To:	**Trust Board**
From:	**Medical Director**
Date:	**27 June 2013**
CQC regulation:	Outcome 16 – Assessing and Monitoring the Quality of Service Provision

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

Author/Responsible Director: Medical Director

Purpose of the Report:
This report provides the Board with an update to the BAF and oversight of all high and extreme risks within the Trust and includes:-

a) A copy of the Board Assurance Framework (BAF) as of 31 May 2013.
b) An action tracker to monitor progress of BAF actions
c) A heat map of risk movements from the previous month.
d) Suggested parameters for scrutiny of the BAF.
e) An extract from the UHL risk register showing any new high and extreme risks opened during the reporting period.

The Report is provided to the Board for:

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

Summary :

- During May 2013 the UHL Executive Team (ET) refreshed the BAF bringing it into line with risks identified from the UHL Integrated Business Plan (IBP) and Annual Operating Plan (AOP).
- Four new risks identified as listed below:
  Ineffective strategic planning and response to external influences.
  Failure to exploit the potential of IM&T.
  Failure to achieve and sustain quality standards (amalgamating the previous risks *'Reducing avoidable harms'* and *'patient experience /satisfaction')*.
  Failure to achieve and maintain high standards of operational performance (replacing previous risk '*Failure to achieve and sustain operational targets'*).
- The BAF is now accompanied by a new 'action tracker' developed to provide more robust management of actions.
- Board members are invited to review the following risks.
  Risk 4 Ineffective organisational transformation.
  Risk 5 Ineffective strategic planning and response to external influences.
  Risk 12 Failure to exploit the potential of IM&T.
- One new high risk and one extreme risk opened during May 2013 are detailed in appendix 5.

Recommendations:

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

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

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

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

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

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

(f) Note any new high or extreme risk opened during the reporting period.

Strategic Risk Register Yes	**Performance KPIs year to date** N/A
Resource Implications (eg Financial, HR) N/A	
Assurance Implications: Yes	
Patient and Public Involvement (PPI) Implications: Yes	
Equality Impact N/A	
Information exempt from Disclosure: No	
Requirement for further review? Yes. Monthly review by the Board	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **27 JUNE 2013**

REPORT BY: **MEDICAL DIRECTOR**

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

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1. INTRODUCTION

1.1 This report provides the Board with:-

a) A copy of the Board Assurance Framework (BAF) as of 31 May 2013 (appendix 1).
b) An action tracker to monitor progress of BAF actions (appendix 2).
c) A heat map of risk score movements from the previous month (appendix 3).
d) Parameters for scrutiny of the BAF (appendix 4).
e) New high / extreme risks opened during May 2013 (appendix 5).

2. BAF POSITION AS OF 31 MAY 2013

2.1 During May 2013 the UHL Executive Team (ET) refreshed the BAF bringing it into line with risks identified from the UHL Integrated Business Plan (2013 - 18) and Annual Operating Plan (2013/14). This has resulted in some changes from previous versions including renumbering of risks, changes to the executive leads for some of the risks and the identification of 4 new risks as listed below:

- Ineffective strategic planning and response to external influences.
- Failure to exploit the potential of IM&T.
- Failure to achieve and sustain quality standards (amalgamating the previous risks *'Reducing avoidable harms'* and *'patient experience /satisfaction').*
- Failure to achieve and maintain high standards of operational performance (replacing previous risk '*Failure to achieve and sustain operational targets'*).

A copy of the BAF is attached at appendix 1 with changes to narrative shown in red text.

2.2 The BAF is now accompanied by a new 'action tracker' developed to provide more robust management of actions by showing whether actions are on trajectory to be completed within their specified timescales and any issues that may cause a departure from the original timescales for completion. Each action within the BAF is assigned a numeric reference and these numbers are included on the tracker to cross-reference the actions. Progress of actions is reviewed on a monthly basis at a UHL Executive Team (ET) meetings and a copy of the updated tracker will be provided at each Board meeting.

2.3 To provide scrutiny and oversight of BAF risks on a cyclical basis, Board members are invited to review the following risks against the parameters listed in appendix 4.

Risk 4	Ineffective organisational transformation.
Risk 5	Ineffective strategic planning and response to external influences.
Risk 12	Failure to exploit the potential of IM&T.

3 NEW HIGH AND EXTREME RISKS.

3.1 To provide a more robust line of sight from 'ward to Board' the Board will now receive monthly notification of any high and/ or extreme risks opened during the reporting period. One new high risk and one extreme risk opened during May 2013 are detailed in appendix 5.

4. RECOMMENDATIONS

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

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

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

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

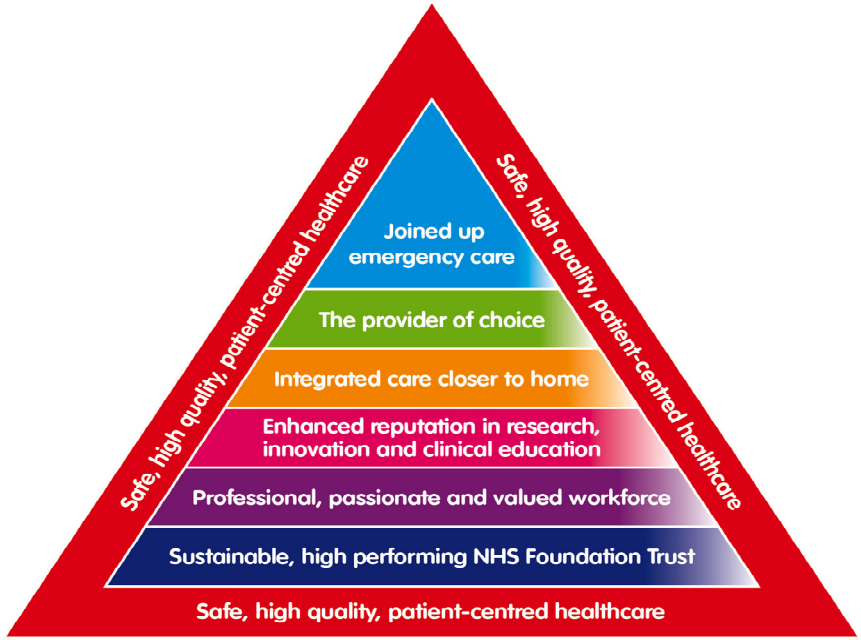
(d) identify any gaps in assurances about the effectiveness of the controls in place to manage the principal risks and consider the nature of, and timescale for, any further assurances to be obtained;

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

(f) Note any new high or extreme risk opened during the reporting period.

Peter Cleaver,
Risk and Assurance Manager,
19 May 2013.

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



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

PERIOD: 1 MAY – 30 MAY 2013

RISK TITLE	STRATEGIC OBJECTIVE	CURRENT SCORE	TARGET SCORE
Risk 1 – Failure to achieve financial sustainability	g - To be a sustainable, high performing NHS Foundation Trust	25	12
Risk 2 – Failure to transform the emergency care system	b - To enable joined up emergency care	25	12
Risk 3 – Inability to recruit, retain, develop and motivate staff	f - To maintain a professional, passionate and valued workforce e - To enjoy an enhanced reputation in research, innovation and clinical education.	16	12
Risk 4 – Ineffective organisational transformation	a - To provide safe, high quality patient-centred health care c - To be the provider of choice d - To enable integrated care closer to home	12	12
Risk 5 – Ineffective strategic planning and response to external influences	a - To provide safe, high quality patient-centred health care c - To be the provider of choice g - To be a sustainable, high performing NHS Foundation Trust	16	12
Risk 6 – Failure to achieve FT status	g - To be a sustainable, high performing NHS Foundation Trust	16	12
Risk 7 – Failure to maintain productive and effective relationships	c - To be the provider of choice d - To enable integrated care closer to home f - To maintain a professional, passionate and valued workforce	15	10
Risk 8 – Failure to achieve and sustain quality standards	a - To provide safe, high quality patient-centred health care c - To be the provider of choice	16	12
Risk 9 – Failure to achieve and sustain high standards of operational performance	a - To provide safe, high quality patient-centred health care	12	12
Risk 10 – Inadequate reconfiguration of buildings and services	a - To provide safe, high quality patient-centred health care	12	9
Risk 11– Loss of business continuity	g - To be a sustainable, high performing NHS Foundation Trust	9	6
Risk 12 – Failure to exploit the potential of IM&T	a - To provide safe, high quality patient-centred health care d - To enable integrated care closer to home	9	6

STRATEGIC OBJECTIVES:-

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

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	Current Score I x L	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	Target Score I x L	**Timescale** When will the action be completed?
Failure to achieve financial sustainability including:	Overarching financial governance processes including PLICS process and expenditure controls.	5X5=25	Monthly /weekly financial reporting to Exec Team Performance Board, F&P Committee and Board. Cost centre reporting and monthly PLICS reporting. Monthly confirm and challenge processes at CBU and Divisional level. Annual internal and external audit programmes.	Lack of effective forecasting processes (C). Variability in controls over non-contractual pay (C). SLM programme	Revised variance analysis and reporting metrics especially for the ETPB (1.2) Review of non-contractual pay controls (1.3) Self-assessment exercise of embedding of SLM (1.4)	4x3=12	Jun 2013 DFBS Review Jun 2013 DHR Jun 2013 DFBS
Failure to achieve CIP.	Strengthened CIP governance structure.		Progress in delivery of CIPs is monitored by CIP Programme Board (meeting fortnightly) and reported to ET and Board.	Under-delivery of CIP programme (C)	Refreshed CIP programme management arrangements (1.5)		Commenced May 2013 Review Aug 2013 DFBS
Locum expenditure.	Workforce plan to identify effective methods to recruit to 'difficult to fill' areas Reinstatement of weekly workforce panel to approve all new posts. STAFFflow for medical locums saving £130k of every £1m expenditure		The use of locum staff in 'difficult to fill' areas is reported to the Board on a monthly basis via the Quality and Performance report. A reduction in the use of such staff would be an assurance of our success in recruiting substantive staff to 'difficult to fill' areas. Increase in substantive staff of 200wte to Oct 12. Saving in excess of £0.6m 5 weeks after 'go live' date	(c) Failure to reduce locum spend. 587 wte locum staff currently used.			
Loss of income due to tariff/tariff changes (including referral rate for emergency admissions – MRET)	Contract meetings with Commissioners Negotiations with Commissioners concluded at a transactional level.		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board.	(c) Failing to manage marginal activity efficiently and effectively.			

Ineffective processes for Counting and Coding.	Clinical coding project.		Ad-Hoc reports on annual counting and coding process. PbR clinical coding audit Jan 2013 (final report received 29 May 2013). IG toolkit audit (sample of 200 General Surgery episodes).	Error rates in audit sample could be indicative of underlying process issues (c) Error rates identified as: Primary diagnoses incorrect 8.0% › Secondary diagnoses incorrect 3.6%. › Primary procedure incorrect 6.4% › Secondary procedure incorrect 4.5%.	Re-establishing clinical coding improvement team under John Roberts. Initial action plan in place (1.6)		Review Jun 2013 COO
Loss of liquidity.	Liquidity Plan.		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board.		Cash management plan to be presented at F&P committee (1.7)		Jun 2013 DFBS
Lack of robust control over non-pay expenditure.	Non-pay action plan (agreed by F&P Committee). Catalogue control project.		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board. Ongoing Monitoring via F&P Committee.	(c) Failing to control adverse trends in non-pay - NB positive trend in year to date.	Non-pay management plan to be presented at F&P committee (1.8)		Jun 2013 DFBS
Commissioner fines against performance targets.	Contract meetings with Commissioners Negotiations with Commissioners concluded at a transactional level. Divisions have developed plans and trajectories to reduce admission rates that are monitored at monthly C&C meetings.		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board.	(c) Failing to reduce readmission trends.			
Use of readmission monies.	Contract meetings with Commissioners Negotiations with Commissioners concluded at a transactional level		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board.	(c) Failing to reduce readmission trends.			
Ineffective organisational transformation.	See risk 7		See risk 7.	See risk 7.	See risk 7.		

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to transform emergency care system leading to demands on ED and admissions units continuing to exceed capacity.	Health Economy has submitted response plan to NHSE requirements for an Emergency Care system under the A&E Performance Gateway Reference 00062.	5x5=25	Once plan agreed with NTDA, it will be circulated to the Board	No gaps	No actions	4x3=12	
	Emergency Care Action Team formed. Chaired by Chief executive to ensure Emergency Care Pathway Programme actions are being undertaken in line with NHSE action plan and any blockages to improvement removed. Development of action plan to address key issues		Action Plan will be circulated to the Board on a monthly basis as part of the Report on the Emergency Access Target within the Quality and Performance Report	Gaps described below	Actions described below		
	Key themes from plan: Single front door		Project plan developed by CCG project manager	Still significant gaps in staffing Protocols need to be agreed between UCC and UHL.	Risks to be escalated via ECAT and raised with CCG Managing Director as required (2.10)		Aug 2013 COO
	ED assessment process is being operated.		Forms part of Quality Metrics for ED reported daily update and part of monthly board performance report	(a) Data entry issues mean that times can appear longer than in reality	CD for ED and GM will validate all data entry (2.6)		Jul 2013 COO
	Recruitment campaign for continued recruitment of ED medical and nursing staff including fortnightly meetings with HR to highlight delays and solutions in the recruitment process.		Vacancy rates and bank/agency usage reported to Trust Board on a monthly basis Recruitment plan being led by HR and monitored as part of ECAT	(c) Difficulties are being encountered in filling vacancies within the emergency care pathway. Agency and bank requests continue to increase in response to increasing sickness rates, additional capacity, and vacancies. (c) Staffing vacancies for medical and nursing staff remain high.	Continue with substantive appts until funded establishment is achieved (2.7)		Review of action Sep 2013 COO

	Formation of an EFU and AFU to meet increased demand of elderly patients		'Time to see consultant' metric included in National ED quarterly indicator.	No gaps	No actions		
	Maintenance of AMU discharge rate above 40%		Reported to Operational Board twice monthly and will be included in Emergency Care Update report in Quality and Performance Report.	No gaps	No actions		
	New daily MDT Board Rounds on all medical wards and medical plans within 24hrs of admission		Reported to Operational Board twice monthly and will be included in Emergency Care Update report in Quality and Performance Report.	No gaps	No actions		
	EDDs to be available on all patients within 24 hours of admission		Monitored and reported to Operational Board twice monthly and will be included in Emergency Care Update report in Quality and Performance Report.	(c) Provision of EDDs for all patients not yet achieved	Roll out of actions from ECAT action plan (2.8)		Jun / Jul 2013 CO O
	Maintain winter capacity in place to allow new process to embed		All winter capacity beds are to be kept open until the target is consistently met	No gaps	No actions		
	DTOCs to be kept to a minimal level		Forms part of the Report on Emergency Access in the Quality and Performance Report.	(c) Lack of availability of rehabilitation beds for increasing numbers of patients.	CCG/LPT to increase capacity by use of Intermediate Care Services (2.9)		Aug 2013 CO O

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inability to recruit, retain, develop and motivate suitably qualified staff leading to inadequate organisational capacity and development.	Leadership and talent management programmes to identify and develop 'leaders' within UHL.	4x4=16	Development of UHL talent profiles.	No gaps identified.	No actions required.	4x3=12	
			Talent profile update reports to Remuneration Committee.	No gaps identified.	No actions required.		
	Substantial work program to strengthen leadership contained within OD Plan.			No gaps identified.	No actions required.		
	Organisational Development (OD) plan.		A central enabler of delivering against the OD Plan work streams will be adopting, 'Listening into Action' (LiA) and progress reports on the LiA will be presented to the Trust Board on a quarterly basis.	No gaps identified.	No actions required.		
	A central enabler of delivering against the OD Plan work streams will be adopting, 'Listening into Action (LiA). A Sponsor Group personally led by our Chief Executive and including, Executive Leads and other key clinical influencers has been established.		Progress reports on the LiA will be presented to the Trust Board on a quarterly basis.	No gaps identified. No gaps identified.	No actions required. No actions required.		
	Staff engagement action plan encompassing six integrated elements that shape and enable successful and measurable staff engagement		Results of National staff survey and local patient polling reported to Board on a six monthly basis. Improving staff satisfaction position.	No gaps identified.	No actions required.		
			Staff sickness levels may also provide an indicator of staff satisfaction and targets for staff sickness rates are 3.4% (rolling 12 months) and 3.9% for April 13	No gaps identified	No actions required.		

	Appraisal and objective setting in line with UHL strategic direction.		Appraisal rates reported monthly to Board via Quality and Performance report. April 13 appraisal rate = 90.9%	No gaps identified.	No actions required.		
			Results of quality audits to ensure adequacy of appraisals reported to the Board via the quarterly workforce and OD report.	No gaps identified.	No actions required.		
			Quality Assurance Framework to monitor appraisals on an annual cycle (next due March 2013).	No gaps identified.	No actions required.		
	Workforce plan to identify effective methods to recruit to 'difficult to fill areas). Divisions and Directorates 2013/14 Workforce Plans.		The use of locum staff in 'difficult to fill' areas is reported to the Board on a monthly basis via the Quality and Performance report. Reduction in the use of such staff would be an assurance of our success in recruiting substantive staff.	No gaps identified.	No actions required.		
	Reward /recognition strategy and programmes (e.g. salary sacrifice, staff awards, etc).			(a) Reward and recognition strategy requires revision to include how we will provide assurance that reward and recognition programmes are making a difference to staffing recruitment/ retention/ motivation.	Revise reward and recognition strategy. (3.1)		Oct 2013 DHR

	UHL Branding – to attract a wider and more capable workforce. Includes development of recruitment literature and website, recruitment events, international recruitment. This includes a recently held nurse recruitment day (Jan 2013). Reporting and monitoring of posts with 5 or less applicants.		Evaluate recruitment events and numbers of applicants. Reports issued to Nursing Workforce Group (last report 4 Feb). Report to Workforce and OD Committee in March. Positive feedback from nurse recruitment day on 26 Jan 2013. Future reporting will be to the Board via the quarterly workforce an OD report. Quarterly report to senior HR team and to Board via quarterly workforce and OD report	(a) Better baselining of information to be able to measure improvement. (c) Lack of engagement in production of website material.	Take baseline from January and measure progress now that there is a structured plan for bulk recruitment. Identify a lead from each professional group to develop and encourage the production of fresh and up to date material. (3.2)		Dec 2013 DHR

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to put in place a robust approach to organisational transformation, adequately linked to related initiatives and financial planning/outputs	Development of Improvement and Innovation Framework	4x3=12	Monthly progress reports to Exec Strategy Board and F&P Committee. Approval of framework and operational arrangements due at Trust Board June 2013. Thereafter monitoring of overall Framework will be via IIF Board and F&P Ctte and monitoring of financial outputs (CIPs) will be via CIP Delivery Board, Exec Performance Board and F&P Ctte.	None identified	Not applicable	4x3=12	N/A

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to put in place appropriate systems to horizon scan and respond appropriately to external drivers. Failure to proactively develop whole organisation and service line clinical strategies	Appointment of Strategy Director	4x4=16	Plan agreed by Remuneration Committee	None identified	Not applicable	4x3=12	N/A
	Allocation of market intelligence responsibility to Director of Marketing and Communications		Agreed by Remuneration Committee	None identified	Not applicable		N/A
				Need to establish co-ordinated approach to business intelligence gathering and response	Establish Business Strategy Support Team (5.13)		Jul 2013 CEO
				Need to agree approach to gathering of marketing intelligence and response	Agree approach via proposal from DMC. (5.14)		Jul 2013 CEO
				Need to forward plan Executive Strategy Board agendas to reflect a 12 month programme aligned with: • the development of the IBP/LTFM • the reconfiguration programme • the development of the next AOP • The TB Development Programme The TB formal agenda	Present ESB forward plan for approval to July meeting. (5.15)		Jul 2013 CEO

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

RISK NUMBER/ TITLE:	**RISK 6 – FAILURE TO ACHIEVE FT STATUS**
LINK TO STRATEGIC OBJECTIVE(S)	**g. - To be a sustainable, high performing NHS Foundation Trust.**
EXECUTIVE LEAD:	Chief Executive

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to meet the requirements of the FT application process in terms of service quality, strategy, financial resilience and governance	FT Programme Board provides strategic direction and monitors the FT application programme.	4x4=16	Monthly progress against the FT programme is reported to the Board to provide oversight.	No gaps identified.	No actions required.	4x3=12	
	FT Workstream group of Executive and operational Leads to ensure delivery of IBP and evidence to support HDD1 and 2 processes.		Feedback from external assessment of application progress by SHA (readiness review meeting Dec 2012.	No gaps identified.	No actions required.		
	FT application project plan / project team in place FT Integrated Development Plan		Reports to FTPB and Trust Board	No gaps identified	Not applicable		N/A
	Progression of Better Care Together Programme which underpins the UHL service strategy and LTFM.		Economic modelling incorporated into the Trust Reconfiguration Strategic Outline Case (SOC) structure and process. Ad hoc reports to Exec Strategy Board and Trust Board Various inputs from Exec Team to BCT work.	(a) Need more regular reporting on BCT progress to Exec Strategy Board and Trust Board	Introduce regular report to ESB and Trust Board (6.9)		Jun 2013 CEO
				(c)Need to identify clear BCT Exec Lead	Director of Strategy to be lead. Ad hoc cover to continue until appointment in place. (6.10)		Oct 2013 CEO
			Feedback and recommendations from the independent reviews against the Quality Governance Framework and the Board Governance Framework.	(c) Independent reports identify a number of recommendations.	Action plans in place to address recommendations from independent reviews. (6.11)		Review Jul 2013 CEO
	Monitoring of KPIs in particular in relation to financial position and key operational performance indicators.		Monthly reports to Executive Performance Board, F&P Committee and Trust Board	None identified.	Not applicable		N/A
			Achievement against the new TDA Accountability Framework is reported to the Trust board and the TDA on a monthly basis.	None identified	Not applicable		N/A

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to maintain productive relationships with external partners/ stakeholders leading to potential loss of activity and income, poor reputation and failure to retain/ reconfigure clinical services.	Stakeholder Engagement Strategy. Regular meetings with external stakeholders and Director of Communications and member of Executive Team to identify and resolve concerns. Regular stakeholder briefing provided by an e-newsletter to inform stakeholders of UHL news. Leicester, Leicestershire and Rutland (LLR) health and social care partners have committed to a collaborative programme of change known as the 'Better Care Together' programme.	5X3=15	Twice yearly GP surveys with results reported to UHL Executive Team. Latest survey results discussed at the April 2013 Board and showed increasing levels of satisfaction… a trend which has now continued for 18 months. Anecdotal feedback from partners and soft intelligence indicates that relations with key organisations and individuals are improving under new UHL leadership.	(a) No surveys currently undertaken to identify relationship issues with wider group of stakeholders e.g. CCGs / LAT / Social Care / Universities etc.	Extend the surveys into wider group of stakeholders to complement the 'soft intel' (7.2)	5X2=10	Sep 2013 DCER

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to achieve and sustain quality standards leading to failure to reduce patient harm with subsequent deterioration in patient experience/ satisfaction/ outcomes, loss of reputation and deterioration of NET promoter score.	Standardised M&M meetings in each speciality	4x4=16	Monitoring and CBU and Divisional Boards	(a) Routine analysis of out of hours/weekend mortality	Better exploit use of routine data analysis tools including DFI and HED (8.1)	4x3=12	Sep 2013 MD
	Systematic speciality review of "alerts" of deterioration to address cause and agree remedial action. Corporate oversight via QPMG, QAC and by exception to ET and TB		Quality and Performance Report and National Quality dashboard presented to Exec and TB. Currently SMHI "within expected"	(a) UHL risk adjusted perinatal mortality rate below regional and national average.	Women's CBU to work with Dr Foster and other trusts to better understand risk adjustment model (8.2)		Jan 2014 MD
	Robust implementation of actions to achieve Quality Commitment (save 1000 extra lives in 3 years)		SHMI remains "within expected"	(a) community wide review of mortality to consider out of hospital mortality – methodology now agreed	Undertake LLR Mortality review. (8.3)		Jun/Jul 20 13 MD
	Agreed patient centred care priorities for 2013-14: - Older people's care - Dementia care - Discharge Planning		Quality Assurance Group meets monthly – provides direction, pace and support Achievement against key objectives and milestones report to Trust board on a monthly basis	(a) Obtain Divisional representations on Quality Assurance Group	Confirm Divisional representation to ensure engagement and delivery (8.4)		Jun 2013 CN
	Multi-professional training in older peoples care and dementia care in line with LLR dementia strategy		Quality Assurance Group monitoring of training numbers and location	No gaps identified	No action needed		
	Protected time for matrons and ward sisters to lead on key outcomes		Divisional/CBU reporting on matron activity and implementation or supervisory practice	(c) Present vacancy levels prevent adoption of supervisory practice	Active recruitment to ward nursing establishment so releasing ward sister – supervisory practice (8.5)		Sep 2013 CN
	To promote and support older peoples champions network and new dementia champions network		Monthly monitoring of numbers and activity	No gaps identified	No action needed		

	Targeted development activities for key performance indicators - answering call bells - assistance to toilet - involved in care - discharge information		Monthly monitoring and tracking of patient feedback results Monthly monitoring of Friends and Family Test reported to the Trust board	(c) Present vacancy level for permanent staff limit development opportunities	Prioritise clinical staff development opportunities in CBU's/Division (8.6)		Jul 2013 CN
	Appointment of carers advocacy post to lead carers involvement in care		Funding agreed for 12 months	No gaps identified	No action needed		
	Ensure completion of patient profile on every appropriate patient admitted		Audit results every 6 month	No gaps identified	No action needed		
	Agreed avoiding harm priorities: ➢ Falls ➢ Acting on results in ED ➢ Senior review, ward rounds, and notation.		Quality Action Group meets monthly – provides direction, pace and support Achievement against key objectives and milestones report to Trust board on a monthly basis	(a) Obtain Divisional representations on Quality Assurance Group	Confirm Divisional representation to ensure engagement and delivery (8.7)		Jun 2013 CN
	Relentless attention to 5 Critical Safety Actions (CSA) initiative to lower mortality		Q&P report to Trust Board showing outcomes for 5 CSAs. 4CSAs form part of local CQUIN monitoring. RAG rated green at end of quarter 2. M&M CSA removed from CQUIN monitoring due to full implementation	(c) Lack of a unified IT system in relation to ordering and receiving results means that many differing processes are being used to acknowledge/respond to results. Potential risk of results not being acted upon in a timely fashion.	Feasibility of a less cumbersome IT platform to be investigated by IBM. (8.8)		Review Jun 2013 CIO
	NHS Safety thermometer utilised to measure the prevalence of harm and how many patients remain 'harm free' (Monthly point prevalence for '4 Harms'). Monthly meetings with operational/clinical and managerial leads for each harm in place. Utilisation of CQUIN monies for 2013/14 to invest in data collection posts at ward level.		Monthly outcome report of '4 Harms' is reported to Trust board via Q&P report New DoH definitions may see an increase in harm attributed to UHL to encourage closer working between primary and secondary care.	a) There is a risk that some data may not be accurate due to complex DoH definitions of each harm in relation to whether it is community or hospital acquired.	Action to be identified.		

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to achieve and sustain operational targets leading to contractual penalties, patient dissatisfaction and poor reputation.	Backlog plans to recover 18 week referral to treatment (RTT) target.	4x3=12	Monthly Q&P report to Trust Board showing 18 week RTT rates Weekly monitoring of backlog numbers via Head of Performance Improvement.	(c) Capacity issues created by emergency demand causes cancellations of operations.	On-going work on ward processes in Acute to free up capacity. (9.1) Re-configuration of surgical beds to create a 'protected area' for surgical patients. (9.2)	4x3=12	Jun 2013 COO Nov 2013COO
	Referral pathways to decrease demand and ensure discharge to GP where appropriate.			(a) Lack assurance in relation to performance metrics to show activity versus number of patients deferred onto a different care pathway.	Development of key metrics at a local level. (9.3)		Review Jul 13 COO
	Transformational theatre project to improve theatre efficiency to 80 -90%.		Monthly theatre utilisation rates. Theatre Transformation monthly meeting. Transformation update to Board.	No gaps identified.	No actions required.		
	Emergency Care process redesign (phase 1) implemented 18 February 2013 to improve and sustain ED performance.		Monthly report to Trust Board in relation to Emergency Dept (ED) flow (including 4 hour breaches).	See risk number 4.	See risk number 4.		

	Each tumour site has developed action plans to achieve targets. (Expected that target of 85% to be delivered by April 2013)		Chief Operating Officer receives reports from Cancer Manager and information included within Monthly Q&P report to Trust Board. Monthly trajectory agreed and monitored at Board via exception report. Cancer 62 action plan agreed with CCG and reported and monitored at Executive Performance board.	(c) Gaps identified in Imaging (c) 62 day cancer target delivery below target	Action plan to resolve Imaging issues to be developed (9.7) Cancer Clinical lead, Cancer Centre Managers and Trackers to be recruited. (9.5)		Jul 2013 COO Jun 2013 COO
	Ongoing monitoring of key performance indicators.		Monthly Q&P report to Trust Board.	No gaps identified.	No actions required.		
	Outpatient delivery plan to reduce cancellation rates has been developed and circulated to Divisions for inclusion in their CIP plans.			(c) Not reducing cancellation rates for outpatients appointments.	Continued monitoring of outpatient delivery plan. (9.6)		Review Jun 2013 COO

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inadequate reconfiguration of buildings and services leading to less effective use of estate and services.	Clinical Strategy.	3x4=12		(a) Key measures to demonstrate success of strategy and reporting lines not yet identified.	Key measures for gauging success of strategy to be developed by specialties as part of their 'mini-IBPs' and will be monitored via divisional and directorate boards. (10.1)	3X3=9	Dec 2013 MD
	Estates Strategy including award of FM contract to private sector partner to deliver an Estates solution that will be a key enabler for our clinical strategy in relation to clinical adjacencies.		Facilities Management Collaborative (FMC) will monitor against agreed KPIs to provide assurance of successful outsourced service.	(c) Estates plans not fully developed to achieve the strategy. (c) The success of the plans will be dependent upon capital funding and successful FT application.	Ensure success of FT Application (see risk 6 for further detail). (10.2) Secure capital funding. (10.3)		Apr 2015 CEO Dec 2013 DFBS
	Divisional service development strategies and plans to deliver key developments.		Progress of divisional development plans reported to Service Reconfiguration Board.	No gaps identified.	No actions required.		
	Service Reconfiguration Board.		Monthly ET Strategy session to provide oversight of reconfiguration.				
	Capital expenditure programme to fund developments.		Capital expenditure reports reported to the Board via Finance and Performance Committee.	No gaps identified.	No actions required.		
	Managed Business Partner for IM&T services to deliver IT that will be a key enabler for our clinical strategy. IM&T incorporated into Improvement and Innovation Framework.		IM&T Board in place.				

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inability to react /recover from events that threaten business continuity leading to sustained downtime and inability to provide full range of services.	Major incident/business continuity/ disaster recovery and Pandemic plans developed and tested for UHL/ wider health community. This includes UHL staff training in major incident planning/ coordination and multi agency involvement across Leicestershire to effectively manage and recover from any event threatening business continuity.	3x3=9	Annual Emergency planning Report identifying good practice presented to the Governance and Risk Management Committee July 2012. Training Needs Analysis developed to identify training requirements for staff supported by appropriate training packages for Senior Managers on Call External auditing and assurances to SHA, Business Continuity Self-Assessment, June 2010, completed by Richard Jarvis Completion of the National Capabilities Survey, November 2013 completed by Aaron Vogel. Results will be included in the annual report on Emergency Planning and Business Continuity to the QAC. Audit by Price Waterhouse Coopers LLP Jan 2013. Results being compiled and will be reported to Trust Board (date to be agreed). Documented evidence from key critical suppliers has been collected to ensure that contracts include business continuity arrangements.	(c) On-going continual training of staff to deal with an incident. (a) Do not consider realistic testing of different failure modes for critical IT systems to ensure IT Disaster Recovery arrangements will be effective during invocation. (c) Validating and assessing the results from critical suppliers.	Tailored training packages for service area based staff. (11.1) Determine an approach to delivering a physical testing of the IT Disaster Recovery arrangements which have been identified as a dependency for critical services. Include assessment of the benefits of realistic testing of arrangements against the potential disruption of testing to operations. (11.2) Assess our requirements of the critical suppliers and ensure that their response fulfils our requirements. (11.3)	2x3=6	COO Jul 2013 CIO Sep 2013 COO Sep 2013

	Emergency Planning Officer appointed to oversee the development of business continuity within the Trust.		Outcomes from Price Waterhouse Coopers LLP audit identified that there is a programme management system in place through the Emergency Planning Officer to oversee. A year plan for Emergency Planning has been developed. Production/updates of documents/plans relating to Emergency Planning and Business Continuity aligned with national guidance have begun. Including Business Impact Assessments for all CBUs	(c) 1 CBU not yet completed (c) Local plans for loss of critical services not completed due to change over of facilities provider	Complete BIA for outstanding CBU (11.5) Continue to engage with Interserve and service areas around development of Business Continuity Plans (11.6)		COO Jun 2013 COO Sep 2013
	New policy to identify key roles within the Trust of those responsible for ensuring business continuity planning /learning lessons is undertaken.		Minutes/action plans from Emergency Planning and Business Continuity Committee. Any outstanding risks/issues will be raised through the Chief Operating Officer.	No gaps identified.	No actions required.		
			New Policy on InSite Emergency Planning and Business Continuity Committee ensures that processes outlined in the Policy are followed, including the production of documents relating to business continuity within the service areas. 3 incidents within the Trust have been investigated and debrief reports written, which include recommendations and actions to consider.	(c) Do not effectively communicate issues/lessons learnt that have been identified in service area disruptions and follow up actions.	Issues/lesson will feed into the development of local plans and training and exercising events. (11.7)		COO Sep 2013
				(c)Do not always consider the impact on business continuity and resilience when implementing new systems and processes.	Further processes require development, particularly with the new Facilities and IM&T providers to ensure resilience is considered/ developed when implementing new systems, infrastructure and processes. (11.8)		COO Jul 2013

				(a) Lack of coordination of plans between different service areas and across the CBUs.	Emergency Planning Officer and Divisional BCM leads will ensure that plans developed are coordinated between service areas/CBUs/Divisions (11.9) Training and Exercising events to involve multiple CBUs/Divisions to validate plans to ensure consistency and coordination. (11.10)		COO Sep 2013 COO Aug 2014

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

RISK NUMBER/ TITLE:	**RISK 12 FAILURE TO EXPLOIT THE POTENTIAL OF IM&T**
LINK TO STRATEGIC OBJECTIVE(S))	**a. - To provide safe, high quality patient-centred health care.** **d. - To enable integrated care closer to home**
EXECUTIVE LEAD:	Director of Finance and Business services

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to integrate the IM&T programme into mainstream activities	Managed Business Partner for IM&T services to deliver IT that will be a key enabler for our clinical strategy. IM&T now incorporated into Improvement and Innovation Framework	3x3=9	IM&T Board in place. Quarterly reports to Trust Board	No gaps identified	No actions required	3x2=6	
	Engagement with the wider clinical communities (internal)		CMIO(s) now in place, and active members of the IM&T meetings The joint governance board monitors the level of communications with the organisation	(c) Formal meetings of the representative clinical leads (a) No formal feedback within the present communications plan	Formal meetings of the newly created advisory groups/ clinical IT groups to be re-established with new membership. (12.2) An improved communications plan to be presented to the JGB for approval. (12.3)		June 2013, CMIOs July 2013, CI O
	Engagement with the wider clinical communities (External		UHL membership of the wider LLR IM&B board	(c) UHL CMIOs to attend LLR meeting to drive the LLR wide programme alongside CCG clinicians	Ensure clinical views are represented on the LLR IM&T Board. (12.4)		June 2013, CIO

Benefits are not well defined or delivered	Appointment of IBM to assist in the development of an incentivised, benefits driven, programme of activities to get the most out of our existing and future IM&T investments		Minutes of the joint governance board, the transformation board and the service delivery board	(c) the delivery programme is dependent on TDA approvals for some elements	Initial engagement with key members of the TDA to ensure there is sufficient understanding of technology roadmap and their involvement (12.7)		
	The development of a strategy to ensure we have a consistent approach to delivering benefits		Benefits are part of all the projects that are signed off by the relevant groups	(c) ensure that all divisions/CBUs have the approach to IM&T benefits as part of delivery projects	Increased engagement and communications with the relevant departments to ensure that we capture requirements and communicate benefits (12.5)		Aug 2013 CMIO or CIO depending on the type
				(a) production of a standard report on the delivery of benefits	Refine the proposal around benefits reporting to ensure we have a standard reporting methodology and that it is in line with trust expectations (12.6)		Sept 2013 CIO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

ACTION TRACKER FOR THE 2013/14 BOARD ASSURANCE FRAMEWORK (BAF)

Monitoring body (Internal and/or External):	Executive Team
Reason for action plan:	Board Assurance Framework
Date of this review	**May 2013**
Frequency of review:	Monthly
Date of last review:	April 2013

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
1	**Failure to achieve financial sustainability**					
1.1	Divisions to develop plans and trajectories to be monitored at monthly C&C meetings.	COO	DMs	May 2013	Complete	5
1.2	Revised variance analysis and reporting metrics especially for the ETPB (1.2)	DFBS	DDF&P	June 2013	Draft revised reporting will be submitted to the June ETPM	4
1.3	Review of non-contractual pay controls	DHR		Review June 2013	Change of action owner (previously DFBS). Review of progress to be provided next month.	4
1.4	Self-assessment exercise of embedding of SLM	DFBS	FTPM	June 2013	Self assessment questionnaire completed and reported to the ETSB in early June looking at all 4 themes. A complementary self assessment undertaken on the information indicator, predominately on the use of PLICS and SLR. The 4 themes to be each led by an Exec Director – DHR, DM&C, COO and DFBS	4
1.5	Refreshed CIP programme management arrangements	DFBS	HTCIP	Commenced May 2013 Review August 2013	Recently appointed (early May) interim Head of Trust Cost Improvement Programme to lead overall programme	4
1.6	Re-establishing clinical coding	COO	ADI	Review June	Change of action owner (previously	4

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
	improvement team under John Roberts. Initial action plan in place			2013	DFBS). Review of progress to be provided next month.	
1.7	Cash management plan to be presented at F&P committee	DFBS	FC	June 2013	Cash Management plan to be presented to the F&P Committee on 26 June 2013	4
1.8	Non-pay management plan to be presented at F&P committee	DFBS	ADP&S	June 2013	Non Pay Framework to be presented to the F&P Committee on 26 June 2013	4
2	**Failure to transform the emergency care system**					
2.1	Continued fortnightly meetings with HR to highlight delays and solutions in the recruitment process.	COO		Ongoing review of action	Complete	5
2.2	Continue to advertise for permanent and locum consultant positions	COO		Review May 2013	Complete	5
2.3	Head of Operations is working with community on process for increasing scope of beds available in community	COO	HO	July 2013	Complete	5
2.4	Via key stakeholders (medical, nursing and managerial) enforce steps to address the core issues	COO		N/A	Action removed during refresh of BAF as operational in nature	0
2.5	Recruitment to permanent ward nursing establishment.	COO	HoN - Acute	N/A	Action reworded following refresh of BAF entry (see action 2.7)	0
2.6	CD for ED and GM will validate all data entry	COO	CD and DM for ED	July 2013	Data entry has improved but still not 100%	3
2.7	Continue with substantive appts until funded establishment is achieved	COO		Review Sep 2013	On track	4
2.8	Roll out of actions from ECAT action plan	COO		June / July 2013	On track	4
2.9	CCG/LPT to increase capacity by use of Intermediate Care Services	COO		August 2013	DTOCs reduced but not at level required yet	3

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
2.10	Risks to be escalated via ECAT and raised with CCG Managing Director as required	COO		August 2013	On track	4
3	**Inability to recruit, retain, develop and motivate staff**					
3.1	Revise reward and recognition strategy.	DHR		October 2013	On track	4
3.2	Take baseline from January and measure progress now that there is a structured plan for bulk recruitment. Identify a lead from each professional group to develop and encourage the production of fresh and up to date material.	DHR		December 2013	On track	4
4	**Ineffective organisational transformation**					
4.1	'Lot 2' systems replacement plan to be developed.	DFBS	CIO	2013/14	Action removed during revision of BAF	0
5	**Ineffective strategic planning and response to external influences**					
5.1	Agree methodology for comprehensive Market Assessment	CEO		July 2013	Action removed during revision of BAF	0
5.2	Extend the scope of the Market Assessment to reflect agreed methodology	CEO		July 2013	Action removed during revision of BAF	0
5.3	Refresh and update the Market Assessment	CEO		July 2013	Action removed during revision of BAF	0
5.4	Define methodology for comprehensive horizon scanning and assign responsibility	CEO		July 2013	Action removed during revision of BAF	0
5.5	Agree methodology for acting on the results of the Market Assessment and horizon scanning	CEO		July 2013	Action removed during revision of BAF	0
5.6	Update the PESTLE & SWOT	CEO		July 2013	Action removed during revision of BAF	0

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
5.7	Forward plan Executive Strategy Board agendas to reflect a 12 month programme aligned with: • the development of the IBP/LTFM • the reconfiguration programme • the development of the next AOP • The TB Development Programme • The TB formal agenda	CEO		July 2013	Action removed during revision of BAF	0
5.8	Reflect aspirations of the Strategic Direction in the IBP/LTFM (5.8)	CEO		December 2013	Action removed during revision of BAF	0
5.9	Further, more extensive stakeholder engagement / consultation on the Trust's Strategic Direction	CEO		January 2014	Action removed during revision of BAF	0
5.10	Reflect clinical workforce implications of the Clinical Strategy in the IBP/LTFM/Workforce Plan	CEO		December 2013	Action removed during revision of BAF	0
5.11	Further, more extensive stakeholder engagement / consultation on the Trust's Strategic Direction	CEO		January 2014	Action removed during revision of BAF	0
5.12	Agree Strategy Director portfolio and appoint	CEO		July 2013	Action removed during revision of BAF	0
5.13	Establish Business Strategy Support Team	CEO		July 2013	Proposal to ET 11-6-13	4
5.14	Agree approach to gathering market intelligence and response via proposal from DMC.	CEO		July 2013	Proposal to ET 11-6-13	4

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
5.15	Present ESB forward plan for approval to July meeting.	CEO		July 2013	On track	4
6	**Failure to achieve FT status**					
6.1	Collaborative delivery programmes; establishing robust governance structures (programme director and collaborative delivery teams) to be agreed at BCT Board meeting 18/4/13.	CEO		May 2013	Action removed during revision of BAF	0
6.2	Trust Board consideration of the SOC (following high level option appraisal in July 2013).	CEO		August 2013	Action removed during revision of BAF	0
6.3	Collaborative delivery programmes to be agreed by the BCT Board / partner organisations	CEO		May 2013	Action removed during revision of BAF	0
6.4	Statutory consultation to commence Jun 2013 pending the output of the economic modelling and agreement of the resulting LLR wide plans.	CEO		June 2013	Action removed during revision of BAF	0
6.5	BCT communication and engagement plans to be developed for collaborative delivery programmes June/July 2013.	CEO		June / July 2013	Action removed during revision of BAF	0
6.6	Consultation timescales to be agreed pending defining the scope of the delivery programmes.	CEO		August 2013	Action removed during revision of BAF	0
6.7	Service developments underpinning the Trust's Clinical Strategy will be costed as further iterations of the IBP / LTFM are Developed.	CEO		May 2013	Action removed during revision of BAF	0
6.8	Action plans in place to address recommendations from independent reviews	CEO		June 2013	Action removed during revision of BAF	0

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
6.9	Introduce regular report to ESB and Trust Board	CEO		June 2013	To commence from June ESB	4
6.10	Director of Strategy to be Exec lead for BCT. Ad hoc cover to continue until appointment in place.	CEO		October 2013	Recruitment of DS in progress. Interim arrangements in place.	4
6.11	Action plans in place to address recommendations from independent reviews.	CEO		Review July 2013	Progressing to schedule	4
7	**Failure to maintain productive and effective relationships**					
7.1	Productive relationships with CCGs are likely to improve further only if UHL performance around ED improves therefore the target score is dependent upon actions from other risks within this document being taken.	DCER		N/A	Action removed from BAF and replaced with 7.2	0
7.2	Extend the surveys into wider group of stakeholders to complement the 'soft intel'	DCER		September 2013		3
8	**Failure to achieve and sustain quality standards**					
8.1	Better exploit use of routine data analysis tools including DFI and HED	MD		September 2013		3
8.2	Women's CBU to work with Dr Foster and other trusts to better understand risk adjustment model	MD		January 2014		3
8.3	Undertake LLR Mortality review.	MD		June /July 2013		3
8.4	Confirm Divisional representation to ensure engagement and delivery	CN		June 2013	Senior Lead reviewing group membership and identifying Divisional representatives	3
8.5	Active recruitment to ward nursing establishment so releasing ward sister – supervisory practice	CN		September 2013	On going recruitment process in place	3

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
8.6	Prioritise clinical staff development opportunities in CBUs/Division	CN		July 2013	Need to meet with Divisional staff gain agreement	3
8.7	Confirm Divisional representation to ensure engagement and delivery	CN		June 2013		4
8.8	Feasibility of a less cumbersome IT platform to be investigated by IBM.	CIO		June 2013	IBM and relevant leads for this action have been engaged and currently reviewing the options available producing a roadmap for this area by the end of June 2013.	4
9	**Failure to achieve and sustain high standards of operational performance**					
9.1	On-going work on ward processes in Acute to free up capacity.	COO		June 2013	Plan in place to release a ward to haematology to enable refurbishment although acute still occupy surgical ward	3
9.2	Re-configuration of surgical beds to create a 'protected area' for surgical patients.	COO	HO/DM Planned	November 2013	On track	4
9.3	Development of key metrics at a local level	COO		Review July 2013	On track	4
9.4	Urgent assessment of the gap between what is required and what is provided	COO	HPI	Review May 2013	Complete. Gaps in Imaging now identified	5
9.5	Cancer Clinical lead, Cancer Centre Managers and Trackers to be recruited.	COO	DM Planned	June 2013	On track	4
9.6	Continued monitoring of outpatient delivery plan.	COO	TT	Review June 2013	On track	4
9.7	Action plan to resolve Imaging issues to be developed	COO		July 2013		1
10	**Inadequate reconfiguration of buildings and services**					

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
10.1	Key measures for gauging success of strategy to be developed by specialties as part of their 'mini-IBPs' and will be monitored via divisional and directorate boards.	Medical Director		December 2013	On track	4
10.2	Ensure success of FT Application (see risk 6 for further detail)	Chief Executive Officer		April 2015	On track	4
10.3	Secure capital funding.	DFBS		~~May 2013~~ December 2013	Work underway on capital planning around reconfiguration – SOC due for completion in Dec '13 / Jan '14 which will be the key vehicle to agree availability of capital funding.	4
10.4	IM&T to be incorporated into Improvement and Innovation Framework.	Chief Executive Officer		May 2013	Complete. IM&T has been incorporated into the IIF which will get final approval at the June Board.	5
11	**Loss of business continuity**					
11.1	Tailored training packages for service area based staff. (11.1)	COO	EPO	July 2013	On track	4
11.2	Determine an approach to delivering a physical testing of the IT Disaster Recovery arrangements which have been identified as a dependency for critical services. Include assessment of the benefits of realistic testing of arrangements against the potential disruption of testing to operations	COO	CIO	September 2013	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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
11.3	Assess our requirements of the critical suppliers and ensure that their response fulfils our requirements.	COO	EPO	September 2013	On track – currently reviewing all responses to develop a benchmark criteria to assess resilience within suppliers	4
11.4	Review IT service continuity arrangements against the recovery requirements determined by the BIAs to validate existing arrangements.	COO	CIO	May 2013	This is completed but will be a continuing exercise to ensure IM&T recovery priorities meet the needs of Trust services	5
11.5	Complete BIA for outstanding CBU	COO	EPO	~~May 2013~~ June 2013	18 completed currently 6 in draft stage (awaiting final confirmation of details) 1 outstanding	3
11.6	Continue to engage with Interserve and service areas around development of Business Continuity Plans	COO	EPO	September 2013	Still no dedicated lead in Interserve to oversee BCM.	3
11.7	Issues/lesson will feed into the development of local plans and training and exercising events.	COO	EPO	September 2013	This will be a continual process and will feed into the first set of plans to be produced	4
11.8	Further processes require development, particularly with the new Facilities and IM&T providers to ensure resilience is considered/ developed when implementing new systems, infrastructure and processes.	COO	EPO	July 2013	IM&T – Completed, Emergency Planning and Head of Ops are consulted as part of the change board approval process. Interserve – Process still to be agreed	3
11.9	Emergency Planning Officer and Divisional BCM leads will ensure that plans developed are coordinated between service areas/CBUs/Divisions	COO	EPO/ Divisional BCM leads	September 2013	This will be a continual process and will feed into the first set of plans to be produced	4
11.10	Training and Exercising events to involve multiple CBUs/Divisions to validate plans to ensure consistency and coordination.	COO	EPO Divisional BCM leads	August 2014	BCM training and exercising programme has been developed.	4

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
12	**Failure to exploit the potential of IM&T**					
12.1	To be incorporated into Improvement and Innovation Framework.	CEO		May 2013	Complete. IM&T has been incorporated into the IIF which will get final approval at the June Board.	5
12.2	Formal meetings of the newly created advisory groups/ clinical IT groups to be re-established with new membership.	CIO	CMIO	June 2013	CMIOs have received representation from the divisions and are in process of setting up the formal meetings	4
12.3	An improved communications plan to be presented to the JGB for approval.	CIO		July 2013	Communications is now a standing item on the JGB agenda and an improved plan will be presented in June	4
12.4	Ensure clinical views are represented on the LLR IM&T Board.	CIO		June 2013	CMIOs have now been added as invitees to the meetings, as have the clinical (IM&T) leads from each of the CCGs with Dr Nick Pullman chairing the group	4
12.5	Increased engagement and communications with the relevant departments to ensure that we capture requirements and communicate benefits		CIO/ CMIO	August 2013	We have met with all divisions and produced a standard presentation Key stakeholders have been identified and have had an initial engagement around requirements and benefits Further activities are planned as part of specific projects or general communications	4

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
12.6	Refine the proposal around benefits reporting to ensure we have a standard reporting methodology and that it is in line with trust expectations	CIO		September 2013	Initial conversations have taken place with the IBM and benefits stakeholders. IBM have produced an approach to identification and realisation of benefits; this will need to be verified by the trust and amended to reflect our new "to-be" processes as part of the Innovation Framework	4
12.7	Initial engagement with key members of the TDA to ensure there is sufficient understanding of technology roadmap and their involvement	DFBS	CIO	Aug 2013	Initial conversations have happened, we now have their approvals paperwork and we are working through the implications.	4

Key to initials of leads

CEO	Chief Executive Officer
DFBS	Director of Finance and Business Services
MD	Medical Director
COO	Chief Operating Officer
DHR	Director of Human Resources
CN	Chief Nurse
DCER	Director of Communications and External Relations
CIO	Chief Information Officer
CMIO	Chief Medical Information Officer
EPO	Emergency Planning Officer
HPO	Head of Performance Improvement
HO	Head of Operations
CD	Clinical Director
DM	Divisional Manager
DDF&P	Deputy Director Finance and Procurement
FTPM	Foundation Trust Programme 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

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

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 TWO

UHL BOARD ASSURANCE FRAMEWORK SUMMARY REPORT – PERIOD ENDING MAY 2013

Risk No	Risk Title	Current Risk Score (May 13)	Previous Risk Score (Apr 13)	Target Risk Score and Final Action Date	Risk Owner	Comment
1	Failure to achieve financial sustainability	25	25	12 – Jun 13	DFBS	
2	Failure to transform the emergency care system	25	25	12 – review Sep 13	COO	
3	Inability to recruit, retain, develop and motivate staff	16	16	12 – Dec 13	DHR	
4	Ineffective organisational transformation	12	16	12	CEO	
5	Ineffective strategic planning and response to external influences	16	n/a	12 – Jul 13	CEO	New risk
6	Failure to achieve FT status	16	16	12 – Oct 2013	CEO	
7	Failure to maintain productive and effective relationships	15	15	10 – Sep 13	DCER	
8	Failure to achieve and sustain quality standards	16	n/a	12 – Sep 13	CN/MD	New risk (amalgamating 'patient experience/ satisfaction' and 'reducing avoidable harms')
9	Failure to achieve and maintain high standards of operational performance	12	n/a	12 – Jul 13	COO	New risk (replaces 'failure to achieve and sustain operational targets')
10	Inadequate reconfiguration of buildings and services	12	12	9 – Apr 13	DFBS	
11	Loss of business continuity	9	9	6 – Aug 14	COO	
12	Failure to exploit the potential of IM&T	9	n/a	6 – Sep 13	DFBS	New risk

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

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

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

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

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

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

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

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

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

8) Are the assigned risk scores realistic?

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

RISKS SCORING 15 OR ABOVE FOR THE PERIOD ENDING 31 MAY 2013

REPORT PRODUCED BY: UHL RISK AND ASSURANCE MANAGER

Key

Red	Extreme risk (risk score 25)
Orange	High risk (risk score 15 - 20)
Yellow	Moderate risk (risk score 8 - 12)
Green	Low risk (risk score below 8)
▲	Risk score increased from initial risk score
▼	Risk score decreased from initial risk score
★	New risk since previous reporting period
⇔	No Change in risk score since previous reporting period

Division	Directorate	Risk Title	Opened	Description of Risk	Risk subtype	Controls in place	Likelihood	Impact	Current Risk Score	Action summary	Target Risk Score	Risk Movement	Div/Exec Director	Strategic risk No.
Acute	Emergency Care	Overcrowding in ED	14/05/2013	Fire: Inability to evacuate safely; Burns / Respiratory harm; Damage to Property; Loss of life, contact injuries, crushing and panic injuries. Patients in close proximity on trolleys: Cross infection//contamination staff/patients/visitors; Loss of patient privacy and dignity; Loss of confidentiality of medical information; Poor patient and family experience; Inability/Difficulty accessing patients for medical examination/Emergency Situations; Medical and nursing staff adopting unnatural postures to carry out patient examination treatment and care; Increased manual handling of patients and movement of trolleys; Increased risk of needle-stick incidents; Increased risk of damage to equipment Staff shortages: Inability to provide patient care; Increased patient waiting times. Delayed diagnosis; Lack of specialty input to patient care. Increased waiting times/Delayed treatment: Assault/Abuse/Complaints needing to be handled; Loss of confidence/alarm and distress; Breach of 4 hour target. Inability to admit emergency ambulance arrivals into majors: Failure to provide timely treatment; Delay in EMAS Trust ability to attend 999 calls; Excess Staff pressure and demand: Staff illness; Increased risk of error; Increased risk of medication errors; Increased risk of poor comms. Ongoing care taking second place to delivering immediate care: Repeat engagement with patient, deterioration signs missed; ncreased risk of PUs. Unplanned, repeated patient movement in order to create space: Trips/ falls injuries; Cross contamination; Patients going missing; Patients self discharge. Performing patient diagnosis and treatment in open areas: Loss of privacy, dignity and confidentiality; Risk of medical error; Embarrassment and distress to other patients & visitors . Insufficient Medical devices and Equipment: Delay/ failure in diagnosis and treatment; Medication errors; reduced time for patient care; Poor patient experience. Insufficient bay availability in Resus: Resus patient in majors bay with risk of unnoticed deterioration and lower nurse:patient ratio; loss of Privacy/Dignity high risk of Serious Untoward Incidents; High acuity patients being cared for with inappropriate facilities and resources High lengths of stay: Breach of infection control policies; Increased risk of pre	Patients	Close adherence to UHL Escalation policies Regular risk stratification of patient dependency level and infection risk to maximise use of all possible floor space Adherence to ED internal Minimal Professional Standards when possible, and alerting senior staff when these are breached New expanded Majors Assessment Bay area (March 2013) Restructuring of acute flow processes by Right Place, Right Time consultancy firm 2013	Extreme	Extreme	25	Notify Executive Team and non-executive directors of direct risks of overcrowding - 31/5/2013 Multidisciplinary working party within ED to create action cards for green, amber and red states of overcrowding - 31/5/2013 Request dedicated cleaning staff 24/7 to mitigate infection control risks - 31/5/2013 Request that UHL escalation policies include decanting of ED patients as soon as agreed thresholds of over-crowding are reached - 31/5/2013	9	★	PR/COO	2

Division	Directorate	Risk Title	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Movement	Div/Exec Director	Strategic risk No.
Acute	All	Risk of ePMA system deadlocking	13/05/2013	Electronic prescribing and administration system (ePMA) is currently experiencing numerous issues with users sessions being terminated as a result of "deadlocks" on the system. **Causes:** A deadlock happens when a user accesses a record and the record is not released correctly - this results in the record being locked and terminates the users login. **Consequences:** As a result of this fault with the application the administration of medication is not being recorded correctly. This is forcing users to have to log back into the system and re-enter the administration or prescription history (After the event). In the case of nurses this is happening on multiple occasions on 1 single drug round. The missed administration of medication poses a significant clinical risk of either double dosing or the patient missing their medication all together.	Patients	IM&T have added an extra CPU to the Support Module Server for ePMA which has seen a marked improvement on the performance of the Support Module. Communication to wards utilising ePMA to ask that they never leave the electronic chart blank and to persist with issues with the system to ensure all information pertaining to drug administration is accurately recorded. Worse case scenario the communication is to revert back to using a paper drug chart. The ePMA trainers continue to support Ward 15/16/33 whilst we seek resolution on this issue. Also trainers are closely working with AMU on the design and development of a paper chart for those patients that are acutely unwell. Any further go lives in UHL have been put on hold until resolution is met.	Extreme	Likely	20	CSC the provider of the software will provide an interim fix. This will not fix the problem completely, however it will reduce the likelihood of occurrence - due 27/05/2013. CSC the provider will identify a complete fix for deadlocking - 29/07/13.	5	★	PR/DFBS	12