To:	**Trust Board**
From:	**Medical Director**
Date:	**30 May 2013**
CQC regulation:	Outcome 16 – Assessing and Monitoring the Quality of Service Provision

Title:	**UHL RISK REPORT INCORPORATING THE BOARD ASSURANCE FRAMEWORK (BAF) 2012/13**

Author/Responsible Director: Medical Director

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

a) A copy of the Board Assurance Framework (BAF) as of 30 April 2013.
b) A heat map of risk movements from the previous month.
c) A summary of progress of actions due for completion in the reporting period.
d) Suggested parameters for scrutiny of the BAF.
e) An extract from the UHL risk register showing all high risks.

The Report is provided to the Board for:

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

Summary :

- An updated version of the BAF is attached at appendix 1 with changes from the previous report highlighted in red text.
- There are 16 actions due for completion in April 2013 and of these, 8 have been completed, 7 have had deadlines extended and 1 action has been removed as no longer relevant. Two actions due for completion in June 2013 have already been completed.
- Following discussion at the previous TB meeting the following changes to the BAF have been included:
  Increase in risk score to 25 for *'Failure to transform the emergency care system'.*
  Risks are now presented in numerical sequence as opposed to risk score.
- Board members are invited to review the following risks:
  Risk 3 Inability to recruit, retain, develop and motivate staff.
  Risk 6 Failure to achieve FT status.
  Risk 8 Failure to achieve financial sustainability.
- A draft BAF for 2013/14 is being developed by the UHL Executive team revision to the current action tracker in order to provide a more robust audit trail and an improved method of providing assurance to the Board that any actions to mitigate any risks are on trajectory. The newly developed BAF to be presented at the June 2013 Board meeting.
- The Board is asked to note the following extreme risk opened on 14 May 2013.
  'Overcrowding in ED'
  Details of which are attached at appendix 7.

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

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

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

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

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

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

Strategic Risk Register	**Performance KPIs year to date**
No	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. Future reports to include evidence of effective implementation.	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **30 MAY 2013**

REPORT BY: **MEDICAL DIRECTOR**

SUBJECT: **UHL RISK REPORT INCORPORATING THE BOARD ASSURANCE FRAMEWORK (BAF) 2012/13**

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1. INTRODUCTION

1.1 This report provides the Board with:-

a) A copy of the Board Assurance Framework (BAF) as of 30 April 2013.
b) A heat map of risk movements from the previous month.
c) A summary of progress of actions due for completion in the reporting period.
d) Suggested parameters for scrutiny of the BAF.
e) An extract from the UHL risk register showing all high risks.

2. BAF POSITION AS OF 30 APRIL 2013

2.1 An updated version of the BAF is attached at appendix 1 with changes from the previous report highlighted in red text.

2.2 A heat map to show the movement of risk scores from the previous month is attached at appendix 2.

2.3 There are 16 actions due for completion in April 2013 and of these, 8 have been completed, 7 have had deadlines extended and 1 action has been removed as no longer relevant. Two actions due for completion in June 2013 have already been completed (See appendix 3 for further details).

2.4 Following discussion at the previous TB meeting the following changes to the BAF have been included:

- Increase in risk score to 25 for *'Failure to transform the emergency care system'.*
- Risks are now presented in numerical sequence as opposed to risk score.

Progress against the BAF will be monitored on a monthly basis at a UHL Executive Team (ET) meeting.

2.5 To provide scrutiny and oversight of BAF risks on a cyclical basis, Board members are invited to review the following risks against the parameters listed in appendix 4.

Risk 3	Inability to recruit, retain, develop and motivate staff.
Risk 6	Failure to achieve FT status.
Risk 8	Failure to achieve financial sustainability.

2.6 At the April 2013 Board meeting it was suggested that an ET strategy meeting be used to enable the ET to ascertain whether we have the correct risks on the BAF in light of recent updates to the Trust's Annual Operating Plan. This was completed at the ET meeting on 7 May 2013 and a draft BAF for 2013/14 is in the process of development. Appendix 5 provides the Board with a list of risks to be included in the revised BAF along with their Executive sponsors and the Board will note that the 2013/14 version identifies 4 new risks as listed below:

- Ineffective strategic planning and response to external influences.
- Failure to exploit the potential of IM&T.
- Failure to achieve and sustain quality standards (replacing previous risks *'Reducing avoidable harms'* and *'Patient experience/satisfaction').*
- Failure to achieve and maintain high standards of operational performance (replacing previous risk *'Failure to achieve and sustain operational targets'*).

Further amendments will include a revision to the current action tracker in order to provide a more robust audit trail and an improved method of providing assurance to the Board that any actions associated with the BAF are on trajectory.

2.7 It is proposed that a final version of the 2013/14 BAF will be submitted to the June 2013 Board meeting.

3 UHL RISK REGISTER.

3.1 The UHL risk reporting framework requires a twice yearly report to be submitted to the Board for oversight of all high risks within the Trust. An extract from the UHL risk register is attached at appendix 6 showing this detail as at 30 April 2013. There is also a requirement for the Board to receive notice of any extreme risks (i.e. a score of 25) that have been opened during the month. To this end the Board is asked to note the following extreme risk opened on 14 May 2013.

- *'Overcrowding in ED'.*

This risk amalgamates two previous risks *('overcrowding in ED'* and *'Inability to maintain acute patient flow to meet ED performance targets'*) and is graded as extreme to reflect unresolved issues with over capacity in the department. A copy of the risk register entry is attached at appendix 7.

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);

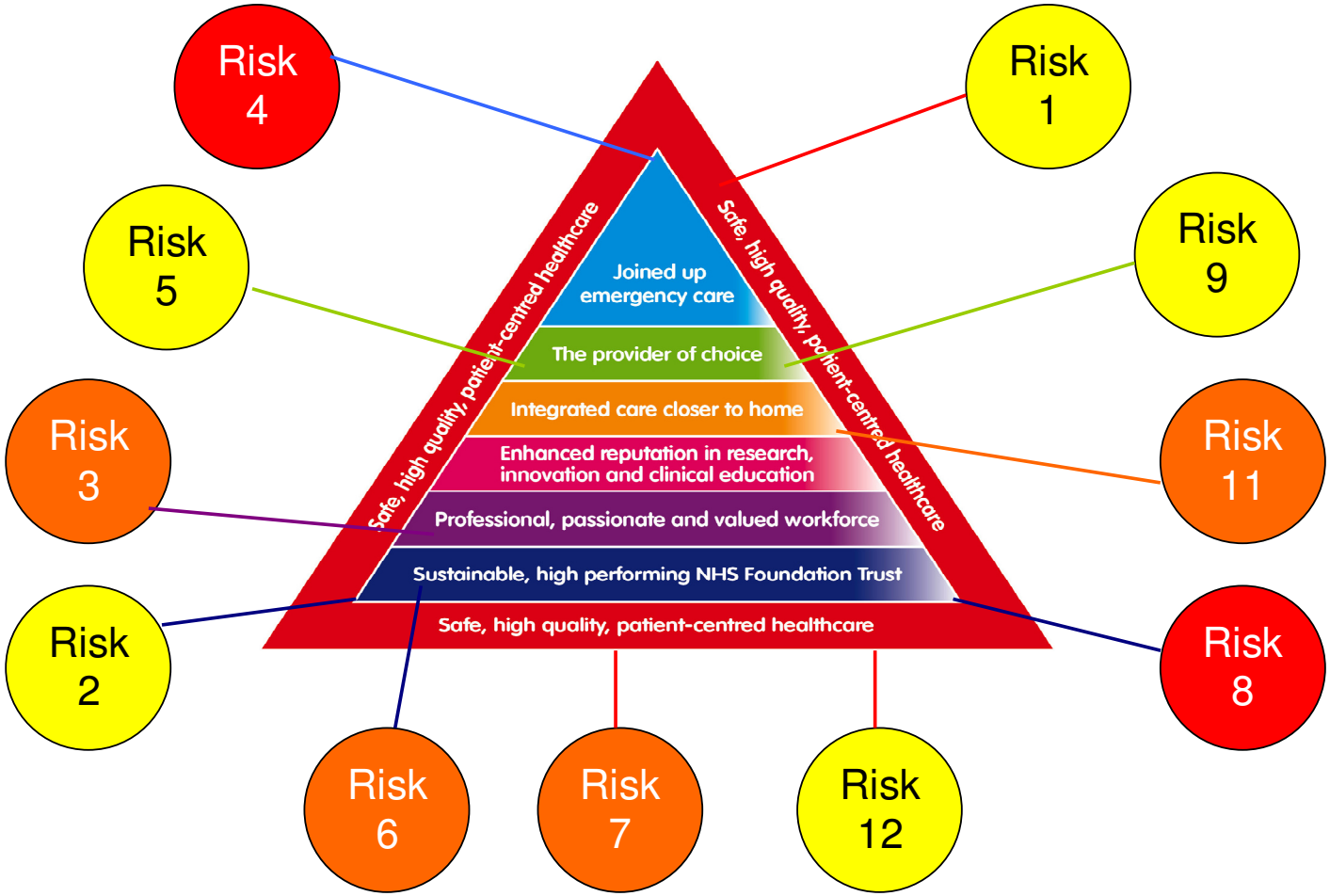
(c) identify any areas which it feels that the Trust's controls are inadequate and do not, therefore, effectively manage the principal risks to the organisation achieving its objectives;

(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,
22 May 2013.

BOARD ASSURANCE FRAMEWORK - APRIL 2013



PERIOD: 1 APRIL – 30 APRIL 2013

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

STRATEGIC OBJECTIVES:-

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	Current Score I x L	**How do we know we are doing it?** **(Key assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	Target Score I x L	**Timescale** When will the action be completed?
Failure to reduce avoidable harms and mortality and morbidity leading to decreasing patient experience/ patient satisfaction and loss of reputation.	Policies and procedures.	4x3=12	Hospital Standardised Mortality Indicators reported monthly to Trust Board via Quality and Performance (Q&P) report. HSMI 'within expected' for elective and non-elective activity. Review of SHMI and other mortality data by Boston Consultancy Group.	(a) Lack of mortality analysis out of hours/weekend (a) absence of community-wide mortality review. (a) UHL risk adjusted perinatal mortality rate below regional and national average. (a) Concerns about matching UHL data to that used by Dr Fosters in relation to perinatal mortality.	LLR Mortality Summit (interface review). Women's CBU to work with Dr Foster and other trusts to better understand risk adjustment model	3x2=6	Chief Nurse May/ June 2013 TBA
	Relentless attention to 5 Critical Safety Actions (CSA) initiative to lower mortality		Q&P report to Trust Board 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	(c) Lack of a unified IT system in relation to ordering and receiving results means that many differing processes are being used to acknowledge/respond to results. Potential risk of results not being acted upon in a timely fashion.	Feasibility of a less cumbersome IT platform to be investigated by IBM.		Chief Information Officer Review May 2013
	Never events thematic review action plan.						
	Learning lessons from incidents, complaints and claims to reduce the likelihood of recurrence.		Monthly patient safety report to Quality Assurance Committee (QAC) and Quality and Performance management Group (QPMG) Number of formal complaints received reducing (2 per 1000 attendances – M12, 1.6 per 1000 attendances YTD).	No gaps identified.	No actions required.		

	Infection prevention plan to ensure hospital acquired infections are reduced.		MRSA/C. Difficile rates reported to Trust board via monthly Q&P report. 0 MRSA cases reported to end of Mar 13. YTD MRSA cases = 2. Target = 6 C. Difficile currently below trajectory. 94 cases YTD to end of Mar 13 against full year target of 103.	No gaps identified.	No actions required.		
	Monthly patient experience monitoring 'Net Promoter'.		Monthly patient experience report to Trust board included within Q&P report. Improving Net Promoter results (64.5% at month 12 > 10% In-patient coverage).	No gaps identified.	No actions required.		
	Implementation of UHL Quality and Safety Commitment' 2012 – 15 (launched Jan 13) Key priorities: Reducing harm, reducing mortality rates and improving the patient experience. Agreement for CQUIN proposal in relation 'Quality Ambition' to be funded. Wider engagement of CCG partners in relation to health economy initiatives via 2013 CQUINS.		Monitoring of CQUINS outcomes via monthly Q&P report to Trust Board. Published SHMI = 105 (July 11 – Jun 12) 'within expected' range. Harm free care increasing from 91.11% (M11) to 93.33% (M12).	(c) Newly acquired UTIs with catheter causing adversely affecting the number of 'harm free' care episodes. Slight increases in falls, hospital acquired pressure ulcers and VTE during M12.	Infection Prevention team to review actions required in relation to patients acquiring a catheter acquired UTI (CAUTI) whilst an in-patient.		Chief Nurse May 2013
	NHS Safety thermometer utilised to measure the prevalence of harm and how many patients remain 'harm free' (Monthly point prevalence for '4 Harms'). Monthly meetings with operational/clinical and managerial leads for each harm in place. Utilisation of CQUIN monies for 2013/14 to invest in data collection posts at ward level.		Monthly outcome report of '4 Harms' is reported to Trust board via Q&P report New DoH definitions may see an increase in harm attributed to UHL to encourage closer working between primary and secondary care.	a) There is a risk that some data may not be accurate due to complex DoH definitions of each harm in relation to whether it is community or hospital acquired.	Action to be identified.		

	Measurement through clinical audit programme to identify adherence to practice standards and outcomes.		Bimonthly reports to UHL Clinical Audit Committee. Clinical audit dashboards presented at QAC, QPMG and divisional boards. 100% participation in eligible national clinical audits and national confidential enquiries (2012/13).	No gaps identified.	No actions required.		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	Current Score I x L	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives 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.	3x3=9	Annual Emergency planning Report identifying good practice presented to the Governance and Risk Management Committee 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 will be included in the annual report on Emergency Planning and Business Continuity to the QAC. Audit by Price Waterhouse Coopers LLP Jan 2013. Results being compiled and will be reported to Trust Board (date to be agreed). 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) Validating and assessing the results from critical suppliers.	Tailored training packages for service area based staff. 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. Assess our requirements of the critical suppliers and ensure that their response fulfils our requirements.	2x3=6	Director of Operations Jul 2013 Chief Information Officer Sep 2013 Director of Operations Sep 2013

	Emergency Planning Officer appointed to oversee the development of business continuity within the Trust.		Outcomes from Price Waterhouse Coopers LLP audit identified that there is a programme management system in place through the Emergency Planning Officer to oversee. A year plan for Emergency Planning has been developed. Production/updates of documents/plans relating to Emergency Planning and Business Continuity aligned with national guidance have begun. Including Business Impact Assessments for all CBUs	 (c) 1 CBU not yet completed (c) Local plans for loss of critical services not completed due to change over of facilities provider	Review IT service continuity arrangements against the recovery requirements determined by the BIAs to validate existing arrangements. Complete BIA for outstanding CBU Continue to engage with Interserve and service areas around development of Business Continuity Plans		Chief Information Officer May 2013 Director of Operations May 2013 Director of Operations Sep 2013
	New policy to identify key roles within the Trust of those responsible for ensuring business continuity planning /learning lessons is undertaken.		Minutes/action plans from Emergency Planning and Business Continuity Committee. Any outstanding risks/issues will be raised through the Director of Operations.	No gaps identified.	No actions required.		
			New Policy on InSite Emergency Planning and Business Continuity Committee ensures that processes outlined in the Policy are followed, including the production of documents relating to business continuity within the service areas. 3 incidents within the Trust have been investigated and debrief reports written, which include recommendations and actions to consider.	(c) Do not effectively communicate issues/lessons learnt that have been identified in service area disruptions and follow up actions.	Issues/lesson will feed into the development of local plans and training and exercising events.		Director of Operations Sep 2013
				(c)Do not always consider the impact on business continuity and resilience when implementing new systems and processes.	Further processes require development, particularly with the new Facilities and IM&T providers to ensure resilience is considered/ developed when implementing new systems, infrastructure and processes.		Director of Operations Jul 2013

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inability to recruit, retain, develop and motivate suitably qualified staff leading to inadequate organisational capacity and development.	Leadership and talent management programmes to identify and develop 'leaders' within UHL.	4x4=16	Development of UHL talent profiles.	No gaps identified.	No actions required.	4x3=12	
			Talent profile update reports to Workforce and OD Committee.	No gaps identified.	No actions required.		
	Substantial work program to strengthen leadership contained within OD Plan.			No gaps identified.	No actions required.		
	Organisational Development (OD) plan.		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. Reporting and monitoring of posts with 5 or less applicants. Quarterly report to senior HR team.	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 via Workforce and OD Committee on a six monthly basis. Improving staff satisfaction position.	No gaps identified.	No actions required.		

			Staff sickness levels may also provide an indicator of staff satisfaction and targets for staff sickness rates are close to being achieved (4.1% at Month 12, 3.4% over a rolling 12 month period).	No gaps identified	No actions required.		
	Appraisal and objective setting in line with UHL strategic direction.		Appraisal rates reported monthly to Board via Quality and Performance report. Current rates 90.1% at end of month 12 (reduction of 1% over previous month).	No gaps identified.	No actions required.		
			Results of quality audits to ensure adequacy of appraisals reported to the Board via the Workforce and OD Committee.	No gaps identified.	No actions required.		
			Quality Assurance Framework to monitor appraisals on an annual cycle (next due March 2013).	No gaps identified.	No actions required.		
	Workforce plan to identify effective methods to recruit to 'difficult to fill areas). Divisions and Directorates 2013/14 Workforce Plans.		The use of locum staff in 'difficult to fill' areas is reported to the Board on a monthly basis via the Quality and Performance report. A reduction in the use of such staff would be an assurance of our success in recruiting substantive staff to 'difficult to fill' areas.	No gaps identified.	No actions required.		
	Reward /recognition strategy and programmes (e.g. salary sacrifice, staff awards, etc).			(a) Reward and recognition strategy requires revision to include how we will provide assurance in the future that reward and recognition programmes are making a difference to staffing recruitment/ retention/ motivation.	Revise reward and recognition strategy.		Director of HR Oct 2013

	UHL Branding – to attract a wider and more capable workforce. Includes development of recruitment literature and website, recruitment events, international recruitment. This includes a recently held nurse recruitment day (Jan 2013).		Evaluate recruitment events and numbers of applicants. Reports issued to Nursing Workforce Group (last report 4 Feb). Report to Workforce and OD Committee in March. Positive feedback from nurse recruitment day on 26 Jan 2013.	(a) Better baselining of information to be able to measure improvement. (c) Lack of engagement in production of website material.	Take baseline from January and measure progress now that there is a structured plan for bulk recruitment. Identify a lead from each professional group to develop and encourage the production of fresh and up to date material.		Director of HR Dec 2013

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to transform emergency care system leading to demands on ED and admissions units continuing to exceed capacity.	Emergency Care Action Team formed. Chaired by Chief executive to ensure Emergency Care Pathway Programme actions are being undertaken and any blockages to improvement removed	5x5=25	Monthly report to Trust Board in relation to Emergency Dept (ED) flow. Trust has an improvement trajectory. Weekly performance will be monitored against the trajectory and reported to Execs and Trust Board.	ED performance not achieving targets. UHL (+ UCC) Type 1 and 2 = 91.9% YTD (M11). UHL Type 1 and 2 = 89.8% YTD (M11). In month (M 11) UHL (+ UCC) Type 1 and 2 = 84.7%. UHL Type 1 and 2 = 80.4%.		4x3=12	
	Increased recruitment of ED Medical and nursing staff.		Monthly Quality and Performance summary report to TB including use of locum staff.	(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. Staffing vacancies for medical and nursing staff remain high.	Continued fortnightly meetings with HR to highlight delays and solutions in the recruitment process. Continue to advertise for permanent and locum consultant positions.		Director of Operations Ongoing review of progress Director of Operations Ongoing review of progress May 13
	LLR Emergency Plan to ensure that delays to transfer of care are minimised.		Monthly report to Trust Board in relation to Emergency Dept (ED) flow.	(c) Lack of availability of rehabilitation beds for increasing numbers of patients. 169 delayed episodes of transfer of Care (M12).	Head of Operations is working with community on process for increasing scope of beds available in community		Head of Operations Jul 2013

	Emergency Care Pathway Programme to enable a comprehensive and co-ordinated approach to the design and implementation of process improvements across the end-to-end patient flow for our ED attendees and medical non-elective patients.		Monthly report to Trust Board in relation to Emergency Dept (ED) flow.	(c) ED performance against target not being sustained. *'What is not working'* key themes are Resourcing, Clinical Leadership, Untimely flow onto base wards and Entrenched behaviours.	Via key stakeholders (medical, nursing and managerial) enforce steps to address the core issues:		Director of Operations Review Jun 2013
	Metrics in place in relation to AMU assessment process.		'Time to see consultant' metric included in National ED quarterly indicator.	No gaps identified.	No actions required.		
	External review of Emergency Care Network (ECN)		The CCG's have commissioned a review of the role and operations of the ECN. Will be available end of May 2013	No gaps	No actions required		
	All 'extra capacity areas' are to be kept open.		All winter capacity beds are to be kept open until the target is consistently met	(c) Lack of nursing staff can restrict amount of capacity being opened	Recruitment to permanent ward nursing establishment		Head of Nursing Acute Division. Ongoing review

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Levels of patient satisfaction/experience may deteriorate leading to poor reputation and deterioration in Net Promoter scores.	Patient experience plan and associated projects. Patient Experience Strategy incorporated into Goal 3 of the Quality & Safety Commitment 2012 – 2015.	4x3=12	Patient experience progress reports to Quality Assurance Committee (QAC). Patient stories presented at Trust Board. Discharge project outcomes (i.e. delayed transfer of care) reported to the Discharge and Transfer of Care (DTOC) Group and monthly to the emergency Care Network and Clinical Quality Review Group (CQRG). Data included in monthly Quality and Performance report to Trust Board.	(c) Trust-wide communications of patient experience learning.		2x3=6	
	Net Promoter scores to identify key areas for focus.		Ongoing Patient Experience surveys Net Promoter scores reported monthly to Trust Board via Q&P report. Improving picture in relation to Net Promoter scores (64.5% @M12).	No gaps identified.	No actions required.		
	Caring @its best, releasing time to care initiatives and implementation of UHL Quality and Safety commitment (launched Jan 13). Key priorities: Reducing harm, reducing mortality rates and improving the patient experience.		Caring @ its best awards Improving patient experience reports. Improved infection prevention outcomes. 0 MRSA cases reported to end of Mar 13. YTD MRSA cases = 2. Target = 6 C. Difficile currently below trajectory. 94 cases YTD to end of Mar 13 against full year target of 103.	(c) Lack of supervisory headroom for ward managers.	Implement proposal for ward managers to have rostered supervisory time in line with Francis recommendations.		Chief Nurse Review Jun 2013

	Patient experience programme (across 85 clinical areas to gain feedback from patients relating to their experience of care) and national patient survey.		Ongoing Patient Experience surveys. Net Promoter scores reported monthly to Trust Board via Q&P report. Annual reporting to trust board of national patient survey.	No gaps identified. No gaps identified. (c) Absence of support facility at main entrance to respond to patient/public concerns.	No actions required. No actions required. Space to be identified for provision of PILS support and 3rd sector support		Director of Comms/Director of Nursing May 2013
	Trust values instilled within UHL staff.		UHL staff awards demonstrating individuals who demonstrate the values. Ongoing Patient Experience surveys. Net Promoter scores reported monthly to Trust Board via Q&P report.	No gaps identified.	No actions required.		
	Patient Adviser engagement at divisional level to ensure consistent involvement in the development of services.		Patient Advisors meet bi-monthly and these meetings are minuted and as such their involvement is formally captured. Non-attendance at two or more meetings triggers contact from UHL to see if they are still active and engaged.	(a) No current mechanism to monitor involvement Healthwatch to provide assurance of involvement/ engagement. (c) Evidence to suggest lack of PPI involvement in early stages of service developments.	Further work is required with Healthwatch to establish protocols and monitoring processes as they develop. PPI strategy to be revised/ rewritten and launched via communication campaign. Integrated as part of the Quality & Safety Commitment. Develop PPI training programme and toolkit for managers. Review and refresh PPI leads post divisional restructure.		Director of Comms and External Relations Sep 2013 Director of Comms and External Relations Sep 2013 Director of Comms and External Relations Oct 2013 Director of Comms and External Relations May 2013

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	Current Score I x L	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	Target Score I x L	**Timescale** When will the action be completed?
Failure to achieve Foundation Trust (FT) Status within specified timescale (April 2015).	FT Programme Board provides strategic direction and monitors the FT application programme.	4x4=16	Monthly progress against the FT programme is reported to the Board to provide oversight.	No gaps identified.	No actions required.	4x3=12	
	FT Workstream group of Executive and operational Leads to ensure delivery of IBP and evidence to support HDD1 and 2 processes.		Feedback from external assessment of application progress by SHA (readiness review meeting Dec 2012.	No gaps identified.	No actions required.		
	FT application project plan / project team in place FT Integrated Development Plan		Achievement against the key milestones set out in UHL's TFA is reported to the Trust Board and Trust Development Authority (TDA) on a monthly basis through the trust over-sight self certification.	(c) Development of LLR Clinical Strategy and Site and Service Reconfiguration Proposals not fully achieved.	Collaborative delivery programmes; establishing robust governance structures (programme director and collaborative delivery teams) to be agreed at BCT Board meeting 18/4/13.		Chief Executive May 2013
	Outcome of the LLR Better Care Together (BCT) economic modelling reported to all partner organisations.		Economic modelling incorporated into the Trust Reconfiguration Strategic Outline Case (SOC) structure and process.	(c)Confirmation of specific LLR reconfiguration priorities over a 3 year time horizon not fully achieved.	Trust Board consideration of the SOC (following high level option appraisal in July 2013).		Chief Executive Aug 2013
				(c)Draft pre-consultation Business Case considered by Trust Boards not fully achieved.	Collaborative delivery programmes to be agreed by the BCT Board / partner organisations. Statutory consultation to commence Jun 2013 pending the output of the economic modelling and agreement of the resulting LLR wide plans.		Chief Executive May 2013 Chief Executive Jun 2013

					BCT communication and engagement plans to be developed for collaborative delivery programmes June/July 2013.		Chief Executive Jun/Jul 2013
				(c) Formal Consultation on LLR Reconfiguration Proposals not fully achieved.	Consultation timescales to be agreed pending defining the scope of the delivery programmes.		Chief Executive Aug 2013
				c) UHL Clinical Strategy developed but preferred options costs not yet identified.	Service developments underpinning the Trust's Clinical Strategy will be costed as further iterations of the IBP / LTFM are Developed.		Chief Executive Review May 2013
			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 in place to address recommendations from independent reviews.		Chief Executive Review Jun 2013
	Monitoring of KPIs in particular in relation to financial position and ED performance that are crucial for a successful FT application.		Monthly Finance and Performance report to Board.	c) Significant financial variance from plan.	See actions associated with risk number 8.		
			Achievement against the governance and finance risk rating based on Monitors Compliance Framework is reported to the Trust board and the TDA on a monthly basis through the trust oversight self certification.	(c) Underperformance in relation to ED targets.	Transform emergency care system to reduce demand and increase footprint of ED (see risk 4)		Chief Executive During 2013/14

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	Current Score I x L	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	Target Score I x L	**Timescale** When will the action be completed?
Ineffective organisational transformation preventing the development of safer, more effective and productive services. Among other consequences this will impact on the Trust's FT timeline.	Clinical strategy. Transformation Board/ team including CIP Programme Manager	4x4=16	CIP Programme Board monitors project plans associated with clinical strategy to ensure achievement of key milestones. Good progress in development of 2013/14 CIP plans.			4x3=12	
	Managed Business Partner for IM&T services to deliver IT that will be a key enabler for our clinical strategy.		MBP programme board monitors defined KPIs for 'Lot 1 services'. Non-compliance with KPIs reported to Board.	(c) New systems (lot 2) not yet specified.	'Lot 2' systems replacement plan to be developed.		Director of Finance and Business Services 2013/14
	Development of lean processes improvement capability to deliver more efficient and effective services and greater patient / staff satisfaction. Head of Process Improvement now in post (Jan '13). The Head of Service Improvement and Head of Transformation will report to the CEO, and be an integral part of the Improvement and Innovation Framework to ensure that process improvement initiatives gain traction		Board monitoring of patient and staff survey results. Improved levels of patient / staff satisfaction are expected when lean processes are embedded.				
	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 Co-operative (FMC) will monitor FM contract against agreed KPIs to provide assurance of successful service.	No gaps identified.	No actions required.		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to achieve financial sustainability including:	Overarching financial governance processes including PLICS process and expenditure controls.	5X5=25	Monthly /weekly financial reporting to Exec Team, F&P Committee and Board. Cost centre reporting and monthly PLICS reporting. Annual internal and external audit programmes. Comparison with PLICS benchmarking against other NHS organisations. Prior to accounts sign-off by Audit, the Trust is reporting a £90k surplus.			4x3=12	
Failure to achieve CIP.	Strengthened CIP governance structure.		Progress in delivery of CIPs is monitored by CIP Programme Board (meeting fortnightly) and reported to ET and Board.	(c) CIP shortfall of £5.2m against target.			
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		The use of locum staff in 'difficult to fill' areas is reported to the Board on a monthly basis via the Quality and Performance report. A reduction in the use of such staff would be an assurance of our success in recruiting substantive staff to 'difficult to fill' areas. Increase in substantive staff of 200wte to Oct 12. Saving in excess of £0.6m 5 weeks after 'go live' date	(c) Failure to reduce locum spend. 587 wte locum staff currently used.			

Loss of income due to tariff/tariff changes (including referral rate for emergency admissions – MRET)	Contract meetings with Commissioners Negotiations with Commissioners concluded at a transactional level.		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board.	(c) Failing to manage marginal activity efficiently and effectively.			
Ineffective processes for Counting and Coding.	Clinical coding project.		Ad-Hoc reports on annual counting and coding process. PbR clinical coding audit Jan 2013 (final report awaited). IG toolkit audit (sample of 200 General Surgery episodes).	(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%.			
Loss of liquidity.	Liquidity Plan.		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board.				
Lack of robust control over non-pay expenditure.	Non-pay action plan (agreed by F&P Committee). Catalogue control project.		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board. Ongoing Monitoring via F&P Committee.	(c) Failing to control adverse trends in non-pay (running ahead of activity growth). YTD (M12) non-pay expenditure £20.6m adverse to plan.			
Commissioner fines against performance targets.	Contract meetings with Commissioners Negotiations with Commissioners concluded at a transactional level.		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board.	(c) Failing to reduce readmission trends. YTD readmission rate 7.8% (M11 7.7%).	Divisions to develop plans and trajectories to be monitored at monthly C&C meetings.		Director of Operations May 2013
Use of readmission monies.	Contract meetings with Commissioners Negotiations with Commissioners concluded at a transactional level		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board.	(c) Failing to reduce readmission trends.			
Ineffective organisational transformation.	See risk 7		See risk 7.	See risk 7.	See risk 7.		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to achieve and sustain operational targets leading to contractual penalties, patient dissatisfaction and poor reputation.	Backlog plans to recover 18 week referral to treatment (RTT) target.	4x3=12	Monthly Q&P report to Trust Board showing 18 week RTT rates. RTT admitted and non-admitted rates favourable against target (91.3% and 97% respectively for month 12). Weekly monitoring of backlog numbers via Head of Performance Improvement.	(c) Capacity issues created by emergency demand causes cancellations of operations.	On-going work on ward processes in Acute to free up capacity. Re-configuration of surgical beds to create a 'protected area' for surgical patients.	4x3=12	Director of Operations Jun 2013 Director of Operations Nov 2013
	Referral pathways to decrease demand and ensure discharge to GP where appropriate.			(a) Lack assurance in relation to performance metrics to show activity versus number of patients deferred onto a different care pathway.	Development of key metrics at a local level.		Director of Operations Review Jul 13
	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 4.	See risk number 4.		

	Each tumour site has developed action plans to achieve targets. (Expected that target of 85% to be delivered by April 2013)		Director of Operations receives reports from Cancer Manager and information included within Monthly Q&P report to Trust Board. Monthly trajectory agreed and monitored at Board via exception report. Cancer 62 action plan agreed with CCG and reported and monitored at Executive Performance board.	(c) Gaps identified in Cancer Structure. (c) 62 day cancer target delivery 75.3% (target 85%). YTD 83.7% (M11).	Urgent assessment of the gap between what is required and what is provided. Cancer Clinical lead, Cancer Centre Managers and Trackers to be recruited.		Director of Operations Review May 2013 Director of Operations Jun 2013
	Ongoing monitoring of key performance indicators.		Monthly Q&P report to Trust Board.	No gaps identified.	No actions required.		
	Outpatient delivery plan to reduce cancellation rates has been developed and circulated to Divisions for inclusion in their CIP plans.			(c) Not reducing cancellation rates for outpatients appointments.	Continued monitoring of outpatient delivery plan.		Director of Operations Review Jun 2013

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inadequate reconfiguration of buildings and services leading to less effective use of estate and services.	Clinical Strategy.	3x4=12		(a) Key measures to demonstrate success of strategy and reporting lines not yet identified.	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.	3X3=9	Medical Director December 2013
	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 Co-operative (FMC) will monitor against agreed KPIs to provide assurance of successful outsourced service.	(c) Estates plans not fully developed to achieve the strategy. (c) The success of the plans will be dependent upon capital funding and successful FT application.	Ensure success of FT Application (see risk 6 for further detail). Secure capital funding.		Chief Executive Officer Apr 2015 Director of Finance and Business Services May 2013
	Divisional service development strategies and plans to deliver key developments.		Progress of divisional development plans reported to Service Reconfiguration Board.	No gaps identified.	No actions required.		
	Service Reconfiguration Board.		Monthly ET Strategy session to provide oversight of reconfiguration.				
	Capital expenditure programme to fund developments.		Capital expenditure reports reported to the Board via Finance and Performance Committee.	No gaps identified.	No actions required.		
	Managed Business Partner for IM&T services to deliver IT that will be a key enabler for our clinical strategy.		IM&T Board in place.	(c) Need to link to wider transformational agenda.	To be incorporated into Improvement and Innovation Framework.		Chief Executive May 2013

APPENDIX TWO

UHL BOARD ASSURANCE FRAMEWORK SUMMARY REPORT – PERIOD ENDING APRIL 2013

Risk No	Risk Title	Current Risk Score (Apr 13)	Previous Risk Score (Mar 13)	Target Risk Score and Final Action Date	Risk Owner	Comment
1	Reducing avoidable harms	12	12	6 – Review May 13	Chief Nurse	
2	Business continuity	9	9	6 – Aug 14	Director of Operations	
3	Inability to recruit, retain, develop and motivate staff	16	16	12 – Dec 13	Director of HR	
4	Failure to transform the emergency care system	25	12	12 – Review May 13	Director of Operations	
5	Patient experience/ satisfaction	12	12	6 – Oct 13	Chief Nurse	
6	Failure to achieve FT status	16	16	12 – Apr - 15	Chief Executive Officer	
7	Ineffective organisational transformation	16	16	12 – 2013/14	Director of Finance and Business Services	
8	Failure to achieve financial sustainability	25	25	12 – May 13	Director of Finance and Business services	
9	Failure to achieve and sustain operational targets	12	12	12 – Review Nov 13	Director of Operations	Deadline extended to reflect re-configuration of surgical beds to create a 'protected area' for surgical patients.
10	Loss of reputation			n/a	n/a	
11	Failure to maintain productive relationships	15	15	10	Director of Comms and External Relations	
12	Inadequate reconfiguration of buildings and services	12	12	9 – Dec-13	Chief Executive Officer	

APPENDIX THREE

UHL BOARD ASSURANCE FRAMEWORK SUMMARY OF CHANGES TO ACTIONS – APRIL 2013

Risk No.	Action Description	Action Owner	Comment
1	Resource requirements identified and to be discussed at ET on 16/4/13	Chief Nurse/ Deputy Chief Executive	**Complete.** Agreement reached for CQUIN proposal to be funded. Now a control.
1	2013 CQUIN and quality negotiations.	Chief Nurse/ Deputy Chief Executive	**Complete.** Final CQUIN agreed with commissioners. Now a control.
1	Ongoing education from the operational leads for each harm during the monthly data collection and validation process.	Chief Nurse/ Deputy Chief Executive	**Complete.** Monthly meetings with operational/clinical and managerial leads for each harm in place. Now a control.
1	Utilisation of CQUIN monies for 2013/14 to invest in data collection posts at ward level to improve data quality and release time of ward managers to focus on reducing harms.	Chief Nurse/ Deputy Chief Executive	**Complete.** Bids constructed with lead SRO. Analytical time included in requests.
2	Training Needs Analysis to be developed to identify training requirements for staff.	Director of Operations	**Complete.**
2	Develop an appropriate training programme and supporting materials for staff involved in the planning and response to an incident. Training and education materials to be produced in line with ISO 22301 and National Occupational Standards	Director of Operations	**Complete.** Training packages in place for on-call managers. Next stage to develop tailored training packages for service area staff
2	Ensure that contracts awarded include reference to business continuity commitments and providing	Director of Operations	**Complete**. Documented evidence from key critical suppliers has been collected

UHL BOARD ASSURANCE FRAMEWORK SUMMARY OF CHANGES TO ACTIONS – APRIL 2013

	assurances to the Trust of their arrangements.		
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.	Chief Information Officer	**Ongoing.** Deadline extended to September 2013.
2	All CBUs require a Business Impact Assessment to identify critical services	Director of Operations	**Ongoing** 1 CBU still to complete. Action for CBU to complete BIA by May 2013.
2	Review IT service continuity arrangements against the recovery requirements determined by the BIAs to validate existing arrangements.	Chief Information Officer	**Ongoing.** IM&T have assessed the impact of their own BIAs and have taken/planned any appropriate action. IM&T are waiting for the CBUs BIAs to complete this work. IM&T are working closely with the emergency planning officer to ensure that this is fully coordinated. Action to be further reviewed May 2013.
3	To develop a monitoring and reporting process for the number of applicants received for advertised (due June 2013)	Director of HR	**Complete.** Posts with 5 or less applicants to be reported to and reviewed quarterly at the HR senior team meeting. This will commence with June adverts.
3	Revise reward and recognition strategy.	Director of HR	**Ongoing.** Deadline extended from June 2013 to October 2013 to align with the development of a Pay Progression Policy
4	Via key stakeholders (medical, nursing and managerial) enforce	Director of Operations	**Ongoing.** Action to be reviewed in June 2013 to ascertain whether steps to

APPENDIX THREE

UHL BOARD ASSURANCE FRAMEWORK SUMMARY OF CHANGES TO ACTIONS – APRIL 2013

	steps to address the core issues:		address the core issues have been embedded.
5	Develop proposal for the ward managers to have rostered supervisory time in line with Francis recommendations.	Chief Nurse/ Deputy Chief Executive	**Complete.** Proposal in place and part of cost pressure discussions at ET rostered for 23rd April and 30th April. The proposal now needs to be implemented in order to be an effective control. Action reworded and timescale for review extended accordingly.
6	Collaborative delivery programmes to be agreed by the BCT Board / partner organisations	Chief Executive Officer	**Ongoing.** Continued dialogue between Chief Officers to determine future delivery structures and robust governance arrangements for BCT (programme director and collaborative delivery teams). It was anticipated that this would be agreed at BCT Board meeting 18/4/13. Further work on the accountability framework, delivery programme definition and scope is required and will be presented in May to Chief Officers Meeting for consideration (May 2013). Governance arrangements to maintain control of the overall LLR BCT economic Model was agreed by BCT Programme Board on 18/4/13 (April 2013). Deadline extended to May 2013.
6	Integrate outcome of the BCT economic modelling into UHL's improvement framework / future configuration of services (Due June 2013)	Chief Executive Officer	**Complete.** Economic modelling is now incorporated into the Trust Reconfiguration Strategic Outline Case (SOC) structure and process.
7	Interim transformation resources	Director of Finance and Business Services	**Complete.** Phillip Burns, CIP Programme Manager started 7 May to support the 13/14 CIP Programme and develop the 14/15 schemes
7	Board level sponsorship and Leadership	Director of Finance and Business Services	**Complete.** The Head of Service Improvement and Head of Transformation will report to the CEO, and be an integral part of the Improvement and Innovation Framework

APPENDIX THREE

UHL BOARD ASSURANCE FRAMEWORK SUMMARY OF CHANGES TO ACTIONS – APRIL 2013

9	Development of key metrics at a local level	Director of Operations	**Ongoing.** Deadline for review extended to July 2013 due to CCGs wanting involvement in setting metrics. .
9	Urgent assessment of the gap between what is required and what is provided.	Director of Operations	**Ongoing.** All the tumour sites have submitted an assessment of their capacity constraints relating to the diagnostic element of the 62 day pathway and an urgent assessment of the gap between what is required and what is provided is being undertaken. A significant proportion of these gaps are in imaging modalities mainly relating to turnaround times for tests and reports. Action to be reviewed in May 2013
9	Planned care to perform urgent review of Cancer Centre management structure to ensure ownership of entire cancer pathway at tumour site level.	Director of Operations	**Complete** A senior clinician appointment on an agreed number of sessions to work closely with all cancer MDT's has been agreed by the Planned Care Division. In addition the Data manager (vacancy) in the cancer centre had been appointed to and they will start in post 15th May. Two additional tracking posts, 1 specifically to support urology, but also to provide cross cover are anticipated to be in post during June. An additional senior tracker role is also being appointed to; and this role will provide additional management support to the tracking and MDT process.
9	Consider inviting NHS Interim Management and Support team to review and advice in relation to process.	Director of Operations	Action removed from BAF as no longer thought necessary. May appear again if improvement not forthcoming
12	Establish monthly ET Strategy Session	Chief Executive Officer	**Complete**

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 – BOARD ASSURANCE FRAMEWORK

RISK TITLE	LINK TO STRATEGIC OBJECTIVE	EXEC LEAD
Risk 1 – Failure to achieve financial sustainability (Previous Exec Lead: Director of Finance & Business Services)	g - To be a sustainable, high performing NHS Foundation Trust	Director of Finance and Business Services
Risk 2 – Failure to transform the emergency care system (Previous Exec Lead: Director of Operations)	b - To enable joined up emergency care	Director of Operations (vice COO)
Risk 3 – Inability to recruit, retain, develop and motivate staff (Previous Exec Lead: Director of HR)	e - To enjoy an enhanced reputation in research, innovation and clinical education. f - To maintain a professional, passionate and valued workforce	Director of Human Resources
Risk 4 – Ineffective organisational transformation (Previous Exec Lead: Director of Finance & Business Services)	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	Chief Executive Officer (vice DS)
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 e - To enjoy an enhanced reputation in research, innovation and clinical education g - To be a sustainable, high performing NHS Foundation Trust	Chief Executive Officer (vice DS)
Risk 6 – Failure to achieve FT status (Previous Exec Lead: Chief Executive)	g - To be a sustainable, high performing NHS Foundation Trust	Chief Executive Officer (vice DS)
Risk 7 – Failure to maintain productive and effective relationships (Previous Exec Lead: Director of Communications and External Relations)	c - To be the provider of choice d - To enable integrated care closer to home f - To maintain a professional, passionate and valued workforce	Director of Communications and External Relations
Risk 8 – Failure to achieve and sustain quality standards	a - To provide safe, high quality patient-centred health care a - To provide safe, high quality patient-centred health care	Chief Nurse(with Medical Director)
Risk 9 – Failure to achieve and maintain high standards of operational performance	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	Chief Operating Officer
Risk 9 – Inadequate reconfiguration of buildings and services (Previous Exec Lead: Chief Executive)	a - To provide safe, high quality patient-centred health care	Director of Finance and Business Services
Risk 10 – Loss of business continuity (Previous Exec Lead: Director of Operations)	g - To be a sustainable, high performing NHS Foundation Trust	Director of Operations (vice COO)
Risk 11 – 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.	Director of Finance and Business Services

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

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

REPORT PRODUCED BY: UHL RISK AND ASSURANCE MANAGER

Key

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

Division	Directorate	Risk Title	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Movement	Div/Exec Director	Strategic risk No.
Women's & Children's	Women's	Lack of Capacity in maternity services	28/09/2007	**Causes** Continuing increase to the birth-rate in Leicester . The number of maternity beds has decreased. Consultant cover for Delivery Suite is 60 hours a week with long term business plans to increase the hours in accordance with Safer Childbirth Recommendations **Consequences** Midwifery staffing levels are not in accordance with national guidance however are in line with regional averages Transfer of activity between the LGH and LRI occurs on a frequent basis with Leicestershire having to close to maternity admissions on a number of occasions Increase in incidents reported where there has been a delay in elective CS, IOL and augmentation due to lack of beds Staff frequently go without meal breaks Increased waiting time in MAC and therefore increased risk of a clinical adverse outcome to both mother and baby	HR	Length of postnatal stay in hospital as short as possible. Community staff prepare women for early discharge home if straightforward delivery. Extra triage room on Delivery Suite, LRI completed July 2012 Triage and admission areas in acute units to ensure no category x women sitting on delivery suite Use of Escalation Plan to inform staff on actions required if capacity is high Capacity is managed between the two acute units by temporarily transferring care if one site is busy Liaison with neighbouring maternity hospitals if high risk of closure of Leicestershire Maternity Hospitals Prioritisation of both elective and 'emergency' work according to clinical urgency and need On call Manager On call SOM Funded midwife places increased to 1:32	Extreme	Likely	20	Prepare escalation and contingency plans - Complete Relocation of all elective gynaecology beds to LGH - complete Relocation of MAC services out of Delivery Suite on both sites to PAS in order to increase the capacity of Delivery Suite - due 31/8/2013 Increase ward capacity on LRI site by having EL CS women on level 1 - due 31/8/2013 Gynae theatres to be refurbished to accomodate EL CS at LRI - due 31/12/2013	12	⇔	IS/SH	3
Women's & Children's	Women's	Unavailability of USS and not meeting National Standards for USS in Maternity	10/10/2008	Failure to diagnose abnormality which we would normally expect to diagnose due to changes in National standards. The potential for other consequences are apparent.	Quality	Detailed scan pro-forma US performed by suitable trained staff Self audit Use of regular pre-booked agency sonographers Daily review of outstanding requests to monitor the situation Access to consultants for second opinion if suspicious re possible abnormality All ultrasound machines now of suitable specification and replaced 5 yearly Incident report forms Update 18.10.12 "□Continued use of Agency Sonographers "□Continued 'extra' lists by Fetal Med Consultants "□Additional u/s machine in place but next step is need for additional scan room - this is built in to the interim solution for Maternity (phase 1) and should be converted by April 2013	Extreme	Likely	20	Provide support for sonographers through training and reducing pressure on the time for appointments - Complete Create further USS space or utilise existing space out of hours to increase capacity - due 30/04/13 Divisional Manager to request a more robust recruitment plan from Imaging CBU - complete Extra scan room to be included as part of the interim solution (LGH) - due 30/4/13 Funding of additional list so pressure on appointments less, giving more time for detailed scanning - Complete Business case for 2 further USS machines - Complete Recruitment of further sonographer - due 30/04/13 Capital bid in for additional ultrasound machine - Complete Divisional Manager to request a more robust recruitment plan from Imaging CBU - complete Extra scan room to be included as part of the interim solution (LGH) - 30/4/13	6	⇔	IS/SH	1

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Acute	Professional Services	Risk to the production of aseptic pharmaceutical products	03/05/2007	**Causes** Provision of aseptically prepared chemotherapy is being undertaken from a temporary rental unit. Temporary nature and age of facility indicates high probability of failure. Arrangements for segregation of in-process and completed items is inadequate leading to high possibility of error. Current temporary unit is outside the range of the department's temperature monitoring system. Failure of refrigerated storage will remain undetected outside working hours, and has already occurred. Planning permission for temporary unit only valid until August 2012 Contingency arrangements are insufficient and could only provide for the very short term. Project is already 6 months behind schedule Storage, receipts and dispensing facility for dose-banded chemotherapy and other outsourced items purchased. Alternative arrangements will need to be found when unit is refurbished **Consequences** Failure of Current Temporary Facility; Inability to provide 50% of current chemotherapy products for adult services. Inability to provide chemotherapy for paediatric services. Substantial delay in re-establishing service provision from alternative supplier Limitations of treatments that can be sourced from an alternative supplier. Inability to support research where aseptic compounding required. High cost of sourcing required products from alternative supplier at short notice. Increase in datix incidents pertaining to the Aseptic Unit.	Business	Planned servicing & maintenance of existing facility being undertaken. - Constant environmental monitoring of facility in place. - Alternative preparation facility being maintained as contingency although only adequate for short term contingency and not recommended for preparation of chemotherapy. N.B. this option may be lost depending on the outcome of the business case for a permanent solution for the aseptic dispensing service. -□Contingency arrangement for supply from external source currently being pursued. -□Business Case for new unit (refurbishment of facility within the Windsor building) has been presented and approved by the commercial exec board in 2011. -□Facilities are working with Pharmacy and commercial architects in order to finalise plans and get refurbishment started	Extreme	Likely	20	Evaluation of tenders & contact awarded -30/4/13 Sign off from chairman - 7/5/13 Build to commence - 22 week contract - 30/06/13 Build complete, unit in operation - 31/07/13	3	⇔	SC/JA	12

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Corporate	Nursing	Exceeding agreed numbers of pre-registration nursing and midwifery students allocated to placements	30/06/2010	**Causes:** UHL Bed reduction programme and reconfiguration of services has caused a reduction in available clinical placements. **Consequences:** Increasing the number of students allocated to a clinical placement, above the audited (i.e. the agreed number) will have a direct impact on the quality of the learning which takes place. Increasing ratio of students to mentors may increase the risk of unsafe practice and subsequent patient harm. Students are not exposed to the range of learning experiences to ensure progression through training and fitness to practice at point of registration. Increased numbers of students will result in mentors being unable to spend time observing practice and ensuring that skills are developed and sustained over a period of time. Potential for students to pass their outcomes without sufficient evidence to support that decision. No assurance that mentors will be able to commit the time required to each and every student, therefore increasing the risk that students will practice unsupervised. Trust's ability to demonstrate the maintenance of high quali Trust may fail to meet the requirements within the Learning	Patients	Placements for the immediate future have been completed and the situation has stayed the same since the last assessment. However, the situation needs to be closely monitored by the PLLs and Assistant Director of Nursing as the next round of placements for October 2012 will be in the planning stage in June 2012 and as previously highlighted, it is anticipated that there will be an increased capacity concern from June 2012 onwards Any increase, or decrease, in numbers is agreed between the Placement Manager and the PLL based on the most recent staffing information. The LLR Placement Strategy is implemented in partnership with De Montfort University. Current status is Green for the Management of Capacity for Students on Commissioned Pre-registration Nursing and Midwifery Programmes in Leicester, Leicestershire and Rutland as existing students have been placed Continue to strengthen and empower the role of the Student Link Nurse. Where any additional ward or department closures takes place, resulting in the loss or change of the learning environment, the Practice Learning Lead wil All learning environments will be audited annually to Student evaluations completed following placements Update June 2012 - DMU are aware of the potential i Update October 2012 - DMU are aware of the potent	Major	Likely	16	The LLR Workforce Development team to be informed of the demands on placements - 31/03/2014 Updates to be given at the next Health and Life Sciences Meeting by the Assistant Director of Nursing - 31/12/13 Practice Learning Leads (PLLs) to monitor any Trust reconfiguration to establish the impact on the learning environment and the support of students. - 31/12/2013 PLLs to ensure that when changes occur to clinical areas; there is communication with student nurses, midwives and all learners accessing the placement area and their Higher Education Institutes - 31/12/2013 PLLs to provide local support to Student Link Nurses and mentors - 31/12/2013 PLLs and Assistant Director of Nursing to work in partnership with colleagues across LLR and De Montfort University to ensure adherence to the LLR Placement Strategy and to work collaboratively to develop new placement areas - 31/12/2013 PLLs and Assistant Director of Nursing to ensure UHL continues to meet the requirements of the Learning Development Agreement - 31/12/2013 Regular updates on progress /issues to be reported	9	⇔	SC/JA	12

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Corporate	Operations	Risk of inaccuracies in clinical coding	02/08/2011	**Causes** HISS constraints (HRG codes not generated) High workload (coding per person above national average) Inaccuracies / omissions in source documentation (e.g. case notes may not include co-morbidities, high cost drugs may not be listed) Inability to provide training to large groups of coders due to lack of time and financial constraints **Consequences** Loss of income (PbR) Outlier for CHKS/HSMR data Non- optimisation of HRG Loss of Trust reputation	Economic	Coding improvement project initiated April 2011. Project Board commenced 5th September 2011 (PID, project plan and highlight report agreed). Electronic coding implemented February 2012 and to be upgraded November 2012 - HRG code generated. Will aid with audit, implementation of local policies and performance management. Task and finish groups completed in Divisions review improvements in coding using PeRL, PLICs, CHKS and medicode (encoder). New process for medical records retrieving notes. Due to changes in recording and payment of EDU and CAU episodes number of episodes coded has reduced. Shifts from day case to outpatient will reduce workload. Lead clinicians identified and Trust wide communication to move coding closer to the clinician. Tick lists introduced in both the ward area and discharge letter. Bank staff and overtime authorised to meet deadline. Scorecard developed to demonstrate improvements and benchmark against other Trusts. Two additional coders accredited 3 year refresher programme completed November 2011. Quarterly updates/briefings to be led by Asst Directo Coder workshops on all 3 sites during May to review £6m additional income generated in 2011/12 (mixtu Improved audit results Regular progress updates to F&P and GRMC. Clinical Coding Manager has a regular slot on Junior	Major	Likely	16	12 month coding project commencing 01/04/11 - project manager appointed - PID agreed - complete Implement electronic encoder software for use by coders and clinicians - completed Scoping exercise to identify future business/resource need - 31/1/13 Clinical coding dashboard bringing a range of published metrics together - complete Consultant and clinical staff accurately recording diagnosis, co-morbidities and complications - complete Internal audit programme to be developed complimented with an annual external audit. - complete Review the priority of this risk after go live with the encoder as all actions will have been taken - 31/1/13 External PbR Audit - 2 areas 31/1/13	8	⇔	JT/AS	8

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Planned Care	Intensive Care, Theatres, Anaethesia, Pain Management, Sleep	Patient Safety and Financial risk due to failure to deliver sufficient resident Anaesthetic cover across three hospital sites	12/11/2012	**Causes** Current under populated rotas National Drive to reduce trainee anaesthetists (by 150 for UK) Change in process for allocation of ICM numbers and proportion trainees work in ITU Necessity at present to cover 3 acute sites **Consequences** Increased Agency and Locum spend - leading to poorer patient care, increased risk of adverse events and increased cost to the CBU Increased use of consultant cover on the rota - leading to increased cost to the CBU and inability to cover elective activity Reduction in moral and reputation with Trainees - leading to increased difficulty getting new trainees to apply for future posts. Clinical consequences as highlighted above.	Economic	Trust-level Task & Finish Group established to scope issues, identify immediate, short term and medium term action - Weekly publication and circulation of forward anaesthetic rota cover by the Anaesthetic Office - highlighting covered shifts and any outstanding rota gaps - Escalation plan in place to alert Head of Service for Anaesthesia LRI, LGH and CBU Medical Lead, then to alert Divisional management team should any rota gaps remain uncovered 48hrs prior - Use of consultants - Trainees covering additional sessions as locums - Increase in local payments to encourage jr medical staff - Use of Agency doctors - Increase in agency payments for higher graded staff - Appointment of specialist doctors where possible (recruitment underway) - Programme in place to bolster number of trainee doctors by taking on foreign trainees for 12 month visits, however doctors are proving difficult to source. - Appoint anaesthetic assistants to reduce some pressures during day time shifts - The use of cardiac trainees to cover ITU at GGH	Major	Likely	16	Review on call provision across all services, across all sites. Original on-call need s not changed, still awaiting service site reconfiguration moves - due by 01/10/13. Interviews of additional Specialty Doctors undertaken on 28/03/13 - Confirmation of appointments awaited Further recruitment round awaiting interviews - 18/04/13	5	⇔	SC/SH	1
Women's & Children's	Children's	Paediatric Respiratory Service Capacity and Demand	28/05/2012	**Causes** Staffing levels at Consultant Medical Grade level are insufficient to cope with current demand. National shortage of Paediatric Respiratory Consultants **Consequences** Patient referrals both new and follow up are waiting longer than acceptable for appointments and in line with their medical care plan. Significant risk both clinically and in relation to performance targets. Increase in complaints likely.	Patients	Monitoring of waiting list fortnightly. Families can call the Medical secretaries, e mail into the service. Call back from Specialist nurse or the Consultant. for advice.	Major	Likely	16	To consider transfer of care to other providers and or close to new referrals. (business risk if this option taken) - Complete To review extra clinics (WLI) - 30/4/13 Recruitment of Two Respiratory Consultants under way. - 30/4/13 Service capacity to be reviewed through annual business planning process - 30/4/13	4	⇔	IS/KB	3

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Corporate	R & D	Athena Swan - potential Biomedical Research Unit funding issues.	12/10/2012	The Athena SWAN Charter is a recognition scheme for UK universities and celebrates good employment practice for women working in science, engineering and technology (SET) departments. Standards required for next round of Biomedical Research Unit (BRU) submissions. Academic partners required to be at least Silver Status. Failure for the University to achieve this will result in UHL being unable to bid successfully for repeat funding of the BRUs.	Economic	Every meeting with the University, Athena Swan is on the Agenda. Out of UHL control directly, but every avenue is being used to keep the emphasis high at the University.	Major	Likely	16	Add Athena Swan to every agenda at Leicester & Loughborough Universities attended by UHL R&D Personnel	4	⇔	DR	
Acute	Emergency Care	Overcrowding in ED	29/12/2011	**Causes** High inflow surges from EMAS Inadequate number of cubicles in correlation to patient demographics served to provide adequate quality and safety in nursing and medical care. Lack of outflow to Assessment units with UHL. Delays in cross site transfers due to Ambulance provision. **Consequences** Increased risk of clinical incident Lack of oxygen and suction in Oresus viewing room Lack of Tannoy and telephone in Fracture clinic No emergency resuscitation trolley readily available in fracture clinic Sub-optimal treatment Poor patient experience Increased risk of complaints Patient confidentiality breaches High risk of cross infection Privacy and dignity compromised when patients are moved to the centre of the dept Staff stress and morale due to increased risk in caring adequately for excessive numbers of patients. Increased risk of staff injury due to reduced access in department Breach of clinical quality indicators Delays for EMAS turnaround times Lack of staff to deal with new inflow	Patients	Liaison with EMAS Ambulance control, including EMAS senior staff in ED to raise awareness of ED workload. EMAS inform ED of predicted inflow from their service. Ambulance crew remain with and monitor patients until 'formal' handover to ED staff or Ambulance senior staff take handover for a number of patients to release Ambulance crews. Overflow into other areas of department if available. (minors cubicles utilised for patients awaiting admission when flow allows) Use of the centre of majors (limited floor space) as a waiting area for patients to be admitted, more recently the use of fracture clinic for more stable patients. Patients assessed if able to wait in chairs. Escalation via CBU manager/lead nurses or Duty Management team and Divisional Manager / Director as appropriate.	Major	Likely	16	UHL 4 hour emergency process escalation policy / winter capacity plan - Complete ED proactively reviewing initial assessment process to ensure patients investigation plan started early to reduce patient time in ED - Complete Bed management process in UHL under review - Complete Plans to process map the internal bed management system between ED and AMU - Complete Plans to increase ED footprint - 28/02/2013 Development of a robust escalation policy/risk assessment tool. Highlighting issues in ED to senior management in the trust and partners to enable ED to function effectively - Complete	4	⇔	PR/JT	4

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Acute	All	Low Nursing staffing levels	21/02/2013	**Causes** The opening of additional capacity areas with short term notice Inability to recruit to fill the numbers of vacancies available Last minute sickness **Consequences** Reduced staffing levels within clinical areas High potential for the quality of care delivery to be sub-optimal impacting on safety of patient and increasing clinical risk and potential for patient harm Increased delays in discharge, as time to plan if minimal staffing and inability to allocate discharge coordinator resulting in increasing length of stay Poor patient experience Poor staff moral due to continued short staffing and stress within the workplace High ratio of agency/bank staff Increased staff absence due to stress caused, resulting in further staff shortage. Inability to admit patients to the right place first time based on clinical need Care that is not personalised to the individual patient Temporary staff unsure of process and policies and what is expected of them reducing their impact, contribution and value Increased staffing costs resulting in overspent budgets.	HR	Review of staffing levels prior to shift by Matrons and Senior Nurses Escalation process in place to the Divisional Head of Nursing Moving staff between clinical areas as a means to balance risk Agency and bank as a means to increase nursing numbers- agreed contracts to block book allowing temporary staff to get use to environment and standards within the workplace Right Place consulting - reviewing process across assessment units, demand and capacity, reducing the demand for beds resulting in improved staffing levels and CEO leadership A 'job card' to be designed to ensure temporary staff understand the expectation of their shift and high quality of clinical management required Orientation to each of the clinical ares for agency/bank staff -(green book compliance) Clinical matron/consultant/senior nurse available on assessment units 24/7 to ensure clinical risk is mitigated and managed. Bed management meeting at 8.30, 12.00 16.00 and 18.30 to review bed demands and staffing issues across the Trust.Forum agrees the strategic plan for the 24/7 with on-call director and Senior Manager Active recruitment strategies to reduce vacancies Matron viability on wards Senior Manager walk aorunds Agreed staffing levels Risk assessment for any new area open to plan to m	Major	Likely	16	Aim to recruit over and above establishment to minimise risk of vacancies 1/9/13 Active recruitment days, supporting easy, safe and timely recruitment of staff, minimizing recruitment time. 1/9/13 Block book contracts with agency to improve fill rate and allow orientation of temporary nurses becoming familiar with the clinical areas. 28/2/13 Plan to close wards in response to RPC by improving assessment process and reducing the demands for impatient beds. 31/5/13 Job cards to be written to ensure that temporary staff understand the role they have and the impact of quality in the clinical area. 28/2/13 Workstreams established which will help support the effective management of improved simple & complex discharge to support nursing staff in minimizing patient say reducing LOS & supporting potential closure of beds reducing demands on nurse staffing. 31/5/2014 Design dashboard for each ward to monitor quality to enable early detection of any deterioration and early action to include net promoter, thermometer and harms. 31/5/13 Undertake regular stress assessments and manage 9. Ensure time is taken to complete staff appraisals	4	⇔	PR/SH	5

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Acute	Emergency Care	Inability to maintain acute patient flow to meet ED performance targets	26/02/2013	**Causes** High inflow of patients on day or/and for several days Inability to recruit to all posts in ED Delays in diagnostics for assessment Delayed decision making Poor skill mix due to inability to recruit Admissions in the earlier part of the day exceed discharges Hidden waits places delays in the system which prolong stay Bed base does not meet the peak in variance Patient choice Increases in LOS Increased Delayed Transfers of Care (DTOC) Poor processes across CBUs Lack of consultant lead ward rounds 24/7 Unfamiliar staff working the areas - Increased agency/bank workers **Consequences** Increased wait time to be assessed/admitted Impact on quality of patient experience Impact on safety of patient and increased clinical risk Lack of equipment due to increased numbers Inability to admit patients to the right place first time based on clinical need Care not personalised to the individual patient Clinical and non clinical staff working long hours Increased staff stress in the workplace Inability to manage effectively the complexity of the patients Breaches of confidentiality Temporary staff unsure of process and policies	Patients	Live monitoring of the ED environment Escalation process - reflecting each stage of the process - escalated on a daily basis to the executive team/ and the wider external health economy where necessary and appropriate Right Place consulting - reviewing process across assessment units, demand and capacity, and ED processes with executive and CEO leadership Workstreams to address issues of Hidden wait, LOS (elective and non elective), Diversion rates Simple and complex discharge, recruitment in ED. There is an established board to monitor progressed Chaired by the Acute division with Executive leadership. Opening of a DTOC ward on behalf of the CCGs Orientation to each of the clinical areas for agency/bank staff -(green book compliance) Establish a RAT/STAT process - to ensure all patients are assessed on entry and graded according to clinical propriety Consultant Medical physicians and Registrar to improve assessment of medical patients with the potential to fast track patients where possible to the assessment units Clinical matron/consultant/senior nurse available on a Manager of the day allocated to solve flow in assessi Bed augment meeting at 8.30, 12.00 16.00 and 18.3(Internal to ED and medicine manager's of the day rot Involvement of all 'Head of Service' when there are b EDD monitored by consultant everyday - discharge c Review of all consultant job plans Review of the spinal pathways by Planned Care	Major	Likely	16	Establish systems for continuous review allowing decisions to be made and risk to be evaluated. Audit process to ensure this is embedded - 31/8/2013 Adhere to the escalation process to enable assistance and action to minimize impact of issues - 31/08/2013 Right Place consulting are reviewing assessment process and bed capacity to enable fast assessment and treatment of patients to release capacity - 31/5/2013 Ward 2 to be opened to manage the DTOC - to monitor its performance and effectiveness in reducing DTOC in acute beds - 31/3/2013 'Job cards' to be written by ED to ensure that temporary staffs understand the role they have and the impact of quality in the department - 28/2/2013 Ensure 100% orientation of all locum staff in all areas of the acute pathway - 28/2/2013 Establish RAT/STAT process to enable rapid assessment and transfer to most appropriate clinical area - 31/5/2013 Improved assessment capacity by additional acute consultant physician and registrar senior assessment support. 31/5/2013 EDD monitoring - establishing live processes that supports proactive planning for discharge - 30/4/201 24/7 Senior decision maker in the medical assessme Establishment of a 'discharge co-coordinator' role - 3 Review of consultant job plans will enable dedicated 7/7 assessment of patients - 30/6/2013 Workstream has been established to support and im The review of the spinal pathway which causes signi Corporate bed management meeting enables the ab	2	⇔	PR/JT	4and 9

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Planned Care	Intensive Care, Theatres, Anaethesia, Pain Management, Sleep	Insufficient Level 3 Critical Care beds	26/06/2012	**Cause:** Critical care occupancy has continued to rise through 2010/11 to 2011/12 resulting in elective cancellations and a lack of physical space to facilitate working more efficiently and effect infection prevention practice. UHL Critical care bed occupancy for 2010/11 was 91.07% and 97.7% for 2011/12 (ICNARC). The Intensive Care Society recommendations are 70% to enable flexibility to respond as an emergency provider. **Consequences:** Lack of Level 3 beds resulting in elective cancellations. This equals 127 @ month 11. Delayed ITU discharges to specialty based wards	Patients	Reallocation of Level 3 beds flexibly across UHL to meet demand Reallocation wherever possible of nursing staff across Critical Care areas in UHL to meet demand Daily SITREP report for critical care distributed throughout the Division and end users of the service stating occupancy, staffing, bed capacity and delayed discharges. Presence of ITU senior nursing staff at Trust's operational bed meeting @ 08.30 daily Bed management policy in place for ITU and all specialties with differing responsibilities for each area. Escalation policy in place inclusive of ITU, PACU and elective users of critical care Ability to escalate to bank/overtime/agency to open extra level 3 capacity as required Presence of ITU senior nursing staff a Trust's weekly theatre activity meeting to plan ahead for elective activity Access to web based system for critical care capacity across the central England network to exercise transfers of Level 3 patients if no capacity available in UHL	Major	Likely	16	Introduction of temporary block agency contract for critical care nurses to expand bed base being explored - Complete Development of critical care expansion document to meet current and future demand introducing a phased approach to expansion of bed base in progress. This is currently awaiting Trust Exec approval - Complete Initial meetings with architects in progress to scope new build options for long term expansion - Complete Outline business case in progress for consideration by the Reconfiguration Board - 28/02/2013 - Complete Gain full support from Trust and Commissioners for phased, funded bed base expansion - 31/07/13 Ensure appropriate utilisation of current resources, for example, patient flow - 31/07/13 Recruitment of nurses to staff the additional Critical Care beds - 30/09/13	1	⇔	PR/JT	9

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Acute	Cardiac, Renal, Respiratory	Insufficient Echo provision cross-site	07/08/2012	**Causes** Insufficient BSE accredited Cardiac Physiologists for level of current/increasing demand. Staffing levels will reduce further during the next few months due to resignation and adoption leave of 2.0 WTE experienced/senior BSE Cardiac Physiologists. **Consequences** Failure to meet National Diagnostic Target for New referrals - loss of reputation; financial penalties. Failure to meet internal standard (<48hrs) for I/P (New) referrals - increased LOS; delays for further treatment/intervention Failure to perform Planned workload - hampers clinicians to manage patient's care effectively for this group of patient's who are at an increased risk of a significant clinical event. Increased risk of RSI's for Physiologists. Staff retention & recruitment issues - due to very limited training (including Mandatory); essential development in routine/advanced techniques; low staff morale; loss of key staff.	HR	Cardiac physiologists working additional hours to avoid National Target breeches for New referrals. SAC (some slots available on same day as O/P consultant visit) for Planned referrals not performed prior to OP appointment. Clinicians also able to re refer and change planned referral to New referral if Echo not performed prior to OP appointment. All new referrals attract 5 wk target.	Major	Likely	16	Upgrade 0.65 WTE BSE Trainee - Complete Recruit 2.0 WTE BSE Cardiac Physiologists - 31/03/2013 Upgrade 0.35 WTE BSE Trainee - Complete Upgrade 1.0 WTE BSE Trainee - Complete Waiting list initiative for Planned workload - Complete Negotiate BRU support - cover for 1/7 - 28/02/2013 Explore options with Cardiology SpR lists - Complete Explore options with External provider - Complete Contact all Service Managers where increase in demand to set SLA. Set up trading account for activity over SLA from April 2013. - Complete Consider review of funding of diagnostic budget - 31/01/2013 Paper reflecting the capacity restraints and associated risks presented at Acute Divisional Board on 18th January - response awaited - 31/03/2013	1	⇔	PR/KB	3

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Acute	Cardiac, Renal, Respiratory	Inappropriate environment and infection prevention Renal Transplant	25/10/2011	**Cause** Insufficient side room capacity Inadequate space in existing side room for haemodialysis and line procedures. Insufficient en suite facilities in side rooms Vascular access and % of patients with dialysis catheters Procedure room on ward 10 not fit for purpose Inappropriate areas used for renal biopsy on ward 17 Inadequate drug preparation areas Inadequate domestic storage areas No separate facility for isolating patients in ward 10/17 DCU Movement of patients to accommodate admissions or haemodialysis in another area **Consequence** Poor compliance with cannula care Challenges in maintaining integrity of commode lids using Chlorclean Infection prevention risk Transportation of contamination through patient occupied areas (15N/A)	Patients	Preventing Transmission of Infection including Isolation Guidelines (DMS 47699) MRSA Screening policy Weekly MRSA audits undertaken by IP Team Local Infection Prevention Group Communication of IP issues regular agenda item on local meetings Link Nurse Network Daily side room list Monthly Nursing Metrics audits Monthly HII audits Monthly Environment audits Recent refurbishment and upgrade of ward 15N/A accommodation Steam cleaning post CDT patients Vascular access being monitored by CQUIN & EMRN Medically led Vascular Access coordination Expert specialty trained competent staff Use 'cohort facility' as required Ongoing competency based programme for the training and implementation of ANTT	Extreme	Possible	15	Development of renal relocation plan - 31/01/2017 Ad-hoc Matron/Consultant IP ward audits - Completed Presentation of IP issues at MDT audit meeting - Completed Infected patients will have procedures last on the list in ward 10 procedure room - Completed Entire commodes will be used to transport body fluids to sluice through patient occupied areas where appropriate and the commode will be cleaned - Completed Undertake commode review to ensure commodes are fit for purpose and replace accordingly - Completed Undertake a review of ward 17 facilities available for transplant biopsies - Completed Undertake review of drug preparation areas as part of RT2C project - Complete Undertake a review of domestic storage areas - Completed Being reviewed by Lead Nurse with a view to closing the risk / reducing risk score - Completed	15	⇔	PR/SH	1
Acute	Specialty Medicine	Patients not being effectively resuscitated	06/06/2012	**Causes** Due to UHL reconfiguration Medical wards moved to LRI with associated medical staff. Arrest team structure significantly reduced (Medical Registrar, SHO, possibly registrar anaesthetist if able to attend) Lack of engagement with UHL resus committee with regard to this change **Consequences** Potential for increased mortality /morbidity Potential for adverse attention affecting Trust reputation Potential increase of complaints / claims	Patients	Medicine continuing to provide Resus team cover (on a temporary basis pending an alternative solution)	Extreme	Possible	15	Resus team medical staff cover must continue under current arrangements until appropriate resource / funding is available. - Complete Begin negotiations to increase the resuscitation team to include additional Dr support - 31/10/2012	10	⇔	PR/SH	1

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Corporate	Nursing	Failure to manage Category C documents on UHL Document Management system (DMS)	14/03/2011	**Causes** Lack of resource at Divisional/ directorate level Lack of resource in CASE team Delays in the development of 'SharePoint' that would enable automatic reminders for expired documents to be generated for the document authors. **Consequences** DMS does not contain the most recent versions of all category C documents Staff may be following incorrect guidance (clinical or non-clinical) May not be able to demonstrate compliance with NHSLA ARMS	Quality	Acting Head of Outcomes has discussed the problems with Clinical Business Units (CBUs) to identify which documents can be managed by the CBUs Reminders to be manually generated by the CASE team (one day a week only)	Moderate	Almost certain	15	Use of bank staff or redeployed staff for 3 - 6 months to update information on DM'S and migrate to 'SharePoint' - Complete	9	⇔	SH/KB	1
Planned Care	Specialist Surgery	Business and patient safety risk due to number of A+C vacancy and unskilled workers remaining & Delay in Dic8 IT roll out	12/10/2012	**Causes** -Delays in recruitment through HR / references etc -Outcomes of transcription project -inability to recruit to substantive posts in a timely manner -Fixed term recruitment leave to get substantive jobs -bank and agency cannot fill vacancies **Consequences** -Outcomes missing -Outcome slips being filed in wrong places -Reception areas not covered -Notes and results unavailable for clinic -Staff stress high	Patients	-Stress audits in place -Appointment of Patient Access Manager -Flexible workforce appointed where available -Other Divisions helping out -Training set up and in progress -Recruited and further recruitment in progress -Outsource typing to DICT8 for ENT and about to for Ophthalmology -Ophthalmology using templates and ICE -Regular meeting with teams	Moderate	Almost certain	15	-outsource typing - 30/04/13 -Staff training - 30/04/13 -Recruitment of substantive A+C - 30/04/13	8	⇔	AF/KB	3
Corporate	Communications	Loss of charity funder	01/10/2011	Loss of (up to) £300k income to Charity from WRVS as a result of single FM supplier contract award. The Charity currently has no recovery plan for such a loss of income. The WRVS funding covers a number of posts within the Trust which would be put at risk.	Economic	The Charitable Funds Committee monitors income and expenditure at bi-monthly meetings. A reduction or cessation of funding is manageable if necessary. Currently awaiting outcome of discussions between WRVS and Interserve.	Moderate	Almost certain	15	To review options for developing new income streams for the Charity (Charity 5 year Plan); to review the funded posts to determine their future viability	8	▲	AS	

Division	Directorate	Risk Title	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Movement	Div/Exec Director	Strategic risk No.
Corporate	Communications	Failure to achieve Foundation Trust (FT) status	30/04/2007	Public opinion does not support our FT application; Failure of the Trust to persuade the public about the benefits and importance of FT status. Failure to engage staff / public re: FT / Strategic Direction; Disengagement of members / public from the process. Disengagement of staff from the process. Public perception may be of a ""failing"" Trust. We will be required by Monitor to show that staff and the public / stakeholders are aware of and support the Trust's Strategic Direction and FT Trust application. The consultation fails to generate sufficient responses / poor demographic representation among responders; Consultation document / communications do not reach sufficient numbers of people / organisations. Responses do not reflect the diversity of the population.	Public	FT programme Board meets regularly to drive and monitor progress on FT application. Ft programme leads meet weekly to keep application on track. Dedicated FT Programme Manager in post, supported by the Trust's strategy team. Consultation Document and supporting communication clearly sets out aspirations and benefits. Communications and Engagement strategy established for FT consultation and strategic direction. FT consultation will be supported and monitored by Membership Engagement Services (MES) Regular briefings to members of staff/ public/ members/ stakeholders. Bi - monthly Prospective Governor meetings established Consultation Strategy specifically targets a wide demographic range of groups / organisations	Moderate	Almost certain	15	Consultation and Engagement actions - 30/06/13	6	⇔	MW/JA	6

Division	Directorate	Risk Title	Opened	Description of Risk	Risk subtype	Controls in place	Likelihood	Impact	Current Risk Score	Action summary	Target Risk Score	Risk Movement	Div/Exec Director	Strategic risk No.
Acute	Imaging & Medical Physics	Lack of planned maintenance for medical equipment maintained by Medical Physics	14/05/2009	**Causes:** Lack of Medical Physics technical staff No mechanism to ensure that the revenue consequences of maintenance are identified and funding given to Medical Physics to perform this maintenance. **Consequences:** Potential for equipment to perform out of specification leading to increased risk of patient/ staff harm. Equipment failure due to non-replacement / maintenance of limited life parts Failure to meet statutory requirements for electrical safety testing of medical equipment. Increased risk of patient complaints / claims Potential for adverse media attention and risk to the reputation of the Trust May impact upon successful outcome of future NHSLA assessments Possibility of non-compliance with CQC Outcome 11 May attract attention of Medicines and Healthcare products Regulatory Agency (MHRA) Low morale / unreasonable pressure on Medical Physics technical staff.	Statutory	Some critical equipment is being maintained under service agreements set up with supplier. Medical Physics team are targeting "High" risk equipment as a first priority. Trust wide project team has been assembled to categorise the risk rating of equipment categories for both Maintenance and training needs - work from this team will eventually lead to many of the recommended actions being possible Identified all critical equipment and maintenance needs through the risk assessment process Reviewed the Medical Devices policy Site wide audit of medical devices Standardise medical equipment wherever possible Trust wide communication about future of medical device management issued.	Moderate	Almost certain	15	Develop process to allow appropriate funding for Medical Physics to ensure programmed maintenance can be performed - 30/4/13 Develop robust mechanism to ensure the revenue consequences of maintenance for medical equipment purchases are identified - 30/4/13 Secure funding to increase current staff base for Medical Physics technical staff or outsource maintenance contracts - 30/4/13 Quantify the shortfall in maintenance provision from existing resources and identify to the Trust (to enable Trust decision on corrective to be made) - 30/04/13 Establish infusion pump libraries at LGH and LRI - 1/1/14	6	⇔	SC/SH	1

Division	Directorate	Risk Title	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Movement	Div/Exec Director	Strategic risk No.
Corporate	Medical Directorate	Risk of user error associated with non-standardisation of manual and automated external defibrillators	16/12/2009	**Causes:** Medical staff using the defibrillator will rotate to other sites within the Trust Different make / model of defibrillator used at LGH site (Zoll defibrillators as opposed to Medtronic LifePak 20) Defibrillator training at LRI/ Glenfield hospital uses Lifepak defibrillators for practical element of training but purely illustrates the differences between Zoll and Lifepak. This includes how to turn on, how to activate manual mode (2-stage activation), and location of 'shock' button. Defibrillator training at LGH hospital uses Zoll defibrillator for practical element of training but purely illustrates the differences between Zoll and Lifepak. This includes how to turn on, how to activate manual mode (finding release button and opening manual door), and location of 'shock' button. **Consequences:** Potential for unsuccessful defibrillation attempt Potential for injury to the patient (death) Potential to disrupt the advanced life support universal algorithm Non-compliance with recommendations of the CPR Standards for Clinical Practice and Training	Patients	Defibrillation training Defibrillator will give automated instructions (depending on clinical setting)	Extreme	Possible	15	Submit business case to IMC/ Capital Equipment sub group - Completed Standardise make/ model of defibrillator across the Trust - 1/8/13 Funding available for purchase - 1/4/13 Installation of new defibs - 1/8/13	5	⇔	KH/SH	1
Corporate	Facilities	Patient Smoking - Fire due to Oxygen Enrichment Therapy	29/06/2012	There have been four patient 'Fire' incidents in the last 12 months caused by smokers on oxygen therapy in hospital wards. **Cause:** patients using smoking materials whilst undergoing oxygen therapy treatment. **Consequence:** fire incident	Fire	Smoking Policy (under review) No smoking Signage Clinical Supervision Fire Safe nozzles fitted to oxygen appliances - designed to arrest flow of oxygen in a fire situation to reduce risk of explosion (Internal alert issued to Clinical Divisions in July 2012).	Extreme	Possible	15	Create new/update smoking policy - complete Internal alert re compliance with Fire safe nozzles - complete	5	⇔	AC/SH	1

Division	Directorate	Risk Title	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Movement	Div/Exec Director	Strategic risk No.
Acute	Cardiac, Renal, Respiratory	Harborough Lodge environment stops staff safely delivering haemodialysis	16/08/2012	**Causes:** Insufficient space to: Safely carry out dialysis procedures Safely carry out manual handling procedures Safely carry out emergency procedures Maintain patient privacy & dignity Poor state of repair of within clinical areas **Consequences** Cross contamination/infection Manual handling injury to staff/patient/visitor Poor patient experience Negative reputation of Trust Complaints	Patients	Specialist haemodialysis trained and competency assessed staff Haemodialysis/other clinical policies Annual manual handling training Annual infection prevention training Infection prevention policy Infection prevention audits Environment audits Curtains at each bed space Minimum cleaning standards	Extreme	Possible	15	UHL undertake Duty of Care review and produce recommendations - 31/05/2013 UHL undertake Health & Safety review and produce recommendations - Complete Coordinate redecoration/refurbishment - Complete Discuss at Strategy meeting re short/long term plan - Complete Reduce the number of dialysis spaces using a phased approach to reduce overcrowding - Complete UHL undertake Manual Handling review and produce recommendations - Complete	5	⇔	PR/SH	1
Corporate	R & D	Commercial Research Partner withdrawl	29/06/2012	Catalogue of incidents involving Pharmacy storage of Clinical Trial drug and temperature monitoring / control	Business	Process for receipt and storage of product Process for temperature monitoring Process for reporting incidents to research sponsors	Extreme	Possible	15	Replacement for IceSpy Pharmacy department temperature monitoring Minor temperature excursions LRI cold store LGH cold store	4	⇔	DR	
Corporate	IM&T	PACS	26/05/2011	Breast Care Service : Need to improve D.R. capability by providing local storage to Reporting Work Station, so that the service can be sustained in the event of a PACS outage. This could potentially be achieved by adding extra disk capacity to their local Reporting work Station.	Patients	Current controls in place to be identified. IM&T and Imaging IT support are currently in the process of determining whether to move the current archive server process to new hardware to mitigate the risk, or defer to a possible managed service provider.	Extreme	Possible	15	The Board has approved the transition to a 'managed service provider'. Awaiting dates for service transition.	2	⇔	JC	2
Acute	Imaging & Medical Physics	No comprehensive out of hours on call Rota for consultant Paediatric radiologists	29/06/2009	**Causes** There are Consultant Radiologists on call however there are not sufficient numbers to provide an on call service. Registrars are available but they have variable experience **Consequences** Delays for patients requiring Paediatric radiological investigations. Sub-optimal treatment Paediatric patients may have to be sent outside Leicester for treatment Potential for patient dissatisfaction / complaints Consultants are called in when they are not officially on call and they take Lieu time back for this, resulting in loss of expertise during the normal working day.	Patients	There are Consultant Radiologists on call however there are not sufficient numbers to provide an on call service. Registrars are available but they have variable experience. Non Paediatric radiology consultants are not able to perform or interpret Paediatric radiological interventions.	Moderate	Almost certain	15	Review Paediatric service to determine the employment of further Consultants	2	▲	KB	

Appendix five

Division	Directorate	Risk Title	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Manager	Div/Exec Director	Strategic risk No.
ACUTE		Overcrowding in ED	14/05/2013	Fire: Inability to evacuate safely; Burns / Respiratory harm; Damage to Property; Loss of Emergency Medical Service; Disruption to other services; Loss of life, contact injuries, crushing and panic injuries. Patients in close proximity to each other: Cross infection//contamination staff/patients/visitors; Loss of privacy and dignity; Loss of confidentiality of medical information; Poor patient and family experience; Inability/Difficulty accessing patients Medical and nursing staff adopting unnatural postures to carry out patient examination treatment and care; Increased manual handling of patients and movement of trolleys; Transmission of infections to patients/staff and others. Increased length of stay, additional illness to treat; Increased risk of needle-stick incidents; Increased risk of damage to equipment Staff shortages: Inability to provide patient care and meet personal care needs; Increased patient waiting times; Poor patient experience and care; Delayed diagnosis; Medical deterioration from lack of clinical review of their condition; Lack of specialty input to patient care. Increased waiting times/Delayed treatment: Assault/Abuse/Complaints needing to be handled; Loss of confidence/alarm and distress; Breach of 4 hour target. Inability to admit emergency ambulance arrivals into majors: Failure to provide timely treatment; Failure to provide toileting to patients; Delay in EMAS Trust ability to attend 999 calls; Excess Staff pressure and demand - Staff Stress: resulting in- :Staff illness; Increased risk of human error; Loss of concentration; Loss of confidence; Increased risk of incorrect diagnosis or treatment; Increased risk of medication errors; Increased risk of poor communication. Ongoing care taking second place to delivering immediate care: Repeat engagement with patient, measuring of observations and ECG's missed; Deterioration signs therefore missed; Increased risk of pressure sores. Unplanned, repeated patient movement away from their ideal or designated area in order to create space: Trips/Falls injuries;Cross contamination; Spillages; Contact injuries with moving equipment; Patients absconding; Patients taking their own discharge and not being counselled / noticed.	Patients	Close adherence to UHL Escalation policies Regular risk stratification of patient dependency level and infection risk to maximise use of all possible floor space Adherence to ED internal Minimal Professional Standards when possible, and alerting senior staff when these are breached New expanded Majors Assessment Bay area (March 2013) Restructuring of acute flow processes by Right Place, Right Time consultancy firm 2013	Extreme	Almost certain	25	Notify Executive Team and non-executive directors of direct risks of overcrowding - 31/5/2013 Multidisciplinary working party within ED to create action cards for green, amber and red states of overcrowding - 31/5/2013 Request dedicated cleaning staff 24/7 to mitigate infection control risks - 31/5/2013 Request that UHL escalation policies include decanting of ED patients as soon as agreed thresholds of over-crowding are reached - 31/5/2013	1	MHAR	PR/CR	4

Division	Directorate	Risk Title	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Manager	Div/Exec Director	Strategic risk No.
				Carrying out patient diagnosis and treatment in open areas due to overcrowding: Loss of privacy, dignity and confidentiality; Risk of medical error due to incomplete history/examination; Embarrassment and distress to other patients & visitors when medical assessment & intervention carried out in public. Insufficient Medical devices and Equipment available to meet patient demand: Delay in diagnosis and treatment; Failure in treatment; Medication errors; Staff stress and anxiety; Time spent away from delivering patient care; Failure to meet time constraints/targets; Poor patient experience. Insufficient bay availability in Resus: Resus patient in majors bay with risk of unnoticed deterioration and lower nurse:patient ratio; Resus activity performed in view of others; Alarm and distress to other patients and visitors in majors; Loss of Privacy/Dignity for resus patient and family; High risk of Serious Untoward Incidents; High acuity patients being care for in Majors with inappropriate facilities and resources High lengths of stay (target 4 hours, often 4-8+ hours): Breach of infection control policies; Increased risk of pressure sores; Increased risk of malnutrition; Clinical risk of poor medical treatment due to lack of staff skills in providing complex, ongoing care.									