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| **To:** | **Trust Board** |
| **From:** | **Medical Director** |
| **Date:** | **25 July 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: Medical Director**

**Purpose of the Report:**
This report provides the Board with an update to the BAF and oversight of all high and extreme risks within the Trust and includes:-

a) A copy of the Board Assurance Framework (BAF) as of 31 May 2013.
b) An action tracker to monitor progress of BAF actions
c) A heat map of risk movements from the previous month.
d) Suggested parameters for scrutiny of the BAF.
e) An extract from the UHL risk register showing any new high and extreme risks opened during the reporting period.
f) An extract from the UHL risk register showing all current high and extreme risks across UHL.

**The Report is provided to the Board for:**

| | | | |
|---|---|---|---|
| Decision | | Discussion | **X** |
| Assurance | **X** | Endorsement | |

**Summary :**


- The BAF is now accompanied by a new 'action tracker' developed to provide more robust management of actions.
- Board members are invited to review the following risks.
  Risk number one.
  Risk number two.
  Risk number three.
- Following a presentation to the Board by Professor Sue Carr in relation to medical education and training at UHL it was agreed that a new entry on the BAF is required to provide assurance to the Board that any associated risks are being adequately controlled. The new entry will submitted to the August 2013 Board meeting.
- Two new high risks have opened during June 2013 details of which can be found at appendix five.
- As of 30 June 2013 there are a total of 22 high risks and one extreme risk that are currently open across UHL details of which can be found at appendix six.


**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) Note any new high or extreme risk opened during the reporting period.

| **Strategic Risk Register**<br>Yes | **Performance KPIs year to date**<br>N/A |
|---|---|
| **Resource Implications (eg Financial, HR)**<br>N/A | |
| **Assurance Implications:**<br>Yes | |
| **Patient and Public Involvement (PPI) Implications:**<br>Yes | |
| **Equality Impact**<br>N/A | |
| **Information exempt from Disclosure:**<br>No | |
| **Requirement for further review?**<br>Yes. Monthly review by the Board | |

**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST**

**REPORT TO:** **TRUST BOARD**

**DATE:** **25 JULY 2013**

**REPORT BY:** **MEDICAL DIRECTOR**

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

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## 1. INTRODUCTION

1.1 This report provides the Board with:-

a) A copy of the Board Assurance Framework (BAF) as of 30 June 2013.
b) An action tracker to monitor progress of BAF actions.
c) A heat map of BAF risk score movements from the previous month.
d) Parameters for scrutiny of the BAF.
e) New high / extreme risks opened during June 2013 (appendix 5).
f) An excerpt for the UHL risk register showing all currently open high / extreme risks.

## 2. BAF POSITION AS OF 30 JUNE 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.

2.3 During this reporting period there have been no changes to BAF risk scores as evidenced in appendix three.

2.4 To provide an opportunity for more detailed review three BAF risks will be presented on a monthly basis for Board members to review against the areas listed in appendix four. Following discussion at the UHL Executive Team it was agreed that from now on these risks will be presented in numerical sequence and the risks below are presented for review:
Risk one – Failure to achieve financial sustainability (risk score 25);
Risk two - Failure to transform the emergency care system (risk score 25);
Risk three - Inability to recruit, retain, develop and motivate staff (risk score 16).

2.5 Following a presentation to the Board by Professor Sue Carr in relation to medical education and training at UHL it was agreed that a new entry on the BAF is required to provide assurance to the Board that any associated risks are being adequately controlled. To this end discussions are being held with the Clinical Education team to provide the content for a new entry that will be included in the August 2013 BAF report to the Board.

## 3 HIGH AND EXTREME RISKS.

3.1 As described in the UHL Risk Management Policy the Board will receive notification of any high / extreme risks that have opened during the reporting period and, in addition, a quarterly excerpt from the UHL risk register to show all currently open high/ extreme risks. The Board are therefore asked to note:

a. Two new high risks have opened during June 2013 details of which can be found at appendix five.

b. There are a total of 22 high risks and one extreme risk that are currently open across UHL details of which can be found at appendix six.

## 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);

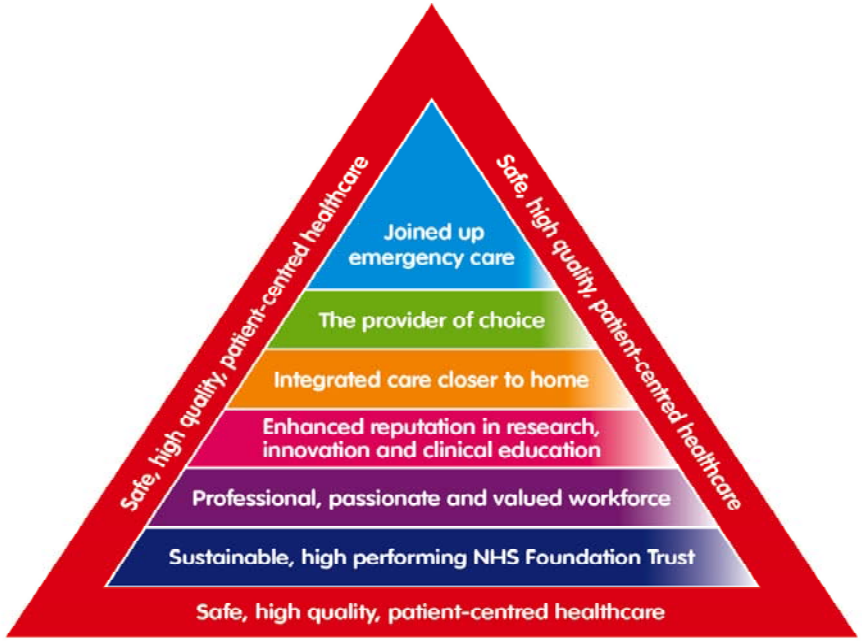
(c) identify any areas which it feels that the Trust's controls are inadequate and do not, therefore, effectively manage the principal risks to the organisation achieving its objectives;

(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) Note any new high or extreme risk opened during the reporting period.

Peter Cleaver,
Risk and Assurance Manager,
18 July 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

**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK JUNE 2013**

# PERIOD: JUNE 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<br>e - To enjoy an enhanced reputation in research, innovation and clinical education. | 16 | 12 |
| Risk 4 – Ineffective organisational transformation | a - To provide safe, high quality patient-centred health care<br>c - To be the provider of choice<br>d - To enable integrated care closer to home | 12 | 12 |
| Risk 5 – Ineffective strategic planning and response to external influences | a - To provide safe, high quality patient-centred health care<br>c - To be the provider of choice<br>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<br>d - To enable integrated care closer to home<br>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<br>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 | 12 | 12 |
| Risk 10 – Inadequate reconfiguration of buildings and services | a - To provide safe, high quality patient-centred health care | 12 | 9 |
| Risk 11– Loss of business continuity | g - To be a sustainable, high performing NHS Foundation Trust | 9 | 6 |
| Risk 12 – Failure to exploit the potential of IM&T | a - To provide safe, high quality patient-centred health care<br>d - To enable integrated care closer to home | 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 – BOARD ASSURANCE FRAMEWORK JUNE 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**<br><br>(What could prevent the objective(s) being achieved) | **What are we doing about it?**<br><br>**(Key Controls)**<br><br>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?**<br><br>**(Key Assurances of controls)**<br><br>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?**<br><br>**(Gaps in Controls C) / Assurance (A)**<br><br>What gaps in systems, controls and assurance have been identified? | **How can we fill the gaps or manage the risk better?**<br><br>**(Actions to address gaps)** | **Target Score I x L** | **Timescale**<br><br>When will the action be completed? |
|---|---|---|---|---|---|---|---|
| Failure to achieve financial sustainability including: | Overarching financial governance processes including PLICS process and expenditure controls.<br><br>Revised variance analysis and reporting metrics especially for the ETPB<br><br>Self-assessment and SLM baseline exercise completed and project manager identified | 5X5=25 | Monthly /weekly financial reporting to Exec Team Performance Board, F&P Committee and Board.<br><br>Cost centre reporting and monthly PLICS reporting.<br><br>Monthly confirm and challenge processes at CBU and Divisional level.<br><br>Annual internal and external audit programmes. | (c).Variability in controls over non-contractual pay<br><br>(c) SLM programme not fully implemented | Review of non-contractual pay controls (1.3)<br><br>SLM Action plan is awaited. (1.9) | 4x3=12 | Review Jun 2013 DHR<br><br>Jul 2013 DFBS |
| Failure to achieve CIP. | Strengthened CIP governance structure. | | Progress in delivery of CIPs is monitored by CIP Programme Board (meeting fortnightly) and reported to ET and Board. | Under-delivery of CIP programme (C) | Refreshed CIP programme management arrangements (1.5) | | Review Aug 2013 DFBS |
| Locum expenditure. | Workforce plan to identify effective methods to recruit to 'difficult to fill' areas<br><br>Reinstatement of weekly workforce panel to approve all new posts.<br><br>STAFFflow for medical locums saving £130k of every £1m expenditure | | The use of locum staff in 'difficult to fill' areas is reported to the Board on a monthly basis via the Quality and Performance report. A reduction in the use of such staff would be an assurance of our success in recruiting substantive staff to 'difficult to fill' areas. Increase in substantive staff of 200wte to Oct 12.<br><br>Saving in excess of £0.6m 5 weeks after 'go live' date | (c) Failure to reduce locum spend. 587 wte locum staff currently used. | Financial Recovery plans being developed by Acute and Planned Care divisions – to be agreed at ET Performance Board. (1.10) | | Jul 2013 DFBS |

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|---|---|---|---|---|---|---|---|
| Loss of income due to tariff/tariff changes (including referral rate for emergency admissions – MRET) | Contract meetings with Commissioners Negotiations with Commissioners concluded at a transactional level. | | Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board. | (c) Failing to manage marginal activity efficiently and effectively. | Ongoing discussions with commissioners about planned re-investment of the MRET deductions. (1.11) | | Review Aug 2013 |
| Ineffective processes for Counting and Coding. | Clinical coding project. | | Ad-Hoc reports on annual counting and coding process.<br><br>PbR clinical coding audit Jan 2013 (final report received 29 May 2013).<br><br>IG toolkit audit (sample of 200 General Surgery episodes). | (c) Error rates in audit sample could be indicative of underlying process issues<br><br>(c) Error rates identified as:<br>Primary diagnoses incorrect 8.0%<br>› Secondary diagnoses incorrect 3.6%.<br>› Primary procedure incorrect 6.4%<br>› Secondary procedure incorrect 4.5%. | Re-establishing clinical coding improvement team under John Roberts. Initial action plan in place (1.6) | | Review Jun 2013<br>COO |
| Loss of liquidity. | Liquidity Plan. | | Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board.<br><br>Cash management plans presented at June 2013 F&P committee | | | | |
| Lack of robust control over pay and non-pay expenditure. | Pay and Non-pay recovery action plan in place<br><br>Catalogue control project. | | Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board.<br><br>Non-pay management plan presented at June F&P committee<br><br>Ongoing Monitoring via F&P Committee. | (c) Failing to control adverse trends in pay and non-pay | Monthly monitoring of action plan to ensure recovery. (1.12) | | Review Jul 2013<br>DFBS |
| Commissioner fines against performance targets. | Contract meetings with Commissioners Negotiations with Commissioners concluded at a transactional level.<br><br>Divisions have developed plans and trajectories to reduce admission rates that are monitored at monthly C&C meetings. | | Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board. | (c) Failing to reduce readmission trends. | Ongoing discussions with commissioners about planned re-investment of contract deductions and performance fines. (1.13) | | Jul 2013<br>DFBS |
| Use of readmission monies. | Contract meetings with Commissioners Negotiations with Commissioners concluded at a transactional level | | Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board. | (c) Failing to reduce readmission trends. | Ownership of readmissions work stream at divisions to be clarified. (1.14) | | July 2013<br>DFBS |
| Ineffective organisational transformation. | See risk 7 | | See risk 7. | See risk 7. | See risk 7. | | |

# UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK JUNE 2013

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| **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**<br><br>(What could prevent the objective(s) being achieved) | **What are we doing about it?**<br><br>**(Key Controls)**<br><br>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?**<br><br>**(Key Assurances of controls)**<br><br>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?**<br><br>**(Gaps in Controls C) / Assurance (A)**<br><br>What gaps in systems, controls and assurance have been identified? | **How can we fill the gaps or manage the risk better?**<br><br>**(Actions to address gaps)** | Target Score I x L | **Timescale**<br><br>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.<br><br>Development of action plan to address key issues | | Action Plan will be 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 | | |
| | Key themes from plan:<br>Single front door | | Project plan developed by CCG project manager | Still significant gaps in staffing<br><br>Protocols need to be agreed between UCC and UHL. | Risks to be escalated via ECAT and raised with CCG Managing Director as required (2.10) | | Aug 2013<br>COO |
| | ED assessment process is being operated. | | Forms part of Quality Metrics for ED reported daily update and part of monthly board performance report | (a) Data entry issues mean that times can appear longer than in reality | CD for ED and GM will validate all data entry (2.6) | | Jul 2013<br>COO |
| | 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<br><br>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.<br><br>(c) Staffing vacancies for medical and nursing staff remain high. | Continue with substantive appts until funded establishment is achieved (2.7) | | Review of action Sep 2013<br>COO |

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|---|---|---|---|---|---|---|---|
| | 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 Quality and Performance 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 Quality and Performance Report. | No gaps | No actions | | |
| | EDDs to be available on all patients within 24 hours of admission | | Monitored and reported to Operational Board twice monthly and will be included in Emergency Care Update report in Quality and Performance Report. | (c) Provision of EDDs for all patients not yet achieved | Roll out of actions from ECAT action plan (2.8) | | Jun / Jul 2013 CO O |
| | 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 Quality and Performance 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) | | Aug 2013 CO O |

# UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK JUNE 2013

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|---|---|
| **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**<br>**f. - To maintain a professional, passionate and valued workforce** |
| EXECUTIVE LEAD: | Director of Human Resources |

| **Principal Risk**<br><br>(What could prevent the objective(s) being achieved) | **What are we doing about it?**<br><br>**(Key Controls)**<br><br>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?**<br><br>**(Key Assurances of controls)**<br><br>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?**<br><br>**(Gaps in Controls C) / Assurance (A)**<br><br>What gaps in systems, controls and assurance have been identified? | **How can we fill the gaps or manage the risk better?**<br><br>**(Actions to address gaps)** | **Target Score I x L** | **Timescale**<br><br>When will the action be completed? |
|---|---|---|---|---|---|---|---|
| Inability to recruit, retain, develop and motivate suitably qualified staff leading to inadequate organisational capacity and development. | Leadership and talent management programmes to identify and develop 'leaders' within UHL. | 4x4=16 | Development of UHL talent profiles. | No gaps identified. | No actions required. | 4x3=12 | |
| | | | Talent profile update reports to 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.<br><br>No gaps identified. | No actions required.<br><br>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 targets for staff sickness rates are 3.4% (rolling 12 months) and 3.9% for April 13 | No gaps identified | No actions required. | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Appraisal and objective setting in line with UHL strategic direction. | | Appraisal rates reported monthly to Board via Quality and Performance report.<br>April 13 appraisal rate = 90.9% | No gaps identified. | No actions required. | | |
| | | | 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. | | |
| | | | Quality Assurance Framework to monitor appraisals on an annual cycle (next due March 2013). | No gaps identified. | No actions required. | | |
| | Workforce plan to identify effective methods to recruit to 'difficult to fill areas).<br><br>Divisions and Directorates 2013/14 Workforce Plans. | | The use of locum staff in 'difficult to fill' areas is reported to the Board on a monthly basis via the Quality and Performance report. Reduction in the use of such staff would be an assurance of our success in recruiting substantive staff. | No gaps identified. | No actions required. | | |
| | 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 that reward and recognition programmes are making a difference to staffing recruitment/ retention/ motivation. | Revise reward and recognition strategy. (3.1) | | Oct 2013<br>DHR |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | UHL Branding – to attract a wider and more capable workforce. Includes development of recruitment literature and website, recruitment events, international recruitment. This includes a recently held nurse recruitment day (Jan 2013).<br><br>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). Report to Workforce and OD Committee in March. Positive feedback from nurse recruitment day on 26 Jan 2013. Future reporting will be to the Board via the quarterly workforce an OD report.<br><br>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.<br>(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.<br>Identify a lead from each professional group to develop and encourage the production of fresh and up to date material. (3.2) | | Dec 2013<br>DHR |

# UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK JUNE 2013

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

| **Principal Risk**<br><br>(What could prevent the objective(s) being achieved) | **What are we doing about it?**<br><br>**(Key Controls)**<br><br>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?**<br><br>**(Key Assurances of controls)**<br><br>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?**<br><br>**(Gaps in Controls C) / Assurance (A)**<br><br>What gaps in systems, controls and assurance have been identified? | **How can we fill the gaps or manage the risk better?**<br><br>**(Actions to address gaps)** | **Target Score I x L** | **Timescale**<br><br>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 | 4x3=12 | Monthly progress reports to Exec Strategy Board and F&P Committee. Approval of framework and operational arrangements due at Trust Board June 2013.<br><br>Thereafter 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 Ctte. | None identified | Not applicable | 4x3=12 | N/A |

# UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK JUNE 2013

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|---|---|
| **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.**<br>**c. - To be the provider of choice.**<br>**e. - To enjoy an enhanced reputation in research innovation and clinical education.**<br>**g. - To be a sustainable, high performing NHS Foundation Trust** |
| EXECUTIVE LEAD: | Chief Executive (via Director of Strategy) |

| **Principal Risk**<br><br>(What could prevent the objective(s) being achieved) | **What are we doing about it?**<br><br>**(Key Controls)**<br><br>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?**<br><br>**(Key assurances of controls)**<br><br>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?**<br><br>**(Gaps in Controls C) / Assurance (A)**<br><br>What gaps in systems, controls and assurance have been identified? | **How can we fill the gaps or manage the risk better?**<br><br>**(Actions to address gaps)** | **Target Score I x L** | **Timescale**<br><br>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 |
| | | | | (c)Need to establish co-ordinated approach to business intelligence gathering and response | Establish Business Strategy Support Team (5.13) | | Jul 2013<br>CEO |
| | | | | (c) Need to agree approach to gathering of marketing intelligence and response | Agree approach via proposal from DMC. (5.14) | | Jul 2013<br>CEO |
| | | | | (c) Need to forward plan Executive Strategy Board agendas to reflect a 12 month programme aligned with:<br>• the development of the IBP/LTFM<br>• the reconfiguration programme<br>• the development of the next AOP<br>• The TB Development Programme<br>The TB formal agenda | Present ESB forward plan for approval to July meeting. (5.15) | | Jul 2013<br>CEO |

# UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK JUNE 2013

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| **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: | Chief Executive |

| **Principal Risk**<br><br>(What could prevent the objective(s) being achieved) | **What are we doing about it?**<br><br>**(Key Controls)**<br><br>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?**<br><br>**(Key Assurances of controls)**<br><br>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?**<br><br>**(Gaps in Controls C) / Assurance (A)**<br><br>What gaps in systems, controls and assurance have been identified? | **How can we fill the gaps or manage the risk better?**<br><br>**(Actions to address gaps)** | Target Score I x L | **Timescale**<br><br>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 (readiness review meeting Dec 2012. | No gaps identified. | No actions required. | | |
| | FT application project plan / project team in place<br><br>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. | | Economic modelling incorporated into the Trust Reconfiguration Strategic Outline Case (SOC) structure and process.<br><br>Regular reports to Exec Strategy Board and Trust Board<br><br>Various inputs from Exec Team to BCT work. | (c)Need to identify clear BCT Exec Lead | Director of Strategy to be lead. Ad hoc cover to continue until appointment in place. (6.10) | | Oct 2013<br>CEO |
| | | | 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) | | Review Jul 2013<br>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 JUNE 2013

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

| **Principal Risk**<br><br>(What could prevent the objective(s) being achieved) | **What are we doing about it?**<br><br>**(Key Controls)**<br><br>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?**<br><br>**(Key Assurances of controls)**<br><br>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?**<br><br>**(Gaps in Controls C) / Assurance (A)**<br><br>What gaps in systems, controls and assurance have been identified? | **How can we fill the gaps or manage the risk better?**<br><br>**(Actions to address gaps)** | **Target Score I x L** | **Timescale**<br><br>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.<br><br>Regular meetings with external stakeholders and Director of Communications and member of Executive Team to identify and resolve concerns.<br><br>Regular stakeholder briefing provided by an e-newsletter to inform stakeholders of UHL news.<br><br>Leicester, Leicestershire and Rutland (LLR) health and social care partners have committed to a collaborative programme of change known as the 'Better Care Together' programme. | 5X3=15 | Twice yearly GP surveys with results reported to UHL Executive Team.<br><br>Latest survey results discussed at the April 2013 Board and showed increasing levels of satisfaction… a trend which has now continued for 18 months.<br><br>Anecdotal feedback from partners and soft intelligence indicates that relations with key organisations and individuals are improving under new UHL leadership. | (a) No surveys currently undertaken to identify relationship issues with wider group of stakeholders e.g. CCGs / LAT / Social Care / Universities etc. | Extend the surveys into wider group of stakeholders to complement the 'soft intel' (7.2) | 5X2=10 | Sep 2013 DMC |

# UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK JUNE 2013

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| **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**<br><br>(What could prevent the objective(s) being achieved) | **What are we doing about it?**<br><br>**(Key Controls)**<br><br>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?**<br><br>**(Key Assurances of controls)**<br><br>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?**<br><br>**(Gaps in Controls C) / Assurance (A)**<br><br>What gaps in systems, controls and assurance have been identified? | **How can we fill the gaps or manage the risk better?**<br><br>**(Actions to address gaps)** | **Target Score I x L** | **Timescale**<br><br>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 NET promoter score. | Standardised M&M meetings in each speciality | 4x4=16 | Monitoring and CBU and Divisional Boards | (a) Routine analysis of out of hours/weekend mortality | Better use of routine data analysis tools including DFI and HED (8.1) | 4x3=12 | Sep 2013 MD |
| | Systematic speciality review of "alerts" of deterioration to address cause and agree remedial action. Corporate oversight via QPMG, QAC and by exception to ET and TB | | Quality and Performance Report and National Quality dashboard presented to Exec and TB. Currently SMHI "within expected" | (a) UHL risk adjusted perinatal mortality rate below regional and national average. | Women's CBU to work with Dr Foster and other trusts to better understand risk adjustment model (8.2) | | Jan 2014 MD |
| | Robust implementation of actions to achieve Quality Commitment (save 1000 extra lives in 3 years) | | SHMI remains "within expected" | (a) community wide review of mortality to consider out of hospital mortality – methodology now agreed | Undertake LLR Mortality review. (8.3)<br><br>Analysis of mortality review by Public Health (8.9) | | Jun/Jul 20 13 MD<br><br>Sep 2013 MD |
| | Agreed patient centred care priorities for 2013-14:<br>- Older people's care<br>- Dementia care<br>- Discharge Planning | | Quality Action Group meets monthly – provides direction, pace and support and includes divisional representation<br><br>Achievement against key objectives and milestones report to Trust board on a monthly basis | 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 | | Divisional/CBU 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 ACN |
| | 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 | | |

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|---|---|---|---|---|---|---|---|
| | Targeted development activities for key performance indicators<br>- answering call bells<br>- assistance to toilet<br>- involved in care<br>- discharge information | | Monthly monitoring and tracking of patient feedback results<br><br>Monthly monitoring of Friends and Family Test reported to the Trust board | (c) Present vacancy level for permanent staff limit development opportunities | Prioritise clinical staff development opportunities in CBU's/Division (8.6) | | Jul 2013<br>ACN |
| | Appointment of carers advocacy post to lead carers involvement in care | | Funding agreed for 12 months | No gaps identified | No action needed | | |
| | Ensure completion of patient profile on every appropriate patient admitted | | Audit results every 6 month | No gaps identified | No action needed | | |
| | Agreed avoiding harm priorities:<br>➢ Falls<br>➢ Acting on results in ED<br>➢ Senior review, ward rounds, and notation. | | Quality Action Group meets monthly – provides direction, pace and support and includes divisional representation<br><br>Achievement against key objectives and milestones report to Trust board on a monthly basis | No gaps identified | No action needed | | |
| | Relentless attention to 5 Critical Safety Actions (CSA) initiative to lower mortality | | Q&P report to Trust Board showing outcomes for 5 CSAs.<br><br>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 | (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<br>CIO |
| | NHS Safety thermometer utilised to measure the prevalence of harm and how many patients remain 'harm free' (Monthly point prevalence for '4 Harms').<br><br>Monthly meetings with operational/clinical and managerial leads for each harm in place.<br><br>Utilisation of CQUIN monies for 2013/14 to invest in data collection posts at ward level. | | Monthly outcome report of '4 Harms' is reported to Trust board via Q&P report<br>New DoH definitions may see an increase in harm attributed to UHL to encourage closer working between primary and secondary care. | a) There is a risk that some data may not be accurate due to complex DoH definitions of each harm in relation to whether it is community or hospital acquired. | Action to be identified. | | |

# UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK JUNE 2013

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| **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**<br>**c. - To be the provider of choice.**<br>**g. - To be a sustainable, high performing NHS Foundation Trust.** |
| EXECUTIVE LEAD: | Chief Operating Officer |

| **Principal Risk**<br><br>(What could prevent the objective(s) being achieved) | **What are we doing about it?**<br><br>**(Key Controls)**<br><br>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?**<br><br>**(Key Assurances of controls)**<br><br>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?**<br><br>**(Gaps in Controls C) / Assurance (A)**<br><br>What gaps in systems, controls and assurance have been identified? | **How can we fill the gaps or manage the risk better?**<br><br>**(Actions to address gaps)** | **Target Score I x L** | **Timescale**<br><br>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<br><br>Weekly monitoring of backlog numbers via Head of Performance Improvement. | (c) Capacity issues created by emergency demand causes cancellations of operations. | On-going work on ward processes in Acute to free up capacity. (9.1)<br><br>Re-configuration of surgical beds to create a 'protected area' for surgical patients. (9.2) | 4x3=12 | Jul 2013 COO<br><br>Nov 2013COO |
| | 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. (9.3) | | Review Jul 13 COO |
| | Transformational theatre project to improve theatre efficiency to 80 -90%. | | Monthly theatre utilisation rates.<br><br>Theatre Transformation monthly meeting.<br><br>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 4. | See risk number 4. | | |

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|---|---|---|---|---|---|---|---|
| | Each tumour site has developed action plans to achieve targets. (Expected that target of 85% to be delivered by April 2013) | | Chief Operating Officer receives reports from Cancer Manager and information included within Monthly Q&P report to Trust Board.<br><br>Monthly trajectory agreed and monitored at Board via exception report.<br><br>Cancer 62 action plan agreed with CCG and reported and monitored at Executive Performance board. | (c) Gaps identified in Imaging<br><br>(c) 62 day cancer target delivery below target | Action plan to resolve Imaging issues to be developed (9.7)<br><br>Cancer Clinical lead, Cancer Centre Managers and Trackers to be recruited. (9.5) | | Jul 2013 COO<br><br>Aug 2013 COO |
| | Ongoing monitoring of key performance indicators. | | Monthly Q&P report to Trust Board. | No gaps identified. | No actions required. | | |
| | Outpatient delivery plan to reduce cancellation rates has been developed and circulated to Divisions for inclusion in their CIP plans. | | | (c) Not reducing cancellation rates for outpatients appointments. | Continued monitoring of outpatient delivery plan. (9.6) | | Review Jun 2013 COO |

# UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK JUNE 2013

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| **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 Finance and Business Services |

| **Principal Risk**<br><br>(What could prevent the objective(s) being achieved) | **What are we doing about it?**<br><br>**(Key Controls)**<br><br>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?**<br><br>**(Key Assurances of controls)**<br><br>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?**<br><br>**(Gaps in Controls C) / Assurance (A)**<br><br>What gaps in systems, controls and assurance have been identified? | **How can we fill the gaps or manage the risk better?**<br><br>**(Actions to address gaps)** | **Target Score I x L** | **Timescale**<br><br>When will the action be completed? |
|---|---|---|---|---|---|---|---|
| Inadequate reconfiguration of buildings and services leading to less effective use of estate and services. | Clinical Strategy. | 3x4=12 | | (a) Key measures to demonstrate success of strategy and reporting lines not yet identified. | Key measures for gauging success of strategy to be developed by specialties as part of their 'mini-IBPs' and will be monitored via divisional and directorate boards. (10.1) | 3X3=9 | Dec 2013<br>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. | | 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.<br><br>(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). (10.2)<br><br>Secure capital funding. (10.3) | | Apr 2015<br>CEO<br><br>Dec 2013<br>DFBS |
| | Divisional service development strategies and plans to deliver key developments. | | Progress of divisional development plans reported to Service Reconfiguration Board. | No gaps identified. | No actions required. | | |
| | Service Reconfiguration Board. | | 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 Finance and Performance Committee. | No gaps identified. | No actions required. | | |
| | Managed Business Partner for IM&T services to deliver IT that will be a key enabler for our clinical strategy. 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 JUNE 2013

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| **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 (Via Chief Operating Officer) |

| **Principal Risk**<br><br>(What could prevent the objective(s) being achieved) | **What are we doing about it?**<br><br>**(Key Controls)**<br><br>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?**<br><br>**(Key Assurances of controls)**<br><br>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?**<br><br>**(Gaps in Controls C) / Assurance (A)**<br><br>What gaps in systems, controls and assurance have been identified? | **How can we fill the gaps or manage the risk better?**<br><br>**(Actions to address gaps)** | **Target Score I x L** | **Timescale**<br><br>When will the action be completed? |
|---|---|---|---|---|---|---|---|
| Inability to react /recover from events that threaten business continuity leading to sustained downtime and inability to provide full range of services. | Major incident/business continuity/ disaster recovery and Pandemic plans developed and tested for UHL/ wider health community. This includes UHL staff training in major incident planning/ coordination and multi agency involvement across Leicestershire to effectively manage and recover from any event threatening business continuity. | 3x3=9 | Annual Emergency planning Report identifying good practice presented to the Governance and Risk Management Committee July 2012.<br><br>Training Needs Analysis developed to identify training requirements for staff supported by appropriate training packages for Senior Managers on Call<br><br>External auditing and assurances to SHA, Business Continuity Self-Assessment, June 2010, completed by Richard Jarvis<br><br>Completion of the National Capabilities Survey, November 2013 completed by Aaron Vogel. Results will be included in the annual report on Emergency Planning and Business Continuity to the QAC.<br><br>Audit by Price Waterhouse Coopers LLP Jan 2013. Results being compiled and will be reported to Trust Board (date to be agreed).<br><br>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.<br><br>(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.<br><br>(c) Validating and assessing the results from critical suppliers. | Tailored training packages for service area based staff. (11.1)<br><br>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)<br><br>Assess our requirements of the critical suppliers and ensure that their response fulfils our requirements. (11.3) | 2x3=6 | Jul 2013<br>COO<br><br>Sep 2013<br>CIO<br><br>Sep 2013<br>COO |

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| | Emergency Planning Officer appointed to oversee the development of business continuity within the Trust. | | Outcomes from Price Waterhouse Coopers LLP audit identified that there is a programme management system in place through the Emergency Planning Officer to oversee.<br><br>A year plan for Emergency Planning has been developed.<br><br>Production/updates of documents/plans relating to Emergency Planning and Business Continuity aligned with national guidance have begun. Including Business Impact Assessments for all CBUs | (c) Local plans for loss of critical services not completed due to change over of facilities provider | Continue to engage with Interserve and service areas around development of Business Continuity Plans (11.6) | | Sep 2013<br>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 Chief Operating Officer. | No gaps identified. | No actions required. | | |
| | | | New Policy on InSite<br><br>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.<br><br>3 incidents within the Trust have been investigated and debrief reports written, which include recommendations and actions to consider. | (c) Do not effectively communicate issues/lessons learnt that have been identified in service area disruptions and follow up actions. | Issues/lesson will feed into the development of local plans and training and exercising events. (11.7) | | Sep 2013<br>COO |
| | | | | (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) | | Jul 2013<br>COO |

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| | | | | (a) Lack of coordination of plans between different service areas and across the CBUs. | Emergency Planning Officer and Divisional BCM leads will ensure that plans developed are coordinated between service areas/CBUs/Divisions (11.9)<br><br>Training and Exercising events to involve multiple CBUs/Divisions to validate plans to ensure consistency and coordination. (11.10) | | Sep 2013 COO<br><br>Aug 2014 COO |

# UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK JUNE 2013

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| **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.**<br>**d. - To enable integrated care closer to home** |
| EXECUTIVE LEAD: | Director of Finance and Business services |

| **Principal Risk**<br><br>(What could prevent the objective(s) being achieved) | **What are we doing about it?**<br><br>**(Key Controls)**<br><br>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?**<br><br>**(Key Assurances of controls)**<br><br>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?**<br><br>**(Gaps in Controls C) / Assurance (A)**<br><br>What gaps in systems, controls and assurance have been identified? | **How can we fill the gaps or manage the risk better?**<br><br>**(Actions to address gaps)** | **Target Score I x L** | **Timescale**<br><br>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.<br><br>IM&T now incorporated into Improvement and Innovation Framework | 3x3=9 | IM&T Board in place.<br>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 | | CMIO(s) now in place, and active members of the IM&T meetings<br><br>The joint governance board monitors the level of communications with the organisation | (a) No formal feedback within the present communications plan | An improved communications plan to be presented to the JGB for approval. (12.3) | | July 2013, CI O |
| | 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 | | |

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| 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 | | Minutes of the joint governance board, the transformation board and the service delivery board | (c) the delivery programme is dependent on TDA approvals for some elements | Initial engagement with key members of the TDA to ensure there is sufficient understanding of technology roadmap and their involvement (12.7) | | Aug 2013 CIO |
| | The development of a strategy to ensure we have a consistent approach to delivering benefits | | Benefits are part of all the projects that are signed off by the relevant groups | (c) ensure that all divisions/CBUs have the approach to IM&T benefits as part of delivery projects | Increased engagement and communications with the relevant departments to ensure that we capture requirements and communicate benefits (12.5) | | Aug 2013 CMIO or CIO depending on the type |
| | | | | (a) production of a standard report on the delivery of benefits | Refine the proposal around benefits reporting to ensure we have a standard reporting methodology and that it is in line with trust expectations (12.6) | | Sept 2013 CIO |

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

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

| REF | ACTION | SENIOR LEAD | OPS LEAD | COMPLETION DATE | PROGRESS UPDATE | STATUS |
|---|---|---|---|---|---|---|
| **1** | **Failure to achieve financial sustainability** | | | | | |
| 1.2 | Revised variance analysis and reporting metrics especially for the ETPB (1.2) | DFBS | DDF&P | June 2013 | Complete. Draft revised reporting submitted to the June ETPM | 5 |
| 1.3 | Review of non-contractual pay controls | DHR | | Review June 2013 | Change of action owner (previously DFBS). Review of progress to be provided next month. | 4 |
| 1.4 | Self-assessment exercise of embedding of SLM | DFBS | FTPM | June 2013 | Complete. Self assessment questionnaire completed and reported to the ETSB in early June looking at all 4 themes. A complementary self assessment undertaken on the information indicator, predominately on the use of PLICS and SLR. The 4 themes to be each led by an Exec Director – DHR, DM&C, COO and DFBS | 5 |
| 1.5 | Refreshed CIP programme management arrangements | DFBS | HTCIP | Commenced May 2013 Review August 2013 | Recently appointed (early May) interim Head of Trust Cost Improvement Programme to lead overall programme | 4 |
| 1.6 | Re-establishing clinical coding improvement team under John Roberts. Initial action plan in place | COO | ADI | Review June 2013 | Change of action owner (previously DFBS). June update: New coding positions went before the panel in June, | 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 |
|---|---|---|---|---|---|---|
| | | | | | further work required on JDs to be submitted again in July. Actions being taken to expedite this. This will cause delay in recruitment to revised structure. | |
| 1.7 | Cash management plan to be presented at F&P committee | DFBS | FC | June 2013 | Complete. Cash Management plan presented to the F&P Committee on 26 June 2013 as part of the monthly Finance report | 5 |
| 1.8 | Non-pay management plan to be presented at F&P committee | DFBS | ADP&S | June 2013 | Complete. Non Pay Framework presented to the F&P Committee on 26 June 2013 | 5 |
| 1.9 | SLM Action plan is awaited. | DFBS | | July 2013 | | 4 |
| 1.10 | Financial Recovery plans being developed by Acute and Planned Care divisions – to be agreed at ET Performance Board. | DFBS | DM Acute Care and Planned Care | July 2013 | | 4 |
| 1.11 | Ongoing discussions with commissioners about planned re-investment of the MRET deductions. | DFBS | | Review August 2013 | | 4 |
| 1.12 | Monthly monitoring of action plan to ensure financial recovery | DFBS | | Review July 2013 | | 4 |
| 1.13 | Ongoing discussions with commissioners about planned re-investment of contract deductions and performance fines. | DFBS | | July 2013 | | 4 |
| 1.14 | Ownership of readmissions work stream at divisions to be clarified. | DFBS | CD/DM | July 2013 | | 4 |
| **2** | **Failure to transform the emergency care system** | | | | | |



| 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 |
|---|---|---|---|---|---|---|
| 2.6 | CD for ED and GM will validate all data entry for quality metrics. | COO | CD and DM for ED | July 2013 | Data entry has improved but still not 100% | 3 |
| 2.7 | Continue with substantive appts until funded establishment within ED is achieved | COO | | Review Sep 2013 | On track | 4 |
| 2.8 | Roll out of actions from ECAT action plan | COO | | July 2013 | On track | 4 |
| 2.9 | CCG/LPT to increase capacity by use of Intermediate Care Services | COO | | August 2013 | DTOCs reduced but not at level required yet | 3 |
| 2.10 | Risks from 'single front door' theme to be escalated via ECAT and raised with CCG Managing Director as required | COO | | August 2013 | On track | 4 |
| **3** | **Inability to recruit, retain, develop and motivate staff** | | | | | |
| 3.1 | Revise UHL reward and recognition strategy. | DHR | | October 2013 | On track | 4 |
| 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.<br>Identify a lead from each professional group to develop and encourage the production of fresh and up to date material. | DHR | | December 2013 | On track | 4 |
| **4** | **Ineffective organisational transformation** | | | | | |
| **5** | **Ineffective strategic planning and response to external influences** | | | | | |
| 5.13 | Establish Business Strategy Support Team | CEO | MW | July 2013 | Approved by ET and Trust Board. Moving to implementation | 4 |
| 5.14 | Agree approach to gathering market intelligence and response via proposal from DMC. | CEO | MW | July 2013 | Approved by ET and to be implemented by BSST. | 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 |
|---|---|---|---|---|---|---|
| 5.15 | Present ESB forward plan to reflect 12 month programme for approval to July meeting. | CEO | | July 2013 | On track | 4 |
| **6** | **Failure to achieve FT status** | | | | | |
| 6.9 | Introduce regular report in relation to BCT to ESB and Trust Board | CEO | | June 2013 | Complete. On agenda for June ESB meeting (now standing item) | 5 |
| 6.10 | Director of Strategy to be Exec lead for BCT. Ad hoc cover to continue until appointment in place. | CEO | | October 2013 | Recruitment of DS in progress. Interim arrangements in place. | 4 |
| 6.11 | Action plans to be developed to address recommendations from independent reviews. | CEO | DCLA | Review July 2013 | DCLA requested to develop new Trust policy to better address this requirement. | 4 |
| **7** | **Failure to maintain productive and effective relationships** | | | | | |
| 7.2 | Extend the surveys into wider group of stakeholders to complement the 'soft intel' | DMC | | September 2013 | On target for plan caution over resource implications, maintain current RAG rating | 3 |
| **8** | **Failure to achieve and sustain quality standards** | | | | | |
| 8.1 | Better use of routine data analysis tools including DFI and HED to assist in analysis of out of hour/ weekend mortality figures | MD | | September 2013 | | 4 |
| 8.2 | Women's CBU to work with Dr Foster and other trusts to better understand risk adjustment model related to the national quality dashboard. | MD | | January 2014 | | 4 |
| 8.3 | Undertake LLR Mortality review. | MD | | June /July 2013 | Review currently in progress however results won't be available until public health has undertaken the analysis – September 2013. | 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 |
|---|---|---|---|---|---|---|
| 8.4 | Confirm Divisional representation to ensure engagement and delivery in patient centred care priorities for 2013-14: | ACN | | June 2013 | Complete | 5 |
| 8.5 | Active recruitment to ward nursing establishment so releasing ward sister for supervisory practice | ACN | | September 2014 | On going recruitment process in place and is likely to take 12 -18months. Deadline extended to reflect this. | 3 |
| 8.6 | Prioritise clinical staff development opportunities in CBUs/Division | ACN | | July 2013 | Need to meet with Divisional staff gain agreement | 3 |
| 8.7 | Confirm Divisional representation to ensure engagement and delivery in patient centred care priorities for 2013-14: | ACN | | June 2013 | Complete | 5 |
| 8.8 | Feasibility of a less cumbersome IT platform to reduce risk of results not being acted upon in a timely fashion to be investigated by IBM. | CIO | | June 2013 | Complete.<br>IBM and relevant leads for this action have been engaged and currently reviewing the options available producing a roadmap for this area by the end of June 2013.<br><br>The review has concluded that we concentrate on providing the EPR solution and the work for this area (which would have been the clinical portal) is now subsumed under that project. | 5 |
| 8.9 | Analysis of mortality review by Public Health | MD | | September 2013 | | 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 |
|---|---|---|---|---|---|---|
| 8.10 | Implementation of Electronic Patient Record (EPR) | CIO | | 2015 | | 4 |
| **9** | **Failure to achieve and sustain high standards of operational performance** | | | | | |
| 9.1 | On-going work on ward processes in Acute to free up capacity to recover RTT target. | COO | | ~~June 2013~~ July 2013 | Plan in place to release a ward to Haematology to enable refurbishment although acute still occupy surgical ward.<br>June update: The Haematology ward is planned to go to Odames on the 18th July. Remedial work to Odames has now started; project group is set up and have met twice to deal with the detail. Completion date extended to July 2013 | 3 |
| 9.2 | Re-configuration of surgical beds to create a 'protected area' for surgical patients. | COO | HO/DM Planned | November 2013 | On track | 4 |
| 9.3 | Development of key metrics at a local level to show number of patients deferred onto a different care pathway. | COO | | Review July 2013 | On track | 4 |
| 9.5 | Cancer Clinical lead, Cancer Centre Managers and Trackers to be recruited. | COO | DM Planned | ~~June 2013~~ August 2013 | Cancer clinical lead and trackers in post in June 2013. Cancer senior manager / nurse interview is arranged for the 9th July. | 3 |
| 9.6 | Continued monitoring of outpatient delivery plan to reduce cancellations. | COO | TT | Review June 2013 | On track.<br>Focus is on reducing DNA's and improving clinic utilisation. | 4 |
| 9.7 | Action plan to resolve Imaging issues to be developed | COO | | July 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 |
|---|---|---|---|---|---|---|
| **10** | **Inadequate reconfiguration of buildings and services** | | | | | |
| 10.1 | Key measures for gauging success of clinical strategy to be developed by specialties as part of their 'mini-IBPs' and will be monitored via divisional and directorate boards. | MD | | December 2013 | On track | 4 |
| 10.2 | Ensure success of FT Application (see risk 6 for further detail) | CEO | | April 2015 | On track | 4 |
| 10.3 | Secure capital funding to implement Estates Strategy | DFBS | | ~~May 2013~~ December 2013 | Work underway on capital planning around reconfiguration – SOC due for completion in Dec '13 / Jan '14 which will be the key vehicle to agree availability of capital funding. | 4 |
| **11** | **Loss of business continuity** | | | | | |
| 11.1 | Tailored training packages for service area based staff to ensure continued delivery of major incident training. | COO | EPO | July 2013 | On track | 4 |
| 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 2013 | On track | 4 |
| 11.3 | Assess our requirements of the critical suppliers and ensure that their response fulfils our requirements and include business continuity arrangements. | COO | EPO | September 2013 | On track – currently reviewing all responses to develop a benchmark criteria to assess resilience within suppliers | 4 |
| 11.5 | Complete BIA for outstanding CBU | COO | EPO | ~~May 2013~~ June 2013 | Complete | 5 |



| 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 |
|---|---|---|---|---|---|---|
| 11.6 | Continue to engage with Interserve and service areas around development of Business Continuity Plans. | COO | EPO | September 2013 | Still no dedicated lead in Interserve to oversee BCM. | 3 |
| 11.7 | Issues/lessons will feed into the development of local plans and training and exercising events to ensure lessons are learnt from incidents. | COO | EPO | September 2013 | This will be a continual process and will feed into the first set of plans to be produced | 4 |
| 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 2013 | IM&T – Completed, Emergency Planning and Head of Ops are consulted as part of the change board approval process.<br>Interserve – Process still to be agreed | 3 |
| 11.9 | Emergency Planning Officer and Divisional BCM leads will ensure that business continuity plans developed are coordinated between service areas/CBUs/Divisions | COO | EPO/ Divisional BCM leads | September 2013 | This will be a continual process and will feed into the first set of plans to be produced | 4 |
| 11.10 | Training and Exercising events to involve multiple CBUs/Divisions to validate plans to ensure consistency and coordination. | COO | EPO Divisional BCM leads | August 2014 | BCM training and exercising programme has been developed. | 4 |
| **12** | **Failure to exploit the potential of IM&T** | | | | | |



| 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 |
|---|---|---|---|---|---|---|
| 12.2 | Formal meetings of the newly created advisory groups/ clinical IT groups to be re-established with new membership to ensure clinical engagement | CIO | CMIO | June 2013 | Complete<br>CMIOs have received representation from the divisions and are in process of setting up the formal meetings<br><br>We now have 80 identified clinical individuals and, as part of the change plan, we have allocated them to the appropriate groups.<br>Meetings/engagements are being arranged for July and August depending on need. | 5 |
| 12.3 | An improved communications plan for IM&T strategy to be presented to the JGB for approval. | CIO | | July 2013 | Communications is now a standing item on the JGB agenda and an improved plan will be presented in June.<br><br>The plan was presented in June and further refinements are being undertaken. A final plan will be presented in July however elements of the work have already started. | 4 |
| 12.4 | Ensure clinical views are represented on the LLR IM&T Board. | CIO | | June 2013 | Complete. CMIOs have now been added as invitees to the meetings, as have the clinical (IM&T) leads from each of the CCGs with Dr Nick Pullman chairing the group | 5 |



| 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 |
|---|---|---|---|---|---|---|
| 12.5 | Increased engagement and communications with the relevant departments to ensure that we capture requirements and communicate benefits of IM&T strategy | | CIO/ CMIO | August 2013 | We have met with all divisions and produced a standard presentation<br><br>Key stakeholders have been identified and have had an initial engagement around requirements and benefits<br><br>Further activities are planned as part of specific projects or general communications<br><br>A new round of engagement activities with the CBUs has started | 4 |
| 12.6 | Refine the proposal around benefits reporting to ensure we have a standard reporting methodology and that it is in line with trust expectations | CIO | | September 2013 | Initial conversations have taken place with the IBM and benefits stakeholders.<br><br>IBM have produced an approach to identification and realisation of benefits; this will need to be verified by the trust and amended to reflect our new "to-be" processes as part of the Innovation Framework | 4 |
| 12.7 | Initial engagement with key members of the TDA to ensure there is sufficient understanding of technology roadmap and their involvement. | DFBS | CIO | Aug 2013 | Initial conversations have happened, we now have their approvals paperwork and we are working through the implications. | 4 |

**Key to initials of leads**

| | |
|---|---|
| CEO | Chief Executive Officer |
| DFBS | Director of Finance and Business Services |
| MD | Medical Director |
| COO | Chief Operating 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

| | |
|---|---|
| DHR | Director of Human Resources |
| ACN | Acting Chief Nurse |
| DMC | Director of Marketing and Communications |
| CIO | Chief Information Officer |
| CMIO | Chief Medical Information Officer |
| EPO | Emergency Planning Officer |
| HPO | Head of Performance Improvement |
| HO | Head of Operations |
| CD | Clinical Director |
| DM | Divisional 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 |



| **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 3**

**UHL BOARD ASSURANCE FRAMEWORK SUMMARY REPORT – PERIOD ENDING JUNE 2013**

| Risk No | Risk Title | Current Risk Score (May 13) | Previous Risk Score (May 13) | Target Risk Score and Final Action Date | Risk Owner | Comment |
|---|---|---|---|---|---|---|
| 1 | Failure to achieve financial sustainability | 25 | 25 | 12 – Jun 13 | DFBS | |
| 2 | Failure to transform the emergency care system | 25 | 25 | 12 – review Sep 13 | COO | |
| 3 | Inability to recruit, retain, develop and motivate staff | 16 | 16 | 12 – Dec 13 | DHR | |
| 4 | Ineffective organisational transformation | 12 | 12 | 12 | CEO | |
| 5 | Ineffective strategic planning and response to external influences | 16 | 16 | 12 – Jul 13 | CEO | |
| 6 | Failure to achieve FT status | 16 | 16 | 12 – Oct 2013 | CEO | |
| 7 | Failure to maintain productive and effective relationships | 15 | 15 | 10 – Sep 13 | DMC | |
| 8 | Failure to achieve and sustain quality standards | 16 | 16 | 12 – Sep 13 | ACN/MD | |
| 9 | Failure to achieve and maintain high standards of operational performance | 12 | 12 | 12 – Jul 13 | COO | |
| 10 | Inadequate reconfiguration of buildings and services | 12 | 12 | 9 – Apr 13 | DFBS | |
| 11 | Loss of business continuity | 9 | 9 | 6 – Aug 14 | COO | |
| 12 | Failure to exploit the potential of IM&T | 9 | 9 | 6 – Sep 13 | DFBS | |

**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

## OPERATIONAL RISKS SCORING 15 OR ABOVE OPENED DURING JUNE 2013

## REPORT PRODUCED BY: UHL RISK AND ASSURANCE MANAGER

**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 score increased from initial risk score |
| ⮟ | Risk score decreased from initial risk score |
| ★ | New risk since previous reporting period |
| ⇔ | No Change in risk score since previous reporting period |

| Division | Directorate | Risk Title | Opened | Description of Risk | Risk subtype | Controls in place | Impact | Likelihood | Current Risk Score | Action summary | Target Risk Score | Risk Owner |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Planned Care | Intensive Care, Theatres, Anaesthesia, Pain Management, Sleep | Risk of unplanned loss of theatre and/or recovery capacity at the LRI | 28/06/2013 | **Causes:**<br>1. The Theatre and Recovery estate and supporting plant(s) are old, unsupported from a maintenance perspective and not fit for purpose. There is recent history of unplanned loss of surgical functionality at the LRI site due to plant failure, problems with sluice plumbing and ventilation.<br>2. In addition, the poor quality of the floors, walls, doors, fittings and ceilings mean an unfit working environment from a working life, infection prevention and patient experience perspectives.<br>3. There is insufficient electricity and medical gas outlets per bed.<br><br>**Consequences:**<br>1. Periodic failure of the theatre estate (ventilation etc) so elective operating has to stop<br>2. Risk of complete failure of the theatre estate so elective and emergency operating has to stop<br>3. Increase risk of patient infections<br>4. Poor staff morale working in an aged and difficult working environment<br>5. Difficulty in recruiting and retaining specialised staff (theatre and anaesthetic) due to poor working environment<br>6. Poor patient experience - our most vulnerable patients arrive and are recovered in a dated environment, which does<br>7. May impair delivery of life support technologies | HR | 1. Regular contact with plant manufacturers to ensure any possible maintenance is carried out<br>2. Use of limited charitable funds available to purchase improvements such as new staff room chairs and anaesthetic stools<br>3. TAA building work has started<br>4. Plan to develop full business case for new recovery build 2013 - start 2014<br>5. 5S'ing events taking place within the theatre transformation project frame work<br>6. Compliance with all IP&C recommendations where estate allows<br>7. Purchase of new disposable curtains for recovery area, reducing infection risk and improving look of environment | Major | Likely | 16 | 1. TAA Build - due 15/12/13<br><br>2. Recovery re-build - due 01/12/14<br><br>3. Replacement of all theatre corridor floors and doors - due 01/10/13<br><br>4. Completion of ITAPS nursing recruitment plan - regular monitoring<br><br>5. Integration of ITAPS LiA pilot to underpin improvements in staff morale, pulse check and theatre transformation work - due 06/11/13<br><br>6. Capital investment and refurbishment of LRI theatres - plan in place and commenced - due 01/12/15 | 4 | Paula Vaughan |

| Division | Directorate | Risk Title | Opened | Description of Risk | Risk subtype | Controls in place | Impact | Likelihood | Current Risk Score | Action summary | Target Risk Score | Risk Owner |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Planned Care | Intensive Care, Theatres, Anaesthesia, Pain Management, Sleep | Risk of unplanned loss of theatre, recovery or Critical Care capacity across UHL due to insufficient nursing staffing | 28/06/2013 | **Causes:**<br>Theatre nursing staff are on the national difficult to recruit register. Locally, ITU nursing staff have been historically difficult to recruit and retain.<br><br>Turnover regularly negates recruitment efforts and the effects of a poor working environment in a high stress and risk area has meant difficulties in resolving the issue previously.<br><br>**Consequences:**<br>1. Increased overtime and waiting list payments required to run the core service<br>2. Tired and unmotivated staff in post<br>3. Poor staff morale working in an aged and difficult working environment<br>4. Difficulty in recruiting and retaining specialised staff (theatre and Critical care ) due to poor working environment and low staff morale in general<br>5. Reduction in critical care capacity across UHL<br>6. Inability to respond to increases in demand in theatre, recovery and critical care capacity<br>7. Elective patient cancellations including cancer patients<br>8. Critical Care alternatives becoming the norm for high level of care patients e.g. Kinmonth, overnight PACU and specialty "HDU's".<br>9. Poor patient and carer experience for some of our sickest | HR | 1. Use of Bank and Agency staff with block contracts for consistency and cost effectiveness.<br>2. Regular team and leadership meetings/training events<br>3. Rolling adverts in place<br>4. International recruitment with HRSS and relevant agencies commenced<br>5. Exit interviews used regularly and in line with trust policy to understand issues exacerbating higher than wanted turnover of staff | Major | Likely | 16 | 1. Working with TMP to improve recruitment advertising quality and branding - due 01/07/13<br><br>2. Further work with TMP to maximise Internet advertising, link promotion etc. - due 01/07/13<br><br>3. Attendance at NMC national recruitment fairs - due 30/09/13<br><br>4. Improve the working environment at the LRI ITU - small works and new storage to be completed - due 31/08/13<br><br>5. Continuation of monthly rolling adverts - monthly monitoring<br><br>6. Use of summer internship to drive recruitment process in a timely way to minimise loss of appointed staff - due 01/08/13<br><br>7. MOC to standardise ITU shift patterns - regular monitoring<br><br>8. Introduction of electronic rostering to standardise shift patterns and maximise efficient use of theatre, recovery and ITU staff - due 30/09/13<br><br>9. Full demand and capacity review of ITU to enable further flexibility of staffing to be introduced - flex up and down with demand - due 30/06/13 | 4 | Joanne Hollidge |

# UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

## OPERATIONAL RISKS SCORING 15 OR ABOVE FOR THE PERIOD ENDING 30 JUNE 2013

## REPORT PRODUCED BY: UHL RISK AND ASSURANCE MANAGER

**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 score increased from initial risk score |
| ⮟ | Risk score decreased from initial risk score |
| ★ | New risk since previous reporting period |
| ⇔ | No Change in risk score since previous reporting period |

| Division | Directorate | Risk Title | Opened | Description of Risk | Risk subtype | Controls in place | Impact | Likelihood | Current Risk Score | Action summary | Target Risk Score | Risk Movement | Div/Exec Director | Strategic risk No. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Acute | Emergency Care | Overcrowding in ED | 14/05/2013 | Fire: Inability to evacuate safely;<br>Patients in close proximity alongside each other on trolleys: Cross infection//contamination; Loss of patient privacy and dignity; Loss of confidentiality of medical information; Poor patient and family experience; Inability/Difficulty accessing patients for medical examination/Emergency Situations; Medical and nursing staff adopting unnatural postures to carry out patient examination treatment and care; Increased manual handling of patients and movement of trolleys; Increased risk of damage to equipment<br>Staff shortages Inability to provide patient care and meet personal care needs; Increased patient waiting times for treatments and investigations; Delayed diagnosis and treatment; Medical deterioration from lack of clinical review; Lack of specialty input to patient care.<br>Increased waiting times/Delayed treatment: Breach of 4 hour target.<br>Inability to admit emergency ambulance arrivals into majors: Delay in EMAS Trust ability to attend 999 calls;<br>Excess staff pressure and demand<br>Ongoing care taking second place to delivering immediate care:<br>Unplanned, repeated patient movement away from their idea or designated area in order to create space:<br>Risk of medical error<br>Insufficient Medical devices and Equipment available<br>Resus patient in majors bay at risk of unnoticed deterioration and lower nurse:patient ratio; Resus activity performed in view of others; High risk of Serious Untoward Incidents; High acuity patients being cared for in Majors with inappropriate facilities and resources<br>Breach of infection control policies; Increased risk of pressure sores; Increased risk of malnutrition; Risk of poor medical treatment . | Patients | Close adherence to UHL Escalation policies<br>Regular risk stratification of patient dependency level and infection risk to maximise use of all possible floor space<br>Adherence to ED internal Minimal Professional Standards when possible, and alerting senior staff when these are breached<br>New expanded Majors Assessment Bay area (March 2013)<br>Restructuring of acute flow processes by Right Place, Right Time consultancy firm 2013 | Extreme | 25 | Notify Executive Team and non-executive directors of direct risks of overcrowding - 31/7/2013<br><br>Multidisciplinary working party within ED to create action cards for green, amber and red states of overcrowding - 31/7/2013<br><br>Request dedicated cleaning staff 24/7 to mitigate infection control risks - 31/7/2013<br><br>Request that UHL escalation policies include decanting of ED patients as soon as agreed thresholds of over-crowding are reached - 31/7/2013 | 9 | ⇳ | PR/COO | 2 |

| Division | Directorate | Risk Title | Opened | Description of Risk | Risk subtype | Controls in place | Impact | Likelihood | Current Risk Score | Action summary | Target Risk Score | Risk Movement | Div/Exec Director | Strategic risk No. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Acute | All | Risk of ePMA system deadlocking | 13/05/2013 | Electronic prescribing and administration system (ePMA) is currently experiencing numerous issues with users sessions being terminated as a result of "deadlocks" on the system. **Causes:** A deadlock happens when a user accesses a record and the record is not released correctly - this results in the record being locked and terminates the users login. **Consequences:** As a result of this fault with the application the administration of medication is not being recorded correctly. This is forcing users to have to log back into the system and re-enter the administration or prescription history (After the event). In the case of nurses this is happening on multiple occasions on 1 single drug round. The missed administration of medication poses a significant clinical risk of either double dosing or the patient missing their medication all together. | Patients | IM&T have added an extra CPU to the Support Module Server for ePMA which has seen a marked improvement on the performance of the Support Module. Communication to wards utilising ePMA to ask that they never leave the electronic chart blank and to persist with issues with the system to ensure all information pertaining to drug administration is accurately recorded. Worse case scenario the communication is to revert back to using a paper drug chart. The ePMA trainers continue to support Ward 15/16/33 whilst we seek resolution on this issue. Also trainers are closely working with AMU on the design and development of a paper chart for those patients that are acutely unwell. Any further go lives in UHL have been put on hold until resolution is met. | Extreme | Likely | 20 | CSC the provider will identify a complete fix for deadlocking - 29/07/13. | 5 | ★ | PR/DFBS | 12 |

| Division | Directorate | Risk Title | Opened | Description of Risk | Risk subtype | Controls in place | Impact | Likelihood | Current Risk Score | Action summary | Target Risk Score | Risk Movement | Div/Exec Director | Strategic risk No. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Acute | Professional services | Risk to the production of aseptic pharmaceutical products | 03/05/2007 | **Causes**<br>Provision of aseptically prepared chemotherapy is being undertaken from a temporary rental unit.<br>Temporary nature and age of facility indicates high probability of failure.<br>Arrangements for segregation of in-process and completed items is inadequate leading to high possibility of error.<br>Current temporary unit is outside the range of the department's temperature monitoring system. Failure of refrigerated storage will remain undetected outside working hours, and has already occurred.<br>Planning permission for temporary unit only valid until August 2012<br>Contingency arrangements are insufficient and could only provide for the very short term.<br>Project is already 6 months behind schedule<br>Storage, receipts and dispensing facility for dose-banded chemotherapy and other outsourced items purchased.<br>Alternative arrangements will need to be found when unit is refurbished<br>**Consequences**<br>Failure of Current Temporary Facility;<br>Inability to provide 50% of current chemotherapy products for adult services.<br>Inability to provide chemotherapy for paediatric services.<br>Substantial delay in re-establishing service provision from alternative supplier<br>Limitations of treatments that can be sourced from an alternative supplier.<br>Inability to support research where aseptic compounding required.<br>High cost of sourcing required products from alternative supplier at short notice.<br>Increase in datix incidents pertaining to the Aseptic Unit. | Business | Planned servicing & maintenance of existing facility being undertaken.<br>Constant environmental monitoring of facility in place.<br>Alternative preparation facility being maintained as contingency although only adequate for short term contingency and not recommended for preparation of chemotherapy. N.B. this option may be lost depending on the outcome of the business case for a permanent solution for the aseptic dispensing service.<br>Contingency arrangement for supply from external source currently being pursued.<br>Business Case for new unit ( refurbishment of facility within the Windsor building) has been presented and approved by the commercial exec board in 2011.<br>Facilities are working with Pharmacy and commercial architects in order to finalise plans and get refurbishment started | Extreme | Likely | 20 | Build to commence - 6 months from start to fully commissioned complete 17/12/2013<br>Build complete unit in operation 31/12/2013 | 3 | ⇳ | PR/ CN & MD | 8 |

| Division | Directorate | Risk Title | Opened | Description of Risk | Risk subtype | Controls in place | Impact | Likelihood | Current Risk Score | Action summary | Target Risk Score | Risk Movement | Div/Exec Director | Strategic risk No. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Planned Care | Specialist Surgery | Delayed roll out of outsourced Transcription process, unavailability of skilled workforce and flexible workers | 12/10/2012 | Delayed roll out of outsourced Transcription process , unavailability of skilled workforce and flexible workers is leading to extensive delays in relation to typing of referral letters leading to potential adverse patient outcomes and ineffective service delivery<br><br>**Causes:**<br>-Reduction in secretarial skilled staffing due to previous MoC process<br>-Delays in recruitment process preventing appointment to posts in a timely manner.<br>-Use of DICT8 not delivering anticipated efficiencies.<br>-High turnover of staff on fixed-term contracts that leave when substantive posts become available.<br>-Bank and agencies cannot supply adequate numbers of staff to fill vacancies<br><br>**Consequences:**<br>-Outcomes missing from system.<br>-Outcome slips filed in incorrect locations.<br>-Patient notes may not contain relevant documentation.<br>-Extensive delays in referral letter process (current backlog of approximately 11000 letters in -Ophthalmology, 3000 letters in ENT, 2000 letters in Breast Care) may lead to: Longer waiting times for treatment.<br>-Increased number of complaints.<br>-Adverse impact on reputation of specialty/Trust.<br>-Insufficient staff to cope in cases of IT system failures.<br>-H&S risk to staff due to numbers of patient notes stored inap<br>-Existing staff under increased stress due to increased workl<br>-Additional costs for overtime/ agency staff. | Patients | -Stress audits performed<br>-Regular team meetings to provide support for A&C staff<br>-Staff training<br>-Significant number of vacancies filled in supporting A+C<br>-ENT typing outsourced to DICT8.<br>-Ophthalmology using ICE and template letters for referrals.<br>-Overtime and additional hours worked by existing staff.<br>-Trajectories developed and monitored in relation to addressing backlog.<br>-Urgent cases given priority for typing.<br>-Time allowed for 'protected typing' whenever possible.<br>-Involvement of UHL Health and safety team to help address staff safety issues. Additional racking for notes sourced and installed. | Major | Almost certain | 20 | Recruitment to 2 x Team Leader posts- 30/06/13<br>Recruit further temporary audio typists- 30/06/13<br>Recruit to long-term audio typist roles (timescale dependent upon outcome of vacancy control panel) - 31/07/13 | 8 | ▲ | AF/DHR | 3 |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Women's & Children's | Women's | Lack of Capacity in maternity services | 28/09/2007 | **Causes**<br>Continuing increase to the birth-rate in Leicester .<br>The number of maternity beds has decreased.<br>Consultant cover for Delivery Suite is 60 hours a week with long term business plans to increase the hours in accordance with Safer Childbirth Recommendations<br>**Consequences**<br>Midwifery staffing levels are not in accordance with national guidance however are in line with regional averages<br>Transfer of activity between the LGH and LRI occurs on a frequent basis with Leicestershire having to close to maternity admissions on a number of occasions<br>Increase in incidents reported where there has been a delay in elective CS, IOL and augmentation due to lack of beds<br>Staff frequently go without meal breaks<br>Increased waiting time in MAC and therefore increased risk of a clinical adverse outcome to both mother and baby | HR | Length of postnatal stay in hospital as short as possible.<br>Community staff prepare women for early discharge home if straightforward delivery.<br>Extra triage room on Delivery Suite, LRI completed July 2012<br>Triage and admission areas in acute units to ensure no category x women sitting on delivery suite<br>Use of Escalation Plan to inform staff on actions required if capacity is high<br>Capacity is managed between the two acute units by temporarily transferring care if one site is busy<br>Liaison with neighbouring maternity hospitals if high risk of closure of Leicestershire Maternity Hospitals<br>Prioritisation of both elective and 'emergency' work according to clinical urgency and need<br>On call Manager<br>On call SOM<br>Funded midwife places increased to 1:32 | Extreme | Likely | 20 | Relocation of MAC services out of Delivery Suite on both sites to PAS in order to increase the capacity of Delivery Suite - due 31/8/2013<br>Increase ward capacity on LRI site by having EL CS women on level 1 - due 31/8/2013<br>Gynae theatres to be refurbished to accommodate EL CS at LRI - due 31/12/2013 | 12 | ⇳ | IS/DHR | 3 |

| Division | Directorate | Risk Title | Opened | Description of Risk | Risk subtype | Controls in place | Impact | Likelihood | Current Risk Score | Action summary | Target Risk Score | Risk Movement | Div/Exec Director | Strategic risk No. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Women's & Children's | Women's | Unavailability of USS and not meeting National Standards for USS in Maternity | 10/10/2008 | Failure to diagnose abnormality which we would normally expect to diagnose due to changes in National standards. The potential for other consequences are apparent. | Quality | Detailed scan pro-forma<br>US performed by suitable trained staff<br>Self audit<br>Use of regular pre-booked agency sonographers<br>Daily review of outstanding requests to monitor the situation<br>Access to consultants for second opinion if suspicious re possible abnormality<br>All ultrasound machines now of suitable specification and replaced 5 yearly<br>Incident report forms<br>Continued use of Agency Sonographers<br>Continued 'extra' lists by Foetal Med Consultants<br>Additional u/s machine in place but next step is need for additional scan room - this is built in to the interim solution for Maternity (phase 1) and should be converted by April 2013 | Extreme | Likely | 20 | Create further USS space or utilise existing space out of hours to increase capacity - due 30/06/13<br>Extra scan room to be included as part of the interim solution (LGH) - due 30/6/13<br>Recruitment of further sonographer - due 30/06/13 | 6 | ⇳ | IS/DHR | 3 |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Acute | Imaging & Medical Physics | No out of hours nursing support for interventional radiology procedures | 17/06/2011 | **Causes**<br>There is not a radiology nurse present to support radiologists and radiographers undertake interventional radiological procedures out of normal working hours.<br>**Consequences**<br>Procedures undertaken out of hours are by their nature 'urgent' and thus the patients are likely to be sick/unstable and require a high level of nursing/medical care. These patients do not have the usual level of service that would be available to them during normal hours and thus the RCR recommendations for interventional radiology are not followed.<br>The radiographer must cover the roles of nurse, runner and radiographer their urgent nature the patients are unstable, monitoring is basic as at best there may be a nurse accompanying the patient from the ward but they are unfamiliar with the environment and the procedure.<br>Moving the patient can be difficult, the patient often has a lot of drips etc and needs pat sliding, there can be just 3 people to do this which may cause injury to staff or patient.<br>No scrub assistant for the radiologist, they often do not have a registrar either so procedure can be challenging, this affect speed and success of procedure.<br>Post procedure the radiographer is alone to see the patient off with a porter, clear up and lock up. This is unsafe for the patient and radiographer. | Patients | Nurse requested from ward, radiographers trained in patient monitoring.<br>Manual handling training, slide-sheets, use of porter and escort nurse to transfer.<br>Registrar to assist radiologist when able.<br>Radiographer request the doctor stays until patient leaves and closes the main doors if alone cleaning up. | Major | Likely | 16 | Further recruitment required due to recent sickness and resignations - 01/07/2013 | 3 | ▲ | PR/DHR | 3 |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Corporate | Operations | Risk of inaccuracies in clinical coding | 02/08/2011 | **Causes**<br>HISS constraints (HRG codes not generated)<br>High workload (coding per person above national average)<br>Inaccuracies / omissions in source documentation (e.g. case notes may not include co-morbidities, high cost drugs may not be listed)<br>Inability to provide training to large groups of coders due to lack of time and financial constraints<br>**Consequences**<br>Loss of income (PbR)<br>Outlier for CHKS/HSMR data<br>Non- optimisation of HRG<br>Loss of Trust reputation | Economic | Coding improvement project initiated.<br>Project Board commenced 5th September 2011.<br>Electronic coding implemented February 2012 and upgraded November 2012 - HRG code generated.<br>Will aid with audit, implementation of local policies and performance management.<br>Task and finish groups completed in Divisions review improvements in coding using PeRL, PLICs, CHKS and medicode.<br>New process for medical records retrieving notes.<br>Due to changes in recording and payment of EDU and CAU episodes number of episodes coded has reduced.<br>Shifts from day case to outpatient will reduce workload.<br>Lead clinicians identified and Trust wide communication to move coding closer to the clinician. Tick lists introduced in both the ward area and discharge letter.<br>Bank staff and overtime authorised to meet deadline.<br>Scorecard developed to demonstrate improvements and benchmark against other Trusts.<br>Two additional coders accredited<br>3 year refresher programme.<br>Quarterly updates/briefings led by Asst Director of Information.<br>Regular progress updates to F&P and GRMC.<br>Clinical Coding Manager has a regular slot on Junior induction day, presentation including financial examples are delivered. | Major | Likely | 16 | Review the priority of this risk after go live with the encoder as all actions will have been taken - 31/07/13<br>Restructure team as per agreed proposal - 31/07/13 | 8 | ⇳ | JR/DFBS | 1 |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Corporate | R & D | Athena Swan - potential Biomedical Research Unit funding issues. | 12/10/2012 | The Athena SWAN Charter is a recognition scheme for UK universities and celebrates good employment practice for women working in science, engineering and technology (SET) departments. Standards required for next round of Biomedical Research Unit (BRU) submissions. Academic partners required to be at least Silver Status. Failure for the University to achieve this will result in UHL being unable to bid successfully for repeat funding of the BRUs. | Economic | Every meeting with the University, Athena Swan is on the Agenda. Out of UHL control directly, but every avenue is being used to keep the emphasis high at the University. | Major | Likely | 16 | Add Athena Swan to every agenda at Leicester & Loughborough Universities attended by UHL R&D Personnel | 4 | ⇳ | DR/ CN & MD | 8 |
| Planned Care | Intensive Care, Theatres, Pain Management, Sleep | Risk of unplanned loss of theatre and/or recovery capacity at the LRI | 28/06/2013 | **auses:**<br>The Theatre and Recovery estate and supporting plant(s) are old, unsupported from a maintenance perspective and not fit for purpose. There is recent history of unplanned loss of surgical functionality at the LRI site due to plant failure, problems with sluice plumbing and ventilation.<br>In addition, the poor quality of the floors, walls, doors, fittings and ceilings mean an unfit working environment from a working life, infection prevention and patient experience perspectives.<br>There is insufficient electricity and medical gas outlets per bed.<br>**Consequences:**<br>Periodic failure of the theatre estate (ventilation etc) so elective operating has to stop<br>Risk of complete failure of the theatre estate so elective and emergency operating has to stop<br>Increase risk of patient infections<br>Poor staff morale working in an aged and difficult working environment<br>Difficulty in recruiting and retaining specialised staff (theatre and anaesthetic) due to poor working environment<br>Poor patient experience - our most vulnerable patients arrive and are recovered in a dated environment, which does not promote confidence in the service, a sense of professionalism or safety<br>May impair delivery of life support technologies | HR | 1. Regular contact with plant manufacturers to ensure any possible maintenance is carried out<br>2. Use of limited charitable funds available to purchase improvements such as new staff room chairs and anaesthetic stools<br>3. TAA building work has started<br>4. Plan to develop full business case for new recovery build 2013 - start 2014<br>5. 5S'ing events taking place within the theatre transformation project frame work<br>6. Compliance with all IP&C recommendations where estate allows<br>7. Purchase of new disposable curtains for recovery area, reducing infection risk and improving look of environment | Major | Likely | 16 | 1. TAA Build - due 15/12/13<br>2. Recovery re-build - due 01/12/14<br>3. Replacement of all theatre corridor floors and doors - due 01/10/13<br>4. Completion of ITAPS nursing recruitment plan - regular monitoring<br>5. Integration of ITAPS LiA pilot to underpin improvements in staff morale, pulse check and theatre transformation work - due 06/11/13<br>6. Capital investment and refurbishment of LRI theatres - plan in place and commenced - due 01/12/15 | 4 | ★ | AF/DFBS | 10 |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Planned Care | Intensive Care, Theatres, Pain Management, Sleep | Risk of unplanned loss of theatre, recovery or Critical Care capacity across UHL due to insufficient nursing staffing | 28/06/2013 | **Causes:**<br>Theatre nursing staff are on the national difficult to recruit register. Locally, ITU nursing staff have been historically difficult to recruit and retain.<br>Turnover regularly negates recruitment efforts and the effects of a poor working environment in a high stress and risk area has meant difficulties in resolving the issue previously.<br><br>**Consequences:**<br>1. Increased overtime and waiting list payments required to run the core service<br>2. Tired and unmotivated staff in post<br>3. Poor staff morale working in an aged and difficult working environment<br>4. Difficulty in recruiting and retaining specialised staff (theatre and Critical care ) due to poor working environment and low staff morale in general<br>5. Reduction in critical care capacity across UHL<br>6. Inability to respond to increases in demand in theatre, recovery and critical care capacity<br>7. Elective patient cancellations including cancer patients<br>8. Critical Care alternatives becoming the norm for high level of care patients e.g. Kinmonth, overnight PACU and specialty "HDU's".<br>9. Poor patient and carer experience for some of our sickest patients | HR | 1. Use of Bank and Agency staff with block contracts for consistency and cost effectiveness.<br>2. Regular team and leadership meetings/training events<br>3. Rolling adverts in place<br>4. International recruitment with HRSS and relevant agencies commenced<br>5. Exit interviews used regularly and in line with trust policy to understand issues exacerbating higher than wanted turnover of staff | Major | Likely | 16 | 1. Working with TMP to improve recruitment advertising quality and branding - due 01/07/13<br>2. Further work with TMP to maximise Internet advertising, link promotion etc. - due 01/07/13<br>3. Attendance at NMC national recruitment fairs - due 30/09/13<br>4. Improve the working environment at the LRI ITU - small works and new storage to be completed - due 31/08/13<br>5. Continuation of monthly rolling adverts - monthly monitoring<br>6. Use of summer internship to drive recruitment process in a timely way to minimise loss of appointed staff - due 01/08/13<br>7. MOC to standardise ITU shift patterns - regular monitoring<br>8. Introduction of electronic rostering to standardise shift patterns and maximise efficient use of theatre, recovery and ITU staff - due 30/09/13<br>9. Full demand and capacity review of ITU to enable further flexibility of staffing to be introduced - flex up and down with demand - due 30/06/13 | 4 | ★ | AF/DHR | 3 |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Planned Care | Intensive Care, Theatres, Pain Management, Sleep | Patient Safety and Financial risk due to failure to deliver sufficient resident Anaesthetic cover across three hospital sites | 12/11/2012 | **Causes**<br>Current under populated rotas<br>National Drive to reduce trainee anaesthetists (by 150 for UK)<br>Change in process for allocation of ICM numbers and proportion trainees work in ITU<br>Necessity at present to cover 3 acute sites<br>**Consequences**<br>Increased Agency and Locum spend - leading to poorer patient care, increased risk of adverse events and increased cost to the CBU<br>Increased use of consultant cover on the rota - leading to increased cost to the CBU and inability to cover elective activity<br>Reduction in morale and reputation with Trainees - leading to increased difficulty getting new trainees to apply for future posts.<br>Clinical consequences as highlighted above. | Economic | Trust-level Task & Finish Group established to scope issues, identify immediate, short term and medium term action<br>- Weekly publication and circulation of forward anaesthetic rota cover by the Anaesthetic Office - highlighting covered shifts and any outstanding rota gaps<br>- Escalation plan in place to alert Head of Service for Anaesthesia LRI, LGH and CBU Medical Lead, then to alert Divisional management team should any rota gaps remain uncovered 48hrs prior<br>- Use of consultants<br>- Trainees covering additional sessions as locums<br>- Increase in local payments to encourage jr medical staff<br>- Use of Agency doctors<br>- Increase in agency payments for higher graded staff<br>- Appointment of specialist doctors where possible (recruitment underway)<br>- Programme in place to bolster number of trainee doctors by taking on foreign trainees for 12 month visits, however doctors are proving difficult to source.<br>- Appoint anaesthetic assistants to reduce some pressures during day time shifts<br>- The use of cardiac trainees to cover ITU at GGH | Major | Likely | 16 | Review on call provision across all services, across all sites. Original on-call need s not changed, still awaiting service site reconfiguration moves - due by 01/10/13.<br><br>Interviews of additional Specialty Doctors undertaken on 28/03/13 - Confirmation of appointments - 15 appointed and 4 on a waiting list - due by 01/07/13. | 5 | ⇳ | AF/CN & MD | 8 |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Planned Care | Intensive Care, Theatres, Pain Management, Sleep | Insufficient Staffed Level 3 Critical Care Beds | 26/06/2012 | **Cause:**<br>Critical care occupancy has continued to rise through 2010/11 to 2011/12 resulting in elective cancellations and a lack of physical space to facilitate working more efficiently and effect infection prevention practice.<br>UHL Critical care bed occupancy for 2010/11 was 91.07% and 97.7% for 2011/12 (ICNARC). The Intensive Care Society recommendations are 70% to enable flexibility to respond as an emergency provider.<br>**Consequences:**<br>Lack of Level 3 beds resulting in elective cancellations. This equals 127 @ month 11.<br>Delayed ITU discharges to specialty based wards | Patients | Reallocation of Level 3 beds flexibly across UHL to meet demand<br>Reallocation wherever possible of nursing staff across Critical Care areas in UHL to meet demand<br>Daily SITREP report for critical care distributed throughout the Division and end sers of the service stating occupancy, staffing, bed capacity and delayed discharges.<br>Presence of ITU senior nursing staff at Trust's operational bed meeting @ 08.30 daily<br>Bed management policy in place for ITU and all specialties with differing responsibilities for each area.<br>Escalation policy in place inclusive of ITU, PACU and elective users of critical care<br>Ability to escalate to bank/overtime/agency to open extra level 3 capacity as required<br>Presence of ITU senior nursing staff at Trust's weekly theatre activity meeting to plan ahead for elective activity<br>Access to web based system for critical care capacity across the central England network to exercise transfers of Level 3 patients if no capacity available in UHL<br>On 03/04/13, it was announced that Critical Care had been successful with the commissioners in their bid to expand the Critical Care bed base. Nursing rec | Major | Likely | 16 | Gain full support from Trust and Commissioners for phased, funded bed base expansion (3 beds initially) - 31/07/13<br>Ensure appropriate utilisation of current resources, for example, patient flow - 31/07/13<br>Recruitment of nurses to staff the additional Critical Care beds (rolling advert went live 15 05 13; mini link videos 20 05 13; TMP promotion; RCN recruitment fair July & Sept 13; job swap and in-house Planned Care rotation) - 30/09/13 | 12 | ⇳ | AF/COO | 9 |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Acute | Cardiac, Renal & Respiratory | Inappropriate environment and infection prevention Renal Transplant | 25/10/2011 | **Cause**<br>Insufficient side room capacity<br>Inadequate space in existing side room for haemodialysis and line procedures.<br>Insufficient en suite facilities in side rooms<br>Vascular access and % of patients with dialysis catheters<br>Procedure room on ward 10 not fit for purpose<br>Inappropriate areas used for renal biopsy on ward 17<br>Inadequate drug preparation areas<br>Inadequate domestic storage areas<br>No separate facility for isolating patients in ward 10/17 DCU<br>Movement of patients to accommodate admissions or haemodialysis in another area<br>**Consequence**<br>Poor compliance with cannula care<br>Challenges in maintaining integrity of commode lids using Chlorclean<br>Infection prevention risk<br>Transportation of contamination through patient occupied areas (15N/A) | Patients | Preventing Transmission of Infection including Isolation Guidelines (DMS 47699)<br>MRSA Screening policy<br>Weekly MRSA audits undertaken by IP Team<br>Local Infection Prevention Group<br>Communication of IP issues regular agenda item on local meetings<br>Link Nurse Network<br>Daily side room list<br>Monthly Nursing Metrics audits<br>Monthly HII audits<br>Monthly Environment audits<br>Recent refurbishment and upgrade of ward 15N/A accommodation<br>Steam cleaning post CDT patients<br>Vascular access being monitored by CQUIN & EMRN<br>Medically led Vascular Access coordination<br>Expert specialty trained competent staff<br>Use 'cohort facility' as required<br>Ongoing competency based programme for the training and implementation of ANTT | Extreme | Possible | 15 | Development of renal relocation plan - 31/01/2017 | 15 | ⇔ | PR/DFBS | 10 |
| Acute | Cardiac, Renal & Respiratory | Harborough Lodge environment stops staff safely delivering haemodialysis | 16/08/2012 | **Causes:**<br>Insufficient space to:<br>Safely carry out dialysis procedures<br>Safely carry out manual handling procedures<br>Safely carry out emergency procedures<br>Maintain patient privacy & dignity<br>Poor state of repair of within clinical areas<br>**Consequences:**<br>Cross contamination/infection<br>Manual handling injury to staff/patient/visitor<br>Poor patient experience<br>Negative reputation of Trust<br>Complaints | Patients | Specialist haemodialysis trained and competency assessed staff<br>Haemodialysis/other clinical policies<br>Annual manual handling training<br>Annual infection prevention training<br>Infection prevention policy<br>Infection prevention audits<br>Environment audits<br>Curtains at each bed space<br>Minimum cleaning standards | Extreme | Possible | 15 | UHL undertake Duty of Care review and produce recommendations - 31/08/2013 | 5 | ⇔ | PR/DFBS | 10 |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Acute | Imaging & Medical Physics | No comprehensive out of hours on call Rota for consultant Paediatric radiologists | 29/06/2009 | **Causes**<br>There are Consultant Radiologists on call however there are not sufficient numbers to provide an on call service.<br>Registrars are available but they have variable experience<br>**Consequences**<br>Delays for patients requiring Paediatric radiological investigations.<br>Sub-optimal treatment<br>Paediatric patients may have to be sent outside Leicester for treatment<br>Potential for patient dissatisfaction / complaints<br>Consultants are called in when they are not officially on call and they take Lieu time back for this, resulting in loss of expertise during the normal working day. | Patients | There are Consultant Radiologists on call however there are not sufficient numbers to provide an on call service.<br>Registrars are available but they have variable experience.<br>Non Paediatric radiology consultants are not able to perform or interpret Paediatric radiological interventions. | Moderate | Almost certain | 15 | Review Paediatric service to determine the employment of further Consultants - due 26/07/13 | 2 | ⇳ | PR/DHR | 3 |
| Acute | Imaging & Medical Physics | Lack of planned maintenance for medical equipment maintained by Medical Physics | 14/05/2009 | **Causes:**<br>Lack of Medical Physics technical staff<br>No mechanism to ensure that the revenue consequences of maintenance are identified and funding given to Medical Physics to perform this maintenance.<br>**Consequences:**<br>Potential for equipment to perform out of specification leading to increased risk of patient/ staff harm.<br>Equipment failure due to non-replacement / maintenance of limited life parts<br>Failure to meet statutory requirements for electrical safety testing of medical equipment.<br>Increased risk of patient complaints / claims<br>Potential for adverse media attention and risk to the reputation of the Trust<br>May impact upon successful outcome of future NHSLA assessments<br>Possibility of non-compliance with CQC Outcome 11<br>May attract attention of Medicines and Healthcare products Regulatory Agency (MHRA)<br>Low morale / unreasonable pressure on Medical Physics technical staff. | Statutory | Some critical equipment is being maintained under service agreements set up with supplier.<br>Medical Physics team are targeting "High" risk equipment as a first priority.<br>Trust wide project team has been assembled to categorise the risk rating of equipment categories for both Maintenance and training needs - work from this team will eventually lead to many of the recommended actions being possible<br>Identified all critical equipment and maintenance needs through the risk assessment process<br>Reviewed the Medical Devices policy<br>Site wide audit of medical devices<br>Standardise medical equipment wherever possible<br>Trust wide communication about future of medical device management issued. | Moderate | Almost certain | 15 | Develop process to allow appropriate funding for Medical Physics to ensure programmed maintenance can be performed - 30/9/13<br>Develop robust mechanism to ensure the revenue consequences of maintenance for medical equipment purchases are identified - 30/9/13<br>Secure funding to increase current staff base for Medical Physics technical staff or outsource maintenance contracts - 30/9/13<br>Quantify the shortfall in maintenance provision from existing resources and identify to the Trust (to enable Trust decision on corrective to be made) - 30/07/13<br>Establish infusion pump libraries at LGH and LRI - 1/1/14 | 6 | ⇳ | PR/CN &MD | 8 |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Corporate | Communications | Failure to achieve Foundation Trust (FT) status | 30/04/2007 | Public opinion does not support our FT application; Failure of the Trust to persuade the public about the benefits and importance of FT status.<br>Failure to engage staff / public re: FT / Strategic Direction;<br>Disengagement of members / public from the process.<br>Disengagement of staff from the process.<br>Public perception may be of a ""failing"" Trust. We will be required by Monitor to show that staff and the public / stakeholders are aware of and support the Trust's Strategic Direction and FT Trust application.<br>The consultation fails to generate sufficient responses / poor demographic representation among responders;<br>Consultation document / communications do not reach sufficient numbers of people / organisations. Responses do not reflect the diversity of the population. | Public | FT programme Board meets regularly to drive and monitor progress on FT application.<br>Ft programme leads meet weekly to keep application on track.<br>Dedicated FT Programme Manager in post, supported by the Trust's strategy team.<br>Consultation Document and supporting communication clearly sets out aspirations and benefits.<br>Communications and Engagement strategy established for FT consultation and strategic direction.<br>FT consultation will be supported and monitored by Membership Engagement Services (MES)<br>Regular briefings to members of staff/ public/ members/ stakeholders.<br>Bi - monthly Prospective Governor meetings established<br>Consultation Strategy specifically targets a wide demographic range of groups / organisations | Moderate | Almost certain | 15 | Consultation and Engagement actions - 30/09/13 | 6 | ⇳ | MW/CEO | 6 |
| Corporate | Communications | Loss of charity funder | 01/10/2011 | Loss of (up to) £300k income to Charity from WRVS as a result of single FM supplier contract award. The Charity currently has no recovery plan for such a loss of income. The WRVS funding covers a number of posts within the Trust which would be put at risk. | Economic | The Charitable Funds Committee monitors income and expenditure at bi-monthly meetings. A reduction or cessation of funding is manageable if necessary. Currently awaiting outcome of discussions between WRVS and Interserve. | Moderate | Almost certain | 15 | To review options for developing new income streams for the Charity (Charity 5 year Plan); to review the funded posts to determine their future viability - due 30/08/13 | 8 | ⇳ | MW/DHR | 3 |
| Corporate | IM&T | PACS | 26/05/2011 | Breast Care Service : Need to improve D.R. capability by providing local storage to Reporting Work Station, so that the service can be sustained in the event of a PACS outage. This could potentially be achieved by adding extra disk capacity to their local Reporting work Station. | Patients | Current controls in place to be identified.<br>IM&T and Imaging IT support are currently in the process of determining whether to move the current archive server process to new hardware to mitigate the risk, or defer to a possible managed service provider. | Extreme | Possible | 15 | The Board has approved the transition to a 'managed service provider'. Contact the service now that it is being managed by Accenture to see if the risk can be downgraded - also asked if they want to invest in a local DR solution - 31/07/13 | 2 | ⇳ | JC/ DFBS | 12 |

| Division | Directorate | Risk Title | Opened | Description of Risk | Risk subtype | Controls in place | Impact | Likelihood | Current Risk Score | Action summary | Target Risk Score | Risk Movement | Div/Exec Director | Strategic risk No. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Corporate | Medical Directorate | Risk of user error associated with non-standardisation of manual and automated external defibrillators | 16/12/2009 | **Causes:**<br>Medical staff using the defibrillator will rotate to other sites within the Trust<br>Different make / model of defibrillator used at LGH site (Zoll defibrillators as opposed to Medtronic LifePak 20)<br>Defibrillator training at LRI/ Glenfield hospital uses Lifepak defibrillators for practical element of training but purely illustrates the differences between Zoll and Lifepak. This includes how to turn on, how to activate manual mode (2-stage activation), and location of 'shock' button.<br>Defibrillator training at LGH hospital uses Zoll defibrillator for practical element of training but purely illustrates the differences between Zoll and Lifepak. This includes how to turn on, how to activate manual mode (finding release button and opening manual door), and location of 'shock' button.<br>**Consequences:**<br>Potential for unsuccessful defibrillation attempt<br>Potential for injury to the patient (death)<br>Potential to disrupt the advanced life support universal algorithm<br>Non-compliance with recommendations of the CPR Standards for Clinical Practice and Training | Patients | Defibrillation training<br>Defibrillator will give automated instructions (depending on clinical setting) | Extreme | Possible | 15 | Standardise make/ model of defibrillator across the Trust - 1/8/13<br>Funding available for purchase - 28/06/13<br>Installation of new defibs - 1/8/13 | 5 | ⇳ | KH/ CN & MD | 8 |
| Corporate | Nursing | Failure to manage Category C documents on UHL Document Management system (DMS) | 14/03/2011 | **Causes**<br>Lack of resource at Divisional/ directorate level<br>Lack of resource in CASE team<br>Delays in the development of 'SharePoint' that would enable automatic reminders for expired documents to be generated for the document authors.<br>**Consequences**<br>DMS does not contain the most recent versions of all category C documents<br>Staff may be following incorrect guidance (clinical or non-clinical) | Quality | Acting Head of Outcomes has discussed the problems with Clinical Business Units (CBUs) to identify which documents can be managed by the CBUs<br>Reminders to be manually generated by the CASE team (one day a week only) | Moderate | Almost certain | 15 | Use of bank staff or redeployed staff for 3 - 6 months to update information on DM'S and migrate to 'SharePoint' | 9 | ⇳ | SH/ CN &MD | 8 |

| Division | Directorate | Risk Title | Opened | Description of Risk | Risk subtype | Controls in place | Impact | Likelihood | Current Risk Score | Action summary | Target Risk Score | Risk Movement | Div/Exec Director | Strategic risk No. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Corporate | R & D | Commercial Research Partner withdrawal | 29/06/2012 | Catalogue of incidents involving Pharmacy storage of Clinical Trial drug and temperature monitoring / control | Business | Process for receipt and storage of product<br>Process for temperature monitoring<br>Process for reporting incidents to research sponsors<br>28.06.13 a new system is due | Extreme | Possible | 15 | Replacement for IceSpy<br>Pharmacy department temperature monitoring<br>Minor temperature excursions<br>LRI cold store<br>LGH cold store | 4 | ⇳ | DR | |