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

Trust Board Paper V

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

Author/Responsible Director: Medical Director

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

The Report is provided to the Board for:

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

Summary / Key Points:

- Eight actions were due for completion in January 2013 and of these, seven have been completed and one action has a deadline that is extended to April.
- An increase in the risk score from 16 to 20 in relation to risk number four ('Failure to transform the emergency care system').
- Additional narrative to risk number seven ('Ineffective organisational transformation') in an attempt to show the close links between this risk and risk number eight ('Failure to achieve financial sustainability').
- Additional narrative to risk number three ('Inability to recruit, retain, develop and motivate staff') to reflect the continued work in relation to 'UHL branding' to attract a wider and more capable workforce.

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

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

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

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

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

(e) identify any other actions which it feels need to be taken to address any 'significant control issues' to provide assurance on the Trust meeting its principal objectives;	
Previously considered at another corporate UHL Committee? **Yes – Executive Team 12 February 2013**	
Strategic Risk Register **Yes**	**Performance KPIs year to date** **No**
Resource Implications (e.g. Financial, HR) **N/A**	
Assurance Implications **Yes**	
Patient and Public Involvement (PPI) Implications **Yes.**	
Equality Impact **N/A**	
Information exempt from Disclosure **No**	
Requirement for further review? **Yes. Monthly at Executive Team meeting and Board meeting.**	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **28 FEBRUARY 2013**

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

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

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1. INTRODUCTION

1.1 This report provides the Board with:-

a) A copy of the SRR/BAF as of 31 January 2013
b) A heat map of risk movements from the previous month
c) A summary of progress of actions due for completion in the reporting period.
d) Suggested parameters for scrutiny of the SRR/BAF.

2. CURRENT POSITION AS OF 31 JANUARY 2013

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

2.2 A heat map to show how the strategic risk scores have changed from the previous month is attached at appendix two.

2.3 Eight actions were due for completion in January 2013 and of these, seven have been completed and one action has a deadline that is extended to April 2013 (see appendix three for more detail).

2.4 Following discussion at the January Board meeting and subsequently the Executive Team meeting of 12 February the Board's attention is drawn to:

a. An increase in the risk score from 16 to 20 in relation to risk number four ('Failure to transform the emergency care system') reflecting a continuing adverse position in relation to ED performance. Changes to ED processes designed to make it easier for us to cope with this pressure and offer all patients a high standard of care have been implemented from 18 February. The intention is that by 1 April we will be able to provide sustained delivery of ED targets. As a result the deadline to meet the target score of this risk has been extended.

b. Additional narrative to risk number seven ('Ineffective organisational transformation') in an attempt to show the close link between this risk and risk number eight ('Failure to achieve financial sustainability').

c. Additional narrative to risk number three ('Inability to recruit, retain, develop and motivate staff') to reflect the continued work in relation to 'UHL branding' to attract a wider and more capable workforce.

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

Risk 6	-	Failure to achieve FT status.
Risk 7	-	Ineffective organisational transformation
Risk 11	-	Failure to maintain productive relationships

3. RECOMMENDATIONS

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

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

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

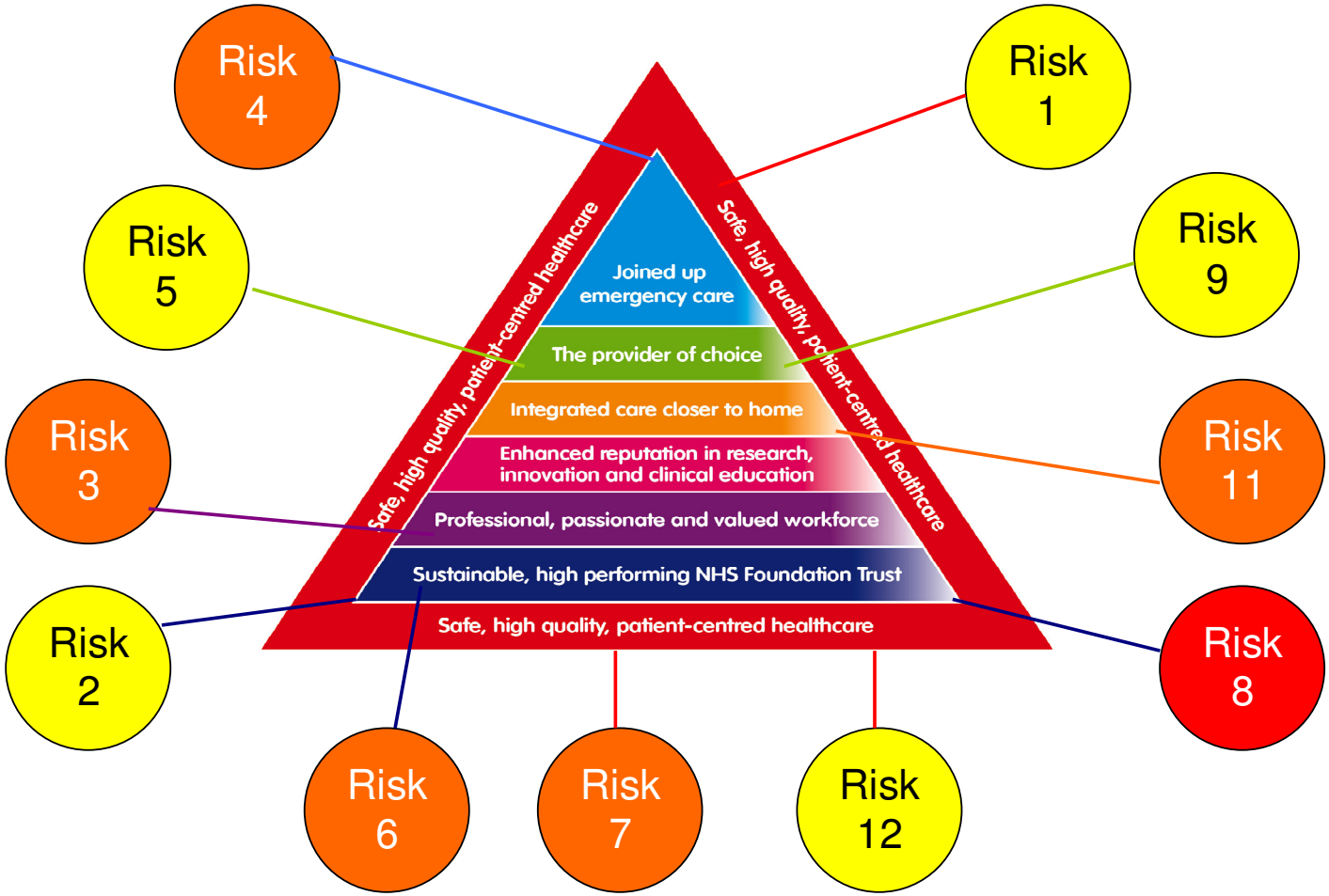
(c) identify any areas in respect of which it feels that the Trust's controls are inadequate and do not, therefore, effectively manage the principal risks to the organisation meeting its objectives;

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

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

Peter Cleaver,
Risk and Assurance Manager
21 February 2013

UHL STRATEGIC RISK REGISTER / BOARD ASSURANCE FRAMEWORK JANUARY 2013



PERIOD: 1 JANUARY 2013 – 31 JANUARY 2013

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

STRATEGIC OBJECTIVES:-

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

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

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	Current Score I x L	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	Target Score I x L	**Timescale** When will the action be completed?
Failure to achieve financial sustainability including:	Overarching financial governance processes including PLICS process and expenditure controls	5X5=25	Monthly /weekly financial reporting to Exec Team, F&P Committee and Board Cost centre reporting and monthly PLICS reporting Annual internal and external audit programmes Comparison with PLICS benchmarking against other NHS organisations	(c) Underlying deficit	Recovery plan to be developed and monitored by Executive Team (ET)/ F&P Committee and Board	4x3=12	Mar 2013 Director of Finance and Business Services
Failure to achieve CIP	Strengthened CIP governance structure		Progress in delivery of CIPs is monitored by CIP Programme Board and reported to ET and Board.	(c) At Month 9, Divisions have reported £19.5m of savings, short of the £23.1m target by £3.6m.			
Locum expenditure	Workforce plan to identify effective methods to recruit to 'difficult to fill' areas		The use of locum staff in 'difficult to fill' areas is reported to the Board on a monthly basis via the Quality and Performance report. A reduction in the use of such staff would be an assurance of our success in recruiting substantive staff to 'difficult to fill' areas.	(c) Failure to reduce locum spend – ytd to Jan '13.	Reinstate weekly workforce panel to approve all new posts (Feb '13).		Feb 13 Director of Finance and Business Services
Loss of income due to tariff/tariff changes (including referral rate for emergency admissions – MRET)	Contract meetings with Commissioners Negotiations with Commissioners concluded at a transactional level		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board	(c) Failing to manage marginal activity efficiently and effectively			
Ineffective processes for Counting and Coding	Clinical coding project		Ad-Hoc reports on annual counting and coding process				

Loss of liquidity	Liquidity Plan		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board				
Lack of robust control over non-pay expenditure	Non-pay action plan (agreed by F&P Committee)		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board.	(c) Failing to control adverse trends in non-pay (running ahead of activity growth).	Implementation of catalogue control project		Mar 13 Director of Finance and Business Services
Commissioner fines against performance targets	Contract meetings with Commissioners Negotiations with Commissioners concluded at a transactional level		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board	(c) Failing to reduce readmission trends			
Use of readmission monies	Contract meetings with Commissioners Negotiations with Commissioners concluded at a transactional level		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board	(c) Failing to reduce readmission trends			
Ineffective organisational transformation	See risk 7		See risk 7	See risk 7	See risk 7		

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inability to recruit, retain, develop and motivate suitably qualified staff leading to inadequate organisational capacity and development.	Leadership and talent management programmes to identify and develop 'leaders' within UHL	4x4=16	Development of UHL talent profiles	No gaps identified	No actions required	4x3=12	
			Talent profile update reports to Workforce and OD Committee	No gaps identified	No actions required		
	Substantial work program to strengthen leadership contained within OD Plan			No gaps identified	No actions required		
	Organisational Development (OD) plan			(c) OD plan not ratified (a) A potential measure of the number of applicants received for advertised posts may be a useful future assurance of the success of the OD plan	Ratification by incoming Chief Executive Officer To develop a monitoring and reporting process		Chief Executive Feb 2013 Jun 2013
	Workforce and OD Committee to monitor progress and oversee implementation of OD plan		Progress reports to Board via Workforce and OD Committee	(c) Executive group required to lead on OD plan	Formation of OD executive group		Mar 2013 Director of HR
	Staff engagement action plan		Results of National staff survey and local patient polling reported to Board via Workforce and OD Committee on a six monthly basis. Improving staff satisfaction position. Staff sickness levels may also provide an indicator of staff satisfaction and targets for staff sickness rates are close to being achieved (3.5% ytd at Dec 12)	No gaps identified No gaps identified	No actions required No actions required		

	Appraisal and objective setting in line with UHL strategic direction		Appraisal rates reported monthly to Board via Quality and Performance report. Current rates 90.8% ytd at end of Dec 12 Results of quality audits to ensure adequacy of appraisals reported to the Board via the Workforce and OD Committee. Quality Assurance Framework to monitor appraisals on an annual cycle (next due March 2013).	No gaps identified No gaps identified No gaps identified	No actions required No actions required No actions required		
	Workforce plan to identify effective methods to recruit to 'difficult to fill areas)		The use of locum staff in 'difficult to fill' areas is reported to the Board on a monthly basis via the Quality and Performance report. A reduction in the use of such staff would be an assurance of our success in recruiting substantive staff to 'difficult to fill' areas.	(c) Detailed workforce plan for 2013/14 required	Work being undertaken with Divisions, HR and Finance Colleagues to produce detailed workforce numbers for 2013/14. this will include key transformational projects		Feb 2013 Director of HR
	Reward /recognition strategy and programmes (e.g. salary sacrifice, staff awards, etc)			(a) Reward and recognition strategy requires revision to include how we will provide assurance in the future that reward and recognition programmes are making a difference to staffing recruitment/ retention/ motivation.	Revise strategy		Jun 2013 Director of HR
	UHL Branding – to attract a wider and more capable workforce. Includes development of recruitment literature and website, recruitment events, international recruitment. This includes a recently held nurse recruitment day (Jan 2013)		Evaluate recruitment events and numbers of applicants. Reports issued to Nursing Workforce Group (last report 4 Feb). Report to Workforce and OD Committee in March. Positive feedback from nurse recruitment day on 26 Jan 2013	(a) Better baselining of information to be able to measure improvement. (c) Lack of engagement in production of website material	Take baseline from January and measure progress now that there is a structured plan for bulk recruitment. Identify a lead from each professional group to develop and encourage the production of fresh and up to date material		Dec 2013 Director of HR

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to transform emergency care system leading to demands on ED and admissions units continuing to exceed capacity	LLR emergency Care Network Project to reduce emergency attendances and ensure maximum use of the Urgent care centre.	5x4=20	Monthly report to Trust Board in relation to Emergency Dept (ED) flow	ED 4 hour standard (Target 95%): ED - (UHL + UCC) = 94.1% ytd (Dec) ED - UHL Type 1 and 2 = 92.6% ytd (Dec) ED Waits - Type 1 = 91.8% ytd (Dec)		4x3=12	
	Increased recruitment of ED Medical and nursing staff		Monthly Quality and Performance summary report to TB including use of agency staff	No gaps identified	No actions required		
	LLR Emergency Plan to ensure that delays to transfer of care are minimised.		Monthly report to Trust Board in relation to Emergency Dept (ED) flow	No gaps identified	No actions required		
	'Right time, right place' initiative to ensure ED process provides timely assessment in Ed to facilitate transfer to AMU or discharge. Metrics in place in relation to AMU assessment process		'Time to see consultant' metric included in National ED quarterly indicator	No gaps identified	No actions required		
	Emergency Care Pathway Programme to enable a comprehensive and co-ordinated approach to the design and implementation of process improvements across the end-to-end patient flow for our ED attendees and medical non-elective patients.		Monthly report to Trust Board in relation to Emergency Dept (ED) flow	No gaps identified	No actions required		

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

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

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

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to achieve Foundation Trust (FT) Status within specified timescale (April 2014)	FT Application Programme Board to provide strategic direction and monitoring of FT application programme FT Workstream group of Executive and operational Leads to ensure delivery of IBP and evidence to support HDD1 and 2 processes FT application project plan/ team	4x4=16	Monthly progress against project reported to Board to provide oversight. Feedback from external assessment of application progress by SHA (readiness review board-to-board meeting scheduled for 19/12/12	No gaps identified No gaps identified	No actions required No actions required	4x3=12	
	Monitoring of KPIs in particular in relation to financial position and ED performance that are crucial for a successful FT application		Monthly Finance and Performance report to Board	(c) significant financial variance from plan (c) Underperformance in relation to ED targets	See actions associated with risk number 8 Transform emergency care system to reduce demand and increase footprint of ED (see risk 4)		During 2013/14 Chief Executive Officer

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

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

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

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to achieve and sustain operational targets leading to contractual penalties, patient dissatisfaction and poor reputation.	Backlog plans to recover 18 week referral to treatment (RTT) target	4x3=12	Monthly Q&P report to Trust Board showing 18 week RTT rates. RTT admitted and non-admitted rates favourable against target	No gaps identified	No actions required	4x3=12	
	Referral pathways to decrease demand and ensure discharge to GP where appropriate			(a) Lack assurance in relation to performance metrics to show activity versus number of patients deferred onto a different care pathway.	Development of key metrics at a local level		**tba**
	Transformational theatre project to improve theatre efficiency to 80 -90%		Monthly theatre utilisation rates included in divisional heat map presented to Trust Board on a monthly basis. Target utilisation is 86%; month 7 position is 81.4% (I/P) and 74.6% (O/P).	No gaps identified	No actions required		
	'Right place, right time' initiative		Monthly report to Trust Board in relation to Emergency Dept (ED) flow (including 4 hour breaches)	No gaps identified	No actions required		
	Each tumour site has developed processes to achieve targets		Director of Operations receives reports from Cancer Manager and information included within Monthly Q&P report to Trust Board	No gaps identified	No actions required		
	Ongoing monitoring of key performance indicators		Monthly Q&P report to Trust Board	No gaps identified	No actions required		

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

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

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

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

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	Current Score I x L	**How do we know we are doing it?** **(Key assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives are discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	Target Score I x L	**Timescale** When will the action be completed?
Failure to reduce avoidable harms and mortality and morbidity leading to decreasing patient experience/ patient satisfaction and loss of reputation	Policies and procedures	4x3=12	Hospital Standardised Mortality Indicators reported monthly to Trust Board via Quality and Performance (Q&P) report. Improving position in relation to (HSMI) and HSMI @within expected' for elective and non-elective activity	(a) Lack of mortality analysis out of hours/weekend (a) absence of community-wide mortality review		3x2=6	
	Relentless attention to 5 Critical Safety Actions (CSA) initiative to lower mortality		Q&P report to Trust Board showing outcomes for 5 CSAs. 5 CSAs form part of local CQUIN monitoring. RAG rated green at end of quarter 2.	(c) Lack of a unified IT system in relation to ordering and receiving results means that many differing processes are being used to acknowledge/respond to results. Potential risk of results not being acted upon in a timely fashion.	Feasibility of a less cumbersome IT platform to be investigated by IBM.		Review May 2013 Dep Chief Executive / Chief Nurse
	Learning lessons from incidents, complaints and claims to reduce the likelihood of recurrence.		Monthly patient safety report to Quality Assurance Committee (QAC) and Quality and Performance management Group (QPMG) Number of formal complaints received reducing	No gaps identified	No actions required		
	Infection prevention plan to ensure hospital acquired infections are reduced		MRSA/C. Difficile rates reported to Trust board via monthly Q&P report. 1MRSA case reported to end of Dec 12 Target = 6. Last case Sep 12 C. Difficile currently below trajectory. 69 cases to end of Dec 12 against target of 113.	No gaps identified	No actions required		

	Monthly patient experience monitoring 'Net Promoter'		Monthly patient experience report to Trust board included within Q&P report. Improving Net Promoter results (57.5% at Dec 12)	No gaps identified	No actions required		
	Implementation of UHL Quality and Safety Commitment' 2012 – 15 (launched Jan 13) Key priorities: Reducing harm, reducing mortality rates and improving the patient experience		Monitoring of CQUINS outcomes via monthly Q&P report to Trust Board Further reductions in SHMI.	(c) Resource to support the delivery of the 'Quality Ambition' is still to be identified. (c) Need wider engagement of CCG partners for health economy initiatives	Delivery of 3 clinical task groups to identify resource requirements 2013 CQUIN and quality negotiations		Dep CEO/ Chief Nurse Mar 2013 Dep CEO/ Chief Nurse Mar 2013
	NHS Safety thermometer utilised to measure the prevalence of harm and how many patients remain 'harm free' (Monthly point prevalence for '4 Harms')		Monthly outcome report of '4 Harms' is reported to Trust board via Q&P report Trust is seeing an improving 'harm' position. However, new DoH definitions may see an increase in harm attributed to UHL to encourage closer working between primary and secondary care	a) The collection of ST data at ward level is resource intensive. There is also a risk that some data may not be accurate due to complex DoH definitions of each harm in relation to whether it is community or hospital acquired	Ongoing education from the operational leads for each harm during the monthly data collection and validation process Utilisation of CQUIN monies for 2013/14 to invest in data collection posts at ward level to improve data quality and release time of ward managers to focus on reducing harms		Dep CEO / Chief Nurse Apr 2013 Dep CEO / Chief Nurse Apr 2013
	Measurement through clinical audit programme to identify adherence to practice standards and outcomes		Bimonthly reports to UHL Clinical Audit Committee Clinical audit dashboards presented at QAC, QPMG and divisional boards	No gaps identified	No actions required		

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	Current Score I x L	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	Target Score I x L	**Timescale** When will the action be completed?
Levels of patient satisfaction/experience may deteriorate leading to poor reputation and deterioration in NET provider scores	Patient experience plan and associated projects	4x3=12	Patient experience progress reports to Quality Assurance Committee (QAC) Patient stories presented at Trust Board Discharge project outcomes (i.e. delayed transfer of care) reported to the Discharge and Transfer of Care (DTOC) Group and monthly to the emergency Care Network and Clinical Quality Review Group (CQRG). Data included in monthly Quality and Performance report to Trust Board.	(c) Lack of patient experience strategy including: • Improving services for older people • Improve services for patients with dementia • Improve services for 'End of Life' (c) Trust-wide communications of patient experience learning	Final version of Patient Experience Strategy document to be presented at TB	2x3=6	Feb 2013 Dep. CEO/Chief Nurse
	Net Promoter scores to identify key areas for focus		Ongoing Patient Experience surveys Net Promoter scores reported monthly to Trust Board via Q&P report. Improving picture in relation to Net Promoter scores (55% ytd at Dec 12)	No gaps identified	No actions required		
	Caring @its best, releasing time to care initiatives and implementation of UHL Quality and Safety Ambition (launched Jan 13). Key priorities: Reducing harm, reducing mortality rates and improving the patient experience		Caring @ its best awards Improving patient experience reports Improved infection prevention outcomes	(c) Lack of supervisory headroom for ward managers	Develop proposal for the ward managers to have rostered supervisory time in line with Francis recommendations		Apr 2013 Dep CEO/Chief Nurse

	Patient experience programme (across 85 clinical areas to gain feedback from patients relating to their experience of care) and national patient survey		Ongoing Patient Experience surveys. Net Promoter scores reported monthly to Trust Board via Q&P report. Annual reporting to trust board of national patient survey	No gaps identified No gaps identified	No actions required No actions required		
	Trust values instilled within UHL staff.		UHL staff awards demonstrating individuals who demonstrate the values. Ongoing Patient Experience surveys. Net Promoter scores reported monthly to Trust Board via Q&P report.	No gaps identified	No actions required		
	Patient Adviser /LINKS engagement at divisional level to ensure consistent involvement in the development of services			(a) No current mechanism to monitor involvement of patient adviser/ LINKS to provide assurance of involvement/ engagement	Identify monitoring mechanism		Mar 2013 Director of Comms

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

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

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

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

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

APPENDIX TWO

UHL STRATEGIC RISKS SUMMARY REPORT – JANUARY 2013

Risk No	Risk Title	Current Risk Score (Jan 13)	Previous Risk Score (Dec 12)	Target Risk Score and Final Action Date	Risk Owner	Comment
8	Failure to achieve financial sustainability	25	25	12 – Mar 13	Director of Finance and Business services	
3	Inability to recruit, retain, develop and motivate staff	16	16	12 – Jun 13	Director of HR	
4	Failure to transform the emergency care system	20	16	12 – Q1 2013	Director of Operations	Likelihood score increased following discussions at January Board meeting and ET meeting on 12/2/13. Further actions to be identified to reduce the risk to its target score
7	Ineffective organisational transformation	16	16	12 – 2013-14	Director of Finance and Business Services	
6	Failure to achieve FT status	16	16	12 – 2013-14	Chief Executive Officer	
11	Failure to maintain productive relationships	15	15	10	Director of Communications and External Relations	
9	Failure to achieve and sustain operational targets	12	12	12	Director of Operations	
12	Inadequate reconfiguration of buildings and services	12	12	9 - Apr-14	Chief Executive Officer	
1	Reducing avoidable harms	12	12	6 – Mar 13	Dep. Chief Executive/ Chief Nurse	
5	Patient experience/ satisfaction	12	12	6 – Apr 13	Dep. Chief Executive/ Chief Nurse	Deadline for target score extended to allow for proposal to be developed in relation to ward managers having rostered supervisory time.
2	Business continuity	9	9	6 – Jan 13	Director of Operations	
10	Loss of reputation		n/a	n/a	n/a	This risk has been deleted. Loss of reputation is a consequence of failure to control other risks

APPENDIX THREE

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

Risk No.	Action Description	Action Owner	Comment
1	Trust-wide launch of 'Quality and Safety Commitment'	Deputy Chief Executive/ Chief Nurse	**Completed.** Approved by Trust Board in December 2013. Rolling programme of Divisional briefing planned in place.
2	New terms of reference and membership of the Emergency Planning and Business Continuity Committee to oversee and provide strategic oversight and commitment to business continuity.	Director of Operations	**Completed.** New terms of reference agreed. Minor alterations to Committee membership required to reflect recent organisational change.
2	New policy to identify key roles within the Trust of those responsible for ensuring business continuity planning /learning lessons is undertaken.	Director of Operations	**Completed.** New Business Continuity policy approved by UHL Policy and Guidelines Committee (subject to minor amendments) 18 January 2013.
4	Right Place consulting to be appointed to identify performance metrics in relation to AMU assessment process	Director of Operations	**Completed.** Copy of metrics to be used presented to Board in January 2013
5	Outpatient project delivery plan to be developed	Director of Operations	**Completed.** A roll out plan developed and circulated to Divisions for inclusion in their CIP plans. The plan is based on having a team of 5 people to work with services on the roll-out. 2 are already in place, 1 starts on the 4th of March and we will be going out for advert for the remaining 2 (band 5 posts) in the next 2 weeks.
5	Develop proposal for the ward managers to have rostered supervisory time in line with Francis recommendations	Deputy Chief Executive/ Chief Nurse	**Ongoing.** Proposal to be developed following TB workshop on 15 February. Deadline for completion extended to April 2013
8	Ongoing negotiations with Commissioners in relation to managing marginal activity efficiently/effectively and failing to reduce admission trends	Director of Finance and Business Services	**Completed.** Negotiations concluded at a transactional level.
12	Finalise and ratify clinical strategy	Medical Director	**Completed.** Final version ratified by the Board December 2012.

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	Manager	Div/Exec Director	Strategic risk No.
Women's and Children's	Women's	Lack of Capacity in maternity services	28/09/2007	**Causes** Continuing increase to the birth-rate in Leicester . The number of maternity beds has decreased. 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 **Consequences** Midwifery staffing levels are not in accordance with national guidance however are in line with regional averages 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 Increase in incidents reported where there has been a delay in elective CS, IOL and augmentation due to lack of beds Staff frequently go without meal breaks Increased waiting time in MAC and therefore increased risk of a clinical adverse outcome to both mother and baby	Human resources	Length of postnatal stay in hospital as short as possible. Community staff prepare women for early discharge home if straightforward delivery. Extra triage room on Delivery Suite, LRI completed July 2012 Triage and admission areas in acute units to ensure no category x women sitting on delivery suite Use of Escalation Plan to inform staff on actions required if capacity is high Capacity is managed between the two acute units by temporarily transferring care if one site is busy Liaison with neighbouring maternity hospitals if high risk of closure of Leicestershire Maternity Hospitals Prioritisation of both elective and 'emergency' work according to clinical urgency and need On call Manager On call SOM Funded midwife places increased to 1:32	Extreme	Likely	20	Prepare escalation and contingency plans - Complete Relocation of all elective gynaecology beds to LGH - complete 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 Increase ward capacity on LRI site by having EL CS women on level 1 - due 31/8/2013 Gynae theatres to be refurbished to accomodate EL CS at LRI - due 31/12/2013	12	⇔	JPORT	PR/ KB	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	Manager	Div/Exec Director	Strategic risk No.
Women's and 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 US performed by suitable trained staff Self audit Use of regular pre-booked agency sonographers Daily review of outstanding requests to monitor the situation Access to consultants for second opinion if suspicious re possible abnormality All ultrasound machines now of suitable specification and replaced 5 yearly Incident report forms Update 18.10.12 "□Continued use of Agency Sonographers "□Continued 'extra' lists by Fetal Med Consultants "□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	Provide support for sonographers through training and reducing pressure on the time for appointments - Complete Create further USS space or utilise existing space out of hours to increase capacity - due 31/03/13 Divisional Manager to request a more robust recruitment plan from Imaging CBU - complete Extra scan room to be included as part of the interim solution (LGH) - due 30/4/13 Funding of additional list so pressure on appointments less, giving more time for detailed scanning - Complete Business case for 2 further USS machines - Complete Recruitment of further sonographer - due 31/03/13 Capital bid in for additional ultrasound machine - Complete Divisional Manager to request a more robust recruitment plan from Imaging CBU - complete Extra scan room to be included as part of the interim solution (LGH) - 30/4/13	6	⇔	LPA	PR/SH	1

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	Manager	Div/Exec Director	Strategic risk No.
Clinical Support	Professional Services	Risk to the production of aseptic pharmaceutical products	03/05/2007	**Causes** Temporary nature and age of facility indicates high probability of failure. Temporary nature of current facility and cramped working conditions indicate arrangements for segregation of in-process and completed items is inadequate leading to high possibility of error. Current temporary unit is outside the range of the department's temperature monitoring system. Failure of refrigerated storage will remain undetected outside working hours. Current planning permission for temporary unit only valid until August 2012 Current contingency arrangements are insufficient. The current commercial architects assigned to the project build are not deleivring to deadlines. Storage, receipts and dispensing facility for dose-banded chemotherapy and other outsourced items purchased - alternative arrangements will need to be found when unit is refurbished **Consequences** Inability to provide 50% of current chemotherapy products for adult services. Inability to provide any chemotherapy for paediatric services. Substantial delay in re-establishing service provision from alternative supplier, plus increased revenue costs for an alt Limitations of treatments that can be sourced from an alternative supplier Inability to support research where aseptic compounding required. Financial impact. High cost of sourcing required products from alternative supplier at short notice. Increase in incidents pertaining to the Aseptic Unit.	Business	Planned servicing & maintenance of existing facility being undertaken. Constant environmental monitoring of facility in place. 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. Contingency arrangement for supply form external source currently being pursued. Business Case for new unit (refurbishment of facility within the Windsor building) has been presented and approved by the commercial exec board in 2011. Facilities are working with Pharmacy and commercial architects in order to finalise plans and get refurbishment started	Extreme	Likely	20	Evaluation of tenders & contact awarded - 31/01/13 Sign off from chairman - 31/03/13 Build to commence - 22 week contract - 30/06/13 Build complete, unit in operation - 31/07/13	3	⇔	GH	SC/ JA	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	Manager	Div/Exec Director	Strategic risk No.
Corporate	Corporate Medical	Reduction in numbers of middle grade trainees	18/11/2010	**Causes** National reduction in number of middle grade Dr's. **Consequences** Less training places offered in specialty training. Impact on General Surgery and ENT trainees planned for 2011, other specialties will follow (Hewitt- Johnson numbers). Reduced pool of more experienced trainees who traditionally support training and supervision of the more junior trainees. This will result in increased workload for consultants Shifts may be uncovered leading to the potential for: Sub-optimal treatment Delays to treatment impacting upon national targets (e.g. ED 4 hour wait, 18 week RTT, etc) Loss of Trust reputation Increased incidents, complaints, claims Reduction in GMC status	Human resources	The Education teams (Nurse education, HR training and Directorate of Clinical Education) are working with key clinical members of the CBU's to explore possibilities of non medical staff being offered additional, accredited training to advance their practice roles.	Major	Almost certain	20	Clinical Divisions to develop action plans based on loss of posts. - 31/01/13 Other staff groups to be developed to perform some of the existing roles - 31/01/13 Discussions will take place with both Leicester University and DMU to explore which organisation is best placed to support the teaching and delivery of this training - 31/01/13 A generic model will be developed so that once a core programme of training has been followed; specialty or sub specialty to match workforce need can be added. - 31/01/13	12	⇔	SCAR	KH/KB	3
Corporate	Corporate Medical	Reduction in income from SIFT monies	18/11/2010	**Causes** Rebasing of educational funding including national rebasing of placement fees leading to reduction of up to £5 million income over a four year period for the Trust to support undergraduate medical student teaching. **Consequences** Loss of continuity of services (yet to be identified which services will be affected. Reduction in teaching activity for medical students Loss of Trust reputation as a teaching hospital Potential loss of Medical School due to destabilisation by the reduction in activity and teaching with subsequent potential loss of all SIFT monies	Economic	The Department of Clinical Education has made efforts to maintain student presence in UHL and maintain the funding stream into UHL.	Major	Almost certain	20	Identify the services that will be impacted upon by the shortfall in funding. Complete Deficit to be carried forward as one of a number of 'corporate' CIP's whilst a detailed breakdown of how the funding are used in CBU's is undertaken 31/01/13 Review the allocation of Educational Programmed activities to ensure the correct facilitator support matches the need of the educational programme and the work streams within the Directorate of Clinical Education, whilst seeking efficiency opportunities 31/01/13	20	⇔	SCAR	KH/AS	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	Manager	Div/Exec Director	Strategic risk No.
Acute Care	Cardiac Critical Care and Renal	Inappropriate environment and infection prevention Renal Transplant	25/10/2011	**Cause** Insufficient side room capacity Inadequate space in existing side room for haemodialysis and line procedures. Insufficient en suite facilities in side rooms Vascular access and % of patients with dialysis catheters Procedure room on ward 10 not fit for purpose Inappropriate areas used for renal biopsy on ward 17 Inadequate drug preparation areas Inadequate domestic storage areas No separate facility for isolating patients in ward 10/17 DCU Movement of patients to accommodate admissions or haemodialysis in another area **Consequence** Poor compliance with cannula care Challenges in maintaining integrity of commode lids using Chlorclean Infection prevention risk Transportation of contamination through patient occupied areas (15N/A)	Patients	Preventing Transmission of Infection including Isolation Guidelines (DMS 47699) MRSA Screening policy Weekly MRSA audits undertaken by IP Team Local Infection Prevention Group Communication of IP issues regular agenda item on local meetings Link Nurse Network Daily side room list Monthly Nursing Metrics audits Monthly HII audits Monthly Environment audits Recent refurbishment and upgrade of ward 15N/A accommodation Steam cleaning post CDT patients Vascular access being monitored by CQUIN & EMRN Medically led Vascular Access coordination Expert specialty trained competent staff Use 'cohort facility' as required Ongoing competency based programme for the training and implementation of ANTT	Major	Almost certain	20	Development of renal relocation plan - 31/01/2017 Ad-hoc Matron/Consultant IP ward audits - Completed Presentation of IP issues at MDT audit meeting - Completed Infected patients will have procedures last on the list in ward 10 procedure room - Completed Entire commodes will be used to transport body fluids to sluice through patient occupied areas where appropriate and the commode will be cleaned - Completed Undertake commode review to ensure commodes are fit for purpose and replace accordingly - Completed Undertake a review of ward 17 facilities available for transplant biopsies - Completed Undertake review of drug preparation areas as part of RT2C project - Complete Undertake a review of domestic storage areas - Completed Being reviewed by Lead Nurse with a view to closing the risk / reducing risk score - 31/01/2013	15	⇔	JPR	DS/SH	1

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	Manager	Div/Exec Director	Strategic risk No.
Women's and Children's	Women's	Inability to archive Echocardiography clips	28/05/2012	**Causes** Since taking possession of a new ultrasound machine we have been unable to archive any echocardiograms performed. Previously they have been stored on the hard drive of the machine but this has now become full so older images are being lost. Several months worth of images were lost following repair of equipment. No longer able to store images on VHS cassettes. The ultrasound machine does not interface to the hospital PACS system due to issues with CRIS. There are storage issues with CDs and managing a library of these that prevent their use. **Consequences** There is currently no way to review an echocardiogram on the Neonatal unit of LRI once the image is deleted from the hard drive of the scanner. The management of sick newborn infants is potentially compromised and the ability to prove or justify what occurred and what the echocardiography findings were in the event of a complaint / litigation is seriously undermined.	Patients	Peer review of Echocardiograms (however there are occasions when this is not done due to other priorities). Hand written report by the person who performed the echocardiogram.	Major	Likely	16	UHL Radiology and IM&T services need to actively work with Neonatology service to find a solution. - 31/12/12 The resolution of issues with CRIS and PACS to allow video clips to be stored for archiving. - 31/12/12	2	⇔	ACURR	PR/SH	1
Women's and Children's	Children's	Paediatric Respiratory Service Capacity and Demand	28/05/2012	**Causes** Staffing levels (particularly at Consultant Medical Grade level) are insufficient to cope with current demand of new patients. National shortage of paediatric Respiratory Consultants **Consequences** New patient referrals are waiting longer than acceptable for first appointments and follow up patients are not being seen in a timely manner and in line with their medical care plan. Significant risk both clinically and in relation to performance targets. Increased complaints are likely.	Patients	Monitoring of waiting list fortnightly. All contacts from concerned parents, routed to clinicians for advice.	Major	Likely	16	To consider transfer of care to other providers and or close to new referrals. (business risk if this option taken) - Complete To review extra clinics (WLI) - 30/4/13 Recruitment of Two Respiratory Consultants under way. - 30/4/13 Service capacity to be reviewed through annual business planning process - 30/4/13	4	⇔	NK	PR/KB	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	Manager	Div/Exec Director	Strategic risk No.
Clinical Support	Imaging and Medical Physics	Risk of non-compliance with NHSLA ARMS criterion 5.4	04/01/2012	**Causes:** UHL currently uses several different databases / spreadsheets and local systems to retain records and evidence applying to the management of medical devices / equipment. A recent visit by the NHSLA assessor for UHL determined that; Issue around different equipment databases will make it difficult to provided succinct evidence for level 2. **Consequences:** There is a risk that the current practice of using several different data sources will lead to UHL being unable to provide satisfactory evidence of compliance with the organisations policy for criterion 5.4 and a failure against this standard will be the outcome as a result.	Statutory	Local evidence is the responsibility of the holding Corporate or Clinical Division / CBU The Lead Officer for NHSLA criterion 5.4 requests evidence from the holding Corporate or Clinical Division / CBU to create a central evidence file. Note: this does not provide assurance that all medical devices are being managed according to policy; only that those where evidence has been provided are. Provide 4 temporary staff to undertake AIMS record update 30/7/12 - action completed 10/8/12	Major	Likely	16	Amalgamate key datasets held across UHL onto single database (AIMS) - 31/3/13 Medical Physics manage 3rd party PPM contracts and hold associated records on AIMS - 31/3/13 Update all current asset records held on AIMS - 31/03/2013	8	⇔	MNO	SC	

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	Manager	Div/Exec Director	Strategic risk No.
Clinical Support	TAPS	Patient Safety and Financial risk due to failure to deliver sufficient resident Anaesthetic cover across three hospital sites	12/11/2012	**Causes** Insufficient trainees to safety cover all the areas required over all three main UHL sites while complying with both the Working Time Directive and ensuring all trainees have sufficient core days to undertake their training. National move to reduce the number of trainee doctors by (SHA reduction aim 25%) 3 for UHL. This reduction of 3 trainees will start to effect the rota's from February 2013 and will progressively reduce the number of trainees by 3 each year for the next 5 years. Current under populated rotas National Drive to reduce trainee anaesthetists (by 150 for UK) Change in process for allocation of ICM numbers and proportion trainees work in ITU Necessity at present to cover 3 acute sites **Consequences** Increased Agency and Locum use - leading to poorer patient care, increased risk of adverse events and increased cost to the CBU Increased use of consultant cover on the rota - leading to increased cost to the CBU and inability to cover elective activity Reduction in morale and reputation with Trainees There will be an increased probability of a greater than 30 minute response time to the following: Paediatric cardiac arrest team Adult cardiac arrest team Trauma team Emergency CT scanning Opening of a second COD operating theatre in an emergency Opening of a second maternity emergency theatre Transfer of critically ill patients	Economic	Use of consultants Trainees covering additional sessions as locums Increase in local payments to encourage junior medical staff Use of Agency doctors Appointment of specialist doctors where possible 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. Appoint anaesthetic assistants to reduce some pressures during day time shifts The use of cardiac trainees to cover ITU at GGH	Major	Likely	16	Review on call provision across all services, across all sites - 01/04/13 Authorise recruitment of additional Specialty Doctors as priority, having reviewed job descriptions and rota duties - 11/01/13 Contact local Trusts to offer sessions to other medical staff - 09/01/13 New MTI training grade doctor to be appointed to start - start 07/03/13	5	⇔	NDV	SC/SH	1

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	Manager	Div/Exec Director	Strategic risk No.
Planned Care	GI Medicine, Urology, Surgery	Typing backlog	07/01/2013	Typing backlog **Cause:** A & C review resulting in a shortage of staff. Secretary Sickness Volume of letters **Consequence:** Delay in communication with GPs and clinicians Delay in treating pts	Patients	Agency & Bank appointments Outsourcing to Dictate IT - gastro commenced Dec 12 Outsourcing to Dict 8 Urology/ gastro	Major	Likely	16	Outsource Dict 8 other specialties, Roll out Dictate IT to GS & Urology	4	★	FG	KB	
Planned Care	All	Detrimental impact on service delivery during implementation of Medical Transcription Outsourcing.	13/04/2011	**Causes** Significant management of change process which impacts on a large number of staff. **Consequences** Potential resultant A & C redeployment/redundancies. Adverse media attention Impact on staff motivation & goodwill & therefore productivity. Increased backlog of typing workload Increased sickness Potential lack of support from clinical colleagues in implementation. Gap in service provision. Stress for significant numbers of employees.	Patients	Project Board established Communication plan underway way - pre-consultation & formal consultation with staff A & C vacancies recruited to on short term basis only. Risks reviewed as standing item on divisional board. Communication to be undertaken simultaneously across CBU's Full procurement and evaluation exercise to be undertaken Where backlogs identified local CBU/Specialty to consider use of agency staff Monitor of typing time Stress risk assessments	Major	Likely	16	Implement outsourcing in Pilot specialty then role out - 31 03 13 Retaining vacant posts on an ongoing basis to minimise redundancies - 31 03 13	6	⇳	STA	AF/KB	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	Manager	Div/Exec Director	Strategic risk No.
Corporate	Operations	Risk of inaccuracies in clinical coding	02/08/2011	**Causes** HISS constraints (HRG codes not generated) High workload (coding per person above national average) Inaccuracies / omissions in source documentation (e.g. case notes may not include co-morbidities, high cost drugs may not be listed) Inability to provide training to large groups of coders due to lack of time and financial constraints **Consequences** Loss of income (PbR) Outlier for CHKS/HSMR data Non- optimisation of HRG Loss of Trust reputation	Economic	Coding improvement project initiated Project Board commenced 5th September 2011 Electronic coding implemented February 2012 and to be upgraded November 2012 Task and finish groups completed in Divisions review improvements in coding using PeRL, PLICs, CHKS and medicode (encoder). New process for medical records retrieving notes. Due to changes in recording and payment of EDU and CAU episodes number of episodes coded has reduced. Shifts from day case to outpatient will reduce workload. 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. Bank staff and overtime authorised to meet deadline. Scorecard developed to demonstrate improvements and benchmark against other Trusts. Two additional coders accredited 3 year refresher programme completed November 2011. Quarterly updates/briefings led by Asst Director of Information Coder workshops on all 3 sites during May to review structure. Regular progress updates to F&P and GRMC. Clinical Coding Manager has a regular slot on Junior Doctor's induction day, presentation including financial examples are delivered.	Major	Likely	16	12 month coding project commencing 01/04/11 - project manager appointed - PID agreed - complete Implement electronic encoder software for use by coders and clinicians - completed Scoping exercise to identify future business/resource need - 31/1/13 Clinical coding dashboard bringing a range of published metrics together - complete Consultant and clinical staff accurately recording diagnosis, co-morbidities and complications - complete Internal audit programme to be developed complimented with an annual external audit. - complete Review the priority of this risk after go live with the encoder as all actions will have been taken - 31/1/13 External PbR Audit - 2 areas 31/1/13	8	⇔	JRO	JT/AS	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	Manager	Div/Exec Director	Strategic risk No.
Corporate	R&D	Athena Swan	12/10/2012	Athena Swan - Women in science. Standards required for next round of 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 University	4	⇔	CMAL		
Corporate	Nursing	Lack of capacity and funding within IT to progress rollout of the standardised nursing transfer discharge letter project	29/06/2012	**Cause:** That due to capacity and funding issues within the Trust the rollout of the standardised electronic and paper nursing transfer letter has been significantly delayed. **Consequence:** With no date set for resolution, this means that essential information relating to the safety of patients may not be effectively shared with the receiving care provider	Quality	That across the Trust a revised and agreed nursing discharge summary form has been created and piloted Monthly audits in place (please note these are currently demonstrating non compliance) Monthly discharge training day Sharing of the findings from recent reports with Heads of Nursing and members of the Adult Safeguarding Reference Group A business request has already been submitted to IT to support project rollout Highlight finding from recent audits to the Trust Nursing Executive Group	Major	Likely	16	Explore funding to arrange for a paper supply of the agreed transfer sheet pro forma with Director of Nursing for a 6 month supply - Complete Include letter template on DMS MG - Complete Raise with district nursing services to request a faxed discharge form is sent on referral to them - complete Inform the Leicester City Safeguarding Board of actions taken - Complete Formally request Head of Nursing to implement the new paper transfer form and audit compliance within one month - Complete Formally raise risk at the Trust discharge group - Complete Liaison with IT to agree a date for wider roll out of pilot project - 28/2/13	12	⇔	MCLA	PR/ KB	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	Manager	Div/Exec Director	Strategic risk No.
Corporate	Nursing	Exceeding agreed numbers of pre-registration nursing and midwifery students allocated to placements	30/06/2010	**Causes:** UHL Bed reduction programme and reconfiguration of services has caused a reduction in available clinical placements. **Consequences:** Increasing the number of students allocated to a clinical placement, above the audited (i.e. the agreed number) will have a direct impact on the quality of the learning which takes place. Increasing ratio of students to mentors may increase the risk of unsafe practice and subsequent patient harm. Students are not exposed to the range of learning experiences to ensure progression through training and fitness to practice at point of registration. Increased numbers of students will result in mentors being unable to spend time observing practice and ensuring that skills are developed and sustained over a period of time. Potential for students to pass their outcomes without sufficient evidence to support that decision. No assurance that mentors will be able to commit the time required to each and every student, therefore increasing the risk that students will practice unsupervised. Trust's ability to demonstrate the maintenance of high quali Trust may fail to meet the requirements within the Learning	Patients	Placements for the immediate future have been completed and the situation has stayed the same since the last assessment. However, the situation needs to be closely monitored by the PLLs and Assistant Director of Nursing as the next round of placements for October 2012 will be in the planning stage in June 2012 and as previously highlighted, it is anticipated that there will be an increased capacity concern from June 2012 onwards Any increase, or decrease, in numbers is agreed between the Placement Manager and the PLL based on the most recent staffing information. The LLR Placement Strategy is implemented in partnership with De Montfort University. Current status is Green for the Management of Capacity for Students on Commissioned Pre-registration Nursing and Midwifery Programmes in Leicester, Leicestershire and Rutland as existing students have been placed Continue to strengthen and empower the role of the Student Link Nurse. Where any additional ward or department closures takes place, resulting in the loss or change of the learning environment, the Practice Learning Lead wil All learning environments will be audited annually to Student evaluations completed following placements Update June 2012 - DMU are aware of the potential i Update October 2012 - DMU are aware of the potent	Major	Likely	16	The LLR Workforce Development team to be informed of the demands on placements - Complete Updates to be given at the next Health and Life Sciences Meeting by the Assistant Director of Nursing - Complete Practice Learning Leads (PLLs) to monitor any Trust reconfiguration to establish the impact on the learning environment and the support of students - 31/12/13 PLLs to ensure that when changes occur to clinical areas; there is communication with student nurses, midwives and all learners accessing the placement area and their Higher Education Institutes - 31/12/13 PLLs to provide local support to Student Link Nurses and mentors - 31/12/13 PLLs and Assistant Director of Nursing to work in partnership with colleagues across LLR and De Montfort University to ensure adherence to the PLLs and Assistant Director of Nursing to ensure UHL continues to meet the requirements of the Learning Development Agreement - 31/03/13 Regular updates on progress /issues to be reported to the UHL Learning and Development Strategy Group - 31/03/13	9	▲	EM	KB	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	Manager	Div/Exec Director	Strategic risk No.
Acute Care	ED	Overcrowding in ED	29/12/2011	**Causes** High inflow surges from EMAS Inadequate number of cubicles in correlation to patient demographics served to provide adequate quality and safety in nursing and medical care. Lack of outflow to Assessment units with UHL. Delays in cross site transfers due to Ambulance provision. **Consequences** Increased risk of clinical incident Lack of oxygen and suction in resus viewing room Lack of Tannoy and telephone in Fracture clinic No emergency resuscitation trolley readily available in fracture clinic Sub-optimal treatment Poor patient experience Increased risk of complaints Patient confidentiality breaches High risk of cross infection Privacy and dignity compromised Staff stress and morale due to increased risk in caring adequately for excessive numbers of patients in respect to nursing numbers. Increased risk of staff injury Breach of clinical quality indicators Delays for EMAS turnaround times Lack of staff to deal with new inflow	Patients	Liaison with EMAS Ambulance control, including EMAS senior staff in ED to raise awareness of ED workload. EMAS inform ED of predicted inflow from their service. Ambulance crew remain with and monitor patients until 'formal' handover to ED staff or Ambulance senior staff take handover for a number of patients to release Ambulance crews. Overflow into other areas of department if available. (minors cubicles utilised for patients awaiting admission when flow allows) Use of the centre of majors (limited floor space) as a waiting area for patients to be admitted, more recently the use of fracture clinic for more stable patients. Patients assessed if able to wait in chairs. Escalation via CBU manager/lead nurses or Duty Management team and Divisional Manager / Director as appropriate.	Major	Likely	16	UHL 4 hour emergency process escalation policy / winter capacity plan - Complete ED proactively reviewing initial assessment process to ensure patients investigation plan started early to reduce patient time in ED - Complete Bed management process in UHL under review - Complete Plans to process map the internal bed management system between ED and AMU - Complete Plans to increase ED footprint - 28/02/2013 Development of a robust escalation policy/risk assessment tool. Highlighting issues in ED to senior management in the trust and partners to enable ED to function effectively - Complete	4	⇔	JHA	DF/JT	4

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	Manager	Div/Exec Director	Strategic risk No.
Acute Care	Cardiac Critical Care and Renal	Insufficient Level 3 critical care beds	26/06/2012	**Cause:** 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. 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. **Consequences:** Lack of Level 3 beds resulting in elective cancellations. This equals 127 @ month 11. Delayed ITU discharges to specialty based wards	Patients	Reallocation of Level 3 beds flexibly across UHL to meet demand Reallocation wherever possible of nursing staff across Critical Care areas in UHL to meet demand Daily SITREP report for critical care distributed throughout the Division and end users of the service stating occupancy, staffing, bed capacity and delayed discharges. Presence of ITU senior nursing staff at Trust's operational bed meeting @ 08.30 daily Bed management policy in place for ITU and all specialties with differing responsibilities for each area. Escalation policy in place inclusive of ITU, PACU and elective users of critical care Ability to escalate to bank/overtime/agency to open extra level 3 capacity as required Presence of ITU senior nursing staff a Trust's weekly theatre activity meeting to plan ahead for elective activity 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	Major	Likely	16	Introduction of temporary block agency contract for critical care nurses to expand bed base being explored - Complete Development of critical care expansion document to meet current and future demand introducing a phased approach to expansion of bed base in progress. This is currently awaiting Trust Exec approval - Complete Initial meetings with architects in progress to scope new build options for long term expansion - Complete Outline business case in progress for consideration by the Reconfiguration Board - 28/02/2013	1	⇔	JSP	DS/JT	9

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	Manager	Div/Exec Director	Strategic risk No.
Acute Care	Cardiac Critical Care and Renal	Insufficient Echo provision cross-site	07/08/2012	**Causes** Insufficient BSE accredited Cardiac Physiologists for level of current/increasing demand. Staffing levels will reduce further during the next few months due to resignation and adoption leave of 2.0 WTE experienced/senior BSE Cardiac Physiologists. **Consequences** Failure to meet National Diagnostic Target for New referrals - loss of reputation; financial penalties. Failure to meet internal standard (<48hrs) for I/P (New) referrals - increased LOS; delays for further treatment/intervention Failure to perform Planned workload - hampers clinicians to manage patient's care effectively for this group of patient's who are at an increased risk of a significant clinical event. Increased risk of RSI's for Physiologists. Staff retention & recruitment issues - due to very limited training (including Mandatory); essential development in routine/advanced techniques; low staff morale; loss of key staff.	Human resources	Cardiac physiologists working additional hours to avoid National Target breeches for New referrals. SAC (some slots available on same day as O/P consultant visit) for Planned referrals not performed prior to OP appointment. Clinicians also able to re refer and change planned referral to New referral if Echo not performed prior to OP appointment. All new referrals attract 5 wk target.	Major	Likely	16	Upgrade 0.65 WTE BSE Trainee - Complete Recruit 2.0 WTE BSE Cardiac Physiologists - 28/02/2013 Upgrade 0.35 WTE BSE Trainee - Complete Upgrade 1.0 WTE BSE Trainee - 30/04/2013 Waiting list initiative for Planned workload - Complete Negotiate BRU support - cover for 1/7 - 28/02/2013 Explore options with Cardiology SpR lists - Complete Explore options with External provider - Complete Contact all Service Managers where increase in demand to set SLA. Set up trading account for activity over SLA from April 2013. - Complete Consider review of funding of diagnostic budget - 31/01/2013	1	⇔	MCA	DS/KB	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	Manager	Div/Exec Director	Strategic risk No.
Clinical Support	Imaging and Medical Physics	Potential failure to maintain breast screening targets when NHS Breast Screening Programme age extension is implemented	24/10/2012	**Causes** The mobile breast screening unit at Loughborough has not been fully functional or reliably functional since it was transferred to the Loughborough Morrison's car park. The reason for this is that Morrison's have installed a voltage optimisation device to one of their electricity mains supply lines that is reducing the voltage to below operating levels required by the screening equipment **Consequences** Delay in diagnosis or missed diagnosis of breast cancer Failure to maintain NHS Breast Screening Programme targets as required in the contract Potential for financial penalties (£680K suggested for failure to implement age extension) Adverse impact on UHL reputation Potential loss of income as reduced attendance Adverse impact on UHL reputation Potential loss of income as reduced attendance	Economic	Women from Loughborough invited to the Breast Care Centre for their breast screening appointment in order to avoid breaches in the screening round length target, however attendance is below what is expected for the Loughborough area	Extreme	Possible	15	Explore feasibility of alternative sites for breast screening in Loughborough- Pinfold site - 30/03/2013	10	▼	JGI	SC/JT	9

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Clinical Support	Pathology	Failure of Blood Transfusion Service at LGH	10/05/2006	**Causes** Staff stress, reduced session payments and the ongoing management of change process to introduce 24/7 working have all had an impact on the volunteers that are willing to cover the sessions.- 24/7 NOW INTRODUCED The volatile nature of using a voluntary rota - VOLUNTARY ELEMENT OF EXTRA SESSIONS (24/7) Requirement to cover 3 sites with limited staff Age and ill health of some of the the staff employed Working time directive compliance - 24/7 SYSTEM IS COMPLIANT **Consequences** Adverse outcome to patients requiring urgent transfusion at LGH site Impact to Obstetric Services+ additional acute services; who will need to transfer admissions of women in labour to another external centre if the transfusion service fails Increased risk of claim /complaint Adverse media attention / loss of reputation Staff stress	Patients	Full 24/7 rota implemented. Voluntary rota for spare sessions - sickness leave etc. See outstanding actions and notes for current issues (03/01/2013) Additional sessions at GH Associate practitioners to work overnight (to 23:00) Associate practitioners to cover entire night at LRI Phased extended contractual hours 8 to 8 B.S & B.Transfusion Phased extended day B Transfusion to 23:00 Employed Bank/Locum BMS staff to cover short term deficiencies in rota Investigate additional lean working options to reduce pressure on laboratory staff. Introduced a forced rota Multi discipline staff to assist cover overnight B.S(24/7) at LRI Retrained Lab Manager One-off training Risk assessed the process of a "Plan B" 24/7 Rotas with voluntary sessions in place from May 2012 2 new BMS band 5 staff recruited 24/09/2012 - to complete local competecy training Feb 2013	Extreme	Possible	15	Appt x 2 BMS Bank staff -01.04.2013; Review meeting 01.03.2013	5	⇔	JHY	SC/KB	3

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Clinical Support	Imaging and Medical Physics	Ambulatory Syringe Drivers	19/12/2011	**Causes:** The NPSA has identified risks associated with the use of current models of ambulatory syringe drivers. UHL has audited the current model used across the Trust and found it to be unfit for purpose. The NPSA has identified reports of 8 deaths and 167 non fatal incidents involving ambulatory syringe drivers used in the NHS in England & Wales between 1st Jan 2005 and 30th June 2010. **Consequences:** There is potential for similar incidents to occur at UHL because of the current model of syringe driver in use.	Patients	Medical Physics service devices when required. Clinical staff have been trained in their use. The NPSA report has been identified to the Trust Medical Devices Group and a sub group has been established to identify a replacement model that is fit for purpose. The current syringe driver model will no longer be purchased by UHL. Identify new equipment model - 16/12/11 - completed Standardise model selection with PCT organisations - 16/12/11 - completed Purchase NPSA recommended model - 01/12/12 - completed	Extreme	Possible	15	Train clinical users and patients on use of new model - 31/03/13	9	⇔	MNO	SC/SH	1
Clinical Support	Imaging and Medical Physics	Lack of planned maintenance for medical equipment maintained by Medical Physics	14/05/2009	**Causes:** Lack of Medical Physics technical staff No mechanism to ensure that the revenue consequences of maintenance are identified and funding given to Medical Physics to perform this maintenance. **Consequences:** Potential for equipment to perform out of specification leading to increased risk of patient/ staff harm. Equipment failure due to non-replacement / maintenance of limited life parts Failure to meet statutory requirements for electrical safety testing of medical equipment. Increased risk of patient complaints / claims Potential for adverse media attention and risk to the reputation of the Trust May impact upon successful outcome of future NHSLA assessments Possibility of non-compliance with CQC Outcome 11 May attract attention of Medicines and Healthcare products Regulatory Agency (MHRA) Low morale / unreasonable pressure on Medical Physics technical staff.	Statutory	Some critical equipment is being maintained under service agreements set up with supplier. Medical Physics team are targeting "High" risk equipment as a first priority. 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 Identified all critical equipment and maintenance needs through the risk assessment process Reviewed the Medical Devices policy Site wide audit of medical devices Standardise medical equipment wherever possible 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 - 31/3/13 Develop robust mechanism to ensure the revenue consequences of maintenance for medical equipment purchases are identified - 31/3/13 Secure funding to increase current staff base for Medical Physics technical staff or outsource maintenance contracts - 31/3/13 Quantify the shortfall in maintenance provision from existing resources and identify to the Trust (to enable Trust decision on corrective to be made) - 31/03/13 Establish infusion pump libraries at LGH and LRI - 1/1/14	6	⇔	MNO	SC/SH	1

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Planned Care	Specialist Surgery	Business and patient safety risk due to number of A+C vacancy and unskilled workers remaining	12/10/2012	**Causes** Delays in recruitment through HR/ references etc Outcomes of transcription project inability to recruit to substantive posts in a timely manner Fixed term recruitment leave to get substantive jobs bank and agency cannot fill vacancies **Consequences** Outcomes missing Outcome slips being filed in wrong places Reception areas not covered Notes and results unavailable for clinic Staff stress high	Patients	Stress audits in place Appointment of Patient Access Manager Flexible workforce appointed where available Other Divisions helping out Training set up and in progress Recruited and further recruitment in progress Outsource typing to DICT8 for ENT and about to for Ophthalmology Ophthalmology using templates and ICE	Moderate	Almost certain	15	outsource typing - January 13 Staff training - January 13 Recruitment of substantive A+C - January 13	8	⇔	DTR	/AF/KB	3
Corporate	R&D	Commercial Research Partner withdrawl	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 Process for temperature monitoring Process for reporting incidents to research sponsors	Extreme	Possible	15	Replacement for IceSpy Pharmacy department temperature monitoring Minor temperature excursions LRI cold store LGH cold store	4	⇔	CMAL	DR	
Corporate	Facilities	Patient Smoking - Fire due to Oxygen Enrichment Therapy	29/06/2012	There have been four patient 'Fire' incidents in the last 12 months caused by smokers on oxygen therapy in hospital wards. **Cause:** patients using smoking materials whilst undergoing oxygen therapy treatment. **Consequence:** fire incident	Fire	Smoking Policy (under review) No smoking Signage Clinical Supervision Fire Safe nozzles fitted to oxygen appliances - designed to arrest flow of oxygen in a fire situation to reduce risk of explosion (Internal alert issued to Clinical Divisions in July 2012).	Extreme	Possible	15	Create new/update smoking policy - complete Internal alert re compliance with Fire safe nozzles - complete	5	⇔	NBO	AC/SH	1
Corporate	Nursing	Failure to manage Category C documents on UHL Document Management system (DMS)	14/03/2011	**Causes** Lack of resource at Divisional/ directorate level Lack of resource in CASE team Delays in the development of 'SharePoint' that would enable automatic reminders for expired documents to be generated for the document authors. **Consequences** DMS does not contain the most recent versions of all category C documents Staff may be following incorrect guidance (clinical or non-clinical) May not be able to demonstrate compliance with NHSLA ARMS	Quality	Acting Head of Outcomes has discussed the problems with Clinical Business Units (CBUs) to identify which documents can be managed by the CBUs 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' - Complete	9	⇔	SH	SH	1

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Corporate	Corporate Medical	Changes to study leave funding availability for Trust funded Drs.	18/11/2010	**Causes** From April 2013 the Specialty Schools will take over from the Directorate of Clinical Education with regard to the management, administration and monitoring of trainee study leave for those trainees within their school. Currently the funding is held at divisional level and where there is a surplus (due to trainees not taking their annual allocation of study leave) this is used to support requests for study leave funding from Trust funded Drs. New software programme will not support funding for applications from others not on the training programme. **Consequences** No availability of study leave funding (via Deanery) for Trust funded Drs. Trust required to fund study leave in line with terms and conditions of employment Loss of Trust reputation. Lack of development opportunities for Trust funded Drs.	Human resources	Clinical Divisions aware of impending changes Approximate numbers affected by change identified.	Moderate	Almost certain	15	Associate Director of Clinical Education to meet with Clinical Divisions to identify approximate no's affected by this change - Completed Divisions to be made aware of impending changes - completed Involve UHL Finance department in discussions regarding future funding processes - complete Divisions to identify approximate costs associated with the change and develop plans to retain current levels of study leave and absorb additional costs within existing budgets - 31/03/13	9	⇔	SCAR	KH/KB	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. 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'. Awaiting dates for service transition.	2	⇔	DCK	JC	2

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Corporate	Corporate Medical	Risk of user error associated with non-standardisation of manual and automated external defibrillators	16/12/2009	**Causes:** Medical staff using the defibrillator will rotate to other sites within the Trust Different make / model of defibrillator used at LGH site (Zoll defibrillators as opposed to Medtronic LifePak 20) 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. 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. **Consequences:** Potential for unsuccessful defibrillation attempt Potential for injury to the patient (death) Potential to disrupt the advanced life support universal algorithm Non-compliance with recommendations of the CPR standards for Clinical Practice and Training	Patients	Defibrillation training Defibrillator will give automated instructions (depending on clinical setting)	Extreme	Possible	15	Submit business case to IMC/ Capital Equipment sub group - Completed Standardise make/ model of defibrillator across the Trust - 1/8/13 Funding available for purchase - 1/4/13 Installation of new defibs - 1/8/13	5	⇔	LR	KH/SH	1
Corporate	Communications	Failure to achieve Foundation Trust (FT) status in required timescale / Failure to engage staff / public re: FT / G2G	30/04/2007	**Cause** Disengagement of members from the process. Disengagement of staff from the process. 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 enthusiastic about the Trust's journey from G2G. **Consequence** Trust may not be in control of its own destiny.	Public	Regular briefings to members of staff/ public/ members/ stakeholders. Members engagement plan seeking to increase the number and significance of consultation. G2G engagement action plan at Divisional level. Regular polling of the penetration of G2G showing 20-25% of staff have seen the presentation. Red Poster campaign to raise awareness amongst staff.	Moderate	Almost certain	15	Continue to ensure appropriate messages are communicated within and outside the Trust. New video made for all staff to view. New internal campaign due to launch Apr 2011 for G2G and FT. - Complete	6	⇔	MWIG	MW/JA	6

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	Manager	Div/Exec Director	Strategic risk No.
Acute Care	Cardiac Critical Care and Renal	Harborough Lodge environment stops staff safely delivering haemodialysis	16/08/2012	**Causes:** Insufficient space to: Safely carry out dialysis procedures Safely carry out manual handling procedures Safely carry out emergency procedures Maintain patient privacy & dignity Poor state of repair of within clinical areas **Consequences** Cross contamination/infection Manual handling injury to staff/patient/visitor Poor patient experience Negative reputation of Trust Complaints	Patients	Specialist haemodialysis trained and competency assessed staff Haemodialysis/other clinical policies Annual manual handling training Annual infection prevention training Infection prevention policy Infection prevention audits Environment audits Curtains at each bed space Minimum cleaning standards	Extreme	Possible	15	UHL undertake Duty of Care review and produce recommendations - 31/01/2013 UHL undertake Health & Safety review and produce recommendations - 28/02/2013 Coordinate redecoration/refurbishment - Complete Discuss at Strategy meeting re short/long term plan - 31/01/2013 Reduce the number of dialysis spaces using a phased approach to reduce overcrowding Complete UHL undertake Manual Handling review and produce recommendations - Complete	5	⇔	JPR	DS/SH	1
Acute Care	Medicine	Patients not being effectively resuscitated	06/06/2012	**Causes** Due to UHL reconfiguration Medical wards moved to LRI with associated medical staff. Arrest team structure significantly reduced (Medical Registrar, SHO, possibly registrar anaesthetist if able to attend) Lack of engagement with UHL resus committee with regard to this change **Consequences** Potential for increased mortality /morbidity Potential for adverse attention affecting Trust reputation Potential increase of complaints / claims	Patients	Medicine continuing to provide Resus team cover (on a temporary basis pending an alternative solution)	Extreme	Possible	15	Resus team medical staff cover must continue under current arrangements until appropriate resource / funding is available. - Complete Begin negotiations to increase the resuscitation team to include additional Dr support - 31/10/2012	10	⇔	PMC	DS/SH	1

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	Manager	Div/Exec Director	Strategic risk No.
Acute Care	Cardiac Critical Care and Renal	Inappropriate environment and infection prevention - Adult ITU	22/02/2012	**Cause** Insufficient side room capacity Inadequate space in existing side room for haemodialysis and line procedures. Insufficient en suite facilities in side rooms Vascular access and % of patients with dialysis catheters Procedure room on ward 10 not fit for purpose Inappropriate areas used for renal biopsy on ward 17 Inadequate drug preparation areas Inadequate domestic storage areas No separate facility for isolating patients in ward 10/17 DCU Movement of patients to accommodate admissions or haemodialysis in another area **Consequence** Poor compliance with cannula care Challenges in maintaining integrity of commode lids using Chlorclean Infection prevention risk Transportation of contamination through patient occupied areas (15N/A)	Patients	Preventing Transmission of Infection including Isolation Guidelines UHL MRSA Screening policy Weekly MRSA audits undertaken by IP Team Local Infection Prevention Group Communication of IP issues regular agenda item on local meetings PI Link Nurse Network Daily side room list Monthly Nursing Metrics audits Monthly HII audits Monthly Environment audits Monthly handwashing audits Steam cleaning post CDT patients Medically led Vascular Access coordination Expert specialty trained competent staff Use of 'cohort facility' as required Ongoing competency based programme for the training and implementation of ANTT Close 'hands on' bed management by senior medical and nursing staff to ensure optimal use of beds.	Moderate	Almost certain	15	Redevelopment of Critical Care Unit with increased bed spaces, more side rooms, formal isolation facilities, more sinks and electrical and gas outlets - 31/01/2013 Reduce occupancy by increasing staffed bed numbers or reducing hospital activity requiring critical care - 31/01/2013 Being reviewed by Lead Nurse with a view to closing the risk / reducing risk score - 31/01/2013	8	⇔	JPR	DS/SH	1