Trust Board paper P

To:	**Trust Board**
From:	**Rachel Overfield - Chief Nurse**
Date:	**26 June 2014**
CQC regulation:	Outcome 16 – Assessing and Monitoring the Quality of Service Provision

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

Author/Responsible Director: Chief Nurse

Purpose of the Report:

The report provides the Board with an updated BAF and oversight of any new extreme and high risks opened within the Trust during the reporting period. The report includes:-

a) A copy of the BAF as of 31 May 2014.
b) An action tracker to monitor progress of BAF actions
c) New extreme and/ or high risks opened during the reporting period.
d) An update of progress with the review and development of a 2014/15 BAF.

The Report is provided to the Board for:

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

Summary :

- This 'interim' 2014/15 BAF provides a continuation of the previous 2013/14 BAF until such time that a full review of the contents is completed.
- The TB is asked to note the following points :

  a. In relation to action 1.24; the question as to whether it will be possible to complete the IBP and SOC at the same time.

  b. In relation to action 1.30; the change from a green to an amber rating due to delays caused by the lack of agreement on the consequences of fines and penalties.

  c. In relation to action 9.15 the reduction in the total number of additional beds to be opened from 44 to 18.

  d. In relation to action 13.8 the further slippages of the completion date to November 2014 due to delays in the tendering process for works.

  e. Updates to actions under the ownership of the CIO have not been possible due to annual leave of the CIO.
- The following three BAF entries are suggested for review.
  Risk 1 – Failure to achieve financial sustainability
  Risk 12 – Failure to exploit the potential of IM&T
  Risk 13 – Failure to enhance education and training culture
- The production of a fully revised 2014/15 BAF is delayed pending agreement of the principal risks for inclusion. It is anticipated that this will be produced for the July 2014 TB meeting.
- Three new high risks have been opened on the UHL register during May 2014.

Trust Board paper P

Recommendations:

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

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

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

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

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

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

(f) Note the requirement for principal risks to be identified by the TB before further work on the revised 2014/15 BAF can commence.

Board Assurance Framework	**Performance KPIs year to date**
Yes	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: **26th JUNE 2014**

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

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

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1. INTRODUCTION

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

a) A copy of the interim BAF as of 31 May 2014.
b) An action tracker to monitor progress of BAF actions.
c) Notification of any new extreme or high risks opened during the reporting period.
d) An update of progress with the review and development of a 2014/15 BAF

2. BAF POSITION AS OF 31 MAY 2014

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

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

2.3 The TB is asked to note the following points :

a. In relation to action 1.24; the question as to whether it will be possible to complete the IBP and SOC at the same time.

b. In relation to action 1.30; the change from a green to an amber rating due to delays caused by the lack of agreement on the consequences of fines and penalties. Following intervention by NHSE/TDA regarding the application of local fines and penalties the Trust is in a position to agree a contract and a proposal is now awaited from the CCG.

c. In relation to action 9.15 the reduction in the total number of additional beds to be opened from 44 to 18.

d. In relation to action 13.8 the further slippages of the completion date to November 2014 due to delays in the tendering process for works.

e. Updates to actions under the ownership of the CIO have not been possible due to annual leave of the CIO therefore updates to actions due for completion in May will be presented in the July BAF report to the TB

2.4 To provide an opportunity for more detailed scrutiny the following three BAF entries are suggested for review against the parameters listed in appendix three.

- Risk 1 – Failure to achieve financial sustainability
- Risk 12 – Failure to exploit the potential of IM&T
- Risk 13 – Failure to enhance education and training culture

3 REVIEW OF PROGRESS IN THE DEVELOPMENT OFTHE 2014/15 BAF

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

- Establish strategic objectives (and their owners).
- Identify the principal risks to the achievement of the objectives (and, in addition, identifying the risk owners).
- Identify the key controls that are at our disposal to achieve the objective and control the principal risks.
- Identify the mechanisms by which the Board receives assurance (positive or negative) that the controls are effective.
- Identify any gaps in control or gaps in assurance
- Put in place plans to address any gaps

3.2 Best practice dictates that the TB *'must be appropriately engaged in developing and monitoring the BAF'* (ref. Board Assurance Frameworks – Good Governance Institute 2009). This includes involvement in the identification of principal risks (ref. Building an Assurance framework – A Practical guide for NHS Boards – Dept. of Health 2003).

3.3 Principal risks should wherever possible be aligned with the UHL 5 year integrated business plan (IBP) that sets out the road map of how our strategic objectives will be achieved. To do otherwise would mean that the TB may not be seeking assurance in relation to the correct risks. It was therefore felt prudent to delay the complete revision of the 2014/15 BAF until the IBP was approved in principle by the TB at the meeting on 16 June 2014. It is important for the TB to be engaged in the identification of the principal risks (see 3.2) and further work will be required to distil the 50 - 60 risks contained in the IBP into a set of principal risks for inclusion in the BAF. It must be noted that the identification of appropriate principal risks is the key to an accurate BAF and further work on the BAF will not be able to commence until this is complete.

3.4 Taking into account section 3.3 it is not possible to provide the Board with a fully revised 2014/15 BAF and it is now anticipated that this will be produced for the July 2014 TB meeting.

4. EXTREME AND HIGH RISK REPORT.

4.1 Three new high risks have opened during May 2014 as described below. The details of these risks are included at appendix four for information

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Risk ID	Risk Title	Risk Score	CMG/Corporate Directorate
2339	Potential risk to Renal transplant patients as a result of deterioration of team working & deviation from policy	20	RRC

	and procedures		
2338	There is a risk of patients not receiving medication and patients receiving the incorrect medication due to an unstable homecare	16	Medical Directorate
2341	Long term follow up outpatient appointments not made	16	Operations

5. RECOMMENDATIONS

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

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

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

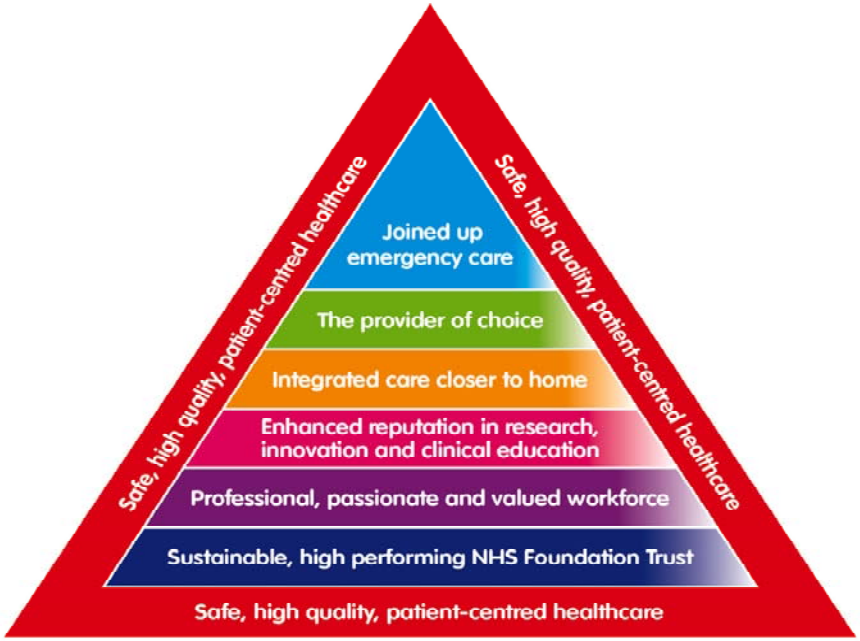
(c) identify any areas which it feels that the Trust's controls are inadequate and do not, therefore, effectively manage the principal risks to the organisation achieving its objectives;

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

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

(f) Note the requirement for principal risks to be identified by the TB before further work on the revised 2014/15 BAF can commence.

Peter Cleaver,
Risk and Assurance Manager,
19 June 2014.


Safe, high quality, patient-centred healthcare
Safe, high quality, patient-centred healthcare
Joined up emergency care
The provider of choice
Integrated care closer to home
Enhanced reputation in research, innovation and clinical education
Professional, passionate and valued workforce
Sustainable, high performing NHS Foundation Trust
Safe, high quality, patient-centred healthcare

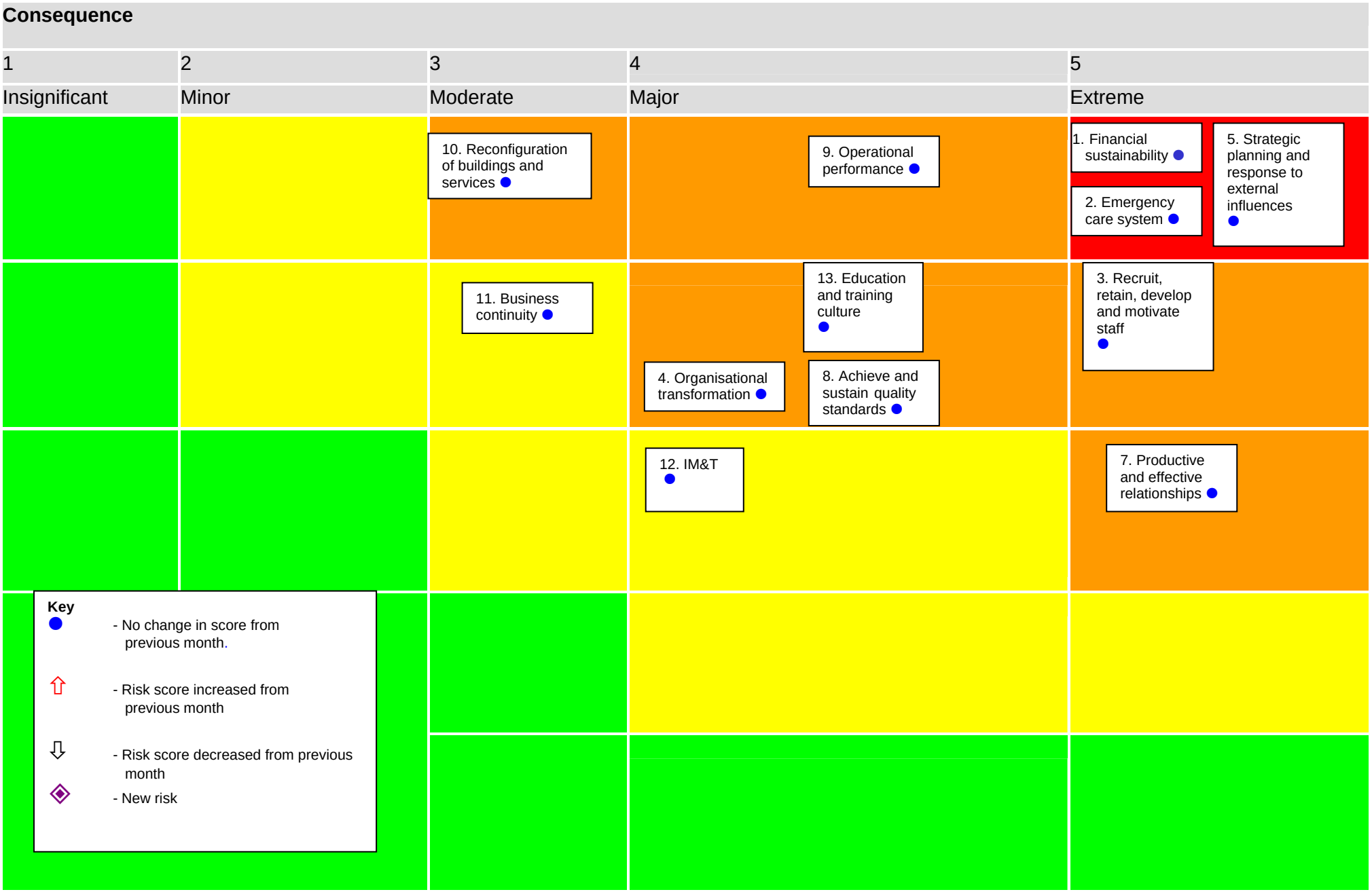
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK (INTERIM) MAY 2014

PERIOD: MAY 2014

RISK TITLE	STRATEGIC OBJECTIVE	CURRENT SCORE	TARGET SCORE
Risk 1 – Failure to achieve financial sustainability	g - To be a sustainable, high performing NHS Foundation Trust	25	20
Risk 2 – Failure to transform the emergency care system	b - To enable joined up emergency care	25	12
Risk 3 – Inability to recruit, retain, develop and motivate staff	f - To maintain a professional, passionate and valued workforce e - To enjoy an enhanced reputation in research, innovation and clinical education.	20	12
Risk 4 – Ineffective organisational transformation	a - To provide safe, high quality patient-centred health care c - To be the provider of choice d - To enable integrated care closer to home	16	12
Risk 5 – Ineffective strategic planning and response to external influences	a - To provide safe, high quality patient-centred health care c - To be the provider of choice g - To be a sustainable, high performing NHS Foundation Trust	25	12
Risk 6 – **Risk deleted from BAF following approval of Trust Board**	**Not applicable**	**N/A**	**N/A**
Risk 7 – Failure to maintain productive and effective relationships	c - To be the provider of choice d - To enable integrated care closer to home f - To maintain a professional, passionate and valued workforce	15	10
Risk 8 – Failure to achieve and sustain quality standards	a - To provide safe, high quality patient-centred health care c - To be the provider of choice	16	12
Risk 9 – Failure to achieve and sustain high standards of operational performance	a - To provide safe, high quality patient-centred health care	20	12
Risk 10 – Inadequate reconfiguration of buildings and services	a - To provide safe, high quality patient-centred health care	15	9
Risk 11– Loss of business continuity	g - To be a sustainable, high performing NHS Foundation Trust	12	6
Risk 12 – Failure to exploit the potential of IM&T	a - To provide safe, high quality patient-centred health care d - To enable integrated care closer to home	12	6
Risk 13 - Failure to enhance education and training culture	e – To enjoy an enhanced reputation in research, innovation and clinical education	16	6

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

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



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

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to deliver recurrent balance	Standing Financial Instructions & Standing Orders Overarching Financial Governance Processes	5x5=25	Monthly progress reports to F&P Committee, Executive Board, & Trust Board Development Sessions TDA Monthly Meetings Chief Officers meeting CCGs/Trusts TDA/NHSE meetings Trust Board Monthly Reporting UHL Programme Board, F&P Committee, Executive Board & Trust Board	(c) Varying level of financial understanding/ control within the organisation. (c) Lack of supporting service strategies to deliver recurrent balance	Finance Training Programme (1.21) Production of a FRP to deliver recurrent balance within five years (1.22) Health System External Review to define the scale of the financial challenge and possible solutions (1.23) Production of UHL Service & Financial Strategy including Reconfiguration/SOC (1.24)	5x4=20	Jun 2014 IDFS Jun 2014 IDFS Jun 2014 IDFS Jun 2014 IDFS

Failure to achieve CIPs	Establishment of Weekly CIP Meetings Executive ownership of cross CIP cutting themes Engagement of Ernst & Young to provide external support to the delivery of the programme Executive Sign off of Plans Establishment of CIP Board Establishment of Project Management Office Short Term Expenditure Reserves CIP Performance Management as part of Integrated Performance Management		Weekly Progress meetings with CEO, COO, FD Monthly Reports to F&P Committee Trust Board Development Sessions Formal sign off documents with CMGs as part of agreement of IBPs Weekly meetings Briefings to Trust Board, F&P Committee, Executive Board regarding establishment of PMO Weekly meeting with Ernst & Young to formalise progress	(c) CIP Quality Impact Assessments not yet agreed internally or with CCGs (c) PMO structure not yet in place to ensure continuity of function following departure of Ernst & Young	Expedite agreement of CIP quality impact assessments both internally and with CCGs. (1.25) PMO Arrangements need to be finalised (1.26)		This is a continuous process therefore review July 2014 IDFS Jun 2014 IDFS
Failure to effectively manage financial performance	Monthly CMG Performance Reviews Escalation meetings at FD/COO level Internal Contracts Management Group Revised Integrated Performance Management Process Revised financial reporting to Trust Board, Executive Performance Board and F&P Committee 2014/15 'budget book/ financial plan		Formal documentation for sign off Report to Trust Board, F&P Committee and Executive Board Formal approval of process by Executive Board Agenda, action notes and supporting papers for meetings Schedule of meetings	(c) The organisation has not effectively identified its service model. (c) Varying level of financial understanding/ control within the organisation. (c) Finance department having difficulties in recruiting to finance posts leading to temporary staff being employed. (	Finance Training Programme (1.21) Restructuring of financial management via MoC (1.28)		Jun 2014 Jul 2014
Failure to agree financially and operationally deliverable contracts	Contract Arbitration & TDA Mediation Internal Contracts Group -		Agreed contracts document through the dispute resolution process/arbitration Regular updates to F&P Committee, Executive Board, Escalation meeting between CEOs/CCG Accountable Officers	(c) Failure to agree appropriate levels of financial impact for QIPP, fines and penalties and MRET. (c) Failure to agree levels of operational performance in relation to the above.	Negotiate realistic contracts with CCGs and Specialised Commissioning - QIPP - Fines & Penalties - MRET rebase - Counting & Coding - CCG Non Recurring Funding (1.30)		Jun 2014 IDFS

Failure to receive capital funding	Capital Group Established TDA Monthly IDM Meeting IBM Commercial Sub Group to Joint Governance Board Link to Strategy & SOC Assessment of affordability of Business Cases and consistency with financial recovery Link to Health Systems Review and Service Strategy		UHL Programme Board, Trust Board, F&P Committee and Capital Group Agreement through Commercial Executive (or it's replacement), F&P Committee and Trust Board Health Economy Steering Group, FD's Sub-Group Regular reports to F&P Committee, Trust Board and Executive Board	(c) Lack of clear strategy for reconfiguration of services.	Production of Business Cases to support Reconfiguration and Service Strategy (1.31)		Jun 2014 IDFS

Failure to obtain sufficient cash resources	Agreeing short term borrowing requirements with TDA Short Term borrowing applications Formalised arrangements with TDA/CCGS Escalation to TDA Rolling cash-flow forecasts Cash-flow Monitoring/Reporting		Board reporting and F&P Committee review of cash flow Integral to Service & Financial Strategy UHL Programme Board, F&P Committee, Executive Board and Trust Board Reports to F&P Committee Trust Board and F&P Committee reporting	**(c)** Lack of service strategy to deliver recurrent balance	Agreeing long term loans as part of June Service & Financial Plan (1.32)		Jun 2014 IDFS

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to transform emergency care system leading to demands on ED and admissions units continuing to exceed capacity.	Health Economy has submitted response plan to NHSE requirements for an Emergency Care system under the A&E Performance Gateway Reference 00062.	5x5=25	Once plan agreed with NTDA, it will be circulated to the Board.	No gaps	No actions	4x3=12	
	Emergency Care Action Team formed. Chaired by Chief executive to ensure Emergency Care Pathway Programme actions are being undertaken in line with NHSE action plan and any blockages to improvement removed. Development of action plan to address key issues.		Action Plan circulated to the Board on a monthly basis as part of the Report on the Emergency Access Target within the Quality and Performance Report.	Gaps described below	Actions described below		
	A new plan has been submitted detailing a clear trajectory for performance improvement and includes key themes from plan: Single front door.		Project plan developed by CCG project manager Risks from 'single front door' to be escalated via ECAT and raised with CCG Managing Director as required.	No gaps	No actions		
	ED assessment process is being operated.		Forms part of Quality Metrics for ED reported daily update and part of monthly board performance report.	No gaps	No actions		
	Recruitment campaign for continued recruitment of ED medical and nursing staff including fortnightly meetings with HR to highlight delays and solutions in the recruitment process.		Vacancy rates and bank/agency usage reported to Trust Board on a monthly basis. Recruitment plan being led by HR and monitored as part of ECAT.	(c) Difficulties are being encountered in filling vacancies within the emergency care pathway. Agency and bank requests continue to increase in response to increasing sickness rates, additional capacity, and vacancies. (c) Staffing vacancies for medical and nursing staff remain high.	Continue with substantive appts until funded establishment is achieved. (2.7)		Review Jun 2014 COO

	Formation of an EFU and AFU to meet increased demand of elderly patients.		'Time to see consultant' metric included in National ED quarterly indicator.	No gaps	No actions		
	Maintenance of AMU discharge rate above 40%.		Reported to Operational Board twice monthly and will be included in Emergency Care Update report in Q&P Report.	No gaps	No actions		
	New daily MDT Board Rounds on all medical wards and medical plans within 24hrs of admission.		Reported to Operational Board twice monthly and will be included in Emergency Care Update report in Q&P Report.	No gaps	No actions		
	EDDs to be available on all patients within 24 hours of admission. Review built in to daily discharge meetings to check accuracy of EDDs (from 2/09/13).		Monitored and reported to Operational Board twice monthly and will be included in Emergency Care Update report in Q&P report.	No gaps	No actions		
	Maintain winter capacity in place to allow new process to embed.		All winter capacity beds are to be kept open until the target is consistently met.	No gaps	No actions		
	DTOCs to be kept to a minimal level by increasing bed capacity. 24 Additional beds available from December 2013.		Forms part of the Report on Emergency Access in the Q&P Report.	No gaps	No actions		

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inability to recruit, retain, develop and motivate suitably qualified staff leading to inadequate organisational capacity and development.	Leadership and talent management programmes to identify and develop 'leaders' within UHL.	4x5=20	Development of UHL talent profiles.	No gaps identified.	No actions required.	4x3=12	
			Talent profile update reports to Remuneration Committee.	No gaps identified.	No actions required.		
	Substantial work program to strengthen leadership contained within OD Plan.			No gaps identified.	No actions required.		
	Organisational Development (OD) plan.		A central enabler of delivering against the OD Plan work streams will be adopting, 'Listening into Action' (LiA) and progress reports on the LiA will be presented to the Trust Board on a quarterly basis.	No gaps identified.	No actions required.		
	A central enabler of delivering against the OD Plan work streams will be adopting, 'Listening into Action (LiA). A Sponsor Group personally led by our Chief Executive and including, Executive Leads and other key clinical influencers has been established.		Progress reports on the LiA will be presented to the Trust Board on a quarterly basis.	No gaps identified. No gaps identified.	No actions required. No actions required.		
	Staff engagement action plan encompassing six integrated elements that shape and enable successful and measurable staff engagement.		Results of National staff survey and local patient polling reported to Board on a six monthly basis. Improving staff satisfaction position.	No gaps identified.	No actions required.		
			Staff sickness levels may also provide an indicator of staff satisfaction and performance and are reported monthly to Board via Quality and Performance report	No gaps identified	No actions required.		

	Appraisal and objective setting in line with UHL strategic direction. Local actions and appraisal performance recovery plans/ trajectories agreed with CMGs and Directorates Boards.		Appraisal rates reported monthly to Board via Quality and Performance report. Appraisal performance features on CMG / Directorate Board Meetings to monitor the implementation of agreed local actions.				
	Summary of quality findings communicated across the Trust; to identify how to improve the quality of the appraisal experience for the individual and the quality of appraisal meeting recording.		Results of quality audits to ensure adequacy of appraisals reported to the Board via the quarterly workforce and OD report.	No gaps identified.	No actions required.		
			Appraisal Quality Assurance Findings reported to Trust Board via OD Update Report June 2013 Quality Assurance Framework to monitor appraisals on an annual cycle (next due March 2014).	No gaps identified.	No actions required.		
	Workforce plans to identify effective methods to recruit to 'difficult to fill areas). CMG and Directorates 2013/14 Workforce Plans. Active recruitment strategy including implementation of a dedicated nursing recruitment team. Programme of induction and adaptation for international pool of nurses.		Nursing Workforce Plan reported to the Board in September 2013 highlighting demand and initiatives to reduce gap between supply and demand. The use of locum staff in 'difficult to fill' areas is reported to the Board on a monthly basis via the Q&P report. Reduction in the use of such staff would be an assurance of our success in recruiting substantive staff.	(c) Risks with employing high number from an International Pool in terms of ensuring competence	Develop an employer brand and maximise use of social media (3.9).		Jul 2014 DHR
	Reward /recognition strategy and programmes (e.g. salary sacrifice, staff awards, etc). Recruitment and Retention Premia for ED medical and nursing staff.				Development of Pay Progression Policy for Agenda for Change staff (3.3).		Sep 2014 DHR
	UHL Branding – to attract a wider and more capable workforce. Includes development of recruitment literature and website, recruitment events, international recruitment. Recruitment progress is measured now there is a structured plan for bulk recruitment. Leads have been identified to develop and encourage the production of fresh and up to date recruitment material. Reporting and monitoring of posts with 5 or less applicants.		Evaluate recruitment events and numbers of applicants. Reports issued to Nursing Workforce Group. Reporting will be to the Board via the quarterly workforce an OD report. Quarterly report to senior HR team and to Board via quarterly workforce and OD report.	(a) Better baselining of information to be able to measure improvement. (c) Lack of engagement in production of website material.			

	Statutory and mandatory training programme (e-learning) for 10 key subject areas in line with National Core Skills Framework.		Monthly monitoring of statutory and mandatory training attendance data from e-UHL via reports to TB and ESB against 9 key subject areas (				

RISK NUMBER/ TITLE:	**RISK 4 – INEFFECTIVE ORGANISATIONAL TRANSFORMATION**						
LINK TO STRATEGIC OBJECTIVE(S)	**a. - To provide safe, high quality patient-centred health care.** **c. - To be the provider of choice.** **d. - To enable integrated care closer to home**						
EXECUTIVE LEAD:	Director of Strategy						
Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?

Failure to put in place a robust approach to organisational transformation, adequately linked to related initiatives and financial planning/outputs.	Developing an integrated business plan based upon an overarching strategy for UHL supported by service based strategies. Ensuring that the 2 year operating plan and the 5 year strategy describe the outputs of the clinical strategy and workforce strategy and reflect the estates and financial consequences Engaging in the BCT 2014 programme to ensure cross LLR alignment and ensuring that, allowing for appropriate transition our 2 year and 5 year plans reflect direction of travel in respect of system wide clinical service (and wider social care transformation e.g. more care, closer to home where it is safe and cost effective to do so. Implementing the 'Delivering Caring at its Best' work programmes and put the clear governance arrangements in place Cross LLR capacity and activity plan. Capacity planning workshop with all CMGs to build internal capacity and capability	4x4=16	Delivery of 'Delivering Caring at its Best' work programmes will be formally reported through sub-committees of the Board. This requires alignment with the whole local Health Economy change programme Better Care Together 2014 Track delivery against key programme metrics and CMG based delivery targets through ESB, EPB and Trust Board Monitored through the LLR Better Care Together 2014 programme	(c) Gaps are evident in the alignment of transformational process between UHL and principle partners – this is being raised through the Better Care Together Programme structures. (c) Gaps are evident in medium term capacity planning across the Trust and LLR	Review outputs from Chief Officers Group and strategic Planning Group to ensure gaps in current processes are being addressed (4.1). The LLR BCT 2014 planning process will support and facilitate the development and agreement of an LLR wide capacity plan in May/June 2014 (4.3)	4x3=12	Jun 2014 DS Jun 2014 DS

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?

Failure to put in place appropriate systems to horizon scan and respond appropriately to external drivers. Failure to proactively develop whole organisation and service line clinical strategies.	Integrated business planning processes in place across CMGs. Forward programme developed. CMG Strategy Leads now engaged in the Business and Strategy Support Teams (BSST) meetings to improve engagement, alignment and teamwork. ESB forward plan to reflect a 12 month programme aligned with: • the development of the IBP/LTFM • the reconfiguration programme • the development of the next AOP • The TB Development Programme. The TB formal agenda Processes now in place to deliver a rolling 2 year operational plan based upon a 5 year strategic plan.	5x5=25	Weekly strategic planning meetings in place – cross CMG and corporate team attendance with delivery led through the Strategy Directorate. Progress reported through reports to ESB and Trust Board Development of a clear, clinically based 5 year strategic for Trust Board sign off in June 2014 and subsequent TDA sign off by the TDA will provide assurance that strategic planning is taking place. Reports to ESB. Regular reports to TB reflecting progress against 12 month rolling programme.	.(c) No high level plan yet developed	High level plan for the Trust to be developed. (5.16)	4x3=12	Jun 2014

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?

Failure to maintain productive relationships with external partners/ stakeholders leading to potential loss of activity and income, poor reputation and failure to retain/ reconfigure clinical services.	Stakeholder Engagement Strategy including engagement with the Trust's Commissioners	5X3=15	Twice yearly GP surveys with results reported to UHL Executive Team. Latest survey results discussed at the April 2013 Board and showed increasing levels of satisfaction… a trend which has now continued for 18 months. Annual Reputation / Relationship survey to key professional and public stakeholders Nov 13.	(c) No external and 'dispassionate' professional view of stakeholder / relationship management activity.	Invite PWC (Trust's Auditors) to offer opinion on the plan / talk to a selection of stakeholders. (7.3)	5X2=10	Jul 2014 DCM
	Regular meetings with external stakeholders and Director of Communications and member of Executive Team to identify and resolve concerns.						
	Regular stakeholder briefing provided by an e-newsletter to inform stakeholders of UHL news.						
	Leicester, Leicestershire and Rutland (LLR) health and social care partners have committed to a collaborative programme of change ('Better Care Together').						
	The Board to meet 3 times per year in external venues hosted by stakeholders						
	The Chairman, with CCG colleagues hosts regular meetings with CCG lay members to improve dialogue and understanding and foster a culture of teamwork between providers and commissioners.						
	A joint report by local Healthwatch organisations to be included in Trust Board papers as a means of bringing community and stakeholder views to the Board's attention.						

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	Current Score I x L	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	Target Score I x L	**Timescale** When will the action be completed?

Failure to achieve and sustain quality standards leading to failure to reduce patient harm with subsequent deterioration in patient experience/ satisfaction/ outcomes, loss of reputation and deterioration of 'friends and family test' score.	Standardised M&M meetings in each speciality.	4x4=16	Routine analysis and monitoring of out of hours/weekend mortality at CMG Boards.	No gaps.	No action needed.	4x3=12	
	Systematic speciality review of "alerts" of deterioration to address cause and agree remedial action by Mortality Review Committee. All deaths in low risk groups identified. Working with DFI to ensure data has been recorded accurately.		Quality and Performance Report and National Quality dashboard presented to ET and TB. Currently SMHI "within expected" (i.e. 107 based on HSCIC data from July 12 to June 13). UHL subscribes to the Hospital Evaluation Dataset (HED) which is similar to the Dr Foster Intelligence clinical benchmarking system but also includes a 'SHMI analysis tool'. Independent analysis of mortality review performed by Public Health. Results reported at November 2013 TB meeting.	(a) UHL risk adjusted perinatal mortality rate above regional and national average.			
	Agreed patient centred care priorities for 2013-14: - Older people's care - Dementia care - Discharge Planning		Quality Action Group meets monthly. Achievement against key objectives and milestones report to Trust board on a monthly basis. A moderate improvement in the older people survey scores has been recorded.	No gaps identified.	No action needed.		
	Multi-professional training in older peoples care and dementia care in line with LLR dementia strategy.		Quality Action Group monitoring of training numbers and location.	No gaps identified.	No action needed.		
	Protected time for matrons and ward sisters to lead on key outcomes.		CMG/ specialty reporting on matron activity and implementation or supervisory practice.	(c) Present vacancy levels prevent adoption of supervisory practice.	Active recruitment to ward nursing establishment so releasing ward sister –for supervisory practice (8.5).		Sep 2014 CN
	Promote and support older people's champion's network and new dementia champion's network.		Monthly monitoring of numbers and activity.	No gaps identified.	No action needed.		
	Targeted development activities for key performance indicators - answering call bells - assistance to toilet - involved in care - discharge information		Monthly monitoring and tracking of patient feedback results. Monthly monitoring of Friends and Family Test reported to the Board				

	Quality Commitment 2013 – 2016: • Save 1000 extra lives • Avoid 5000 harm events • Provide patient centred care so that we consistently achieve a 75 point patient recommendation score.		Quality Action Groups monitoring action plans and progress against annual priority improvements. A Quality Commitment dashboard has been developed to present updates to the TB on the 3 core metrics for tracking performance against our 3 goals. These metrics will be tracked up to 2015. Impressive drops in fall numbers have been observed in Datix reports and in the Safety Thermometer audit. Quality commitment has been refreshed and aligned with the components of quality (experience, safety, effectiveness) that the Trust is undertaking				
	Relentless attention to 5 Critical Safety Actions (CSA) initiatives to lower mortality.		Q&P report to TB showing outcomes for 5 CSAs. 4CSAs form part of local CQUIN monitoring and there is full compliance against agreed action plans. Full CQUIN funding received	(c) Lack of a unified IT system in relation to ordering and receiving results means that many differing processes are being used to acknowledge/respond to results. Potential risk of results not being acted upon in a timely fashion.	Implementation of Electronic Patient Record (EPR). (8.10)		2015 CIO

	NHS Safety thermometer utilised to measure the prevalence of harm and how many patients remain 'harm free' (Monthly point prevalence for '4 Harms'). Monthly meetings with operational/clinical and managerial leads for each harm in place.		Monthly outcome report of '4 Harms' is reported to Trust board via Q&P report. There are no areas of concern in relation to the prevalence of New Harms.	(a) There is some concern that the revised DH monitoring tool is still not an effective measure to produce accurate information. Local actions to resolve this are not practicable.			

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to achieve and sustain operational targets leading to contractual penalties, patient dissatisfaction and poor reputation.	Referral to treatment (RTT) backlog plans (patients over 18 weeks) and operational performance of 90% (for admitted) and 95 % (for non-admitted). Further recovery plans for RTT performance agreed by Commissioners Use of independent sector for key specialties. Reissue across UHL of cancelled operations policy UHL action plan signed off by Commissioners (to reduce cancellations on the day for non-clinical reasons to <0.8%and rebook within 28days)	4x5=20	Key specialities in weekly performance meetings with COO to implement plans. Monthly monitoring of RTT performance recovery plans Daily RTT performance and prospective reports to inform decision making. Weekly patient level reporting meeting for all key specialties. Monthly Q&P report to Trust Board showing 18 week RTT performance. Operational group meeting alternate weeks Operational improvement plan in place Weekly monitoring and actioning 28 day rebooking via access meeting Monthly report to Trust Board and commissioners	(c) Inadequate elective capacity. (c) Not creating ring-fenced elective capacity to prevent cancellations due to no beds on the day	To open an additional 18 beds (9.15)	4x3=12	COO Aug 2014
	Transformational theatre project to improve theatre efficiency to 80 -90%.		Monthly theatre utilisation rates. Theatre Transformation monthly meeting. Transformation update to Board.	No gaps identified.	No actions required.		

	Emergency Care process redesign (phase 1) implemented 18 February 2013 to improve and sustain ED performance.		Monthly report to Trust Board in relation to Emergency Dept (ED) flow (including 4 hour breaches).	See risk number 2.	See risk number 2.		
	Cancer 62 day performance - Tumour site improvement trajectory agreed and each tumour site has developed action plans to achieve targets. Senior Cancer Manager appointed. Lead Cancer Clinician appointed. Action plan to resolve Imaging issues implemented.		Cancer action board established and weekly meetings with all tumour sites represented. Monthly trajectory agreed and Cancer action plan agreed with CCGs and reported and monitored at Executive Performance board. Chief Operating Officer receives reports from Cancer Manager and 62 day performance included within Monthly Q&P report to Trust Board. The ongoing management of cancer performance is carried out by a weekly cancer action board to provide operational assurance. Performance against 62 day standard has been achieved for the past 6 months. Commissioners have formally removed the contract performance notice in relation to 62 day standard.	No gaps identified.	No actions required.		

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inadequate reconfiguration of buildings and services leading to less effective use of estate and services.	Reviewing and refreshing our Clinical Strategy. LLR Better Care Together 2014 Strategy	3x5=15	Trust Board development session on development of approach to strategic planning and development of strategic case for change. On-going monitoring of service outcomes by MRC to ensure outcomes improve. Improvement in health outcomes and effective Infection Prevention and Control practices monitored by Executive Quality Board (Q+P report) with escalation to ET, QAC and TB as required.	(a) Service specific KPIs not yet identified for all services.	Iterative development of operational and strategic plans (10.5)	3X3=9	Jun 2014 DS
	Review and refresh of our current Estates Strategy to ensure that it will support the delivery of an Estates solution that will be a key enabler for our clinical strategy. Reconfiguration Programme working with clinicians to develop a 'preferred' way forward' completed.		Trust Board development sessions and Board reports in respect of estate related developments over a 2 year and 5 year time horizon. Facilities Management Collaborative (FMC) monitors operational estate delivery against agreed KPIs to provide assurance of successful outsourced service.	(c) Estates plans not fully developed to achieve the strategy.	Reconfiguration programme to develop a strategic outline case which will inform the future estate strategy (10.6)		Jun 2014 DS
				The success of the plans will be dependent upon capital funding beyond our own capital resources and successful approval by the NTDA.	Deliver our financial plan, activity plans (10.7)		Jun 2014 IDFS/COO
				Access to discretionary capital will be dependent on delivery of our agreed financial plan	Secure capital funding (10.3).		Jun 2014 IDFS/COO

	CMG service development strategies and plans to deliver key developments.		Progress on CMG development plans reported to Development Meetings with execs	No gaps identified.	No actions required.		
	Executive Strategy Board - Reconfiguration		Monthly ESB to provide oversight of reconfiguration.	No gaps identified.	No actions required.		Jun 2014 DS
	Capital expenditure programme to fund developments. Capital Board to oversee in year performance management		Capital expenditure reports reported to the Board via F&P Committee. Capital Board re-established	Require financial strategy by the end of Q1 to reflect how the Trust anticipates sourcing external capital for strategic business cases.	Develop and secure TDA approval for access to strategic capital. (10.8)		Jun 2014 IDFS
	Managed Business Partner for IM&T services to deliver IT that will be a key enabler for our clinical strategy. IM&T incorporated into Improvement and Innovation Framework.		IM&T Board in place.	No gaps identified.	No actions required.		

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inability to react /recover from events that threaten business continuity leading to sustained downtime and inability to provide full range of services.	Major incident/business continuity/ disaster recovery and Pandemic plans developed and tested for UHL/ wider health community. This includes UHL staff training in major incident planning/ coordination and multi agency involvement across Leicestershire to effectively manage and recover from any event threatening business continuity. Tailored training packages for service area based staff. Contingency plans developed to manage loss of critical supplier and how we will monitor and respond to incidents affecting delivery of critical supplies.	3x4=12	Annual Emergency planning Report Training Needs Analysis developed to identify training requirements for staff External auditing and assurances to SHA, Business Continuity Self-Assessment, Completion of the National Capabilities Survey, November 2013 Results included in the annual report on Emergency Planning and Business Continuity to the QAC. Audit by PwC Jan 2013. Completed Jan 2014. Documented evidence from key critical suppliers has been collected to ensure that contracts include business continuity arrangements.	(c) On-going continual training of staff to deal with an incident. (a) Lack of coordination of plans between different service areas and across the specialties. c) Not all the critical suppliers questioned provided responses. (c) Contracts aren't assessed for their potential BC risk on the Trust.	Training and Exercising events to involve multiple specialties/CMGs to validate plans to ensure consistency and coordination (11.13). Finance and procurement staff to be trained how to assess the BC risk to a contract and utilise the tools developed. (11.14)	2x3=6	Aug 2014 COO Aug 2014 COO

	Emergency Planning Officer appointed to oversee the development of business continuity within the Trust.		Outcomes from PwC LLP audit identified that there is a programme management system in place through the Emergency Planning Officer to oversee. A year plan for Emergency Planning developed and updated annually. Production/updates of documents/plans relating to Emergency Planning and Business Continuity aligned with national guidance have begun. Including Business Impact Assessments for all specialties. Plan templates for specialties now include details/input from Interserve. 2014/2015 work plan based on priority tasks to undertake and plans to review	(c) Local plans for loss of critical services not completed due to change over of facilities provider. (c) Plans have not been provided by Interserve as to how they would respond or escalate issues to the Trust. (c) A number of plans are out of date and risk being inadequate for a response due to operational changes. (c)Call out system designed to notify staff of a major incident and activate the plan is not suitable.	Further work required to develop escalation plans and response plans for Interserve. (11.11) Review and consider options for an automated system to reduce time and resources required to initiate a staff call out (11.16).		Jun 2014 COO Sep 2014 COO
			Minutes/action plans from Emergency Planning and Business Continuity Committee. Any outstanding risks/issues will be raised through the COO.	No gaps identified.	No actions required.		
			New Policy on InSite Emergency Planning and Business Continuity Committee ensures that processes outlined in the Policy are followed, including the production of documents relating to business continuity within the service areas. Incidents within the Trust are investigated and debrief reports written, which include recommendations and actions to consider. Issues/lessons feed into the development of local plans and training and exercising events.	No gaps identified.	No actions required.		

			Head of Operations and Emergency Planning Officer are consulted on the implementation of new IM&T projects that will disrupt user's access to IM&T systems.	(c) Do not always consider the impact on business continuity and resilience when implementing new systems and processes. (c) End users aren't always consulted adequately prior to downtime of a system.	Further processes require development, particularly with the new Facilities and IM&T providers to ensure resilience is considered/ developed when implementing new systems, infrastructure and processes. (11.8)		Review Jun 2014 COO
	All priority IT systems have disaster recovery testing completed as part of the change approvals for major upgrades or at least once per year if no upgrade is planned within a financial year.			(a) Lack of clarity around how the trust receives assurance that disaster recovery testing for IT systems takes place	Develop an assurance process (11.17)		May 2014 CIO

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to integrate the IM&T programme into mainstream activities.	IM&T is required to be part of the short/medium and long term planning processes	4x3=12	Strategic IM&T Board in place. Quarterly reports to Trust Board IM&T represented on key groups such as ESB, capital planning etc…	(c) late notice of significant changes that have a material impact on M&T provision (c) lack of uptake of IM&T opportunities within the planning processes	Ensure that there is further integration of IM&T within planning groups (12.9) Ensure that there are no unforeseen IM&T requirements coming out of the 2014-2016 planning phase. (12.10)	3x2=6	May 2014 CIO Review Jun 2014 CIO
	Creation of an exciting portfolio of opportunities for UHL to use within its delivery and reporting activities		A clear plan for 2014/15 exists, within the IM&T strategic framework. Work with directly affected areas has commenced	(c) lack of a fully signed off five year plan for IMT (c) a clear communications and engagement plan to inform all stakeholders of these opportunities	Work with the DOF and the capital group to ensure a coherent 5 year plan is in place for the delivery of the core IM&T components (12.11) Work with specialists from UHL and IBM to better define the communications and engagement strategy. (12.12) Review and reissue the IM&T strategy (12.13)		May 2014 CIO May 2014 CIO Jun 2014 CIO
	Engagement with the wider clinical communities (internal) including formal meetings of the newly created advisory groups/ clinical IT. Improved communications plan incorporating process for feedback of information.		CMIO(s) now in place, and active members of the IM&T meetings The joint governance board monitors the level of communications with the organisation.				

	Engagement with the wider clinical communities (External). UHL CMIOs are added as invitees to the meetings, as are the clinical (IM&T) leads from each of the CCGs.		UHL membership of the wider LLR IM&T board	(c) no involvement of external stakeholders on our significant internal projects	Review any relevant groups and engage our external stakeholders for membership (12.15)		May 2014 CIO/CMIO
Benefits are not well defined or delivered	Appointment of IBM to assist in the development of an incentivised, benefit driven, programme of activities to get the most out of our existing and future IM&T investments. Initial engagement with key members of the TDA to ensure there is sufficient understanding of technology roadmap and their involvement. The development of a strategy to ensure we have a consistent approach to delivering benefits. Increased engagement and communications with departments to ensure that we capture requirements and communicate benefits. Standard benefits reporting methodology in line with trust expectations. Paperwork and processes have be re-modelled and issued to all IM&T project staff to ensure they work to required standards.		Minutes of the joint governance board, the transformation board and the service delivery board. Benefits are part of all the projects that are signed off by the relevant groups.	. (c) Ownership of benefits delivery is being overlooked when a project, from IM&T's perspective, is finished. (c) Requirements within projects are moving significantly from the time a project specification is signed off.	Post project benefit realisation plans and ownership is identified at pre-commencement phase to ensure the total work is identified. (12.17) Requirements and benefits are fully signed off prior to any work commencing (12.18)		Jul 2014 CIO Jul 2014 CIO
Major programmes of work do not deliver on time and budget	A joint Programme and project methodology is in place between UHL and IBM for managing and tracking activities. Monthly meetings with a nominated lead to discuss projects and overall performance with the CMGs. Enhanced communications with the CMGs to include new opportunities that they could consider within their planning processes going forward		Weekly and Monthly reports are in place to track both at a programme level and at an individual project level	(c) sufficient feedback to individual CMGs on both the progress, benefits and further opportunities from their IM&T projects	Monitor the meetings and review for effectiveness (12.23)		Jul 14 CIO

	External factors such as CCG alignment and NTDA approval are in place to ensure smooth passage of approvals		Bi monthly LLR meetings are in place to ensure alignment across all healthcare stakeholders in Leicestershire	(c) Agree LLR joint priorities for 2014	Invite key external parties to be part of the significant projects. The first of these will be the EPR project (12.24) Further work through the IM&T strategy board is required to refine the large set of requirements into a realistic deliverable plan (12.22)		Jul 14 CIO May 2014 CIO

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to implement and embed an effective medical training and education culture with subsequent critical reports from commissioners, loss of medical students and junior doctors, impact on reputation and potential loss of teaching status.	Medical Education Strategy and Action Plan.	4x4=16	Strategy approved by the Trust Board. Strategy monitored by Operations Manager and reviewed monthly in Full team Meetings. Favourable Deanery visit in relation to ED Drs training.	(c) Lack of engagement/awareness of the Strategy with CMGs.	Meetings to discuss strategy with CMGs (13.1).	3x2 = 6	Jun 2014 MD
	UHL Education Committee. 'Doctors in Training' Committee established. Education and Patient Safety. Links with LEG/ QAC and EQB		Professor Carr reports to the Trust Board. Reports submitted to the Education Committee. Terms of reference and minutes of meetings.	(c) Attendance at the Committee could be improved. (c) Improved trainee representation on Trust wide committees. (c) Improve engagement with other patient safety activities/groups.	Relevance of the committee to be discussed at specialty/ CMG meetings (13.2).		Jun 2014 MD
	Quality Monitoring. Engagement with specialties to share findings from education and training dashboards		Quality dashboard for education and training (including feedback from GMC and LETB visits) monitored monthly by Operations Manager, Quality Manager and Education Committee. Education Quality Visits to specialties. Exit surveys for trainees. Monitor progress against the Education Strategy and GMC Training Survey results.	(a) Do not currently ensure progress against strategic and national benchmarks. (c) Inadequate educational resources.	Monitor UHL position against other trusts nationally. (13.7) New Library/learning facilities to be developed at the LRI .(13.8)		Review Jun 2014 MD Nov 2014 MD

	Educational project teams to lead on education transformation projects.		Project team meets monthly. Favourable outcome from Deanery visit in relation to ED Drs training.				
	Financial Monitoring.		SIFT monitoring plan in place.	(c) Poor engagement with specialties in relation to implication of SIFT.	Need to engage with the specialties to help them understand the implication of SIFT and their funding streams. (13.10)		Jun 2014 MD

Appendix two

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 2014**
Frequency of review:	Monthly
Date of last review:	April 2014

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
1	**Failure to achieve financial sustainability**					
1.21	Implementation of financial training programme to address variability of financial knowledge and control across UHL.	IDFS		June 2014	On track	4
1.22	Production of a FRP to deliver recurrent balance within five years. (*Note: It is highly likely that recurrent balance will be within 5 years and not 3 years. The LTFM is a five year model*	IDFS		June 2014	On track, but reliant on and overlap with the delivery of outputs from the Challenged Health economy (LLR) work (1.23)	4
1.23	Health System External Review to define the scale of the financial challenge and possible solutions.	IDFS		June 2014	On track	4
1.24	Production of UHL Service & Financial Strategy including Reconfiguration SOC. (	IDFS		June 2014	On track however there is a question whether it will be possible to complete the IBP and SOC at the same time	4
1.25	Expedite agreement of CIP quality impact assessments both internally and with CCGs.	IDFS		~~April~~ ~~May 2014~~ Continuous process therefor further review July 2014	The balance of the QIA cannot be completed until red CIP schemes have been defined. 11/06 – process for approval of QIA of additional CIP schemes as they are developed through the Contract Performance review process	4
1.26	PMO Arrangements need to be finalised to ensure continuity following departure of Ernst & Young.	IDFS/ COO/ DS		~~May 2014~~ Review June 2014	PMO arrangements to be finalised as part of Delivering Care at Its Best arrangements	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

1.27	Production of 2014/15 'budget book'/ financial plan *(NB this action reworded in June 2014 following discussion with IDFS)*	IDFS		June 2014	**Complete** – April Trust Board approval	5
1.28	Restructuring of financial management via MoC.	IDFS		July 2014	On track	4
1.30	Negotiate realistic contracts with CCGs and Specialised Commissioning	IDFS		~~April~~ ~~May~~ Review June 2014	Discussions at CEO level continue but the Trust is unable to reach agreement on the consequences of fines and penalties. The Specialised services contract is ready to sign but national issues prevent progress. Situation is being escalated with TDA and NHSE 11/06 – following intervention by NHSE/TDA re the application of local fines and penalties the Trust is in a position to agree a contract. Proposal awaited from CCG	3
1.31	Production of Business Cases to support Reconfiguration and Service Strategy	IDFS		June 2014		4
1.32	Agreeing long term loans as part of June Service & Financial Plan	IDFS		June 2014		
2	**Failure to transform the emergency care system**					
2.7	Continue with substantive appts until funded establishment within ED is achieved.	COO	HO	Review ~~Sept~~ ~~Nov 2013~~ ~~Jan 2014~~ June 2014	Still on track to recruit to funded establishment. International recruitment has been successful. Continued review of progress.	4

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

3	**Inability to recruit, retain, develop and motivate staff**					
3.3	Development of Pay Progression Policy for Agenda for Change staff.	DHR	DDHR	~~October~~ ~~November~~ ~~December 2013~~ ~~February 2014~~ Review ~~April~~ September 2014	Confirmation has been received from Unison that they intend to ballot members in relation to one element of the proposed pay progression criteria from 21.06.14. Other Unions are still consulting. Indicative timescales are that this will be completed by September 2014.	3
3.9	Develop an employer brand and maximise use of social media to describe benefits of working at UHL	DHR		~~April~~ July 2014	Action plan in development, focused on three elements of employment cycle. A focused piece of work will take place on the development of the work for us area. Best nursing practice in relation to values based recruitment will be shared with other staff groups. Linkedin to be used to promote upcoming recruitment campaigns. There has been an extension to timescales for completion due as UHL needs to acquire a credit card in order to register for Linkedin for advertising and we need to find a way to progress this. The Employer Brand task and finish has been re-established to progress this work.	4
4	**Ineffective organisational transformation**					

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	Review outputs from Chief Officers Group and strategic Planning Group to ensure gaps in current processes are being addressed	DS		~~Review~~ ~~February~~ ~~May~~ June 2014	The Trust is fully engaged in the LLR BCT 5 year planning process and is actively working with E&Y to ensure that our processes and plans are aligned. An LLR 5-year plan will be submitted on 20 June as will UHLs. Between June and September there will be a further period of reconciliation for the UHL and LLR plan.	3
4.2	Capacity planning workshop with all CMGs in April/May to build internal capacity and capability and to scope and develop our internal planning assumptions	DS		May 2014	**Complete**	5
4.3	The LLR BCT 2014 planning process will support and facilitate the development and agreement of an LLR wide capacity plan in May/June			June 2014	On track- Submission of LLR and UHL plan to NHS England and the NTDA on 20 June	4
5	**Ineffective strategic planning and response to external influences**					
5.16	High level plan for the Trust to be developed	DS		June 2014	CMG planning and strategy workshops undertaken January – June 2014. Forward programme developed.	4
7	**Failure to maintain productive and effective relationships**					
7.3	Invite PWC (Trust's Auditors) to offer opinion on the plan / talk to a selection of stakeholders.	DMC		~~January 2014~~ ~~March~~ ~~May~~ Review July 2014	PWC conducting phone and F2F interviews with stake holders currently. Review progress in July 2014	4
8	**Failure to achieve and sustain quality standards**					
8.5	Active recruitment to ward nursing establishment so releasing ward sister for supervisory practice.	CN		September 2014	On going recruitment process in place and is likely to take 12 -18months. Deadline extended to reflect this.	4

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

8.10	Implementation of Electronic Patient Record (EPR)	CIO		2015	On track. Procurement has commenced - ITT issued to 11 vendors	4
9	**Failure to achieve and sustain high standards of operational performance**					
9.15	To open an additional 18 beds	COO		~~Feb 2015~~ August 2014	On track. This has now been reduced to opening an additional 18 beds (10 less in respiratory due to their request, 28 less in medicine due to staffing issues) Agreed at ET 10.6.14	4
10	**Inadequate reconfiguration of buildings and services**					
10.3	Secure capital funding to implement Estates Strategy.	IDFS		~~May 2013~~ ~~December 2013~~ ~~March~~ ~~Review April~~ June 2014	Capital funding requirements will be reflected in the LTFM for additional PDC as part of the Service and Financial plan (see 1.24)	3
10.5	Iterative development of operational and strategic plans with specialities.	MD		~~March~~ June 2014	Iterative development of operational and strategic plans with specialities to be reflected in our 5 year Integrated Business Plan by June 2014 – including proposed configuration to best meet the clinical and financial sustainability challenges faced by the Trust and the local health and care community. This is monitored by CMG and Executive Boards. Operational plans due April 2014 and strategic plans by June 2014	4
10.6	Reconfiguration programme to develop a strategic outline case which will inform the future estate strategy	DS		June 2014	A decision was made at the Reconfiguration Board that, we need to refresh the programme structure, work stream ownership and governance arrangements. We are developing clinical and service based strategies that will inform all aspects of our IBP This will inform the future estate strategy and associated reconfiguration programme.	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

10.7	Deliver our financial plan, activity plans	IDFS/ COO		June 2014	On track.	4
10.8	Develop and secure TDA approval for access to strategic capital.	IDFS		June 2014	On track. Capital funding requirements will be reflected in the LTFM for additional PDC as part of the Service and Financial plan (see 1.24)	4
11	**Loss of business continuity**					
11.8	Further processes require development, particularly with the new Facilities and IM&T providers to ensure resilience is considered/ developed when implementing new systems, infrastructure and processes.	COO	EPO	~~July~~ ~~August~~ Review ~~October~~ ~~November 2013~~ ~~December 2013~~ ~~March~~ June 2014	Lack of progress with Interserve escalated via Chief Nurse and NHS Horizons; however still no formal assurance from Interserve of the BCM policy/process/plans. Meeting scheduled (19/05/2014) to review process and determine an appropriate process. Deadline extended to reflect this.	3
11.11	Further work required to develop escalation plans and response plans for Interserve.	COO	EPO	~~October~~ ~~December 2013~~ ~~March~~ ~~April~~ ~~May 2014~~ June 2014	Draft escalation plan received 1st May. Plan reviewed and updated based on feedback. To be implemented within UHL and Interserve within the revised deadline	3
11.13	Training and Exercising events to involve multiple CMGs/ specialties to validate plans to ensure consistency and coordination	COO	EPO	August 2014	BCM training and exercising programme has been developed. Training sessions for bleep holders in cardiology and MSK and Specialist Surgery undertaken with more to be planned. New exercises planned for May and July with more to follow.	4
11.14	Finance and procurement staff to be trained how to assess the BC risk to a contract and utilise the tools developed.	COO	EPO	~~March~~ ~~May~~ August 2014	Materials developed awaiting availability to run training session. Propose to include in the routine training and exercise timetable.	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

11.16	Review and consider options for an automated system to reduce time and resources required to initiate a staff call out	COO	EPO	~~April~~ ~~June~~ September 2014	A number of solutions considered but high costs and integration with current trust systems are not ideal. IBM considering a design specification further discussions are on-going.	3
11.17	Develop an assurance process for IT disaster recovery testing in order to provide the Trust with confidence that testing is being performed.	CIO		May 2014	We have achieved the ISO 27001 accreditation which has been externally validated. Awaiting update from CIO	4
12	**Failure to exploit the potential of IM&T**					
12.9	Ensure that there is further integration of IM&T within planning groups (12.9)	CIO		May 2014	On track Awaiting update from CIO	4
12.10	Ensure that there are no unforeseen IM&T requirements coming out of the 2014-2016 planning phase.	CIO		Review June 2014	Significant work still needed to assess the 2016 planning horizon and what all the elements of UH:\CMG\LLR plans mean with regards to IM&T	2
12.11	Work with the DOF and the capital group to ensure a coherent 5 year plan is in place for the delivery of the core IM&T components	CIO		May 2014	On track Awaiting update from CIO	4
12.12	Work with specialists from UHL and IBM to better define the communications and engagement strategy.	CIO		May 2014	On track Awaiting update from CIO	4
12.13	Review and reissue the IM&T strategy	CIO		June 2014	On track	4
12.15	Review any relevant groups and engage our external stakeholders for membership	CIO/ CMIO		May 2014	On track Awaiting update from CIO	4
12.17	Post project benefit realisation plans and ownership is identified at pre-commencement phase to ensure the total work is identified.	TBA		July 2014	Paperwork and processes have be re-modelled and issued to all IM&T project staff. Further work required to test the output from this work	4

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

12.18	Requirements and benefits are fully signed off prior to any work commencing	TBA		July 2014	Paperwork and processes have be re-modelled and issued to all IM&T project staff. Further work required to test the output from this work	4
12.22	Further work through the IM&T strategy board is required to refine the large set of requirements into a realistic deliverable plan	CIO		May 2014	On track. Awaiting update from CIO	4
12.23	Monitor the monthly meetings with nominated leads and review for effectiveness	CIO		July 2014	On track	4
12.24	Invite key external parties to be part of the significant projects. The first of these will be the EPR project	CIO		July 2014	On track	4
13	**Failure to enhance education and training culture**					
13.1	To improve CMG engagement facilitate meetings to discuss Medical Education Strategy and Action Plans with CMGs.	MD	AMD	~~December 2013/January 2014 March April~~ June 2014	Meetings held with CMGs other than RRC. Previous meeting with Cardiac Services had to be postponed. New meeting date 6/6/14.	4
13.2	Relevance of the UHL Education Committee to be discussed at CMG Meetings in an effort to improve attendance.	MD	AMD	~~December 2013/January 2014 March April~~ June 2014	Meetings held with CMGs other than RRC. Previous meeting with Cardiac Services had to be postponed. New meeting date 6/6/14... Previous meeting with Cardiac Services had to be postponed. New meeting date 6/6/14.	4
13.7	Monitor UHL position against other trusts nationally to ensure progress against strategic and national benchmarks.	MD	AMD	Review ~~October 2013 March~~ June 2014	Following further discussions with the LETB this data is not readily available. LETB to investigate how we can acquire this data.	2

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

13.8	New Library/learning facilities to be developed at the LRI to help resolve inadequate educational resources.	MD	AMD	~~October 2013~~ ~~April~~ November 2014	Delay in the tendering process means that this project will not start until July and should end in November 2014.	2
13.10	Need to engage with the CMGs to help them understand the implication of SIFT and their funding streams.	MD	AMD	~~December 2013/January 2014~~ ~~March~~ ~~April~~ June 2014	Meetings held with CMGs other than RRC. Previous meeting with Cardiac Services had to be postponed. New meeting date 6/6/14.Previous meeting with Cardiac Services had to be postponed. New meeting date 6/6/14.	4

Key

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

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

TT	Transformation Team
CN	Chief Nurse

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

Appendix three

University Hospitals of Leicester NHS Trust

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

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

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

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

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

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

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

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

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

8) Are the assigned risk scores realistic?

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

OPERATIONAL RISKS SCORING 15 OR ABOVE FOR THE PERIOD ENDING 31/05/14

REPORT PRODUCED BY: UHL CORPORATE RISK MANAGEMENT TEAM

Key

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

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2339	RRC	Renal Transplant	Potential risk to Renal transplant patients as a result of deterioration of team working & deviation from policy and procedures	02/05/2014	30/06/2014	Causes Poor lines of communication Poor interpersonal relationships Lack of clarity of procedures and policies Consequences Potential for patient harm Suboptimal transplant outcomes Potential for morbidity and mortality related to transplant process.	Targets	Clear lines of communication have been defined The 4 surgical consultants have agreed significantly improved ways of working and are demonstrating significantly improved team working skills and attitudes. Appointment of an external clinical lead (Chris Rudge) who will be working with the team 2 days a week for 3 - 6 months Policies / guidelines have been written for ward rounds, OPD and kidney acceptance MDT's and M&M's will be in place for the restart of the process	Extreme	Likely	20	Confirming the unit director - TBC Completion and ratification of ward policies and protocols document - 31/5/14 Establishment of multidisciplinary governance meetings overseeing all aspects of practice - 20/05/14	5	SLEA

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2338	Medical Directorate	Medical Directorate	There is a risk of patients not receiving medication and patients receiving the incorrect medication due to an unstable homecare	01/05/2014	30/06/2014	Causes A major homecare company has left the Homecare market requiring remaining companies to take on large numbers of patients. These companies are now experiencing difficulties in maintaining their current levels of service. UHL patients are now being affected. One homecare supplier has changed their compounding to Bath ASU causing concerns about UHL supply of chemotherapy drugs over the next few weeks. Healthcare at Home (H@H) 1)H@H have changed their logistics provider (to Movianto). There are IT incompatibilities between both providers resulting in a large number of failed deliveries. 2) H@H no longer accepting new referrals for CF, respiratory and haemophilia patients who need to be repatriated to UHL urgently. There are also patients in whom homecare has been agreed and they are now referring back 3) H@H have changed their compounding to Bath ASU. This has resulted in Bath ASU not having enough capacity to carry out their routine production. UHL is a large user of dose banded chemotherapy. Currently we do not have the facility to compound all of our dose banded chemotherapy, a Alcura 1)Experiencing difficulties that have resulted in failed deliveri 2)There are on-going issues with invoicing. No invoices for A Consequences	Quality	UHL Homecare team liaising with homecare companies to try and resolve issues of which they are made aware. H@H high risk patients currently being repatriated to UHL. UHL procurement pharmacist in discussion with NHS England (statement due out soon - timeframe unsure), and with the CMU. Patient groups and peer group discussions also been held to support patient education and support during this uncertain period. Reviewing which medicines can be done through UHL out-patient provider or through UHL Discussions with Medical Director and CMG (CSI) and clinical specialty teams to ensure that any necessary clinical pathway changes are supported	Major	Likely	16	Long term review or all homecare products and understand business continuity. - 30/6/14 Financial risk associated with repatriation and highlight this to commissioners - 30/6/14 Healthcare at Home currently addressing IT issues with logistics provider - 26/5/14 UHL Pharmacy procurement team investigating the procurement of drugs which are currently only available through a homecare provider - 5/5/14	9	CELL

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2341	Operations		Long term follow up outpatient appointments not made	06/05/2014	30/06/2014	As the result of one specialty (rheumatology) finding they were not managing long term follow up appointments in accordance with clinical requirements, the Trust has undertaken a further assessment across all specialties of the risk of the same occurring. Initial assessment indicates that there are 24, 582 patient records on HISS / PAS where follow up appointments are not being managed in a timely way. These fall into 4 categories: 1) Patients with outcomes of waiting reports , but they have no follow up appointment booked 2)Outcome of long term follow up not made and patients are not on a waiting list and do not have a future appointment 3) Those on an outpatient waiting list but they are overdue their date to be seen 4)Outcome of future appointment but no appointment has been made. Full validation of patient level records is required to determine the size of the real risk in particular to patient care. Each CMG is required to make this assessment and report back to the Governance group on a weekly basis.(this is part of the action plan) Causes: The root cause for this failure has not yet been established a Potential consequences: (NB: until validation of all patient re Adverse impact on patient safety / care, potential for irrevers	Patients	-A Governance group, chaired by the Chief Operating Officer and Medical Director set up 23rd April , meeting weekly, terms of reference agreed and reporting to Executive Quality Board - Trust wide action plan written , updated weekly. Including clear instructions to CMG management teams - From 6th May patient level validation at specialty level underway , with weekly monitoring of progress	Major	Likely	16	Establish weekly Governance meeting to manage Trust wide approach - Complete Communicate required actions to all CMGs - Weekly Issue specialty level patient reports for validation to all CMGs - Complete Issue corporate guidance on validation process to all CMGs - Complete Collate weekly returns to monitor validation progress - Weekly Run weekly Trust wide report to monitor progress of validation - Weekly CMGs to provide weekly update action plans on progress - Weekly Undertake Root Cause Analysis incident investigation - 15/07/14 Arrange standard external communication to patients - on track	2	KHAR