To:	**Trust Board**
From:	**Rachel Overfield - Chief Nurse**
Date:	**24 April 2014**
CQC regulation:	Outcome 16 – Assessing and Monitoring the Quality of Service Provision

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

Author/Responsible Director: Chief Nurse

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

a) A copy of the BAF as of 31 March 2014.
b) An action tracker to monitor progress of BAF actions
c) New extreme and/ or high risks opened during the reporting period.
d) Summary of all UHL extreme and high risks

The Report is provided to the Board for:

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

Summary :

- The content of risk one has been fully revised by the Interim Director of Financial Strategy (IDFS).
- The current risk score for risk number three has been revised from 20 to 16.
- There have been minor revisions to risk eight and a further review will take place to identify the risks to the non-delivery of the updated UHL Quality Commitment.
- Interserve has not yet provided assurance that their business continuity policies/ plans have been adequately prepared.
- Significant revisions have been made to risks four, five and ten to reflect our current position.
- The Board should note the significant number of risks relating to staff shortages of medical, nursing, radiography/ radiology and Pathology grades (see risks 1157, 1196, 2153, 2234, 2275, 2278, 2294, 2300, 2307 and 2320).
- The Board is also asked to note risk 607 in relation to failure to fully comply with BCSH and BSQR blood traceability standards.
- Finally the Board is asked to note that outside of this reporting period (i.e. during April 2014) a new extreme risk has been entered on the risk register which will be included in next month's full report. This is a patient/staff safety risk caused by Interserve declining to provide trained staff to carry out non-harmful physical intervention where control is necessary to deliver essential critical care to patients lacking capacity to consent to treatment.

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

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

(b) note the actions identified within the framework to address any gaps in either

controls or assurances (or both); (c) identify any areas which it feels that the Trust's controls are inadequate and do not, therefore, effectively manage the principal risks to the organisation achieving its objectives; (d) identify any gaps in assurances about the effectiveness of the controls in place to manage the principal risks and consider the nature of, and timescale for, any further assurances to be obtained; (e) identify any other actions which it feels need to be taken to address any 'significant control issues' to provide assurance on the Trust meeting its principal objectives.	
Board Assurance Framework Yes	**Performance KPIs year to date** N/A
Resource Implications (eg Financial, HR) N/A	
Assurance Implications: Yes	
Patient and Public Involvement (PPI) Implications: Yes	
Equality Impact N/A	
Information exempt from Disclosure: No	
Requirement for further review? Yes. Monthly review by the Board	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **24 APRIL 2014**

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

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

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1. INTRODUCTION

1.1 This report provides the Board with:-

a) A copy of the BAF as of 31st March 2014.
b) An action tracker to monitor progress of BAF actions.
c) Notification of any new extreme or high risks opened during the reporting period.
d) Summary of all UHL extreme and high risks.

2. BAF POSITION AS OF 31st MARCH 2014

2.1 A copy of the BAF is attached at appendix one with changes to narrative since the previous version shown in red text. A summary to show the movement of risk scores since the previous report is now included within the BAF.

2.2 The progress of actions associated with the BAF is monitored by reference to the action tracker attached at appendix two. Actions completed prior to March 2014 have been removed from the tracker however a full audit trail of these is available by reference to previous documents.

2.3 The Board is asked to note the following points:

a. The content of risk one has been fully revised by the Interim Director of Financial Strategy (IDFS) and agreed by the UHL Finance and Performance Committee.

b. Following discussion at the previous Board meeting the current risk score for risk number three has been revised from 20 to 16.

c. Following discussions at EQB on 5th March, there have been minor revisions to risk eight; however the Chief Nurse advises that a further review will take place to identify the risks to the non-delivery of the updated UHL Quality Commitment following agreement of the content of the draft version.

d. Delay to the completion of action 3.3 due to the staff side intention to ballot members in relation to one element of the proposed pay progression criteria.

e. The continued lack of progress in relation to Interserve being able to provide assurance that business continuity policies/ plans have been adequately prepared. The Managing Director of LLRFMC is now

aware of this issue and has asked Interserve to respond as a high priority.

f. The Director of Strategy has made significant revisions to risks four, five and ten to reflect our current position.

g. No BAF or action tracker updates have been received from the Chief Information Officer (CIO) in relation to risk 12. As a consequence of this, action number 12.21 (due for completion at the end of March 2014) is showing as 'on-going' within the action tracker and action numbers 12.17 and 12.18 have completion dates yet to be agreed. The CIO has been asked to advise the Risk and Assurance Manager accordingly and the updates will be included in the next submission to the Board.

h. In instances where action completion dates have slipped from those originally agreed there are no increased risks.

2.4 In order to provide an opportunity for more detailed scrutiny the following three BAF entries are suggested for review against the parameters listed in appendix three.

- Risk 1 – Failure to achieve financial sustainability.
- Risk 5 – Ineffective strategic planning and response to external influences.
- Risk 7 – Failure to maintain productive and effective relationships.

3 2013/14 QUARTER FOUR EXTREME AND HIGH RISK REPORT.

3.1 A summary of all currently open extreme and high risks is attached at appendix three and the details of these risks are attached at appendix four. As of 31st March 2014 there are 34 high risks (including those listed in section 3.2) and one extreme risk on the UHL organisational risk register.

3.2 The Board should note the significant number of risks relating to staff shortages of medical, nursing, radiography/ radiology and Pathology grades (see risks 1157, 1196, 2153, 2234, 2275, 2278, 2294, 2300, 2307 and 2320) and are asked to consider whether the actions to mitigate the risks are robust and within appropriate timescales..

3.3 The Board is also asked to note risk 607 in relation to failure to fully comply with BCSH and BSQR blood traceability standards and consider whether the actions listed to reduce the risk are adequate. This risk has been on the risk register since December 2006 and a recent inspection of the UHL Blood transfusion Service identified issues around the lack of a full blood traceability system within UHL.

3.4 Three new high risks have opened during March 2014 as described below. The details of these risks are included at appendix four.

Risk ID	Risk Title	Risk Score	CMG/Corporate Directorate
2320	Risk of inadequate staffing levels in therapy radiography and radiotherapy physics causing a serious radiotherapy treatment	16	CHUGGS

2300	There is a risk of not meeting the national guidelines for out of hours Vascular cover	16	CSI
2318	Blocked drains causing leaks and localized flooding of sewage	16	Operations

3.5 In line with the UHL risk reporting process, for information, the Board is also asked to note that outside of this reporting period (i.e. during April 2014) a new extreme risk has been entered on the risk register which will be included in next month's full report. The new extreme risk is a patient/staff safety risk caused by Interserve declining to provide trained staff to carry out non-harmful physical intervention, holding and restraint skills where control is necessary to deliver essential critical care to patients lacking capacity to consent to treatment.

4. RECOMMENDATIONS

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

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

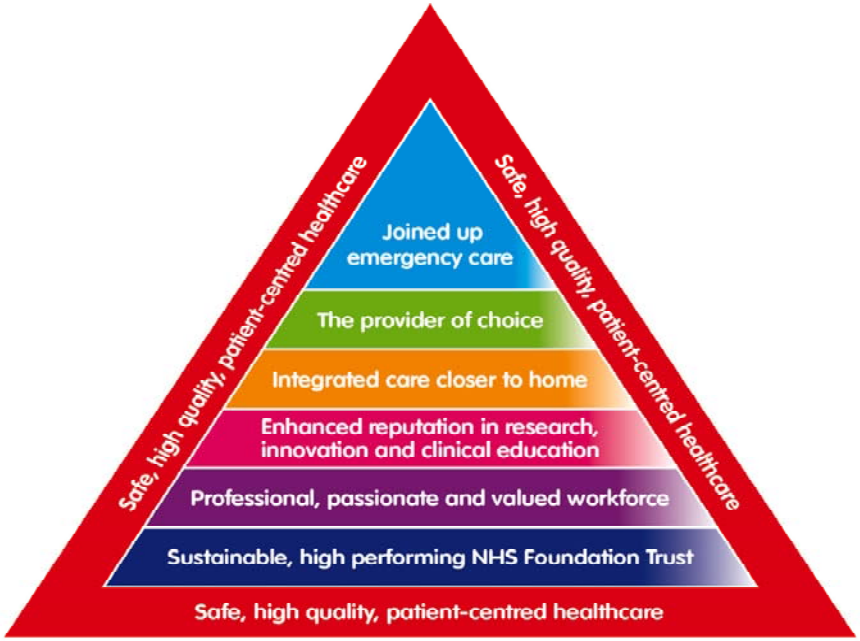
(b) note the actions identified within the framework to address any gaps in either controls or assurances (or both);

(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,
16 April 2014.


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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK MARCH 2014

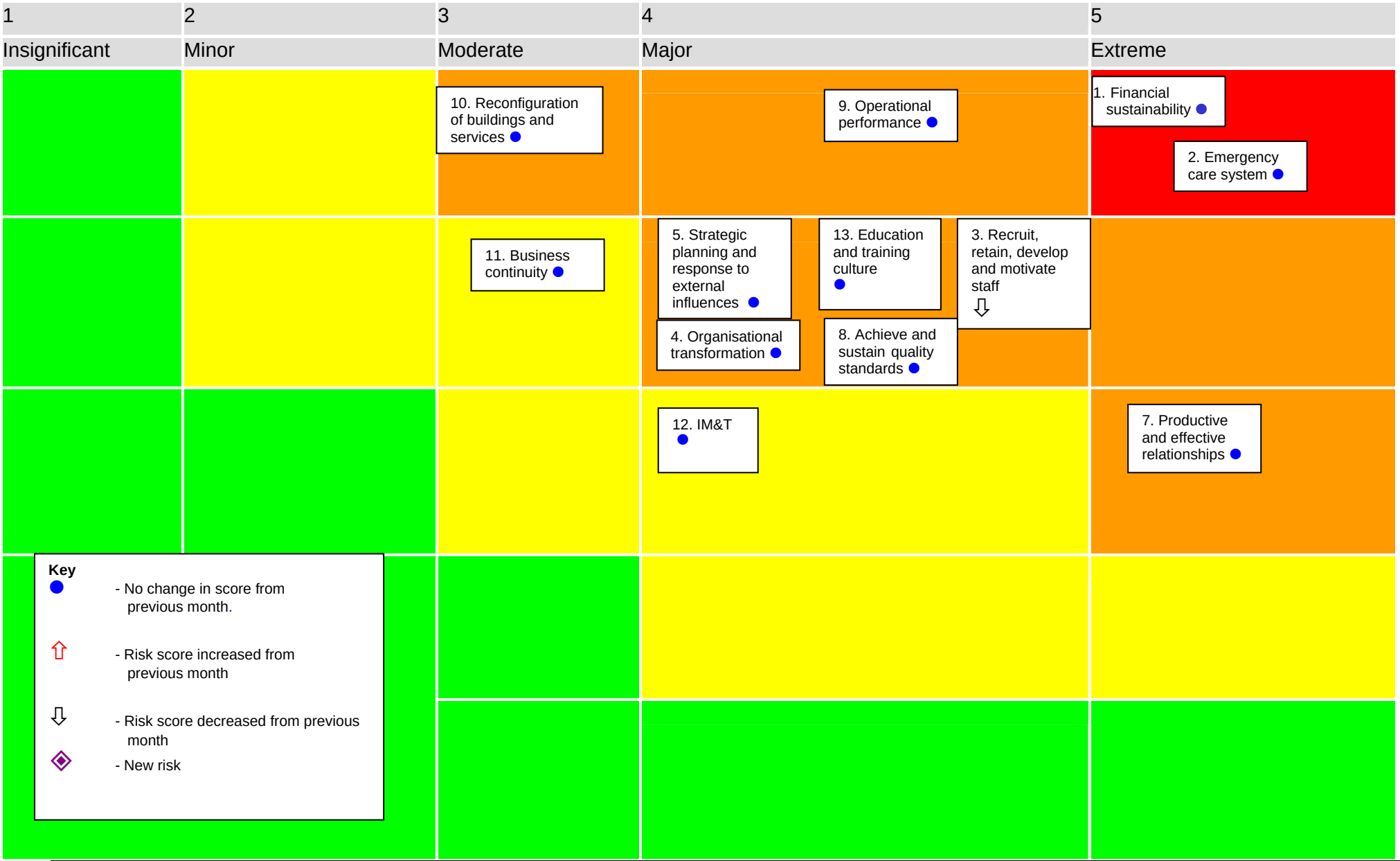
PERIOD: MARCH 2014

RISK TITLE	STRATEGIC OBJECTIVE	CURRENT SCORE	TARGET SCORE
Risk 1 – Failure to achieve financial sustainability	g - To be a sustainable, high performing NHS Foundation Trust	25	20
Risk 2 – Failure to transform the emergency care system	b - To enable joined up emergency care	25	12
Risk 3 – Inability to recruit, retain, develop and motivate staff	f - To maintain a professional, passionate and valued workforce e - To enjoy an enhanced reputation in research, innovation and clinical education.	16	12
Risk 4 – Ineffective organisational transformation	a - To provide safe, high quality patient-centred health care c - To be the provider of choice d - To enable integrated care closer to home	16	12
Risk 5 – Ineffective strategic planning and response to external influences	a - To provide safe, high quality patient-centred health care c - To be the provider of choice g - To be a sustainable, high performing NHS Foundation Trust	16	12
Risk 6 – **Risk deleted from BAF following approval of Trust Board**	**Not applicable**	**N/A**	**N/A**
Risk 7 – Failure to maintain productive and effective relationships	c - To be the provider of choice d - To enable integrated care closer to home f - To maintain a professional, passionate and valued workforce	15	10
Risk 8 – Failure to achieve and sustain quality standards	a - To provide safe, high quality patient-centred health care c - To be the provider of choice	16	12
Risk 9 – Failure to achieve and sustain high standards of operational performance	a - To provide safe, high quality patient-centred health care	20	12
Risk 10 – Inadequate reconfiguration of buildings and services	a - To provide safe, high quality patient-centred health care	15	9
Risk 11– Loss of business continuity	g - To be a sustainable, high performing NHS Foundation Trust	12	6
Risk 12 – Failure to exploit the potential of IM&T	a - To provide safe, high quality patient-centred health care d - To enable integrated care closer to home	12	6
Risk 13 - Failure to enhance education and training culture	e – To enjoy an enhanced reputation in research, innovation and clinical education	16	6

STRATEGIC OBJECTIVES:-	
a - To provide safe, high quality patient-centred health care.	**e - To enjoy an enhanced reputation in research, innovation and clinical education.**
b - To enable joined up emergency care.	**f - To maintain a professional, passionate and valued workforce.**

Consequence

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK MARCH 2014



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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK MARCH 2014

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 deliver recurrent balance	Standing Financial Instructions & Standing Orders Overarching Financial Governance Processes	5x5=25	Monthly progress reports to F&P Committee, Executive Board, & Trust Board Development Sessions TDA Monthly Meetings Chief Officers meeting CCGs/Trusts TDA/NHSE meetings Trust Board Monthly Reporting UHL Programme Board, F&P Committee, Executive Board & Trust Board	(c) Varying level of financial understanding/ control within the organisation. (c) Lack of supporting service strategies to deliver recurrent balance	Finance Training Programme (1.21) Production of a FRP to deliver recurrent balance within three years (1.22) Health System External Review to define the scale of the financial challenge and possible solutions (1.23) Production of UHL Service & Financial Strategy including Reconfiguration/SOC (1.24)	5x4=20	Jun 2014 IDFS Jun 2014 IDFS Jun 2014 IDFS Jun 2014 IDFS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK MARCH 2014

Failure to achieve CIPs	Establishment of Weekly CIP Meetings Executive ownership of cross CIP cutting themes Engagement of Ernst & Young to provide external support to the delivery of the programme Executive Sign off of Plans Establishment of CIP Board Establishment of Project Management Office Short Term Expenditure Reserves CIP Performance Management as part of Integrated Performance Management		Weekly Progress meetings with CEO, COO, FD Monthly Reports to F&P Committee Trust Board Development Sessions Formal sign off documents with CMGs as part of agreement of IBPs Weekly meetings Briefings to Trust Board, F&P Committee, Executive Board regarding establishment of PMO Weekly meeting with Ernst & Young to formalise progress	(c) CIP Quality Impact Assessments not yet agreed internally or with CCGs (c) PMO structure not yet in place to ensure continuity of function following departure of Ernst & Young	Expedite agreement (1.25) PMO Arrangements need to be finalised (1.26)		Apr 2014 IDFS May 2014 IDFS
Failure to effectively manage financial performance	Monthly CMG Performance Reviews Escalation meetings at FD/COO level Internal Contracts Management Group Revised Integrated Performance Management Process Revised financial reporting to Trust Board, Executive Performance Board and F&P Committee		Formal documentation for sign off Report to Trust Board, F&P Committee and Executive Board Formal approval of process by Executive Board Agenda, action notes and supporting papers for meetings Schedule of meetings	(c) The organisation has not effectively identified its service model. (c) Varying level of financial understanding/ control within the organisation. (c) Finance department having difficulties in recruiting to finance posts leading to temporary staff being employed. (c) CMG General Managers not yet signed-off department managers finance plans	Production of Integrated Business Plan (Activity, Capacity, Operational Targets, Workforce, CIPS, Budgets, Capital & Risks) (1.27) Finance Training Programme (1.21) Restructuring of financial management via MoC (1.28) 'Sign-off' 'of local finance plans (1.29)		Jun 2014 IDFS Jun 2014 Jul 2014 Apr 2014
Failure to agree financially and operationally deliverable contracts	Contract Arbitration & TDA Mediation Internal Contracts Group -		Agreed contracts document through the dispute resolution process/arbitration Regular updates to F&P Committee, Executive Board, Escalation meeting between CEOs/CCG Accountable Officers	(c) Failure to agree appropriate levels of financial impact for QIPP, fines and penalties and MRET. (c) Failure to agree levels of operational performance in relation to the above.	Negotiate realistic contracts with CCGs and Specialised Commissioning - QIPP - Fines & Penalties - MRET rebase - Counting & Coding - CCG Non Recurring Funding (1.30)		Apr 2014 IDFS

Failure to receive capital funding	Capital Group Established TDA Monthly IDM Meeting IBM Commercial Sub Group to Joint Governance Board Link to Strategy & SOC Assessment of affordability of Business Cases and consistency with financial recovery Link to Health Systems Review and Service Strategy		UHL Programme Board, Trust Board, F&P Committee and Capital Group Agreement through Commercial Executive (or it's replacement), F&P Committee and Trust Board Health Economy Steering Group, FD's Sub-Group Regular reports to F&P Committee, Trust Board and Executive Board	(c) Lack of clear strategy for reconfiguration of services.	Production of Business Cases to support Reconfiguration and Service Strategy (1.31)		Jun 2014 IDFS

Failure to obtain sufficient cash resources	Agreeing short term borrowing requirements with TDA Short Term borrowing applications Formalised arrangements with TDA/CCGS Escalation to TDA Rolling cash-flow forecasts Cash-flow Monitoring/Reporting		Board reporting and F&P Committee review of cash flow Integral to Service & Financial Strategy UHL Programme Board, F&P Committee, Executive Board and Trust Board Reports to F&P Committee Trust Board and F&P Committee reporting	**(c)** Lack of service strategy to deliver recurrent balance	Agreeing long term loans as part of June Service & Financial Plan		Jun 2014 IDFS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK MARCH 2014

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to transform emergency care system leading to demands on ED and admissions units continuing to exceed capacity.	Health Economy has submitted response plan to NHSE requirements for an Emergency Care system under the A&E Performance Gateway Reference 00062.	5x5=25	Once plan agreed with NTDA, it will be circulated to the Board.	No gaps	No actions	4x3=12	
	Emergency Care Action Team formed. Chaired by Chief executive to ensure Emergency Care Pathway Programme actions are being undertaken in line with NHSE action plan and any blockages to improvement removed. Development of action plan to address key issues.		Action Plan circulated to the Board on a monthly basis as part of the Report on the Emergency Access Target within the Quality and Performance Report.	Gaps described below	Actions described below		
	A new plan has been submitted detailing a clear trajectory for performance improvement and includes key themes from plan: Single front door.		Project plan developed by CCG project manager Risks from 'single front door' to be escalated via ECAT and raised with CCG Managing Director as required.	No gaps	No actions		
	ED assessment process is being operated.		Forms part of Quality Metrics for ED reported daily update and part of monthly board performance report.	No gaps	No actions		
	Recruitment campaign for continued recruitment of ED medical and nursing staff including fortnightly meetings with HR to highlight delays and solutions in the recruitment process.		Vacancy rates and bank/agency usage reported to Trust Board on a monthly basis. Recruitment plan being led by HR and monitored as part of ECAT.	(c) Difficulties are being encountered in filling vacancies within the emergency care pathway. Agency and bank requests continue to increase in response to increasing sickness rates, additional capacity, and vacancies. (c) Staffing vacancies for medical and nursing staff remain high.	Continue with substantive appts until funded establishment is achieved. (2.7)		Review Jun 2014 COO

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK MARCH 2014

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inability to recruit, retain, develop and motivate suitably qualified staff leading to inadequate organisational capacity and development.	Leadership and talent management programmes to identify and develop 'leaders' within UHL.	4x4=16	Development of UHL talent profiles.	No gaps identified.	No actions required.	4x3=12	
			Talent profile update reports to Remuneration Committee.	No gaps identified.	No actions required.		
	Substantial work program to strengthen leadership contained within OD Plan.			No gaps identified.	No actions required.		
	Organisational Development (OD) plan.		A central enabler of delivering against the OD Plan work streams will be adopting, 'Listening into Action' (LiA) and progress reports on the LiA will be presented to the Trust Board on a quarterly basis.	No gaps identified.	No actions required.		
	A central enabler of delivering against the OD Plan work streams will be adopting, 'Listening into Action (LiA). A Sponsor Group personally led by our Chief Executive and including, Executive Leads and other key clinical influencers has been established.		Progress reports on the LiA will be presented to the Trust Board on a quarterly basis.	No gaps identified. No gaps identified.	No actions required. No actions required.		
	Staff engagement action plan encompassing six integrated elements that shape and enable successful and measurable staff engagement.		Results of National staff survey and local patient polling reported to Board on a six monthly basis. Improving staff satisfaction position.	No gaps identified.	No actions required.		
			Staff sickness levels may also provide an indicator of staff satisfaction and performance. Staff sickness rate is 4.48% for M10 (M11 figures not yet available)	No gaps identified	No actions required.		

	Appraisal and objective setting in line with UHL strategic direction. Local actions and appraisal performance recovery plans/ trajectories agreed with CMGs and Directorates Boards.		Appraisal rates reported monthly to Board via Quality and Performance report. Appraisal performance features on CMG / Directorate Board Meetings to monitor the implementation of agreed local actions.				
	Summary of quality findings communicated across the Trust; to identify how to improve the quality of the appraisal experience for the individual and the quality of appraisal meeting recording.		Results of quality audits to ensure adequacy of appraisals reported to the Board via the quarterly workforce and OD report.	No gaps identified.	No actions required.		
			Appraisal Quality Assurance Findings reported to Trust Board via OD Update Report June 2013 Quality Assurance Framework to monitor appraisals on an annual cycle (next due March 2014).	No gaps identified.	No actions required.		
	Workforce plans to identify effective methods to recruit to 'difficult to fill areas). CMG and Directorates 2013/14 Workforce Plans. Active recruitment strategy including implementation of a dedicated nursing recruitment team. Programme of induction and adaptation for international pool of nurses.		Nursing Workforce Plan reported to the Board in September 2013 highlighting demand and initiatives to reduce gap between supply and demand. The use of locum staff in 'difficult to fill' areas is reported to the Board on a monthly basis via the Q&P report. Reduction in the use of such staff would be an assurance of our success in recruiting substantive staff.	(c) Risks with employing high number from an International Pool in terms of ensuring competence	Develop an employer brand and maximise use of social media (3.9).		Apr 2014 DHR
	Reward /recognition strategy and programmes (e.g. salary sacrifice, staff awards, etc). Recruitment and Retention Premia for ED medical and nursing staff.				Development of Pay Progression Policy for Agenda for Change staff (3.3).		Review Jun 2014 DHR
	UHL Branding – to attract a wider and more capable workforce. Includes development of recruitment literature and website, recruitment events, international recruitment. Recruitment progress is measured now there is a structured plan for bulk recruitment. Leads have been identified to develop and encourage the production of fresh and up to date recruitment material. Reporting and monitoring of posts with 5 or less applicants.		Evaluate recruitment events and numbers of applicants. Reports issued to Nursing Workforce Group. Reporting will be to the Board via the quarterly workforce an OD report. Quarterly report to senior HR team and to Board via quarterly workforce and OD report.	(a) Better baselining of information to be able to measure improvement. (c) Lack of engagement in production of website material.			

	Statutory and mandatory training programme (e-learning) for 10 key subject areas in line with National Core Skills Framework.		Monthly monitoring of statutory and mandatory training uptake via reports to TB and ESB against 9 key subject areas (currently showing month on month improvements (76% at M12).	(a) Potentially there may be inaccuracies of training data within the e-UHL system.	Update e-UHL records to ensure accuracy of reporting on a real time basis (3.7).		Review Apr 2014 DHR

RISK NUMBER/ TITLE:	**RISK 4 – INEFFECTIVE ORGANISATIONAL TRANSFORMATION**						
LINK TO STRATEGIC OBJECTIVE(S)	**a. - To provide safe, high quality patient-centred health care.** **c. - To be the provider of choice.** **d. - To enable integrated care closer to home**						
EXECUTIVE LEAD:	Director of Strategy						
Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?

Failure to put in place a robust approach to organisational transformation, adequately linked to related initiatives and financial planning/outputs.	Developing an integrated business plan based upon an overarching strategy for UHL supported by service based strategies. Ensuring that the 2 year operating plan and the 5 year strategy describe the outputs of the clinical strategy and workforce strategy and reflect the estates and financial consequences Engaging in the BCT 2014 programme to ensure cross LLR alignment and ensuring that, allowing for appropriate transition our 2 year and 5 year plans reflect direction of travel in respect of system wide clinical service (and wider social care transformation e.g. more care, closer to home where it is safe and cost effective to do so. Implementing the 'Delivering Caring at its Best' work programmes and put the clear governance arrangements in place Cross LLR capacity and activity plan.	4x4=16	Delivery of 'Delivering Caring at its Best' work programmes will be formally reported through sub-committees of the Board. This requires alignment with the whole local Health Economy change programme Better Care Together 2014 Track delivery against key programme metrics and CMG based delivery targets through ESB, EPB and Trust Board Monitored through the LLR Better Care Together 2014 programme	(c) Gaps are evident in the alignment of transformational process between UHL and principle partners – this is being raised through the Better Care Together Programme structures. (c) Gaps are evident in medium term capacity planning across the Trust and LLR	Review outputs from Chief Officers Group and strategic Planning Group to ensure gaps in current processes are being addressed (4.1). Capacity planning workshop with all CMGs in April/May to build internal capacity and capability and to scope and develop our internal planning assumptions (4.2) The LLR BCT 2014 planning process will support and facilitate the development and agreement of an LLR wide capacity plan in May/June 2014 (4.3)	4x3=12	May 2014 DS May 2014 DS May/ Jun 2014 DS
RISK NUMBER / TITLE	**RISK 5 - INEFFECTIVE STRATEGIC PLANNING AND RESPONSE TO EXTERNAL INFLUENCES**						
LINK TO STRATEGIC OBJECTIVE(S)	**a. - To provide safe, high quality patient-centred health care.** **c. - To be the provider of choice.** **e. - To enjoy an enhanced reputation in research innovation and clinical education.** **g. - To be a sustainable, high performing NHS Foundation Trust**						
EXECUTIVE LEAD:	Director of Strategy						
Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?

Failure to put in place appropriate systems to horizon scan and respond appropriately to external drivers. Failure to proactively develop whole organisation and service line clinical strategies.	Integrated business planning processes in place across CMGs. Forward programme developed. CMG Strategy Leads now engaged in the Business and Strategy Support Teams (BSST) meetings to improve engagement, alignment and teamwork. ESB forward plan to reflect a 12 month programme aligned with: • the development of the IBP/LTFM • the reconfiguration programme • the development of the next AOP • The TB Development Programme. The TB formal agenda Processes now in place to deliver a rolling 2 year operational plan based upon a 5 year strategic plan.	4x4=16	Weekly strategic planning meetings in place – cross CMG and corporate team attendance with delivery led through the Strategy Directorate. Progress reported through reports to ESB and Trust Board Development of a clear, clinically based 5 year strategic for Trust Board sign off in June 2014 and subsequent TDA sign off by the TDA will provide assurance that strategic planning is taking place. Reports to ESB. Regular reports to TB reflecting progress against 12 month rolling programme.	.(c) No high level plan yet developed	High level plan for the Trust to be developed. (5.16)	4x3=12	Jun 2014

RISK NUMBER/ TITLE:	**RISK 7– FAILURE TO MAINTAIN PRODUCTIVE AND EFFECTIVE RELATIONSHIPS**						
LINK TO STRATEGIC OBJECTIVE(S)	**c. - To be the provider of choice.** **d. - To enable integrated care closer to home.** **f. – To maintain a professional, passionate and valued workforce.**						
EXECUTIVE LEAD:	Director of Marketing and Communications						
Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	Current Score I x L	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	Target Score I x L	**Timescale** When will the action be completed?

Failure to maintain productive relationships with external partners/ stakeholders leading to potential loss of activity and income, poor reputation and failure to retain/ reconfigure clinical services.	Stakeholder Engagement Strategy. Regular meetings with external stakeholders and Director of Communications and member of Executive Team to identify and resolve concerns. Regular stakeholder briefing provided by an e-newsletter to inform stakeholders of UHL news. Leicester, Leicestershire and Rutland (LLR) health and social care partners have committed to a collaborative programme of change ('Better Care Together').	5X3=15	Twice yearly GP surveys with results reported to UHL Executive Team. Latest survey results discussed at the April 2013 Board and showed increasing levels of satisfaction… a trend which has now continued for 18 months. Annual Reputation / Relationship survey to key professional and public stakeholders Nov 13.	(c) No external and 'dispassionate' professional view of stakeholder / relationship management activity.	Invite PWC (Trust's Auditors) to offer opinion on the plan / talk to a selection of stakeholders. (7.3)	5X2=10	May 2014 DCM
	The Board have committed to regular meetings in Public around LLR with hosts including Healthwatch and AGE UK						
	The Chairman, with CCG colleagues hosts regular meetings with CCG lay members to improve dialogue and understanding and foster a culture of teamwork between providers and commissioners.						
	A joint report by local Healthwatch organisations to be included in Trust Board papers as a means of bringing community and stakeholder views to the Board's attention.						

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	Current Score I x L	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	Target Score I x L	**Timescale** When will the action be completed?

Failure to achieve and sustain quality standards leading to failure to reduce patient harm with subsequent deterioration in patient experience/ satisfaction/ outcomes, loss of reputation and deterioration of 'friends and family test' score.	Standardised M&M meetings in each speciality.	4x4=16	Routine analysis and monitoring of out of hours/weekend mortality at CMG Boards.	No gaps.	No action needed.	4x3=12	
	Systematic speciality review of "alerts" of deterioration to address cause and agree remedial action by Mortality Review Committee. All deaths in low risk groups identified. Working with DFI to ensure data has been recorded accurately.		Quality and Performance Report and National Quality dashboard presented to ET and TB. Currently SMHI "within expected" (i.e. 107 based on HSCIC data from July 12 to June 13). UHL subscribes to the Hospital Evaluation Dataset (HED) which is similar to the Dr Foster Intelligence clinical benchmarking system but also includes a 'SHMI analysis tool'. Independent analysis of mortality review performed by Public Health. Results reported at November 2013 TB meeting.	(a) UHL risk adjusted perinatal mortality rate above regional and national average.			
	Agreed patient centred care priorities for 2013-14: - Older people's care - Dementia care - Discharge Planning		Quality Action Group meets monthly. Achievement against key objectives and milestones report to Trust board on a monthly basis. A moderate improvement in the older people survey scores has been recorded.	No gaps identified.	No action needed.		
	Multi-professional training in older peoples care and dementia care in line with LLR dementia strategy.		Quality Action Group monitoring of training numbers and location.	No gaps identified.	No action needed.		
	Protected time for matrons and ward sisters to lead on key outcomes.		CMG/ specialty reporting on matron activity and implementation or supervisory practice.	(c) Present vacancy levels prevent adoption of supervisory practice.	Active recruitment to ward nursing establishment so releasing ward sister –for supervisory practice (8.5).		Sep 2014 CN
	Promote and support older people's champion's network and new dementia champion's network.		Monthly monitoring of numbers and activity.	No gaps identified.	No action needed.		
	Targeted development activities for key performance indicators - answering call bells - assistance to toilet - involved in care - discharge information		Monthly monitoring and tracking of patient feedback results. Monthly monitoring of Friends and Family Test reported to the TB (69% at M11). England average 71%.				

	Quality Commitment 2013 – 2016: • Save 1000 extra lives • Avoid 5000 harm events • Provide patient centred care so that we consistently achieve a 75 point patient recommendation score.		Quality Action Groups monitoring action plans and progress against annual priority improvements. A Quality Commitment dashboard has been developed to present updates to the TB on the 3 core metrics for tracking performance against our 3 goals. These metrics will be tracked up to 2015. Impressive drops in fall numbers have been observed in Datix reports and in the Safety Thermometer audit. Quality commitment has been refreshed and aligned with the components of quality (experience, safety, effectiveness) that the Trust is undertaking				
	Relentless attention to 5 Critical Safety Actions (CSA) initiatives to lower mortality.		Q&P report to TB showing outcomes for 5 CSAs. 4CSAs form part of local CQUIN monitoring and there is full compliance against agreed action plans. Full CQUIN funding received	(c) Lack of a unified IT system in relation to ordering and receiving results means that many differing processes are being used to acknowledge/respond to results. Potential risk of results not being acted upon in a timely fashion.	Implementation of Electronic Patient Record (EPR). (8.10)		2015 CIO

	NHS Safety thermometer utilised to measure the prevalence of harm and how many patients remain 'harm free' (Monthly point prevalence for '4 Harms'). Monthly meetings with operational/clinical and managerial leads for each harm in place.		Monthly outcome report of '4 Harms' is reported to Trust board via Q&P report. The percentage of Harm Free Care for M11 was 94.8 % reflecting a reduction in the number of patients with newly acquired harms. There are no areas of concern in relation to the prevalence of New Harms.	(a) There is some concern that the revised DH monitoring tool is still not an effective measure to produce accurate information. Local actions to resolve this are not practicable.			

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK MARCH 2014

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to achieve and sustain operational targets leading to contractual penalties, patient dissatisfaction and poor reputation.	Referral to treatment (RTT) backlog plans (patients over 18 weeks) and operational performance of 90% (for admitted) and 95 % (for non-admitted). Further recovery plans for RTT performance agreed by Commissioners Use of independent sector for key specialties. Reissue across UHL of cancelled operations policy UHL action plan signed off by Commissioners (to reduce cancellations on the day for non-clinical reasons to <0.8%and rebook within 28days)	4x5=20	Key specialities in weekly performance meetings with COO to implement plans. Monthly monitoring of RTT performance recovery plans Daily RTT performance and prospective reports to inform decision making. Weekly patient level reporting meeting for all key specialties. Monthly Q&P report to Trust Board showing 18 week RTT performance. Operational group meeting alternate weeks Operational improvement plan in place Weekly monitoring and actioning 28 day rebooking via access meeting Monthly report to Trust Board and commissioners	(c) Inadequate elective capacity. (c) Not creating ring-fenced elective capacity to prevent cancellations due to no beds on the day	UHL ET to discuss and consider implementing ring-fenced facilities (9.14)	4x3=12	COO April 2014
	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). 4 hour wait performance 83.5% (M11)	See risk number 2.	See risk number 2.		
	Cancer 62 day performance - Tumour site improvement trajectory agreed and each tumour site has developed action plans to achieve targets. Senior Cancer Manager appointed. Lead Cancer Clinician appointed. Action plan to resolve Imaging issues implemented.		Cancer action board established and weekly meetings with all tumour sites represented. Monthly trajectory agreed and Cancer action plan agreed with CCGs and reported and monitored at Executive Performance board. Chief Operating Officer receives reports from Cancer Manager and 62 day performance included within Monthly Q&P report to Trust Board. The ongoing management of cancer performance is carried out by a weekly cancer action board to provide operational assurance. Performance against 62 day standard has been achieved for the past 6 months. Commissioners have formally removed the contract performance notice in relation to 62 day standard.	No gaps identified.	No actions required.		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK MARCH 2014

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	Current Score I x L	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	Target Score I x L	**Timescale** When will the action be completed?
Inadequate reconfiguration of buildings and services leading to less effective use of estate and services.	Reviewing and refreshing our Clinical Strategy. LLR Better Care Together 2014 Strategy	3x5=15	Trust Board development session on development of approach to strategic planning and development of strategic case for change. On-going monitoring of service outcomes by MRC to ensure outcomes improve. Improvement in health outcomes and effective Infection Prevention and Control practices monitored by Executive Quality Board (Q+P report) with escalation to ET, QAC and TB as required.	(a) Service specific KPIs not yet identified for all services.	Iterative development of operational and strategic plans (10.5)	3X3=9	Jun 2014 DS
	Review and refresh of our current Estates Strategy to ensure that it will support the delivery of an Estates solution that will be a key enabler for our clinical strategy. Reconfiguration Programme working with clinicians to develop a 'preferred' way forward' completed.		Trust Board development sessions and Board reports in respect of estate related developments over a 2 year and 5 year time horizon. Facilities Management Collaborative (FMC) monitors operational estate delivery against agreed KPIs to provide assurance of successful outsourced service.	(c) Estates plans not fully developed to achieve the strategy. The success of the plans will be dependent upon capital funding beyond our own capital resources and successful approval by the NTDA. Access to discretionary capital will be dependent on delivery of our agreed financial plan	Reconfiguration programme to develop a strategic outline case which will inform the future estate strategy (10.6) Deliver our financial plan, activity plans (10.7) Secure capital funding (10.3).		Jun 2014 DS Jun 2014 IDFS/COO Jun 2014 IDFS/COO

	CMG service development strategies and plans to deliver key developments.		Progress on CMG development plans reported to Development Meetings with execs	No gaps identified.	No actions required.		
	Executive Strategy Board - Reconfiguration		Monthly ESB to provide oversight of reconfiguration.	No gaps identified.	No actions required.		Jun 2014 DS
	Capital expenditure programme to fund developments. Capital Board to oversee in year performance management		Capital expenditure reports reported to the Board via F&P Committee. Capital Board re-established	Require financial strategy by the end of Q1 to reflect how the Trust anticipates sourcing external capital for strategic business cases.	Develop and secure TDA approval for access to strategic capital. (10.8)		Jun 2014 IDFS
	Managed Business Partner for IM&T services to deliver IT that will be a key enabler for our clinical strategy. IM&T incorporated into Improvement and Innovation Framework.		IM&T Board in place.	No gaps identified.	No actions required.		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK MARCH 2014

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inability to react /recover from events that threaten business continuity leading to sustained downtime and inability to provide full range of services.	Major incident/business continuity/ disaster recovery and Pandemic plans developed and tested for UHL/ wider health community. This includes UHL staff training in major incident planning/ coordination and multi agency involvement across Leicestershire to effectively manage and recover from any event threatening business continuity. Tailored training packages for service area based staff. Contingency plans developed to manage loss of critical supplier and how we will monitor and respond to incidents affecting delivery of critical supplies.	3x4=12	Annual Emergency planning Report Training Needs Analysis developed to identify training requirements for staff External auditing and assurances to SHA, Business Continuity Self-Assessment, Completion of the National Capabilities Survey, November 2013 Results included in the annual report on Emergency Planning and Business Continuity to the QAC. Audit by PwC Jan 2013. Completed Jan 2014. 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) Lack of coordination of plans between different service areas and across the specialties. c) Not all the critical suppliers questioned provided responses. (c) Contracts aren't assessed for their potential BC risk on the Trust.	Training and Exercising events to involve multiple specialties/CMGs to validate plans to ensure consistency and coordination (11.13). Finance and procurement staff to be trained how to assess the BC risk to a contract and utilise the tools developed. (11.14)	2x3=6	Aug 2014 COO May 2014 COO

	Emergency Planning Officer appointed to oversee the development of business continuity within the Trust.		Outcomes from PwC LLP audit identified that there is a programme management system in place through the Emergency Planning Officer to oversee. A year plan for Emergency Planning developed and updated annually. Production/updates of documents/plans relating to Emergency Planning and Business Continuity aligned with national guidance have begun. Including Business Impact Assessments for all specialties. Plan templates for specialties now include details/input from Interserve. 2014/2015 work plan based on priority tasks to undertake and plans to review	(c) Local plans for loss of critical services not completed due to change over of facilities provider. (c) Plans have not been provided by Interserve as to how they would respond or escalate issues to the Trust. (c) A number of plans are out of date and risk being inadequate for a response due to operational changes. (c)Call out system designed to notify staff of a major incident and activate the plan is not suitable.	Further work required to develop escalation plans and response plans for Interserve. (11.11) Review and consider options for an automated system to reduce time and resources required to initiate a staff call out (11.16).		Apr 2014 COO Jun 2014 COO
No gaps identified.	No actions required.		Minutes/action plans from Emergency Planning and Business Continuity Committee. Any outstanding risks/issues will be raised through the COO.	No gaps identified.	No actions required.		
			New Policy on InSite Emergency Planning and Business Continuity Committee ensures that processes outlined in the Policy are followed, including the production of documents relating to business continuity within the service areas. Incidents within the Trust are investigated and debrief reports written, which include recommendations and actions to consider. Issues/lessons feed into the development of local plans and training and exercising events.	No gaps identified.	No actions required.		

			Head of Operations and Emergency Planning Officer are consulted on the implementation of new IM&T projects that will disrupt user's access to IM&T systems.	(c) Do not always consider the impact on business continuity and resilience when implementing new systems and processes. (c) End users aren't always consulted adequately prior to downtime of a system.	Further processes require development, particularly with the new Facilities and IM&T providers to ensure resilience is considered/ developed when implementing new systems, infrastructure and processes. (11.8)		Review Apr 2014 COO
	All priority IT systems have disaster recovery testing completed as part of the change approvals for major upgrades or at least once per year if no upgrade is planned within a financial year.			(a) Lack of clarity around how the trust receives assurance that disaster recovery testing for IT systems takes place	Develop an assurance process (11.17)		May 2014 CIO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK MARCH 2014

RISK NUMBER/ TITLE:	**RISK 12 FAILURE TO EXPLOIT THE POTENTIAL OF IM&T**
LINK TO STRATEGIC OBJECTIVE(S))	**a. - To provide safe, high quality patient-centred health care.** **d. - To enable integrated care closer to home**
EXECUTIVE LEAD:	Chief Information 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 integrate the IM&T programme into mainstream activities.	IM&T is required to be part of the short/medium and long term planning processes	4x3=12	Strategic IM&T Board in place. Quarterly reports to Trust Board IM&T represented on key groups such as ESB, capital planning etc…	(c) late notice of significant changes that have a material impact on M&T provision (c) lack of uptake of IM&T opportunities within the planning processes	Ensure that there is further integration of IM&T within planning groups (12.9) Ensure that there are no unforeseen IM&T requirements coming out of the 2014-2016 planning phase. (12.10)	3x2=6	May 2014 CIO Apr 2014 CIO
	Creation of an exciting portfolio of opportunities for UHL to use within its delivery and reporting activities		A clear plan for 2014/15 exists, within the IM&T strategic framework. Work with directly affected areas has commenced	(c) lack of a fully signed off five year plan for IMT (c) a clear communications and engagement plan to inform all stakeholders of these opportunities	Work with the DOF and the capital group to ensure a coherent 5 year plan is in place for the delivery of the core IM&T components (12.11) Work with specialists from UHL and IBM to better define the communications and engagement strategy. (12.12) Review and reissue the IM&T strategy (12.13)		May 2014 CIO May 2014 CIO Jun 2014 CIO
	Engagement with the wider clinical communities (internal) including formal meetings of the newly created advisory groups/ clinical IT. Improved communications plan incorporating process for feedback of information.		CMIO(s) now in place, and active members of the IM&T meetings The joint governance board monitors the level of communications with the organisation.	(c Whilst there is increased clinical engagement this is still not flowing through the anticipated cascade methodology	To review the means by which we communicate to clinical teams, including reviewing working models from successful organisations. (12.14)		Apr 2014 CMIO

	Engagement with the wider clinical communities (External). UHL CMIOs are added as invitees to the meetings, as are the clinical (IM&T) leads from each of the CCGs.		UHL membership of the wider LLR IM&T board	(c) no involvement of external stakeholders on our significant internal projects	Review any relevant groups and engage our external stakeholders for membership (12.15)		May 2014 CIO/CMIO
Benefits are not well defined or delivered	Appointment of IBM to assist in the development of an incentivised, benefit driven, programme of activities to get the most out of our existing and future IM&T investments. Initial engagement with key members of the TDA to ensure there is sufficient understanding of technology roadmap and their involvement. The development of a strategy to ensure we have a consistent approach to delivering benefits. Increased engagement and communications with departments to ensure that we capture requirements and communicate benefits. Standard benefits reporting methodology in line with trust expectations.		Minutes of the joint governance board, the transformation board and the service delivery board. Benefits are part of all the projects that are signed off by the relevant groups.	(a) Not all projects are fully reporting on the benefits realised. (c) Ownership of benefits delivery is being overlooked when a project, from IM&T's perspective, is finished. (c) Requirements within projects are moving significantly from the time a project specification is signed off.	Ensure that all teams working on IM&T projects work to the required standards. (12.16) Post project benefit realisation plans and ownership is identified at pre-commencement phase to ensure the total work is identified. (12.17) Requirements and benefits are fully signed off prior to any work commencing (12.18)		Apr 2014 CIO TBA TBA
Major programmes of work do not deliver on time and budget	A joint Programme and project methodology is in place between UHL and IBM for managing and tracking activities.		Weekly and Monthly reports are in place to track both at a programme level and at an individual project level	(c) sufficient feedback to individual CMGs on both the progress, benefits and further opportunities from their IM&T projects	Re-establish monthly meetings with a nominated lead to discuss projects and overall performance with the CMGs (12.19) Enhance the communications with the CMGs to include new opportunities that they could consider within their planning processes going forward (12.20)		Apr 2014 CIO Apr 2014 CIO
	External factors such as CCG alignment and NTDA approval are in place to ensure smooth passage of approvals		Bi monthly LLR meetings are in place to ensure alignment across all healthcare stakeholders in Leicestershire	(a) more early engagement with the NTDA is required to ensure visibility of the IM&T programme (c) Agree LLR joint priorities for 2014	To provide a plan/dates to the relevant NTDA bodies of the expected business case release plan (12.21) Further work through the IM&T strategy board is required to refine the large set of requirements into a realistic deliverable plan (12.22)		Mar 2014 CIO May 2014 CIO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK MARCH 2014

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to implement and embed an effective medical training and education culture with subsequent critical reports from commissioners, loss of medical students and junior doctors, impact on reputation and potential loss of teaching status.	Medical Education Strategy and Action Plan.	4x4=16	Strategy approved by the Trust Board. Strategy monitored by Operations Manager and reviewed monthly in Full team Meetings. Favourable Deanery visit in relation to ED Drs training.	(c) Lack of engagement/awareness of the Strategy with CMGs.	Meetings to discuss strategy with CMGs (13.1).	3x2 = 6	Apr 2014 MD
	UHL Education Committee. 'Doctors in Training' Committee established. Education and Patient Safety. Links with LEG/ QUAC and QPMG		Professor Carr reports to the Trust Board. Reports submitted to the Education Committee. Terms of reference and minutes of meetings.	(c) Attendance at the Committee could be improved. (c) Improved trainee representation on Trust wide committees. (c) Improve engagement with other patient safety activities/groups.	Relevance of the committee to be discussed at specialty/ CMG meetings (13.2).		Apr 2014 MD
	Quality Monitoring. Engagement with specialties to share findings from education and training dashboards		Quality dashboard for education and training (including feedback from GMC and LETB visits) monitored monthly by Operations Manager, Quality Manager and Education Committee. Education Quality Visits to specialties. Exit surveys for trainees. Monitor progress against the Education Strategy and GMC Training Survey results.	(a) Do not currently ensure progress against strategic and national benchmarks. (c) Inadequate educational resources.	Monitor UHL position against other trusts nationally. (13.7) New Library/learning facilities to be developed at the LRI .(13.8)		Review Jun 2014 MD Apr 2014 MD

	Educational project teams to lead on education transformation projects.		Project team meets monthly. Favourable outcome from Deanery visit in relation to ED Drs training.				
	Financial Monitoring.		SIFT monitoring plan in place.	(c) Poor engagement with specialties in relation to implication of SIFT.	Need to engage with the specialties to help them understand the implication of SIFT and their funding streams. (13.10)		Apr 2014 MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
ACTION TRACKER FOR THE 2013/14 BOARD ASSURANCE FRAMEWORK (BAF)

Monitoring body (Internal and/or External):	Executive Team
Reason for action plan:	Board Assurance Framework
Date of this review	**March 2014**
Frequency of review:	Monthly
Date of last review:	February2014

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
1	**Failure to achieve financial sustainability**					
1.21	Implementation of financial training programme to address variability of financial knowledge and control across UHL.	IDFS		June 2014	On track	4
1.22	Production of a FRP to deliver recurrent balance within three years.	IDFS		June 2014	On track	4
1.23	Health System External Review to define the scale of the financial challenge and possible solutions.	IDFS		June 2014	On track	4
1.24	Production of UHL Service & Financial Strategy including Reconfiguration/SOC.	IDFS		June 2014	On track	4
1.25	Expedite agreement of CIP quality impact assessments both internally and with CCGs.	IDFS		April 2014	On track	4
1.26	PMO Arrangements need to be finalised to ensure continuity following departure of Ernst & Young.	IDFS		May 2014	On track	4
1.27	Production of Integrated Business Plan (Activity, Capacity, Operational Targets, Workforce, CIPS, Budgets, Capital & Risks).	IDFS		June 2014	On track	4
1.28	Restructuring of financial management via MoC.	IDFS		July 2014	On track	4
1.29	'Sign-off' 'of local finance plans.	IDFS		April 2014	On track	4
1.30	Negotiate realistic contracts with CCGs and Specialised Commissioning	IDFS		April 2014	On track	4

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

2	**Failure to transform the emergency care system**					
2.7	Continue with substantive appts until funded establishment within ED is achieved.	COO	HO	Review ~~Sept~~ ~~Nov 2013~~ ~~Jan 2014~~ June 2014	Still on track to recruit to funded establishment. International recruitment has been successful. Continued review of progress.	4
3	**Inability to recruit, retain, develop and motivate staff**					
3.3	Development of Pay Progression Policy for Agenda for Change staff.	DHR	DDHR	~~October~~ ~~November~~ ~~December 2013~~ ~~February 2014~~ Review ~~April~~ June 2014	At the JSCNC on 12.03.14, staff side indicated their intention to ballot members in relation to one element of the proposed pay progression criteria. In line with Policy, this means that status quo will be maintained. Work is continuing on progress towards a non agenda for change pay proposal for bands 8C 8D and 9. Timescale for action completion adjusted to reflect this.	3
3.5	Ensure Statutory and Mandatory training is easy to access and complete with 75% compliance by reviewing delivery mode, access and increasing capacity to deliver against specific subject areas.	DHR	ADLOD	March 2014	**Complete** Performance improved to 76% (1% ahead of trajectory) at the end of March 2014 and Trust target met. All 10 newly designed e-learning packages have been completed and are available for staff to complete.	5
3.7	Update e-UHL records to ensure accuracy of reporting on a real time basis	DHR	ADLOD	Review April ~~March~~ 2014	System performance issues continue to be worked on with interface between OCB Media and eUHL strengthened as required for accurately recording learner completion. OCB Media currently working on putting together a detailed specification that will meet business requirements set out in the Project Specification document	3

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

3.9	Develop an employer brand and maximise use of social media to describe benefits of working at UHL	DHR		April 2014	Action plan in development, focused on three elements of employment cycle – attraction, retaining existing staff and understanding why individuals exit. A focused piece of work will take place on the development of the work for us area. Best nursing practice in relation to values based recruitment will be shared with other staff groups.	4
4	**Ineffective organisational transformation**					
4.1	Review outputs from Chief Officers Group and strategic Planning Group to ensure gaps in current processes are being addressed	DS		~~Review February~~ May 2014	This hasn't been done yet as we now have E&Y in across the health community to test and support the development of our LLR plans for transformation over the medium term (5 years)	3
4.2	Capacity planning workshop with all CMGs in April/May to build internal capacity and capability and to scope and develop our internal planning assumptions	DS		May 2014	On track	4
4.3	The LLR BCT 2014 planning process will support and facilitate the development and agreement of an LLR wide capacity plan in May/June			May/ June 2014	On track	4
5	**Ineffective strategic planning and response to external influences**					
5.16	High level plan for the Trust to be developed	DS		June 2014	CMG planning and strategy workshops undertaken January – June 2014. Forward programme developed.	4
7	**Failure to maintain productive and effective relationships**					

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

7.3	Invite PWC (Trust's Auditors) to offer opinion on the plan / talk to a selection of stakeholders.	DMC		~~January 2014~~ ~~March~~ May 2014	Meeting held to scope the work, however delays in sending the raw data to PWC have delayed this action. Timescale for completion adjusted to reflect this.	3
8	**Failure to achieve and sustain quality standards**					
8.5	Active recruitment to ward nursing establishment so releasing ward sister for supervisory practice.	CN		September 2014	On going recruitment process in place and is likely to take 12 -18months. Deadline extended to reflect this.	4
8.10	Implementation of Electronic Patient Record (EPR)	CIO		2015	Currently developing the procurement strategy for the EPR solution	4
9	**Failure to achieve and sustain high standards of operational performance**					
9.13	Implementation of recovery action plan (including speciality level action plan / recovery trajectory at Trust and speciality level of RTT standards).	COO		March 2014	**Complete.** Recovery action plan signed off by commissioners 5th March 2014 and implementation underway. Achievement of RTT non-admitted and admitted targets anticipated August and November 201 respectively	5
9.14	UHL Exec Team to discuss and consider implementing ring-fenced facilities to avoid cancellation of operations on the day due to lack of beds			April 2014	On track.	4
10	**Inadequate reconfiguration of buildings and services**					
10.3	Secure capital funding to implement Estates Strategy.	IDFS		~~May 2013~~ ~~December 2013~~ ~~March~~ ~~Review April~~ June 2014	Work underway on capital planning around reconfiguration – SOC due for completion in March 2014 which will be the key vehicle to agree availability of capital funding.	3

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

10.5	Iterative development of operational and strategic plans with specialities.	MD		~~March~~ June 2014	Iterative development of operational and strategic plans with specialities to be reflected in our 5 year Integrated Business Plan by June 2014 – including proposed configuration to best meet the clinical and financial sustainability challenges faced by the Trust and the local health and care community. This is monitored by CMG and Executive Boards. Operational plans due April 2014 and strategic plans by June 2014	3
10.6	Reconfiguration programme to develop a strategic outline case which will inform the future estate strategy	DS		June 2014	A decision was made at the Reconfiguration Board of 12th February that, to ensure that we place the activities to progress the SOC in the correct sequence and develop a robust plan, we need to refresh the programme structure, work stream ownership and governance arrangements. We are developing clinical and service based strategies that will inform all aspects of our Integrated Business Plan and reflect model of care change and required estate configuration. This will inform the future estate strategy and associated reconfiguration programme. New timescale.	4
10.7	Deliver our financial plan, activity plans	IDFS/ COO		June 2014	On track	4
10.8	Develop and secure TDA approval for access to strategic capital.	IDFS		June 2014	On track	4
11	**Loss of business continuity**					

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

11.8	Further processes require development, particularly with the new Facilities and IM&T providers to ensure resilience is considered/ developed when implementing new systems, infrastructure and processes.	COO	EPO	~~July~~ ~~August~~ Review ~~October~~ ~~November 2013~~ ~~December 2013~~ ~~March~~ April 2014	Lack of progress with Interserve escalated via Chief Nurse and NHS Horizons; however still no formal assurance from Interserve of the BCM policy/process/plans. Meeting to be scheduled on w/c 31st March 2014 to resolve with Interserve. Deadline extended to reflect this.	2
11.10	Training and Exercising events to involve multiple CMGs/specialties to validate plans to ensure consistency and coordination. **Action merged with 11.13**			N/A	**Action merged with 11.13**	
11.11	Further work required to develop escalation plans and response plans for Interserve.	COO	EPO	~~October~~ ~~December 2013~~ ~~March~~ April 2014	Lack of progress with Interserve escalated via Chief Nurse and NHS Horizons; however still no formal assurance from Interserve of the BCM policy/process/plans. Meeting to be scheduled on w/c 31st March 2014 to resolve with Interserve. Deadline extended to reflect this.	2
11.13	Training and Exercising events to involve multiple CMGs/ specialties to validate plans to ensure consistency and coordination	COO	EPO	August 2014	BCM training and exercising programme has been developed. Training sessions for bleep holders in cardiology and MSK and Specialist Surgery undertaken with more to be planned. New exercises planned for May and July with more to follow.	4
11.14	Finance and procurement staff to be trained how to assess the BC risk to a contract and utilise the tools developed.	COO	EPO	~~March~~ May 2014	Materials developed awaiting availability to run training session.	3
11.15	Review all the plans and identify priority for updating and work into 2014/2015 year plan	COO	EPO	March 2014	**Complete.** 2014/2015 work plan based on priority tasks to undertake and plans to review	5

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

11.16	Review and consider options for an automated system to reduce time and resources required to initiate a staff call out	COO	EPO	~~April~~ June 2014	A number of solutions considered but high costs and integration with current trust systems are not ideal. Awaiting consideration from IBM to develop an in house option.	3
11.17	Develop an assurance process for IT disaster recovery testing in order to provide the Trust with confidence that testing is being performed.	CIO		May 2014		1
12	**Failure to exploit the potential of IM&T**					
12.9	Ensure that there is further integration of IM&T within planning groups (12.9)	CIO		May 2014	On track	4
12.10	Ensure that there are no unforeseen IM&T requirements coming out of the 2014-2016 planning phase.	CIO		April 2014	On track	4
12.11	Work with the DOF and the capital group to ensure a coherent 5 year plan is in place for the delivery of the core IM&T components	CIO		May 2014	On track	4
12.12	Work with specialists from UHL and IBM to better define the communications and engagement strategy.	CIO		May 2014	On track	4
12.13	Review and reissue the IM&T strategy	CIO		June 2014	On track	4
12.14	To review the means by which we communicate to clinical teams, including reviewing working models from successful organisations.	CMIO		April 2014	On track	4
12.15	Review any relevant groups and engage our external stakeholders for membership	CIO/ CMIO		May 2014	On track	4
12.16	Ensure that all teams working on IM&T projects work to the required standards.	CIO		April 2014	On track	4

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

12.17	Post project benefit realisation plans and ownership is identified at pre-commencement phase to ensure the total work is identified.	TBA		TBA		1
12.18	Requirements and benefits are fully signed off prior to any work commencing	TBA		TBA		1
12.19	Re-establish monthly meetings with a nominated lead to discuss projects and overall performance with the CMGs	CIO		April 2014	On track	4
12.20	Enhance the communications with the CMGs to include new opportunities that they could consider within their planning processes going forward	CIO		April 2014	On track	4
12.21	To provide a plan/dates to the relevant NTDA bodies of the expected business case release plan	CIO		March 2014	Awaiting update	
12.22	Further work through the IM&T strategy board is required to refine the large set of requirements into a realistic deliverable plan	CIO		May 2014	On track	4
13	**Failure to enhance education and training culture**					
13.1	To improve CMG engagement facilitate meetings to discuss Medical Education Strategy and Action Plans with CMGs.	MD	AMD	~~December 2013/January 2014~~ ~~March~~ April 2014	Meetings held with – ES Medicine, O&G, MSS, ITAPS, and discussion with CMG Leads from CHUGS and CSI Meeting with RRC tbc. Previous meeting with Cardiac Services had to be postponed so deadline extended to reflect this	3
13.2	Relevance of the UHL Education Committee to be discussed at CMG Meetings in an effort to improve attendance.	MD	AMD	~~December 2013/January 2014~~ ~~March~~ April 2014	Meetings held with – ES Medicine, O&G, MSS, ITAPS, and discussion with CMG Leads from CHUGS and CSI Meeting with RRC tbc. . Previous meeting with Cardiac Services had to be postponed so deadline extended to reflect this	3

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

13.7	Monitor UHL position against other trusts nationally to ensure progress against strategic and national benchmarks.	MD	AMD	Review ~~October 2013~~ ~~March~~ June 2014	Following further discussions with the LETB this data is not readily available. LETB to investigate how we can acquire this data.	2
13.8	New Library/learning facilities to be developed at the LRI to help resolve inadequate educational resources.	MD	AMD	~~October 2013~~ April 2014	A Project Manager is now in place. Odames Ward will be handed over on 1st February for work to start on 1st April 2014.	4
13.10	Need to engage with the CMGs to help them understand the implication of SIFT and their funding streams.	MD	AMD	~~December 2013/January 2014~~ ~~March~~ April 2014	Meetings held with – ES Medicine, O&G, MSS, ITAPS, and discussion with CMG Leads from CHUGS and CSI Meeting with RRC tbc. Previous meeting with Cardiac Services had to be postponed so deadline extended to reflect this	3

Key

CEO	Chief Executive Officer
IDFBS	Interim Director of Financial Strategy
MD	Medical Director
AMD	Assistant Medical Director
COO	Chief Operating Officer
DHR	Director of Human Resources
DDHR	Deputy Director of Human Resources
DS	Director of Strategy
ADLOD	Asst Director of Learning and Organisational Development
DMC	Director of Marketing and Communications
CIO	Chief Information Officer
CMIO	Chief Medical Information Officer
EPO	Emergency Planning Officer
HPO	Head of Performance Improvement
HO	Head of Operations
CD	Clinical Director
CMGM	Clinical Management Group Manager
DDF&P	Deputy Director Finance and Procurement

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

FTPM	Foundation Trust Programme Manager
HTCIP	Head of Trust Cost Improvement Programme
ADI	Assistant Director of Information
FC	Financial Controller
ADP&S	Assistant Director of Procurement and Supplies
HoN	Head of Nursing
TT	Transformation Team
CN	Chief Nurse

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

Appendix 3 - UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – RISK REGISTER SUMMARY (RISKS SCORING 15 OR ABOVE)

PERIOD: AS AT 31 MARCH 2014

ID	RISK TITLE	CURRENT SCORE	TARGET SCORE	RISK MOVEMENT
2236	There is a risk of overcrowding due to the design and size of the ED footprint	25	16	⇔
2234	There is a medical staffing shortfall resulting in a risk of an understaffed Emergency Department	20	6	⇔
2294	Risks to the clinical care of patients with CHD due to the shortfall of paediatric cardiac anaesthetists	20	1	⇔
698	Risk to the production of aseptic pharmaceutical products	20	3	⇔
847	Lack of Capacity in maternity services	20	12	⇔
2267	Risk of reduced compliance with DoH requirements in relation to adherence to antimicrobial prescribing policy	20	4	⇔
2320	Inadequate staffing levels in therapy radiography and radiotherapy physics causing a serious radiotherapy treatment error	16	4	NEW
2193	Risk of unplanned loss of theatre and/or recovery capacity at the LRI	16	4	⇔
2307	The Forensic Toxicology service will fail resulting in a substantial loss of income and prestige for the Department/empath	16	4	⇔
2194	Risk of unplanned loss of theatre, recovery or Critical Care capacity across UHL due to insufficient nursing staffing	16	4	⇔
2191	Follow up backlogs and capacity issues in Ophthalmology	16	8	⇔
607	Failure of UHL BT to fully comply with BCSH guidance and BSRs may adversely impact on patient safety and service delivery	16	4	⇔
2300	There is a risk of not meeting the national guidelines for out of hours Vascular cover	16	4	NEW
2248	Lack of IR(ME)R training records held across the Trust	16	4	⇔
2245	There is a risk that staff vacancies within the medical records departments will have an impact on service delivery	16	6	⇔
2153	Shortfall in the number of qualified nurses in Children's Hospital including ECMO staffing and Capacity	16	8	⇔
1312	Poor quality of information on UHL document management system (DMS)	16	6	⇔
2237	Risk of results of outpatient diagnostic tests not being reviewed or acted upon resulting in patient harm	16	8	⇔
2271	Failure to achieve compliance of 75% attendance at Safeguarding training may have adverse impact on UHL safeguarding processes	16	6	⇔
2247	There are 500 Registered Nurse vacancies across UHL leading to a deterioration in service and adverse effect on financial position	16	12	⇔
2318	Blocked drains causing leaks and localized flooding of sewage	16	2	NEW
1693	Risk of inaccuracies in clinical coding	16	8	⇔
697	Failure to achieve Foundation Trust (FT) status	16	6	⇔
1737	Inappropriate environment and infection prevention Renal Transplant	15	15	⇔
2070	Harborough Lodge environment stops staff safely delivering haemodialysis	15	5	⇔
1196	No comprehensive out of hours on call rota for consultant Paediatric radiologists	15	2	⇔
1157	Lack of planned maintenance for medical equipment maintained by Medical Physics	15	6	⇔
2278	Risk that the Leicester Fertility Centre could have its licence for the provision of treatment and services withdrawn	15	6	⇔
1310	Risk of user error associated with non-standardisation of manual and automated external defibrillators	15	5	⇔
2275	There is a lack of robust clinical processes relating to Subcutaneous Methotrexate therapy due to staff shortages	15	2	⇔
2270	Failure to achieve compliance of 75% attendance at Fire Safety training may cause UHL to fail to meet its statutory obligation	15	9	⇔
2268	Failure to meet targets for training compliance for M and H training may adversely affect patient care /staff safety	15	9	⇔
2272	Failing to meet internal and external targets in relation to undertaking IG training may adversely affect UHL compliance with IP	15	6	⇔
2269	Failure to meet UHL target of a minimum of 75% of clinical staff undertaking IP/Hand hygiene training	15	10	⇔
1551	Failure to manage Category C documents on UHL Document Management system (DMS)	15	9	⇔

⇔ = Risk score not changed from previous reporting period
NEW = New risk entered during this reporting period
↑ = Risk score increased from previous reporting period

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

OPERATIONAL RISKS SCORING 15 OR ABOVE FOR THE PERIOD ENDING 31/03/14

REPORT PRODUCED BY: UHL CORPORATE RISK MANAGEMENT TEAM

Key

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

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2236	Emergency and Specialist Medicine	ED	There is a risk of overcrowding due to the design and size of the ED footprint	04/10/2013	31/03/2014	Design and size of footprint in paediatrics causes delay in being seen by clinician. Risk of deterioration. Risk of four hour target and local CQUINS. Lack of patient confidentiality. Increased violence and aggression. Design and size of footprint in resus causes delay in definitive treatment, delay in obtaining critical care, risk of serious incidents, increased crowding in majors, risk to four hour target. Poorer quality care. Risk of rule 43. Lack of privacy and dignity. Increased staff stress. Design and size of majors causes delay in definitive treatment and medical care. Poor quality care. Lack of privacy and dignity. High number of patient complaints. Risk of deterioration. Difficulty in responding to unwell patient in majors. Risk of adverse media interest. Staff stress. Risk of serious incident. Inability to meet four hour target resulting in patient safety and financial consequences. High number of incidents. Increased staff stress. Infection control risk. Risk of rule 43. Design and size of assessment bay causes delay in time to assessment. Paramedics unable to reach turnaround targets Design and size of minors results in delay in receiving medic Design and size footprint in streaming rooms causes threat t	Patients	The Emergency Care Action Team, which was established in spring 2013 aims to improve emergency flow and therefore reduce the ED crowding. The Emergency department is actively engaging in plans to increase the ED footprint via the 'hot floor' initiative, but in the shorter term to increase the capacity of assessment bay and resus.	Extreme	Almost certain	25	New ED plus associated hot floor rebuild approved by the trust and OBC (Outline Business Case) submitted and first phase of construction of new ED to completed by December 2015 . Bays to be allocated and staffed appropriately in majors to act as resus step-down bays for when space in resus is at a premium and some patients are well enough to be moved to majors with the appropriate level of observation - 16/06/14. The resus viewing room is to be made into a fully equipped resus bay - 31/03/14. Resus space to be increased to 8 bays - 31/03/14.	16	JE

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2234	Emergency and Specialist Medicine	ED	There is a medical staffing shortfall resulting in a risk of an understaffed Emergency Department impacting on patient care	04/10/2013	31/03/2014	**Causes:** Consultant vacancies. Middle grade vacancies. Risk of losing trainees due to incorrect service/training balance. Trainee attrition. Trainees not wanting to apply for consultant positions. Reduced cohesiveness as a trainee group. Junior grade vacancies. Juniors defecting to other specialties. Poorer quality of training resulting in poor deanery reports. Non ED medical consultants. Locums. Increased consultant workload. Lack of uniformity. Paediatric medical staffing. Poorer quality care for paediatric population. **Consequences:** Poor quality care. Lack of retention. Stress, poor morale and burnout. Increased sickness. Increased incidents (SUI's), claims and complaints. Inability to do the general work of the department, including breaches of 4 hour target. Financial impacts. Reduced ability to maintain CPD commitments for consultants/medical staff with subspeciality interest. Reduced ability to train and supervise junior doctors. Deskilling of consultants without subspeciality interest. Suboptimal training.	Patients	The chief executive and medical director have met with senior trainees in Leicester ED to invite them to apply for consultant positions. The East Midlands Local Education and training board has recognised middle grade shortages as a workforce issues and has set up several projects aiming to attract and retain emergency medicine trainees and consultants. Advanced nurse practitioners and non-training CT1 grades have been employed in order to backfill the shortage of SHO grade junior doctors. There has been shared teaching sessions in which non ED consultants and ED consultants have shared skills, (i.e. ED consultants learning about collapse in the elderly and elderly medicine consultants doing ALS). The non ED consultants have been set up on a specific mailing list so that new developments and departmental 'mini-teaches' (= learning cases from incidents) can be shared. Only approved locum agencies are used for ED internal locums and their CVs are checked for suitability prior to appointing them. Locums receive a brief shop floor induction on arrival and also must sign Locum doctors are only placed in paeds ED in except The grid paediatric trainees shift pattern has changed ED employs medical registrars to work night shifts in E ED consultants have extended their shop-floor hours f ED employs locum medical consultants to improve se ED has employed several well performing locums on s	Extreme	Likely	20	Review of shift vs rota and the required number of juniors per shift - 01/03/14	6	BTD

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
698	Clinical Support and Imaging	Pharmacy	Risk to the production of aseptic pharmaceutical products	03/05/2007	03/04/2014	**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 alt Limitations of treatments that can be sourced from an alterna Inability to support research where aseptic compounding req	Targets	Planned servicing & maintenance of temporary facility being undertaken. Constant environmental monitoring of facility in place. 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. Project to refurbish the aspetic unit has now started - nov 2013	Extreme	Likely	20	New unit in operation - due 12/05/2014	3	GH

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2294	Women's and Children's	Paediatrics (Cardiorespiratory)	Risks to the clinical care of patients with CHD due to the shortfall of paediatric cardiac anaesthetists	29/01/2014	03/03/2014	Shortfall in availability of paediatric anaesthetists. Currently the consultant cardiac anaesthetists with paediatric/adult congential expertise are having to provide 1in 2 cover due to a number of absences.vacancies in the last 12 months. This has lead to unacceptable delays in surgery/interventional or diagnostic catheterisation with the potential for deterioration in the patients condition leading to higher risk intervention. Breaching of national and local waiting list targets Decreased patient/family satisfaction Increase in complaints Difficulty in recruiting and obtaining suitably trained locums due to a national shortage of expertise and training in this field	Patients	Use of Locums via agency	Major	Almost certain	20	Locum agency bookings to continue via agency - due 31/3/14 Explore sabbaticals for experienced congenital cardiac anaesthetists in Italy - due 28/2/14 Explore other options to cover adult congenital only lists with adult cardiac anaesthetists - due 28/2/14 National/International advert for replacement Anaesthetist - due 31/3/14	1	EA

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
847	Women's and Children's	Maternity	Lack of Capacity in maternity services	28/09/2007	06/04/2014	**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 they 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.	Patients	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. Escalation and contingency plans in place. Relocation of all elective gynaecology beds to LGH.	Extreme	Likely	20	Increase ward capacity on LRI site by opening 13 AN beds on level 1 - due 31/5/2014 Transfer of EL CS lists to level 1 on tuesdays & thursdays - due 28/4/14 Complete transfer of all EL CS to level 1 - due 30/9/14	12	JPORT

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2267	Nursing	IPC	Risk of reduced compliance with DoH requirements in relation to adherence to antimicrobial prescribing policy	09/12/2013	30/04/2014	**Causes:** Change over from paper prescription chart which contains a dedicated section for prescribing antimicrobials, with a prompt for only a 5 days duration, extended duration verification code requirements, and dedicated boxes for documentation of the indication and duration. The current EPMA system does not allow antimicrobials to be differentiated from any other drug and hence duration cannot be mandated, and there is no section to record indication - the lack of this information leads to poor compliance with the duration policy. **Consequences:** On the EPMA wards there has been a reduced compliance with the antimicrobial duration policy and antimicrobial documentation requirements compared to non EPMA wards. Increased risk of C. difficile infection. Increased resistance to anti-microbials. Potential financial penalty via CQUINS in relation to C difficile cases (£50k per patient above C Diff. target). Poor Trust reputation with Commissioners in relation to quality of care.	Quality	Education and training of prescribers (including educating prescribers to record duration for antimicrobials). Monitoring of progress (including weekly telecommunications) in relation to including an antimicrobial section within EPMA and exception reports to TIPAC if there is a failure to progress. Attendance on EPMA board to review progress.	Major	Almost certain	20	Mandate use of indication and duration fields in EPMA - 30/04/14 Create second microbial tab within EPMA - to be advised	4	KDA

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2320	CHUGS	Radiotherapy	Inadequate staffing levels in therapy radiography and radiotherapy physics causing a serious radiotherapy treatment error	21/03/2014	21/04/2014	**Causes** Inadequate staffing levels caused by insufficient budget to recruit to recommended levels. Increased demand and complexity of activity **Consequences** Staff fatigue (due to increased overtime working) resulting in greater risk of error with potential for severe patient injury. Lack of resilience in case of unplanned events such as staff sickness / machine breakdown. Inability to cope with increases in demand Non compliance with national recommendations (i.e. only 75% of patients receive on-treatment verification - national recommendation 100% and possible failure to meet NHS England standard for IMRT capacity). Shortage of Medical Physics Expert (MPE) cover leading to lack of ability to deal with unusual cases requiring variation from protocol and delays in approving new protocols / techniques. (MPE cover is legal requirement under IRMER) Inadequate oversight of new techniques/trials Lack of strategic planning and delays to service critical developments such as IGRT, SABR. Change management process (including risk assessments) not consistently applied potentially meaning that process cha Participation in radiotherapy trials reduced. Staff training compromised. Potential for increased external scrutiny. Low morale and difficulties in retaining staff.	Quality	Planned shifts limit daily working hours Practice controlled by quality system with training/competency records. New techniques can only be authorised by senior staff. Processes carefully defined with checklists Minimum senior staffing levels	Major	Likely	16	Increase radiographers - recruit 2 band 7's from vacancy money 31/514 Protected time for training / development (dependant on business case) - 1/10/14 Increase treatment imaging to 100% to prevent risk of treatment error, aim to increase imaging to 100% of patients (dependant on business case) - 1/10/14 Submit second business case to increase in linac capacity by generating income from further increase in activity / complexity - 1/10/14 Enforce change management process to include risk assessment of new development and controlled documentation - 1/8/14 Identify resource for quality system - appoint dedicated staff member to update and maintain quality system - 1/9/14 Identify resource for quality system - appoint dedicated staff member to update and maintain quality system - 1/9/14	4	LWI

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2193	ITAPS	Theatres	Risk of unplanned loss of theatre and/or recovery capacity at the LRI	28/06/2013	31/03/2014	**Causes:** The Theatre and Recovery estate and supporting plant(s) are old, unsupported from a maintenance perspective and not fit for purpose. There is recent history of unplanned loss of surgical functionality at the LRI site due to plant failure, problems with sluice plumbing and ventilation. In addition, the poor quality of the floors, walls, doors, fittings and ceilings mean an unfit working environment from a working life, infection prevention and patient experience perspectives. There is insufficient electricity and medical gas outlets per bed. Aged electrical sockets resulting in actual and potential electrical faults - fire in theatres at LRI (Theatre 4) in July 2013. **Consequences:** Periodic failure of the theatre estate (ventilation etc) so elective operating has to cease. Risk of complete failure of the theatre estate so elective and emergency operating has to stop. Increase risk of patient infections. Poor staff morale working in an aged and difficult working environment. Difficulty in recruiting and retaining specialised staff (theatre and anaesthetic) due to poor working environment. Poor patient experience - our most vulnerable patients arrive May impair delivery of life support technologies.	HR	1. Regular contact with plant manufacturers to ensure any possible maintenance is carried out 2. Use of limited charitable funds available to purchase improvements such as new staff room chairs and anaesthetic stools - improve staff morale. 3. TAA building work has started 4. Plan to develop full business case for new recovery build 2013 - start 2014 5. 5S'ing events taking place within the theatre transformation project frame work 6. Compliance with all IP&C recommendations where estate allows 7. Purchase of new disposable curtains for recovery area, reducing infection risk and improving look of environment	Major	Likely	16	Recovery re-build - due 01/12/14 Replacement of all theatre corridor floors and doors - due 31/12/14 (Will not be implemented as no funding for works) Completion of ITAPS nursing recruitment plan - regular monitoring Capital investment and refurbishment of LRI theatres - plan in place and commenced - due 01/12/15 Detailed appraisal from 'Interserve' for LRI site of theatre estate 31 Jan 14	4	PV

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2194	ITAPS	Theatres	Risk of unplanned loss of theatre, recovery or Critical Care capacity across UHL due to insufficient nursing staffing	28/06/2013	31/03/2014	**Causes:** Locally, ITU and theatre nursing staff have been historically difficult to recruit and retain. Turnover regularly negates recruitment efforts and the effects of a poor working environment in a high stress and risk area has meant difficulties in resolving the issue previously. **Consequences:** Increased overtime and waiting list payments required to run the core service. Tired and unmotivated staff in post. Poor staff morale working in an aged and difficult working environment. Difficulty in recruiting and retaining specialised staff (theatre and Critical care) due to poor working environment and low staff morale in general. Reduction in critical care capacity across UHL. Inability to respond to increases in demand in theatre, recovery and critical care capacity. Elective patient cancellations including cancer patients. Critical Care alternatives becoming the norm for high level of care patients e.g. Kinmonth, overnight PACU and specialty "HDU's". Poor patient and carer experience for some of our sickest patients.	HR	1. Use of Bank and Agency staff with block contracts for consistency and cost effectiveness. 2. Regular team and leadership meetings/training events. 3. Rolling adverts in place. 4. International recruitment with HRSS and relevant agencies commenced. 5. Exit interviews used regularly and in line with trust policy to understand issues exacerbating higher than wanted turnover of staff. 6. PULSE check underway/ Health and Safety Stress Assessments 7. Staff engagement strategy being devised and implemented	Major	Likely	16	1. Continuation of monthly rolling adverts - monthly monitoring 31 March 3. Introduction of electronic rostering to standardise shift patterns and maximise efficient use of theatre, recovery and ITU staff - due 30/04/14 (slippage on action due to roll out plans and implementation of theatre off duty into current system) -Consolidate Gynae capacity 31 march 14	4	JHOL

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2191	Musculoskeletal and Specialist Surgery	Ophthalmology	Follow up backlogs and capacity issues in Ophthalmology	12/06/2013	01/10/2014	**Causes:** Lack of capacity within services. Junior Doctor decision makers resulting in increased follow-ups. Follow-ups not protocol led. No partial booking. Non adherence to 6/52 leave policy. Clinic cancellation process unclear, inadequate communication and escalation. **Consequences:** Backlog of patients to be seen. Risk of high risk patients not being seen/delayed. Poor patient outcomes. Increased complaints and potential for litigation.	Patients	Outpatient efficiency work ongoing. Full recovery plan for improvements to ophthalmology service are in process . Outsourcing of follow up patients to Newmedica (IS) has been agreed. All overdue patients will be triaged by them, with the company following up the appropriate patients. The company have agreed to flag high risk patients to us for follow up that do not meet their criteria	Major	Likely	16	Monitor and review impact of NEW MEDICA - 01/10/14.	8	DTR
607	Clinical Support and Imaging	Blood Transfusion	Failure of UHL BT to fully comply with BCSH guidance and BSQR in relation to tracebility and positive patient identification (PP	22/12/2006	02/06/2014	**Causes:** Failure to implement electronic tracking for blood and blood products to provide full traceability from donor to recipient At UHL blood is tracked electronically up to the point of transfer of blood from local fridge to patient with a manual system thereafter which is not 100% effective (currently approximately 1 - 2% (approx 1200 units) of all transfusion recording is non-compliant = 98% compliance). Non-compliance with blood transfusion policies resulting in incorrect identification processes resulting in sample identification and labeling error resulting in wrong blood cross-matched and / or provided for patient (last incident of ABO incompatibility by wrong transfusion approx. 4 years ago (yr 2008); approximately 6 near misses per year). New British Committee for Standards in Haematology (BCSH) guidelines state that unless a secure electronic PPI system is in place for the taking of blood transfusion samples, except in cases of acute clinical urgency, 2 samples on 2 separate ocassions should be tested prior to blood issue. An electronic system would require only 1 samp Critical report received from MHRA in October 2012 in relatic **Consequences:** Potential loss of blood bank licence (via MHRA) with severe Financial penalty for non-compliance due to increased numb	Quality	Policies and procedures in place for correct patient identification and blood/ blood product identification to reduce risk of wrong transfusion. Paper system provides a degree of compliance with the regulations. Training and competency assessment for UHL staff involved in the transfusion process including e-learning and induction training with competency assessment for key staff groups. Regular monitoring and reporting system in relation to blood/ blood product traceability performance within department, to clinical areas and Transfusion Committee.	Major	Likely	16	IMT project approval ;board approval 02.06.2014 ; Develop implementation plan 30.07.2014	4	KJON

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2300	Clinical Support and Imaging	Cardiovascular Procedures	There is a risk of not meeting the national guidelines for out of hours Vascular cover	03/03/2014	30/04/2014	**Causes** From April 2014 there is a requirement to meet a 1in 6 cover for Vascular radiology out of hours service 1 members of staff unable to cover vascular work out of hours Not all staff covering out of hours trained in EVAR procedures **Consequences** Failure to comply with guidelines loss of reputation and service standard Stress for those staff members covering the extra work currently 1in 5 Patient safety Loss of contract income loss/interruption to service provision	HR	Locum cover and partime cover Extra worked covered by existing staff	Major	Likely	16	Business case for 6th vascular radiologist - 30/04/14 Provide training in EVAR technique to those lacking the skills - 30/05/14 Recruitment to 6th Radiologist post - 30/06/14	4	JGI

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2248	Clinical Support and Imaging	Medical Physics	Lack of IR(ME)R training records held across the Trust	14/11/2013	30/04/2014	Although the Trust Radiation Protection Policy states that "IRMER training records must be managed and maintained by individual Directorates (to be changed to Clinical Business Units in the current review) involved in the use of radiation" audits carried out routinely find that these training records are not sufficient, particularly for medical staff. Audits therefore suggest the policy is not being followed. **Causes** Current training records are poorly designed and / or incomplete / do not exist Inadequate or missing training records for IR(ME)R defined roles due to lack of compliance with the Trust policy in some areas. Staff working independently without reaching full competency No central records are kept of which staff have responsibilities under IRMER **Consequences** Lack of suitable training records may result in a failure to comply with standards set by regulatory and healthcare agencies (e.g. HSE / CQC). Failure at assessment might result in financial penalty and / or warning notices being issued. Non-compliance with national standards leading to enforcement action taken on the Trust following a routine ins Increased patient radiation doses due to lack of training. Increased staff doses due to lack of awareness of the potent	Quality	There is a defined method of recording training across the Trust in the Trust Radiation Safety policy. Although this is working in some areas it is not working consistently in all areas. The issue has been raised at the Trust Radiation Protection Committee numerous times where representatives of each Division have been in attendance. This has not so far led to a an increase in compliance. Radiation Protection produced a specific plan of what is required to demonstrate compliance. Mock audit completed 2/12/13. Investigate potential of using e-UHL to deliver a centralised record of IRMER training - Completed 3/3/14 7. CMG and service to manage and maintain records for the staff groups identified - completed 3/3/14	Major	Likely	16	1. Identify Trust staff with responsibilities under IRMER - due 30/4/2014 4. Introduce centralised training records for IRMER compliance - due 30/4/2014 5. Review training in the policy. due 31/5/2014 6. Ongoing monitoring of the effectiveness of the determined method of recording training will be detailed in the new policy. due 31/5/2014	4	MNO

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2245	Clinical Support and Imaging	Medical Records	There is a risk that staff vacancies within the medical records departments will have an impact on service delivery	24/10/2013	30/04/2014	The Medical Records service should be working 14 days in advance for locating routinely requested records, current performance is 3 to 5 days. Many case notes are being located late or not at all with a consequent impact on patient care, causing delays in clinics and delayed decision making on wards in some instances. **Causes (hazard)** High level of turnover and vacancies, predominantly caused by the anticipated impact of the proposed Electronic Document Records Management project. **Consequences (harm / loss event)** Deterioration in service provided due to inability to deal with level of medical records requests leading to cancellation of these and failure to provide service. Patients appointments and elective surgery are being cancelled due to records not being available in some clinical areas with a potential adverse impact on patient care. Delays to emergency flow and extension of length of stay due to a lengthened decision making process (due to lack of available clinical information in a timely manner). Increase in daily internal complaints and Datix incidents and Backlog of cases of 'Access to Health Records' requests, res Case notes overcrowding in Library areas creating a health a	HR	Use of A&C bank staff where possible, though very limited in supply. Use of overtime from remaining substantive staff (though dwindling due to length of time during recruitment process; staff are under pressure). Reduction / cancellation of staff attendance at mandatory training (though with clear consequent impact on this Trust deliverable target). Cancellation of non-clinical requests for case notes daily (e.g. audit) to minimise disruption to front line clinical need (though with clear consequent impact on other areas of service delivery). On going urgent recruitment to existing vacancies. A waiting list of suitable applicants has been created to minimise the risk of the current staffing levels reoccurring in the future. Medical records management supporting HRSS by chasing references and other checks. Daily review of staffing levels and management of requests with concentration of staffing in areas of greatest demand and clinical priority.	Major	Likely	16	Continuing review of short-term reduction in service for non-clinical requests for case notes located within specialty areas of UHL (records within library areas will continue to be located). Communication to affected clinical areas as required - 30/04/2014. Monitoring and review of need for short-term agency usage (limited bank availability) to make library locations safe - 30/04/2014 Continuation of substantive overtime and utilisation of bank staff if available - 30/04/2014 Monitoring storage capacity in the libraries - 30/04/2014	6	CSH

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2307	Clinical Support and Imaging	Special Biochemistry	The Forensic Toxicology service will fail resulting in a substantial loss of income and prestige for the Department/empath	17/02/2014	02/05/2014	**Causes:** The Coronial Forensic Toxicology workload will treble in January after the appointment of a new consultant Toxicologist. Work previously analysed in Sheffield will transfer to Leicester in January 2014. - insufficient qualified and experienced staff to perform analysis and interpret and report findings. - insufficient analytical platforms to perform analysis and address workload. - insufficient staff and time to administer increased workload **Consequences:** There are no resources in place for our Forensic Toxicology department to be able to process this workload in a timely manner. We will fail the agreed targets with our current users of the service. Failure to address the above will result in loss of current Toxicology contracts.with a large loss of income. Loss of prestiege will compromise our ability to win new contracts in the future.	Patients	Staff are working extra sessions and overtime at weekends but this is not sustainable in the long term. This doesn't address the lack of analytical time available on the current equipment.	Major	Likely	16	Recruitment/Transfer of staff -02.05.2014 ;Procure additional LCMS platform - 02.06.2014;Procure Forensic LIMS - 02.05.2014	4	BDI

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2153	Women's and Children's	Paediatrics	Shortfall in the number of qualified nurses in Children's Hospital including ECMO staffing and Capacity	05/03/2013	30/04/2014	**Causes** The Children's Hospital is currently experiencing a shortfall in the number of appropriately qualified Children's nurses. This is in part due to the increased numbers of staff on maternity leave and the issues with recruiting Children's trained nurses. The demand for PICU beds currently outweighs capacity. There is an establishment of 6.5 beds but due to vacancies and long-term sickness/maternity leave the unit is currently only able to run at maximum capacity of 6 beds and on specific days only 5 beds (depending on the overall ECMO activity across adults and children). In addition to NHS activity the Trust has contracted to provide cardiac surgery for a cohort of Libyan children. At the time that the contract was developed (Nov-December 2012) it was assessed that there would be sufficient capacity to operate on one child per week without impacting on NHS Activity. However, the current staffing and long-term profile of patients on PICU has resulted in pressures on both NHS work and the delivery of the Libyan contract. Currently there are vacancies for 5.82 wte qualified and 1 wt **Consequences** There is a short fall in the number of appropriately qualified c Balancing the demand for PICU beds between NHS contract Unsafe staffing levels, therefore unable to provide the recom	HR	The bed base in Leicester Royal infirmary has been reduced. There is an active campaign being undertaken to recruit new nurses from around the country. Additional health care assistance have been employed to support the shortfall of qualified nurses. No further Libyan patients are being operated on until agency staff can be recruited to support their PICU stay or until the patient flow changes on PICU to allow week-end operating which does not compromise week-day operating or access to PICU. Active Recruitment in progress Educational team cover clinical shifts Cardiac Liaison Team cover Outpatient clinics Overtime, bank & agency staff requested Lead Nurse, Matron and ECMO Co-ordinator cover clinical shifts Children's Hospital & Adult ICU staff cover shifts The beds on Ward 30 have been reduced from 13 to 10 PICU beds are closed where necessary	Major	Likely	16	Recruitment of suitably trained/experienced agency PICU/ECMO/ward nurses - due 30/4/14	8	LBLA

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697	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 Risk monitored at Board level in Board Assurance Framework.	Major	Likely	16	Consultation and Engagement actions	12	KMAY

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1312	Communications		Poor quality of information on UHL document management system (DMS)	17/12/2009		Documents are not managed properly by UHL owners (staff) ie. Have an owner, are version controlled, are managed appropriately through their lifecycle then they become worthless to the user trying to access them because the user cannot be sure the document is timely or accurate. The further development of standards in a UHL records management programme is currently on hold (Jan 2013) due to organisational restructure and removal of records manager post. UPDATE Jun 2013: migration and testing in progress. Further development work required for completion. Agreed with Ascribe consulting - cost £7k. UPDATE Sep 2013: migration of data complete for informatics; rest of docs migrated across by Nov 13. Lead person on project put at risk of redundancy Oct 13 which increases risk of not completing project. UPDATE DEC 2013: Handover plan to IM&T in place and progressing.	Quality	Internal documented procedures at http://insite.uhl.nhs.uk/document management. Asst Knowledge Manager provides all training. Discussion with HR Training to take on user training due May 2013. System supported by IM&T via an Operating Level Agreement April 2013. Update Sep 2013: IM&T will take on the duties of the project lead for sharepoint.	Major	Likely	16	User support is limited with only one corporate administrator. Improve user support processes. DMS to be replaced with Sharepoint: review support and document management processes	6	SAN

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2237	Medical Directorate		Risk of results of outpatient diagnostic tests not being reviewed or acted upon resulting in patient harm.	07/10/2013	30/06/2014	**Causes** Outpatients use paper based requesting system and results come back on paper and electronically. Results not being reviewed acknowledged on IT results systems due to; Volume of tests. Lack of consistent agreed process. IT systems too slow and 'lock up'. Results reviewed not being acted upon due to; No consistent agreed processes for management of diagnostic test results. Actions taken not being documented in medical notes due to; Volume of work and lack of capacity in relation to medical staff. Lack of agreed consistent process. Referrals for some tests still being made on paper with no method of tracking for receipt of referral, test booked or results. Poor communication process for communicating abnormal results back to referring clinician; Abnormal pathology results- cannot always contact clinician that requested test and paper copies of results not being sent to correct clinicians or being turned off to some areas. Suspicious imaging findings- referred to MDT but not always also communicated back to clinician that referred for test. Lack of standards or meeting standards for diagnostic tests i	Patients	Abnormal pathology results escalation process Suspicious imaging findings escalated to MDTs	Major	Likely	16	Implementation of Diagnostic testing policy across Trust - to ensure agreed speciality processes for outpatient management of diagnostic tests results. March 14 Development IT work with IBM to improve results system for clinicians and Trust to develop EPR with fit for purpose results management system. - Jan 16	8	CER

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2271	Nursing		Failure to achieve compliance of 75% attendance at Safeguarding training may have adverse impact on UHL safeguarding processes	11/12/2013	31/03/2014	**Causes:** Adult Safeguarding e-learning modules have only been available for the last 4/5 months as previous programme was not SCORN compliant and due to length of development had to then be further reviewed to ensure accuracy of content. Safeguarding Childrens e-learning modules have also only been available since early 2013. Poor uptake for medical staff training. Difficulties in releasing staff to undertake training. Lack of staff awareness in relation to the availability of an e-learning module. Current accuracy of e-UHL data is questionable. e-UHL does not show the individual the training that is required to be undertaken. **Consequences:** Delays in Safeguarding referrals and / or referrals to wrong agency leading to: Potential for loss of evidence. Greater risk of harm. Patient discharged prior to alert being raised. Additional staff time required to retrospectively resolve issues. Non-compliance with CQC outcomes. Potential for critical reports from OFSTED/ CCGs etc. Loss of good reputation as specific safeguarding cases are publicly reportable. Potential for 'Rule 43' to be applied.	Quality	Safeguarding team and Safeguarding web pages to provide guidance in relation to Safeguarding issues. New SCORN compliant e-learning package developed and live on e-UHL. Face to face training carried out by Divisional education teams in clinical Divisions (now CMGs) since April 2012 to cover gaps in safeguarding training programme.	Major	Likely	16	Incentivise medical staff attendance for safeguarding training - 31/03/14. Continue to develop -eUHL to ensure that individuals are aware of their mandatory training requirements - 31/03/14. Implement protected learning time for clinical staff - 31/03/14. Validate e-UHL attendance data - 31/03/14. Implement more effective management control in relation to non-attendance - 31/03/14. CMG education leads to raise awareness of Safeguarding training at local level - 31/03/14. Advertise Safeguarding training on InSite - 31/03/14.	6	MCLA

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2247	Nursing		There are 500 Registered Nurse vacancies in UHL leading to a deterioration in service and adverse effect on financial position	30/10/2013	31/05/2014	**Causes:** Shortage of available Registered Nurses in Leicestershire. Nursing establishment review undertaken resulting in significant vacancies due to investment. Insufficient HRSS Capacity leading to delays in recruitment. **Consequences:** Potential increased clinical risk in areas. Increase in occurrence of pressure damage and patient falls. Increase in patient complaints. Reduced morale of staff, affecting retention of new starters. Risk to Trust reputation. Impact on Trust financial position due to premium rate staffing being utilised to maintain safety. Increased vacancies across UHL. Increased pay bill in terms of cover for establishment rotas prior to permanent appointments. HRSS capacity has not increased to coincide and support the increase in vacancies across the Trust. Delays in processing of pre employment checks due to increased recruitment activity. Delayed start dates for business critical posts. Benefits of bulk and other recruitment campaigns not being realised as effectively as anticipated and expected. Service areas outside of nursing being impacted upon due to	Patients	HRSS structure review. A temporary Band 5 HRSS Team Leader appointed. A Nursing lead identified. Recruitment plan developed with fortnightly meetings to review progress. Vacancy monitoring. Bank/agency utilisation. Shift moves of staff. Ward Manager/Matron return to wards full time.	Major	Likely	16	Over recruit HCAs. - 31/05/14 Utilise other roles to liberate nursing time - 31/05/14	12	CRIB

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2318	Operations		Blockaged drains causing leaks and localized flooding of sewage	17/03/2014	01/07/2014	**Causes (hazard)** Aging infrastructure that can no longer cope with the volume of sewage due to restrictions and narrowing of the pipes Staff, visitors and patients placing materials other than toilet paper into the drainage system Staff placing non maceratorable items in the macerators causing breakages and loss of containment Back flow sink drains are unprotected resulting in foreign bodies **Consequences (harm / loss event)** Blockages build up easier and the older pipes cannot cope with the additional pressure causing leaks of raw sewage into occupied areas. Approximately 250 calls a month are being received by LRI estates relating to blockages Pipes cannot cope with the non-degradable materials and flooding occurs Localised flooding of clinical areas often involving areas on the floors below Foreign bodies block the drains and cause back fill and overspill of sinks and other facilities Clinical areas and staff areas become contaminated with raw sewage, ED 21st September, 12th August EDU 25th September, Ward 8 23rd August, ITU and CT 5th August. Patients contaminated with sewage from leaks in the ceilings Whilst repairs are underway it may become necessary to iso Potential media coverage (one request for information from L Quality and safe delivery of care will be compromised in area Risk to health and safety of staff from an unsafe working env	Statutory	Interserve and Hospital response teams. Awareness raised at local inductions. Business Continuity Plans. Communications and awareness with staff - poster campaign (launched September 2013). Approval for drain survey (Kensington and Balmoral Building).	Major	Likely	16	Samples of suitable wipes to be considered (dissolvable/maceratorable) to NET and decide from there. Liz Collins - due 31.3.14 Implement single choice patient wipes from end of March. Liz Collins/ Jeff Oliver - due 31.3.14 Discuss use of patient wipes in toilets with NET. Liz Collins - due 31.3.14. Survey being done in Kensington and Balmoral. Nigel Bond - due 19.4.14. Cost of replacement of stacks to be assessed. Nigel Bond - due 30.4.14. Need to link to new emergency floor. Phil Walmsley - due 31.3.14. Jet washing pipes. Andrew Martin due 30.4.14. To check macerator posters and if necessary contact with company with regards to posters on limiting numbers of items in macerator. Aaron Vogel - due 31.3.14. Comms campaign to be revisited. Tiff Jones - due 31.3.14.	2	PWA

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1693	Strategy		Risk of inaccuracies in clinical coding	02/08/2011	31/03/2014	**Causes:** Casenote availability. 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 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. 3 year refresher programme completed November 2011. Quarterly updates/briefings to be led by Asst Director of Information - commenced April 2012. Team restructure Annual External Audit Internal Audit - commences November 2013 Audit Committee updates Clinical Coding Manager has a regular slot on Junior I Improvement and Innovation Framework Board - stan	Major	Likely	16	Succession Planning for Coding Manager - 31/03/14 CIP - to increase income for Trust by £1.5m - 31/03/14 Review the priority of this risk after go live with the encoder as all actions will have been taken - 30/06/14	8	JRO

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1737	RRC	Renal Transplant	Inappropriate environment and infection prevention Renal Transplant	25/10/2011	31/03/2014	**Causes:** 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. **Consequences:** Poor compliance with cannula care. Challenges in maintaining integrity of commode lids using Chlorclean. Infection prevention risks. 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	15	JPR
2070	RRC	Satellite Units	Harborough Lodge environment stops staff safely delivering haemodialysis	16/08/2012	31/03/2014	**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. Increase in number of 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 - 31/03/2014	5	JPR

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2275	Emergency and Specialist Medicine	Rheumatology	There is a lack of robust clinical processes relating to Subcutaneous Methotrexate therapy due to staff shortages	02/01/2014	28/02/2014	**Causes** There is no dedicated person within rheumatology or pharmacy to generate the scripts for Subcutaneous Methotrexate (ScMTX). **Consequences** Patient safety - Patients often do not receive their drug on time, and as a result have worsening joint pains and in some cases have a flare of their arthritis. This can often result in an emergency out-patient clinic visit and sometimes can rarely even precipitate an emergency hospital admission. Quality - Increase in the amount of complaints being received with Service being considered sub-optimal by patients and GPs as well as hospital clinical staff. Human Resources - Late delivery of services for patients due to the lack of appropriate staffing resources. Increased workload to the Specialist Nursing team.	HR	Short-term resource has been assigned to clear the backlog ;A Junior Dr is supplying short-term overtime; admin resource has been assigned to the CNS team to release their time for other duties. Pharmacy Lead is pushing the recruitment into the pharmacy prescriber role.	Moderate	Almost certain	15	Review of Service Requirements for Rheumatology Specialist Nurses - capacity, establishment, admin support - including short term medical cover to support Junior doctor assisting with Scripts - technician identified for Specialist Nursing team 28/02/14 *** 14/3/24 Jnr Dr has been managing the prescribing list since Dec 13 and the overtime costs recharged to the budget in pharmacy that the recruitment was meant to have come from. Admin function introduced - will pay for itself via helpline virtual clinic set up Pharmacy prescriber role to be filled - Lead pharmacy role for this service provision is crucial for this system to work efficiently 31/3/14 24/3/14 still o/s Lessons learned exercise to understand in order to establish a more robust communications plans with patients Letter issued to all clinicians and GPs requiring them to notify CNS/Admin team immediately of any bloods frequency/dose changes required. Improvements to be tracked Delays caused by Rheum Clinicians and Pharmacy working to different parameters. JF and pharmacy to meet and agree use of Chemocare parameters movir Changes made to data shared between CNS team LF DAWN data load is manual and first record can only b	2	LDAL

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1196	Clinical Support and Imaging		No comprehensive out of hours on call rota for consultant Paediatric radiologists	29/06/2009	30/04/2014	**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	Recruit to Consultants vacancies - due 01/06/14	2	RG

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1157	Clinical Support and Imaging	Medical Physics	Lack of planned maintenance for medical equipment maintained by Medical Physics	14/05/2009	30/04/2014	**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. Develop robust mechanism to ensure the revenue consequences of maintenance for medical equipment purchases are identified - 30/9/13 - completed Develop process to allow appropriate funding for Medical Physics to ensure programmed maintenance can be performed - completed 2/12/13	Moderate	Almost certain	15	Secure funding to increase current staff base for Medical Physics technical staff or outsource maintenance contracts - 31/5/14 Quantify the shortfall in maintenance provision from existing resources and identify to the Trust (to enable Trust decision on corrective to be made) - 31/5/14 Establish infusion pump libraries at LGH and LRI - 31/12/14	6	MNO

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2278	Women's and Children's		Risk that the Leicester Fertility Centre could have its licence for the provision of treatment and services withdrawn	17/12/2013	04/05/2014	**Causes:** Inadequate staffing levels and inappropriate quality systems in place. ISO 15189 accreditation would be an outcome if the service was adequately staffed with appropriate quality systems in place. **Consequences:** Patient safety and quality issues if unable to deliver service. Financial impact if patients choose to move elsewhere or NHS contracts not obtained. Risk to Trust reputation. Challenging external recommendations/improvement notice from HFEA - critical report received Feb 2013.	Statutory	1 fulltime trained Embryologist to a national recognised level 3 part time trained Embryologist to a national recognised level 1 0.8wte Band 6 BMS	Moderate	Almost certain	15	Review of protocols to ensure meet ISO 15189 standards - due 30/4/2014. Improve information for patient and service users - due 30/4/2014. Formulation of business plan for Quality Manager post - due 30/4/2014. Overhaul of specimen request, collection and delivery procedures - due 30/4/2014. Review of the need for a automated semen analyser due 30/4/2014.	6	DMARS

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1310	Medical Directorate		Risk of user error associated with non-standardisation of manual and automated external defibrillators	16/12/2009	30/04/2014	**Causes:** 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. Medical staff using the defibrillator will rotate to other sites within the Trust. Internal audit shows further education and training is required to train clinical staff. **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 Standard	Patients	Defibrillation training programme in place which highlights the issues. Defibrillator will give automated instructions (depending on clinical setting). Internal Alert issued and closed for clinical areas.	Extreme	Possible	15	Training and educating staff to use new defibs - due 30/04/14	5	LR
2272	Nursing		Failing to meet internal and external targets in relation to undertaking IG training may adversely affect UHL compliance with IP	11/12/2013		**Causes:** Lack of availability of face to face IG training sessions. Previous on-line e-learning facility increasingly unreliable **Consequences:** Potential for an increase in IG incidents leading to: Adverse media attention and loss of good reputation. Fines from the Information Commissioner. Critical reports from external regulators.	HR	Blended learning using work books and e-learning. New IG e-learning package has been developed (live since mid October 2013). Already seeing an improvement in compliance rates.	Moderate	Almost certain	15	Market new on-line session Re-issue workbook and FIT training	6	RSMI

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2268	Nursing		Failure to meet targets for Moving and Handling training may adversely affect patient care /staff safety / quality	11/12/2013		**Causes** Lack of dedicated training space/venues. Possible inaccuracies in e-UHL data (M&H records held by M&H team identify approx. 11,000 staff trained). Some areas have reduced training opportunities for staff from every year to 2 yearly against the advise of the MH service. **Consequences** Increased risk of patient and/ or staff injury during moving and handling. Risk to reputation of the Trust if an outlier against national targets. Gross failure to meet national standards.	Quality	Cascade training utilised within UHL (approx 160 trainers available). Direct input from UHL M&H team in relation to MH processes/ equipment etc. e-learning package available from October 2013.	Extreme	Possible	15	Redesign of induction training to ensure appropriate level of M&H training Implement weekly M&H training to smaller groups	9	NH
2270	Nursing		Failure to achieve compliance of 75% attendance at Fire Safety training may cause UHL to fail to meet its statutory obligation	11/12/2013	31/03/2014	**Causes:** CMG mandatory training study days may not be capturing the specific Fire Safety training as an individual component of the day therefore bringing into question the accuracy of e-UHL data. Difficulty in releasing staff to attend Fire Safety training (10 - 15% rate of non-attendance following booking). Lack of venues for additional sessions. Lack of managerial action re repeat non-attendees. **Consequences:** Non-compliance with statutory obligation. Potential non-compliance with CQC outcomes. Potential for staff / patient safety to be adversely affected in the event of a fire (it must be noted that no incidents recorded are attributable to lack of staff training). Loss of good reputation.	HR	Existing training developed to ensure that refresher training on alternate years can be via a e-learning module for non-clinical staff. Face to face training run at differing times in an attempt to satisfy everyone's needs.	Moderate	Almost certain	15	Increase the number of fire safety training sessions to two per month at each site (if venues are available) - 31/03/14. Education leads to be made aware that mandatory training days must be broken into their specific components on e-UHL in order to ensure attendance is accurately recorded - 31/03/14. Raise awareness of fire safety training via utilisation of Intranet and PC desktop messages - 31/03/14. Incentivise medical staff attendance - 31/03/14.	9	GBRO

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2269	Nursing		Failure to meet UHL target of a minimum of 75% of clinical staff undertaking IP/Hand hygiene training	11/12/2013	31/03/2014	**Causes:** Poor attendance rates for all staff groups (UHL compliance 58%). Staff not released to undertake IP face-face training. e-UHL has not signposted Infection Prevention training for Clinical Staff. UHL is unable to demonstrate that all clinical staff within the trust has received Infection Prevention Training (including Hand Hygiene). **Consequences:** Poor attendance may be a contributory factor to patients acquiring Healthcare Associated Infections. Financial impact of CDT infections in relation to CCG fines. Potential risk of staff acquiring infections through lack of basic hand hygiene. Non-compliance with national standards (CQC, Health and Social care Act 2010).	Patients	High risk areas (e.g. with increased infection rates, SI) targeted for focused training. Active liaison with Clinical Skills Unit and UHL Education and Training team to resolve issues.	Extreme	Possible	15	e-learning package to be re-developed to meet core skills framework and UHL requirements. 31/03/14. Hold discussions with Medical Director to incentivise medical staff attendance for hand hygiene 31/3/2014. Ensure e-UHL accurately signposts relevant staff to their role specific Infection Prevention training requirements. 1/4/14. Ensure e-UHL accurately signposts relevant staff to their mandatory Infection Prevention training requirements 1/4/14. Develop more robust links with medical staff training team. 31/3/14. Refine job role of link staff network to support ward managers in raising IP awareness at a local level. 31/3/14. Ward Managers to use observed assessment of ANTT for nurses and discuss the process for assessment of medical staff with medical staff training team. 31/3/14.	10	LCOL
1551	Nursing		Failure to manage Category C documents on UHL Document Management system (DMS)	14/03/2011	31/03/2014	**Causes:** Lack of resource at CMG/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) which could impact on patient care.	Quality	Head of Outcomes & Effectiveness has discussed the problems with CMGs to identify which documents can be managed at local level. 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 DMS and migrate to 'SharePoint' - 31/03/2014	9	SH