Trust Board paper Y

To:	**Trust Board**
From:	**Rachel Overfield - Chief Nurse**
Date:	**31 July 2014**
CQC regulation:	Outcome 16 – Assessing and Monitoring the Quality of Service Provision

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

Author/Responsible Director: Chief Nurse

Purpose of the Report:

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

a) A copy of the revised UHL BAF as of 23rd July 2014.
b) Notification of any new extreme or high risks opened during June 2014
c) Notification of all extreme and high risks that are on the UHL risk register as of 30th June 2014.

The Report is provided to the Board for:

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

Summary :

- A revised suite of risks based on the recently revised UHL objectives is included in the 2014/15 BAF.
- The format of the BAF has changed to provide the TB with a greater level of assurance.
- A simplified table of likelihood and consequence descriptors has been developed for the 2014/15 BAF in order to provide a consistent and less subjective approach to risk scoring.
- As of 30th June 2014 there were 34 risks on the organisational risk register scoring 15 and above (i.e. 32 high and two extreme risks).
- Three new high risks have been opened on the UHL register during May 2014.

Recommendations:

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

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

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

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

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

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

principal objectives; (f) Endorse the UHL 2014/15 BAF as 'fit for purpose' (notwithstanding the additional work required as described in section 2.1 of this report).	
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 TB	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **31 JULY 2014**

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

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

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1. INTRODUCTION

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

a) A copy of the revised UHL BAF as of 23rd July 2014.

b) Notification of any new extreme or high risks opened during June 2014

c) Notification of all extreme and high risks that are on the UHL risk register as of 30th June 2014.

2. BAF POSITION AS OF 23rd JULY 2014

2.1 Following the revision of the UHL's 2014/15 strategic objectives and the TB approval of the five year integrated business plan a revised suite of principal risks have been worked up through the Executive Team. At the same time consideration has been given to a change in format of the BAF. This formed the basis of discussions at a Trust Board Development Session (TBDS) that took place on 17th July 2014. During these discussions three additional principal risks were identified (i.e. 6, 18 and 21) and have been included in the BAF that is attached at appendix one. Further work from their executive leads is required in order to provide a completed BAF, however notwithstanding this the UHL 2014/15 BAF is submitted to the TB for endorsement. In doing so the TB is asked to note the following:

a. The change in format to the BAF is designed to provide the TB with a greater level of assurance by focussing on how we measure / monitor the effectiveness of each control in relation to moving us towards our objectives. The assurance element will record performance against the relevant key performance indicators.

b. A simplified table of likelihood and consequence descriptors has been developed for the 2014/15 BAF in order to provide a consistent and less subjective approach to risk scoring and is included within the BAF for ease of reference. Each risk will also have a current and target rating assigned indicating the level of risk to the objective not being achieved. For completeness, all scores are calculated by multiplying the consequence score by the likelihood score.

c. Future iterations of the BAF will be accompanied by a summary sheet to show the movement of scores from one month to the next and an action tracker to reflect progress in implementing actions from the BAF.

d. The corporate risk team will carry out an exercise to ensure that where risks from the previous BAF are not included in the 2014/15 version they are included on the UHL risk register under the ownership of the appropriate director.

4. 2014/15 QUARTER ONE EXTREME AND HIGH RISK REPORT.

4.1 A summary of all currently open extreme and high risks is attached at appendix two and the details of these risks are attached at appendix three. As of 30th June 2014 there were 34 risks on the organisational risk register scoring 15 and above (i.e. 32 high and two extreme risks).

4.2 Three new high risks have opened during June 2014 as described below. The details of these risks are included at appendix three for information

Risk ID	Risk Title	Risk Score	CMG/ Directorate
2391	Inadequate numbers of Junior Doctors to support the clinical services within Gynaecology & Obstetrics	20	W & C
2384	There is an increased risk in the incidence of babies being born with HIE (moderate & severe) within UHL	16	W & C
2380	Risk of breach of Same Sex Accommodation Legislation	15	CSI

5. RECOMMENDATIONS

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

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

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

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

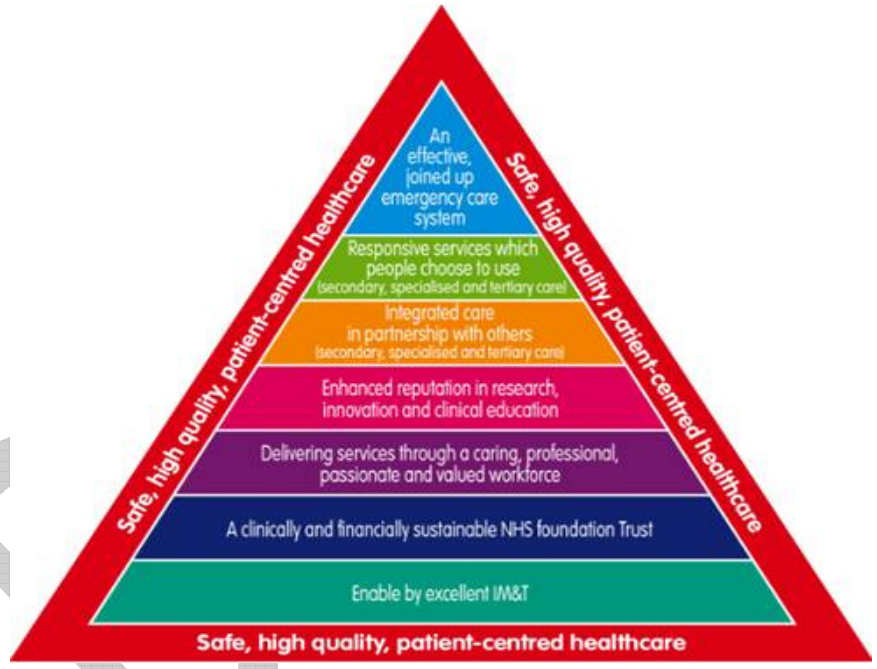
(d) identify any gaps in assurances about the effectiveness of the controls in place to manage the principal risks and consider the nature of, and timescale for, any further assurances to be obtained;

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

(f) Endorse the UHL 2014/15 BAF as 'fit for purpose' (notwithstanding the additional work required as described in section 2.1 of this report).

Peter Cleaver,
Risk and Assurance Manager,
24 July 2014.

UHL BOARD ASSURANCE FRAMEWORK 2014/15



UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

STRATEGIC OBJECTIVES

Objective	Description	Objective Owner(s)
a	Safe, high quality, patient centred healthcare	Chief Nurse
b	An effective, joined up emergency care system	Chief Operating Officer
c	Responsive services which people choose to use (secondary, specialised and tertiary care)	Director of Strategy / Chief Operating Officer/ Director of Marketing & Communications
d	Integrated care in partnership with others(secondary, specialised and tertiary care)	Director of Strategy
e	Enhanced reputation in research, innovation and clinical education	Medical Director
f	Delivering services through a caring, professional, passionate and valued workforce	Director of Human Resources
g	A clinically and financially sustainable NHS Foundation Trust	Director of Finance
h	Enabled by excellent IM&T	Chief Executive / Chief Information Officer

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

PERIOD: JULY 2014

Risk No.	Link to objective	Description	Risk owner	Current Score C x L	Target Score C x L
1.	Safe, high quality, patient centred healthcare	Lack of progress in implementing UHL Quality Commitment.	CN	12	8
2.	An effective joined up emergency care system	Failure to implement LLR emergency care improvement plan.	COO	12	6
3.		Failure to effectively implement UHL Emergency Care quality programme	COO	12	6
4.		Delay in the approval of the Emergency Floor Business Case.	MD	9	6
5.	Responsive services which people choose to use (secondary, specialised and tertiary care)	Failure to deliver RTT improvement plan.	COO	9	6
6.		Failure to achieve effective patient and public involvement	DMC		
7.		Failure to effectively implement Better Care together (BCT) strategy.	DS	12	8
8.		Failure to respond appropriately to specialised service specification.	DS	15	8
	Integrated care in partnership with others (secondary, specialised and tertiary care)	Failure to effectively implement Better Care together (BCT) strategy.**(See 7 above)**	DS		
9.		Failure to implement network arrangements with partners.	DS	8	6
10.		Failure to develop effective partnership with primary care and LPT.	DS	12	8
11.	Enhanced reputation in research, innovation and clinical education	Failure to meet NIHR performance targets.	MD	9	6
12.		Failure to retain BRU status.	MD	9	6
13.		Failure to provide consistently high standards of medical education.	MD	9	6
14.		Lack of effective partnerships with universities.	MD	9	6
15.	Delivering services through a caring, professional, passionate and valued workforce	Failure to adequately plan workforce needs of the Trust.	DHR	12	8
16.		Inability to recruit and retain staff with appropriate skills.	DHR	12	8
17.		Failure to improve levels of staff engagement.	DHR	9	6
18	A clinically and	Lack of effective leadership capacity and capability	DHR		

19.	financially sustainable NHS Foundation Trust	Failure to deliver the financial strategy (including CIP).	DF	15	10
20		Failure to deliver internal efficiency and productivity improvements.	COO	16	6
21.		Failure to maintain effective relationships with key stakeholders	DMC		
22.		Failure to deliver service and site reconfiguration programme and maintain the estate effectively.	DS	10	5
23.	Enabled by excellent IM&T	Failure to effectively implement EPR programme.	CIO	15	9
24.		Failure to implement the IM&T strategy and key projects effectively	CIO	15	9

Consequence and Likelihood Descriptors:

Impact/Consequence			**Likelihood**	
5	Extreme	Catastrophic effect upon the objective, making it unachievable	5	Almost Certain (81%+)
4	Major	Significant effect upon the objective, thus making it extremely difficult/ costly to achieve	4	Likely (61% - 80%)
3	Moderate	Evident and material effect upon the objective, thus making it achievable only with some moderate difficulty/cost.	3	Possible(41% - 60%)
2	Minor	Small, but noticeable effect upon the objective, thus making it achievable with some minor difficulty/ cost.	2	Unlikely(20% - 40%)
1	Insignificant	Negligible effect upon the achievement of the objective.	1	Rare (Less than 20%)

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 1	Lack of progress in implementing UHL Quality Commitment.	**Overall level of risk to the achievement of the objective**	**Current score 4 x 3 = 12**	**Target score 4 x 2 = 8**
Executive Risk Lead(s)	Chief Nurse			
Link to strategic objectives	Provide safe, high quality, patient centred healthcare			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Corporate leads agreed for all component parts of the Quality Commitment.	Q&P Report. Reports to EQB and QAC.	(C) Need to embed new Quality Commitment into organisation. (A) Need to complete formulation of KPIs for each part of the Quality Commitment.	Corporate leads required to complete by September 2014	September 2014 Sharron Hotson
Objectives agreed for all parts of the Quality Commitment.	Reports to EQB and QAC based on key outcome/KPIs.	(C) Need to complete KPIs for all parts of the Quality Commitment.	Corporate leads required to complete by September 2014	September 2014 Sharron Hotson
Clear action plans agreed for all parts of the Quality Commitment.	Action plans reviewed regularly at EQB and annually reported to QAC. Annual reports produced.	(C) Some action plans remain outstanding.	Corporate leads required to complete by September 2014	September 2014 Sharron Hotson
Committee structure is in place to ensure delivery of key work streams – led by appropriate senior individuals with appropriate support.	Regular committee reports. Annual reports. Achievement of KPIs.	No gaps identified		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 2	Failure to implement LLR emergency care improvement plan.	**Overall level of risk to the achievement of the objective**	**Current score 4 x 3 = 12**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Chief Operating Officer			
Link to strategic objectives	An effective joined up emergency care system			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Establishment of emergency care delivery and improvement group with named sub groups	Meetings are minuted with actions circulated each week. Trust Board emergency care report references the LLR steering group actions.	(C) Format of LLR meeting has changed recently and regularity of meetings and membership needs to be confirmed	Chair of group will confirm membership and sub group activities in the next fortnight	Aug 14 Dave Briggs
Appointment of Dr Ian Sturgess to work across the health economy	Weekly meetings between Dr Sturgess, UHL CEO and UHL COO. Dr Sturgess attends Trust Board.	(A) Dr Sturgess is contracted to finish work here in mid-November 2014.	CEO and Dr Sturgess are agreeing plans to ensure his legacy is sustainable	August 2014 John Adler
Allocation of winter monies	Allocation of winter monies is regularly discussed in the LLR steering group	(C) Allocation of money across the health economy has not been confirmed – i.e. how much will UHL receive?	Dr Sturgess tasked with chairing a group that recommends how the money can be used most effectively.	July 2014 Dave Briggs

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 3	Failure to effectively implement UHL Emergency Care quality programme.	**Overall level of risk to the achievement of the objective**	**Current score 4 x 3 = 12**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Chief Operating Officer			
Link to strategic objectives	An effective joined up emergency care system			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Emergency care action team meeting has been remodelled as the 'emergency quality steering group' (EQSG) chaired by CEO and significant clinical presence in the group. Four sub groups are chaired by three senior consultants and chief nurse.	Trust Board are sighted on actions and plans coming out of the EQSG meeting.	(C) Progress has been made with actions outside of ED and we now need to see the same level of progress inside it	One of the subgroups is focussed on the front end of the pathway	Sept 14 Mark Ardron
Reworked emergency plans are focussing on the new dashboard with clear KPIs which indicates which actions are working and which aren't	Dashboard goes to EQSG and Trust Board	(C) ED performance against national standards	As above	As above

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 4	Delay in the approval of the Emergency Floor Business Case.	**Overall level of risk to the achievement of the objective**	**Current score 3 x 3 = 9**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Medical Director			
Link to strategic objectives	An effective joined up emergency care system			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Monthly ED project program board to ensure submission to NTDA as required Gateway review process Engagement with stakeholders	Monthly reports to Executive Team and Trust Board Gateway review	Inability to control NTDA internal approval processes	Regular communication with NTDA	Aug 14 Kevin Harris

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 5	Failure to deliver RTT improvement plan.	**Overall level of risk to the achievement of the objective**	**Current score 3 x 3 = 9**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Chief Operating Officer			
Link to strategic objectives	Responsive services which people choose to use (secondary, specialised and tertiary care)			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Fortnightly RTT meeting with commissioners to monitor overall compliance with plan	Trust Board receives a monthly report detailing performance against plan	(C) UHL is behind trajectory on its admitted RTT plan	Action plans developed in key specialities – general surgery and ENT to regain trajectory	Sept 14 Richard Mitchell
Weekly meeting with key specialities to monitor detailed compliance with plan	Trust Board receives a monthly report detailing performance against plan	(C) UHL is behind trajectory on its admitted RTT plan	Action plans developed in key specialities – general surgery and ENT to regain trajectory	Sept 14 Richard Mitchell
Intensive support team back in at UHL (July 2014) to help check plan is correct	IST report including recommendations to be presented to Trust Board	(A) Report has not been seen yet	Await publication of report and act on findings and recommendations	Aug 14 Richard Mitchell

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 6	Failure to achieve effective patient and public involvement	**Overall level of risk to the achievement of the objective**	**Current score**	**Target score**
Executive Risk Lead(s)	Director of Marketing and Communications			
Link to strategic objectives	Responsive services which people choose to use (secondary, specialised and tertiary care)			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 7	Failure to effectively implement Better Care together (BCT) strategy.	**Overall level of risk to the achievement of the objective**	**Current score 4 x 3 = 12**	**Target score 4 x 2 = 8**
Executive Risk Lead(s)	Director of Strategy			
Link to strategic objectives	Responsive services which people choose to use (secondary, specialised and tertiary care) Integrated care in partnership with others (secondary, specialised and tertiary care)			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Better Care Together Strategy: **1)** UHL activelyengaged in the Better Care Together governance structure, from an operational to strategic level: • John Adler - the Chair of the Strategy Delivery Group • Kate Shields - member of the LLR Strategy Delivery Group • Peter Hollinshead / Simon Sheppard - members of the finance sub-group **2)** Better Care Together plans co–created in partnership with LLR partners e.g. sub-acute project with LPT	LLR Better Care Together Executive Summary (directional plan): ○ received and approved at the June 2014 UHL Trust Board meeting	(C) Work plan for June to September 2014 to be developed	Work plan to be developed by the LLR BCT Strategy Delivery Group to be considered by the BCT Programme Board at the end of August 2014.	August 2014 Kate Shields
Effective partnerships with primary care and Leicestershire Partnership Trust (LPT): 1) Active engagement and leadership of the LLR Elective Care Alliance 2) LLR Urgent Care and Planned Care work streams in partnership with local GPs 3) A joint project has been established to test the concept of early transfer of sub-acute care to a community hospitals setting or home in partnership with LPT. The impact of this is reflected in UHLs, LPTs the LLR BCT 5 year plans. 4) Mutual accountability for the delivery of shared objectives are reflected in the LLR BCT 5 year directional plan	Minutes of the June public Trust Board meeting: ○ Trust Board approved the LLR BCT 5 year directional plan and UHLs 5 year directional plan on 16 June, 2014 ○ urgent care and planned care work streams reflected in both of these plans	(C) Between June and September 2014 respective plans need to reconciled and developed in a greater level of detail to support operational delivery.	Work plan to be developed by the LLR BCT Strategy Delivery Group to be considered by LLR BCT Programme Board at the end of August 2014.	August 2014 Kate Shields / Richard Mitchell

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 8	Failure to respond appropriately to specialised service specification.	**Overall level of risk to the achievement of the objective**	**Current score 5 x 3 = 15**	**Target score 4 x 2 = 8**
Executive Risk Lead(s)	Director of Strategy			
Link to strategic objectives	Responsive services which people choose to use (secondary, specialised and tertiary care) Integrated care in partnership with others (secondary, specialised and tertiary care)			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source**(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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Regional partnerships: UHL is actively engaging with partners with a view to: • establishing a Leicestershire Northamptonshire and Rutland partnership for the specialised service infrastructure in partnership with Northampton General Hospital and Kettering General Hospital • establishing a provider collaboration across the East Midland's as a whole • Developing an engagement strategy for the delivery of the long term vision for and East Midlands network for both acute and specialised services	Minutes of the April 2014 Trust Board meeting: ○ Paper presented to the April 2014 UHL Trust Board meeting, setting out the Trust's approach to regional partnerships Project Initiation Document (PID): ○ Developed as part of UHL's Delivering Care at its Best ○ Reviewed at the June 2014 Executive Strategy Board (ESB) meeting	(C) Head of External Partnership Development with administrative support to be appointed (C) Programme Plan to be developed	Highlight report to be presented at the August 2014 ESB meeting for sign off.	December 2014 Kate Shields
Specialised Services specifications: CMGs addressing Specialised Service derogation plans	Plans issued to CMGs in February 2014. Follow up meetings being convened for w/c 14th July 2014to identify progress to date.	(A) Progress will be monitored via the Contracts Team as part of their interface with CMG Managers / Service Managers	Contracts Team to develop simple monthly reporting to track progress	Sept 2014 Kate Shields

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 9	Failure to implement network arrangements with partners.	**Overall level of risk to the achievement of the objective**	**Current score 4 x 2 = 8**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Director of Strategy			
Director of Strategy	Integrated care in partnership with others (secondary, specialised and tertiary care)			

Integrated care in partnership with others (secondary, specialised and tertiary care)	**Assurance Source**(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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Network relationships with partners: Directional 5 year Integrated Business Plan (IBP) submitted to the NHS Trust Development Authority (NTDA) defines three principle partnership networks to support the integration of services (Local, regional and academic). These will progress in a structured and methodical way. Clear lines of reporting have been established through the Executive Strategy Board (ESB) Delivering Care at its Best structure. Highlight reports will be presented to monitor progress.	Minutes of the April 2014 Trust Board meeting: ○ Paper presented to the April 2014 UHL public Trust Board meeting, describing the development of an East Midlands Provider Partnership Project Initiation Document (PID): ○ Developed as part of UHL's Delivering Care at its Best ○ Reviewed at the June 2014 ESB meeting	(C) PID to be developed for local partnerships (Executive Lead Mark Wightman) and academic partnerships (Executive Lead Nigel Brunskill – DR&D) - to be presented at the August 2014 ESB meeting.	PIDs and overarching highlight report to be presented at the August 2014 ESB meeting for sign off.	August 2014 Nigel Brunskill / Mark Wightman
Delivery of Better Care Together: 1) UHL is activelyengaged in the Better Care Together governance structure, from an operational to strategic level: • John Adler is the Chair of the Strategy Delivery Group • Kate Shields is a member of the LLR Strategy Delivery Group • Peter Hollinshead / Simon Sheppard are members of the finance sub-group 2) Better Care Together plans are co–created in partnership with LLR partners e.g. sub-acute project with LPT	LLR Better Care Together Executive Summary (directional plan): ○ received and approved at the June 2014 UHL Trust Board meeting	(C) LLR BCT plan submitted on 20 June to NHS England and the NTDA is 'directional' i.e. it outlines the broad direction of travel. Detailed delivery plans to be discussed and agreed between June and September 2014.	Work plan developed by the LLR BCT Strategy Delivery Group to be considered by the BCT Programme Board at the end of August 2014.	August 2014 Kate Shields

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 10	Failure to develop effective partnership with primary care and LPT.	**Overall level of risk to the achievement of the objective**	**Current score 4 x 3 = 12**	**Target score 4 x 2 = 8**
Executive Risk Lead(s)	Director of Strategy			
Director of Strategy	Integrated care in partnership with others (secondary, specialised and tertiary care)			

Integrated care in partnership with others (secondary, specialised and tertiary care)	**Assurance Source**(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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Effective partnerships with LPT: A joint project has been established to test the concept of early transfer of sub-acute care to be delivered in community Hospitals or home in partnership with LPT for specific cohorts of patients e.g. frail older person The impact of this is reflected in UHLs, LPTs the LLR BCT 5 year plans.	Reflected in UHL directional 5 year plan presented to TB June 20 2014	(C) Between June and September UHLs and LPTs 5 year plans will be reconciled and developed in greater detail to support operational delivery.	Joint project established:PID & draft Terms of Reference to be reviewed at the August 2014 ESB meeting.	August 2014 Kate Shields / Richard Mitchell
Effective partnerships with primary care: Elective Care Alliance established with agreed terms of reference for the Leadership Board and other sub groups thereby allowing structured engagement and partnership working with local GPs through the LLR Provider Company LTD. Joint business plan under development.	Minutes of the March 2014 Trust Board meeting: ○ establishment of the Alliance formally approved by Trust Board in March, 2014 Minutes of ESB meetings: ○ Progress against plan is reported to the ESB	(C) Between June and September the Alliance Business Plan and our own plans needs to reconciled and developed in a greater level of detail to support operational delivery.	Business plan to be finalised prior to consideration by the ESB and then the Trust Board at the end of August 2014.	August 2014 Kate Shields
Effective partnerships with primary care and LPT: Active engagement and leadership of the LLR Urgent Care and Planned Care work streams in partnership with local GPs. Mutual accountability for the delivery of shared objectives reflected in the LLR BCT 5 year plan.	Minutes of the June public Trust Board meeting: ○ Trust Board approved the LLR BCT 5 year directional plan and UHLs 5 year directional plan on 16 June, 2014 ○ urgent care and planned care work streams reflected in both of these plans	(C) Between June and September 2014 respective plans need to be reconciled and developed in a greater level of detail to support operational delivery.	Work plan developed by the LLR BCT Strategy Delivery Group to be considered by the LLR BCT Programme Board at the end of August 2014.	August 2014 Kate Shields

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 11	Failure to meet NIHR performance targets.	**Overall level of risk to the achievement of the objective**	**Current score 3 x 3 = 9**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Medical Director			
Link to strategic objectives	Enhanced reputation in research, innovation and clinical education			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source**(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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Action Plan developed in response to the introduction of national metrics and potential for financial sanctions	Performance in Initiation & Delivery of Clinical Research (PID) reports from NIHR – to CE and R&D (quarterly) UHL R&D Executive (monthly) R&D Report to Trust Board (quarterly) R&D working with CMG Research Leads to educate and embed understanding of targets across CMGs (regular; as required)	No gaps identified		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 12	Failure to retain BRU status.	**Overall level of risk to the achievement of the objective**	**Current score 3 x 3 = 9**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Medical Director			
Link to strategic objectives	Enhanced reputation in research, innovation and clinical education			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source**(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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Maintaining relationships with key partners to support joint NIHR/ BRU infrastructure	Joint BRU Board (bimonthly) Annual Report Feedback from NIHR for each BRU (annual) UHL R&D Executive (monthly) R&D Report to Trust Board (quarterly) Athena Swan Silver Status by University of Leicester and Loughborough University. (The Athena Swan charter applies to higher education institutions)	No gaps identified		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 13	Failure to provide consistently high standards of medical education.	**Overall level of risk to the achievement of the objective**	**Current score 3 x 3 = 9**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Medical Director			
Link to strategic objectives	Enhanced reputation in research, innovation and clinical education			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source**(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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Medical Education Strategy	A joint Programme and project methodology is in place between UHL and IBM for managing and tracking activities.			
UHL Education Committee	Reports to Trust Board (quarterly)			

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 14	Lack of effective partnerships with universities.	**Overall level of risk to the achievement of the objective**	**Current score 3 x 3 = 9**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Medical Director			
Link to strategic objectives	Enhanced reputation in research, innovation and clinical education			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source**(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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Maintaining relationships with key academic partners	Joint Strategic Meeting (University of Leicester and UHL Trust) Joint BRU Board (quarterly) UHL R&D Executive (monthly)	No gaps identified		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 15	Failure to adequately plan the workforce needs of the Trust.	**Overall level of risk to the achievement of the objective**	**Current score 4 x 3 = 12**	**Target score 4 x 2 = 8**
Executive Risk Lead(s)	Director of Human Resources			
Link to strategic objectives	Delivering services through a caring, professional, passionate and valued workforce			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source**(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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
UHL Workforce Plan (by staff group)	Reduction in number of 'hotspots' for staff shortages across UHL reported as part of workforce plan update. Executive Workforce Board will consider progress in relation to the overarching workforce plan through highlight report from CMG action plans.	(c) Workforce planning difficult to forecast more than a year ahead as changes are often dependent on transformation activities outside UHL eg social services/ community services and primary care and broad based planning assumptions around demographics and activity. (c) Difficulty in recruiting to hotspots as frequently reflect a national shortage occupation	We are working on an integrated approach to workforce planning with LPT in the first instance in order that we can plan an overall workforce to deliver the right care in right place at the right time. A joint group of strategy, finance and workforce leads is being established to share plans and numbers Mulitprofessional new roles group to be established to devise and monitor processes for the creation of new roles particularly those focused on	Oct 2014 Kate Bradley Oct 2014 Rachel Overfield

			reducing known gaps in the workforce. Innovative approaches to recruitment and retention to address shortages. Each CMG has clearer picture of supply and demand trajectories and actions to close gaps	March 2015 Kate Bradley
Nursing Recruitment Trajectory	Overall nursing vacancies are monitored and reported monthly by the Board and NET as part of the Quality and Performance Report NHS Choices will be publishing the planned and actual number of nurses on each shift on every inpatient ward in England	(C) Nurse staffing vacancies	International recruitment plan in place for nursing staff	On-going Rachel Overfield
Development of an Employer Brand and Improved Recruitment Processes	Reports of the LIA recruitment project Reports to Executive Workforce Board regarding innovative approaches to recruitment	(C) Capacity to develop and build employer brand marketing (C) Capacity to build innovative approaches to recruitment of future service/ operational managers	Delivering our Employer Brand group is sharing best practice and development social media techniques to promote opportunities at UHL Development of internship model and potential management trainee model supported by robust education	March 2015 Kate Bradley November 2014 Kate Bradley

		(c) capacity to build innovative approaches to consultant recruitment	programme and education scheme. Consultant recruitment review team to develop professional assessment centre approach to recruitment utilising outputs to produce a development programme	Date to be confirmed Kate Bradley

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 16	Inability to recruit and retain staff with appropriate skills.	**Overall level of risk to the achievement of the objective**	**Current score 4 x 3 = 12**	**Target score 4 x 2 = 8**
Executive Risk Lead(s)	Director of Human Resources			
Link to strategic objectives	Delivering services through a caring, professional, passionate and valued workforce			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source**(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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Refreshed Organisational Development Plan (2014-16) including five work streams: 'Live our Values' by embedding values in HR processes including values based recruitment, implementing our Reward and Recognition Strategy (2014-16) and continuing to showcase success through Caring at its Best Awards	Quarterly reports to EWB and Trust Board and measured against implementation plan milestones set out in PID	(a) Improvements required in 'measuring how we are doing'	Team Health Dashboard to be developed – mock up to be presented to EWB at September Meeting	September 2014 Kate Bradley
'Improve two-way engagement and empower our people' by implementing the next phase of Listening into Action (see Principal Risk 16), building on medical engagement, experimenting in autonomy incentivisation and shared governance and further developing health and wellbeing and Resilience Programmes.	Quarterly reports to and EWB and measured againstImplementation Plan Milestones set out in PID	No gaps identified		
'Strengthen leadership' by implementing the Trust's Leadership into Action Strategy (2014-16) with particular emphasis on 'Trust Board Effectiveness', 'Technical Skills Development' and 'Partnership Working'	Quarterly reports to EWB and bi-monthly reports to UHL LETG. Measured against implementation Plan milestones set out in PID	No gaps identified		
'Enhance workplace learning' by building on training capacity and resources, improvements in medical education and developing new roles	Quarterly report to EQB, EWB and bi-monthly reports to UHL LETG and LLR WDC. Measured against implementation plan milestones set out in PID	(a) eUHL System requires significant improvement in centrally managing all development activity (C) Robust processes required in relation to e-learningdevelopment	eUHL system updates required to meet Trust needs Robust ELearningpolicy and procedures to be developed to reflect P&GC approach	March 2015 Kate Bradley Oct 2014 Kate Bradley

'Quality Improvement and innovation' by implementing quality improvement education, continuing to develop quality improvement networks and creating a Leicester Improvement and Innovation Centre	Quarterly reports to EQB and EWB and measured against implementation plan milestones set out in PID.	No gaps identified		
Appraisal and Objective Setting in line with Strategic Direction	Appraisal rates reported monthly via Quality and Performance Report. Appraisal performance features on CMG/Directorate Board Meetings. Board/CMG Meetings to monitor the implementation of agreed local improvement actions	No gaps identified		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 17	Failure to improve levels of staff engagement	**Overall level of risk to the achievement of the objective**	**Current score 3 x 3 = 9**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Director of Human Resources			
Link to strategic objectives	Delivering services through a caring, professional, passionate and valued workforce			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Year 2 Listening into Action (LiA) Plan (2014 to 2015) including five work streams: Work stream One: **Classic LiA** • Two waves of Pioneering teams to commence (with 12 teams per wave) using liA to address changes at a ward/department/pathway level	Quarterly reports to Executive Workforce Board (EWB) and Trust Board Updates provided to LiA Sponsor group on success measures per team and reports on Pulse Check improvements Annual Pulse Check Survey conducted (next due in Feb 2015) Update reports provided to JSCNC meetings	(A) Triangulation of LiA Pulse Check Survey results with National Staff Opinion Survey and Friends and Family Test for Staff	Team Health Dashboard to be developed – mock up to be presented to EWB at September 2014 meeting (Please see Principal Risk 15)	March 2015 Kate Bradley
Work stream Two: **Thematic LiA** • Supporting senior leaders to host Thematic LiA activities. These activities will respond to emerging priorities within Executive Directors' portfolios. Each Thematic event will be hosted and led by a member of the Executive Team or delegated lead.	Quarterly reports to Executive Workforce Board (EWB) and Trust Board Updates provided to LiA Sponsor group on each thematic activity Update reports provided to JSCNC meetings	No gaps identified		
Work stream Three: **Management of Change LiA** • LiA Engagement Events held as a precursor to change projects associated with service transformation and / orr HR Management of Change (MoC) initiatives.	Quarterly reports to Executive Workforce Board (EWB) and Trust Board Updates provided to LiA Sponsor group on each thematic activity Update reports provided to JSCNC meetings	(C) Reliant on IBM / HR to notify LiA Team of MoC activity	Ensure IBM aware of requirements. HR Senior Team aware of need to include Engagement event prior to formal	March 2015 Kate Bradley

			consultation (with MoC impacting on staff – more than 25 people)	
Work stream Four: **Enabling LiA** • Provide support to delivering UHL strategic priorities (Caring At its Best), where employee engagement is required.	Quarterly reports to Executive Workforce Board (EWB) and Trust Board Updates provided to LiA Sponsor group on each thematic activity Update reports provided to JSCNC meetings	(C) Resource requirements in terms of people and physical resources difficult to anticipate from LiA activity linked to Caring at its Best engagement events	Include as regular agenda item on LiA sponsor group identifying activity and anticipated resources required	March 2015 Kate Bradley
Work stream Five: **Nursing into Action (NiA)** • Support all nurse led Wards or Departments to host a listening event aimed at improving quality of care provided to patients and implement any associated actions.	Quarterly reports to Executive Workforce Board (EWB) and Trust Board Updates provided to LiA Sponsor group every 6 months on success measures per set and reports on Pulse Check improvements Update reports provided to JSCNC meetings Monthly updates to Nursing Executive Team (NET) meetings via Heads of Nursing per CMG	No gaps identified		
Annual National Staff Opinion and Attitude Survey	Annual Survey report presented to EWB and Trust Board Analysis of results in comparison to previous year's results and to other similar organisations presented to EWB and Trust Board annually Updates on CMG / Corporate actions taken to address improvements to National Survey presented to EWB Staff sickness levels may also provide an indicator of staff satisfaction and performance and are reported monthly to Board via Quality and Performance report Results of National staff survey and local patient	(A) Triangulation of National Staff Survey results with local Pulse Check Results (Work stream One: Classic LiA / Work stream Five: NiA) and other indicators of staff engagement such as Friends and Family Test for Staff	Team Health Dashboard to be developed – mock up to be presented to EWB at September 2014 meeting (Please see Principal Risk 15)	March 2015 Kate Bradley

	polling reported to Board on a six monthly basis. Improving staff satisfaction position.			
Friends and Family Test for NHS Staff	Quarterly survey results for Quarter 1, 2 and 4 to be submitted to NHS England for external publication: Submission commencing 28 July 2014 for quarter 1 with NHS England publication commencing September 2014 Local results of response rates to be CQUIN Target for 2014/15 – to conduct survey in Quarter 1 (achieved)	Survey completion criteria variable between NHS organisations per quarter. Survey to include 'NHS Workers' and not restricted to UHL staff therefore creating difficulty in comparisons between organisations as unable to identify % response rates. No guidance available (as at 8 July 2014) regarding how NHS England will present the data published in September 2014, i.e. same format at FFT for Patients or format for National Staff Opinion and Attitude Survey. Triangulation of Friends and Family Test for Staff results with local Pulse Check Results (Work stream One: Classic LiA / Work stream Five: NiA) and other indicators of staff engagement such as National Staff Survey	National data on UHL workforce numbers to be used by NHS England to get a sense of how many staff completed the survey (Same calculations being used for all other Trusts so variables consistent nationally). Various draft internal reports in development in readiness for possible analysis methodology used by NHS England in September 2014. Team Health Dashboard to be developed – mock up to be presented to EWB at September 2014 meeting (Please see Principal Risk 15)	First report published by NHS England September 2014 March 2015 Kate Bradley

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 18	Lack of effective leadership capacity and capability	**Overall level of risk to the achievement of the objective**	**Current score 3 x 3 = 9**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Director of Human Resources			
Link to strategic objectives	A clinically and financially sustainable NHS Foundation Trust			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 19	Failure to deliver financial strategy (including CIP).	**Overall level of risk to the achievement of the objective**	**Current score**	**Target score**
			5 x 3 = 15	**5 x 2 = 10**
Executive Risk Lead(s)	Director of Finaince			
Link to strategic objectives	A clinically and financially sustainable NHS Foundation Trust			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Delivering recurrent balance via effective management controls including SFIs and SOs	Monthly progress reports to F&P Committee, Executive Board, & Trust Board Development Sessions TDA Monthly Meetings Chief Officers meeting CCGs/Trusts TDA/NHSE meetings Trust Board Monthly Reporting UHL Programme Board, F&P Committee, Executive Board & Trust Board	(C) Varying level of financial understanding/ control within the organisation. (C) Lack of supporting service strategies to deliver recurrent balance	Finance Training Programme Production of a FRP to deliver recurrent balance within three years Health System External Review to define the scale of the financial challenge and possible solutions Production of UHL Service & Financial Strategy including Reconfiguration/ SOC	Jul 2014 Simon Sheppard Aug 2014 Simon Sheppard Jul 2014 Simon Sheppard Jul 2014 Simon Sheppard
CIP performance management including CIP s as part of integrated performance management	Monthly reports to F&P committee and Trust Board. Formal sign-off documents with CMGs as part of agreement of IBPs	(C) CIP Quality Impact Assessments not yet agreed internally or with CCGs	Expedite agreement	Aug 2014 Simon Sheppard

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

		(c) PMO structure not yet in place to ensure continuity of function following departure of Ernst & Young	PMO Arrangements need to be finalised	Aug 2014 Simon Sheppard
Managing financial performance to deliver recurrent balance via SFI and SOs and utilising overarching financial governance processes	Monthly progress reports to Finance and Performance (F&P) Committee, Executive Board and Trust board.	(c) The organisation has not effectively identified its service model. (c) Varying level of financial understanding/ control within the organisation. (c) Finance department having difficulties in recruiting to finance posts leading to temporary staff being employed.	Production of Integrated Business Plan (Activity, Capacity, Operational Targets, Workforce, CIPS, Budgets, Capital & Risks) (1.27) Finance Training Programme (1.21) Restructuring of financial management via MoC (1.28)	Jul 2014 Simon Sheppard Jul 2014 Simon Sheppard Jul 2014 Simon Sheppard
Seeking to agree financially and operationally deliverable by contract arbitration and TDA mediation	Agreed contracts document through the dispute resolution process/arbitration Regular updates to F&P Committee, Executive Board, Escalation meeting between CEOs/CCG Accountable Officers	(c) Failure to agree appropriate levels of financial impact for QIPP, fines and penalties and MRET. (c) Failure to agree levels of operational performance in relation to the above.	Negotiate realistic contracts with CCGs and Specialised Commissioning - QIPP - Fines & Penalties - MRET rebase - Counting & Coding CCG Non Recurring Funding	Jul 2014 Simon Sheppard

Securing capital funding by linking to Strategy, Strategic Outline Case (SOC) and Health Systems Review and Service Strategy	Regular reporting to F&P Committee, Executive Board and Trust Board	(c) Lack of clear strategy for reconfiguration of services.	Production of Business Cases to support Reconfiguration and Service Strategy	Jul 2014 Simon Sheppard
Obtaining sufficient cash resources by agreeing short term borrowing requirements with TDA	Monthly reporting of cash flow to F&P Committee and Trust Board	(c) Lack of service strategy to deliver recurrent balance	Agreement of long-term loans as part of June Service and Financial plan	June 2014 Simon Sheppard

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 20	Failure to deliver internal efficiency and productivity improvements.	**Overall level of risk to the achievement of the objective**	**Current score 4 x 4 = 16**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Chief Operating Officer			
Link to strategic objectives	A clinically and financially sustainable NHS Foundation Trust			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source**(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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
CIP performance management including CIP s as part of integrated performance management	Monthly reports to F&P committee and Trust Board. Formal sign-off documents with CMGs as part of agreement of IBPs	(C) CIP Quality Impact Assessments not yet agreed internally or with CCGs (c) PMO structure not yet in place to ensure continuity of function following departure of Ernst & Young	Expedite agreement PMO Arrangements need to be finalised	Aug 2014 Simon Sheppard Aug 2014 Simon Sheppard
Cross cutting themes are established.	Executive Lead identified. Monthly reports to F&P committee and Trust Board	(A) Not all cross cutting themes have agreed plans and targets for delivery	Will be actioned through the monthly cross cutting theme delivery board	August 2014 Richard Mitchell

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 21	Failure to maintain effective relationships with key stakeholders	**Overall level of risk to the achievement of the objective**	**Current score**	**Target score**
Executive Risk Lead(s)	Director of Marketing and Communications			
Link to strategic objectives	A clinically and financially sustainable NHS Foundation Trust			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source**(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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 22	Failure to deliver service and site reconfiguration programme and maintain the estate effectively.	**Overall level of risk to the achievement of the objective**	**Current score 5 x 2 = 10**	**Target score 5 x 1 = 5**
Executive Risk Lead(s)	Director of Strategy			
Link to strategic objectives	A clinically and financially sustainable NHS Foundation Trust			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source**(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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Capital Monitoring Investment Committee Chaired by the Director of Finance & Procurement – meets monthly. All capital projects are subject to robust monitoring and control within a structured delivery platform to provide certainty of delivery against time, cost and scope. Project scope is monitored and controlled through an iterative process in the development of the project from briefing, through feasibility and into design, construction, commissioning and Post Project Evaluation. Project budget is developed at feasibility stage to enable informed decisions for investment and monitored and controlled throughout design, procurement and construction delivery. Project timescale is established from the outset with project milestone aspirations developed at feasibility stage. Process to follow: • Business case development • Full business case approvals • TDA approvals • Availability of capital • Planning permission • Public Consultation • Commissioner support	Minutes of the Capital Monitoring Investment Committee meetings. Capital Planning & Delivery Status Reports. Minutes of the March 2014 public Trust Board meeting - Trust Board approved the 2014/15 Capital Programme. Project Initiation Document (PID) (as part of UHL's Delivering Care at its Best) and minutes of the May 2014 Executive Strategy Board (ESB) meeting. Estates Strategy - submitted to the NTDA on 20th June in conjunction with the Trust's 5 year directional plan.	(C) Patient and public engagement strategy	Highlight report to be presented at the August 2014 ESB meeting for sign off.	August 2014 Kate Shields

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 23	Failure to effectively implement EPR programme	**Overall level of risk to the achievement of the objective**	**Current score 5 x 3 = 15**	**Target score 3 x 3 = 9**
Executive Risk Lead(s)	Chief Information Officer			
Link to strategic objectives	Enabled by excellent IM&T			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source**(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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Governance in place to manage the procurement of the solution	EPR project board with executive and Non-Executive members. Standard boards in place to manage IBM; Commercial board, transformation board and the joint governance board. UHL reports progress to the CCG IM&T Strategy Board	(C) OBC/FBC approval with NTDA	Working closely with finance, procurement and the NTDA to navigate the approvals process to submit OBC	Aug 2014 John Clarke
Clinical acceptability of the final solution	Clinical sign-off of the specification. Clinical representation on the leadership of the project. The creation of a clinically led (Medical Director) EPR Board which oversees the management of the programme. Highlight reports on objective achievement go through to the Joint Governance Board, chaired by the CEO. The main themes and progress are discussed at the IM&T clinical advisory group.	(C) Not all clinicians can be part of the process	Ensure all clinicians have an opportunity to contribute Re-align the timetable to ensure best fit with clinical workload Improvement in communications to clinical staff/teams	July 2014 John Clarke
Transition from procurement to delivery is a tightly controlled activity	EPR board has a view of the timeline. Trust Board and ESB have had an outline view of the delivery timelines.	(C) No detailed plan is in place for the delivery phase of the project until the vendor is chosen	When the final vendor is chosen we will create and communicate the detail delivery plan and its dependencies.	Sep 2014 John Clarke

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 24	Failure to implement the IM&T strategy and key projects effectively *Note: Projects are defined, in IM&T, as those pieces of work, which require five or more days of IM&T activity.*	**Overall level of risk to the achievement of the objective**	**Current score 5 x 3 = 15**	**Target score 3 x 3 = 9**
Executive Risk Lead(s)	Chief Information Officer			
Link to strategic objectives	Enabled by excellent IM&T			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source**(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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Project Management to ensure we are only proceeding with appropriate projects	Project portfolio reviewed by the ESB every two months. Agreements in place with finance and procurement to catch projects that are not formally raised to IM&T.	(C) Formal prioritisation matrix	Develop, disseminate and implement the new matrix	Aug 2014 John Clarke
Ensure appropriate governance arrangements around the deliverability of IM&T projects	Projects managed through formal methodologies and have the appropriate structures, to the size of project, in place. KPIs are in place for the managed business partner and are reported to the IM&T service delivery board	(C) Lack of ownership at CMG level for IT projects	All IT projects requested by CMGs to be formally signed off through their governance	Aug 2014 John Clarke
Signed off capital plan for 2014/15 and 2015/16	2 year plan in place and a 5 year technical in place highlighting future requirements - signed off by the capital governance routes	(A) In year requirements which could not be reasonable forecasted cause unsustainable pressure within existing resources	Develop, disseminate and implement the new matrix	Aug 2014 John Clarke
Formalised process for assessing a project and its objectives	All projects go through a rigorous process of assessment before being accepted as a proposal	(C) Lack of transparency of the process and unachievable delivery expectations based on the priority of the project	All CMGs to hold formal monthly meeting with IM&T service delivery lead where these issues can be solved	Sep 2014 John Clarke/CMGs

Appendix 2 - UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – RISK REGISTER SUMMARY (RISKS SCORING 15 OR ABOVE)

PERIOD: AS AT 30 JUNE 2014

ID	RISK TITLE	CURRENT SCORE	TARGET SCORE	RISK MOVEMENT
2236	There is a risk of overcrowding due to the design and size of the ED footprint	25	16	⇔
2325	Risk to patient/staff safety due to security staff not assisting with restraint	25	6	⇔
2234	There is a medical staffing shortfall resulting in a risk of an understaffed Emergency Department	20	6	⇔
2333	Lack of paediatric cardiac anaesthetists to maintain a WTD compliant rota leading to service disruption and loss of resilience	20	8	⇔
2330	Risk of increased mortality due to ineffective implementation of best practice for identification and treatment of sepsis	20	6	⇔
2339	Potential risk to Renal transplant patients as a result of deterioration of team working & deviation from policy and procedures	20	5	⇔
698	Risk to the production of aseptic pharmaceutical products	20	3	⇔
847	Lack of Capacity in maternity services	20	12	⇔
2391	Inadequate numbers of Junior Doctors to support the clinical services within Gynaecology & Obstetrics	20	8	NEW
2320	Inadequate staffing levels in therapy radiography and radiotherapy physics causing a serious radiotherapy treatment error	16	4	⇔
2193	Risk of unplanned loss of theatre and/or recovery capacity at the LRI	16	4	⇔
2256	There is a risk of harm to patients, staff and the four hour target due to inadequate nurse staffing levels.	16	6	⇔
2194	Risk of unplanned loss of theatre, recovery or Critical Care capacity across UHL due to insufficient nursing staffing	16	4	⇔
2338	There is a risk of patients not receiving medication and patients receiving the incorrect medication due to an unstable homecare	16	9	⇔
2191	Follow up backlogs and capacity issues in Ophthalmology	16	8	⇔
607	Failure of UHL BT to fully comply with BCSH guidance and BSRs may adversely impact on patient safety and service delivery	16	4	⇔
2300	There is a risk of not meeting the national guidelines for out of hours Vascular cover	16	4	⇔
2248	Lack of IR(ME)R training records held across the Trust	16	4	⇔
2384	There is an increased risk in the incidence of babies being born with HIE (moderate & severe) within UHL	16	8	NEW
2341	Long term follow up outpatient appointments not made	16	2	⇔
2153	Shortfall in the number of qualified nurses in Children's Hospital including ECMO staffing and Capacity	16	8	⇔
2237	Risk of results of outpatient diagnostic tests not being reviewed or acted upon resulting in patient harm	16	8	⇔
2247	500 Registered Nurse vacancies across UHL leading to a deterioration in service and adverse effect on financial position	16	12	⇔
2318	Blocked drains causing leaks and localized flooding of sewage	16	2	⇔
1693	Risk of inaccuracies in clinical coding	16	8	⇔
1737	Inappropriate environment and infection prevention Renal Transplant	15	15	⇔
2070	Harborough Lodge environment stops staff safely delivering haemodialysis	15	5	⇔
2380	Risk of breach of Same Sex Accommodation Legislation	15	3	NEW
1196	No comprehensive out of hours on call rota for consultant Paediatric radiologists	15	2	⇔
2328	Risk of inadvertent wrong route administration of anaesthetic medicines during epidural and regional anaesthesia	15	5	⇔
2278	Risk that the Leicester Fertility Centre could have its licence for the provision of treatment and services withdrawn	15	6	⇔
2270	Failure to achieve compliance of 75% attendance at Fire Safety training may cause UHL to fail to meet its statutory obligation	15	9	⇔
2269	Failure to meet UHL target of a minimum of 75% of clinical staff undertaking IP/Hand hygiene training	15	10	⇔
1551	Failure to manage Category C documents on UHL Document Management system (DMS)	15	9	⇔

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

OPERATIONAL RISKS SCORING 15 OR ABOVE FOR THE PERIOD XX/XX/XX

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 score increased from initial risk score
⮟	Risk score decreased from initial risk score
★	New risk since previous reporting period
⇔	No Change in risk score since previous reporting period

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2236	Emergency and Specialist Medicine	ED	There is a risk of overcrowding due to the design and size of the ED footprint	04/10/2013	31/07/2014	Design and size of footprint in paediatrics causes delay in being seen by clinician. Risk of deterioration. Risk of four hour target and local CQUINS. Lack of patient confidentiality. Increased violence and aggression. Design and size of footprint in resus causes delay in definitive treatment, delay in obtaining critical care, risk of serious incidents, increased crowding in majors, risk to four hour target. Poorer quality care. Risk of rule 43. Lack of privacy and dignity. Increased staff stress. Design and size of majors causes delay in definitive treatment and medical care. Poor quality care. Lack of privacy and dignity. High number of patient complaints. Risk of deterioration. Difficulty in responding to unwell patient in majors. Risk of adverse media interest. Staff stress. Risk of serious incident. Inability to meet four hour target resulting in patient safety and financial consequences. High number of incidents. Increased staff stress. Infection control risk. Risk of rule 43. Design and size of assessment bay causes delay in time to assessment. Paramedics unable to reach turnaround targets Design and size of minors results in delay in receiving medic Design and size footprint in streaming rooms causes threat t	Patients	The Emergency Care Action Team, which was established in spring 2013 aims to improve emergency flow and therefore reduce the ED crowding. The Emergency department is actively engaging in plans to increase the ED footprint via the 'hot floor' initiative, but in the shorter term to increase the capacity of assessment bay and resus.	Extreme	Almost certain	25	New ED plus associated hot floor rebuild approved by the trust and OBC (Outline Business Case) submitted and first phase of construction of new ED to completed by December 2015 .	16	JE

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2325	Corporate Nursing	Nursing	Risk to patient/staff safety due to security staff not assisting with restraint	03/04/2014	30/09/2014	**Causes** Interserve refusal to provide trained staff to carry out non-harmful physical intervention, holding and restraint skills, where patient control is necessary to deliver essential critical care to patients lacking capacity to consent to treatment. Insufficient UHL staff trained in use of non-harmful physical intervention and restraint skills to carry out patient control. Termination of Physical skills training contract with LPT provider in January 2014. **Consequence** Inability to deliver safe clinical interventions for patients lacking capacity who resist treatment and/or examination. Increased risk of Life threatening or serious harm to patients resisting clinical intervention Increased risk of injuries to patients due to physical interventions by inexperienced/untrained staff. Increased risk of injuries to untrained staff carrying out physical interventions. Increased risk of injuries to staff carrying out clinical procedures Requirement for increased staffing presence to carry out safe procedures Reduced quality of service due to diverted staff resources Increased risk of sick absence due to staff injury. Increased risk of complaints from patients and visitors Increased risk of failure to meet targets Adverse publicity	Patients	UHL Nursing and Horizons colleagues have met with Interserve 12/03/14 and UHL have agreed to issue a temporary indemnity notice that will provide vicarious liability cover for Interserve staff in these situations (supported by our legal team). This was rejected by Interserve Management Cover with more UHL employed staff where there may be patients requiring this type of restraint; Staff must take risk assessed decisions about the use of restraint and ensure incidents are reported using the Trust's incident reporting database. In extreme cases staff should be aware that the police should be called Continue to communicate with all staff about the current position.	Extreme	Almost certain	25	High priority recruitment of physical skills trainer - 30/09/14	6	DLO

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
2339	RRC	Renal Transplant	Potential risk to Renal transplant patients as a result of deterioration of team working & deviation from policy and procedures	02/05/2014	30/11/2014	**Causes** Poor lines of communication Poor interpersonal relationships Lack of clarity of procedures and policies **Consequences** Potential for patient harm Suboptimal transplant outcomes Potential for morbidity and mortality related to transplant process.	Targets	Clear lines of communication have been defined The 4 surgical consultants have agreed significantly improved ways of working and are demonstrating significantly improved team working skills and attitudes. Appointment of an external clinical lead (Chris Rudge) who will be working with the team 2 days a week for 3 - 6 months Policies / guidelines have been written for ward rounds, OPD and kidney acceptance MDT's and M&M's will be in place for the restart of the process	Extreme	Likely	20	Completion and ratification of ward policies and protocols document - 30/11/14 Review panel returned on 2.7.14 and currently awaiting the final report (as at 2/7/14).	5	SLEA

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2234	Emergency and Specialist Medicine	ED	There is a medical staffing shortfall resulting in a risk of an understaffed Emergency Department impacting on patient care	04/10/2013	31/08/2014	**Causes:** Consultant vacancies. Middle grade vacancies. Risk of losing trainees due to incorrect service/training balance. Trainee attrition. Trainees not wanting to apply for consultant positions. Reduced cohesiveness as a trainee group. Junior grade vacancies. Juniors defecting to other specialties. Poorer quality of training resulting in poor deanery reports. Non ED medical consultants. Locums. Increased consultant workload. Lack of uniformity. Paediatric medical staffing. Poorer quality care for paediatric population. **Consequences:** Poor quality care. Lack of retention. Stress, poor morale and burnout. Increased sickness. Increased incidents (SUI's), claims and complaints. Inability to do the general work of the department, including breaches of 4 hour target. Financial impacts. Reduced ability to maintain CPD commitments for consultants/medical staff with subspecialty interest. Reduced ability to train and supervise junior doctors. Deskilling of consultants without subspecialty interest. Suboptimal training.	Patients	The chief executive and medical director have met with senior trainees in Leicester ED to invite them to apply for consultant positions. The East Midlands Local Education and training board has recognised middle grade shortages as a workforce issues and has set up several projects aiming to attract and retain emergency medicine trainees and consultants. Advanced nurse practitioners and non-training CT1 grades have been employed in order to backfill the shortage of SHO grade junior doctors. There has been shared teaching sessions in which non ED consultants and ED consultants have shared skills, (i.e. ED consultants learning about collapse in the elderly and elderly medicine consultants doing ALS). The non ED consultants have been set up on a specific mailing list so that new developments and departmental 'mini-teaches' (= learning cases from incidents) can be shared. Only approved locum agencies are used for ED internal locums and their CVs are checked for suitability prior to appointing them. Locums receive a brief shop floor induction on arrival and also must sign Locum doctors are only placed in paeds ED in except The grid paediatric trainees shift pattern has changed ED employs medical registrars to work night shifts in E ED consultants have extended their shop-floor hours f ED employs locum medical consultants to improve se ED has employed several well performing locums on ED has employed oversees doctors at specialty and tr	Extreme	Likely	20	New rota for August 2014 juniors - 31/07/14	6	BTD

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2333	ITAPS	Anaesthesia	Lack of paediatric cardiac anaesthetists to maintain a WTD compliant rota leading to service disruption and loss of resilience	17/04/2014	30/12/2014	**Causes:** 1. Retirement of previous consultants 2. Ill health of consultant 3.lack of applicants to replace substantively **Consequence:** 4.need for remaining paeds anaesthetists to work a 1:2 rota on call 5.Lack of resilience puts cardiac workload at risk 6. May adversely affect the national reputation of GGH as a centre of excellence 7.current rota non complaint WTD 8. patients requiring urgent paeds surgery may be at risk of having to be transferred to other centres 9. Income stream relating to paeds cardiac surgery may be subsequently affected 10. risk of suboptimal treatment	Quality	1. 1:2 rota covered by experience colleagues 2. 12 month locum appointed	Major	Almost certain	20	1. Continue with substantive recruitment strategy and Job to go out to advert - 30/12/14	8	DTR

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
698	Clinical Support and Imaging	Pharmacy	Risk to the production of aseptic pharmaceutical products	03/05/2007	31/08/2014	**Causes** Provision of aseptically prepared chemotherapy is being undertaken from a temporary rental unit. Temporary nature and age of facility indicates high probability of failure. Arrangements for segregation of in-process and completed items is inadequate leading to high possibility of error. Current temporary unit is outside the range of the department's temperature monitoring system. Failure of refrigerated storage will remain undetected outside working hours, and has already occurred. Planning permission for temporary unit only valid until August 2012 Contingency arrangements are insufficient and could only provide for the very short term. Project is already 6 months behind schedule Storage, receipts and dispensing facility for dose-banded chemotherapy and other outsourced items purchased. Alternative arrangements will need to be found when unit is refurbished **Consequences** Failure of Current Temporary Facility; Inability to provide 50% of current chemotherapy products for adult services. Inability to provide chemotherapy for paediatric services. Substantial delay in re-establishing service provision from alt Limitations of treatments that can be sourced from an alterna Inability to support research where aseptic compounding req	Targets	Planned servicing & maintenance of temporary facility being undertaken. Constant environmental monitoring of facility in place. Contingency arrangement for supply from external source currently being pursued. Business Case for new unit (refurbishment of facility within the Windsor building) has been presented and approved by the commercial exec board in 2011. Facilities are working with Pharmacy and commercial architects in order to finalise plans and get refurbishment started. Project to refurbish the aseptic unit has now started - nov 2013	Extreme	Likely	20	New unit in operation - due 31/8/2014	3	GH

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2391	Women's and Children's		Inadequate numbers of Junior Doctors to support the clinical services within Gynaecology & Obstetrics	24/06/2014	31/08/2014	Currently there are not enough Junior Doctors on the rota to provide adequate clinical cover and service commitments within the specialties of Gynaecology & Obstetrics. **Consequences:** Failure to meet the Junior Drs training needs in accordance with the LETB requirements. Potential to lose Junior Drs training within the CMG. Reduced training opportunities and inconsistencies in placements. Increased risk of Junior Doctors seeing complex patients in clinics unsupervised. On call rota gaps/ Increased requirement for locums to fill gaps. Potential for LETB to remove training accreditation within obstetrics and gynaecology. This will lead to the removal of training posts. Increased potential for mismanagement / delay in patients treatment/pathway.	Patients	Locums where available. Specialist Nurses being used to cover the services where possible and appropriate.	Major	Almost certain	20	Business Case to be developed re. how to meet service commitments by backfilling with Consultants, Specialist Nurses, etc due 31.08.14 CMG to continue to pursue recruitment of junior doctors eg Clinical Fellows, Trust grade doctors due 31.08.14 Further development of robust training programme for Junior Drs by Clinical Tutor & Programme Director due 31.08.14	8	ACURR

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
847	Women's and Children's	Maternity	Lack of Capacity in maternity services	28/09/2007	20/07/2014	**Causes** Continuing increase to the birth-rate in Leicester . The number of maternity beds has decreased. Consultant cover for Delivery Suite is 60 hours a week with long term business plans to increase the hours in accordance with Safer Childbirth Recommendations. **Consequences** Midwifery staffing levels are not in accordance with national guidance however they are in line with regional averages. Transfer of activity between the LGH and LRI occurs on a frequent basis with Leicestershire having to close to maternity admissions on a number of occasions. Increase in incidents reported where there has been a delay in elective CS, IOL and augmentation due to lack of beds. Staff frequently go without meal breaks. Increased waiting time in MAC and therefore increased risk of a clinical adverse outcome to both mother and baby.	Patients	Length of postnatal stay in hospital as short as possible. Community staff prepare women for early discharge home if straightforward delivery. Extra triage room on Delivery Suite, LRI completed July 2012. Triage and admission areas in acute units to ensure no category x women sitting on delivery suite. Use of Escalation Plan to inform staff on actions required if capacity is high. Capacity is managed between the two acute units by temporarily transferring care if one site is busy. Liaison with neighbouring maternity hospitals if high risk of closure of Leicestershire Maternity Hospitals. Prioritisation of both elective and 'emergency' work according to clinical urgency and need. On call Manager. On call SOM. Funded midwife places increased to 1:32. Escalation and contingency plans in place. Relocation of all elective gynaecology beds to LGH.	Extreme	Likely	20	Increase ward capacity on LRI site by opening 13 AN beds on level 1 - completed Complete transfer of all EL CS to level 1 - due 30/9/14	12	EBROU

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
2330	Medical Directorate		Risk of increased mortality due to ineffective implementation of best practice for identification and treatment of sepsis	11/04/2014	30/08/2014	**Causes** Failure of clinical staff to consistently recognise and act on early indicators of sepsis Lack of system to 'red flag' early indicators of sepsis. Complex anti-microbial prescribing guidance. **Consequences** Sub-optimal care/ death of patients (2 x SUI reports of death related to sepsis) Potential for increased complaints and claims/ inquests Additional costs to the organisation (estimated additional cost of £4k per patient if best practice is not consistently applied). Risk of adverse media attention and questions in the house in relation to sepsis deaths	Patients	UHL Sepsis working group including representatives from clinical areas Education and training Regular sepsis audits Early Warning scores Regular reporting to Executive Quality Board Sepsis rates monitored via CQUIN performance monitoring Sepsis Care Package	Major	Almost certain	20	Develop sepsis scoring methodology and incorporate into EWS observations - 30/8/14 Roll out of above - 30/9/14 Increased visibility of sepsis care pathway - 30/8/14 'Sepsis champions' to be trained by J Parker and Sepsis Nurse - 30/8/14 Simplification of anti-microbial prescribing for sepsis - 30/8/14 Implement 'sepsis boxes' for use in clinical areas - 30/9/14	6	JPARK

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2320	CHUGS	Radiotherapy	Inadequate staffing levels in therapy radiography and radiotherapy physics causing a serious radiotherapy treatment error	21/03/2014	31/08/2014	**Causes** Inadequate staffing levels caused by insufficient budget to recruit to recommended levels. Increased demand and complexity of activity **Consequences** Staff fatigue (due to increased overtime working) resulting in greater risk of error with potential for severe patient injury. Lack of resilience in case of unplanned events such as staff sickness / machine breakdown. Inability to cope with increases in demand Non compliance with national recommendations (i.e. only 75% of patients receive on-treatment verification - national recommendation 100% and possible failure to meet NHS England standard for IMRT capacity). Shortage of Medical Physics Expert (MPE) cover leading to lack of ability to deal with unusual cases requiring variation from protocol and delays in approving new protocols / techniques. (MPE cover is legal requirement under IRMER) Inadequate oversight of new techniques/trials Lack of strategic planning and delays to service critical developments such as IGRT, SABR. Change management process (including risk assessments) not consistently applied potentially meaning that process cha Participation in radiotherapy trials reduced. Staff training compromised. Potential for increased external scrutiny. Low morale and difficulties in retaining staff.	Quality	Planned shifts limit daily working hours Practice controlled by quality system with training/competency records. New techniques can only be authorised by senior staff. Processes carefully defined with checklists Minimum senior staffing levels	Major	Likely	16	Ensure realistic treatment booking, increase planned work hours with staff working shifts (dependant on business case) - 31/08/14 Protected time for training / development (dependant on business case) - 1/10/14 Increase treatment imaging to 100% to prevent risk of treatment error, aim to increase imaging to 100% of patients (dependant on business case) - 1/10/14 Submit second business case to increase in linac capacity by generating income from further increase in activity / complexity - 1/10/14 Enforce change management process to include risk assessment of new development and controlled documentation - 31/8/14 Identify resource for quality system - appoint dedicated staff member to update and maintain quality system - 1/9/14	4	LWI

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2256	Emergency and Specialist Medicine	ED	There is a risk of harm to patients, staff and the four hour target due to inadequate nurse staffing levels.	27/11/2013	31/07/2014	Approximately 25% of footfall within ED is paediatric, accounting for 36,000 patients per year. There are only two paediatric band 7 nurses and one paediatric matron. The band 7 nurses are frequently required to cover the main shop floor as the nurse in charge or nurse co-coordinating majors, which results in reduced opportunity for supervision and training in the main paeds ED. There is concern that this has lead to increased staff attrition due to lack of support and increased patient risk due to lack of skill, training and supervision of junior nurses. Currently in paeds ED there are junior nurses who require senior support and supervision. The aim of the department is to cover 75% of the time but there is insufficient capacity of available senior PED nurses time. The risk has an impact on patient safety and quality delivered to children in the Paeds ED. **Causes:** There are significant vacancies in paediatric trained nurses, including four vacancies at band 5. As a result of this, the paediatric area is often staffed with non-paeds ED trained nurses, many of which are quite junior. These members of st Band 5 staff have insufficient experience and knowledge to r Paediatric Band 7 nurses currently are allocated to 63 hours Paeds ED is having 2 adult trained staff rotated into the depa Due to a successful recruitment drive, there has been an inc	Patients	To try and maintain senior band 7 nurse presence in paeds ED as much as possible particularly on the late shifts. New appointment of advanced nurse practitioner roles (x 4 with an additional supernumerary) Rolling advert for paediatric nurses, plus rotational roles being offered Two dedicated ENP's who can support the Paediatric nursing team. Advert and appointment of Paeds ED Band 7. From 3rd February 2014 the current Band 7 nurses and matrons have allocated 37.5 hours as clinical supervisors shifts. This addresses supervision but not an increase of clinical hours. Increase in Band 7 appointments across the whole department will help to deliver the allocated 63 hours a week for current staff. The NIC is always available to assist and support junior staff allocated to PED. There is also cover from a senior decision maker (medic) until 10pm daily to support the junior nursing staff.	Major	Likely	16	Continue to recruit band 5 paediatric trained nurses - due 31/08/14	6	LLA

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2193	ITAPS	Theatres	Risk of unplanned loss of theatre and/or recovery capacity at the LRI	28/06/2013	30/11/2014	**Causes:** The Theatre and Recovery estate and supporting plant(s) are old, unsupported from a maintenance perspective and not fit for purpose. There is recent history of unplanned loss of surgical functionality at the LRI site due to plant failure, problems with sluice plumbing and ventilation. In addition, the poor quality of the floors, walls, doors, fittings and ceilings mean an unfit working environment from a working life, infection prevention and patient experience perspectives. There is insufficient electricity and medical gas outlets per bed. Aged electrical sockets resulting in actual and potential electrical faults - fire in theatres at LRI (Theatre 4) in July 2013. **Consequences:** Periodic failure of the theatre estate (ventilation etc) so elective operating has to cease. Risk of complete failure of the theatre estate so elective and emergency operating has to stop. Increase risk of patient infections. Poor staff morale working in an aged and difficult working environment. Difficulty in recruiting and retaining specialised staff (theatre and anaesthetic) due to poor working environment. Poor patient experience - our most vulnerable patients arrive May impair delivery of life support technologies.	HR	1. Regular contact with plant manufacturers to ensure any possible maintenance is carried out 2. Use of limited charitable funds available to purchase improvements such as new staff room chairs and anaesthetic stools - improve staff morale. 3. TAA building work has started 4. Plan to develop full business case for new recovery build 2013 - start 2014 5. 5S'ing events taking place within the theatre transformation project frame work 6. Compliance with all IP&C recommendations where estate allows 7. Purchase of new disposable curtains for recovery area, reducing infection risk and improving look of environment	Major	Likely	16	Recovery re-build - due 01/08/15 Capital investment and refurbishment of LRI theatres - plan in place and commenced - due 01/12/15	4	PV

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2194	ITAPS	Theatres	Risk of unplanned loss of theatre, recovery or Critical Care capacity across UHL due to insufficient nursing staffing	28/06/2013	30/09/2014	**Causes:** Locally, ITU and theatre nursing staff have been historically difficult to recruit and retain. Turnover regularly negates recruitment efforts and the effects of a poor working environment in a high stress and risk area has meant difficulties in resolving the issue previously. **Consequences:** Increased overtime and waiting list payments required to run the core service. Tired and unmotivated staff in post. Poor staff morale working in an aged and difficult working environment. Difficulty in recruiting and retaining specialised staff (theatre and Critical care) due to poor working environment and low staff morale in general. Reduction in critical care capacity across UHL. Inability to respond to increases in demand in theatre, recovery and critical care capacity. Elective patient cancellations including cancer patients. Critical Care alternatives becoming the norm for high level of care patients e.g. Kinmonth, overnight PACU and specialty "HDU's". Poor patient and carer experience for some of our sickest patients.	HR	1. Use of Bank and Agency staff with block contracts for consistency and cost effectiveness. 2. Regular team and leadership meetings/training events. 3. Rolling adverts in place. 4. International recruitment with HRSS and relevant agencies commenced. 5. Exit interviews used regularly and in line with trust policy to understand issues exacerbating higher than wanted turnover of staff. 6. PULSE check underway/ Health and Safety Stress Assessments 7. Staff engagement strategy being devised and implemented	Major	Likely	16	Recruit ITU staffing to provide additional 5 level 3 beds due to open September 2014 - 30/09/14. Continue to recruit Theatre staff to deliver 6 day working - January 2015	4	JHOL

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2191	Musculoskeletal and Specialist Surgery	Ophthalmology	Follow up backlogs and capacity issues in Ophthalmology	12/06/2013	31/10/2014	**Causes:** Lack of capacity within services. Junior Doctor decision makers resulting in increased follow-ups. Follow-ups not protocol led. No partial booking. Non adherence to 6/52 leave policy. Clinic cancellation process unclear, inadequate communication and escalation. **Consequences:** Backlog of patients to be seen. Risk of high risk patients not being seen/delayed. Poor patient outcomes. Increased complaints and potential for litigation.	Patients	Outpatient efficiency work on going. Full recovery plan for improvements to ophthalmology service are in process . Outsourcing of follow up patients to Newmedica (IS) has been agreed. All overdue patients will be triaged by them, with the company following up the appropriate patients. The company have agreed to flag high risk patients to us for follow up that do not meet their criteria	Major	Likely	16	Monitor and review impact of NEW MEDICA - 01/10/14.	8	DTR
607	Clinical Support and Imaging	Blood Transfusion	Failure of UHL BT to fully comply with BCSH guidance and BSQR in relation to traceability and positive patient identification (PP	22/12/2006	02/07/2014	**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 labelling error resulting in wrong blood cross-matched and / or provided for patient (last incident of ABO incompatibility by wrong transfusion approx. 4 years ago (yr 2008); approximately 6 near misses per year). New British Committee for Standards in Haematology (BCSH) guidelines state that unless a secure electronic PPI system is in place for the taking of blood transfusion samples, except in cases of acute clinical urgency, 2 samples on 2 separate occasions should be tested prior to blood issue. An electronic system would require only 1 samp Critical report received from MHRA in October 2012 in relatic **Consequences:** Potential loss of blood bank licence (via MHRA) with severe Financial penalty for non-compliance due to increased numb	Quality	Policies and procedures in place for correct patient identification and blood/ blood product identification to reduce risk of wrong transfusion. Paper system provides a degree of compliance with the regulations. Training and competency assessment for UHL staff involved in the transfusion process including e-learning and induction training with competency assessment for key staff groups. Regular monitoring and reporting system in relation to blood/ blood product traceability performance within department, to clinical areas and Transfusion Committee.	Major	Likely	16	IMT project approval ;board approval 02.07.2014 ; Develop implementation plan 30.07.2014	4	KJON

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2300	Clinical Support and Imaging	Cardiovascular Procedures	There is a risk of not meeting the national guidelines for out of hours Vascular cover	03/03/2014	31/08/2014	**Causes** From April 2014 there is a requirement to meet a 1in 6 cover for Vascular radiology out of hours service 1 members of staff unable to cover vascular work out of hours Not all staff covering out of hours trained in EVAR procedures **Consequence** Failure to comply with guidelines loss of reputation and service standard Stress for those staff members covering the extra work currently 1in 5 Patient safety Loss of contract income loss/interruption to service provision	HR	Locum cover and partime cover Extra worked covered by existing staff	Major	Likely	16	Provide training in EVAR technique to those lacking the skills - 30/08/14 Recruitment to 6th Radiologist post - 30/08/14	4	JGI

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
2248	Clinical Support and Imaging	Medical Physics	Lack of IR(ME)R training records held across the Trust	14/11/2013	30/07/2014	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 **Consequence** Lack of suitable training records may result in a failure to comply with standards set by regulatory and healthcare agencies (e.g. HSE / CQC). Failure at assessment might result in financial penalty and / or warning notices being issued. Non-compliance with national standards leading to enforcement action taken on the Trust following a routine ins Increased patient radiation doses due to lack of training. Increased staff doses due to lack of awareness of the potent	Quality	There is a defined method of recording training across the Trust in the Trust Radiation Safety policy. Although this is working in some areas it is not working consistently in all areas. The issue has been raised at the Trust Radiation Protection Committee numerous times where representatives of each Division have been in attendance. This has not so far led to a an increase in compliance. Radiation Protection produced a specific plan of what is required to demonstrate compliance. Mock audit completed 2/12/13. Investigate potential of using e-UHL to deliver a centralised record of IRMER training - Completed 3/3/14 7. CMG and service to manage and maintain records for the staff groups identified - completed 3/3/14 Policy updated on training and on going monitoring of training - 1/5/14	Major	Likely	16	1. Identify Trust staff with responsibilities under IRMER - due 30/7/2014 2. Implement e-learning module on e-UHL - 31/10/14	4	MNO

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2384	Women's and Children's	Maternity	There is an increased risk in the incidence of babies being born with HIE (moderate & severe) within UHL	24/06/2014	25/08/2014	**Causes:** Increased incidence of Hypoxic Ischemic Encephalopathy (HIE) within UHL 2012 2.3/1000 (2013 - further increase - incidence not defined). Compared to Trent & Yorkshire incidence 1.4/1000 births. Decision-making/capacity /CTG interpretation Midwifery staffing levels/Capacity Medical staffing levels overnight @LGH **Consequences:** Mismanagement of patient care Litigation risk Adverse publicity	Patients	Interim solution to increase capacity Monthly figures of HIE to be included in W&C dashboard Mandatory training for CTG/CTG Masterclass Weekly session to discuss CTG interpretation with junior doctors Active recruitment process for midwifery staff	Major	Likely	16	Monthly review of all cases of babies born with a diagnosis of HIE due 31.08.14 Undertake a peer review visit to Sheffield ude 31.07.14 Review of Consultant working patterns and extension of presence on the DS and MAU due31.08.14 Development of educational meetings for Dr's & midwives with specific focus on HIE, CS and porr outcomes due 31.07.14 Development of a decision education package focusing on the management of the 2nd stage of labour due 31.07.14 Re-launch 'fresh Eyes approach' with regards to CTG interpretation due 15.08.14 Further review of times of day when babies with HIE are born due 31.08.14	8	ACURR

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
2153	Women's and Children's	Paediatrics	Shortfall in the number of qualified nurses in Children's Hospital including ECMO staffing and Capacity	05/03/2013	30/08/2014	**Causes** The Children's Hospital is currently experiencing a shortfall in the number of appropriately qualified Children's nurses. This is in part due to the increased numbers of staff on maternity leave and the issues with recruiting Children's trained nurses. The demand for PICU beds currently outweighs capacity. There is an establishment of 6.5 beds but due to vacancies and long-term sickness/maternity leave the unit is currently only able to run at maximum capacity of 6 beds and on specific days only 5 beds (depending on the overall ECMO activity across adults and children). In addition to NHS activity the Trust has contracted to provide cardiac surgery for a cohort of Libyan children. At the time that the contract was developed (Nov-December 2012) it was assessed that there would be sufficient capacity to operate on one child per week without impacting on NHS Activity. However, the current staffing and long-term profile of patients on PICU has resulted in pressures on both NHS work and the delivery of the Libyan contract. Currently there are vacancies for 5.82 wte qualified and 1 wt **Consequences** There is a short fall in the number of appropriately qualified c Balancing the demand for PICU beds between NHS contract Unsafe staffing levels, therefore unable to provide the recom	HR	The bed base in Leicester Royal infirmary has been reduced. There is an active campaign being undertaken to recruit new nurses from around the country. Additional health care assistance have been employed to support the shortfall of qualified nurses. No further Libyan patients are being operated on until agency staff can be recruited to support their PICU stay or until the patient flow changes on PICU to allow week-end operating which does not compromise week-day operating or access to PICU. Active Recruitment in progress Educational team cover clinical shifts Cardiac Liaison Team cover Outpatient clinics Overtime, bank & agency staff requested Lead Nurse, Matron and ECMO Co-ordinator cover clinical shifts Children's Hospital & Adult ICU staff cover shifts The beds on Ward 30 have been reduced from 13 to 10 PICU beds are closed where necessary	Major	Likely	16	Recruitment of suitably trained/experienced agency PICU/ECMO/ward nurses - due 30/8/14	8	EA

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2237	Medical Directorate		Risk of results of outpatient diagnostic tests not being reviewed or acted upon resulting in patient harm.	07/10/2013	31/12/2014	**Causes** Outpatients use paper based requesting system and results come back on paper and electronically. Results not being reviewed acknowledged on IT results systems due to; Volume of tests. Lack of consistent agreed process. IT systems too slow and 'lock up'. Results reviewed not being acted upon due to; No consistent agreed processes for management of diagnostic test results. Actions taken not being documented in medical notes due to; Volume of work and lack of capacity in relation to medical staff. Lack of agreed consistent process. Referrals for some tests still being made on paper with no method of tracking for receipt of referral, test booked or results. Poor communication process for communicating abnormal results back to referring clinician; Abnormal pathology results- cannot always contact clinician that requested test and paper copies of results not being sent to correct clinicians or being turned off to some areas. Suspicious imaging findings- referred to MDT but not always also communicated back to clinician that referred for test. Lack of standards or meeting standards for diagnostic tests i	Patients	Abnormal pathology results escalation process Suspicious imaging findings escalated to MDTs	Major	Likely	16	Implementation of Diagnostic testing policy across Trust - to ensure agreed speciality processes for outpatient management of diagnostic tests results. June 15 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

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
2338	Medical Directorate		There is a risk of patients not receiving medication and patients receiving the incorrect medication due to an unstable homecare	01/05/2014	31/08/2014	**Causes** A major homecare company has left the Homecare market requiring remaining companies to take on large numbers of patients. These companies are now experiencing difficulties in maintaining their current levels of service. UHL patients are now being affected. One homecare supplier has changed their compounding to Bath ASU causing concerns about UHL supply of chemotherapy drugs over the next few weeks. Healthcare at Home (H@H) 1)H@H have changed their logistics provider (to Movianto). There are IT incompatibilities between both providers resulting in a large number of failed deliveries. 2) H@H no longer accepting new referrals for CF, respiratory and haemophilia patients who need to be repatriated to UHL urgently. There are also patients in whom homecare has been agreed and they are now referring back 3) H@H have changed their compounding to Bath ASU. This has resulted in Bath ASU not having enough capacity to carry out their routine production. UHL is a large user of dose banded chemotherapy. Currently we do not have the facility to compound all of our dose banded chemotherapy, a Alcura 1)Experiencing difficulties that have resulted in failed deliveri 2)There are on-going issues with invoicing. No invoices for A **Consequences**	Quality	UHL Homecare team liaising with homecare companies to try and resolve issues of which they are made aware. H@H high risk patients currently being repatriated to UHL. UHL procurement pharmacist in discussion with NHS England (statement due out soon - timeframe unsure), and with the CMU. Patient groups and peer group discussions also been held to support patient education and support during this uncertain period. Reviewing which medicines can be done through UHL out-patient provider or through UHL Discussions with Medical Director and CMG (CSI) and clinical specialty teams to ensure that any necessary clinical pathway changes are supported	Major	Likely	16	Financial risk associated with repatriation and highlight this to commissioners - 31/08/14	9	CELL

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2247	Corporate Nursing	Nursing	There are 500 Registered Nurse vacancies in UHL leading to a deterioration in service and adverse effect on financial position	30/10/2013	31/07/2014	**Causes:** Shortage of available Registered Nurses in Leicestershire. Nursing establishment review undertaken resulting in significant vacancies due to investment. Insufficient HRSS Capacity leading to delays in recruitment. **Consequences:** Potential increased clinical risk in areas. Increase in occurrence of pressure damage and patient falls. Increase in patient complaints. Reduced morale of staff, affecting retention of new starters. Risk to Trust reputation. Impact on Trust financial position due to premium rate staffing being utilised to maintain safety. Increased vacancies across UHL. Increased pay bill in terms of cover for establishment rotas prior to permanent appointments. HRSS capacity has not increased to coincide and support the increase in vacancies across the Trust. Delays in processing of pre employment checks due to increased recruitment activity. Delayed start dates for business critical posts. Benefits of bulk and other recruitment campaigns not being realised as effectively as anticipated and expected. Service areas outside of nursing being impacted upon due to	Patients	HRSS structure review. A temporary Band 5 HRSS Team Leader appointed. A Nursing lead identified. Recruitment plan developed with fortnightly meetings to review progress. Vacancy monitoring. Bank/agency utilisation. Shift moves of staff. Ward Manager/Matron return to wards full time.	Major	Likely	16	Over recruit HCAs. - 31/07/14 Utilise other roles to liberate nursing time - 31/07/14	12	CRIB

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2341	Operations	Outpatients	Long term follow up outpatient appointments not made	06/05/2014	31/07/2014	As the result of one specialty (rheumatology) finding they were not managing long term follow up appointments in accordance with clinical requirements, the Trust has undertaken a further assessment across all specialties of the risk of the same occurring. Initial assessment indicates that there are 24, 582 patient records on HISS / PAS where follow up appointments are not being managed in a timely way. These fall into 4 categories: 1) Patients with outcomes of waiting reports , but they have no follow up appointment booked 2)Outcome of long term follow up not made and patients are not on a waiting list and do not have a future appointment 3) Those on an outpatient waiting list but they are overdue their date to be seen 4)Outcome of future appointment but no appointment has been made. Full validation of patient level records is required to determine the size of the real risk in particular to patient care. Each CMG is required to make this assessment and report back to the Governance group on a weekly basis.(this is part of the action plan) **Causes:** The root cause for this failure has not yet been established a Potential consequences: (NB: until validation of all patient re Adverse impact on patient safety / care, potential for irrevers	Patients	-A Governance group, chaired by the Chief Operating Officer and Medical Director set up 23rd April , meeting weekly, terms of reference agreed and reporting to Executive Quality Board - Trust wide action plan written , updated weekly. Including clear instructions to CMG management teams - From 6th May patient level validation at specialty level underway , with weekly monitoring of progress	Major	Likely	16	Communicate required actions to all CMGs - Weekly Collate weekly returns to monitor validation progress - Weekly Run weekly Trust wide report to monitor progress of validation - Weekly CMGs to provide weekly update action plans on progress - Weekly Undertake Root Cause Analysis incident investigation - 15/07/14 Arrange standard external communication to patients - on track	2	KHAR

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
2318	Operations	Business continuity	Blocked drains causing leaks and localized flooding of sewage	17/03/2014	31/07/2014	**Causes (hazard)** Aging infrastructure that can no longer cope with the volume of sewage due to restrictions and narrowing of the pipes Staff, visitors and patients placing materials other than toilet paper into the drainage system Staff placing non maceratorable items in the macerators causing breakages and loss of containment Back flow sink drains are unprotected resulting in foreign bodies **Consequence (harm / loss event)** Blockages build up easier and the older pipes cannot cope with the additional pressure causing leaks of raw sewage into occupied areas. Approximately 250 calls a month are being received by LRI estates relating to blockages Pipes cannot cope with the non-degradable materials and flooding occurs Localised flooding of clinical areas often involving areas on the floors below Foreign bodies block the drains and cause back fill and overspill of sinks and other facilities Clinical areas and staff areas become contaminated with raw sewage, ED 21st September, 12th August EDU 25th September, Ward 8 23rd August, ITU and CT 5th August. Patients contaminated with sewage from leaks in the ceilings Whilst repairs are underway it may become necessary to iso Potential media coverage (one request for information from L Quality and safe delivery of care will be compromised in area Risk to health and safety of staff from an unsafe working env	Statutory	Interserve and Hospital response teams. Awareness raised at local inductions. Business Continuity Plans. Communications and awareness with staff - poster campaign (launched September 2013). Approval for drain survey (Kensington and Balmoral Building).	Major	Likely	16	Samples of suitable wipes to be considered (dissolvable/maceratorable) to NET and decide from there. Liz Collins - due 01/08/14 Implement single choice patient wipes from end of March. Liz Collins/ Jeff Oliver - due 01/08/14 Discuss use of patient wipes in toilets with NET. Liz Collins - due 01/08/14. Survey being done in Kensington and Balmoral. Nigel Bond - due 31/07/14. Cost of replacement of stacks to be assessed. Nigel Bond - due 31/07/14. Need to link to new emergency floor. Phil Walmsley - due 01/08/14. Jet washing pipes. Andrew Martin due 01/08/14. To check macerator posters and if necessary contact with company with regards to posters on limiting numbers of items in macerator. Aaron Vogel - due 01/08/14.	2	PWA

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1693	Strategy	Coding	Risk of inaccuracies in clinical coding	02/08/2011	31/07/2014	**Causes:** Case note availability and case note documentation. 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 coding backlog. High level of uncoded spells backlog (10,500 at June 2014) **Consequences:** Loss of income (PbR). Outlier for SHMI/HSMR data. Non- optimisation of HRG. Loss of Trust reputation.	Economics	Coding improvement project initiated April 2011. Project Board commenced September 2011 (PID, project plan and highlight report agreed). Electronic coding implemented February 2012 and to be upgraded November 2012 - HRG code generated. Will aid with audit, implementation of local policies and performance management. Task and finish groups completed in Divisions review improvements in coding using PeRL, PLICs, CHKS and medicode (encoder). New process for medical records retrieving notes. Due to changes in recording and payment of EDU and CAU episodes number of episodes coded has reduced. Shifts from day case to outpatient will reduce workload. Lead clinicians identified and Trust wide communication to move coding closer to the clinician. Tick lists introduced in both the ward area and discharge letter. Bank staff and overtime authorised to meet deadline. Scorecard developed to demonstrate improvements and benchmark against other Trusts. 3 year refresher programme completed November 2011. Quarterly updates/briefings to be led by Asst Director of Information - commenced April 2012. Team restructure Annual External Audit Internal Audit - commences November 2013 Audit Committee updates Clinical Coding Manager has a regular slot on Junior I PbR CIP Project Group commenced April 2014	Major	Likely	16	LIA - application successful with listening event booked for 1qtr 2014 - due 31/07/14	8	JRO

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
1737	RRC	Renal Transplant	Inappropriate environment and infection prevention Renal Transplant	25/10/2011	31/12/2014	**Causes:** Insufficient side room capacity. Inadequate space in existing side room for haemodialysis and line procedures. Insufficient en suite facilities in side rooms. Vascular access and % of patients with dialysis catheters. Procedure room on ward 10 not fit for purpose. Inappropriate areas used for renal biopsy on ward 17. Inadequate drug preparation areas. Inadequate domestic storage areas. No separate facility for isolating patients in ward 10/17 DCU. Movement of patients to accommodate admissions or haemodialysis in another area. **Consequences:** Poor compliance with cannula care. Challenges in maintaining integrity of commode lids using Chlorclean. Infection prevention risks. Transportation of contamination through patient occupied areas (15N/A).	Patients	Preventing Transmission of Infection including Isolation Guidelines (DMS 47699) MRSA Screening policy Weekly MRSA audits undertaken by IP Team Local Infection Prevention Group Communication of IP issues regular agenda item on local meetings Link Nurse Network Daily side room list Monthly Nursing Metrics audits Monthly HII audits Monthly Environment audits Recent refurbishment and upgrade of ward 15N/A accommodation Steam cleaning post CDT patients Vascular access being monitored by CQUIN & EMRN Medically led Vascular Access coordination Expert specialty trained competent staff Use 'cohort facility' as required On going competency based programme for the training and implementation of ANTT	Extreme	Possible	15	Development of renal relocation plan - 31/01/2017	15	JPR
2070	RRC	Satellite Units	Harborough Lodge environment stops staff safely delivering haemodialysis	16/08/2012	31/07/2014	**Causes:** Insufficient space to: Safely carry out dialysis procedures. Safely carry out manual handling procedures. Safely carry out emergency procedures. Maintain patient privacy & dignity. Poor state of repair of within clinical areas. **Consequences:** Cross contamination/infection. Manual handling injury to staff/patient/visitor. Poor patient experience. Negative reputation of Trust. Increase in number of complaints.	Patients	Specialist haemodialysis trained and competency assessed staff. Haemodialysis/other clinical policies. Annual manual handling training. Annual infection prevention training. Infection prevention policy. Infection prevention audits. Environment audits. Curtains at each bed space. Minimum cleaning standards.	Extreme	Possible	15	UHL undertake Duty of Care review and produce recommendations - 31/07/2014	5	JPR

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2328	ITAPS	Anaesthesia	Risk of inadvertent wrong route administration of anaesthetic medicines during epidural and regional anaesthesia.	16/04/2014	30/09/2014	**Causes** Continued use of Luer fitting syringes, needles etc increases the risk of anaesthetic medicines being administered via the wrong route. Distractions during anaesthetic procedure. **Consequences** Permanent injury on irreversible health effects. Death of patient Adverse publicity affecting reputation of the Trust and its staff Litigation leading to medical negligence claim	Patients	Labelling of syringes to indicate content Two people to check drugs during 'drawing up' procedure wherever possible. Training	Extreme	Possible	15	Use of Non-Luer syringes for all LA injections(following introduction of ISO standard) - 30/09/14 Introduction of Non-Luer giving sets(following introduction of ISO standard) - 30/09/14 Introduction of Non-Luer connector to epidural filter (following introduction of ISO standard) - 30/09/14	5	PSE

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2380	Clinical Support and Imaging		Risk of breach of Same Sex Accommodation Legislation	23/06/2014	01/09/2014	**Causes:** Inpatients and outpatients of the opposite sex have to wait together whilst wearing gowns/nightwear. **Consequences:** Breach of Same Sex Accommodation statutory legislation. Reduction in privacy and dignity for patients. Potential for increasing complaints. Potential for psychological harm/distress to patients. Repeated failure of internal standards around Same Sex Accommodation. Public expectations around Same Sex Accommodation and privacy and dignity not being met.	Patients	Imaging staff can provide patients with wrap-around gowns (or two gowns, one worn backwards) to reduce exposure, but this practice is inconsistent. Patients can be offered the opportunity to wait in the cubicles (where available) if preferred, but again this practice is inconsistent. Portable screens are available in CT waiting area for use when inpatients overflow into this area. (LRI)	Moderate	Almost certain	15	Glenfield Action Plan:- 1. Ascertain feasibility of splitting areas into separate male and female provision: " Waiting Area B " Room 2 " Room 3 " CT/MRI Waiting Area C Where not feasible, review options around providing privacy screens to separate male and female patients. Where feasible, implement appropriate changes, based on business case, costings approval and planning. 01/09/14 2. Ascertain feasibility of creating an additional cubicle in Barium Waiting Room to allow sufficient space for all patients to wait in the cubicle. 01/09.14 3. Ascertain costings associated with replacing cubicle curtains with solid doors to improve privacy & dignity whilst changing/waiting in cubicles. This applies to the cubicles in Waiting Areas A, B and MRI/CT area. 01/09/14 4. Explore options around redesigning the cubicles and waiting area in the MRI and CT zone, including relocation of storage area to create an additional cubicle, reallocate the current open waiting area into a fourth large cubicle. All cubicles to have solid doors. 01/09/14 5. Investigate possibility of single sex sessions, i.e. r 6. Create standard operating procedure to ensure th	3	JHA

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
1196	Clinical Support and Imaging		No comprehensive out of hours on call rota for consultant Paediatric radiologists	29/06/2009	30/07/2014	**Causes** There are Consultant Radiologists on call however there are not sufficient numbers to provide an on call service. Registrars are available but they have variable experience. **Consequences** Delays for patients requiring Paediatric radiological investigations. Sub-optimal treatment. Paediatric patients may have to be sent outside Leicester for treatment. Potential for patient dissatisfaction / complaints. Consultants are called in when they are not officially on call and they take lieu time back for this, resulting in loss of expertise during the normal working day.	Patients	There are Consultant Radiologists on call however there are not sufficient numbers to provide an on call service. Registrars are available but they have variable experience. Non Paediatric radiology consultants are not able to perform or interpret Paediatric radiological interventions.	Moderate	Almost certain	15	Recruit to Consultants vacancies - due 01/09/14	2	RG
2278	Women's and Children's	Family Planning	Risk that the Leicester Fertility Centre could have its licence for the provision of treatment and services withdrawn	17/12/2013	17/07/2014	**Causes:** Inadequate staffing levels and inappropriate quality systems in place. ISO 15189 accreditation would be an outcome if the service was adequately staffed with appropriate quality systems in place. **Consequences:** Patient safety and quality issues if unable to deliver service. Financial impact if patients choose to move elsewhere or NHS contracts not obtained. Risk to Trust reputation. Challenging external recommendations/improvement notice from HFEA - critical report received Feb 2013.	Statutory	1 fulltime trained Embryologist to a national recognised level 3 part time trained Embryologist to a national recognised level 1 0.8wte Band 6 BMS	Moderate	Almost certain	15	Formulation of business plan for Quality Manager post - due 31/7/2014. Overhaul of specimen request, collection and delivery procedures - due 31/7/2014.	6	DMARS

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
2270	Corporate Nursing	Fire	Failure to achieve compliance of 75% attendance at Fire Safety training may cause UHL to fail to meet its statutory obligation	11/12/2013	31/08/2014	**Causes:** CMG mandatory training study days may not be capturing the specific Fire Safety training as an individual component of the day therefore bringing into question the accuracy of e-UHL data. Difficulty in releasing staff to attend Fire Safety training (10 - 15% rate of non-attendance following booking). Lack of venues for additional sessions. Lack of managerial action re repeat non-attendees. **Consequences:** Non-compliance with statutory obligation. Potential non-compliance with CQC outcomes. Potential for staff / patient safety to be adversely affected in the event of a fire (it must be noted that no incidents recorded are attributable to lack of staff training). Loss of good reputation.	HR	Existing training developed to ensure that refresher training on alternate years can be via a e-learning module for non-clinical staff. Face to face training run at differing times in an attempt to satisfy everyone's needs.	Moderate	Almost certain	15	Increase the number of fire safety training sessions to two per month at each site (if venues are available) - 31/08/14. 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 - 31/08/14. Raise awareness of fire safety training via utilisation of Intranet and PC desktop messages - 31/08/14. Incentivise medical staff attendance - 31/08/14.	9	GBRO

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
2269	Corporate Nursing	IPC	Failure to meet UHL target of a minimum of 75% of clinical staff undertaking IP/Hand hygiene training	11/12/2013	31/07/2014	**Causes:** Poor attendance rates for all staff groups (UHL compliance 58%). Staff not released to undertake IP face-face training. e-UHL has not signposted Infection Prevention training for Clinical Staff. UHL is unable to demonstrate that all clinical staff within the trust has received Infection Prevention Training (including Hand Hygiene). **Consequences:** Poor attendance may be a contributory factor to patients acquiring Healthcare Associated Infections. Financial impact of CDT infections in relation to CCG fines. Potential risk of staff acquiring infections through lack of basic hand hygiene. Non-compliance with national standards (CQC, Health and Social care Act 2010).	Patients	High risk areas (e.g. with increased infection rates, SI) targeted for focused training. Active liaison with Clinical Skills Unit and UHL Education and Training team to resolve issues.	Extreme	Possible	15	e-learning package to be re-developed to meet core skills framework and UHL requirements. 29/07/14. Hold discussions with Medical Director to incentivise medical staff attendance for hand hygiene 29/07/14.. Ensure e-UHL accurately signposts relevant staff to their role specific Infection Prevention training requirements. 29/07/14.. Ensure e-UHL accurately signposts relevant staff to their mandatory Infection Prevention training requirements 29/07/14.. Develop more robust links with medical staff training team. 29/07/14.. Refine job role of link staff network to support ward managers in raising IP awareness at a local level. 29/07/14.. Ward Managers to use observed assessment of ANTT for nurses and discuss the process for assessment of medical staff with medical staff training team. 29/07/14.	10	LCOL

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
1551	Corporate Nursing	Quality	Failure to manage Category C documents on UHL Document Management system (Insite)	14/03/2011	26/07/2014	**Causes:** Lack of resource at CMG/directorate level to check review dates and enter local guidance onto the system in a timely manner. Lack of resource in CASE team effectively 'police' cat C documents Clinical guidelines very difficult to locate due to difficulties in navigating on InSite During migration from SharePoint 2007 to SharePoint 2010 searched documents displayed the titles of the files rather than the titles of documents. **Consequences** InSite may not contain the most recent versions of all category C documents. There may be duplication of documents with older versions being able to be accessed in addition to the most recent version. Staff may be following incorrect guidance (clinical or non-clinical) which could adversely impact on patient care.	Quality	Reports run from SharePoint to show review dates of guidelines for each CMG A review date and author have now been assigned to each Cat C where this is possible.	Moderate	Almost certain	15	Make contact with lead authors in relation to out of review date documents - 31/12/14 Compile a list of local guidelines requiring review and send to CMGs for action - 31/12/14 CMGs to advise 'CRESPO' of any guidelines requiring urgent revision/ attention or that need to be removed from InSite 31/12/14 Provide a message on InSite to inform staff that work to improve the system is on going and if necessary advise can be sought from Rebecca Broughton/ Claire Wilday - 31/12/14 Implement shared mailbox to receive responses from CMGs - 31/12/14 Ensure input from IM&T to make InSite more effective as a document library - 31/12/14 Continue work to assign review dates and authors to all CAT C documents 31/12/14	9	SH