	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 arrangements against the potential disruption of testing to operations.	COO	CIO	~~September~~ Further review December 2013	Testing programme hasn't been developed but it is part of the work that IBM are doing to achieve ISO 22000. Currently awaiting update from CIO. Further review in December 2013	3
11.8	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.	COO	EPO	~~July~~ ~~August~~ Review ~~October~~ ~~November 2013~~ December 2013	Work with IM&T has been completed. Delays are being encountered in developing agreed processes with Interserve. Briefed by NHS Horizons in terms of large capital projects. No progress with Interserve in terms of planned maintenance works. Meeting scheduled for 9.12.13	3
11.10	Training and Exercising events to involve multiple CMGs/specialties to validate plans to ensure consistency and coordination.	COO	EPO	August 2014	BCM training and exercising programme has been developed.	4
11.11	Further work required to develop escalation plans and response plans for Interserve.	COO	EPO	~~October~~ December 2013	EPO has not received any progress updates from Interserve. Draft escalation plan received and to be reviewed on 9.12.13	3
11.12	Develop a plan and a better understanding of how a loss of critical suppliers will affect the Trust	COO	EPO	~~October~~ ~~November 2013~~ December 2013	Draft plan due w/c 4th November. Final draft received some minor details to include, training and testing programme to be developed. Completion date changed to December 2013	3

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
11.13	Training and Exercising events to involve multiple CMGs/ specialties to validate plans to ensure consistency and coordination	COO	EPO	August 2014	On track	4
12	**Failure to exploit the potential of IM&T**					
12.8	TDA approvals documentation to be completed	CIO		~~October 2013~~ Review Jan 2014	How we procure the EPR solution has a material effect on how or if we proceed with TDA approval. This will be decided in the next two months	2
13	**Failure to enhance education and training culture**					
13.1	To improve CMG engagement facilitate meetings to discuss Medical Education Strategy and Action Plans with CMGs.	MD	AMD	December 2013/January 2014	Delayed response to meeting requests from CMGs.	3
13.2	Relevance of the UHL Education Committee to be discussed at CMG Meetings in an effort to improve attendance.	MD	AMD	December 2013/January 2014	Delayed response to meeting requests from CMGs.	3
13.4	Build relationships with CBU Quality Leads and establish links with LEG/QAC and QPMG in an effort to improve engagement with other patient safety activities/groups.	MD	AMD	December 2013/January 2014	Delayed response to meeting requests from CMGs.	3
13.5	Introduce exit surveys for trainees and communicate feedback from the GMC training survey and LETB Visits via the Dashboard.	MD	AMD	December 2013	On track.	4
13.6	Attend CMG management meetings and liaise with CMGs in an effort to improve engagement of CMGs.	MD	AMD	December 2013/January 2014	Delayed response to meeting requests from CMGs.	3

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
13.7	Monitor UHL position against other trusts nationally to ensure progress against strategic and national benchmarks.	MD	AMD	Review ~~October 2013~~ February 2014	Following further discussions with the LETB this data is not readily available. LETB to investigate how we can acquire this data.	2
13.8	New Library/learning facilities to be developed at the LRI to help resolve inadequate educational resources.	MD	AMD	~~October 2013~~ April 2014	Odames Ward has been identified and a project group has been set up. Currently this area is being used as a decant ward for Osborne patients. We understand that we can begin work on this in April 2014. The project group will continue to meet to ensure this stays on track.	2
13.9	Dr Hooper in post for Acute Medicine to implement project and improve Acute Medicine progress.	MD	AMD	February 2014	On track.	4
13.10	Need to engage with the CMGs to help them understand the implication of SIFT and their funding streams.	MD	AMD	December 2013/January 2014	Delayed response to meeting requests from CMGs.	3

Key

CEO	Chief Executive Officer
DFBS	Director of Finance and Business Services
MD	Medical Director
AMD	Assistant Medical Director
COO	Chief Operating Officer
DHR	Director of Human Resources
DDHR	Deputy Director of Human Resources
DS	Director of Strategy
ADLOD	Asst Director of Learning and Organisational Development
DMC	Director of Marketing and Communications
CIO	Chief Information Officer
CMIO	Chief Medical Information Officer

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

EPO	Emergency Planning Officer
HPO	Head of Performance Improvement
HO	Head of Operations
CD	Clinical Director
CMGM	Clinical Management Group Manager
DDF&P	Deputy Director Finance and Procurement
FTPM	Foundation Trust Programme Manager
HTCIP	Head of Trust Cost Improvement Programme
ADI	Assistant Director of Information
FC	Financial Controller
ADP&S	Assistant Director of Procurement and Supplies
HoN	Head of Nursing
TT	Transformation Team
CN	Chief Nurse

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

Appendix Three

BAF RISK SCORE MAP – NOVEMBER 2013

Likelihood ↓	Consequence				
	1	2	3	4	5
	Insignificant	Minor	Moderate	Major	Extreme
5 Almost Certain			10. Reconfiguration of buildings and services ⇧ (12-15)	3. Recruit, retain, develop and motivate staff ⇧ (16-20) 9. Operational performance ⇧ (12-20)	1. Financial sustainability ● 2. Emergency care system ●
4 Likely			11. Business continuity ⇧ (9-12)	4. Organisational transformation ⇧ (12 –16) 8. Achieve and sustain quality standards ● 6. FT status ● 5. Strategic planning and response to external influences ⇧ (12-16)	
3 Possible			12. IM&T ●	13. Medical Education and training culture ●	7. Productive and effective relationships ●
2 Unlikely					
1 Rare					

Key

- ● - No change in score from previous month.
- ⇧ - Risk score increased from previous month
- ⇩ - Risk score decreased from previous month
- ◈ - New risk

AREAS OF SCRUTINY FOR THE UHL BOARD ASSURANCE FRAMEWORK (BAF)

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 Team) been actively involved in populating the 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 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?

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

NEW EXTREME AND HIGH RISKS OPENED DURING THE PERIOD 1/11/13 - 30/11/13

REPORT PRODUCED BY: UHL CORPORATE RISK MANAGEMENT TEAM

Key

Red	Extreme risk (risk score 25)
Orange	High risk (risk score 15 - 20)
Yellow	Moderate risk (risk score 8 - 12)
Green	Low risk (risk score below 8)

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2248	Clinical Support and Imaging	Medical Physics	Lack of IR(ME)R training records held across the Trust	14/11/2013	31/01/2014	Although the Trust Radiation Protection Policy states that "IRMER training records must be managed and maintained by individual Directorates (to be changed to Clinical Business Units in the current review) involved in the use of radiation" audits carried out routinely find that these training records are not sufficient, particularly for medical staff. Audits therefore suggest the policy is not being followed. **Causes** Current training records are poorly designed and / or incomplete / do not exist Inadequate or missing training records for IR(ME)R defined roles due to lack of compliance with the Trust policy in some areas. Staff working independently without reaching full competency No central records are kept of which staff have responsibilities under IRMER **Consequence** Lack of suitable training records may result in a failure to comply with standards set by regulatory and healthcare agencies (e.g. HSE / CQC). Failure at assessment might result in financial penalty and / or warning notices being issued. Non-compliance with national standards leading to enforcement action taken on the Trust following a routine inspection or follow up to an adverse event and consequent effects on the reputation of the Trust. Increased patient radiation doses due to lack of training. Increased staff doses due to lack of awareness of the potential doses if training is inadequate Potential damage to expensive equipment if training on how to use it is inadequate Management unable to easily identify which staff are trained to undertake a task involving radiation Breach of statutory duty Negative effect on the reputation of the Trust	Quality	There is a defined method of recording training across the Trust in the Trust Radiation Safety policy. Although this is working in some areas it is not working consistently in all areas. The issue has been raised at the Trust Radiation Protection Committee numerous times where representatives of each Division have been in attendance. This has not so far led to a an increase in compliance. Radiation Protection produced a specific plan of what is required to demonstrate compliance. Mock audit completed 2/12/13.	Major	Likely	16	Identify Trust staff with responsibilities under IRMER - due 31/12/2013 Investigate potential of using e-UHL to deliver a centralised record of IRMER training - due 31/12/2013 Introduce centralised training records for IRMER compliance - due 31/03/2014 Review training in the policy. due 01/04/2014 Ongoing monitoring of the effectiveness of the determined method of recording training will be detailed in the new policy. due 01/04/2014 CMG and service to manage and maintain records for the staff groups identified due 31/03/2014	4	MNO