To:	**Trust Board**
From:	**Rachel Overfield - Chief Nurse**
Date:	**29 May 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 30 April 2014.
b) An action tracker to monitor progress of BAF actions
c) New extreme and/ or high risks opened during the reporting period.

The Report is provided to the Board for:

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

Summary :

- This 'interim' 2014/15 BAF provides a continuation of the previous 2013/14 BAF until such time that a full review of the contents is performed.
- The Trust Board is asked to note the following:
  a. The increase in the risk score of risk number five from 16 – 25.
  b. An increase in the risk score of risk number three from 16 – 20.
  c. Significant 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.
  d. In relation to action 11.11, the receipt of a draft business continuity escalation plan from Interserve and subsequent movement from a RAG rating of red to amber.
- The UHL BAF requires review to ensure it aligns with the recently revised and agreed strategic objectives for 2014/15 and following this a fully revised BAF will be submitted for consideration to the TB meeting in June 2014.

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: **29th MAY 2014**

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

SUBJECT: **UHL RISK REPORT INCORPORATING THE BOARD ASSURANCE FRAMEWORK (BAF) 2014/15**

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1. INTRODUCTION

1.1 This report provides the Trust Board (TB) with:-

a) A copy of the BAF as of 30 April 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.

2. BAF POSITION AS OF 30 APRIL 2014

2.1 A copy of the 2014/15 'interim' BAF is attached at appendix one with changes since the previous version highlighted in red text. A copy of the action tracker is attached at appendix two. Actions completed prior to April 2014 have been removed from the tracker and a full audit trail of these is available by reference to previous documents.

2.2 The 'interim' 2014/15 BAF provides a continuation of the previous 2013/14 BAF until such time that a full review of the contents is performed.

2.3 The TB is asked to note the following points:

a. After consideration at the previous TB meeting, an increase in the risk score of risk number five from 16 – 25.

b. Following advice from the Director of Human Resources and the Chief Nurse an increase in the risk score of risk number three from 16 – 20 to take account of the staffing required for the additional bed capacity and the difficulties that may be encountered in recruiting to these posts.

c. The significant delay to the completion of action 3.3 due to the staff side's intention to ballot members in relation to one element of the proposed pay progression criteria. It is expected that the ballot will be completed by September 2014.

d. In relation to action 11.11, the receipt of a draft business continuity escalation plan from Interserve and subsequent movement from a RAG rating of red to amber.

e. In instances where action completion dates have slipped there are no associated increases to the current risk scores.

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 9 – Failure to achieve and maintain high standards of operational performance.
- Risk 10 – Inadequate reconfiguration of buildings and services.
- Risk 11 – Loss of business continuity.

3 REVIEW OF THE 2014/15 BAF

3.1 The UHL BAF requires review to ensure it aligns with the recently revised and agreed strategic objectives for 2014/15 and a fully revised BAF will be submitted for consideration to the TB meeting in June 2014.

4. EXTREME AND HIGH RISK REPORT.

4.1 The TB is asked to note that three new high risks have opened during April 2014 as described below. The details of these risks are included at appendix four.

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Risk ID	Risk Title	Risk Score	CMG/Corporate Directorate
2236	Risk to patient/staff safety due to security staff not assisting with restraint	25	Corporate Nursing
2333	Risk of increased mortality due to ineffective implementation of best practice for identification and treatment of sepsis	20	Corporate Medical
2234	Lack of paediatric cardiac anaesthetists to maintain a WTD compliant rota leading to service disruption and loss of resilience	20	ITAPS

5. RECOMMENDATIONS

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

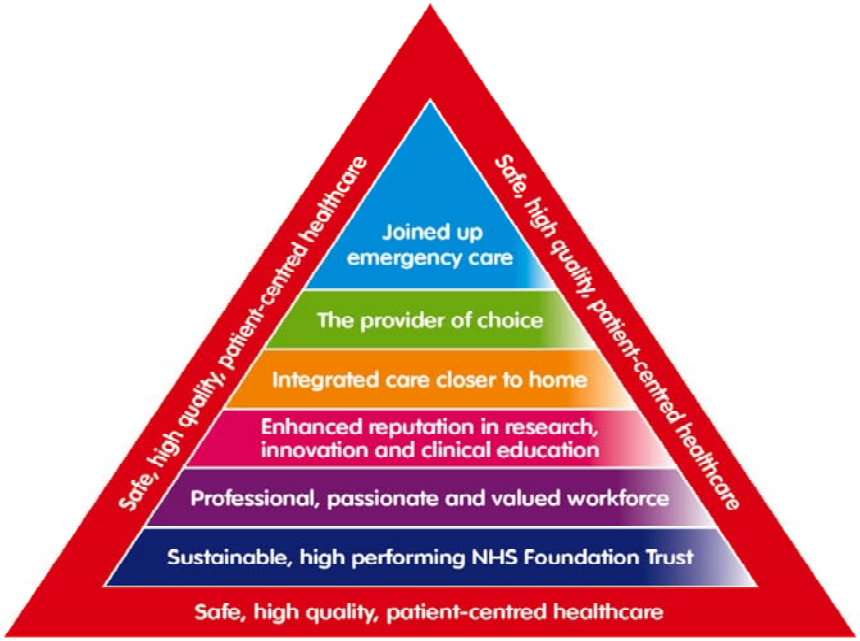
(a) review and comment upon this iteration of the BAF, as it deems appropriate:

(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;


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

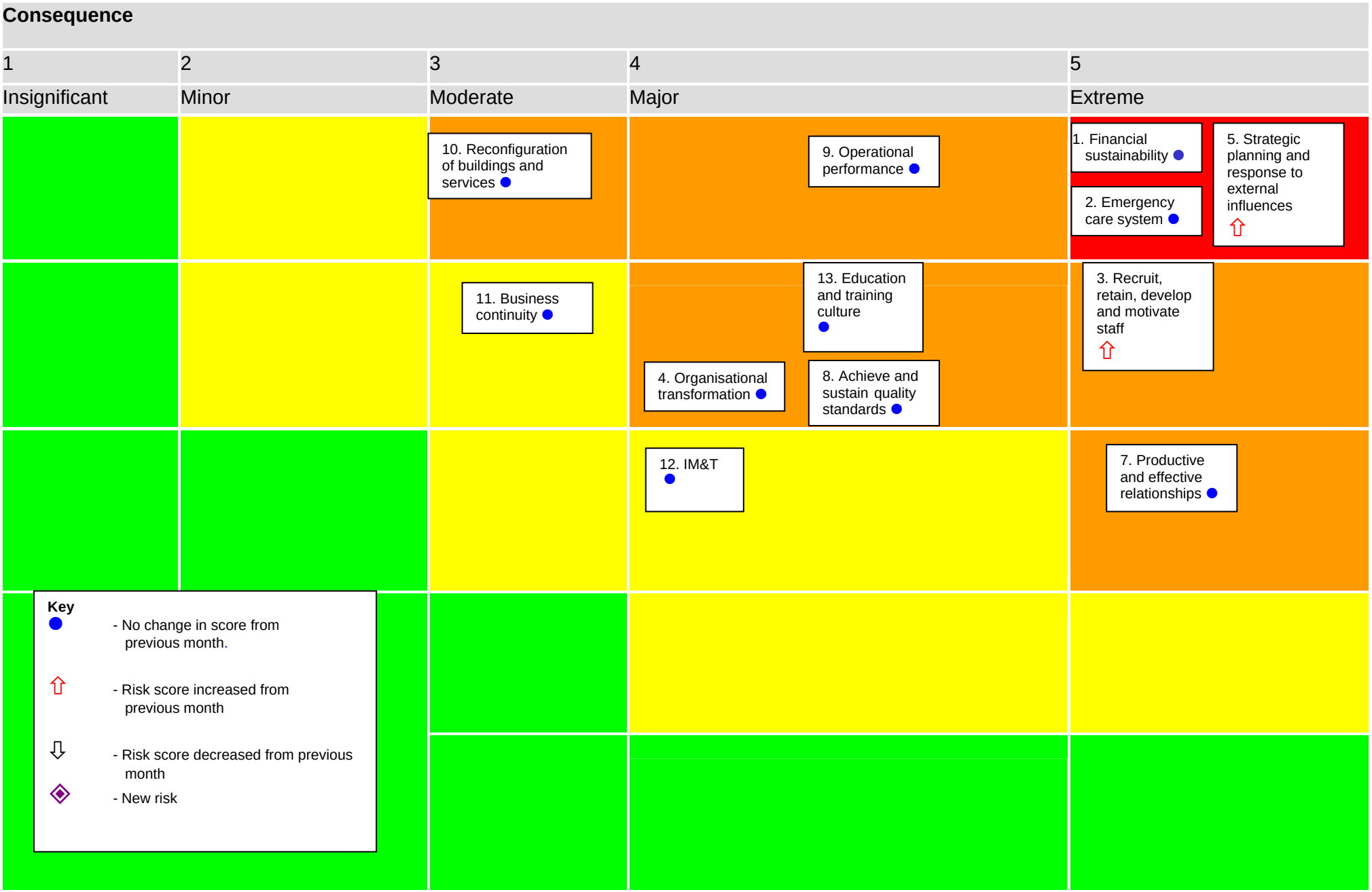
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK (INTERIM) APRIL 2014

PERIOD: APRIL 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.	20	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	25	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.	**d - To be the provider of choice.**
b - To enable joined up emergency care.	**e - To enjoy an enhanced reputation in research, innovation and clinical education.**
c - To be the provider of choice.	**f - To maintain a professional, passionate and valued workforce.**

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK (INTERIM) APRIL 2014



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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK (INTERIM) APRIL 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

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 (INTERIM) APRIL 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)		May 2014 IDFS May 2014 IDFS
Failure to effectively manage financial performance	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 Sign-off' 'of local finance plans		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. (	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)		Jun 2014 IDFS Jun 2014 Jul 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)		May 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 (INTERIM) APRIL 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 (INTERIM) APRIL 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.	4x5=20	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 and are reported monthly to Board via Quality and Performance report	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).		Jul 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).		Sep 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 attendance data from e-UHL via reports to TB and ESB against 9 key subject areas (				

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.	5x5=25	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 including engagement with the Trust's Commissioners	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
	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').						
	The Board to meet 3 times per year in external venues hosted by stakeholders						
	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 Board				

	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. 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 (INTERIM) APRIL 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	To open an additional 55 beds iteratively until February 2015 (9.15)	4x3=12	COO Feb 2015
	Transformational theatre project to improve theatre efficiency to 80 -90%.		Monthly theatre utilisation rates. Theatre Transformation monthly meeting. Transformation update to Board.	No gaps identified.	No actions required.		

	Emergency Care process redesign (phase 1) implemented 18 February 2013 to improve and sustain ED performance.		Monthly report to Trust Board in relation to Emergency Dept (ED) flow (including 4 hour breaches).	See risk number 2.	See risk number 2.		
	Cancer 62 day performance - Tumour site improvement trajectory agreed and each tumour site has developed action plans to achieve targets. Senior Cancer Manager appointed. Lead Cancer Clinician appointed. Action plan to resolve Imaging issues implemented.		Cancer action board established and weekly meetings with all tumour sites represented. Monthly trajectory agreed and Cancer action plan agreed with CCGs 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 (INTERIM) APRIL 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.		

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inability to react /recover from events that threaten business continuity leading to sustained downtime and inability to provide full range of services.	Major incident/business continuity/ disaster recovery and Pandemic plans developed and tested for UHL/ wider health community. This includes UHL staff training in major incident planning/ coordination and multi agency involvement across Leicestershire to effectively manage and recover from any event threatening business continuity. Tailored training packages for service area based staff. 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).		May 2014 COO Jun 2014 COO
			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 Jun 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 (INTERIM) APRIL 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 Review Jun 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.				

	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. Paperwork and processes have be re-modelled and issued to all IM&T project staff to ensure they work to required standards.		Minutes of the joint governance board, the transformation board and the service delivery board. Benefits are part of all the projects that are signed off by the relevant groups.	. (c) 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.	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)		Jul 2014 CIO Jul 2014 CIO
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. Monthly meetings with a nominated lead to discuss projects and overall performance with the CMGs. Enhanced communications with the CMGs to include new opportunities that they could consider within their planning processes going forward		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	Monitor the meetings and review for effectiveness (12.23)		Jul 14 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	(c) Agree LLR joint priorities for 2014	Invite key external parties to be part of the significant projects. The first of these will be the EPR project (12.24) Further work through the IM&T strategy board is required to refine the large set of requirements into a realistic deliverable plan (12.22)		Jul 14 CIO May 2014 CIO

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	Jun 2014 MD
	UHL Education Committee. 'Doctors in Training' Committee established. Education and Patient Safety. Links with LEG/ QAC and EQB		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).		Jun 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 Oct 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)		Jun 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	**April 2014**
Frequency of review:	Monthly
Date of last review:	March 2014

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, but reliant on and overlap with the delivery of outputs from the Challenged Health Economy work	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~~ May 2014	On track Meeting with CCG arranged for 29/04/14 but this will only cover the evaluated 'green' schemes. The balance of the Q&A cannot be completed until red CIP schemes have been defined.	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	IDFS		July 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

	via MoC.					
1.29	'Sign-off' 'of local finance plans.	IDFS		April 2014	**Complete.**	5
1.30	Negotiate realistic contracts with CCGs and Specialised Commissioning	IDFS		~~April~~ May 2014	On track. Discussions at CEO level continue but the Trust is unable to reach agreement on the consequences of fines and penalties. The Specialised services contract is ready to sign but national issues prevent progress. Situation is being escalated with TDA and NHSE	4
2	**Failure to transform the emergency care system**					
2.7	Continue with substantive appts until funded establishment within ED is achieved.	COO	HO	Review ~~Sept~~ ~~Nov 2013~~ ~~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~~ September 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. A formal intention to ballot was received on 30.04.14 with indicative timescales that this will be completed by September 2014. Timescale for action completion adjusted to reflect this	3
3.7	Update e-UHL records to ensure accuracy of reporting on a real time basis	DHR	ADLOD	Review April ~~March~~ 2014	**Complete.** System interface issues resolved to ensure accuracy in reporting Statutory and Mandatory Training completion real time. OCB Media currently working on putting together a detailed specification that will meet business requirements set out in the Project Specification document	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

3.9	Develop an employer brand and maximise use of social media to describe benefits of working at UHL	DHR		~~April~~ July 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. Linkedin to be used to promote upcoming recruitment campaigns. There has been an extension to timescales for completion due as UHL needs to acquire a credit card in order to register for Linkedin for advertising and we need to find a way to progress this	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

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

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**					
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**					
9.14	UHL Exec Team to discuss and consider implementing ring-fenced facilities to avoid cancellation of operations on the day due to lack of beds	COO		April 2014	**Complete.** ET agreement to open additional 55 beds iteratively until February 2015	5
9.15	To open an additional 55 beds iteratively until February 2015	COO		Feb 2015	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	Capital funding requirements will be reflected in the LTFM for additional PDC as part of the Service and Financial plan (see 1.24)	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. Capital funding requirements will be reflected in the LTFM for additional PDC as part of the Service and Financial plan (see 1.24)	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

11	**Loss of business continuity**					
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~~ June 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 scheduled (19/05/2014) to review process and determine an appropriate process. Deadline extended to reflect this.	3
11.11	Further work required to develop escalation plans and response plans for Interserve.	COO	EPO	~~October~~ ~~December 2013~~ ~~March~~ ~~April~~ May 2014	Draft escalation plan received 1st May. To be reviewed and implemented. Deadline extended to reflect this.	3
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
11.16	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	We have achieved the ISO 27001 accreditation which has been externally validated.	4
12	**Failure to exploit the potential of IM&T**					

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

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		Review June 2014	Significant work still needed to assess the 2016 planning horizon and what all the elements of UH:\CMG\LLR plans mean with regards to IM&T	2
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	**Complete.** CMIOs have reviewed their current engagement activities and feel that they have the appropriate mechanisms in place.	5
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	**Complete.** Paperwork and processes have be re-modelled and issued to all IM&T project staff	5
12.17	Post project benefit realisation plans and ownership is identified at pre-commencement phase to ensure the total work is identified.	CIO		July 2014	Paperwork and processes have be re-modelled and issued to all IM&T project staff. Further work required to test the output from this work	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

12.18	Requirements and benefits are fully signed off prior to any work commencing	CIO		July 2014	Paperwork and processes have be re-modelled and issued to all IM&T project staff. Further work required to test the output from this work	4
12.19	Re-establish monthly meetings with a nominated lead to discuss projects and overall performance with the CMGs	CIO		April 2014	**Complete.** Meetings have been established. A further review of the effectiveness is planned	5
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	**Complete.** Senior IM&T and IBM staff have met with all CMGs to discuss planning and opportunities from IM&T investments.	5
12.21	To provide a plan/dates to the relevant NTDA bodies of the expected business case release plan	CIO		March 2014	**Complete.** Planned dates were submitted to the NTDA.	5
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
12.23	Monitor the monthly meetings with nominated leadss and review for effectiveness	CIO		July 2014	On track	4
12.24	Invite key external parties to be part of the significant projects. The first of these will be the EPR project	CIO		July 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~~ June 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. New meeting date 6/6/14.	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

13.2	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~~ June 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. New meeting date 6/6/14.	3
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~~ October 2014	Odames Ward due be handed over on 1st February for work to start on 1st April 2014. However during April there was a delay as there was the possibility that the ward may potentially be used for patients. This is now deemed not feasible and therefore a start date for work to convert to a library will begin on 23/6/14 with a completion date of October 2014. Completion date extended to reflect this.	3
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~~ June 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. New meeting date 6/6/14.	3

Key

CEO	Chief Executive Officer
IDFBS	Interim Director of Financial Strategy
MD	Medical Director
AMD	Assistant Medical Director

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

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

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

Appendix three

University Hospitals of Leicester NHS Trust

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

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

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

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

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

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

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

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

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

8) Are the assigned risk scores realistic?

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

Appendix - Risk Scoring 15 or above opened during April 2014

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
2325	Nursing	Nursing	Risk to patient/staff safety due to security staff not assisting with restraint	03/04/2014	17/04/2014	Causes Interserve refusal to provide trained staff to carry out non-harmful physical intervention, holding and restraint skills, where patient control is necessary to deliver essential critical care to patients lacking capacity to consent to treatment. Insufficient UHL staff trained in use of non-harmful physical intervention and restraint skills to carry out patient control. Termination of Physical skills training contract with LPT provider in January 2014. Consequence Inability to deliver safe clinical interventions for patients lacking capacity who resist treatment and/or examination. Increased risk of Life threatening or serious harm to patients resisting clinical intervention Increased risk of injuries to patients due to physical interventions by inexperienced/untrained staff. Increased risk of injuries to untrained staff carrying out physical interventions. Increased risk of injuries to staff carrying out clinical procedures Requirement for increased staffing presence to carry out safe procedures Reduced quality of service due to diverted staff resources Increased risk of sick absence due to staff injury. Increased risk of complaints from patients and visitors Increased risk of failure to meet targets Adverse publicity	Patients	UHL Nursing and Horizons colleagues have met with Interserve 12/03/14 and UHL have agreed to issue a temporary indemnity notice that will provide vicarious liability cover for Interserve staff in these situations (supported by our legal team). This was rejected by Interserve Management Cover with more UHL employed staff where there may be patients requiring this type of restraint; Staff must take risk assessed decisions about the use of restraint and ensure incidents are reported using the Trust's incident reporting database. In extreme cases staff should be aware that the police should be called Continue to communicate with all staff about the current position.	Extreme	Almost certain	25	Communication circular to senior managers to advise of current position and interim measures (to be cascaded to staff) - ASAP Staff to apply reasonable use of force as appropriate until trained in non-harmful physical skills - Immediate Identification of clinical staff trained in physical skills - as first call for situations requiring intervention - 26/3/2014 Series of management briefings on Lawful use of Force 18/4/14 Provision of guidance note on 'Lawful use of Force' for staff familiarisation 28/2/14 Request police presence where possible due to level of patient resistance/arousal if violent. - Immediate Clear documentation of instances where physical intervention is necessary - Immediate High priority recruitment of physical skills trainer - 2/5/14 Task and Finish group to review physical skills requirement , arrangements and training needs analysis - 20/4/14 Development and delivery of training programme in Physical Skills for clinical staff - 30/5/14 Interserve staff assistance to be requested where patient becomes violent and aggressive. This is an ex	5	DLO

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	10/04/2013	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 subspecialty interest. Reduced ability to train and supervise junior doctors. Deskilling of consultants without subspecialty interest. Suboptimal training.	Patients	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 and set up several projects aiming to attract and retain emergency medicine trainees and consultants. Advanced nurse practitioners and non-training CT1 grades employed in order to backfill the shortage of SHO grade doctors. Shared teaching sessions in which non ED consultants and ED consultants share skills. The non ED consultants have a specific mailing list so that new developments and departmental 'mini-teaches' can be shared. Only approved locum agencies are used and CVs are checked for suitability prior to appointment. Locums receive a brief shop floor induction on arrival and also must sign the green locum induction book, which introduces trust policies . Locums work only in a supervised environment. There is a specific consultant who is concerned with locum issues. Poorly performing locums are not permitted to continue working and this is fed back to their agencies Locum doctors are only placed in paeds ED in excepti Grid paediatric trainees shift pattern has altered, allow ED employs medical registrars to work night shifts in E ED consultants have extended their shop-floor hours	Extreme	Likely	20	Review of shift vs rota and the required number of juniors per shift - 01/03/14	6	BTD
2333	ITAPS	Anaesthesia	Lack of paediatric cardiac anaesthetists to maintain a WTD compliant rota leading to service disruption and loss of resilience	17/04/2014	16/05/2014	Causes: 1. Retirement of previous consultants 2. Ill health of consultant 3.lack of applicants to replace substantively Consequence: 4.need for remaining paeds anaesthetists to work a 1:2 rota on call 5.Lack of resilience puts cardiac workload at risk 6. May adversely affect the national reputation of GGH as a centre of excellence 7.current rota non complaint WTD 8. patients requiring urgent paeds surgery may be at risk of having to be transferred to other centres 9. Income stream relating to paeds cardiac surgery may be subsequently affected 10. risk of suboptimal treatment	Quality	1. 1:2 rota covered by experience colleagues 2. 12 month locum appointed	Major	Almost certain	20	1. Continue with substantive recruitment strategy and planning - 16/05/14 2. Further training to Consultant returning from maternity leave - 31/05/14 3. Explore "acting" roles for trainee to second in to rota gaps - 01/05/2014	8	DTR