University Hospitals of Leicester NHS
NHS Trust

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

Trust Board Paper R

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

Author/Responsible Director: Chief Nurse

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

a) A copy of the BAF as of 31 October 2013.
b) An action tracker to monitor progress of BAF actions
c) A summary diagram of risk movements from the previous month.
d) Suggested parameters for scrutiny of the BAF.
e) New extreme and/ or high risk opened during the reporting period.

The Report is provided to the Board for:

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

Summary :

- There have been no changes to BAF risk scores during the reporting period
- Risk numbers four, five, six and 10 will come under the ownership of the Director of Strategy with immediate effect.
- Actions 12.8, 13.7 and 13.8 are now RAG rated red reflecting significant delays in completion.
- The recent favourable Deanery visit in relation to training of Junior Doctors in ED has been added to the BAF (risk number 13) as evidence of external positive assurance.
- Gaps in controls for risk three in relation to the current nursing vacancies and difficulties in recruitment have been identified along with actions to improve controls.
- Board members are invited to review the following BAF risks.
  Failure to transform the emergency care system (risk owner – COO).
  Inability to recruit, retain, develop and motivate staff (risk owner DHR).
  Ineffective organisational transformation (risk owner DS).
- There have been seven high risks have opened on the UHL risk register during October 2013.

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

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

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

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

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

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **28 NOVEMBER 2013**

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

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

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1. INTRODUCTION

1.1 This report provides the Board with:-

a) A copy of the Board Assurance Framework (BAF) as of 31 October 2013.
b) An action tracker to monitor progress of BAF actions.
c) A summary diagram of BAF risk score to show any changes in BAF risk scores from the previous month.
d) Parameters for Board scrutiny of the BAF.
e) Notification of any new extreme or high risks opened during the reporting period.

2. BAF POSITION AS OF 31 OCTOBER 2013

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

2.2 The progress of actions associated with the BAF is monitored by reference to the action tracker attached at appendix two.

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

2.4 Board members are asked to note that, at the request of the CEO, risk numbers four, five, six and 10 will come under the ownership of the Director of Strategy with immediate effect.

2.5 Actions 12.8, 13.7 and 13.8 are now RAG rated red reflecting significant delays in completion.

2.6 With the agreement of the UHL Executive Team (ET) the recent favourable Deanery visit in relation to training of Junior Doctors in ED has been added to the BAF (risk number 13) as evidence of external positive assurance.

2.7 In relation to risk three, the ET has identified additional gaps in controls and has provided actions to improve the controls relating to the difficulties in recruiting to current nursing vacancies.

2.8 At time of writing the report updates to actions due for completion/review in October 2013 have not been received in respect of action 1.11 The Director of Finance and Business Services is asked to provide the Board with a verbal update of progress for this action.

2.9 To provide an opportunity for more detailed review three BAF risks are presented on a monthly basis for Board members to review against the areas listed in appendix four. These risks will be presented in their numerical sequence and the risks below are presented for review against the parameters outlined in appendix four:

- Failure to transform the emergency care system (risk owner – COO).
- Inability to recruit, retain, develop and motivate staff (risk owner DHR).
- Ineffective organisational transformation (risk owner DS).

3 EXTREME AND HIGH RISK REPORT.

3.1 As described in the UHL Risk Management Policy the Board will receive notification of any extreme/ high risks that have opened during the reporting period. The Board are therefore asked to note that seven new high risks have opened during October 2013 and are listed below. The details of these risks can be found at appendix five.

Risk ID	Risk Title	Risk Score	CMG/Corporate Directorate
2234	There is a medical staffing shortfall resulting in a risk of an understaffed Emergency Department	20	Emergency and Specialist Medicine
2244	Medium-term staffing shortages/ lack of equipment/poor processes in Ophthalmology causing deterioration in service	20	Musculoskeletal and Specialist Surgery
2094	Delayed roll out of outsourced Transcription process , unavailability of skilled workforce and flexible workers	20	Musculoskeletal and Specialist Surgery
2240	The impact of vacancies in Physiotherapy and Occupational Therapy on service delivery	16	Clinical Support and Imaging
2237	Risk of results of outpatient diagnostic tests not being reviewed or acted upon resulting in patient harm	16	Corporate Medical
2247	There are 500 Registered Nurse vacancies across UHL leading to a deterioration in service and adverse effect on financial position	16	Nursing
2239	Impact of closure of the hydrotherapy pool facility at LGH.	15	Clinical Support and Imaging

4. RECOMMENDATIONS

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

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

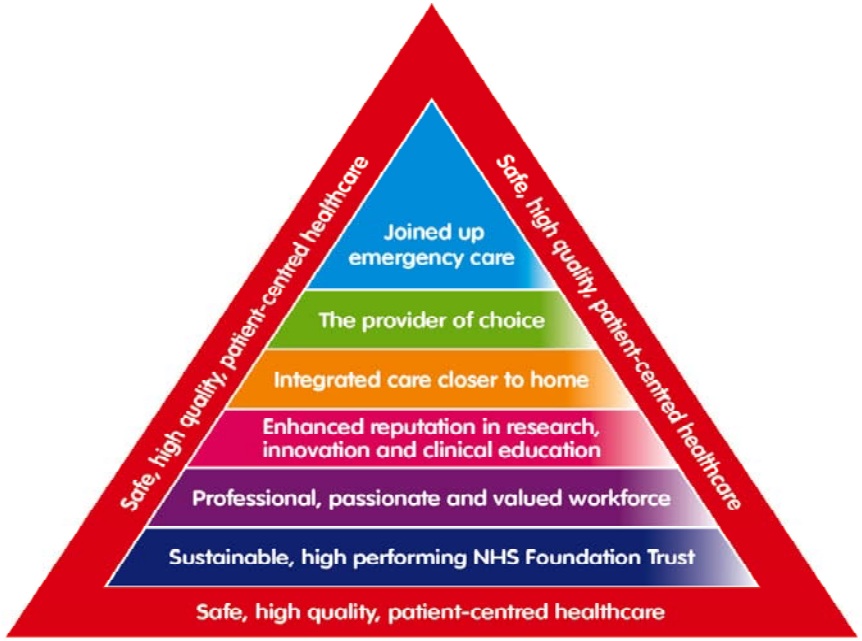
(b) note the actions identified within the framework to address any gaps in either controls or assurances (or both);

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

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

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

Peter Cleaver,
Risk and Assurance Manager,
20 November 2013.


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

PERIOD: OCTOBER 2013

RISK TITLE	STRATEGIC OBJECTIVE	CURRENT SCORE	TARGET SCORE
Risk 1 – Failure to achieve financial sustainability	g - To be a sustainable, high performing NHS Foundation Trust	25	12
Risk 2 – Failure to transform the emergency care system	b - To enable joined up emergency care	25	12
Risk 3 – Inability to recruit, retain, develop and motivate staff	f - To maintain a professional, passionate and valued workforce e - To enjoy an enhanced reputation in research, innovation and clinical education.	16	12
Risk 4 – Ineffective organisational transformation	a - To provide safe, high quality patient-centred health care c - To be the provider of choice d - To enable integrated care closer to home	12	12
Risk 5 – Ineffective strategic planning and response to external influences	a - To provide safe, high quality patient-centred health care c - To be the provider of choice g - To be a sustainable, high performing NHS Foundation Trust	12	12
Risk 6 – Failure to achieve FT status	g - To be a sustainable, high performing NHS Foundation Trust	16	12
Risk 7 – Failure to maintain productive and effective relationships	c - To be the provider of choice d - To enable integrated care closer to home f - To maintain a professional, passionate and valued workforce	15	10
Risk 8 – Failure to achieve and sustain quality standards	a - To provide safe, high quality patient-centred health care c - To be the provider of choice	16	12
Risk 9 – Failure to achieve and sustain high standards of operational performance	a - To provide safe, high quality patient-centred health care	12	12
Risk 10 – Inadequate reconfiguration of buildings and services	a - To provide safe, high quality patient-centred health care	12	9
Risk 11– Loss of business continuity	g - To be a sustainable, high performing NHS Foundation Trust	9	6
Risk 12 – Failure to exploit the potential of IM&T	a - To provide safe, high quality patient-centred health care d - To enable integrated care closer to home	9	6
Risk 13 - Failure to enhance education and training culture	e – To enjoy an enhanced reputation in research, innovation and clinical education	12	6

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

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

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

RISK NUMBER/ TITLE:	**RISK 1 – FAILURE TO ACHIEVE FINANCIAL SUSTAINABILITY**
LINK TO STRATEGIC OBJECTIVE(S)	**g. - To be a sustainable, high performing NHS Foundation Trust.**
EXECUTIVE LEAD:	Director of Finance and Business Services

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to achieve financial sustainability including:	Overarching financial governance processes including PLICS process and expenditure controls. Revised variance analysis and reporting metrics especially for the ETPB Self-assessment and SLM baseline exercise completed and project manager identified Finalised SLM Action plan Full information has now been received on UHL allocations from all the no-recurrent funding streams including transformation monies. This information is being incorporated into the financial forecasts.	5X5=25	Monthly /weekly financial reporting to Exec Team Performance Board, F&P Committee and Board. Cost centre reporting and monthly PLICS reporting. Monthly confirm and challenge processes at specialty and CMG level. Annual internal and external audit programmes. Monthly meetings with the NTDA and the CCG Contract Performance Meeting	(c) SLM programme not fully implemented	ESB will continue to meet every 6 weeks to ensure implementation of SLM across the Trust (expected Mar 2014) (1.19)	4x3=12	Mar 2014 DFBS
Failure to achieve CIP.	Strengthened CIP governance structure including appt of Head of CIP programme		Progress in delivery of CIPs is monitored by CIP Programme Board (meeting fortnightly) and reported to ET and Board.	(c) Under-delivery of CIP programme (£1m adverse to plan M6)			

Locum expenditure.	Workforce plan to identify effective methods to recruit to 'difficult to fill' areas Reinstatement of weekly workforce panel to approve all new posts. STAFFflow for medical locums saving £130k of every £1m expenditure Financial Recovery plans developed Non Contractual Payments are discussed at monthly CMG meetings Confirm and Challenge Meetings All CMGs (by specialty) have produced premium spend trajectories and associated plans until March 2014 Weekly Staff Bank data reports are issued for medical and nursing (qualified and unqualified) staff Action plan to increase bank staff capacity and drive down agency nurse expenditure.		The use of locum staff in 'difficult to fill' areas reported monthly to the Board via the Q&P report. A reduction in the use of locums would be an assurance of success in recruiting substantive staff to 'difficult to fill' areas. Increase in contracted staff numbers of medical and nursing professions of 217wte since Mar 12. Saving in excess of £0.6m 5 weeks after 'go live' date Monthly Q&P report to TB Monthly confirm and challenge meetings Non contractual payments (premium spend) are reported monthly to the Finance and Performance Committee A weekly report is presented to ET. Weekly meetings with HoNs and DHR to monitor progress.				
Loss of income due to tariff/tariff changes (including referral rate for emergency admissions – MRET)	Contract meetings with Commissioners Negotiations with Commissioners concluded at a transactional level.		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board.	(c) Failing to manage marginal activity efficiently and effectively.	Ongoing discussions with commissioners about planned re-investment of the MRET deductions. (1.11)		Review Oct 2013 DFBS

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

Ineffective organisational transformation.	See risk 4		See risk 4.	See risk 4.	See risk 4.		

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

RISK NUMBER/ TITLE:	**RISK 2 – FAILURE TO TRANSFORM THE EMERGENCY CARE SYSTEM**
LINK TO STRATEGIC OBJECTIVE(S)	**b. - To enable joined up emergency care.**
EXECUTIVE LEAD:	Chief Operating Officer

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to transform emergency care system leading to demands on ED and admissions units continuing to exceed capacity.	Health Economy has submitted response plan to NHSE requirements for an Emergency Care system under the A&E Performance Gateway Reference 00062.	5x5=25	Once plan agreed with NTDA, it will be circulated to the Board	No gaps	No actions	4x3=12	
	Emergency Care Action Team formed. Chaired by Chief executive to ensure Emergency Care Pathway Programme actions are being undertaken in line with NHSE action plan and any blockages to improvement removed. Development of action plan to address key issues		Action Plan circulated to the Board on a monthly basis as part of the Report on the Emergency Access Target within the Quality and Performance Report	Gaps described below	Actions described below		
	A new plan has been submitted detailing a clear trajectory for performance improvement and includes key themes from plan: Single front door		Project plan developed by CCG project manager Risks from 'single front door' to be escalated via ECAT and raised with CCG Managing Director as required	No gaps	No actions		
	ED assessment process is being operated.		Forms part of Quality Metrics for ED reported daily update and part of monthly board performance report	No gaps	No actions		
	Recruitment campaign for continued recruitment of ED medical and nursing staff including fortnightly meetings with HR to highlight delays and solutions in the recruitment process.		Vacancy rates and bank/agency usage reported to Trust Board on a monthly basis Recruitment plan being led by HR and monitored as part of ECAT	(c) Difficulties are being encountered in filling vacancies within the emergency care pathway. Agency and bank requests continue to increase in response to increasing sickness rates, additional capacity, and vacancies. (c) Staffing vacancies for medical and nursing staff remain high.	Continue with substantive appts until funded establishment is achieved (2.7)		Review Nov 2013 COO

	Formation of an EFU and AFU to meet increased demand of elderly patients		'Time to see consultant' metric included in National ED quarterly indicator.	No gaps	No actions		
	Maintenance of AMU discharge rate above 40%		Reported to Operational Board twice monthly and will be included in Emergency Care Update report in Q&P Report.	No gaps	No actions		
	New daily MDT Board Rounds on all medical wards and medical plans within 24hrs of admission		Reported to Operational Board twice monthly and will be included in Emergency Care Update report in Q&P Report.	No gaps	No actions		
	EDDs to be available on all patients within 24 hours of admission. Review built in to daily discharge meetings to check accuracy of EDDs (from 2/09/13).		Monitored and reported to Operational Board twice monthly and will be included in Emergency Care Update report in Q&P report	No gaps	No actions		
	Maintain winter capacity in place to allow new process to embed		All winter capacity beds are to be kept open until the target is consistently met	No gaps	No actions		
	DTOCs to be kept to a minimal level		Forms part of the Report on Emergency Access in the Q&P Report.	(c) Lack of availability of rehabilitation beds for increasing numbers of patients.	CCG/LPT to increase capacity by use of Intermediate Care Services (2.9)		Review Nov 2013 CO O

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inability to recruit, retain, develop and motivate suitably qualified staff leading to inadequate organisational capacity and development.	Leadership and talent management programmes to identify and develop 'leaders' within UHL.	4x4=16	Development of UHL talent profiles.	No gaps identified.	No actions required.	4x3=12	
			Talent profile update reports to Remuneration Committee.	No gaps identified.	No actions required.		
	Substantial work program to strengthen leadership contained within OD Plan.			No gaps identified.	No actions required.		
	Organisational Development (OD) plan.		A central enabler of delivering against the OD Plan work streams will be adopting, 'Listening into Action' (LiA) and progress reports on the LiA will be presented to the Trust Board on a quarterly basis.	No gaps identified.	No actions required.		
	A central enabler of delivering against the OD Plan work streams will be adopting, 'Listening into Action (LiA). A Sponsor Group personally led by our Chief Executive and including, Executive Leads and other key clinical influencers has been established.		Progress reports on the LiA will be presented to the Trust Board on a quarterly basis.	No gaps identified. No gaps identified.	No actions required. No actions required.		
	Staff engagement action plan encompassing six integrated elements that shape and enable successful and measurable staff engagement		Results of National staff survey and local patient polling reported to Board on a six monthly basis. Improving staff satisfaction position.	No gaps identified.	No actions required.		
			Staff sickness levels may also provide an indicator of staff satisfaction and performance. Staff sickness rate is 3.85% for M6	No gaps identified	No actions required.		

	Appraisal and objective setting in line with UHL strategic direction. Local actions and appraisal performance trajectories agreed with CMGs and Directorates Boards		**Appraisal rates reported monthly to Board via Quality and Performance report.** **Month 6 appraisal rate = 91.9% -**	No gaps identified.	No actions required.		
	Summary of quality findings communicated across the Trust; to identify how to improve the quality of the appraisal experience for the individual and the quality of appraisal meeting recording.		Results of quality audits to ensure adequacy of appraisals reported to the Board via the quarterly workforce and OD report.	No gaps identified.	No actions required.		
			Appraisal Quality Assurance Findings reported to Trust Board via OD Update Report June 2013 Quality Assurance Framework to monitor appraisals on an annual cycle (next due March 2014).	No gaps identified.	No actions required.		
	Workforce plans to identify effective methods to recruit to 'difficult to fill areas). CMG and Directorates 2013/14 Workforce Plans.		Nursing Workforce Plan reported to the Board in September 2013 highlighting demand and initiatives to reduce gap between supply and demand. The use of locum staff in 'difficult to fill' areas is reported to the Board on a monthly basis via the Q&P report. Reduction in the use of such staff would be an assurance of our success in recruiting substantive staff.	(c) Approximately 500 nursing staff vacancies identified across UHL following nursing staff review. Difficulties in recruitment due to many hospitals within UK looking to recruit in response to Francis report. (c) Risks with employing high number from an International Pool in terms of ensuring competence	Active recruitment strategy including implementation of a dedicated nursing recruitment team. (3.8) Develop an employer brand and maximise use of social media (3.9) Programme of induction and adaptation in development with Nursing education leads, timetabled to ensure capacity to support programme. (3.10)		Dec 2013 CN/ DHR April 2014 DHR April 2014 DHR
	Reward /recognition strategy and programmes (e.g. salary sacrifice, staff awards, etc).			(a) Reward and recognition strategy requires revision to include how we will provide assurance that reward and recognition programmes are making a difference to staffing recruitment/ retention/ motivation.	Revise and launch reward and recognition strategy. (3.1) Development of Pay Progression Policy for Agenda for Change staff (3.3) Consult and implement pay progression policy (3.6) Implementation of Recruitment and Retention Premia for ED staff (3.4)		Jan 2014 DHR Nov 2013 DHR **Nov 2014** **DHR** **Nov 2013** **DHR**

	UHL Branding – to attract a wider and more capable workforce. Includes development of recruitment literature and website, recruitment events, international recruitment. Reporting and monitoring of posts with 5 or less applicants.		Evaluate recruitment events and numbers of applicants. Reports issued to Nursing Workforce Group (last report 4 Feb). Reporting will be to the Board via the quarterly workforce an OD report. Quarterly report to senior HR team and to Board via quarterly workforce and OD report	(a) Better baselining of information to be able to measure improvement. (c) Lack of engagement in production of website material.	Take baseline from January and measure progress now that there is a structured plan for bulk recruitment. Identify a lead from each professional group to develop and encourage the production of fresh and up to date material. (3.2)		Dec 2013 DHR
	Statutory and mandatory training programme for 9 key subject areas in line with National Core Skills Framework		Monthly monitoring of statutory and mandatory training uptake via reports to TB and ESB against 9 key subject areas (currently 55% at M6)	(c) Compliance against the 9 key subject areas is 55% (a) Potentially there may be inaccuracies of training data within the e-UHL system	Ensure Statutory and Mandatory training is easy to access and complete with 75% compliance by reviewing delivery mode, access and increasing capacity to deliver against specific subject areas (3.5) Update e-UHL records to ensure accuracy of reporting on a real time basis (3.7)		**Mar 2014 DHR** Mar 2014 DHR

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to put in place a robust approach to organisational transformation, adequately linked to related initiatives and financial planning/outputs	Development of Improvement and Innovation Framework	4x3=12	Monthly progress reports to Exec Strategy Board and F&P Committee. Approval of framework and operational arrangements due at Trust Board June 2013. Thereafter monitoring of overall Framework will be via IIF Board and F&P Ctte and monitoring of financial outputs (CIPs) will be via CIP Delivery Board, Exec Performance Board and F&P Ctte.	None identified	Not applicable	4x3=12	N/A

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to put in place appropriate systems to horizon scan and respond appropriately to external drivers. Failure to proactively develop whole organisation and service line clinical strategies	Appointment of Strategy Director	4x3=12	Plan agreed by Remuneration Committee	None identified	Not applicable	4x3=12	N/A
	Allocation of market intelligence responsibility to Director of Marketing and Communications		Agreed by Remuneration Committee	None identified	Not applicable		N/A
	Co-ordinated approach to business intelligence gathering and response via Business Strategy Support Team ESB forward plan reflecting a 12 month programme aligned with: • the development of the IBP/LTFM • the reconfiguration programme • the development of the next AOP • The TB Development Programme The TB formal agenda		Regular reports to TB reflecting progress of 12 month programme	None identified	Not applicable		

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	Current Score I x L	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	Target Score I x L	**Timescale** When will the action be completed?
Failure to meet the requirements of the FT application process in terms of service quality, strategy, financial resilience and governance	FT Programme Board provides strategic direction and monitors the FT application programme.	4x4=16	Monthly progress against the FT programme is reported to the Board to provide oversight.	No gaps identified.	No actions required.	4x3=12	
	FT Workstream group of Executive and operational Leads to ensure delivery of IBP and evidence to support HDD1 and 2 processes.		Feedback from external assessment of application progress by SHA	No gaps identified.	No actions required.		
	FT application project plan / project team in place FT Integrated Development Plan		Reports to FTPB and Trust Board	No gaps identified	Not applicable		N/A
	Progression of Better Care Together Programme which underpins the UHL service strategy and LTFM. Appointment of Director of Strategy as BCT lead		Economic modelling incorporated into the Trust Reconfiguration Strategic Outline Case (SOC) structure and process.	No gaps identified	Not applicable		
			Regular reports to Exec Strategy Board and Trust Board Various inputs from Exec Team to BCT work.	No gaps identified	Not applicable		
			Feedback and recommendations from the independent reviews against the Quality Governance Framework and the Board Governance Framework.	(c) Independent reports identify a number of recommendations.	Action plans to be developed to address recommendations from independent reviews. (6.11)		Nov 2013 CEO
	Monitoring of KPIs in particular in relation to financial position and key operational performance indicators.		Monthly reports to Executive Performance Board, F&P Committee and Trust Board	None identified.	Not applicable		N/A
			Achievement against the new TDA Accountability Framework is reported to the Trust board and the TDA on a monthly basis.	None identified	Not applicable		N/A

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to maintain productive relationships with external partners/ stakeholders leading to potential loss of activity and income, poor reputation and failure to retain/ reconfigure clinical services.	Stakeholder Engagement Strategy. Regular meetings with external stakeholders and Director of Communications and member of Executive Team to identify and resolve concerns. Regular stakeholder briefing provided by an e-newsletter to inform stakeholders of UHL news. Leicester, Leicestershire and Rutland (LLR) health and social care partners have committed to a collaborative programme of change ('Better Care Together')	5X3=15	Twice yearly GP surveys with results reported to UHL Executive Team. Latest survey results discussed at the April 2013 Board and showed increasing levels of satisfaction… a trend which has now continued for 18 months. Anecdotal feedback from partners and soft intelligence indicates that relations with key organisations and individuals are improving under new UHL leadership.			5X2=10	

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to achieve and sustain quality standards leading to failure to reduce patient harm with subsequent deterioration in patient experience/ satisfaction/ outcomes, loss of reputation and deterioration of 'friends and family test' score.	Standardised M&M meetings in each speciality.	4x4=16	Routine analysis and monitoring of out of hours/weekend mortality at CMG Boards.	No gaps.	No action needed.	4x3=12	
	Systematic speciality review of "alerts" of deterioration to address cause and agree remedial action. Corporate oversight via QPMG, QAC and by exception to ET and TB.		Quality and Performance Report and National Quality dashboard presented to ET and TB. Currently SMHI "within expected" (i.e. 105).	(a) UHL risk adjusted perinatal mortality rate below regional and national average.	Women's CBU to work with Dr Foster and other trusts to better understand risk adjustment model (8.2).		Jan 2014 MD
	Robust implementation of actions to achieve Quality Commitment (save 1000 extra lives in 3 years).		SHMI remains "within expected" (i.e. 105). Independent analysis of mortality review performed by Public Health. Report of results to go to November 2013 TB meeting.	No gaps identified.	No action needed.		
	Agreed patient centred care priorities for 2013-14: - Older people's care - Dementia care - Discharge Planning		Quality Action Group meets monthly. Achievement against key objectives and milestones report to Trust board on a monthly basis. A moderate improvement in the older people survey scores has been recorded.	No gaps identified.	No action needed.		
	Multi-professional training in older peoples care and dementia care in line with LLR dementia strategy.		Quality Action Group monitoring of training numbers and location.	No gaps identified.	No action needed.		
	Protected time for matrons and ward sisters to lead on key outcomes.		CMG/ specialty reporting on matron activity and implementation or supervisory practice.	(c) Present vacancy levels prevent adoption of supervisory practice.	Active recruitment to ward nursing establishment so releasing ward sister –for supervisory practice (8.5).		Sep 2014 CN
	To promote and support older peoples champions network and new dementia champions network.		Monthly monitoring of numbers and activity.	No gaps identified.	No action needed.		

	Targeted development activities for key performance indicators - answering call bells - assistance to toilet - involved in care - discharge information		Monthly monitoring and tracking of patient feedback results. Monthly monitoring of Friends and Family Test reported to the TB (67.6% at M6).				
	Quality Commitment 2013 – 2016: • Save 1000 extra lives • Avoid 5000 harm events • Provide patient centred care so that we consistently achieve a 75 point patient recommendation score		Quality Action Groups monitoring action plans and progress against annual priority improvements. A Quality Commitment dashboard has been developed to present updates to the TB on the 3 core metrics for tracking performance against our 3 goals. These metrics will be tracked up to 2015. Impressive drops in fall numbers have been observed in Datix reports and in the Safety Thermometer audit.				
	Relentless attention to 5 Critical Safety Actions (CSA) initiatives to lower mortality.		Q&P report to TB showing outcomes for 5 CSAs. 4CSAs form part of local CQUIN monitoring. RAG rated green at end of quarter 2. M&M CSA removed from CQUIN monitoring due to full implementation For Quarter 1 the CSA programme saw a 50% reduction in SUIs against the same period last year.	(c) Lack of a unified IT system in relation to ordering and receiving results means that many differing processes are being used to acknowledge/respond to results. Potential risk of results not being acted upon in a timely fashion.	Implementation of Electronic Patient Record (EPR). (8.10)		2015 CIO
	NHS Safety thermometer utilised to measure the prevalence of harm and how many patients remain 'harm free' (Monthly point prevalence for '4 Harms'). Monthly meetings with operational/clinical and managerial leads for each harm in place.		Monthly outcome report of '4 Harms' is reported to Trust board via Q&P report. The total number of harms recorded in UHL is 122 (i.e. 92.84% harm free) for M6	(a) Some data may not be accurate due to complex DoH definitions of each harm in relation to whether it is community or hospital acquired.	UHL to be part of the DH review in to the use of the Safety Thermometer tool (8.11)		Review Dec 2013 CN

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RISK NUMBER/ TITLE:	**RISK 9 – FAILURE TO ACHIEVE AND MAINTAIN HIGH STANDARDS OF OPERATIONAL PERFORMANCE**
LINK TO STRATEGIC OBJECTIVE(S)	**a. - To provide safe, high quality patient-centred health-care** **c. - To be the provider of choice.** **g. - To be a sustainable, high performing NHS Foundation Trust.**
EXECUTIVE LEAD:	Chief Operating Officer

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to achieve and sustain operational targets leading to contractual penalties, patient dissatisfaction and poor reputation.	Referral to treatment (RTT) backlog plans (patients over 18 weeks) and operational performance of 90% (for admitted) and 95 % (for non-admitted.	4x3=12	Key specialities will go onto weekly performance meetings with COO Weekly patient level reporting meeting for all key specialties Monthly Q&P report to Trust Board showing 18 week RTT performance Daily RTT performance and prospective reports to inform decision making	(c) 81.8% admitted RTT performance (M6). Backlog plans require further development in line with review of demand and capacity in key specialties. (a) No external assurance of recovery plans (c) Capacity issues created by emergency demand causes cancellations of operations.	Further development of backlog plans. RTT revised plans submitted to commissioners 11/9/13 awaiting formal acceptance. (9.8) Outputs from initial capacity and demand review to inform recovery plan development (9.10) Re-configuration of surgical beds to create a 'protected area' for surgical patients or by use of independent sector. (9.2)	4x3=12	Nov 2013 COO Nov 2013 COO Nov 2013 COO
	Transformational theatre project to improve theatre efficiency to 80 -90%.		Monthly theatre utilisation rates. Theatre Transformation monthly meeting. Transformation update to Board.	No gaps identified.	No actions required.		
	Emergency Care process redesign (phase 1) implemented 18 February 2013 to improve and sustain ED performance.		Monthly report to Trust Board in relation to Emergency Dept (ED) flow (including 4 hour breaches).	See risk number 2.	See risk number 2.		

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inadequate reconfiguration of buildings and services leading to less effective use of estate and services.	Clinical Strategy.	3x4=12		(a) Key measures to demonstrate success of strategy and reporting lines not yet identified.	Key measures for gauging success of strategy to be developed by specialties as part of their 'mini-IBPs' and will be monitored via divisional and directorate boards. (10.1)	3X3=9	Dec 2013 MD
	Estates Strategy including award of FM contract to private sector partner to deliver an Estates solution that will be a key enabler for our clinical strategy in relation to clinical adjacencies.		Facilities Management Collaborative (FMC) will monitor against agreed KPIs to provide assurance of successful outsourced service.	(c) Estates plans not fully developed to achieve the strategy. (c) The success of the plans will be dependent upon capital funding and successful FT application.	Ensure success of FT Application (see risk 6 for further detail). (10.2) Secure capital funding. (10.3)		Apr 2015 CEO Dec 2013 DFBS
	CMG service development strategies and plans to deliver key developments.		Progress of divisional development plans reported to Service Reconfiguration Board.	No gaps identified.	No actions required.		
	Service Reconfiguration Board.		Monthly ET Strategy session to provide oversight of reconfiguration.	No gaps identified.	No actions required.		
	Capital expenditure programme to fund developments.		Capital expenditure reports reported to the Board via F&P Committee.	No gaps identified.	No actions required.		
	Managed Business Partner for IM&T services to deliver IT that will be a key enabler for our clinical strategy. IM&T incorporated into Improvement and Innovation Framework.		IM&T Board in place.	No gaps identified.	No actions required.		

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RISK NUMBER/ TITLE:	**RISK 11 – LOSS OF BUSINESS CONTINUITY**
LINK TO STRATEGIC OBJECTIVE(S))	**g. - To be a sustainable, high performing NHS Foundation Trust.**
EXECUTIVE LEAD:	Chief Operating Officer

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inability to react /recover from events that threaten business continuity leading to sustained downtime and inability to provide full range of services.	Major incident/business continuity/ disaster recovery and Pandemic plans developed and tested for UHL/ wider health community. This includes UHL staff training in major incident planning/ coordination and multi agency involvement across Leicestershire to effectively manage and recover from any event threatening business continuity. Tailored training packages for service area based staff.	3x3=9	Annual Emergency planning Report identifying good practice presented to the GRMC July 2012. Training Needs Analysis developed to identify training requirements for staff supported by appropriate training packages for Senior Managers on Call External auditing and assurances to SHA, Business Continuity Self-Assessment, June 2010, completed by Richard Jarvis Completion of the National Capabilities Survey, November 2013 completed by Aaron Vogel. Results included in the annual report on Emergency Planning and Business Continuity to the QAC. Audit by PwC Jan 2013. Results being compiled and will be reported to Trust Board (date to be agreed). Documented evidence from key critical suppliers has been collected to ensure that contracts include business continuity arrangements.	(c) On-going continual training of staff to deal with an incident. (a) Do not consider realistic testing of different failure modes for critical IT systems to ensure IT Disaster Recovery arrangements will be effective during invocation. (c) No clear definition of what makes a critical supplier and how a loss would impact on the Trust. No plan as to how we would manage a loss.	Training and Exercising events to involve multiple specialties/CMGs to validate plans to ensure consistency and coordination (11.13). Determine an approach to delivering a physical testing of the IT Disaster Recovery arrangements which have been identified as a dependency for critical services. Include assessment of the benefits of realistic testing of arrangements against the potential disruption of testing to operations. (11.2) Develop a plan and a better understanding of how a loss of critical suppliers will affect the Trust (11.12)	2x3=6	Aug 2014 COO Review Dec 2013 CIO Nov 2013 COO

	Emergency Planning Officer appointed to oversee the development of business continuity within the Trust.		Outcomes from PwC LLP audit identified that there is a programme management system in place through the Emergency Planning Officer to oversee. A year plan for Emergency Planning developed. Production/updates of documents/plans relating to Emergency Planning and Business Continuity aligned with national guidance have begun. Including Business Impact Assessments for all specialties. Plan templates for specialties now include details/input from Interserve	(c) not all the critical suppliers questioned provided responses (c) contracts aren't assessed for their potential BC risk on the Trust (c) Local plans for loss of critical services not completed due to change over of facilities provider (c) Plans have not been provided by Interserve as to how they would respond or escalate issues to the Trust.	Further work required to develop escalation plans and response plans for Interserve. (11.11)		Dec 2013 COO
	New policy to identify key roles within the Trust of those responsible for ensuring business continuity planning /learning lessons is undertaken.		Minutes/action plans from Emergency Planning and Business Continuity Committee. Any outstanding risks/issues will be raised through the COO.	No gaps identified.	No actions required.		
			New Policy on InSite Emergency Planning and Business Continuity Committee ensures that processes outlined in the Policy are followed, including the production of documents relating to business continuity within the service areas. 3 incidents within the Trust have been investigated and debrief reports written, which include recommendations and actions to consider. Issues/lessons feed into the development of local plans and training and exercising events.				

			Head of Operations and Emergency Planning Officer are consulted on the implementation of new IM&T projects that will disrupt users access to IM&T systems	(c)Do not always consider the impact on business continuity and resilience when implementing new systems and processes.	Further processes require development, particularly with the new Facilities and IM&T providers to ensure resilience is considered/ developed when implementing new systems, infrastructure and processes. (11.8)		Review Nov 2013 COO
				(a) Lack of coordination of plans between different service areas and across the specialties.	Training and Exercising events to involve multiple specialties/CMGs to validate plans to ensure consistency and coordination. (11.10)		Aug 2014 COO

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RISK NUMBER/ TITLE:	**RISK 12 FAILURE TO EXPLOIT THE POTENTIAL OF IM&T**
LINK TO STRATEGIC OBJECTIVE(S))	**a. - To provide safe, high quality patient-centred health care.** **d. - To enable integrated care closer to home**
EXECUTIVE LEAD:	Director of Finance and Business services

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to integrate the IM&T programme into mainstream activities	Managed Business Partner for IM&T services to deliver IT that will be a key enabler for our clinical strategy. IM&T now incorporated into Improvement and Innovation Framework	3x3=9	IM&T Board in place. Quarterly reports to Trust Board	No gaps identified	No actions required	3x2=6	
	Engagement with the wider clinical communities (internal) including formal meetings of the newly created advisory groups/ clinical IT. Improved communications plan incorporating process for feedback of information		CMIO(s) now in place, and active members of the IM&T meetings The joint governance board monitors the level of communications with the organisation	No gaps identified	No actions required		
	Engagement with the wider clinical communities (External). UHL CMIOs are added as invitees to the meetings, as are the clinical (IM&T) leads from each of the CCGs		UHL membership of the wider LLR IM&B board	No gaps identified	No actions required		

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to implement and embed an effective medical training and education culture with subsequent critical reports from commissioners, loss of medical students and junior doctors, impact on reputation and potential loss of teaching status.	Medical Education Strategy and Action Plan	4x3 = 12	Strategy approved by the Trust Board Strategy monitored by Operations Manager and reviewed monthly in Full team Meetings. Favourable Deanery visit in relation to ED Drs training	(c) Lack of engagement/awareness of the Strategy with CMGs.	Meetings to discuss strategy with CMGs (13.1)	3x2 = 6	Dec 2013 MD
	UHL Education Committee 'Doctors in Training' Committee established Education and Patient Safety		Professor Carr reports to the Trust Board Reports submitted to the Education Committee Terms of reference and minutes of meetings	(c) Attendance at the Committee could be improved. (c) Improved trainee representation on Trust wide committees (c) Improve engagement with other patient safety activities/groups	Relevance of the committee to be discussed at specialty/ CMG meetings (13.2) 'Build relationships with CMG Quality Leads. Establish links with LEG/QAC and QPMG. (13.4)		Dec 2013 MD Dec 2013 MD

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

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

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
1	**Failure to achieve financial sustainability**					
1.6	Re-establishing clinical coding improvement team under John Roberts. Initial action plan in place.	DS	ADI	Review ~~August~~ October 2013	**Complete.** Restructure of coding team completed - site leads and audit role in place.	5
1.11	Ongoing discussions with commissioners about planned re-investment of the MRET deductions.	DFBS		Review October 2013	The previous timescale for completion was optimistic and a revised timescale for completion of discussions and resolution of the issue has been provided.	3
1.19	ESB will continue to meet every 6 weeks to ensure implementation of SLM across the Trust (expected Mar 2014)	DFBS		March 2014	On track.	4
1.20	Submit application for clinical coding to be included as a 2nd wave LIA pioneering team to involve clinicians.	DS	ADI	Review January 2014	On track. Successful with LIA application and upgraded to a 2nd wave LIA Enabling our People project with a focus on improving coding at the LRI.	4
2	**Failure to transform the emergency care system**					
2.7	Continue with substantive appts until funded establishment within ED is achieved.	COO	HO	Review ~~Sept~~ Nov 2013	On track.	4

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
2.9	CCG/LPT to increase capacity by use of Intermediate Care Services.	COO	HO	~~August~~ Review ~~October~~ November 2013	DTOCs reduced but not at level required yet. Additional community beds in City (24) and East (24) have been delayed and are now due to start in Nov 2013. Additional 19 IP beds for LPT also in process of being put in place	3
3	**Inability to recruit, retain, develop and motivate staff**					
3.1	Revise and re-launch UHL reward and recognition strategy.	DHR	DDHR	~~October 2013~~ January 2014	A draft strategy is in place which has been further developed through 2 LiA events in September. The next stage is consultation on the final draft before approval by Executive colleagues. The launch of the strategy is anticipated launch date for the strategy is January 2014. The action completion date has been amended to reflect this.	4

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
3.2	Take baseline from January and measure progress in relation to the success of recruitment events now that there is a structured plan for bulk recruitment. Identify a lead from each professional group to develop and encourage the production of fresh and up to date material.	DHR	DDHR	December 2013	There has been a programme of Trust wide recruitment campaigns for Registered nurses and HCA's during 2013 which have proved successful, Key actions have included Development and implementation of a Band 5 registered nurse and Band 2 HCA job swap to limit the number of internal moves from full recruitment processes. Attendance at 3 Registered Nurse jobs fairs in Manchester, London and Glasgow Development to a Nursing recruitment web page. Adverts have appeared on train platforms between Leicester, London and surrounding areas and use of social media as an advertising source has been utilised for the first time. LiA will support further development of all of the above for Nursing and other staff groups in UHL. International Recruitment campaigns are continuing to progress and the success will be evaluated. A comprehensive rolling programme of advertising has been proposed for 2014 which will further support the progress already made	4

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
3.3	Development of Pay Progression Policy for Agenda for Change staff.	DHR	DDHR	~~October~~ November 2013	Presentation of proposal to Executive Strategy Board on 1st October. Comments received and work to finalise a Policy for consultation with staff side underway. Initial staff side comments will be acquired at the JSCNC of 11.11.13. A further progress update will be presented to the ET Strategy Board in December.	3
3.4	Implementation of Recruitment and Retention Premia for ED staff.	DHR	DDHR	~~September~~ ~~October~~ November 2013	**Partial completion**. R and R premia approved by Remuneration Committee and in place for band 5 Nurses. ED Consultants have received communication and further work progressing in terms of job planning. Deadline for completion extended until end of November 13.	3
3.5	Ensure Statutory and Mandatory training is easy to access and complete with 75% compliance by reviewing delivery mode, access and increasing capacity to deliver against specific subject areas.	DHR	ADLOD	March 2014	Performance improved to 57% (at end of October 2013) First three e-learning packages have been completed:- • Information Governance • Manual Handling (non-patient) Equality and Diversity.	4
3.6	Consult and implement Pay Progression Policy	DHR	DDHR	November 2014	First stage of staff side consultation will take place at the JSCNC on 11.11.13	4
3.7	Update e-UHL records to ensure accuracy of reporting on a real time basis	DHR		March 2014	Working progress with designing new system and completion of Project Documentation for review by IMT Project Board on 4 November 2013	4

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
3.8	Active recruitment strategy to recruit to current nurse vacancies including implementation of a dedicated nursing recruitment team	CN/ DHR		December 2013	Team leader appointed and new structure to be implemented from 2 December 2013.	4
3.9	Develop an employer brand and maximise use of social media to describe benefits of working at UHL	DHR		April 2014	First meeting of task and finish group taken place. Use of Linked-In and staff good news stories to describe benefits of working at UHL	4
3.10	Programme of induction and adaptation in development with Nursing education leads, timetabled to ensure capacity to support recruitment programme.	DHR		April 2014	Programme in development which covers induction, interim development and long term development. Includes dedicated older person's training course	4
4	**Ineffective organisational transformation**					
5	**Ineffective strategic planning and response to external influences**					
6	**Failure to achieve FT status**					
6.10	Director of Strategy to be Exec lead for BCT. Ad hoc cover to continue until appointment in place.	CEO		October 2013	**Complete.** Director of Strategy appointed.	5

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
6.11	Action plans to be developed to address recommendations from independent reviews.	CEO	DCLA	~~Review July September~~ November 2013	Document sourced from Sandwell and West Birmingham NHS Trust that will serve to complement our existing policy for responding to external recommendations and requirements. The Director of Clinical Quality will now work to merge these two documents and provide a revised UHL policy. Deadline extended to reflect the timeline for this work. Completion date has slipped as policy now needs to take account of organisational restructuring. Deadline extended to November 2013	3
7	**Failure to maintain productive and effective relationships**					
7.2	Extend stakeholder surveys into wider group of stakeholders (e.g.CCGs, LAT, Universities, etc) to complement the 'soft intel'.	DMC		~~September~~ October 2013	**Complete**	5
8	**Failure to achieve and sustain quality standards**					
8.2	Women's CBU to work with Dr Foster and other trusts to better understand risk adjustment model related to the national quality dashboard.	MD		January 2014		4
8.5	Active recruitment to ward nursing establishment so releasing ward sister for supervisory practice.	CN		September 2014	On going recruitment process in place and is likely to take 12 -18months. Deadline extended to reflect this.	4
8.9	Analysis of mortality review by Public Health.	MD		~~September~~ November 2013	**Complete**. Analysis of mortality review by Public Health performed and report outlining results to go to TB in November	5

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
8.10	Implementation of Electronic Patient Record (EPR)	CIO		2015	We are currently developing the procurement strategy for the EPR solution	4
8.11	UHL to be involved in the DH review in to the use of the Safety Thermometer tool	CN		Review Dec 2013	Timescale DH dependent	4
9	**Failure to achieve and sustain high standards of operational performance**					
9.2	Re-configuration of surgical beds to create a 'protected area' for surgical patients or by use of independent sector.	COO	HO/CMGM Planned	November 2013	On track.	4
9.7	Action plan to resolve Imaging issues to be developed.	COO		~~July~~ ~~August~~ October 2013	**Complete.**. Additional funding secured from commissioners to reduce imaging backlog. Recovery implementation underway and 62 day performance currently on track with trajectory.	5
9.8	Further development of backlog plans. RTT revised plans submitted to commissioners 11/9/13 awaiting formal acceptance.	COO		~~August~~ ~~September~~ End of ~~October~~ November 2013	Formal recovery plan now intended for submission by end November	3
9.9	NHS Intensive Support team will be invited into UHL to review capacity and demand assumptions and provide assurance to recovery plans.	COO		~~September~~ End of October 2013	**Complete.** Initial capacity and demand review completed by IST.	5
9.10	Outputs from IST initial capacity and demand review to inform recovery plan development	COO		~~November 2013~~		4
10	**Inadequate reconfiguration of buildings and services**					

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
10.1	Key measures for gauging success of clinical strategy to be developed by specialties as part of their 'mini-IBPs' and will be monitored via divisional and directorate boards.	MD		December 2013	On track.	4
10.2	Ensure success of FT Application (see risk 6 for further detail).	CEO		April 2015	Timetable subject to change due to changes in national approach.	3
10.3	Secure capital funding to implement Estates Strategy.	DFBS		~~May 2013~~ December 2013	Work underway on capital planning around reconfiguration – SOC due for completion in Dec '13 / Jan '14 which will be the key vehicle to agree availability of capital funding.	4
11	**Loss of business continuity**					
11.2	Determine an approach to delivering a physical testing of the IT Disaster Recovery arrangements which have been identified as a dependency for critical services. Include assessment of the benefits of realistic testing of arrangements against the potential disruption of testing to operations.	COO	CIO	~~September~~ Further review December 2013	Testing programme hasn't been developed but it is part of the work that IBM are doing to achieve ISO 22000. Currently awaiting update from CIO. Further review in December 2013	3
11.8	Further processes require development, particularly with the new Facilities and IM&T providers to ensure resilience is considered/ developed when implementing new systems, infrastructure and processes.	COO	EPO	~~July~~ ~~August~~ Review ~~October~~ November-2013	Work with IM&T has been completed. All projects in IM&T that require downtime have to be signed off by the Change Advisory Board. Part of the process is consulting with EPO and HOO. This process will continue as normal through the managed business partnership. Delays are being encountered developing agreed processes with Interserve. Progress will be reviewed during October 2013.	3

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
11.10	Training and Exercising events to involve multiple CBUs/Divisions to validate plans to ensure consistency and coordination.	COO	EPO	August 2014	BCM training and exercising programme has been developed.	4
11.11	Further work required to develop escalation plans and response plans for Interserve.	COO	EPO	~~October~~ December 2013	EPO has not received any progress updates from Interserve.	3
11.12	Develop a plan and a better understanding of how a loss of critical suppliers will affect the Trust	COO	EPO	~~October~~ November 2013	Draft plan due w/c 4th November	3
11.13	Training and Exercising events to involve multiple CBUs/Divisions to validate plans to ensure consistency and coordination	COO	EPO	August 2014		4
12	**Failure to exploit the potential of IM&T**					
12.8	TDA approvals documentation to be completed	CIO		~~October 2013~~ Review Jan 2014	The current discussion around how we procure the EPR solution has a material effect on how or if we proceed with TDA approval. This will be decided in the next two months	2
13	**Failure to enhance education and training culture**					
13.1	To improve CBU engagement facilitate meetings to discuss Medical Education Strategy and Action Plans with CBUs.	MD	AMD	December 2013	On track.	4
13.2	Relevance of the UHL Education Committee to be discussed at CBU Meetings in an effort to improve attendance.	MD	AMD	December 2013	On track.	4
13.3	Doctors in Training Committee needs to be established along with terms of reference to ensure more effective communication to Juniors.	MD	AMD	November 2013	**Complete.** Group now established	5

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
13.4	Build relationships with CBU Quality Leads and establish links with LEG/QAC and QPMG in an effort to improve engagement with other patient safety activities/groups.	MD	AMD	December 2013	On track.	4
13.5	Introduce exit surveys for trainees and communicate feedback from the GMC training survey and LETB Visits via the Dashboard.	MD	AMD	December 2013	On track.	4
13.6	Attend CBU management meetings and liaise with CBUs in an effort to improve engagement of CBUs.	MD	AMD	December 2013	On track.	4
13.7	Monitor UHL position against other trusts nationally to ensure progress against strategic and national benchmarks.	MD	AMD	Review ~~October 2013~~ February 2014	Following further discussions with the LETB this data is not readily available. LETB to investigate how we can acquire this data.	2
13.8	New Library/learning facilities to be developed at the LRI to help resolve inadequate educational resources.	MD	AMD	~~October 2013~~ April 2014	The Odames Ward has been identified and a project groups has been set up. Currently this area is being used as a decant ward for Osborne patients. We understand that we can begin work on this in April 2014. The project group will continue to meet to ensure this stays on track.	2
13.9	Dr Hooper in post for Acute Medicine to implement project and improve Acute Medicine progress.	MD	AMD	February 2014	On track.	4
13.10	Need to engage with the CBUs to help them understand the implication of SIFT and their funding streams.	MD	AMD	December 2013	On track.	4

Key

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

CEO	Chief Executive Officer
DFBS	Director of Finance and Business Services
MD	Medical Director
AMD	Assistant Medical Director
COO	Chief Operating Officer
DHR	Director of Human Resources
DDHR	Deputy Director of Human Resources
DS	Director of Strategy
ADLOD	Asst Director of Learning and Organisational Development
DMC	Director of Marketing and Communications
CIO	Chief Information Officer
CMIO	Chief Medical Information Officer
EPO	Emergency Planning Officer
HPO	Head of Performance Improvement
HO	Head of Operations
CD	Clinical Director
CMGM	Clinical Management Group Manager
DDF&P	Deputy Director Finance and Procurement
FTPM	Foundation Trust Programme Manager
HTCIP	Head of Trust Cost Improvement Programme
ADI	Assistant Director of Information
FC	Financial Controller
ADP&S	Assistant Director of Procurement and Supplies
HoN	Head of Nursing
TT	Transformation Team
CN	Chief Nurse

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

Appendix four

BAF RISK SCORE MAP – OCTOBER 2013

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

Key

● - No change in score from previous month.

⇧ - Risk score increased from previous month

⇩ - Risk score decreased from previous month

◈ - New risk

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

1) Are the Trust's strategic objectives S.M.A.R.T? i.e. are they :-

- **S**pecific
- **M**easurable
- **A**chievable
- **R**ealistic
- **T**imescaled

2) Have the main risks to the achievement of the objectives been adequately identified?

3) Have the risk owners (i.e. Executive Team) been actively involved in populating the BAF?

4) Are there any omissions or inaccuracies in the list of key controls?

5) Have all relevant data sources been used to demonstrate assurance on controls and positive assurances?

6) Is the BAF dynamic? Is there evidence of regular updates to the content?

7) Has the correct 'action owner' been identified?

8) Are the assigned risk scores realistic?

9) Are the timescales for implementation of further actions to control risks realistic?

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

NEW OPERATIONAL RISKS SCORING 15 OR ABOVE FOR THE PERIOD 01/10/13 - 31/10/13

REPORT PRODUCED BY: UHL RISK AND ASSURANCE MANAGER

Key

Red	Extreme risk (risk score 25)
Orange	High risk (risk score 15 - 20)
Yellow	Moderate risk (risk score 8 - 12)
Green	Low risk (risk score below 8)
⮝	Risk score increased from initial risk score
⮟	Risk score decreased from initial risk score
★	New risk since previous reporting period
⇔	No Change in risk score since previous reporting period

Ref Text Risk with elapsed risk review date and/or elapsed action due date

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2234	Emergency and Specialist Medicine	ED	There is a medical staffing shortfall resulting in a risk of an understaffed Emergency Department	04/10/2013	04/11/2013	Consultant vacancies, Poor quality care, continued lack of retention. Stress and burnout. Increased incidents and complaints. Inability to do the general work of the department. 4 hour target. Increased sickness. Middle grade vacancies, Poor quality care, reputation. Risk of losing trainees due to incorrect service/training balance. Trainee attrition. Stress, poor morale. Trainees not wanting to apply for consultant positions. Reduced cohesiveness as a trainee group. Risk to four hour target. Increased sickeness Junior grade vacancies, Poorer quality care. 4 hour target. Stress. Juniors defecting to other specialities. Increased sickness. Poorer quality of training resulting in poor deanery reports. Non ED medical consultants, Increased incidents. Serious incidents. Stress. Locums□Financial. Poor quality care. Increased complaints, incidents, claims, serious incidents. Increased consultant workload. Lack of uniformity. Risk to 4 hour target. Paediatric medical staffing□Poorer quality care for paediatric population. Increased number of incidents, complaints and claims. Reduced ability to maintain CPD com	Patients	The chief executive and medical director have met with senior trainees in Leicester ED to invite them to apply for consultant positions. The East Midlands Local Education and training board has recognised middle grade shortages as a workforce issues and has set up several projects aiming to attract and retain emergency medicine trainees and consultants. Advanced nurse practitioners and non-training CT1 grades have been employed in order to backfill the shortage of SHO grade junior doctors. There has been shared teaching sessions in which non ED consultants and ED consultants have shared skills, (i.e. ED consultants learning about collapse in the elderly and elderly medicine consultants doing ALS). The non ED consultants have been set up on a specific mailing list so that new developments and departmental 'mini-teaches' (= learning cases from incidents) can be shared. Only approved locum agencies are used for ED internal locums and their CVs are checked for suitability prior to appointing them. Locums receive a brief shop floor induction on arrival and also must sign Locum doctors are only placed in paeds ED in except The grid paediatric trainees shift pattern has changed ED employs medical registrars to work night shifts in E ED consultants have extended their shop-floor hours t	Extreme	Likely	20	To engage with active recruitment at all levels (Consultant, non-training grades, oversees doctors, advanced nurse practitioners) - No due date listed.	6	BTD

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2244	Musculoskeletal and Specialist Surgery	Ophthalmology	Medium-term staffing shortages/ lack of equipment/poor processes in Ophthalmology causing deterioration in service	29/10/2013	29/11/2013	**Causes** Admin staffing shortages following a previous MoC exercise. This is exacerbated by a slow recruitment process following successful interview and unavailability of temporary workforce with necessary skill set and access to hospital systems. Poor management processes and inadequate assurance mechanisms. Staffing vacancies in Medical records. Lack of assurance mechanisms. Use of ICE for outpatient letters (taking existing staff approximately 30% longer to type and process). Lack of computers and printers. A-Scanner (biometry) is broken and replacement not yet delivered. Lack of clinical space in OPD. **Consequences** Transcription: There is a considerable typing backlog in the department which is not maintaining a steady state in relation to patient letters. Currently there is a backlog of 14,500 patient letters. These include letters to GPs and interdepartmental referrals. This leads to ineffective communication with GPs and other eye centres and may impact adversely on the patient's underlying condition e.g. GPs may not prescribe new treatments if patients fail to attend or may commence ne Filing: There is a significant backlog in relation to filing of typed lette Referrals Management: Delays to registering and booking of referrals. Potential for patients newly referred not to be seen by clinica Missing referrals. Files of referrals found in drawers. Clinic Management: New patients booked to inappropriate clinics as referrals are Notes not prepared for clinic. Clinic outcomes not entered onto clinic management system Evening clinics not efficient due to inadequate staffing for tes	Quality	Executive Director leadership/ engagement with current issues. Letter to referrers indicating current situation. ICE no longer used and all letters typed using Microsoft 'word'. Additional audio typists recruited supported by agency staffing. Clinic process in place to ensure all clinics are cashed up on the day and outcomes dealt with All referrals to go to consultants for triage before booking. Route for urgent cases made explicit. Clinicians asked to keep outcome sheet on discharged patients for subsequent handover to clerk at the end of a clinic. Continual monitoring and reporting of the backlog of typed letters and filing of typed letters. Transfer of some cataract (x67) / oculoplastics (x87) cases to independent sector. Weekly monitoring of waiting list and RTT position. Two new Fellows recruited for diabetic oedema retinal injections (backlog expected to be cleared by end of October 2013. Nursing staff and A&C staff available until 8pm (however no technicians available) Use of WHO surgical safety checklist in theatres Ongoing monitoring of incidents and complaints data Weekly senior team meeting to ensure controls are ef Agency staff supporting clinic and notes preparation Skilled staff moved to appropriate areas e.g. waiting li	Major	Almost certain	20	Begin monitoring the backlog and ensure real progress in achieving a steady state (9 - 12 weeks to catch-up with backlog and 20 weeks to achieve steady state (i.e. backlog at a maximum of 1000) - 31/3/14. Identify suitable workstations for additional staff and install computers and printers. - 22/10/13. Monitor the progress in reducing the number of typed letters waiting to be filed and agree a point at which the previous process can be reinstated. - 31/3/14. Improve theatre utilisation by the effective management of operating lists and Implement processes to enable theatre list booking up to 6 weeks in advance. - (4 weeks in advance by) 31/10/14 Organise 'clean room' sessions for Mon, Tues and Thurs am. - 15/10/13. Contact Procurement to expedite delivery of A-Scanner and review progress - 22/10/13. Develop clinical pathways (referral to follow-up). 31/12/13. Facilities to provide quotes for enabling works to alleviate lack of clinical space. - 22/10/13. Training of clinic clerks to be reinforced and data quality checking initiated. - 22/10/13. Close liaison with HR team to expedite the recruitmer Development and 'sign-off' of new protocols for indep	9	DTR

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2094	Musculoskeletal and Specialist Surgery	Ophthalmology	Delayed roll out of outsourced Transcription process , unavailability of skilled workforce and flexible workers	12/10/2012	31/10/2013	**Causes:** -Reduction in secretarial skilled staffing due to previous MoC process -Delays in recruitment process preventing appointment to posts in a timely manner. -Use of DICT8 not delivering anticipated efficiencies. -High turnover of staff on fixed-term contracts that leave when substantive posts become available. -Bank and agencies cannot supply adequate numbers of staff to fill vacancies **Consequences:** -Outcomes missing from system. -Outcome slips filed in incorrect locations. -Patient notes may not contain relevant documentation. -Extensive delays in referral letter process (current backlog of approximately 11000 letters in -Ophthalmology, 3000 letters in ENT, 2000 letters in Breast Care) may lead to: Longer waiting times for treatment. -Increased number of complaints. -Adverse impact on reputation of specialty/Trust. -Insufficient staff to cope in cases of IT system failures. -H&S risk to staff due to numbers of patient notes stored inappropriately increasing the risk of slips, trips, and falls hazards. -Existing staff under increased stress due to increased workl -Additional costs for overtime/ agency staff.	Patients	Stress audits performed Regular team meetings to provide support for A&C staff Staff training Temporary agency staff recruited 2 ops managers Weekly team meetings New Head of Service Outsourcing activity to private sector Significant number of vacancies filled in supporting A+C ENT typing outsourced to DICT8. Ophthalmology using ICE and template letters for referrals. Overtime and additional hours worked by existing staff. Trajectories developed and monitored in relation to addressing backlog. Urgent cases given priority for typing. Time allowed for 'protected typing' whenever possible. Involvement of UHL Health and safety team to help address staff safety issues. Additional racking for notes sourced and installed. ENT commenced using DICTATE IT	Major	Almost certain	20	recruit to vacant service manager post - 31/10/2013 recruit addition medical staffing - 31/10/2013	8	DTR

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2240	Clinical Support and Imaging	Physiotherapy & Occupational Therapy	The impact of vacancies in Physiotherapy and Occupational Therapy on service delivery	09/10/2013	31/10/2013	**Causes** (hazard) The increase in vacancies has been caused by delays to recruitment via a management of change process, maternity leave, turnover and a protracted Trust recruitment process. **Consequence** (harm / loss event) Impact on patient journey time through the emergency process: deterioration in response time for new patient assessment, increased time for 'therapy complete', potential increase in unsafe discharge (patients not therapy complete), increased LoS, inadequate support to admission avoidance schemes, reduced participation in board / ward rounds / MDTs. Increase in outpatient waiting list numbers and breach of targets. Breach of operational targets due to reduced therapy participation e.g. stroke Quality Indicators. Increase in staff stress and sickness absence. Potential loss of income due to reduction in outpatient staffing and redirection of staff from outpatients to inpatients. Increase in complaints (internal service users and external patients, relatives and carers).	HR	Use of bank staff where possible (but limited numbers). Use of overtime (though staff not keen to take up due to work pressures and annual leave). On going discussions with HR to quicken the recruitment / selection process. Therapy management team chasing references and completing CRB risk assessments where possible. Generic adverts out for Band 5 OT / PT; discussions on going regarding over recruitment plan. On going exploration of more efficient ways of working and workload measurement as part of the therapy pathway review. Specific plans in place in service areas where there are critical staffing issues. 5 locum's agreed for August and September to cover critical vacancies; 4 currently sourced.	Major	Likely	16	On going review of services and concentration of staffing in areas of greatest demand - 31/10/2013 Continuation of existing staff working additional hours / overtime; continued use of bank staff - 30/10/2013 Employ further locum staff; on-going needs assessment - 31/10/2013 Continue to work with HR Shared Services to expedite the recruitment process and get staff in to post - 31/10/2013	6	LCOO

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2237	Medical Directorate	Medical Directorate	Risk of results of outpatient diagnostic tests not being reviewed or acted upon resulting in patient harm.	07/10/2013	07/11/2013	**Causes** Outpatients use paper based requesting system and results come back on paper and electronically. Results not being reviewed acknowledged on IT results systems due to; Volume of tests Lack of consistent agreed process IT systems too slow and 'lock up' Results reviewed not being acted upon due to; No consistent agreed processes for management of diagnostic test results Actions taken not being documented in medical notes due to; Volume of work and lack of capacity in relation to medical staff Lack of agreed consistent process Referrals for some tests still being made on paper with no method of tracking for receipt of referral, test booked or results. Poor communication process for communicating abnormal results back to referring clinician; Abnormal pathology results- cannot always contact clinician that requested test and paper copies of results not being sent to correct clinicians or being turned off to some areas. Suspicious imaging findings- referred to MDT but not always also communicated back to clinician that referred for test. Lack of standards or meeting standards for diagnostic tests i **Consequences** Potential for mismanagement of patients to include: Severe harm or death to patient Suboptimal treatment Delayed diagnosis Increased potential for incidents, complaints, inquests and cl Risk of adverse publicity to UHL leading to loss of good repu Financial consequences to include: Potential increase in NHSLA contributions Potential increased LOS.	Patients	Abnormal pathology results escalation process Suspicious imaging findings escalated to MDTs	Major	Likely	16	Implementation of Diagnostic testing policy across Trust - to ensure agreed speciality processes for outpatient management of diagnostic tests results. March 14 Development IT work with IBM to improve results system for clinicians and Trust to develop EPR with fit for purpose results management system. - Jan 16	8	BCOL

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2247	Nursing	Nursing	There are 500 Registered Nurse vacancies across UHL leading to a deterioration in service and adverse effect on financial position	30/10/2013	30/11/2013	**Causes** Shortage of available Registered Nurses in Leicestershire. Nursing establishment review undertaken resulting in significant vacancies due to investment. Insufficient HRSS Capacity leading to delays in recruitment. **Consequences** Potential increased clinical risk in areas Increase in occurrence of pressure damage and patient falls Increase in patient complaints Reduced morale of staff, affecting retention of new starters Risk to Trust reputation Impact on Trust financial position due to premium rate staffing being utilised to maintain safety. Increased vacancies across UHL Increased paybill in terms of cover for establishment rotas prior to permanent appointments HRSS capacity has not increased to coincide and support the increase in vacancies across the Trust Delays in processing of pre employment checks due to increased recruitment activity Delayed start dates for business critical posts Benefits of bulk and other recruitment campaigns not being realised as effectively as anticipated and expected Service areas outside of nursing being impacted upon due to emphasis on nursing roles.	Patients	HRSS structure review. A temporary Band 5 HRSS Team Leader appointed. A Nursing lead identified. Recruitment plan developed with fortnightly meetings to review progress. Vacancy monitoring. Bank/agency utilisation. Shift moves of staff. Ward Manager/Matron return to wards full time.	Major	Likely	16	A team will be formed to manage the complete end to end recruitment processes for all Registered Band 5 Nurses and Midwives and HCA's for all CMG's and specialties - 15/11/13 Shift by shift monitoring of gaps - 30/11/13 Ward Manager/Matron return to wards full time. - TBA Ward dashboards - 30/12/13 Ward performance process - 30/12/13 Over recruit HCAs. - Ongoing Utilise other roles to liberate nursing time - 30/12/13	12	CRIB

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2239	Clinical Support and Imaging	Physiotherapy	Impact of closure of the hydrotherapy pool facility at LGH.	09/10/2013	31/10/2013	**Causes** (hazard) The LGH hydrotherapy pool was closed on 17th May 2013 by Interserve due to problems with the plant room equipment, drainage and the fabric of the pool and that it did not meet current specifications / standards for use. **Consequence** (harm / loss event) Patients cannot access hydrotherapy treatment whilst the pool is out of action, with the potential for some patients to experience deterioration in their condition. Patients may not also be able to commence treatment when clinically indicated. The therapy service will receive no income from pool hire to external NHS users, self-help groups or private businesses during the pool downtime, resulting in under recovery against plan and financial pressure in the short-term. Prolonged closure may encourage users to source alternate facilities, threatening income long-term. A significant increase in complaints, inquiries etc is anticipated from service users, the media, public representatives etc, particularly in light of the emotive closure of the LRI pool facility previously and the attention attracted by this.	Economic	Where appropriate patients are being asked to attend for land based exercises / treatment until such time as the pool re-opens. All current NHS patients using the facility have been contacted and needs assessed. To note, there is no alternate UHL facility since the closure of the LRI pool three years ago and further, there is no access to an alternate facility within the City or County. All external users have been notified of the closure and advised of the estimated downtime. Two of the self-help groups also run land based exercise sessions for their members and will continue with these until the pool re-opens. The service / CBU management team are working intensively with Horizons FM / Interserve to confirm the required capital works, secure the capital funding and undertake the upgrade to the facility as quickly as possible.	Moderate	Almost certain	15	Work commencement and completion - 3/11/2013 Document weekend policy & meet with private users to discuss and agree - 31/10/2013	4	CSH

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Likelihood	Impact	Current Risk Score	Action summary	Target Risk Score	Risk Owner

Clinical Management Groups

CMG	Datix Code
Cancer, Haematology, Urology, Gastroenterology and Surgery (CHUGS)	CMG1
Renal, Respiratory and Cardiac (RRC)	CMG2
Emergency and Specialist Medicine	CMG3
Intensive Care, Theatres, Anaesthesia, Pain Management, Sleep (ITAPS)	CMG4
Musculoskeletal and Specialist Surgery	CMG5
Clinical Support and Imaging	CMG6
Women's and Children's	CMG7

Cancer, Haematology, Urology, Gastroenterology and Surgery (CHUGS) - CM

Old CBUs: GI Med, Surgery, Urology & Cancer, Haematology, Oncology
PLAN2 and PLAN03

Specialty	Datix Code
Clinical Haematology	HAEMC
Gastroenterology	GASTRO
Gastroenterology (Inpatients)	GASIP
General Surgery	GENSUR
Oncology	ONCO
Palliative Care	PALLIA
Radiotherapy	RADT
Urology	UROL
Bowel Cancer Screening	BOWEL

IG1

Renal, Respiratory and Cardiac (RRC) - CMG2

Old CBU: Cardiac, Renal, Respiratory - ACUT03

Specialty	Datix Code
Allergy	ALLERG
Biomedical Research Unit	BIOMED
Cardiac Investigations	CINVST
Cardiac Rehabilitation	CREHAB
Cardiac Surgical Wards	CARSGW
Cardiology	CARDIO
Cardiovascular	CAVASC
Clinical Decisions Unit	CDU
Clinical Immunology	CLIMMU
Coronary Care Unit	CORCAR
Discharge Lounge (GH)	DISCGH
Nephrology	NEPHRO
Renal Transplant	RENTRA
Respiratory Medicine	RM
Satellite Units	SATEL
Thoracic Surgery	TSURG

Emergency and Specialist Medicine - CMG3

Old CBUs: Emergency Care & Specialty Medicine - ACUT01 and ACUT02

Specialty	Datix Code
Dermatology	DERMAT
Discharge lounge (LRI)	DISCHL
Emergency Department	ED
Infectious Diseases	INFECT
Medicine for the Elderly	ELDER
Metabolic Medicine	METBOL
Neurology	NEUROL
Rapid Assessment Unit (Ward 15, LRI)	RAU
Rheumatology	RHEUM
Short Stay Unit (Ward 16, LRI)	SSU
Stroke Services	STRKSV

Intensive Care, Theatres, Anaesthesia, Pain Management, Sleep (ITAPS) - CMG4

Old CBU: ITAPS - PLAN05

Specialty	Datix Code
Anaesthesia	ANAE
Critical Care	CRITCR
Daycase Surgery	DCSURG
ECMO - Adult	ECMO
Pain Management - Acute	PAINAC
Pain Management - Chronic	PAINCH
Recovery	RECOV
Sleep Disorders	SLEEP
Sterile Services	STSERV
Theatres	THETRS

Musculoskeletal and Specialist Surgery - CMG5

Old CBUs: Specialist Surgery & Musculoskeletal - PLAN01 AND PLAN04

Specialty	Datix Code
Breast Surgery	BRESUR
Elective Orthopaedics	ELORTH
Maxillofacial	MAXFAX
Ophthalmology	OPHTHA
Orthodontics & Restorative Denistry	ODONT
Otorhinolaryngology/ENT	ENT
Plastic Surgery	PLAS
Retinal Screening	RETINA
Sports Medicine	SPORT
Trauma Orthopaedics	TRORTH
Vascular Services	VASC

Clinical Support and Imaging - CMG6

Old CBUs: Imaging and Med Physics & Professional Services & Pathology
ACUT05, ACUT06 and PATH (from Corporate Div.)

Specialty	Datix Code
Breast	BREAST
Cardiovascular Procedures	CARVAS
Cross Sectional Imaging (CT/MRI)	CTMRI
Medical Physics	MEDPHY
Plain Films	PLAIN
Radioisotopes	RADIO
Screening Procedures	SCREEN
Ultrasound	ULTRA
Booking Centre	BOOK
Dietetics	DIET
LL Pharmacy	LLPHAR
Medical Records	MEDREC
Nutrition Nurses	NUTRIT
Occupational Therapy	OCCT
Orthotics	ORTHOT
Outpatients	OUTPAT
Pharmacy Home Care	PHARHO
Pharmacy	PHARM
Pharmacy - Anaesthetics	PHARM01
Pharmacy - Lloyds	PHARLL
Pharmacy - Cancer Services	PHARM02
Pharmacy - Cardiorespiratory	PHARM03
Pharmacy - Children's	PHARM04
Pharmacy - Medicine & ED	PHARM05
Pharmacy - Musculoskeletal	PHARM06
Pharmacy - Renal	PHARM07
Pharmacy - Surgical Services	PHARM08
Pharmacy - Women's	PHARM09
Phlebotomy	PHLEB
Physiotherapy	PHYS
Podiatry	POD
Psychology	PSCH
Speech and Language Therapy	SPEE
Old Pathology CBU. Was in Corporate Division	
Blood Transfusion	BLOOD
Clinical Microbiology	CLMICR
Cytogenetics	CYTOGE
Blood Sciences	FAST
General Pathology	GPATH
Cellular Pathology	HIST
Immunology	IMMUNO
IT Services	IT
Logistics and Stores	LOGIST
Special Biochemistry	SPBIO
Special Haematology	SPHAEM
Stem Cell	STEM

Women's and Children's - CMG7

Old CBUs: Women's & Children's - WOCH01 and WOCH02

Specialty	Datix Code
Clinical Genetics	CLIGEN
Family Planning	FAMILY
GU Medicine	GUMED
Gynaecology	GY
Maternity	MATERN
Neonatology	NEONAT
Paediatrics	PAED
Paediatrics (Cardiorespiratory)	CARPAE