University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper L

TRUST BOARD – 5th FEBRUARY 2015

UHL RISK REPORT INCORPORATING THE BOARD ASSURANCE FRAMEWORK 2014/15

DIRECTOR:	RACHEL OVERFIELD – CHIEF NURSE
AUTHOR:	PETER CLEAVER – RISK AND ASSURANCE MANAGER
DATE:	5TH FEBRUARY 2015
PURPOSE:	This report provides the Trust Board (TB) with:- a) A copy of the UHL BAF and action tracker as of 31ST December 2014. b) Notification of any new extreme or high risks opened during December 2014. c) Summary of all open risks as of 31st December 2014 scoring 15 – 25 (i.e. extreme/ high). 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;
PREVIOUSLY CONSIDERED BY:	**UHL Executive team**
Objective(s) to which issue relates *	[X] 1. Safe, high quality, patient-centred healthcare [Y] 2. An effective, joined up emergency care system [Y] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [Y] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [Y] 5. Enhanced reputation in research, innovation and clinical education [Y] 6. Delivering services through a caring, professional, passionate and valued workforce

	☒ 7. A clinically and financially sustainable NHS Foundation Trust ☒ 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	N/A
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	N/A
Strategic Risk Register/ Board Assurance Framework *	☐ **Organisational Risk Register** ☑ **Board Assurance Framework** ☐ **Not Featured**
ACTION REQUIRED *	For decision ☑ For assurance ☑ For information ☐

♦ We treat people how we would like to be treated ♦ We do what we say we are going to do
♦ We focus on what matters most ♦ We are one team and we are best when we work together
♦ We are passionate and creative in our work

* tick applicable box

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **5th FEBRUARY 2015**

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 UHL BAF and action tracker as of 31st December 2014.
b) Notification of any new extreme or high risks opened during December 2014.
c) Summary of all open risks scoring 15 -25 (i.e. extreme and high).

2. BAF POSITION AS OF 31ST DECEMBER 2014

2.1 A copy of the 2014/15 BAF is attached at appendix one with changes since the previous version highlighted in red text. A copy of the BAF action tracker is attached at appendix two with changes also highlighted in red for ease of reference.

2.2 The TB is asked to note the following points:

a. Principal risks one, seven and 22; there are no further gaps in control/assurance identified and therefore consideration should be given to reducing the current risk score to the level of the target score. Alternatively any additional gaps and mitigating actions should be identified and brought to the attention of the UHL corporate risk team.

b. The TB is asked to note the deterioration of actions 2.4 and 3.1 to a RAG rating of red reflecting the current difficulties in reducing admissions and increasing discharges and therefore the increasing risk to the achievement of our ED waiting time target.

c. Principal risk five; the risk score has increased from 9 to 16 reflecting the difficulties in achieving the admitted RTT trajectory. A revised 'admitted' trajectory has been submitted to the Trust Development Agency (TDA) and CCG for agreement. UHL is currently in line with this trajectory.

d. Principal risk 11; the current risk score has reduced to target score and no further gaps in control/ assurance have been identified and the TB is asked to consider whether there is assurance that the existing controls are effective and to accept this risk as treated.

e. Principal 21; all actions have been completed and the TB is asked to consider whether these have been successful in mitigating the gaps in control/ assurance listed and whether the current risk score can be reduced to the target and the risk accepted as treated.

2.3 It has previously been agreed that the monthly TB review of the BAF be structured so as to include all the principal risks relating to an individual strategic objective. The following objective is therefore submitted to this TB for discussion and review:

'A clinically and financially sustainable NHS Foundation Trust'. (Incorporating principal risks 18, 19, 20, 21and 22).

3. DEVELOPMENT OF THE 2015/16 BAF

3.1 To develop a robust BAF there are a number of key actions that must be taken in sequence:

- Establish strategic objectives (and their owners).
- Identify the principal risks to the achievement of the strategic objectives (and, in addition, identify the risk owners).
- Identify the key control measures to achieve the strategic objectives and mitigate the principal risks.
- Identify the mechanisms by which the TB receives assurance that controls are effective.
- Identify any gaps in control or gaps in assurance
- Put in place actions to address any gaps identified.

3.2 It is proposed that the above will take place in a series of steps culminating in a 2015/16 BAF being submitted for endorsement at the April 2015 TB meeting. The first stage will be:

- For the UHL Executive Team (ET) to revise the current strategic objectives, ensuring they are relevant, accurately articulated, measurable and reflect our direction of travel.

- For the ET to revise the principal risks to accurately reflect the high level risks to the achievement of the Trust's strategic objectives The most appropriate executive lead for each of any new risks should be identified at this stage.

3.3 Stage two, will be submission of the revised objectives and risks to a Trust Board development session (TBDS)) on 12th February 2015. At this point new risk entries will not be fully populated with controls/gaps/actions, etc., however this submission will allow Non-Executive TB members to be involved at the initial development stage and will provide the opportunity for them to review any changes to objectives and risks and consider whether these reflect an accurate picture.

3.4 Stage three will be for the corporate risk team to meet individually with the executive leads in order to populate remaining fields within the BAF.

3.5 Stage four will be submission of the 2015/16 BAF to the April 2015 TB meeting for endorsement.

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

4.1 To inform the TB of significant operational risks, a summary of all extreme and high risks open as of 31st December 2014 is attached at appendix three.. There are 45 risks on the organisational risk register scoring 15 and above.

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

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Risk ID	Risk Title	Risk Score	CMG/ Directorate
2467	Outlying Extra Capacity - Winter months	25	ESM
2471	There is a risk of Radiotherapy Treatment on the Linac (Bosworth) being compromised due to poor Imaging capability of this machine	16	CHUGS
2466	Risk of Patient Harm due to delays in timely review of results and Monitoring in Rheumatology	16	ESM

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);

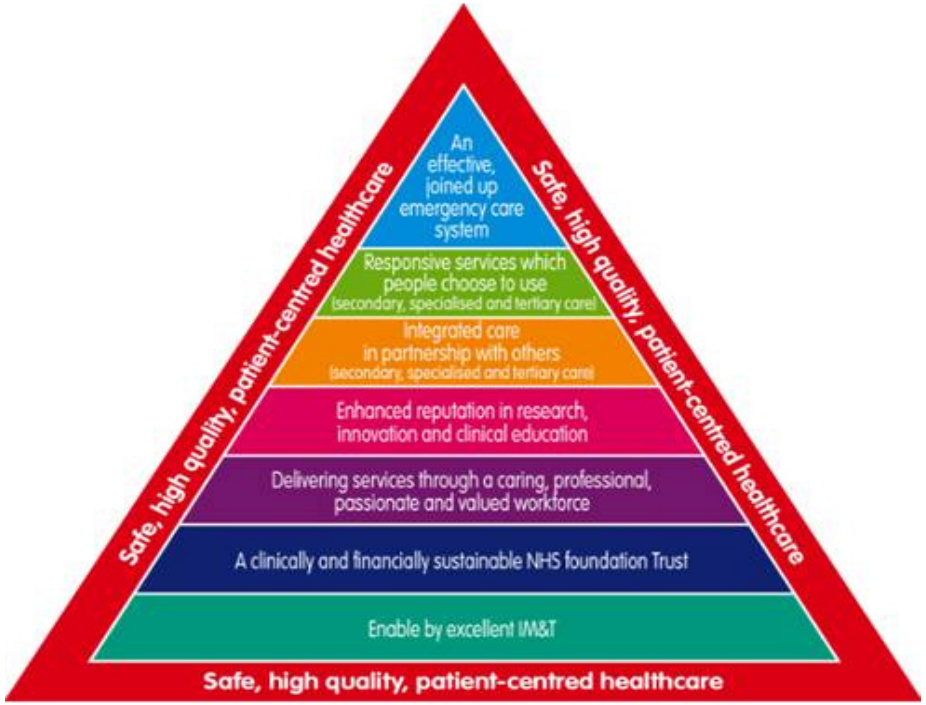
(c) identify any areas which it feels that the Trust's controls are inadequate and do not, therefore, effectively manage the principal risks to the organisation achieving its objectives;

(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;

Peter Cleaver,
Risk and Assurance Manager,
28 January 2015.

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: DECEMBER 2014

Risk No.	Link to objective	Risk Description	Risk owner	Current Score	Target Score
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	20	6
3.		Failure to effectively implement UHL Emergency Care quality programme	COO	16	6
4.		Delay in the approval of the Emergency Floor Business Case.	MD	12	6
5.	Responsive services which people choose to use (secondary, specialised and tertiary care)	Failure to deliver RTT improvement plan.	COO	16	6
6.		Failure to achieve effective patient and public involvement	DMC	12	8
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	6	6
12.		Failure to retain BRU status.	MD	9	6
13.		Failure to provide consistently high standards of medical education.	MD	9	4
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 financially sustainable NHS Foundation Trust	Lack of effective leadership capacity and capability	DHR	9	6
19		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	15	10

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	9	9

BAF 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 each goal and identified leads for each work stream of the Quality Commitment.	Q&P Report. Reports to EQB and QAC.			
KPIs agreed for all parts of the Quality Commitment.	Reports to EQB and QAC based on key outcome/KPIs.	No gaps identified		
Clear work plans agreed for all parts of the Quality Commitment.	Action plans reviewed regularly at EQB and annually reported to QAC. Annual reports produced. Summary report scheduled for EQB February 2015	No gaps identified		
Committee structure is in place to oversee 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 5 = 20**	**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) Emergency admissions are not reducing (C) Discharges are not increasing and delayed discharge rate has not changed	Review effectiveness of specific LLR improvement actions to deliver a reduction in admissions and increase in discharges (2.4)	LLR MD review Feb 2015
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.	(C) IS's time with the health economy finishes in mid-November 2014	Arrangements for IS to return for a two week period (2.5)	Mar 2015 RM
Allocation of winter monies	Allocation of winter monies is regularly discussed in the LLR steering group	None	N/A	

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 4 = 16**	**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) Emergency admissions are not reducing (C) Discharges are not increasing and delayed discharge rate has not changed	Review effectiveness of specific LLR improvement actions to deliver a reduction in admissions and increase in discharges (3.1)	Feb 2015 COO
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 3.1	Feb 2015 COO
Further change leadership support has been identified to help embed the required clinically led changes	Trust Board are sighted on actions and plans coming out of the EQSG meeting.	C) Emergency admissions are not reducing (C) Discharges are not increasing and delayed discharge rate has not changed	As 3.1	Feb 2015 COO

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 4 x 3 = 12**	**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	(c) Inability to control NTDA internal approval processes	Regular communication with NTDA (4.1)	On-going action to complete in Mar 2015 MD

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** 4x4=16	**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**
Weekly RTT meeting with commissioners to monitor overall compliance with plan	Trust Board receives a monthly report detailing performance against plan	(c) There is a revised admitted trajectory which is awaiting agreement with TDA and CCG. UHL is in line with the revised trajectory.	Action plans to be developed in key specialities to regain trajectory for admitted RTT(5.1)	April 2015 COO
Weekly meeting with key specialities to monitor detailed compliance with plan	Trust Board receives a monthly report detailing performance against plan	(c) There is a revised admitted trajectory which is awaiting agreement with TDA and CCG. UHL is in line with the revised trajectory.	As above 5.1	As above COO
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	(c) Recommendations from IST report not yet implemented.	Act on findings from recently published IST report (5.2)	Mar 2015 COO

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 4x3=12**	**Target score 4x2=8**
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**
1. PPI / stakeholder engagement Strategy Named PPI leads in all CMGs 2. PPI reference group meets regularly to assess progress against CMG PPI plans 3. Patient Advisors appointed to CMGs 4. Patient Advisor Support Group Meetings receive regular updates on PPI activity and advisor involvement 5. Bi-monthly Membership Engagement Forums 6. Health watch representative at UHL Board meeting 7. PPI input into recruitment of Chair / Exec' Directors 8. Quarterly meetings with LLR Health watch organisations, including Q's from public. 9. Quarterly meetings with Leicester Mercury Patient Panel	Emergency floor business case (Chapel PPI activity) PPI Reference group reports to QAC July Board Development session discussion about PPI resource. Health watch updates to the Board Patient Advisor Support Group and Membership Forum minutes to the Board.	PPI/ stakeholder engagement strategy requires revision	Update the PPI/stakeholder engagement strategy (6.1)	Feb 2015 DMC

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 (BCT) Strategy: • UHL actively engaged in the Better Care Together governance structure, from an operational to strategic level • Better Care Together plans co–created in partnership with LLR partners • Final approval of the 5 year strategic plan, Programme Initiation Document (PID – 'mobilises' the Programme) and SOC to be made at the Partnership Board of 20th November 2014 • Better Care Together planning assumptions embedded in the Trust's 2015/16 planning round	• BCT resource plan, identifying all work books named leads (SRO, Implementation leads and clinical leads) • Workbooks for all 8 clinical work streams and 4 enabling groups • Feedback from September 2014 Delivery Board and Clinical Reference Group workshops • LLR BCT refreshed 5 year strategic plan approved by the BCT Partnership Board • Minutes and Action Log from the BCT Programme Board			
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 5) Active engagement in the BCT LTC work stream. 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: o Trust Board approved the LLR BCT 5 year directional plan and UHLs 5 year directional plan on 16 June, 2014 o Urgent care and planned care work streams reflected in both of these plans • BCT resource plan, identifying all work books named leads (SRO, Implementation leads and clinical leads agreed at the BCT Partnership Board (formerly the BCT Programme Board) meeting held on 21st August 2014 Workbooks for all 8 clinical work streams and 4 enabling groups underway – progress overseen by implementation			

	group and the Strategy Delivery Group which reports to BCT Partnership Board.			

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**
(i) 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 (DC@IB) ○ Reviewed at the June 2014 Executive Strategy Board (ESB) meeting ○ Updates (DC@IB Highlight Report reviewed at ESB meetings	(c) Lack of Programme Plan	Programme Plan to be developed (8.3)	Apr 2015 DS
(ii) Academic and commercial partnerships. (iii) Local partnerships	Project Initiation Document (PID): ○ Developed as part of UHL's Delivering Care at its Best (DC@IB) ○ Reviewed at the August 2014 Executive Strategy Board (ESB) meeting ○ Updates (DC@IB Highlight Report reviewed at ESB meetings	(c) Lack of PID for local partnerships	PID for Local Partnerships to be developed by the Head of Local Partnerships (8.7)	Jan 2015 DS
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.			

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			
Link to strategic objectives	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	See risk 8	See risk 8	See risk 8	See risk 8
Academic and commercial partnerships	See risk 8	See risk 8	See risk 8	See risk 8
Local partnerships	See risk 8	See risk 8	See risk 8	See risk 8
Delivery of Better Care Together:	See risk 7	See risk 7	See risk 7	See risk 7

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			
Link to strategic objectives	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**
Effective partnerships with LPT	See risk 7	See risk 7	See risk 7	
Effective partnerships with primary care	See risk 7			

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 2 = 6**	**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)	(c) Requirement to replace senior staff and increase critical mass of senior academic staff in each of the three BRUs.	BRUs to re-consider theme structures for renewal, identifying potential new theme leads. (12.1) BRUs to identify potential recruits and work with UoL/LU to structure recruitment packages. (12.2) UHL to use RCF to pump prime appointments if possible and LU planning new academic appointments to support lifestyle BRU. (12.3)	Jun 2015 MD June 2015 MD Jun 2015 MD
	Athena Swan Silver Status by University of Leicester and Loughborough University. (The Athena Swan charter applies to higher	(c) Athena Swan Silver not yet achieved by UoL and Loughborough	UoL and LU to ensure successful applications for	Mar2016 MD

	education institutions)	University. This will be required for eligibility for NIHR awards	Silver swan status and. Individual medical school depts will need to separately apply for Athena Swan Silver status. (12.4) Special meeting of Joint BRU Board: planning to secure BRU funding at the next NIHR competition. Further meetings planned. (12.5)	 Mar 2015 MD

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 2 x 2 = 4**
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	Department of Clinical Education (DCE) Business Plan and risk register are discussed at regular DCE Team Meetings and information given to the Trust Board quarterly Medical Education issues championed by Trust Chairman Bi-monthly UHL Medical Education Committee meetings (including CMG representation) Oversight by Executive Workforce Board Appointment processes for educational roles established KPI are measured using the: • UHL Education Quality Dashboard • CMG Education Leads and stakeholder meetings • GMC Trainee Survey results • UHL trainee survey • Health Education East Midlands Accreditation visits Trainee Survey results • UHL trainee survey Health Education East Midlands	(c) Transparent and accountable management of postgraduate medical training tariff is not yet established (c) Transparent and accountable management of SIFT funding not yet identified in CMGs (proposal prepared for EWB) (c) Job Planning for Level 2 (SPA) Educational Roles not written into job descriptions (c) Appraisal not performed for Educational Roles	To work with Finance to ensure transparency and accountability of undergraduate and postgraduate medical training tariffs (13.1) Ensure appropriate Consultant Job descriptions include job planning (13.2) Develop appraisal methodology for educational roles (13.3) Disseminate agreed	Jan 2015 MD Jan 2015 MD Jan 2015 MD Feb 2015

	Accreditation visits	(c) Trainee Drs in community – anomalous location in DCE budgets	appraisal methodology to CMG s (13.4) Work to relocate anomalous budgets to HR as other Foundation doctor contracts (13.5)	MD Apr 2015 MD
UHL Education Committee	CMG Education Leads sit on Committee. Education Committee delivers to the Workforce Board twice monthly and Prof. Carr presents to the Trust Board Quarterly.	(c) No system of appointing to College Tutor Roles (c) UHL does not support College Tutor roles	Develop more robust system of appointment and appraisal of disparate roles by separating College Tutor roles in order to be able to appoint and appraise as College Tutors (13.6)	Jan 2015 MD

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 Developing relationships with key academic partners. Existing well established partners: • University of Leicester • Loughborough University	Minutes of joint UHL/UoL Strategy meetings Minutes of Joint BRU Board Minutes of NCSEM Management Board	(c) New relationships need to be developed and nurtured with the new VC and President for UHL. New Dean of Medical School expected 2015.	UHL CE to meet with VC in near future. (14.1) LU strategy to be discussed at joint BRU board. (14.2) UHL membership of NCSEM management board (14.3) Meeting with LU VC, UHL MD, UHL DRD and BRU Director to discuss strategy (14.4)	Mar 2015 CEO Mar 2015 Mar 2015 Jun 2015
Developing partnerships; • De Montfort University • University of Nottingham • University College London (Life Study) • Cambridge University (100k project)	100k genome and Life study reports to ESB monthly. Joint meetings held with R&D team for NUH - reported through R&D Exec minutes to ESB. EM CLAHRC Management Board reports via R&D Exec to ESB	(c) Contacts with DMU could be developed more closely	Develop regular meeting with DMU (14.5)	Jun 2015

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) including an integrated approach to workforce planning with LPT.	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 (e.g. 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 (e.g. nurses)	Develop Innovative approaches to recruitment and retention to address shortages. (15.4) Develop new roles that address competency and skill gaps in service delivery areas (15.9)	Mar 2015 DHR Mar 2015 DHR

			Develop Workforce Planning Template to include detailed plans by staff group relating to reduction and growth which triangulate with finance and activity (15.10) Develop Cross Cutting Workforce Programme Board with work streams covering Medical, Nursing, Premium Spend and .3-5 year planning (15.11)	Mar 2015 Feb 2015
Nursing Recruitment Trajectory and international recruitment plan in place for nursing staff	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			
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 consultant recruitment	Deliver our Employer Brand group to share best practice and develop social media techniques to promote opportunities at UHL (15.6) Consultant recruitment review team to develop professional	Mar 2015 DHR April 2015 DHR

			assessment centre approach to recruitment utilising outputs to produce a development programme (15.8)	

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			
'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 against Implementation 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 'development and 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-learning development	eUHL system updates required to meet Trust needs (16.2) Robust ELearningpolicy and procedures to be developed (16.3)	Mar 2015 DHR Jan 2015 DHR
'Quality Improvement and innovation' by implementing quality improvement education, continuing to develop quality improvement	Quarterly reports to EQB and EWB and measured against implementation plan milestones set out in	No gaps identified		

networks and creating a Leicester Improvement and Innovation Centre	PID.			
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: Year 3 Listening into Action (LiA) Plan (2015 to 2016) to be developed in March 2015 for next 12 months. To include continued work with 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 to be conducted March 2015 Update reports provided to JSCNC meetings	(a) Lack of triangulation of LiA Pulse Check Survey results with National Staff Opinion Survey and Friends and Family Test for Staff (a) Organisational Health Dashboard yet to be developed for reporting in EWB and to be available to CMG Management team for monthly actions.	Listening into Action activity within CMGs / Corporate Divisions to be one of the reported Performance Indicators within the Organisational Health Dashboard (17.7)	Mar 2016 DHR
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	(a) Number of Listening events being held within each division unclear due to range of LiA work streams.	See action 17.7	Mar 2016 DHR
Work stream Three: **Management of Change LiA** • LiA Engagement Events held as a precursor to change projects associated with service transformation and / or 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	(c Reliant on IBM / HR to notify LiA Team of MoC activity	CMG HR Leads to notify LiA Team of any listening events – proforma developed to	Mar 2016 DHR

	Update reports provided to JSCNC meetings		capture activities and to be reported in Organisational Health Dashboard. (17.8)	
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	LiA to be rolled out within Alliance utilising Alliance Management Team to support the implementation and to report activity via LiA Sponsor Group (17.9)	Mar 2016 DHR
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	(c) Lack of a clear system for sharing lessons learned and success outcomes from each of the NiA Ward / Department areas to maximise spread of learning and sharing best practice.	Success outcomes to be shared with nursing workforce via new annual Nursing Conference – first one scheduled for April 2015. (17.10)	Mar 2016 DHR/ Chief Nurse
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	(a) Lack of 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	Workshop on 2014 survey results priorities and actions with CEO & DHR on 27 January2015 leading to 2015 / 16 engagement plan for the Trust – to be shared via appropriate management forums and CE	Mar 2016 DHR

	monthly to Board via Quality and Performance report Results of National staff survey and local patient polling reported to Board on a six monthly basis. Improving staff satisfaction position.		Briefing (March & April 2015). TB paper on March Trust Board And ET Paper for March 2015. (17.11)	
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)	(a) Survey completion criteria variable between NHS organisations per quarter. (a) Survey to include 'NHS Workers' and not restricted to UHL staff therefore creating difficulty in comparisons between organisations as unable to identify % response rates. (c) No guidance available 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. (a) Lack of triangulation of Friends and Family Test for Staff results with local Pulse Check Results (Work stream One: Classic LiA / Work stream Five: NiA) and	Workshop on 2014 survey results priorities and actions with CEO & DHR on 27 January 2015. (17.12) See action 17.7 Workshop outputs to lead to 2015/16 engagement plan for the Trust – to be	Mar 2015 DHR Mar 2016 DHR Mar 2016 DHR

		other indicators of staff engagement such as National Staff Survey	shared via appropriate management forums and CE Briefing (March & April 2015). TB and ET Paper for March 2015. (17.13)	
Workforce Sickness Absence levels	Attendance management policy and procedures available to staff and managers. Compliance reports via Workforce Informatics Manager sent to CMGs monthly to support management of individual cases. ESR recording of attendance. Monthly reports available to CMGs / Corporate Divisions HR CMG Teams support front line managers to manage staff in line with policy Sickness levels reported via CE Briefings per month Sickness levels incorporated into Organisational Health Dashboard monthly reporting via EWB quarterly meetings and available to CMG HR Leads via SharePoint Sickness absence rates reported to UHL Leadership Community via CE Briefings per month	(a) Lack of triangulation between the use of premium rate staff to support non-compliance with UHL target for 2014/15 sickness absence rates, with increasing levels of sickness reported for some CMGs / staff groups	Organisational Health Dashboard quarterly via EWB / monthly reports available via SharePoint (17.14) Annual performance target set with CMG breakdown available per month for CMG Board Meetings. (17.15) Workforce KPIs included in Quarterly CMG Workforce meetings from January 2015 – to be attended by HR CMG Leads and Workforce Development Manager (17.16) Premium spend / pay group to be established in February 2015 as part of the CIP	Mar 2016 Mar 2016 /17

			Workforce Charter to review use of premium pay and reasons for use – to support CMGs to identify links to, for example, sickness absence, recruitment, & increased activities during 2015/16 (17.17)	
Mutuals in Health Pathfinder Programme	Submitted application to Cabinet Office (CO) and Department of Health (DH) to participate in the programme as one of the Trusts nationally. Selected to participate in the Pathfinder Programme – 1st January 2015 – 31 March 2015 Mutuals Programme Board established – January 2015 chaired by CEO. Programme Lead identified (Assistant Director of OD & Learning) to work with the assigned external partners (Hempsons, Stepping Out & Albion) Monthly update reports to Executive Team. Progress Report to be presented to EWB in March 2015 Programme of work relates to delivery of 3 pillars identified for UHL – 1. Exploring organisational forms with whole Trust 2. Autonomous Incentivised Teams – elective orthopaedics & trauma team 3. Improving engagement within UHL Production of a Feasibility Report (Business Case) to DH/CO by 31 March 2014 Attendance at national workshops to learn from other Trusts – knowledge transfer. Organise internal workshops on each of the 3 pillars and encourage appropriate attendance by CMG Managers and nominated staff.	a) Due to tight timeframes for delivery of the Feasibility Report (FBC) will the Trust Board and Executive Team be fully signed up to the final produced report and proposals for transferability of lessons learned to UHL service and workforce models.	Feasibility Report (Known as Full Business Case by CO/DH) by 31 March 2015 with Trust Board approval. To be presented to TB in March and EWB in March 2015 (17.18)	Mar 2015 DHR

	Pathfinder Programme Risk Register to be managed by external partners with CO/DH.			

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**
Leadership into Action Strategy (2014:16) including six work streams: 'Providing Coaching and Mentoring' by developing an internal coaching and mentoring network, with associated framework and guidance which will be piloted in agreed areas (targeting clinicians at phase 1).	Quarterly Reports to Executive Workforce Board (EWB) as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.			
'Shadowing and Buddying' by creating shadowing opportunities and devising a buddy system for new clinicians or those appointed into new roles.	Quarterly Reports to Executive Workforce Board as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.	(c) Buddying / Shadowing System Requires Development	System being developed in partnership with HEEM and Assistant Medical Director to ensure support provided to newly appointed Consultants at initial phase (18.3)	Apr 2015 DHR
'Improving local communications and 360 degree feedback' by developing and implementing a 360 Degree feedback Tool for all leaders and developing nurse leaders to facilitate Listening Events in all ward and clinical department areas as set out in Risk 17.	Quarterly Reports to Executive Workforce Board as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16. Updates provided to LiA Sponsor group every 6 months on success measures Monthly updates to Nursing Executive Team (NET) meetings via Heads of Nursing per CMG	(a) 360 Feedback Tool not yet developed		
'Shared Learning Networks' by creating and supporting learning	Quarterly Reports to Executive Workforce Board as			

networks across the Trust, developing action learning sets across disciplines and initiating paired learning.	part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.			
'Talent Management and Succession Planning' by developing a talent management and succession planning framework, reporting on talent profile across the senior leadership community, aligning talent activity to pay progression and ensuring succession plans are in place for business critical roles.	Quarterly Reports to Executive Workforce Board as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.	(c) Talent Management and Succession Planning Framework requires development at regional and national level with alignment to the new NHS Health Care Leadership Model	Support national and regional Talent Management and Succession Planning Projects by National NHS Leadership Academy , EMLA and NHS Employers (18.5)	Mar 2015 DHR
'Leadership Management and Team Development' by developing leaders in key areas, team building across CMG leadership teams, tailored Trust Board Development and devising a suite of internal eLearning programmes	Quarterly Reports to Executive Workforce Board as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.	(c) Improvement required in senior leadership style and approach as identified as part of Board Effectiveness Review (2014)	Board Coach (on appointment) to facilitate Board Development Session (18.6) Update of UHL Leadership Qualities and Behaviours to reflect Board Development, UHL 5 Year Plan and new NHS Healthcare Leadership Model (18.7)	Feb 2015 Jan 2015 CE / DHR

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 5 x 3 = 15**	**Target score 5 x 2 = 10**
Executive Risk Lead(s)	Director of Finance			
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, SOs and on-going Finance Training Programme Health System External Review has defined the scale of the financial challenge and possible solutions UHL Service & Financial Strategy including Reconfiguration/ SOC	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) Lack of supporting service strategies to deliver recurrent balance	Production of a financial strategy to accelerate the recovery programme (19.2)	Feb 2015 DF
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 CIP Quality Impact assessments			
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.			
Financially and operationally deliverable by contract signed off by UHL and CCGs and Specialised Commissioning on 30/6/14	Agreed contracts document through the dispute resolution process/arbitration Regular updates to F&P Committee, Executive Board,			

	Escalation meeting between CEOs/CCG Accountable Officers			
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 (19.10)	On-going action - Review monthly DF
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 an outcome of submission of SOC/ business cases (19.11)	On-going action – Review March 2015 DF

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) PMO structure not yet in place to ensure continuity of function	Recruit substantive staff to vacant posts (20.2)	Feb 2015 COO
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	Simplify cross cutting themes to workforce, beds, outpatients and theatres (20.1)	Feb 2015 COO

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 5x3=15**	**Target score 5x2=10**
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**
Stakeholder Engagement Strategy (including a clinical task force to drive the improvements that come out of learning lessons to improve care)	Annual Stakeholder surveys presented to the Board Feedback from stakeholders in Board 360 as part of Foresight review. BCT strategy and planning Regular meeting with: CCGs and GPs and Health watch(s) Mercury Panel MPs and local politicians TDA / NHSE On-going review of effectiveness of clinical task force via EQB and QAC	(c) No structured key account management approach to commercial relationships (c) Commissioner (clinical) relationships can be too transactional i.e. not creative / transformational.		

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. A paper briefing the TB on the outcome of the DH Gateway 0 review and the actions taken to address them in the form of a Programme Brief and governance arrangements was presented to the December 2014 TB meeting			

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	EPR Board now needs to be re-shaped from procurement to delivery	Review governance arrangements and alignment with other major programmes (23.7)	CIO – Jan 2015
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.			
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.	EPR Board now needs to be re-shaped from procurement to delivery	See action 23.7	CIO – Jan 2015

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 3x3 = 9**	**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 not formally raised to IM&T.			
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			
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			
Formalised process for assessing a project and its objectives	All projects go through a rigorous process of assessment before being accepted as a proposal			

Appendix two

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
ACTION TRACKER FOR THE 2014/15 BOARD ASSURANCE FRAMEWORK (BAF)

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
1	**Lack of progress in implementing UHL Quality Commitment.**					
2	**Failure to implement LLR emergency care improvement plan.**					
2.4	Review effectiveness of specific LLR improvement actions to deliver a reduction in admissions and increase in discharges	COO / LLR MD		Review ~~December 2014~~ February 2015	The actions taken are not having the desired effect. The required changes are being tracked through the LLR urgent care working group	2
2.5	Arrangements for IS to return for a two week in January 2015 (2.5)	COO		~~January 2015~~ March 2015	IS's availability has changed and we are working with the new CMGD to review the best way to use IS's experience if he returns in March 2015	3
3	**Failure to effectively implement UHL Emergency Care quality programme.**					
3.1	Review effectiveness of specific LLR improvement actions to deliver a reduction in admissions and increase in discharges. **NB:** *Original action reworded by COO – Dec 2014*	COO		February 2015	The actions taken are not having the desired effect. The required changes are being tracked through the LLR urgent care working group	2
4	**Delay in the approval of the Emergency Floor Business Case.**					

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

4.1	Regular communication with NTDA	MD		March 2015	Regular communication with the NTDA about the required timeline for approval of the ED business case has continued to ensure all parties understand the critical time dependencies within the scheme. Communication will continue until the submission dates and beyond to keep the NTDA on track therefore this action will be on-going until March 2015. Deadline extended to reflect this.	4
5	**Failure to deliver RTT improvement plan.**					
5.1	Action plans to be developed in key specialities to regain trajectory in admitted RTT	COO		~~September~~ ~~October~~ ~~December 2014~~ ~~February 2015~~ April 2015	Action plans completed. There is a revised admitted trajectory which is awaiting agreement with TDA and CCG. UHL is in line with the revised trajectory. Compliance with RTT target anticipated April 2015	2
5.2	Act on findings from recently published IST report	COO		~~August~~ ~~October 2014~~ March 2015	UHL plan to implement findings and recommendations to be developed. IST commissioned to be working with the Trust until end March 2015, Project plan developed and action deadline extended to reflect this.	4
6	**Failure to achieve effective patient and public involvement**					
6.1	Update the PPI/stakeholder engagement strategy	DMC		February 2015	Board development session on Jan 15th. Final strategy to the Board February 2015	4
6.2	Revised PPI plan			N/A	This action replicates 6.1 above and will therefore be deleted from future versions of the action tracker	N/A
6.3	OD team involvement to reenergise the vision and purpose of Patient Advisors	DMC	PPIMM	~~October~~ November 2014	**Complete**	5
7	**Failure to effectively implement Better Care together (BCT) strategy.**					

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

7.4	BCT SOC to be presented at the December 2014 Trust Board meeting for approval. Action reworded by DS – Dec 2014	DS		December 2014	**Complete.** The BCT SOC and PID were approved at the December 2014 TB meeting.	5
8	**Failure to respond appropriately to specialised service specification.**					
8.3	Programme Plan to be developed	DS		April 2015		4
8.7	PID for Local Partnerships to be developed by the Head of Local Partnerships	DS		~~December 2014~~ January 2015	Timescale extended as Head of Local Partnerships only recently appointed	3
9	**Failure to implement network arrangements with partners.**					
	Actions, 8.1, 8.2, 8.3 and 8.5 refer to risk 9. Action 7.3 refer to risk 7, therefore refer above for progress				See risks 7 & 8	
9.2	*Action removed from BAF / action tracker by DS following further review of content of risk number 9.*	N/A		N/A	See risks 7 & 8	N/A
10	**Failure to develop effective partnership with primary care and LPT.**					
10.1	**Action removed from upon request of DS as action encompassed in risk 7.**	N/A		N/A	See risk 7	N/A
11	**Failure to meet NIHR performance targets.**					
12	**Failure to retain BRU status.**					
12.1	BRUs to re-consider theme structures for renewal, identifying potential new theme leads. (12.1)	MD	DR&D	June 2015	Awaiting National Guidance on structure required for future bids	4
12.2	BRUs to identify potential recruits and work with UoL/LU to structure recruitment packages.	MD	DR&D	June 2015		4
12.3	UHL to use RCF to pump prime appointments if possible and LU planning new academic appointments to support lifestyle BRU.	MD	DR&D	June 2015		4

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

12.4	UoL and LU to ensure successful applications for Silver swan status and. Individual medical school depts will need to separately apply for Athena Swan Silver status.	MD	DR&D	March 2016	VC and President has re-constituted group leading Medical School Bid with appointment of new project manager.	4
12.5	Special meeting of Joint BRU Board: planning to secure BRU funding at the next NIHR competition. Further meetings planned.	MD	DR&D	March 2015		4
13	**Failure to provide consistently high standards of medical education.**					
13.1	To work with Finance to ensure transparency and accountability of undergraduate and postgraduate medical training tariffs *(reworded October 2014)*	MD	AMD (CE)	~~October 2014~~ January 2015	Work on investigating this is taking longer than anticipated and requires coordination with the new Director of Finance.	3
13.2	Ensure appropriate Consultant Job descriptions include job planning	MD	AMD (CE)	January 2015		4
13.3	Develop appraisal methodology for educational roles	MD	AMD (CE)	January 2015	Information to support appraisers developed and include in appraiser development sessions. A new module in Prep is being explored to support appraisal of education roles	4
13.4	Disseminate approved appraisal methodology to CMGs.	MD	AMD (CE)	~~December~~ February 2015	Date changed as appraisal methodology will not be developed until January 2015 (see action 13.3)	3
13.5	Work to relocate anomalous budgets to HR as other Foundation doctor contracts	MD	AMD (CE)	~~January~~ April 2015	Budgets will be relocated at the beginning of 2015/16 financial year to avoid potential confusion of transferring part year budgets. Deadline changed to reflect this.	3
13.6	Develop more robust system of appointment and appraisal of disparate roles by separating College Tutor roles in order to be able to appoint and appraise as College Tutors	MD	AMD (CE)	January 2015	We have a role description agreed between UHL and HEEM – problem is unlike other Trusts UHL does not support College Tutor roles	4

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

14	**Lack of effective partnerships with universities.**					
14.1	UHL CE to meet with VC in near future.	CEO		March 2015	UHL Chairman has already met with VC	4
14.2	LU strategy to be discussed at joint BRU board.	MD	DR&D	March 2015		4
14.3	UHL membership of NCSEM management board	MD	DR&D	March 2015	Currently MD and DR&I attending	4
14.4	Meeting with LU VC, UHL MD, UHL DRD and BRU Director to discuss strategy	MD	DR&D	June 2015	Invitation sent to LU VC	4
14.5	Develop regular meeting with DMU	MD	DR&D	June 2015	Regular meetings established at Exec level – relevant subgroups established	4
15	**Failure to adequately plan the workforce needs of the Trust.**					
15.4	Develop Innovative approaches to recruitment and retention to address shortages.	DHR		March 2015	Medical Workforce Strategy in place and to be updated following feedback from HEEM quality visit and the Clinical Senate. Aim to present to March 2015 Board Consultant recruitment process has been improved to incorporate assessment centres. Services are developing a portfolio to reflect provision in better attracting consultant to services	4

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

15.6	Delivering our Employer Brand group to share best practice and development social media techniques to promote opportunities at UHL	DHR		March 2015	Webpage review originally planned for end of August now changed to end of January 2015. Resource identified to develop website. Hotspots areas now producing career profiles which are successfully attracting into difficult to recruit areas. We will be using Twitter and other social media techniques to attract staff to UHL. Service areas are to provide an overview of the future of their services for use when advertising consultant posts. Scheme to promote managerial and leadership posts to existing NHS MTS scheme graduates to be developed and in place for March 2015. Scheme will include a unique offer in terms of development in order to attract high calibre applicants.	4
15.8	Consultant recruitment review team to develop professional assessment centre approach to recruitment utilising outputs to produce a development programme	DHR		April 2015	Proposal prepared for review by DHR and MD. Agreed to make small adjustments to selection process in first instance and evaluate impact.	4

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

15.9	Develop new roles that address competency and skill gaps in service delivery areas	DHR		March 2015	UHL New Roles Group established with 3 sub-groups with the remit of delivering new roles in Assistant Practitioner, Advanced Practitioner and Physician Assistant. Roles developed will consider work undertaken by the Clinical Senate relating to building the Team Around the Patient. The first cohort of assistant practitioners is planned for March 2015 focused on ITU and HDU areas and the Advanced Practitioner role is underway in ED to be spread into priority recruitment hotspots areas HEEM Funding of £250k has been approved to enable LLR providers to introduce US Physicians Assistants into the workforce. For UHL this means improved capacity of 20-30 Associates to support medical staff particularly in recruitment hotspot areas identified in the annual workforce planning process.	4
15.10	Refine the workforce elements of the Operational Planning cycle to ensure robust workforce plans to support organisational transformation, activity and finance	DHR		March 2015	Template defined which analyses the workforce implications of both CIP and growth schemes. Template also describes workforce improvement which leads to improvement in quality. Schemes to be triangulated with finance and activity and confirmed through Executive dialogue. Final submission of workforce plan will be March 31 2015.	4

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

15.11	Development of Cross Cutting Programme to support focus on workforce efficiency, productivity and development	DOF and DHR		February 2015 established and on-going work programme through 2015/16	Charter to be agreed in January 2015. 4 work streams covering medical, nursing, premium spend and 3-5 year planning with specified actions and deliverables for improving pay governance and efficiency.	4
16	**Inability to recruit and retain staff with appropriate skills.**					
16.1	Team Health Dashboard to be developed and implemented	DHR		~~September 2014~~ December 2014	**Complete.** Health Dashboard will be incorporated into CMG and Corporate performance management arrangements to show the right things are in place to develop a high performing organisation.	5
16.2	eUHL system updates required to meet Trust needs	DHR		March 2015	Supplier selected following tendering process to commence developments during January 2015	4
16.3	Robust ELearning policy and procedures to be developed to reflect P&GC approach	DHR		January 2015	The E-learning policy and procedures will form part of the Core Training Policy currently under development and due for final approval by end of January 2015. Deadline extended to reflect this	4
17	**Failure to improve levels of staff engagement**					
17.1	Team Health Dashboard to be developed – mock up to be presented to EWB at September 2014	DHR		March 2015	**Complete**	5

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

17.2	Ensure IBM aware of requirements.	DHR		March 2015	**Complete.** and .3-5 year planning. CIO aware of LiA MoC associated with IBM related projects. Meetings held with IBM representatives to coach and guide on LiA principles and approach. Further plans to include LiA in pilot of Paediatric Areas for Electronic Document Record Management. MoC information included on Organisational Health Dashboard	5
17.3	HR Senior Team aware of need to include Engagement event prior to formal consultation (with MoC impacting on staff – more than 25 people)	DHR		March 2015	**Complete.** MoC (HR) including LiA as a precursor to formal consultation. A number of events have been concluded using LiA. A specific resource for LiA MoC has been developed	5
17.4	Include as regular agenda item on LiA sponsor group identifying activity and anticipated resources required	DHR		March 2015	**Complete.** Each of the LiA Work streams is included as standing items on LiA Sponsor Group meetings.	5
17.6	Develop draft internal reports in development in readiness for possible analysis methodology used by NHS England in September 2014.	DHR		~~September~~ ~~October~~ December 2014	**Complete.** **Friends and Family Test for Staff:** Submission of first UNIFY report submitted to NHS England in compliance with deadline and CQUIN target. Internal analysis of free text themes being undertaken. UHL data to be included in CE Briefing. Cannot be benchmarked against other organisations as NHS England has still not published results. Awaiting information from NHS England on analysis methodology. Deadline extended to reflect this	5

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

17.7	Listening into Action activity within CMGs / Corporate Divisions to be one of the reported Performance Indicators within the Organisational Health Dashboard	DHR		March 2016		4
17.8	CMG HR Leads to notify LiA Team of any listening events – proforma developed to capture activities and to be reported in Organisational Health Dashboard.	DHR		March 2016		4
17.9	LiA to be rolled out within Alliance utilising Alliance Management Team to support the implementation and to report activity via LiA Sponsor Group	DHR		March 2016		4
17.10	Success outcomes to be shared with nursing workforce via new annual Nursing Conference – first one scheduled for April 2015.	DHR/ CN		March 2016		4
17.11	Workshop on 2014 survey results priorities and actions with CEO & DHR on 27 January 2015 leading to 2015 / 16 engagement plan for the Trust – to be shared via appropriate management forums and CE Briefing (March & April 2015). TB paper on March Trust Board And ET Paper for March 2015.	DHR		March 2016		4
17.12	Workshop on 2014 survey results priorities and actions with CEO & DHR on 27 January 2015. (17.12)	DHR		March 2015		4
17.13	Workshop outputs to lead to 2015/16 engagement plan for the Trust – to be shared via appropriate management forums and CE Briefing (March & April 2015). TB and ET Paper for March 2015.	DHR		March 2016		4

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

17.14	Organisational Health Dashboard quarterly via EWB / monthly reports available via SharePoint	DHR		March 2016		4
17.15	Annual performance target set with CMG breakdown available per month for CMG Board Meetings.	DHR		March 2016		4
17.16	Workforce KPIs included in Quarterly CMG Workforce meetings from January 2015 – to be attended by HR CMG Leads and Workforce Development Manager (	DHR		March 2016		4
17.17	Premium spend / pay group to be established in February 2015 as part of the CIP Workforce Charter to review use of premium pay and reasons for use – to support CMGs to identify links to, for example, sickness absence, recruitment, & increased activities during 2015/16.	DHR		March 2016/17		4
17.18	Feasibility Report (Known as Full Business Case by CO/DH) by 31 March 2015 with Trust Board approval. To be presented to TB in March and EWB in March 2015	DHR		March 2015		4
18	**Lack of effective leadership capacity and capability**					
18.2	Improve internal coaching and mentoring training provision in collaboration with HEEM and at phase 1 establish process for assigning coaches and mentors to newly appointed clinicians	DHR		December 2014	**Complete**	5
18.3	'Shadowing and Buddying' System being developed in partnership with HEEM and Assistant Medical Director to ensure support provided to newly appointed Consultants at initial phase (18.3)	DHR		April 2015	Consultant Forum in place	4

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

18.5	Support national and regional Talent Management and Succession Planning Projects by National NHS Leadership Academy , EMLA and NHS Employers	DHR		March 2015	UHL staff nominated to access National Leadership Academy Programme based on talent conversations.	4
18.6	Board Coach (on appointment) to facilitate Board Development Session	DHR		~~October 2014~~ February 2015	Board development session completed on 16/10/14. Board Coach identified subject to agreement with the Trust Chairman. Awaiting decision and deadline extended to reflect this	4
18.7	Update of UHL Leadership Qualities and Behaviours to reflect Board Development, UHL 5 Year Plan and new NHS Healthcare Leadership Model	DHR/ CE		January 2015	As above, at the initial phase the Trust Board will discuss and agree : (a) the overall leadership model the Board and Executive Team are seeking to build; and (b) the Board culture that it is seeking to shape and exemplify.	4
19	**Failure to deliver financial strategy (including CIP).**					
19.2	Production of a financial strategy to accelerate the recovery programme (action reworded and timescale amended by DF to more accurately portray required action)	DF		~~August Review September 2014~~ February 2015	Amending the consolidated capital investment Program. Refreshed financial strategy to be presented to TB and TDA during February 2015. Timescale reflected to reflect this.	4
19.5	Expedite agreement of CIP quality impact assessments with UHL and CCGs	DF		~~August Review September~~ October 2014	**Complete.** Process in place for on-going submission of CIP quality impact assessments to the CCGs following sign off by the Chief Nurse and Medical Director.	5
19.6	PMO Arrangements need to be finalised	DF		~~August~~ October 2014	**Complete.**	5
19.8	Restructuring of financial management via MoC	DF		~~July Review August~~ October 2014	**Complete.**	5

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

19.10	Business Cases to support Reconfiguration and Service Strategy	DF		~~July Review September 2014~~ On-going as per individual business case timeline	BCT SOC approved by UHL and all LLR partners. SOC submitted to TDA and NHS England and are awaiting approval. Individual business cases will be submitted to the Trust Board and TDA as per the overall reconfiguration strategy	4
19.11	Agreement of long-term loans as an outcome of submission of SOC/ business cases	DF		~~June August~~ On-going action – review March 2015	Trust received a £29m cash loan in line with the Plan and trajectory submitted to the TDA. Application for further loans (via SOC/business cases)to be submitted as necessary	4
20	**Failure to deliver internal efficiency and productivity improvements.**					
20.1	Simplify cross cutting themes to workforce, beds, outpatients and theatres. Action reworded by COO- Dec 2014	COO		~~August 2014~~ February 2015	On track	4
20.2	Recruit substantive staff to vacant posts to ensure continuity of function of PMO	COO		February 2015	On track	4
21	**Failure to maintain effective relationships with key stakeholders**					
21.2	Appoint to new Head of Partnerships role	DS		December 2014	**Complete.** Head of Local and Regional Partnerships are both now in post.	5
22	**Failure to deliver service and site reconfiguration programme and maintain the estate effectively**.					
22.4	Action plan an resource plan in response to the Gateway 0 review to be developed	DS		December 2014	**Complete.** A paper briefing the TB on the outcome of the DH Gateway 0 review and the actions taken to address them in the form of a Programme Brief and governance arrangements was presented to the December 2014 TB meeting	5
23	**Failure to effectively implement EPR programme**					
23.7	Review governance arrangements and alignment with other major programmes	CIO		Jan 2015	On track	4

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

24	**Failure to implement the IM&T strategy and key projects**

Key

CEO	Chief Executive
DF	Director of Finance
MD	Medical Director
AMD	Assistant Medical Director
COO	Chief Operating Officer
DHR	Director of Human Resources
DDHR	Deputy Director of Human Resources
DS	Director of Strategy
DR&D	Director of R&D
DMC	Director of Marketing and Communications
DCQ	Director of Clinical Quality
CIO	Chief Information Officer
CMIO	Chief Medical Information Officer
CD	Clinical Director
CMGM	Clinical Management Group Manager
DDF	Deputy Director Finance
CN	Chief Nurse
AMD (CE)	Associate Medical Director (Clinical Education)
PPIMM	PPI and Membership Manager

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

Appendix 2

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Reference to BAF
2467	Emergency and Specialist Medicine		Outlying Extra Capacity - Winter months	03/12/2014	31/12/2014	There is a risk that owing to the increase in medical admissions that the bed base over winter months will be insufficient resulting in the need to out lie into other speciality/CMG beds jeopardizing delivery of the RTT targets. There is a requirement to outlie medical patients because of: 8% increase in medical admissions and current insufficient medical bed capacity Daily admission levels warranting the need to outlie ahead of the winter months - winter capacity needed Discharge processes not as efficient as they should be internally impacting patient flow and patients waiting in ED for admission Continued delayed transfers of care On-going risks and potential harm to patients as a consequence of overcrowding in ED OOH teams have to make decisions to use all available capacity to cope with pressures in ED The ability to open extra beds within the CMG is compounded by: >100 Nursing vacancies (200 nursing vacancies in the CMG this time last year) Geriatrician and 2.4 Acute Physician vacancies Junior medical staffing shortages	Patients	* Review of capacity requirements throughout the day 4 X daily * Issues escalated at Gold command meetings and outlying plans executed as necessary taking into account impact on elective activity * Opportunities to use community capacity (beds and community services) promoted at site meetings. * Daily board rounds and conference calls to confirm and challenge requirements for patients who have met criteria for discharge and where there are delays * FJW and Ward 2 capacity increased/flexed before patients are outlied * ICRS in reach in place . PCC roles fully embedded * Plans in place for a phased opening of modular wards supported by a surge plan to use "buffer/flex" beds - Papers presented to Executive Team and Emergency Quality Steering Group * Discharges before 11am and 1pm monitored weekly supported by review of weekly ward based metrics * Ward based discharge group working to implement new ways of delivering safe and early discharge *Explicit criteria for outliying in place supported by recent clarification from Assistant HON * Review of complaints and incidents * Safety rota developed to ensure there is an identified consultant to review outliers on non medical wards	Extreme	Almost certain	25	Develop clear escalation plans supported by a decision tree for opening flex/buffer beds (CMG decision only) - 15/12/14 Revised Emergency Quality Steering Group action plan - 15/12/14 Maintain additional beds on ward 2 LGH (21 beds to 27 beds) - 15/12/14 Phase opening of modular beds - 02/01/15 Raise staff awareness re winter plans and access to community resources to enable patients to be discharged in a timely manner - 31/03/15 CMG to access and act on additional corporate support to focus on discharge processes - 31/03/15	9	JE	b

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Reference to BAF
2236	Emergency and Specialist Medicine	ED	There is a risk of overcrowding due to the design and size of the ED footprint	31/03/2015 04/10/2013	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 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 assessment bay causes delay in time to assessment. Paramedics unable to reach turnaround targets. Inability to meet CQUIN targets. Risk of patient deterioration. Delay in diagnosis and treatment. Increased staff stress. Patient complaints. Lack of dignity and privacy. Serious incident risk. Design and size of minors results in delay in receiving medical assessment and treatment. Patient complaints. Four hour target. Increased violence and aggression. Design and size footprint in streaming rooms causes threat to CQUIN target and four hour target. Staff stress. Delay in diagnosis and management. Injury to staff and patients. Increased risk of violence and aggression. Design and size of footprint in EDU causes delay in accessing mental health assessment. Four hour target.	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. The Resus Bed area is being created. Dr Ian Sturges has been employed by the trust to work towards improving flow of patients from the emergency department to the assessment units and wards.	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 - due 31/12/15 . There is to be a receptionist staffing paeds reception at all times(Completed 01/07/2013) creation of "single front door" - all ambulatory ED arrivals now first seen in UCC, thereby reducing total ED attendances.(Completed 10/09/2013) The number of toilets in majors is to be increased to 2 and shower facilities are to be installed(Completed 01/11/2013) Side rooms 2 and 3 are to be converted into formal assessment bays. (Completed 31/10/2013) 3 additional phone lines to be installed in assessment bay(Completed 01/11/2013) The trips and falls hazard in children's ED is to be removed by changing the layout of the minors work area(Completed 22/11/2013) See and treat rooms being made into extra Paeds bays(Completed 30/06/2014) Allocated nurse (and doctor when numbers permit), for patients placed in Majors middle(Completed 30/06/2014) Resus space to be increased to 8 bays(Completed 30/04/2014) The resus viewing room is to be made into a fully equipped resus bay(Completed 30/04/2014) Bays to be allocated and staffed appropriately in majors to act as resus step-down bays for when space in resus is at a premium and some patients are well enough to be moved to majors with the appropriate level of observation(Completed 14/07/2014) Hourly Intentional Rounds by Area Nurse (Completed 02/07/2014)	16	JE	b

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	Reference to BAF
2414	CHUGS	Gastroenterology	The LGH Endoscopy has not passed JAG acrreditation	29/09/2014	30/06/2015	Endoscopy units do not meet JAG standards for dirty to clean flow. Positioning of changing facilities breach SSA guidelines / lack of privacy and dignity for patients. Lack of toilets for relatives and patients in waiting room, does not meet JAG standards / lack of privacy and dignity for patients. Position of enema room on DC2 requires patients post enema to cross main corridor in a gown, breaching privacy and dignity. Due to LGH not passing JAG accreditation , there will be a 5% loss of tariff for procedures carried out at LGH, and loss of training status to run national courses and train SpRs / Nurse Endoscopists., and Loss of national reputation. Patients privacy and dignity compromised. Cost implication for Trust - will have to pay for 3 separate accreditation visits / costs	Quality	JAG accreditation not passed in September 2014 therefore will loose 5% tariff on procedures carried out at LGH.	Major	Almost certain	20	Feasibility of building options to be considered along with director of Operations via walk round - 31/03/15. Relocation of enema room to another area - 31/03/15. Consistent access of relatives to recovery ward areas across the CMG - - 31/03/15. Decluttering in Endoscopy suite - 31/03/15. Implement centralised booking - 31/03/15. Option appraisal required to agree whether to have an unaccredited unit or move the unit to another venue, or close the unit and move the work to another site. Agree plan with CHUGGS management board and Trust Board - 31/03/15. Implementation of computerised booking - 31/03/15. Actions from JAG visit on 26/9/14 to be implemented - 31/03/15.	4	GK	a

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	Reference to BAF
2423	RRC	Respiratory Medicine	Outstanding clinic letters and inability to act on results impacting on patient safety in respiratory services	30/09/2014	31/12/2014	Causes: Cardiology and Respiratory medicine have a significant number of secretarial and typist vacancies. Staff are leaving their posts due to work pressures, low morale and the decrease in secretarial staff. Much of the decrease of staff has been caused by the on-going Management of Change, which is still to reach resolution and has left new recruits on a different banding to existing ones, reducing staff morale further. The planned support to manage these known reductions was due to be undertaken by Audio Typists and Dictate IT. Increased use of ICE was meant to reduce the administrative workload associated with generating individual letters. However, difficulties in recruiting Audio Typists, continuous delay / poor performance of Dictate IT and lack of ICE support have placed unprecedented pressures on the existing staff. Core business functions in the departments of respiratory medicine and cardiology (communication, documentation, acting on results) are no longer deliverable. Consequences: 1.□A large typing backlog The backlog within the Respiratory (as at 23/09/14) is 1795 letters and the oldest letter waiting to be typed is 24/07/14 (8 weeks old). 78% of the outstanding letters are greater than 10 days old and there is a risk that both the backlog figure and the figure in excess of ten days will increase further throughout the summer. Cardiology (as at 23/09/14) has 2356 letters in the back log, 43% are over 10 days and the oldest letter is 19/08/14. 2.□Patients are at risk of significant harm/injury due to the delay in receipt of treatment/care plan information, including medication changes. 3.□Patients are also at risk due to the limited availability of timely clinic letters (which include diagnostic ,treatment and referral information) to GPs and other health care professionals involved in the treatment of the patient. 4.□Consultants are no longer able to reliably act on results	Quality	1.□Recruitment for Audio typists. These roles have been advertised for a third time and so far 2 WTE have started. 2.□Overtime offered to all secretarial and audio typing staff 3.□Continued attempt to get cover through bank/recruitment agency staff. 4.□Additional typing support through Ops Manager, Team Leader and PA's. 5.□Clinical Immunology & Renal secretaries have been offered typing overtime to support Respiratory. 6.□Secretarial staff have been asked to concentrate on the oldest typing first, regardless of whether the dictating Clinician is one they would normally provide administrative support to 7.□Recruitment of Support Secretaries from Cardiology has been undertaken to help cover the shortfall 8.□Use the Dictation service DICT8 to eradicate the typing backlog, 9.□Recruited two Agency Audio Typists for minimum 8 weeks 10.□Other CMG staff working overtime to help manage the backlog of letters - topping and tailing DICT8 files.	Major	Almost certain	20	Ensure named IM&T support for ICE implementation Employ personal user voice recognition software to fill ICE templates Recruitment of two WTE secretary - 31/12/14. Recruitment of two WTE Audio Typists - 31/12/14. Stress Risk assessment to be carried out - 31/12/14.	6	AGIB	α

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	Reference to BAF
2445	Emergency and Specialist Medicine		SpR gaps on the ESM CMG Medical Rota	04/11/2014	31/12/2014	Causes: These vacancies are caused by a national shortage of trainees applying for specialties which have a general medicine component. This is further compounded by sickness and unexpected absence which makes the rotas very vulnerable to short notice absences. Given the high number of vacancies the CMG is unable to fill these all with locum and agency staff. Consequences: There is a delay in assessing patients admitted to the assessment units out of hours or overnight. This may result in delays in recognising severity of illness or initiation of treatment which in may cause harm (death, longer LoS). Delays in decision making which means patients cannot be moved from the assessment unit to base ward beds. This may have the knock on effect of causing crowding in the ED which endangers patients there (see overcrowding in ED risk - number 2236). There is a risk to patients coming to harm on the base wards if there are insufficient senior medical staff to assess unwell patients both in assessment units and on the wards. Staff are unable to take rest breaks which may impact on their ability to take safe decisions and work within their specified working regulations. There is a risk that trainees will be removed from UHL by HEEM if we cannot ensure that they have a manageable workload when on call which will further compound the problem.	Patients	All known vacancies are out to locum bookers - the CMG actively recruits locum and agency staff and works closely with locum bookers and Maria McAuley in order to maximise fill rates. Fortnightly recruitment meetings for medical vacancies (all grades) with HR and service managers to proactively manage vacancies. Recruitment into non training grade positions from international graduates in order to fill gaps in the SpR rota. 8 day in advance schedule for on call rota produced daily and reviewed by senior manager to ensure gaps are cited and acted upon issued daily. 2 weekly advance scheduling shared with base wards to identify short falls and promote action. Monitoring in line with Trust requirements undertaken across key periods during the working year. Maintain advanced look forward for requests to maximise fill of gaps and ensure that all request are a minimum 6 weeks in advance for known vacancies. Daily review of skill mix and reallocation of SpRs following risk and dependency assessments across the CMG.	Major	Almost certain	20	Continue to progress recruitment actively and monitor deanery allocations - 31/12/14. Actively engage medical director for education (Sue Carr) and HEEM to ensure all mid and long term solutions to attracting and retaining SpRs are pursued - 31/12/14. Creative short term appointments offering fixed term opportunities within specialities to maximise interest within the local market - 31/12/14. Continue and progress the allocation of LAS doctors into the Acute rota - replacing the intended LGH team of Trust registrars (all to be in post by mid December) - 31/12/14. Trust to explore other ways of staffing medical rotas (ANPs etc) - 31/03/15.	9	CFRE	f

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Reference to BAF
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	30/05/2015 04/10/2013	Causes: Consultant vacancies. Middle grade vacancies. Due to a National Shortage of available trainees. Trainee attrition. Trainees not wanting to apply for consultant positions. Reduced cohesiveness as a trainee group. Junior grade vacancies. Juniors defecting to other specialties. Non ED medical consultants. Locums. Increased consultant workload. Lack of uniformity. Paediatric medical staffing. Poorer quality care for paediatric population. Consequences: Poor quality care. Lack of retention. Stress, poor morale and burnout. Increased sickness. Increased incidents (SUI's), claims and complaints. Inability to do the general work of the department, including breaches of 4 hour target. Financial impacts. Reduced ability to maintain CPD commitments for consultants/medical staff with subspeciality interest. Reduced ability to train and supervise junior doctors. Deskilling of consultants without subspeciality interest. Suboptimals 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 the green locum induction book, which introduces trust policies such as hand hygiene. Locums work only in a supervised environment (either by an ED consultant or a substantive middle grade). There is a specific consultant who is concerned with locum issues as per their job plan (Ashok Kumar). Poorly performing locums are not permitted to continue working and this is fed back to their agencies. Locum doctors are only placed in paeds ED in exceptional circumstances. Consultants have been allocated specific time in paediatrics on the consultant rota. The grid paediatric trainees shift pattern has changed in the evening, allowing better matching of clinical experience to peak demand. Employment of	Extreme	Likely	20	Deanery report actions, completed 01/10/2013. Guidelines to be created governing minimum standards of locum doctor approval completed 01/09/2013. An internal induction document to be produced for locum grade doctors, completed 01/09/2013 Review of shift vs rota and the required number of juniors per shift, completed 30/04/2014. Doctor In Induction' badges have now been ordered to distinguish staff who cannot yet make decisions, completed 02/07/2014. New rota for August 2014 juniors with higher number of doctors at CT3 level. Although there are still gaps at the Senior Registrar levels ST4 and above, completed 31/08/2014.	6	BTD	f

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2333	ITAPS	Anaesthesia	Lack of paediatric cardiac anaesthetists to maintain a WTD compliant rota leading to service disruption and loss of resilience	30/03/2015	17/04/2014	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 oncall 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	Interviews are being undertaken 12/01/15	8	DTR	f
2415	ITAPS	Critical Care	There is a risk of loss of ITU facilities at the LGH site	31/03/2015 03/09/2014		There will be a loss of Consultant cover, services and capacity at the LGH ITU due to: - Planned move of services from the LGH site makes the recruitment of new Consultant Intensivists difficult -Impending retirement of some current Consultant Intensivists -Lack of Consultant cover reduces ability for other specialties (Urology/Renal/General Surgery/HPB) to undertake planned and emergency major surgery. -Crucial to now down grade surgery at the LGH site. Management of some patient groups could be directed to the LRI site adding additional pressure to the emergency flow at LRI. - Move to a 1:8 rotas may add to further Consultant departures.	Patients	- Cross site cover from current Consultant workforce -Recruitment campaign - Acting down on shifts to cover rotas deficits - ITAPs leading change of ITU level and service moves across to the other 2 sites.	Major	Almost certain	20	Commence Recruitment campaign for one Consultant Intensivist 31/03/15. ITAPs management team to work with the Trusts Strategy leads and speciality leads to start to plan timescales, scope movement of services from the LGH site and scope required environmental and workforce impacts. 30/12/15	2	CAL	a

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	Reference to BAF
698	Clinical Support and Imaging	Pharmacy	Risk to the production of aseptic pharmaceutical products	03/05/2007	31/01/2015	Causes Provision of aseptically prepared chemotherapy is being undertaken from a temporary rental unit. Temporary nature and age of facility indicates high probability of failure. Arrangements for segregation of in-process and completed items is inadequate leading to high possibility of error. Current temporary unit is outside the range of the department's temperature monitoring system. Failure of refrigerated storage will remain undetected outside working hours, and has already occurred. Planning permission for temporary unit only valid until August 2012 Contingency arrangements are insufficient and could only provide for the very short term. Project is already 6 months behind schedule Storage, receipts and dispensing facility for dose-banded chemotherapy and other outsourced items purchased. Alternative arrangements will need to be found when unit is refurbished Consequences Failure of Current Temporary Facility; Inability to provide 50% of current chemotherapy products for adult services. Inability to provide chemotherapy for paediatric services. Substantial delay in re-establishing service provision from alternative supplier Limitations of treatments that can be sourced from an alternative supplier. Inability to support research where aseptic compounding required. High cost of sourcing required products from alternative supplier at short notice. Increase in datix incidents pertaining to the Aseptic Unit.	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 - due28/2/2015	3	GH	a

Risk ID	CMG	Specialty	Risk Title	Review Date	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Reference to BAF
2409	Women's and Children's		There is an insufficient number or middle-grade doctors, both registrars and SHO's to provide adequate service cover	31/01/2015	26/08/2014	Causes: Historically there have been 4 funded SPR posts, 2 paediatric trainee SHO posts on rotation which are usually filled and 1 trust funded SHO post. As the service and demand has grown these posts have remained the same leaving the middle-grade cover inadequate. Consequences: In accordance with the European Working Time Directive on-call rotas should be 1 in 6. The shortfall in middle-grade staff means that 2/6 nights and weekends are not covered and the registrars are over worked during the day. The lack of SHO's also means they are unable to provide resident out-of-hours cover for ward 30 and that HDU patients cannot be managed on the ward. Consultants often have to take time away from their activity, which can often only be done by a consultant, to provide middle-grade cover which is inefficient use of time and resources.	Quality	Consultant cover. The workload is increasing and there is an inadequate number of consultants to provide ward level cover as required	Extreme	Likely	20	Review of medical staffing arrangements due 31/01/15	10	LCOW	f
2391	Women's and Children's		Inadequate numbers of Junior Doctors to support the clinical services within Gynaecology & Obstetrics	31/01/2015	24/06/2014	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 29/06/2015 CMG to pursue overseas recruitment of Drs - 31/1/2015 Further development of robust training programme for Junior Drs by Clinical Tutor & Programme Director due 29.06.15	8	ACURR	f

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847	Women's and Children's	Maternity	Lack of Capacity in maternity services	31/01/2015	28/09/2007	Causes Continuing increase to the birth-rate in Leicester . The number of maternity beds has decreased. Consultant cover for Delivery Suite is 60 hours a week with long term business plans to increase the hours in accordance with Safer Childbirth Recommendations. Consequences Midwifery staffing levels are not in accordance with national guidance however 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	Complete transfer of all EL CS to level 1 - due 31/01/15	12	EBROU	f
2330	Medical Directorate		Risk of increased mortality due to ineffective implementation of best practice for identification and treatment of sepsis	31/03/2015	11/04/2014	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 - 31/01/15 Increased visibility of sepsis care pathway - 31/03/15 Implement 'sepsis boxes' for use in clinical areas - 30/04/15	6	JPARK	a

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	Reference to BAF
2403	Corporate Nursing	IPC	Changes in the organisational structure have adversely affected water management arrangements in UHL	19/08/2014	28/02/2015	Causes National guidance from the Health and Safety Executive advise that water management should fall under the auspices of hospital infection Prevention (IP) teams Resources are not available within the UHL IP team to facilitate the above. Lack of clarity in UHL water management policy/plan Since the award of the Facilities Management contract to Interserve the previous assurance structure for water management has been removed and a suitable replacement has not yet been implemented. Consequences Resources not identified at local (i.e. ward/ CMG) or corporate (e.g. Interserve /IPC) level to perform flushing of water outlets leading to infection risks, including legionella pneumophila and pseudomonas aeruginosa to patients, staff and visitors from contaminated water. Non-compliance with national standards and breeches in statutory duty including financial penalty and/or prosecution of the Chief Executive by the HSE Adverse publicity and damage to reputation of the Trust and loss of public confidence Loss/interruption to service due to water contamination Potential for increase in complaints and litigation cases	HR	Instruction re: the flushing of infrequently used outlets is incorporated into the Mandatory Infection Prevention training package for all clinical staff. Infection Prevention inbox receives all positive water microbiological test results and an IPN daily reviews this inbox and informs affected areas. This is to communicate/enable affected wards/depts to ensure Interserve is taking necessary corrective actions. Flushing of infrequently used outlets is part of the Interserve contract with UHL and this should be immediately reviewed to ensure this is being delivered by Interserve All Heads of Nursing have been advised through the Nursing Executive Team and via the widely communicated National Trust Development Action Plan (following their IP inspection visit in Dec 2013) that they must ensure that their wards and depts are keeping records of all flushing undertaken and this must be widely communicated Monitoring of flushing records has been incorporated into the CMG Infection Prevention Toolkit (reviewed monthly) and the Ward Review Tool (reviewed quarterly)	Major	Almost certain	20	To review and agree Water Safety Plan due 28/02/15. Submit business case for additional funding to provide sufficient resource to either the IP team or NHS Horizons to enable the trust to carry out the requirements of the statutory and regulatory documents, with potential for full introduction and management of the "compass" system. - 28/02/15 Review procedures and practices in other Trusts to ensure that UHL is reaching normative standards of practice - 28/02/15	4	LCOL	a

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2404	Corporate Nursing	IPC	Inadequate management of Vascular Access Devices resulting in increased morbidity and mortality	19/08/2014	31/03/2015	Causes There is currently no process for identifying patients with a centrally placed vascular access (CVAD) device within the trust Lack of compliance with evidence based care bundles identified in areas where staff are not experienced in the management of CVAD's There are no processes in place to assess staff competency during insertion and ongoing care of vascular access devices Inconsistent compliance with existing policies Consequences Increased morbidity, mortality, length of stay, cost of additional treatment non-compliance with epic-3 guidelines 2014, non-compliance with criteria 1, 6 and 9 of the Health and Social Care Act 2010 and non-compliance with UHL policy B13/2010 revised Sept 2013, and UHL Guideline B33/2010 2010, non-compliance with MRSA action plan report on outcomes of root cause analyses submitted to commissioners twice yearly	Quality	Policies are in place to minimise the risk to patients.	Major	Almost certain	20	CVAD's identified on Nerve Centre - 31/03/15. Development of an education programme relating to on-going care of CVAD's - 31/03/15. Targeted surveillance in areas where low compliance identified via trust CVC audit - 31/03/15. Support the recommendations of the Vascular Access Group action plans to reduce the risk of harm to patients and improve compliance with legislation and UHL policies - 31/03/15.	8	LCOL	a

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	Reference to BAF
2471	CHUGS		There is a risk of Radiotherapy Tx on the Linac (Bosworth) being compromised due to poor Imaging capability of this machine.	05/12/2014	31/03/2015	Causes: "□Poor quality images due to deterioration of the imaging panel make it difficult and occasionally impossible to compare planned and set-up positions using the acquired images. This could lead to a geographic miss i.e. incorrect area treated. "□Unavailability of online correction capability may result in acquisition of several high dose images in order to safely correct and check patient position. These high dose images are used since the ageing technology available on this machine does not support good quality low dose kilovoltage imaging. Consequences: "□Dependent upon dose and fractionation this could result in a significant amount of the intended dose being delivered to the wrong area with significant damage to the patient resulting in a reportable incident. "□Repeated high dose imaging due to deteriorating MV imaging panel increases the risk of exceeding current dose limits. "□If kV or cone beam imaging is required, patients will need transferring from Bosworth to Varian machines. This transfer process will entail patients missing treatment days to give staff time to produce back-up plans that are labour intensive. "□There is a risk of increasing waiting times leading to potential breaches in cancer waiting time targets since all complex treatments requiring advanced imaging cannot be performed on Bosworth. "□Restricted participation in National Clinical Trials, due to lack of current imaging technologies such as cone beam CT.	Quality	"□Increase in imaging dose (up to 10 MU) to produce a usable image. This however restricts the number of times an image may be repeated (due to dose limits). N.B imaging dose of 1MU is used on the Varian treatment machines. "□Pre-selection of patients with a reduced imaging requirement are booked on Bosworth. However this list is getting fewer and fewer due to best practice and national guidelines. "□We have introduced long day working on Varian machines to absorb patients that cannot be treated on Bosworth due to imaging limitations "□Clear Set-Up instructions plus photographs are provided to treatment staff to aid set-up. These do not fully eliminate the risk due to variable patient stability and condition hence the need for on-treatment imaging.	Major	Likely	16	Develop business plan for replacement of treatment machine. Briefing paper to be submitted to the Investment Committee Meeting - 31/03/15. Replacement of Imaging panel to improve image quality and reduce imaging dose. However this does not solve the lack of online correction capability -31/03/15. Restriction of patient numbers to be treated on Bosworth. This will have a large impact on the departments waiting times and potential breach patients - 31/03/15.	4	LWI	a

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Reference to BAF
2422	CHUGS	GENSUR	There is a risk to patient safety and quality due to the nurse staffing levels on SAU LRI	31/01/2015 29/09/2014	Causes: The nurse staffing levels within the Surgical Assessment Unit at the Leicester Royal Infirmary are at a critical level with poor retention of staff. Of the recruitment of 6 International nurses, 2 newly qualified nurses and a development band 6 nurse - 7 of these nurses have left or are leaving reporting high workload as the reason. Due to it being a busy, high activity area - it is difficult to get staff to work on the area from the nursing bank and agency. The levels of vacancies are 1 band 6 7wte band 5. We include the recruitment with 2 band 5 waiting to start who will require support an supernumerary time. Consequences: Poor quality of care to patients including increasing patient harms, delays for treatment/care. High levels of complaints for the ward (seven complaints over the past 6 months). Poor Patient Experience (The Friends and Family Test score has been consistently low. (<55).	Quality	1.□ Shifts escalated to bank and agency at an early stage. 2.□ Increased the numbers of Band 6's to provide leadership support. 3. Agency contract in place for one nurse on day shift and night shift to increase nursing numbers.	Major	Likely	16	Increase the number of Deputy Sister posts on the ward for operational leadership on each shift - 31/01/15. Review the possibility of rotational shifts for staff across other surgical/GI med wards to increase attractiveness to staff - 31/01/15. Review established nurse staffing levels for the ward and complete case of need to increase nurse staffing in line with other SAU's - 31/01/15. Continue to actively recruit to the area - 31/01/15.	4	GK	f

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	Reference to BAF
2320	CHUGS	RADT	Inadequate staffing levels in therapy radiography and radiotherapy physics causing a serious radiotherapy treatment error	21/03/2014	31/01/2015	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 changes make human error more likely (with potential for misadministration of radiation) Participation in radiotherapy trials reduced. Staff training compromised. Potential for increased external scrutiny. Low morale and difficulties in retaining staff. Managerial and administrative functions compromised.	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	Treatment bookings adjusted with staff working shifts, physicists and radiographers appointed with start dates given - 31/01/15 Protected time for training / development (dependant on business case) - 31/01/15 Increase treatment imaging to 100% to prevent risk of treatment error, aim to increase imaging to 100% of patients (dependant on business case) - Imaging on Bosworth in need of replacement see separate risk assessment 31/01/15 Submit second business case to increase in linac capacity by generating income from further increase in activity / complexity - Draft written to be submitted Jan 2015 31/01/15 Secure resource for quality system - appoint dedicated staff member to update and maintain quality system. Interview date 17.12.14 anticipated start date March 2015- 31/03/15.	4	LWI	f

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	Reference to BAF
2388	Emergency and Specialist Medicine	ED	There is risk of delivering a poor and potentially unsafe service to patients presenting in ED with mental health conditions	29/10/2014	31/12/2014	Causes: An increase of over 20% in ED attendances relating to mental health conditions in the past 5yrs. Inappropriate referrals into the ED of patients with mental health conditions. Limited resources and experience of staff in the ED to manage mental health conditions. The number of security staff has not increased with the increase in patient numbers (and are unable to restrain patients currently- see associated risk). The facilities in which to manage this patient group are inadequate for this patient group as not currently staffed. Poor systems in place between UHL, LPT, Police & EMAS to manage this patient group. High workload issues in the ED overall and overcapacity. National shortage of mental health beds, leading to placement delays for patients requiring in patient mental health beds. CAMHS service is limited. Consequences: Potentially vulnerable patients are able to leave the ED and are therefore at risk of coming to harm. There have been incidents reported where patients have been able to self harm whilst in the ED. Patients receive sub optimal care in terms of their mental health needs. Increased and serious incidents reported regarding various aspects of care of mental health patients. Patients' privacy and dignity is adversely affected. Risk of staff physical and mental injury/harm.	Patients	Security staff allocated to ED via SLA agreement (can intervene if staff become at risk). Violence & Aggression policy. Staff in ED undergo training with regard to mental health. Staff attend personal awareness training. Mental health pathway and assessment process in place in ED. Mental health triage nurse based in MH assessment area of ED, covering UCC and ED. ED Mental Health Nurse Practitioner employed in ED. Medical lead for mental health identified in ED from Consultant body.	Major	Likely	16	Task & Finish group to review security arrangements in terms of Control & Restraint practice in ED - complete Missing persons process for ED to append to UHL Missing Patients Policy - Complete Agreement of role of security staff in ED and agree service level agreement to reflect this - 31/12/14. Training to be available for ED staff with regard to management of aggressive patients, to include breakaway techniques - 31/12/14. Roll out of Mental Health Study Day for ED staff during 2014/15 - 31/03/15. Develop plans in line with Government's "Mandate" to ensure no one in crisis will be turned away by - 31/03/15. Partnership working group set up to include UHL, LPT, EMAS & Police to look at improving response times and access to assessment for people with MH issues. Local area will have its own crisis care declaration including a joint statement which demonstrates the Concordat principles - 31/12/14.	6	JE	f

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2466	Emergency and Specialist Medicine	Rheumatology	Risk of Patient Harm due to delays in timely review of results and Monitoring in Rheumatology	31/03/2015	03/12/2014	1.□High Volume of paper results that need daily review by registered Nurse, 2.□There is duplication of results as some patients will have results reported through DAWN database and some patients will not (patients on other immunosuppressant drugs); therefore nurses checking all paper copies 3.□There is a gap in the nursing establishment 4.□Only one person trained to input data on DAWN system; they have given notice and will finish end of November	Patients	The Rheumatology Department follows the 'BSR/BHPR guideline for disease-modifying anti-rheumatic drug (DMARD) therapy in consultation with the British Association of Rheumatologists (2). This stipulates the type and frequency of blood test monitoring, as well as recommendations for actions if results are found to be abnormal. Service management team are negotiating more live patient licences with 4s Systems and more users as well as training requirements. Action plan in place to identify and act on further risks, process review supported by LiA programme.	Major	Likely	16	Site visit and further support from 4s systems requested to identify further monitoring of biologics patients - This is an action until support from 4s is in place. LiA work stream to address risks and plan future working - 26/03/15 Every patient on DMARD to be on DAWN system and monitored in real time - 31/03/15.	1	GST	a
2191	Musculoskeletal and Specialist Surgery	Ophthalmology	Follow up backlogs and capacity issues in Ophthalmology	01/03/2015	12/06/2013	Causes: Lack of capacity within outpatient 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 outpatients to be seen. Risk of high risk patients not being seen/delayed. Poor patient outcomes. Increased complaints and potential for litigation.	Patients	Outpatient efficiency work ongoing. Full recovery plan for improvements to ophthalmology service are in process . Outsourcing of follow up patients to Newmedica (IS) has been agreed. All overdue patients will be triaged by them, with the company following up the appropriate patients. The company have agreed to flag high risk patients to us for follow up that do not meet their criteria	Major	Likely	16	Monitor and review impact of NEW MEDICA - 31/01/15.	8	DTR	a

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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	02/01/2015 22/12/2006	Causes: Failure to implement electronic tracking for blood and blood products to provide full traceability from donor to recipient At UHL blood is tracked electronically up to the point of transfer of blood from local fridge to patient with a manual system thereafter which is not 100% effective (currently approximately 1 - 2% (approx 1200 units) of all transfusion recording is non-compliant = 98% compliance). Non-compliance with blood transfusion policies resulting in incorrect identification processes resulting in sample identification and labeling error resulting in wrong blood cross-matched and / or provided for patient (last incident of ABO incompatibility by wrong transfusion approx 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 sample. Critical report received from MHRA in October 2012 in relation to UHL having no credible strategy for compliance with Blood Safety Regulations. Consequences: Potential loss of blood bank licence (via MHRA) with severe impact on surgery and transfusion dependent patients served by UHL. Financial penalty for non-compliance due to increased number of inspections Delay in timely supply of blood and blood components for new surgical and transfusion clinic patients. Increased potential for 'Never event' (i.e. wrong transfusion) leading to increased morbidity /mortality. Potential loss of Trust's good reputation via publication of critical reports.	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	Develop LIMS (Laboratory Information Management System) the IT system which interfaces the laboratory analysers with the Trust system. Implementation plan 02.02.2015; Full implementation of LIMS Feb 2015; Full implementation Blood Track May 2015	4	KJON	a

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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	31/01/2015	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	Recruitment to 6th Radiologist post - 28/02/2015	4	JGI	f

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Reference to BAF
2248	Clinical Support and Imaging	Medical Physics	Lack of IR(ME)R training records held across the Trust	28/02/2015 14/11/2013	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 inspection or follow up to an adverse event and consequent effects on the reputation of the Trust. Increased patient radiation doses due to lack of training. Increased staff doses due to lack of awareness of the potential doses if training is inadequate Potential damage to expensive equipment if training on how to use it is inadequate Management unable to easily identify which staff are trained to undertake a task involving radiation Breach of statutory duty Negative effect on the reputation of the Trust	Quality	There is a defined method of recording training across the Trust in the Trust Radiation Safety policy. Although this is working in some areas it is not working consistently in all areas. The issue has been raised at the Trust Radiation Protection Committee numerous times where representatives of each Division have been in attendance. This has not so far led to a an increase in compliance. Radiation Protection produced a specific plan of what is required to demonstrate compliance. Mock audit completed 2/12/13. 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 ongoing monitoring of training - 1/5/14 Identify Trust staff with responsibilities under IRMER - completed 1/8/14	Major	Likely	16	Implement e-learning module on e-UHL - 28/2/15	4	MNO	a

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2378	Clinical Support and Imaging	Pharmacy	Pharmacy workforce capacity	19/01/2015	19/06/2014	there is a risk that arises because of pharmacy workforce capacity across multiple teams which will result in reduced staff presence on wards or clinics, as well as capacity for core functions. This will result in reduced prescription screening capacity and the ability to intervene to prevent prescribing errors and other medicines governance issues in a number of areas including some high risk. high levels of vacancies and sickness high levels of activity training requirements for newly recruited staff	Patients	extra hours being worked by part time staff team leaders involved in increased 'hands' on delivery staff time focused on patient care delivery (project time, meeting attendance reduced) Prioritisation of specific delivery issues e.g. high risk areas and discharge prescriptions, chemo suite	Major	Likely	16	recruit specialist staff - due 19/01/15	8	CELL	f
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	01/02/2015	24/06/2014	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	Undertake a peer review visit to Sheffield due 31/03/15 Review of Consultant working patterns and extension of presence on the DS and MAU due 28/02/15 Development of a decision education package focusing on the management of the 2nd stage of labour due 30/04/15. Further review of times of day when babies with HIE are born due 28/02/15	8	ACURR	a

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2153	Women's and Children's	Paediatrics	Shortfall in the number of qualified nurses in Children's Hospital including ECMO staffing and Capacity	31/03/2015 05/03/2013	Causes The Children's Hospital is currently experiencing a shortfall in the number of appropriately qualified Children's nurses. This is in part due to the increased numbers of staff on maternity leave and the issues with recruiting Children's trained nurses. The demand for PICU beds currently outweighs capacity. There is an establishment of 6.5 beds but due to vacancies and long-term sickness/maternity leave the unit is currently only able to run at maximum capacity of 6 beds and on specific days only 5 beds (depending on the overall ECMO activity across adults and children). In addition to NHS activity the Trust has contracted to provide cardiac surgery for a cohort of Libyan children. At the time that the contract was developed (Nov-December 2012) it was assessed that there would be sufficient capacity to operate on one child per week without impacting on NHS Activity. However, the current staffing and long-term profile of patients on PICU has resulted in pressures on both NHS work and the delivery of the Libyan contract. Currently there are vacancies for 5.82 wte qualified and 1 wte unqualified nurse within the Children's cardio respiratory services, which cover PICU, ward 30 and the COPD. The ECMO services have vacancies for qualified staff. Consequences There is a short fall in the number of appropriately qualified children's nurses in the Children's Hospital which could impact on patient care. Balancing the demand for PICU beds between NHS contracted activity, emergency cases and Libyan private patients increases the risk of cancellations and increased waiting times. Unsafe staffing levels, therefore unable to provide the recommended nurse to bed ratios in an intensive environment. Staff from PICU are moved to cover ward shifts to ensure minimum nurse to bed requirement. Consequently this	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	Likely	Major	16	Continue to recruit to remaining 5wte vacancies - due 30/4/2015 Completion of a period of perceptorship for newly qualified nurses - due 31/1/2015 Completion of a period of perceptorship for new international qualified nurses - due 30/6/15	8	EA	f

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2237	Medical Directorate		Risk of results of outpatient diagnostic tests not being reviewed or acted upon resulting in patient harm.	31/10/2015 07/10/2013		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 in imaging for time to test and time to report. Consequences Potential for mismanagement of patients to include: Severe harm or death to patient. Suboptimal treatment. Delayed diagnosis. Increased potential for incidents, complaints, inquests and claims. Risk of adverse publicity to UHL leading to loss of good	Patients	Abnormal pathology results escalation process Suspicious imaging findings escalated to MDTs Trust plan to replace iCM (to include mandatory fields requiring clinicians to acknowledge results).	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	1

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2338	Medical Directorate		There is a risk of patients not receiving medication and patients receiving the incorrect medication due to an unstable homecare	31/03/2015	01/05/2014	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. Patients have not been able to get through to H @H via their telephone helpline. 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. Bath ASU usually have a 5 day lead time on this, currently this has been increased to 2 weeks. Bath ASU are prioritising hospitals that do not have the facility to manufacture their own dose banded chemotherapy. Currently we do not have the facility to compound all of our dose banded chemotherapy, and there are concerns about supply over the next few weeks. Alcura 1)Experiencing difficulties that have resulted in failed deliveries and possible breaches of patient confidentiality. 2)There are on-going issues with invoicing. No invoices for Alcura have been paid since November from UHL. This is a national issue and there is a concern that the company may experience a cash-flow problem resulting in closure. Consequences Existing providers of homecare services are having	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 had 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 speciality teams to ensure that any necessary clinical pathway changes are supported Repatriation of urgent drugs back to UHL out-patient provider Self - assessment against Hackett criteria against all homecare schemes	Major	Likely	16	Monitoring of control measures - 31/03/15	9	CELL	1

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2093	Medical Directorate	R&D	Athena Swan - potential Biomedical Research Unit funding issues.	08/08/2014	31/03/2015	The Athena SWAN Charter is a recognition scheme for UK universities and celebrates good employment practice for women working in science, engineering and technology (SET) departments. Standards required for next round of Biomedical Research Unit (BRU) submissions. Academic partners required to be at least Silver Status. Failure for the University to achieve this will result in UHL being unable to bid successfully for repeat funding of the BRUs. There is a very real possibility that UHL will loose ALL BRUs if this is not adequately addressed.	Economic	Every meeting with the University, Athena Swan is on the Agenda. Out of UHL control directly, but every avenue is being used to keep the emphasis high at the University.	Major	Likely	16	Add Athena Swan to every agenda at Leicester & Loughborough Universities attended by UHL R&D Personnel	4	CMAL	e
2365	IMT		IBM lack NHS specific knowledge	17/06/2014	31/07/2015	IBM lack NHS specific knowledge (e.g. PbR, CDS, NHS information structures, mandatory data flows) required to deliver IM&T Business Intelligence service to the expected standard. UHL fails to satisfy mandatory reporting requirements (e.g. CDS) , incurs penalties and reputational damage.	Business	Transition approach is to ensure that key implied knowledge relating to UHL bespoke systems is transferred to MBP staff and documented where possible. Risk cannot be mitigated, is inherent to the MBP offshore delivery model. 03/07/2014: Additional UHL role to be added to IM&T structure to work with MBP to prioritise work correctly and translate business to technical requirements. Interim role in place from 14/07/2014.	Major	Likely	16	Completion of documentation knowledge base as part of MBP transition phase - 31/07/15. Additional post to be added to IM&T structure to provide business knowledge, assist with prioritisation and work with IBM to translate UHL/NHS requirements to requests for technical delivery - 31/07/15.	12	JCK	f

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2247	Corporate Nursing	Nursing	There are significant numbers of RN vacancies in UHL leading to a deterioration in service/ adverse effect on financial position	30/10/2013	31/03/2015	Causes: Shortage of available Registered Nurses (RN) 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 emphasis on nursing roles.	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. - 31/03/15 Utilise other roles to liberate nursing time - 31/103/15	12	CRIB	f

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2325	Corporate Nursing	Nursing	Risk to patient/staff safety due to security staff not assisting with restraint	28/02/2015 03/04/2014	Causes Interserve refusal to provide trained staff to carry out non-harmful physical intervention, holding and restraint skills, where patient control is necessary to deliver essential critical care to patients lacking capacity to consent to treatment. Insufficient UHL staff trained in use of non-harmful physical intervention and restraint skills to carry out patient control. Termination of Physical skills training contract with LPT provider in January 2014. Consequence Inability to deliver safe clinical interventions for patients lacking capacity who resist treatment and/or examination. Increased risk of Life threatening or serious harm to patients resisting clinical intervention Increased risk of injuries to patients due to physical interventions by inexperienced/untrained staff. Increased risk of injuries to untrained staff carrying out physical interventions. Increased risk of injuries to staff carrying out clinical procedures Requirement for increased staffing presence to carry out safe procedures Reduced quality of service due to diverted staff resources Increased risk of sick absence due to staff injury. Increased risk of complaints from patients and visitors Increased risk of failure to meet targets Adverse publicity	Patients	UHL Nursing and Horizons colleagues have met with Interserve 12/03/14 and UHL have agreed to issue a temporary indemnity notice that will provide vicarious liability cover for Interserve staff in these situations (supported by our legal team). This was rejected by Interserve Management Cover with more UHL employed staff where there may be patients requiring this type of restraint; Staff must take risk assessed decisions about the use of restraint and ensure incidents are reported using the Trust's incident reporting database. In extreme cases staff should be aware that the police should be called Continue to communicate with all staff about the current position.	Major	Likely	16	High priority recruitment of physical skills trainer - 28/02/15	6	DLO	a

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2316	Operations	Emergency Planning	Flooding from fluvial and pluvial sources	06/03/2014	30/06/2015	Causes (hazard) Pluvial flooding (all sites) external and internally Fluvial flooding (LRI) from the River Soar Heavy, prolonged rain fall Winter snow/ice melt Blocked drains Consequence (harm / loss event) Loss of service areas/buildings/site To the full extent of the river soar flood plain the majority of the LRI would be flooded Sewage ingress Contamination of infrastructure Patient safety Loss of electrical supplies Loss of mains water and drainage Disruption to supply lines Staff difficulties getting in Staff difficulties getting home - staff car parks and vehicles flooded Reputation and publicity on the impact of flooding, the development of a site at risk from flooding, the response and recovery	Targets	Flood Plan - LRF and UHL Response teams IPC Policy Business Continuity Plans Major Incident Plan UHL/Multi-agency communications plan Insurance Policy Cooperate with LRF partners to test the LRF plans	Major	Likely	16	Update UHL flood plan to identify services and equipment at risk and identify control measures - 30/06/15	12	PWA	a

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2318	Operations	Emergency Planning	Blocked drains causing leaks and localized flooding of sewage	30/06/2015 17/03/2014	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 above their bays/beds. Whilst repairs are underway it may become necessary to isolate and turn of showers, toilets and washing facilities elsewhere in the building. Potential media coverage (one request for information from Leicester Mercury during August) which could result in a loss of reputation and patient satisfaction scores Quality and safe delivery of care will be compromised in areas of sewage leaks resulting in suspension/scaled back delivery of services Risk to health and safety of staff from an unsafe working environment resulting in contamination, slips and falls Increased risk of infections and patient safety	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). single choice patient wipes Surveys done in Kensington and Balmoral Jet washing pipes Reporting of the number of blockages	Major	Likely	16	Cost of replacement of stacks to be assessed. Nigel Bond - due 31/03/15. NHS Horizons to identify additional measures to reduce blockages - Nigel Bond 31/03/15	2	PWA	a

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1693	Strategy	Coding	Risk of inaccuracies in clinical coding	02/08/2011	31/01/2015	Casenote availability and casenote documentation. HISS/PatientCentre constraints (HRG codes not generated due to old version of Patient Administration System) High workload (coding per person above national average). Unable to recruit to trained coder posts (band 4/5) Inaccuracies / omissions in source documentation (e.g. case notes and discharge summaries may not include co-morbidities, high cost drugs may not be listed). Coding proformas/ ticklists designed (LiA scheme and previously) but not widely used. Electronic coding (Medicode Encoder) implemented February 2012 but not updated since (old versions of HRG). The system has no support model with IM&T, so errors are difficult to resolve. Mandatory training not undertaken for 3 years (the maximum span permitted) Consequences: Loss of income (PbR). Potential outlier for SHMI/HSMR data. Non- optimisation of HRG. Loss of Trust reputation.	Economic	Backlog of uncoded episodes actively managed from September 2014 and reduced from 11,000 to 4,000 (as at Dec 14). Where casenotes are delivered to the coding offices, these are coded within 24 hours. This has increased coverage of coding from notes (rather than other electronic sources) and reduced the unnecessary movement of notes between departments. 4 Trainee coders have been appointed to commence in Jan15. Comprehensive training required before able to code independently. Recruitment and retention strategy being developed with support of HR. Currently advertising for replacement band 6 site lead and band 5/6 coding trainer posts. Agency coders being used to backfill vacant positions. Medicode has been upgraded in the test environment. This needs to be applied in the live environment. A comprehensive IT support model is being developed for the system. When upgraded, Medicode will provide an audit functionality to facilitate regular audit of coding Lead clinicians identified to move coding closer to the clinician. Scorecard redevelopment to demonstrate improvements and benchmark against other Trusts. 3 year refresher training to be in place and funded recurrently Regular updates to the Audit Committee. Coding managers present overview for Junior doctor induction PbR CIP Project Group commenced April 2014.	Major	Likely	16	Minimise backlog of coding, monitoring coding quality, appointing to substantive posts to reduce reliance on agency coders - 31/03/15	8	JRO	f

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2354	RRC		Overcrowding in the Clinical Decisions Unit	28/05/2014	31/12/2014	CAUSES 1.□CDU originally designed to take in a 24 hour period 25-30 patients, on average it is now taking 50-60 patients/24 hr period. Therefore the foot print of the unit is inadequate to cope with this number of patients. There is not the physical space to see/examine/review the number of patients that are currently presenting to CDU, particularly in the afternoon and evening. 2.□The workforce on CDU (medical, nursing, therapy, admin/clerical) has not increased in accordance with the increase in the number of patients that require processing in the department. 3.□Due to the pressures within the Emergency Department at the LRI the level 1 and 2 diverts are enacted on a regular basis, compounding the overall processing power within CDU and impacting on bed capacity. 4.□The out of hour's provision from support services such as pharmacy, radiology and pathology does not match the requirements of an increasing emergency take at the GH. CONSEQUENCES 1.□Significant delays in patients being assessed and treated due to inadequate workforce resource to meet demand. This compounds the space issue as patients are not being assessed and treated in an efficient manner. 2.□Overcrowded department leads to inefficiencies ie no physical space to review or examine patients; therefore there are delays in them being assessed and receiving treatment. 3.□Patients dissatisfied with their experience: CDU patient survey results/Friends and Families Score reflect the long waits patients are experiencing. The results are amongst the lowest in the Trust. The detractors all relate to wait times, overcrowding whilst waiting and inappropriate	Patients	1.□Respiratory Consultant on CDU 5 days/week 0800-20 00 hrs 2.□Respiratory Consultant on CDU at weekends and bank holidays 0800-1200 hrs and on call thereafter 3.□Cardio Respiratory Streaming flow, including referral criteria and acceptance 4.□Short stay ward adjacent to CDU 5.□Discharge Lounge utilised 6.□GH duty Manager present 24/7 7.□Patient flow Coordinator 7 days/week daytime 8.□CDU dash board 9.□UHL bed state details CDU current status as well as ED 10.□Daily nurse staffing review with plan to ensure safe staffing levels on CDU 11.□EDIS operational on CDU 12.□Daily patient census conference calls 13.□Daily board rounds across all wards	Moderate	Almost certain	15	ECAT on GH site once/month - Meeting with support services- radiology, pharmacy and Pathology - Review of work force resource- to be prepared for discussion at next ECAT meeting on GH site and then action appropriately - 31/12/14 Plan to hold a CDU flow mapping exercise - to fully utilise the ambulatory area - 31/12/14	3	SM	a

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2328	ITAPS	Anaesthesia	Risk of inadvertent wrong route administration of anaesthetic medicines during epidural and regional anaesthesia.	16/04/2014	31/10/2016	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) - 31/10/16. Introduction of Non-Luer giving sets(following introduction of ISO standard) - 31/10/16. Introduction of Non-Luer connector to epidural filter (following introduction of ISO standard) - 31/10/16.	5	CAL	a
1196	Clinical Support and Imaging		No comprehensive out of hours on call rota and PM cover for consultant Paediatric radiologists	29/06/2009	31/01/2015	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. Lack of cover for PM work 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. Delays in reports for Pathology and Coroner	Patients	To provide as much cover as possible within the working time directive. Registrars cover within the capability of their training period. Other Radiologists assist where practical however have limited experience and are unable to give interventional support. Locums are used when available.	Moderate	Almost certain	15	Recruit to Consultants vacancies - due 30/06/2015	12	RG	f

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2380	Clinical Support and Imaging		Imaging - Risk of breach of Same Sex Accommodation Legislation	23/06/2014	31/01/2015	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.Explore options around redesigning the cubicles and waiting area in the MRI and CT zone - due 01/02/2015 LGH Action Plan:- Where feasible, implement appropriate changes, based on business case, costings approval and planning. Options to consider include: "□Increasing numbers of cubicles "□Provision of solid doors on cubicles instead of curtains "□Investigate possibility of single sex sessions, i.e. males in the morning, females in the afternoon, for both inpatients and outpatients "□Creating single sex recovery areas "□Area D: utilise chair area for dressed patients only. Undressed patients could wait in the cubicles. Trolley area could have cubicles and chairs removed so that curtained area can be created to accommodate 1 trolley patient, allowing maximum of 2 patients in this area at a time. If opposite sex, one could be curtained behind the screened area. 01/02/2015	3	JHA	α

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2426	Clinical Support and Imaging	Dietetics	Compromised safety for pateints with complex nutritional requirements	31/03/2015 28/10/2014	Causes: Increased workload with greater number of patient referrals. Inability to staff the PN round daily due to shortage of staffing resource. Consequences: Increased length of stay, prescription errors, delays in reviewing patients, reduced quality of care, loss of patency of lines and reduced efficiency around checking patients' blood results. Delayed response to complex Home Parenteral Nutrition patients' contacts/referrals due to further increase in inpatient workload. Increased risk of prescribing errors due high workload and pressures to respond quickly. Insufficient nursing and dietetic cover to action promptly the increasing numbers of all referrals in-house and in the community, resulting in a number of patients receiving delayed reviews. Increased levels of stress amongst the team, which could result in increased sickness absence, which would further exacerbate the risks above. Risks to patient safety due to not being reviewed daily, particularly unstable patients. HIFNET bid will fail due to current staffing establishment. Loss of regional and national intestinal failure status. Loss of income from HIFNET bid. This will affect other services throughout the Trust (e.g. bariatric services).	Patients	Temporary controls following previous risk assessment December 2013, in the form of funding 1.0 WTE at Band 6 nurse and 0.21 at Band 8a nurse and 1.0 WTE Band 6 Dietitian, on a temporary basis, currently in place until 30/3/15.	Moderate	Almost certain	15	1. Review possibility of capping numbers of HPN referrals with the clinical teams. Review possibility of capping inpatient PN tailored bags - 31/03/15. 2. Consider converting temporary posts to permanent contracts to ensure continuity of staffing and training needs- 31/03/15. 3. Urgent review of the NST service to ascertain requirements for further uplift in staffing levels - 31/03/15. 4. Consider the option to Identify and facilitate professional checking by qualified pharmacist of the HPN prescriptions on a daily basis - 31/03/15. 5. Review current response times for enteral and HOS referrals, with a view to lengthening (current standard is within 24 hours) on a short term basis, to reduce pressure on the team - 31/03/15. 6. Complete stress risk assessments on all members of the nutrition nurse team and take any identified actions - 31/03/15. 7. Urgent review of job plans to all members of the NST to meet high risk priorities - 31/03/15. 8. Audit readmissions of HPN patients - 31/03/15. 9. To create and develop a specialist pharmacist post dedicated to nutrition in line with the current Pharmacy workforce optimisation review - 31/03/15.	3	MSC	a
2407	Women's and Children's		Failure to meet national non admitted target of 18 weeks	31/01/2015 26/08/2014	Causes: Recent increase in referrals 1.0 wte consultant gynaecologist vacancy Failure to appoint to permanent post or locum position Consequences: Increase in waiting time for appointment 18-30+ weeks Failure to meet 95% performance target Impact on performance with a possibility of 50% performance rate by end August 2014 Performance gone down since June	Patients	Letters sent to GP's advising them of waiting time delays and the need to prioritise the patients they refer Working with GP representative to ensure all GP's are aware Out of area referrals discontinued SpR on maternity leave to return 1 month early Cancer Geneticist increasing workload -assisting with 1 clinic per week	Moderate	Almost certain	15	Recruit into the consultant vacancy - due 31/01/2015	3	DMARS	a

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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	28/02/2015 17/12/2013	Causes: Inadequate staffing levels and inappropriate quality systems in place. ISO 15189 accreditation would be an outcome if the service was adequately staffed with appropriate quality systems in place. Consequences: Patient safety and quality issues if unable to deliver service. Financial impact if patients choose to move elsewhere or NHS contracts not obtained. Risk to Trust reputation. Challenging external recommendations/improvement notice from HFEA - critical report received Feb 2013.	Statutory	1 fulltime trained Embryologist to a national recognised level 3 part time trained Embryologist to a national recognised level 1 0.8wte Band 6 BMS	Moderate	Almost certain	15	Band 6 to be advertised & recruited to - due 28/02/2015 Overhaul of specimen request, collection and delivery procedures - due 28/02/2015.	6	DMARS	a

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2402	Corporate Nursing		Inappropriate Decontamination practise within UHL may result in harm to patients and staff	31/03/2015	19/08/2014	Causes Endoscope Washer Disinfector (EWD) reprocessing is undertaken in multiple locations within UHL other than the Endoscopy Units. These areas do not meet current guidelines with regard to a. Environment b. Managerial oversight c. Education and Training of staff There is decontamination of Trans Vaginal probes being undertaken within the Women's CMG and Imaging CMG according to historical practice, that is no longer considered adequate. Bench top sterilisers within Theatres continue to be used. The use of these sterilisers is monitored by an AED. Purchase of Equipment is not always discussed with the Decontamination Committee Consequences Lack of oversight of Decontamination practice across the Trust Equipment purchased may not be capable of adequate decontamination if not approved by Infection Prevention Current Endoscope Washer Disinfectors (EWD) re-processing locations (other than endoscopy units) are unsatisfactory. All of the above having the potential for inadequately decontaminated equipment to be used Patient harm due to increased risk of infection Risk to staff health either by infection or chemical exposure Reputational damage to the organisation Financial penalty Risk of litigation Additional cost to the organisation when further equipment must be purchased	Statutory	Surgical instrument decontamination outsourced to third party provider. Joint management board and operational group oversee this contract. The endoscopy units undergo Joint Advisory Group on GI endoscopy (JAG) accreditation. This is an external review that includes compliance with decontamination standards. All units are currently compliant. Current policy in place for decontamination of equipment at ward level. Equipment cleanliness at ward level is audited as part of monthly environmental audits and an annual Trust wide audit is carried out. Benchtop sterilisers are serviced by a third party Endoscope washer disinfectors are serviced as part of a maintenance contract Infection prevention team are auditing current decontamination practice within UHL. Position paper sent to Trust Infection Prevention Assurance Committee in November 2013 Infection prevention team provide advice and support to service users if requested Endoscopy water test results monitored by IP team. Failed results sent to the team by Food and Water laboratory and these are followed up with relevant teams to ensure actions have been taken.	Moderate	Almost certain	15	Complete full review of decontamination practice within UHL and make recommendations for future practice - 31/03/15 Review all education and training for staff involved in reprocessing reusable medical equipment - 31/03/15 Review the use of equipment and the appropriateness of their current placement according to national guidance - 31/03/15	3	LCOL	a

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1551	Corporate Nursing	QS	Failure to manage Category C documents on UHL Document Management system (Insite)	30/06/2015	14/03/2011	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 - 30/06/15 Compile a list of local guidelines requiring review and send to CMGs for action - 30/06/15 CMGs to advise 'CRESPO' of any guidelines requiring urgent revision/ attention or that need to be removed from InSite - 30/06/15 Provide a message on InSite to inform staff that work to improve the system is ongoing and if necessary advise can be sought from Rebecca Broughton/ Claire Wilday - 30/06/15 Implement shared mailbox to receive responses from CMGs - 30/06/15 Ensure input from IM&T to make InSite more effective as a document library - 30/06/15 Continue work to assign review dates and authors to all CAT C documents 30/06/15	9	SH	4