University Hospitals of Leicester NHS
NHS Trust

To:	**Trust Board**
From:	**Rachel Overfield - Chief Nurse**
Date:	**30 January 2014**
CQC regulation:	Outcome 16 – Assessing and Monitoring the Quality of Service Provision

Trust Board Paper Y

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 extreme and high risks within the Trust. The report includes:-

a) A copy of the BAF as of 31 December 2013.
b) An action tracker to monitor progress of BAF actions
c) A summary diagram of BAF risk score movements from the previous month.
d) New extreme and/ or high risks opened during the reporting period.
e) Excerpt from the organisational risk register showing all current UHL extreme and high risks.

The Report is provided to the Board for:

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

Summary :

- There have been no changes to BAF risk scores during the reporting period.
- Risk number six has been removed from the BAF.
- Action 6.11 will be removed from future iterations of the action tracker.
- Action 8.11 is no longer relevant and has been removed from the BAF and will be removed from future iterations of the tracker.
- Action 10.1 has been integrated within action 10.5 and has been removed from the BAF and will be removed from future iterations of the action tracker.
- The lack of progress with actions 11.8 and 11.11 due to poor engagement from Interserve has been escalated to *'NHS Horizons'* for resolution.
- Action 13.8 has moved from a red RAG rating to green (on track).
- Seven new high risks have opened during December 2013 as described below.
- The Board is asked to note a moderate risk in relation to the NIHR Clinical Research Network: East Midlands transition plan. As the appointed host organisation, UHL is now leading and facilitating the transition process. The associated risk is reported as an exception to normal reporting due to the contractual obligation with the NIHR and Department of Health to report associated risks to the host Trust Board.

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: **30 JANUARY 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 31 December 2013.
b) An action tracker to monitor progress of BAF actions.
c) A summary diagram of BAF scores to show any changes from the previous month.
d) Notification of any new extreme or high risks opened during the reporting period.
e) Excerpt from the organisational risk register showing all open extreme and high risks.

2. BAF POSITION AS OF 31 DECEMBER 2013

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

2.2 The progress of actions associated with the BAF is monitored by reference to the action tracker attached at appendix two. Actions completed prior to December 2013 have been removed from the tracker however a full audit trail of these is available by reference to previous documents.

2.3 Appendix three provides a summary of changes to BAF scores and the Board is asked to note that there have been no changes to BAF risk scores since the previous report.

2.4 The Board is asked to note the following points:

- Following discussion and agreement at the December 2013 Board meeting, risk number six has been removed from the BAF.
- As a consequence of the above, action 6.11 will be removed from future iterations of the action tracker.
- Action 8.11 is no longer relevant and has been removed from the BAF and will be removed from future iterations of the tracker.
- Action 10.1 has been integrated within action 10.5 and has been removed from the BAF and will be removed from future iterations of the action tracker.
- The lack of progress with actions 11.8 and 11.11 due to poor engagement from Interserve has been escalated to *'NHS Horizons'* for resolution.
- Action 13.8 has moved from a red RAG rating to green (on track) following confirmation that Odames ward will be handed over to

Clinical Education on 1st February 2014 for work to begin in conversion to a library /learning centre.

2.5 In order to provide an opportunity for more detailed scrutiny the following three BAF entries are presented for Board members to review against the parameters listed in appendix four.

- Risk 8 – Failure to achieve and sustain quality standards (risk owners; Chief Nurse and Medical Director).
- Risk 9 – Failure to achieve and sustain high standards of operational performance (risk owner Chief Operating Officer).
- Risk 10 – Inadequate reconfiguration of buildings and services (risk owner Director of Strategy)

3 QUARTER THREE EXTREME AND HIGH RISK REPORT.

3.1 In line with the UHL Risk Management Policy, the Board is provided with a quarterly summary of all currently open extreme and high risks. As of 31 December 2013 there are 31 high risks (including those listed in section 3.2) and one extreme risk on the UHL organisational risk register. These are detailed at appendix five.

3.2 The Board is asked to note that seven new high risks were opened during December 2013 as detailed below.

Risk ID	Risk Title	Risk Score	CMG/Corporate Directorate
2267	Risk of reduced compliance with DoH requirements in relation to adherence to antimicrobial prescribing policy	20	Corporate Nursing
2271	Failure to achieve compliance of 75% attendance at Safeguarding training may have adverse impact on UHL safeguarding processes	16	Corporate Nursing
2278	Risk that the Leicester Fertility Centre could have its licence for the provision of treatment and services withdrawn	15	Women's & Children's
2270	Failure to achieve compliance of 75% attendance at Fire Safety training may cause UHL to fail to meet its statutory obligation	15	Corporate Nursing
2268	Failure to meet targets for training compliance for moving & handling training may adversely affect patient care /staff safety	15	Corporate Nursing
2272	Failing to meet internal and external targets in relation to undertaking IG training may adversely affect UHL compliance with IP	15	Corporate Nursing
2269	Failure to meet UHL target of a minimum of 75% of clinical staff undertaking IP/Hand hygiene training	15	Corporate Nursing

3.3 Finally, the Board is asked to note a moderate risk in relation to the National Institute for Health Research (NIHR) Clinical Research Network: East Midlands transition plan. This plan sets out progress, further actions and risks with respect to the local transition process from existing NIHR research network structures to the NIHR CRN: East Midlands structure by April 1, 2014. As the appointed host organisation, UHL is now leading and facilitating the transition process. The associated risk is reported as an exception to normal reporting due to the contractual obligation with the NIHR and Department of Health to report associated risks to the host Trust Board. Details of the risk are attached at appendix six.

4. RECOMMENDATIONS

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

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

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

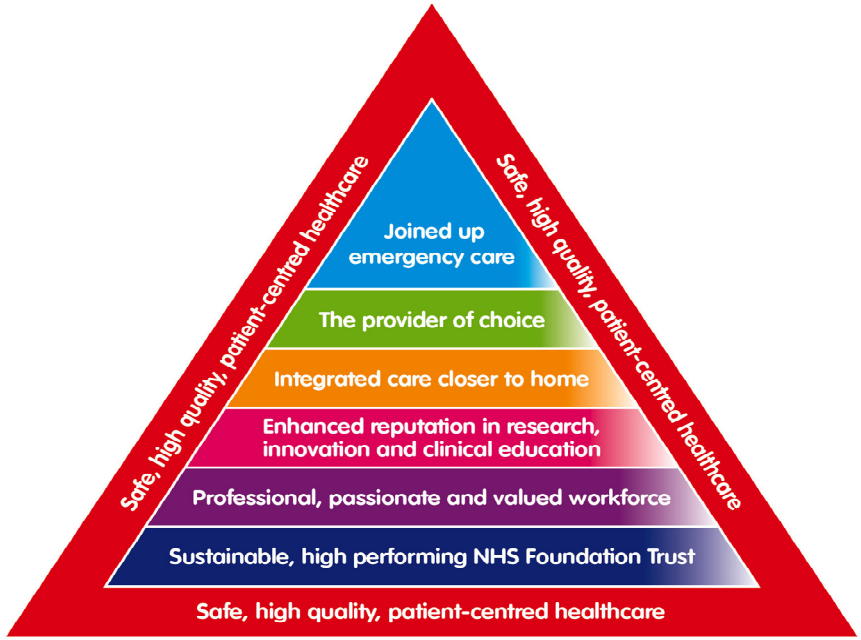
(c) identify any areas which it feels that the Trust's controls are inadequate and do not, therefore, effectively manage the principal risks to the organisation achieving its objectives;

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

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

Peter Cleaver,
Risk and Assurance Manager,
21 January 2014.

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



PERIOD: DECEMBER 2013

RISK TITLE	STRATEGIC OBJECTIVE	CURRENT SCORE	TARGET SCORE
Risk 1 – Failure to achieve financial sustainability	g - To be a sustainable, high performing NHS Foundation Trust	25	12
Risk 2 – Failure to transform the emergency care system	b - To enable joined up emergency care	25	12
Risk 3 – Inability to recruit, retain, develop and motivate staff	f - To maintain a professional, passionate and valued workforce e - To enjoy an enhanced reputation in research, innovation and clinical education.	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	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	9	6
Risk 13 - Failure to enhance education and training culture	e – To enjoy an enhanced reputation in research, innovation and clinical education	12	6

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

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to achieve financial sustainability including:	Overarching financial governance processes including PLICS process and expenditure controls. Revised variance analysis and reporting metrics especially for the ETPB Self-assessment and SLM baseline exercise completed and project manager identified Finalised SLM Action plan Full information has now been received on UHL allocations from all the no-recurrent funding streams including transformation monies. This information is being incorporated into the financial forecasts.	5X5=25	Monthly /weekly financial reporting to Exec Team Performance Board, F&P Committee and Board. Cost centre reporting and monthly PLICS reporting. Monthly confirm and challenge processes at specialty and CMG level. Annual internal and external audit programmes. Monthly meetings with the NTDA and the CCG Contract Performance Meeting	(c) SLM programme not fully implemented	ESB will continue to meet every 6 weeks to ensure implementation of SLM across the Trust (expected Mar 2014) (1.19)	4x3=12	Mar 2014 DFBS
Failure to achieve CIP.	Strengthened CIP governance structure including appt of Head of CIP programme		Progress in delivery of CIPs is monitored by CIP Programme Board (meeting fortnightly) and reported to ET and Board.	(c) Under-delivery of CIP programme (£0.8m adverse to plan M8)			

Locum expenditure.	Workforce plan to identify effective methods to recruit to 'difficult to fill' areas Reinstatement of weekly workforce panel to approve all new posts. STAFFflow for medical locums saving £130k of every £1m expenditure Financial Recovery plans developed Non Contractual Payments are discussed at monthly CMG meetings Confirm and Challenge Meetings All CMGs (by specialty) have produced premium spend trajectories and associated plans until March 2014 Weekly Staff Bank data reports are issued for medical and nursing (qualified and unqualified) staff Action plan to increase bank staff capacity and drive down agency nurse expenditure.		The use of locum staff in 'difficult to fill' areas reported monthly to the Board via the Q&P report. A reduction in the use of locums would be an assurance of success in recruiting substantive staff to 'difficult to fill' areas. Increase in contracted staff numbers of medical and nursing professions of 252wte since Mar 12. Saving in excess of £0.6m 5 weeks after 'go live' date Monthly Q&P report to TB Monthly confirm and challenge meetings Non contractual payments (premium spend) are reported monthly to the Finance and Performance Committee A weekly report is presented to ET. Weekly meetings with HoNs and DHR to monitor progress.	(c) Further investigation required as to the increase in Consultant numbers by 41wte (7.7%)			
Loss of income due to tariff/tariff changes (including referral rate for emergency admissions – MRET)	Contract meetings with Commissioners Negotiations with Commissioners concluded at a transactional level. Ongoing discussions with commissioners about planned re-investment of the MRET deductions.		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board.	(c) Failing to manage marginal activity efficiently and effectively. This is being addressed via ongoing discussions with Commissioners			

Ineffective processes for Counting and Coding.	Clinical coding project. Clinical coding to be included as a 2nd wave LIA pioneering team to involve clinicians.		Ad-Hoc reports on annual counting and coding process. PbR clinical coding audit Jan 2013 (final report received 29 May 2013). IG toolkit audit (sample of 200 General Surgery episodes).	(c) Error rates in audit sample could be indicative of underlying process issues (c) Error rates identified as: Primary diagnoses incorrect 8.0% › Secondary diagnoses incorrect 3.6%. › Primary procedure incorrect 6.4% › Secondary procedure incorrect 4.5%.			
Loss of liquidity.	Liquidity Plan.		Monthly /weekly financial reporting to F&P Committee and Board. Detailed cash management plans presented at August 2013 F&P committee				
Lack of robust control over pay and non-pay expenditure.	Pay and Non-pay recovery action plan in place and monitored monthly Catalogue control project.		Monthly /weekly financial reporting to F&P Committee and Board. Non-pay management plan presented at July F&P committee Ongoing Monitoring via F&P Committee.				
Commissioner fines against performance targets.	Contract meetings with Commissioners and negotiations with Commissioners concluded at a transactional level. Plans and trajectories developed to reduce admission rates that are monitored at monthly C&C meetings.		Monthly /weekly monitoring of action plans, key performance target, and financial reporting to F&P Committee and Board.				
Use of readmission monies.	Contract meetings with Commissioners Negotiations with Commissioners concluded at a transactional level Ownership of readmissions work streams in divisions clarified		Monthly /weekly financial reporting to F&P Committee and Board.				
Ineffective organisational transformation.	See risk 4		See risk 4.	See risk 4.	See risk 4.		See risk 4

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

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

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inability to recruit, retain, develop and motivate suitably qualified staff leading to inadequate organisational capacity and development.	Leadership and talent management programmes to identify and develop 'leaders' within UHL.	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. Staff sickness rate is 4.1% for M8.	No gaps identified	No actions required.		

	Appraisal and objective setting in line with UHL strategic direction. Local actions and appraisal performance trajectories agreed with CMGs and Directorates Boards		Appraisal rates reported monthly to Board via Quality and Performance report. Month 8 appraisal rate = 91.8%	(C) Appraisal rate consistently below target (target =95%)	Implement targeted recovery plans and trajectories for each cost centre (3.11).		Review Jan 2014 DHR
	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		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) Programme of induction and adaptation in development with Nursing education leads, timetabled to ensure capacity to support programme. (3.10)		April 2014 DHR April 2014 DHR
	Reward /recognition strategy and programmes (e.g. salary sacrifice, staff awards, etc). Recruitment and Retention Premia for ED medical and nursing staff			(a) Reward and recognition strategy requires revision to include how we will provide assurance that reward and recognition programmes are making a difference to staffing recruitment/ retention/ motivation.	Revise and launch reward and recognition strategy. (3.1) Development of Pay Progression Policy for Agenda for Change staff (3.3)		Jan 2014 DHR Feb 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 (last report 4 Feb). Reporting will be to the Board via the quarterly workforce an OD report. Quarterly report to senior HR team and to Board via quarterly workforce and OD report	(a) Better baselining of information to be able to measure improvement. (c) Lack of engagement in production of website material.			
	Statutory and mandatory training programme for 9 key subject areas in line with National Core Skills Framework		Monthly monitoring of statutory and mandatory training uptake via reports to TB and ESB against 9 key subject areas (currently showing month on month improvements (58% at M7)	(c) Compliance against the 9 key subject areas is 62% (December 2013) (a) Potentially there may be inaccuracies of training data within the e-UHL system	Ensure Statutory and Mandatory training is easy to access and complete with 75% compliance by reviewing delivery mode, access and increasing capacity to deliver against specific subject areas (3.5) Update e-UHL records to ensure accuracy of reporting on a real time basis (3.7)		Mar 2014 DHR Mar 2014 DHR

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to put in place a robust approach to organisational transformation, adequately linked to related initiatives and financial planning/outputs	Development of Improvement and Innovation Framework (IIF) Outputs from this transformation programme will drive the implementation of the clinical strategy.	4x4=16	Monthly progress reports to Exec Strategy Board and F&P Committee. Approval of framework and operational arrangements due at Trust Board June 2013. Monitoring of overall Framework will be via IIF Board and F&P Ctte and monitoring of financial outputs (CIPs) will be via CIP Delivery Board, Exec Performance Board and F&P Committee. Delivery of whole hospital change programmes requires alignment with the whole local Health Economy change programme – currently described through the Better Care Together 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	Review outputs from Chief Officers Group and strategic Planning Group to ensure gaps in current processes are being addressed (4.1)	4x3=12	Review Feb 2014 DS

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to put in place appropriate systems to horizon scan and respond appropriately to external drivers. Failure to proactively develop whole organisation and service line clinical strategies	Appointment of Strategy Director	4x4=16	Plan agreed by Remuneration Committee	None identified	Not applicable	4x3=12	N/A
	Allocation of market intelligence responsibility to Director of Marketing and Communications		Agreed by Remuneration Committee	None identified	Not applicable		N/A
	Co-ordinated approach to business intelligence gathering and response via Clinical Management Groups Workshop 'hosted by the Director of Strategy 'delivering our strategic direction' held in November with all CMGs to set the external context within which we will need to develop a LLR Integrated 5-yaer plan, within which our 2-yaer operational plans will sit. CMG Strategy Leads now engaged in the BSST meetings to improve engagement, alignment and teamwork. ESB forward plan reflecting a 12 month programme aligned with: • the development of the IBP/LTFM • the reconfiguration programme • the development of the next AOP • The TB Development Programme The TB formal agenda		Weekly strategic planning meetings in place – cross CMG and corporate team attendance with delivery led through the Strategy Directorate Development of a clear, clinically based 5 year strategic will provide assurance that strategic planning is taking place Reports to ESB Regular reports to TB reflecting progress of 12 month programme	None identified None identified	Not applicable Not applicable		

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to maintain productive relationships with external partners/ stakeholders leading to potential loss of activity and income, poor reputation and failure to retain/ reconfigure clinical services.	Stakeholder Engagement Strategy. Regular meetings with external stakeholders and Director of Communications and member of Executive Team to identify and resolve concerns. Regular stakeholder briefing provided by an e-newsletter to inform stakeholders of UHL news. Leicester, Leicestershire and Rutland (LLR) health and social care partners have committed to a collaborative programme of change ('Better Care Together')	5X3=15	Twice yearly GP surveys with results reported to UHL Executive Team. Latest survey results discussed at the April 2013 Board and showed increasing levels of satisfaction… a trend which has now continued for 18 months. 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	Jan 2014 DCM

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

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. Reports to Executive Quality Board, QAC, and by exception to ET and TB. 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. 106).	(a) UHL risk adjusted perinatal mortality rate above regional and national average.	Women's CMG to work with Dr Foster and other trusts to better understand risk adjustment model (8.2).		Jan 2014 MD
	Robust implementation of actions to achieve Quality Commitment (save 1000 extra lives in 3 years).		SHMI remains "within expected" (i.e. 106). Independent analysis of mortality review performed by Public Health. Results reported at November 2013 TB meeting.	No gaps identified.	No action needed.		
	Agreed patient centred care priorities for 2013-14: - Older people's care - Dementia care - Discharge Planning		Quality Action Group meets monthly. Achievement against key objectives and milestones report to Trust board on a monthly basis. A moderate improvement in the older people survey scores has been recorded.	No gaps identified.	No action needed.		
	Multi-professional training in older peoples care and dementia care in line with LLR dementia strategy.		Quality Action Group monitoring of training numbers and location.	No gaps identified.	No action needed.		

	Protected time for matrons and ward sisters to lead on key outcomes.		CMG/ specialty reporting on matron activity and implementation or supervisory practice.	(c) Present vacancy levels prevent adoption of supervisory practice.	Active recruitment to ward nursing establishment so releasing ward sister –for supervisory practice (8.5).		Sep 2014 CN
	To promote and support older peoples champions network and new dementia champions network.		Monthly monitoring of numbers and activity.	No gaps identified.	No action needed.		
	Targeted development activities for key performance indicators - answering call bells - assistance to toilet - involved in care - discharge information		Monthly monitoring and tracking of patient feedback results. Monthly monitoring of Friends and Family Test reported to the TB (70.3% at M8). England average 71% Older Peoples Quality Outcomes: all scores increased from M7 to M8 Discharge: All scores except for the question on being informed of problems/dangers signals increased from M7 to M8				
	Quality Commitment 2013 – 2016: • Save 1000 extra lives • Avoid 5000 harm events • Provide patient centred care so that we consistently achieve a 75 point patient recommendation score		Quality Action Groups monitoring action plans and progress against annual priority improvements. A Quality Commitment dashboard has been developed to present updates to the TB on the 3 core metrics for tracking performance against our 3 goals. These metrics will be tracked up to 2015. Impressive drops in fall numbers have been observed in Datix reports and in the Safety Thermometer audit.				
	Relentless attention to 5 Critical Safety Actions (CSA) initiatives to lower mortality.		Q&P report to TB showing outcomes for 5 CSAs. 4CSAs form part of local CQUIN monitoring. RAG rated green at end of quarter 2. M&M CSA removed from CQUIN monitoring due to full implementation 100%CQUIN funding for CAS programme for quarter two of 2013/14.	(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 M8 was 93.86% reflecting a reduction in the number of patients with newly acquired 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.			

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 submitted to Commissioners for external assurance	4x5=20	Key specialities will go onto weekly performance meetings with COO Weekly patient level reporting meeting for all key specialties Monthly Q&P report to Trust Board showing 18 week RTT performance Daily RTT performance and prospective reports to inform decision making	(c) 83.2% admitted RTT performance (M8). Backlog plans require further development in line with review of demand and capacity in key specialties. Recovery of the admitted and non admitted standards at Trust and speciality level is not anticipated until the new financial year. (c) Capacity issues created by emergency demand causes cancellations of operations. (c) ongoing discussions with commissioners have failed to agree a clear recovery plan at this stage	Re-configuration of surgical beds to create a 'protected area' for surgical patients or by use of independent sector. (9.2) Agree recovery action plan with commissioners to recover Referral to Treatment Performance within required operational standards	4x3=12	Review Jan 2014 COO Feb 2014 COO

	Transformational theatre project to improve theatre efficiency to 80 -90%.		Monthly theatre utilisation rates. Theatre Transformation monthly meeting. Transformation update to Board.	No gaps identified.	No actions required.		
	Emergency Care process redesign (phase 1) implemented 18 February 2013 to improve and sustain ED performance.		Monthly report to Trust Board in relation to Emergency Dept (ED) flow (including 4 hour breaches).	See risk number 2.	See risk number 2.		
	Cancer 62 day performance - Tumour site improvement trajectory agreed and each tumour site has developed action plans to achieve targets. Senior Cancer Manager appointed Lead Cancer Clinician appointed Action plan to resolve Imaging issues implemented.		Cancer action board established and weekly meetings with all tumour sites represented Monthly trajectory agreed and Cancer action plan agreed with CCGs in June 2013 and reported and monitored at Executive Performance board. Chief Operating Officer receives reports from Cancer Manager and 62 day performance included within Monthly Q&P report to Trust Board. Performance against 62 day standard has been above national average and exceeded 85% for the past 3 months.				

RISK NUMBER/ TITLE:		**RISK 10 – INADEQUATE RECONFIGURATION OF BUILDINGS AND SERVICES**					
LINK TO STRATEGIC OBJECTIVE(S)		**a. - To provide safe, high quality patient-centred health care**					
EXECUTIVE LEAD:		Director of Strategy					
Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inadequate reconfiguration of buildings and services leading to less effective use of estate and services.	Clinical Strategy.	3x5=15	Trust Board development session on development of approach to strategic planning and development of SOC. This outlined the methodology being used to ensure any changes in configuration is specifically designed to deliver optimum quality of care Ongoing 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 strategic plans with specialities. This is monitored by CMG and Executive Boards. Work continues with DS and CMGS to prioritise key areas for delivery within the clinical strategy. Further workshops planned for Jan/Feb 2014. (10.5)	3X3=9	March 2014 MD

	Estates Strategy including award of FM contract to private sector partner to deliver an Estates solution that will be a key enabler for our clinical strategy in relation to clinical adjacencies. Reconfiguration Programme working with clinicians to develop a 'preferred' way forwards' with regards to the alignment of the future estate with clinical strategy		Facilities Management Collaborative (FMC) will monitor against agreed KPIs to provide assurance of successful outsourced service.	(c) Estates plans not fully developed to achieve the strategy. (c) The success of the plans will be dependent upon capital funding and successful approval by the NTDA.	Reconfiguration programme to develop a strategic outline case which will inform the future estate strategy (10.6) Secure capital funding. (10.3)		Jan 2014 DS Mar 2014 DFBS
	CMG service development strategies and plans to deliver key developments.		Progress of divisional development plans reported to Service Reconfiguration Board.	No gaps identified.	No actions required.		
	Service Reconfiguration Board.		Monthly ET Strategy session to provide oversight of reconfiguration.	No gaps identified.	No actions required.		
	Capital expenditure programme to fund developments.		Capital expenditure reports reported to the Board via F&P Committee.	No gaps identified.	No actions required.		
	Managed Business Partner for IM&T services to deliver IT that will be a key enabler for our clinical strategy. IM&T incorporated into Improvement and Innovation Framework.		IM&T Board in place.	No gaps identified.	No actions required.		

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 identifying good practice presented to the GRMC July 2012. Training Needs Analysis developed to identify training requirements for staff supported by appropriate training packages for Senior Managers on Call External auditing and assurances to SHA, Business Continuity Self-Assessment, June 2010, completed by Richard Jarvis Completion of the National Capabilities Survey, November 2013 completed by Aaron Vogel. Results included in the annual report on Emergency Planning and Business Continuity to the QAC. Audit by PwC Jan 2013. Results being compiled and will be reported to Trust Board (date to be agreed). Documented evidence from key critical suppliers has been collected to ensure that contracts include business continuity arrangements.	(c) On-going continual training of staff to deal with an incident. (a) Do not consider realistic testing of different failure modes for critical IT systems to ensure IT Disaster Recovery arrangements will be effective during invocation. c) 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). Determine an approach to delivering a physical testing of the IT Disaster Recovery arrangements which have been identified as a dependency for critical services. Include assessment of the benefits of realistic testing of arrangements against the potential disruption of testing to operations. (11.2) 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 Review Jan 2014 CIO Mar 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. Production/updates of documents/plans relating to Emergency Planning and Business Continuity aligned with national guidance have begun. Including Business Impact Assessments for all specialties. Plan templates for specialties now include details/input from Interserve	((c) Local plans for loss of critical services not completed due to change over of facilities provider (c) Plans have not been provided by Interserve as to how they would respond or escalate issues to the Trust.	Further work required to develop escalation plans and response plans for Interserve. (11.11)		Feb 2014 COO

	New policy to identify key roles within the Trust of those responsible for ensuring business continuity planning /learning lessons is undertaken.		Minutes/action plans from Emergency Planning and Business Continuity Committee. Any outstanding risks/issues will be raised through the COO.	No gaps identified.	No actions required.		
			New Policy on InSite Emergency Planning and Business Continuity Committee ensures that processes outlined in the Policy are followed, including the production of documents relating to business continuity within the service areas. 3 incidents within the Trust have been investigated and debrief reports written, which include recommendations and actions to consider. Issues/lessons feed into the development of local plans and training and exercising events.				
			Head of Operations and Emergency Planning Officer are consulted on the implementation of new IM&T projects that will disrupt users access to IM&T systems	(c) Do not always consider the impact on business continuity and resilience when implementing new systems and processes.	Further processes require development, particularly with the new Facilities and IM&T providers to ensure resilience is considered/ developed when implementing new systems, infrastructure and processes. (11.8)		Review Feb 2014 COO
				(a) Lack of coordination of plans between different service areas and across the specialties.	Training and Exercising events to involve multiple specialties/CMGs to validate plans to ensure consistency and coordination. (11.10)		Aug 2014 COO

RISK NUMBER/ TITLE:	RISK 12 FAILURE TO EXPLOIT THE POTENTIAL OF IM&T						
LINK TO STRATEGIC OBJECTIVE(S))	**a. - To provide safe, high quality patient-centred health care.** **d. - To enable integrated care closer to home**						
EXECUTIVE LEAD:	Director of Finance and Business services						
Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?

Failure to integrate the IM&T programme into mainstream activities	Managed Business Partner for IM&T services to deliver IT that will be a key enabler for our clinical strategy. IM&T now incorporated into Improvement and Innovation Framework	3x3=9	IM&T Board in place. Quarterly reports to Trust Board	No gaps identified	No actions required	3x2=6	
	Engagement with the wider clinical communities (internal) including formal meetings of the newly created advisory groups/ clinical IT. Improved communications plan incorporating process for feedback of information		CMIO(s) now in place, and active members of the IM&T meetings The joint governance board monitors the level of communications with the organisation	No gaps identified	No actions required		
	Engagement with the wider clinical communities (External). UHL CMIOs are added as invitees to the meetings, as are the clinical (IM&T) leads from each of the CCGs		UHL membership of the wider LLR IM&B board	No gaps identified	No actions required		
Benefits are not well defined or delivered	Appointment of IBM to assist in the development of an incentivised, benefits driven, programme of activities to get the most out of our existing and future IM&T investments Initial engagement with key members of the TDA to ensure there is sufficient understanding of technology roadmap and their involvement. The development of a strategy to ensure we have a consistent approach to delivering benefits Increased engagement and communications with departments to ensure that we capture requirements and communicate benefits Standard benefits reporting methodology in line with trust expectations		Minutes of the joint governance board, the transformation board and the service delivery board Benefits are part of all the projects that are signed off by the relevant groups	(c) the delivery programme is dependent on TDA approvals for some elements (c) ensure that all CMGs/ specialties have the approach to IM&T benefits as part of delivery projects (a) production of a standard report on the delivery of benefits	TDA approvals documentation to be completed (12.8)		Review Jan 2014 CIO

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to implement and embed an effective medical training and education culture with subsequent critical reports from commissioners, loss of medical students and junior doctors, impact on reputation and potential loss of teaching status.	Medical Education Strategy and Action Plan	4x3 = 12	Strategy approved by the Trust Board Strategy monitored by Operations Manager and reviewed monthly in Full team Meetings. Favourable Deanery visit in relation to ED Drs training	(c) Lack of engagement/awareness of the Strategy with CMGs.	Meetings to discuss strategy with CMGs (13.1)	3x2 = 6	Feb 2014 MD

	UHL Education Committee 'Doctors in Training' Committee established Education and Patient Safety		Professor Carr reports to the Trust Board Reports submitted to the Education Committee Terms of reference and minutes of meetings	(c) Attendance at the Committee could be improved. (c) Improved trainee representation on Trust wide committees (c) Improve engagement with other patient safety activities/groups	Relevance of the committee to be discussed at specialty/ CMG meetings (13.2) 'Build relationships with CMG Quality Leads. Establish links with LEG/QAC and QPMG. (13.4)		Feb 2014 MD Feb 2014 MD
	Quality Monitoring		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) Lack of engagement with specialties to share findings from the dashboards (a) Do not currently ensure progress against strategic and national benchmarks (c) Inadequate educational resources	Attend CMG management meetings and liaise with specialties. (13.6) Monitor UHL position against other trusts nationally. (13.7) New Library/learning facilities to be developed at the LRI .(13.8)		Feb 2014 MD Review Feb 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	(c) Implementation of the project within Acute Medicine needs to be improved.	Dr Hooper in post for Acute Medicine to implement project. (13.9)		Feb 2014 MD
	Financial Monitoring		SIFT monitoring plan in place	(c) Poor engagement with specialties in relation to implication of SIFT	Need to engage with the specialties to help them understand the implication of SIFT and their funding streams. (13.10)		Feb 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	**December 2013**
Frequency of review:	Monthly
Date of last review:	November 2013

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
1	**Failure to achieve financial sustainability**					
1.19	ESB will continue to meet every 6 weeks to ensure implementation of SLM across the Trust (expected Mar 2014)	DFBS		March 2014	On track.	4
1.20	Submit application for clinical coding to be included as a 2nd wave LIA pioneering team to involve clinicians.	DS	ADI	Review January 2014	**Complete.** Successful with LIA application and upgraded to a 2nd wave LIA Enabling our People project with a focus on improving coding at the LRI.	5
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	Remains on track. Further review of progress Jan 2014.	4
2.9	CCG/LPT to increase capacity by use of Intermediate Care Services.	COO	HO	~~August~~ Review ~~October November 2013~~ January 2014	**Complete.** 24 additional beds now open. Rehab capacity increased significantly.	5
3	**Inability to recruit, retain, develop and motivate staff**					
3.1	Revise and re-launch UHL reward and recognition strategy.	DHR	DDHR	~~October 2013~~ January 2014	The Reward and Recognition Strategy was ratified by the Board on December 20th 2013 and the launch of the strategy is anticipated in January 2014.	4

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
3.2	Take baseline from January and measure progress in relation to the success of recruitment events now that there is a structured plan for bulk recruitment. Identify a lead from each professional group to develop and encourage the production of fresh and up to date material.	DHR	DDHR	December 2013	**Complete.** Programme of Trust wide recruitment campaigns for Registered nurses and HCA's during 2013 leading to the appointment of 47 nurses and 234 HCAs. Key actions have included Development and implementation of a Band 5 registered nurse and Band 2 HCA job swap to limit the number of internal moves from full recruitment processes. Attendance at 3 Registered Nurse jobs fairs in Manchester, London and Glasgow (leading to 36 appointments) Development to a Nursing recruitment web page. Adverts have appeared on train platforms between Leicester, London and surrounding areas and use of social media as an advertising source has been utilised. LiA will support further development of all of the above for Nursing and other staff groups in UHL. International Recruitment campaigns are continuing to progress. A comprehensive rolling programme of advertising has been proposed for 2014.	5

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
3.3	Development of Pay Progression Policy for Agenda for Change staff.	DHR	DDHR	~~October~~ ~~November~~ ~~December 2013~~ February 2014	Initial staff side comments acquired and specific meeting to discuss on 16 December 13. A number of points of agreement were made at this meeting. The Policy has been amended to reflect these and further discussions will take place at the JSCNC on 15 January 2014 with a view to reaching agreement on remaining points of difference. The proposal for Agenda for Change staff in Band 8C, D and 9 was agreed in principle and a listening event will be held with affected staff at the beginning of February 2014. Timescales have been amended to reflect these changes.	3
3.5	Ensure Statutory and Mandatory training is easy to access and complete with 75% compliance by reviewing delivery mode, access and increasing capacity to deliver against specific subject areas.	DHR	ADLOD	March 2014	Performance improved to 62%. First seven newly designed e-learning packages have been completed:- All other e-learning packages will be available from the end of December 2013.	4

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
3.7	Update e-UHL records to ensure accuracy of reporting on a real time basis	DHR		March 2014	Work in progress with designing new system and completion of Project Documentation for review by IMT Project Board on 4 November 2013. Data from other systems has been migrated across to the e-UHL System to support accurate reporting. A Project Brief has been completed to reflect e-UHL System upgrade requirements and a Project Board has been established in taking forward this work.	4
3.8	Active recruitment strategy to recruit to current nurse vacancies including implementation of a dedicated nursing recruitment team	CN/ DHR		December 2013	**Complete.**	5
3.9	Develop an employer brand and maximise use of social media to describe benefits of working at UHL	DHR		April 2014	First meeting of task and finish group taken place. Use of Linked-In and staff good news stories to describe benefits of working at UHL. Group has expanded membership to broader range of staff groups. Action Plan in development, focused on three elements of employment cycle – attraction, retaining existing staff and understanding why individuals exit.	4
3.10	Programme of induction and adaptation in development with Nursing education leads, timetabled to ensure capacity to support recruitment programme.	DHR		April 2014	Programme in development which covers induction, interim development and long term development. Includes dedicated older person's training course	4

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
3.11	Implement targeted appraisal recovery plans for each cost centre	DHR		~~Dec 2013~~ Review Jan 2014	Appraisal recovery plans in place, and appraisal performance improved slightly to 91.8% (increase by 0.8%) at the end of November 2013 however the target of 95% has still not been achieved. All areas have been asked to further review appraisal recovery action plans by 6 January 2014 and confirm when the appraisal 95% target will be met.	3
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 Feb 2014	On track	4
5	**Ineffective strategic planning and response to external influences**					
6	**Failure to achieve FT status**					
6.11	Action plans to be developed to address recommendations from independent reviews	CEO		Dec 2013	**Action no longer relevant following deletion of risk number six from the BAF.** This entry will be removed in the next iteration of the action tracker	**N/A**
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	On track	4
8	**Failure to achieve and sustain quality standards**					
8.2	Women's CMG to work with Dr Foster and other trusts to better understand risk adjustment model related to the national quality dashboard.	MD		January 2014	On track	4
8.5	Active recruitment to ward nursing establishment so releasing ward sister for supervisory practice.	CN		September 2014	On going recruitment process in place and is likely to take 12 -18months. Deadline extended to reflect this.	4

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
8.10	Implementation of Electronic Patient Record (EPR)	CIO		2015	Currently developing the procurement strategy for the EPR solution	4
8.11	UHL to be involved in the DH review in to the use of the Safety Thermometer tool	CN		**N/A**	Although the DH had expressed a desire to work with UHL to review the existing tool UHL has not received any further invitation. A revised tool has already been produced by DH and it is felt that this action is no longer relevant and will be removed the BAF and from future iterations of the tracker	0
8.12	Review of all deaths identified in low risk groups. Working with DFI to ensure data has been recorded accurately.	MD		Dec 2013	**Complete.**	5
9	**Failure to achieve and sustain high standards of operational performance**					
9.2	Re-configuration of surgical beds to create a 'protected area' for surgical patients or by use of independent sector.	COO	HO/CMGM Planned	~~November 2013~~ January 2014	Discussions with independent sector regarding sending elective surgical work to them. Paper written and presented to QAC and F&P. RAG rating changed to reflect delays to original completion date. Review progress in January 2014	3
9.11	Agree recovery action plan with commissioners to recover Referral to Treatment Performance within required operational standards	COO	Head of Performance Improvement	Feb 2014	Intensive Support Team model used to determine capacity gap. Continued failure to agree on a recovery plan that is deliverable and affordable. Met with CCGs 12 December, CCG to review UHL / IST modelling. Agreed to meet in early new year with intention to agree plan by end January 14	4
10	**Inadequate reconfiguration of buildings and services**					

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
10.1	Prioritisation of key areas within the clinical strategy for delivery *(Action reworded Nov 2013)* *(action now integrated into action 10.5 – December 2013)*	MD		n/a	This action is now integrated with action 10.5 and has been removed from the BAF. Action will be removed from tracker for future iterations	4
10.3	Secure capital funding to implement Estates Strategy.	DFBS		~~May 2013~~ ~~December 2013~~ March 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
10.5	Iterative development of strategic plans with specialities. This is monitored by CMG and Executive Boards. Work continues with DS and CMGS to prioritise key areas for delivery within the clinical strategy. Further workshops planned for Jan/Feb 2014. *(Action reworded December 2013 to incorporate action 10.1)* .	MD		March 2014	On track	4
10.6	Reconfiguration programme to develop a strategic outline case which will inform the future estate strategy	DS		January 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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
11.2	Determine an approach to delivering a physical testing of the IT Disaster Recovery arrangements which have been identified as a dependency for critical services. Include assessment of the benefits of realistic testing of arrangements against the potential disruption of testing to operations.	COO	CIO	~~September~~ Further review ~~December 2013~~ January 2014	Testing programme hasn't been developed but it is part of the work that IBM are doing to achieve ISO 27001. Further review in December 2013 by an external audit as part of ISO 27001 accreditation. We are awaiting the final written report. initial views are that the new approach is acceptable	3
11.8	Further processes require development, particularly with the new Facilities and IM&T providers to ensure resilience is considered/ developed when implementing new systems, infrastructure and processes.	COO	EPO	~~July~~ ~~August~~ Review ~~October~~ ~~November 2013~~ ~~December 2013~~ February 2014	Work with IM&T has been completed. Delays are being encountered in developing agreed processes with Interserve. Briefed by NHS Horizons in terms of large capital projects. No progress with Interserve in terms of planned maintenance works. Lack of progress with Interserve escalated via NHS Horizons.	3
11.10	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.	4
11.11	Further work required to develop escalation plans and response plans for Interserve.	COO	EPO	~~October~~ ~~December 2013~~ February 2014	Draft escalation plan received and discussions held on 9.12.13. Was due to be implemented w/c 16th Dec. No update received from Interserve. Lack of response from Interserve escalated via NHS Horizons.	3
11.12	Develop a plan and a better understanding of how a loss of critical suppliers will affect the Trust	COO	EPO	~~October~~ ~~November 2013~~ December 2013	**Complete.**	5

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
11.13	Training and Exercising events to involve multiple CMGs/ specialties to validate plans to ensure consistency and coordination	COO	EPO	August 2014	On track	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 2014	On track	4
12	**Failure to exploit the potential of IM&T**					
12.8	TDA approvals documentation to be completed	CIO		~~October 2013~~ Review Jan 2014	How we procure the EPR solution has a material effect on how or if we proceed with TDA approval. This will be decided in the next two months	2
13	**Failure to enhance education and training culture**					
13.1	To improve CMG engagement facilitate meetings to discuss Medical Education Strategy and Action Plans with CMGs.	MD	AMD	~~December 2013/January 2014~~ February 2014	Meetings now arranged for December13 /January 14/ February 14	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~~ February 2014	Meetings now arranged for December13 /January 14/ February 14	3
13.4	Build relationships with CBU Quality Leads and establish links with LEG/QAC and QPMG in an effort to improve engagement with other patient safety activities/groups.	MD	AMD	~~December 2013/January 2014~~ February 2014	Meetings now arranged for December13 /January 14/ February 14	3
13.5	Introduce exit surveys for trainees and communicate feedback from the GMC training survey and LETB visits via the Dashboard.	MD	AMD	December 2013	**Complete.**	5

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
13.6	Attend CMG management meetings and liaise with CMGs in an effort to improve engagement of CMGs.	MD	AMD	~~December 2013/January 2014~~ February 14	Meetings now arranged for December13 /January 14/ February 14	3
13.7	Monitor UHL position against other trusts nationally to ensure progress against strategic and national benchmarks.	MD	AMD	Review ~~October 2013~~ February 2014	Following further discussions with the LETB this data is not readily available. LETB to investigate how we can acquire this data.	2
13.8	New Library/learning facilities to be developed at the LRI to help resolve inadequate educational resources.	MD	AMD	~~October 2013~~ April 2014	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
13.9	Dr Hooper in post for Acute Medicine to implement project and improve Acute Medicine progress.	MD	AMD	February 2014	On track.	4
13.10	Need to engage with the CMGs to help them understand the implication of SIFT and their funding streams.	MD	AMD	~~December 2013/January 2014~~ February 2014	Meetings now arranged for December13 /January 14/ February 14	3

Key

CEO	Chief Executive Officer
DFBS	Director of Finance and Business Services
MD	Medical Director
AMD	Assistant Medical Director
COO	Chief Operating Officer
DHR	Director of Human Resources
DDHR	Deputy Director of Human Resources
DS	Director of Strategy
ADLOD	Asst Director of Learning and Organisational Development
DMC	Director of Marketing and Communications
CIO	Chief Information Officer

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

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

BAF RISK SCORE MAP – DECEMBER 2013

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

Key

● - No change in score from previous month.

⇧ - Risk score increased from previous month

⇩ - Risk score decreased from previous month

◈ - New risk

BAF RISK SCORE MAP – DECEMBER 2013

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

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

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

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

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

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

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

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

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

8) Are the assigned risk scores realistic?

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

OPERATIONAL RISKS SCORING 15 OR ABOVE FOR THE PERIOD ENDING 31/12/13

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	Strategic risk No.
2236	Emergency and Specialist Medicine	ED	There is a risk of overcrowding due to the design and size of the ED footprint	31/01/2014	04/10/2013	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 tar Design and size of minors results in delay in receiving med Design and size footprint in streaming rooms causes threat	Patient safety	The Emergency Care Action Team, which was established in spring 2013 aims to improve emergency flow and therefore reduce the ED crowding. The Emergencey department is actively engaging in plans to increase the ED footprint via the 'hot floor' initiaitve, 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 - 15/02/14.	16	JE	2

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	Strategic risk No.
2234	Emergency and Specialist Medicine	ED	There is a medical staffing shortfall resulting in a risk of an understaffed Emergency Department	31/01/2014	04/10/2013	Consultant vacancies. Poor quality care, continued lack of retention. Stress and burnout. Increased incidents and complaints. Inability to do the general work of the department. 4 hour target. Increased sickness. Middle grade vacancies. Poor quality care, reputation. Risk of losing trainees due to incorrect service/training balance. Trainee attrition. Stress, poor morale. Trainees not wanting to apply for consultant positions. Reduced cohesiveness as a trainee group. Risk to four hour target. Increased sickeness Junior grade vacancies. Poorer quality care. 4 hour target. Stress. Juniors defecting to other specialities. Increased sickness. Poorer quality of training resulting in poor deanery reports. Non ED medical consultants. Increased incidents. Serious incidents. Stress. Locums.Financial. Poor quality care. Increased complaints, incidents, claims, serious incidents. Increased consultant workload. Lack of uniformity. Risk to 4 hour target. Paediatric medical staffing. Poorer quality care for paediatric population. Increased number of incidents, complaints and claims. Reduced ability to maintain CPD co	Patient safety	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 s Locum doctors are only placed in paeds ED in excep The grid paediatric trainees shift pattern has change ED employs medical registrars to work night shifts in 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	3

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	Strategic risk No.
2244	Musculoskeletal and Specialist Surgery	Ophthalmology	Medium-term staffing shortages/ lack of equipment/poor processes in Ophthalmology causing deterioration in service	29/10/2013	31/12/2013	**Causes** Admin staffing shortages following a previous MoC exercise. This is exacerbated by a slow recruitment process following successful interview and unavailability of temporary workforce with necessary skill set and access to hospital systems. Poor management processes and inadequate assurance mechanisms Staffing vacancies in ophthalmology Medical records. Lack of assurance mechanisms. Use of ICE for outpatient letters (taking existing staff approximately 30% longer to type and process). Lack of computers and printers. A-Scanner (biometry) is broken and replacement not yet delivered. Lack of clinical space in OPD. **Consequences** Transcription: There is a considerable typing backlog in the department which is not maintaining a steady state in relation to patient letters. Currently there is a backlog of 14,500 patient letters. These include letters to GPs and interdepartmental referrals. This leads to ineffective communication with GPs and other eye centres and may impact adversely on the patient's underlying condition e.g. GPs may not prescribe new treatments if patients fail to att Filing: There is a significant backlog in relation to filing of typed let Referrals Management: Delays to registering and booking of referrals	Quality	Executive Director leadership/ engagement with current issues. Letter to referrers indicating current situation. ICE no longer used and all letters typed using Microsoft 'word'. Additional audio typists recruited supported by agency staffing. Clinic process in place to ensure all clinics are cashed up on the day and outcomes dealt with All referrals to go to consultants for triage before booking. Route for urgent cases made explicit. Clinicians asked to keep outcome sheet on discharged patients for subsequent handover to clerk at the end of a clinic. Continual monitoring and reporting of the backlog of typed letters and filing of typed letters. Transfer of some cataract (x67) / oculoplastics (x87) cases to independent sector. Weekly monitoring of waiting list and RTT position. Two new Fellows recruited for diabetic oedema retinal injections (backlog expected to be cleared by end of October 2013. Nursing staff and A&C staff available until 8pm (however no technicians available) Use of WHO surgical safety checklist in theatres Ongoing monitoring of incidents and complaints data Weekly senior team meeting to ensure controls are e Agency staff supporting clinic and notes preparation Skilled staff moved to appropriate areas e.g. waiting	Maior	Almost certain	20	Begin monitoring the backlog and ensure real progress in achieving a steady state (9 - 12 weeks to catch-up with backlog and 20 weeks to achieve steady state (i.e. backlog at a maximum of 1000) - 31/3/14. Identify suitable workstations for additional staff and install computers and printers. - 31 12 13. Monitor the progress in reducing the number of typed letters waiting to be filed and agree a point at which the previous process can be reinstated. - 31/3/14. Improve theatre utilisation by the effective management of operating lists and Implement processes to enable theatre list booking up to 6 weeks in advance. - (4 weeks in advance by) 31/03/14 Organise 'clean room' sessions for Mon, Tues and Thurs am. - 31 12 13. Develop clinical pathways (referral to follow-up). 31/12/13. Training of clinic clerks to be reinforced and data quality checking initiated. - 31 03 14. Close liaison with HR team to expedite the recruitment process for successful interviewees - 31 03 14 Development and 'sign-off' of new protocols for independent operating - 31 03 14. Ensure robust assurance / monitoring mechanisms	9	DTR	3

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	Strategic risk No.
698	Clinical Support and Imaging	Pharmacy	Risk to the production of aseptic pharmaceutical products	03/05/2007	31/01/2014	**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 alternative supplier Limitations of treatments that can be sourced from an alternative supplier. Inability to support research where aseptic compounding required. High cost of sourcing required products from alternative supplier at short notice. Increase in datix incidents pertaining to the Aseptic Unit.	Target	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	**10**

Risk ID	CMG	Specialty	Risk Title	Review Date	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
847	Women's and Children's	Maternity	Lack of Capacity in maternity services	28/09/2007	18/01/2014	**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 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	Patient safety	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 having EL CS women on level 1 - due 31/1/2014 Gynae theatres to be refurbished to accommodate EL CS at LRI - due 28/02/2014	12	JPORT	3
2031	Medical Directorate	R&D	Commercial Research Partner withdrawal	29/06/2012	31/03/2014	Failure to install replacement system for ICESPY. Failure to undertake work to assure commercial partners of commitment to fulfil obligations as a research organisation.	Quality	Currently manual temperature monitoring Libero device at LRI & GH but not with alarms.	Extreme	Likely	20	Replacement for IceSpy - revised due date 31/03/2014	4	CMAL	13

Risk ID	CMG	Specialty	Risk Title	Review Date	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
2267	Corporate Nursing	Infection Prevention	Risk of reduced compliance with DoH requirements in relation to adherence to antimicrobial prescribing policy	09/12/2013	31/01/2014	**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.	Patient safety	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.	Maior	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	**8**

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
2193	ITAPS	Theatres	Risk of unplanned loss of theatre and/or recovery capacity at the LRI	28/06/2013	13/01/2014	**Causes:** 1. 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. 2. 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. 3. There is insufficient electricity and medical gas outlets per bed. 4. Aged electrical sockets resulting in actual and potential electrical faults - fire in theatres at LRI (Theatre 4) in July 2013. **Consequences:** 1. Periodic failure of the theatre estate (ventilation etc) so elective operating has to stop 2. Risk of complete failure of the theatre estate so elective and emergency operating has to stop 3. Increase risk of patient infections 4. Poor staff morale working in an aged and difficult working environment 5. Difficulty in recruiting and retaining specialised staff (the 6. Poor patient experience - our most vulnerable patients a 7. 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 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	Maior	Likely	16	1. TAA Build - due 28/02/14 2. Recovery re-build - due 01/12/14 3. Replacement of all theatre corridor floors and doors - due 31/12/14 (Will not be implemented as no funding for works) 4. Completion of ITAPS nursing recruitment plan - regular monitoring 5. Capital investment and refurbishment of LRI theatres - plan in place and commenced - due 01/12/15	4	PV	**10**

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	Strategic risk No.
2194	ITAPS	Theatres	Risk of unplanned loss of theatre, recovery or Critical Care capacity across UHL due to insufficient nursing staffing	28/06/2013	13/01/2014	**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:** 1. Increased overtime and waiting list payments required to run the core service 2. Tired and unmotivated staff in post 3. Poor staff morale working in an aged and difficult working environment 4. Difficulty in recruiting and retaining specialised staff (theatre and Critical care) due to poor working environment and low staff morale in general 5. Reduction in critical care capacity across UHL 6. Inability to respond to increases in demand in theatre, recovery and critical care capacity 7. Elective patient cancellations including cancer patients 8. Critical Care alternatives becoming the norm for high level of care patients e.g. Kinmonth, overnight PACU and specialty "HDU's". 9. 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	Maior	Likely	16	1. Continuation of monthly rolling adverts - monthly monitoring 2. 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)	4	JHOL	**10**

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
2191	Musculoskeletal and Specialist Surgery	Ophthalmology	Follow up backlogs and capacity issues in Ophthalmology	31/01/2014 12/06/2013	**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 outcome Increased complaints	Patient safety	Outpatient efficiency work ongoing Full recovery plan for ophthalmology in process	Maior	Likely	16	Agree management plan with clinicians to address backlogs - 31 01 14. Clinical care, joint commissioning groups to support backlog clearance - 31 01 14. Develop condition specific follow up protocols - 31 03 14.	8	DTR	**3**

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	Strategic risk No.
607	Clinical Support and Imaging	Blood Transfusion	Failure of UHL BT to fully comply with BCSH guidance and BSRs may adversely impact on patient safety and service delivery	22/12/2006	01/02/2014	**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 require 2 samples from a patient where manual pre-transfusion compatibility testing is performed. An electronic system would require only 1 sample. Critical report received from MHRA in relation to UHL having no credible strategy for compliance with Blood Safe **Consequences:** Potential loss of blood bank licence (via MHRA) with severe Financial penalty for non-compliance. Delay in timely supply of blood and blood components for n Increased potential for 'Never event' (i.e. wrong transfusion Potential loss of Trust's good reputation via publication of c Inefficiencies in service delivery.	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. Fortnightly monitoring and reporting system to CBU Managers in relation to blood/ blood product traceability performance.	Maior	Likely	16	Submit briefing paper to UHL Executive Team and EMPATH. 31/01/14 IM&T project approval. 31/1/14 Obtain Board approval for funding. 31/01/14 Develop implementation plan for electronic tracking system. 31/01/14 Complete SOP's and quality documentation. 31/1/14 Training within clinical areas. 31/1/14 Implement system start date - tba	4	KJON	8

Risk ID	CMG	Specialty	Risk Title	Review Date	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
2248	Clinical Support and Imaging	Medical Physics	Lack of IR(ME)R training records held across the Trust	14/11/2013	28/02/2014	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 in Increased patient radiation doses due to lack of training. Increased staff doses due to lack of awareness of the poter Potential damage to expensive equipment if training on hov Management unable to easily identify which staff are traine Breach of statutory duty Negative effect on the reputation of the Trust	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.	Maior	Likely	16	1. Identify Trust staff with responsibilities under IRMER - due 28/2/2014 3. Investigate potential of using e-UHL to deliver a centralised record of IRMER training - due 31/3/2014 4. Introduce centralised training records for IRMER compliance - due 31/03/2014 5. Review training in the policy. due 01/04/2014 6. Ongoing monitoring of the effectiveness of the determined method of recording training will be detailed in the new policy. due 01/04/2014 7. CMG and service to manage and maintain records for the staff groups identified due 31/03/2014	4	MNO	**12**

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	Strategic risk No.
2153	Women's and Children's	Paediatrics	Children's Hospital including ECMO staffing and Capacity	01/02/2014	05/03/2013	**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 w **Consequences** There is a short fall in the number of appropriately qualified Balancing the demand for PICU beds between NHS contra Unsafe staffing levels, therefore unable to provide the reco Staff from PICU are moved to cover ward shifts to ensure n Elective surgery cases have to be cancelled on the day of t Nurses without the key ITU or paediatric skills may be usec Children's medication can be delayed. Communication with parents is not optimum. Staff miss breaks in order to facilitate care. There has been an increase in staff sickness levels and mo There are an increased number of complaints being receiv	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	Maior	Likely	16	Income from the Libyan Ministry of Health programmer will be used to fund agency nursing staff to open an additional PICU bed - 30/04/2014. Recruitment of suitably trained/experienced agency PICU nurses - 30/04/2014.	8	LBLA	3

Risk ID	CMG	Specialty	Risk Title	Review Date	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
697	Communications	Communications	Failure to achieve Foundation Trust (FT) status	31/03/2014	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.	Maior	Likely	16	Consultation and Engagement actions - 31/03/14	12	KMAY	6

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
1312	Communications	Communications	Poor quality of information on UHL document management system (DMS)	31/03/2014 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 March 2012: Records Management Policy approved Feb 2012. DMS migration to Sharepoint in progress but completion delayed pending upgrade to 2010 version. Expected May 2012. UPDATE Dec 2012: IM&T committed to supporting SP2010. Ascribe consultancy working with KM team to implement SP2010 by end Dec 2012. UPDATE Mar 2013: SP2010 installed and formally supported by IM&T. Migration of docs from 2007 to 2010 in progress, expected Jun 2013. 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 informa	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.	Maior	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 - 31/03/14	6	SAN	**12**

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	Strategic risk No.
2237	Medical Directorate	Medical Directorate	Risk of results of outpatient diagnostic tests not being reviewed or acted upon resulting in patient harm.	07/10/2013	28/02/2014	**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 **Consequences** Potential for mismanagement of patients to include: Severe harm or death to patient Suboptimal treatment Delayed diagnosis Increased potential for incidents, complaints, inquests and Risk of adverse publicity to UHL leading to loss of good rep Financial consequences to include: Potential increase in NHSLA contributions	Patient safety	Abnormal pathology results escalation process Suspicious imaging findings escalated to MDTs	Maior	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	12

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	Strategic risk No.
2271	Corporate Nursing	Nursing	Failure to achieve compliance of 75% attendance at Safeguarding training may have adverse impact on UHL safeguarding processes	11/01/2014	11/12/2013	**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. Staff may be vulnerable and under additional stress if they	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 - 31/01/14. Advertise Safeguarding training on InSite - 31/01/14.	6	MCLA	**3**

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
2247	Corporate Nursing	Nursing	There are 500 Registered Nurse vacancies in UHL leading to a deterioration in service and adverse effect on financial position	31/01/2014 30/10/2013	**Causes** Shortage of available Registered Nurses in Leicestershire. Nursing establishment review undertaken resulting in significant vacancies due to investment. Insufficient HRSS Capacity leading to delays in recruitment. **Consequences** Potential increased clinical risk in areas Increase in occurrence of pressure damage and patient falls Increase in patient complaints Reduced morale of staff, affecting retention of new starters Risk to Trust reputation Impact on Trust financial position due to premium rate staffing being utilised to maintain safety. Increased vacancies across UHL Increased paybill in terms of cover for establishment rotas prior to permanent appointments HRSS capacity has not increased to coincide and support the increase in vacancies across the Trust Delays in processing of pre employment checks due to increased recruitment activity Delayed start dates for business critical posts Benefits of bulk and other recruitment campaigns not being realised as effectively as anticipated and expected Service areas outside of nursing being impacted upon due to emphasis on nursing roles.	Patient safety	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.	Maior	Likely	16	Ward dashboards - 31/01/14 Ward performance process - 31/01/14 Over recruit HCAs. - 31/01/14 Utilise other roles to liberate nursing time - 31/01/14	12	CRIB	3

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	Strategic risk No.
1693	Strategy	Strategy	Risk of inaccuracies in clinical coding	02/08/2011	31/12/2013	**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	Maior	Likely	16	Succession Planning for Coding Manager - 31/12/13 Coding Improvement Board - 31/12/13 2013/14 PbR Audit - 22/01/14 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 - 31/03/14	8	JRO	**12**

Risk ID	CMG	Specialty	Risk Title	Review Date	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
1737	Renal, Respiratory and Cardiac (RRC)	Renal Transplant	Inappropriate environment and infection prevention Renal Transplant	31/03/2014	25/10/2011	**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 risk Transportation of contamination through patient occupied areas (15N/A)	Patient safety	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	**10**
2070	Renal, Respiratory and Cardiac (RRC)	Satellite Units	Harborough Lodge environment stops staff safely delivering haemodialysis	31/03/2014	16/08/2012	**Causes:** Insufficient space to: Safely carry out dialysis procedures Safely carry out manual handling procedures Safely carry out emergency procedures Maintain patient privacy & dignity Poor state of repair of within clinical areas **Consequences:** Cross contamination/infection Manual handling injury to staff/patient/visitor Poor patient experience Negative reputation of Trust Complaints	Patient safety	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	**10**

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	Strategic risk No.
1196	Clinical Support and Imaging		No comprehensive out of hours on call rota for consultant Paediatric radiologists	29/06/2009	31/03/2014	**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.	Patient safety	There are Consultant Radiologists on call however there are not sufficient numbers to provide an on call service. Registrars are available but they have variable experience. Non Paediatric radiology consultants are not able to perform or interpret Paediatric radiological interventions.	Moderate	Almost certain	15	Review Paediatric service to determine the employment of further Consultants - due 31/03/14	2	RG	3

Risk ID	CMG	Specialty	Risk Title	Review Date	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
1157	Clinical Support and Imaging	Medical Physics	Lack of planned maintenance for medical equipment maintained by Medical Physics	14/05/2009	28/02/2014	**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 - 01/04/14 Quantify the shortfall in maintenance provision from existing resources and identify to the Trust (to enable Trust decision on corrective to be made) - 28/2/14 Establish infusion pump libraries at LGH and LRI - 1/4/14	6	MNO	**8**

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
2278	Women's and Children's		Risk that the Leicester Fertility Centre could have its licence for the provision of treatment and services withdrawn	17/01/2014 17/12/2013	**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	Recruit to Band 4 associate laboratory practitioner for embryology post - due 28/2/2014 Complete application for ISO accreditation - due 31/3/14 Review of protocols to ensure meet ISO 15189 standards - due 31/3/2014 Improve information for patient and service users - due 31/3/2014 Completion of internal risk assessments with regards to privacy and infection control when delivering samples to reception - due 31/12/13 Formulation of business plan for Quality Manager post - due 31/3/2014 Recruit to Band 4 associate laboratory practitioner for andrology post - due 28/2/2014 Overhaul of specimen request, collection and delivery procedures - due 31/3/2014 IQA system to be improved in order to meet accreditation requirements - due 31/3/2014 review of the need for a automated semen analyser - due 31/3/2014 Introduction of an appointment system for andrology samples - due 31/3/2014	6	DMARS	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	Strategic risk No.
2200	Women's and Children's	Maternity	Failure to achieve compliance with level 3 of the NHSLA CNST Maternity Risk Management Standards (CNST)	13/01/2014	05/08/2013	In February 2013, the Women's CBU successfully attained CNST Level 2. The plan is now to attain Level 3 in February 2014. Possible barriers to successfully attaining Level 3 include: Competing priorities within the Trust (e.g. NHSLA acute risk management assessment 2013/14, CQC registration, CIP schemes, etc) Policy/procedural documents do not reflect recent organisational changes (including reporting frameworks) Failure to implement and embed processes described within polices and procedural documents Failure to monitor effectiveness of policies/ procedural documents Limited understanding of CNST requirements throughout the CBU, Division and the organisation Lack of capacity within divisions for evidence collection / collation Inappropriate quality and / or quantity of evidence at time of assessment (evidence required to cover 12 months preceding assessment across all care settings and sites). Difficulty in monitoring compliance with maternity related policies outside the CBU but within the Trust **Consequences:** Severe financial impact with NHSLA contributions. Failure of assessment would result in an immediate downg Adverse publicity and potential to impact reputation.	Economic	1.Dedicated full-time Project Manager identified. 2.CNST project team identified. 3.Project Specialist Midwife Co-ordinator identified (Quality & Safety Team). 4.Project Obstetric Lead Clinician identified. 5.CNST Facilitator identified (Quality & Safety Team). 6.x2 midwives seconded to assist in the implementation of CNST requirements in the clinical settings. 7.Project action plan and timetable in place. 8.Specific Lead Officers appointed to co-ordinate actions for CNST criterion where required. 9.Regular Lead Officer meetings to assess progress / resolve issues. 10.Regular progress reports to CBU, Divisional and Senior Trust committees. 11.Regular liaison with CNST Local Assessor (including x4 informal visits) 12.Monthly monitoring of evidence to identify areas of non-compliance to enable early resolution.	Extreme	Possible	15	Appointment of Admin & Clerical member of staff (specific to CNST) - due 31/01/14	4	STA	8
2167	Communications	Communications	Loss of charity funder	31/07/2014	01/10/2011	Loss of (up to) £300k income to Charity from WRVS as a result of single FM supplier contract award. The Charity currently has no recovery plan for such a loss of income. The WRVS funding covers a number of posts within the Trust which would be put at risk.	Economic	The Charitable Funds Committee monitors income and expenditure at bi-monthly meetings. A reduction or cessation of funding is manageable if necessary. Currently awaiting outcome of discussions between WRVS and Interserve.	Moderate	Almost certain	15	Implement the new five year plan, beginning with better location for Charity and recruitment of additional staff in first half of 2014 - 31/07/14	8	TDI	1

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
1310	Medical Directorate	Medical Directorate	Risk of user error associated with non-standardisation of manual and automated external defibrillators	28/02/2014 16/12/2009	**Causes:** Medical staff using the defibrillator will rotate to other sites within the Trust Different make / model of defibrillator used at LGH site (Zoll defibrillators as opposed to Medtronic LifePak 20) Defibrillator training at LRI/ Glenfield hospital uses Lifepak defibrillators for practical element of training but purely illustrates the differences between Zoll and Lifepak. This includes how to turn on, how to activate manual mode (2-stage activation), and location of 'shock' button. Defibrillator training at LGH hospital uses Zoll defibrillator for practical element of training but purely illustrates the differences between Zoll and Lifepak. This includes how to turn on, how to activate manual mode (finding release button and opening manual door), and location of 'shock' button. **Consequences:** Potential for unsuccessful defibrillation attempt Potential for injury to the patient (death) Potential to disrupt the advanced life support universal algorithm Non-compliance with recommendations of the CPR Standards for Clinical Practice and Training	Patient safety	Defibrillation training Defibrillator will give automated instructions (depending on clinical setting)	Extreme	Possible	15	Training and educating staff to use new defibs - due 28/02/14	5	LR	**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	Strategic risk No.
2270	Corporate Nursing		Failure to achieve compliance of 75% attendance at Fire Safety training may cause UHL to fail to meet its statutory obligation	31/01/2014	11/12/2013	**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) - 31/01/14. 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 - 31/01/14. Raise awareness of fire safety training via utilisation of Intranet and PC desktop messages - 31/01/14. Incentivise medical staff attendance - 31/01/14.	9	GBRO	3
2268	Corporate Nursing		Failure to meet targets for training compliance for M and H training may adversely affect patient care /staff safety	31/01/2014	11/12/2013	**Causes** Lack of dedicated training space 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	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	Submit business case for additional M&H trainer Redesign of induction training to ensure appropriate level of M&H training - 31/3/14. Implement weekly M&H training to smaller groups - 28/2/14	9	NH	3

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
2272	Corporate Nursing		Failing to meet internal and external targets in relation to undertaking IG training may adversely affect UHL compliance	31/01/2014 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 - 31/1/14. Re-issue workbook and FIT training - 31/01/14	6	RSMI	**3**
2269	Corporate Nursing	Infection Prevention	Failure to meet UHL target of a minimum of 75% of clinical staff undertaking IP/Hand hygiene training	31/01/2014 11/12/2013	**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)	Patient safety	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. 30/1/14. Hold discussions with Medical Director to incentivise medical staff attendance for hand hygiene 31/1/2014. 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	**3**

Risk ID	CMG	Specialty	Risk Title	Review Date	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
1551	Corporate Nursing	QS	Failure to manage Category C documents on UHL Document Management system (DMS)	31/03/2014	14/03/2011	**Causes** Lack of resource at Divisional/ directorate level Lack of resource in CASE team Delays in the development of 'SharePoint' that would enable automatic reminders for expired documents to be generated for the document authors. **Consequences** DMS does not contain the most recent versions of all category C documents Staff may be following incorrect guidance (clinical or non-clinical) May not be able to demonstrate compliance with NHSLA ARMS	Quality	Acting Head of Outcomes has discussed the problems with Clinical Business Units (CBUs) to identify which documents can be managed by the CBUs Reminders to be manually generated by the CASE team (one day a week only)	Moderate	Almost certain	15	Use of bank staff or redeployed staff for 3 - 6 months to update information on DMS and migrate to 'SharePoint' - 31/03/2014	9	SH	**8**

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

EXCEPTION RISK REPORT FOR CLINICAL RESEARCH NETWORK

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	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
2287	Medical Directorate	NIHR Clinical Research Network: East Midlands local transition plan may not be delivered by April 2014.	08/01/2014	08/04/2014	**Causes:** Difficulties in timely appointment of LCRN Leadership Team and in particular the COO and other senior managerial staff. Complex workforce change which will take account of local organisational policy and procedures. Loss of key staff during transition of research delivery functions. Duplication of effort in relation to patient, carer and public involvement and engagement. Delayed transition to LCRN governance arrangements Proposed workforce structure within the East Midlands may not be accepted causing delays. Host's new accommodation to house CRN may not be available by April 2014. **Consequences:** Delay and potential failure to realise significant improvements in supporting and facilitating increased recruitment of patients into high quality clinical research studies. Delayed opportunity to further drive clinical research delivery and enhance patient experience and outcome. CRN fails to function correctly and subsequent reduction in realisation of financial benefits for UHL. Risk of poor reputation of UHL as a 'host' for CRN.	Business	Clinical Director designate in post and taking a more active role and operational role in network management and transition Nominated Executive Director and Interim Partnership group established to operate as active partners in developing and scrutinising the CRN financial plan; driving network performance and challenging underperformance etc. Scheme of delegation and host board controls and assurances in place with clear routes for escalation Pooling of expertise in region to avoid any duplication of effort in relation patient, carer and public involvement. Interim Executive Group and Interim Operational group now established (Sept/Nov 2013) Letter of reassurance to Chief Execs of employing organisations in East Mids from the host to allay staff concerns and reduce the number of key staff likely to be lost during transition. Temporary office accommodation identified.	Major	Possible	12	Recruitment of temporary project management and other expertise - Complete Ensure effective leadership and communications throughout the management structure with people transition being a key objective. - 1/2/14 Convene a regional HR subgroup - Complete	6	DR