To:	**Trust Board**
From:	**Medical Director**
Date:	**29 August 2013**
CQC regulation:	Outcome 16 – Assessing and Monitoring the Quality of Service Provision

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

Author/Responsible Director: Medical Director

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

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

The Report is provided to the Board for:

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

Summary :

- The BAF is now accompanied by an 'action tracker' developed to provide more robust management of actions.
- Risk numbers four and five have achieved their target score and are now closed.
- Risk number nine has also achieved its target score but remains open until final actions are completed and there is confidence of sustainable improvement in performance.
- A new entry on the BAF (risk 13) in relation to *'failure to enhance education and training culture'* is submitted to provide assurance to the Board that any associated risks are being adequately controlled.
- No new high risks have opened in July 2013; however one existing risk has increased from moderate to high during the reporting period.
- Board members are invited to review the following risks.
  Risk number six.
  Risk number seven.
  Risk number eight.

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

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

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

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

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

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

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **29 AUGUST 2013**

REPORT BY: **MEDICAL DIRECTOR**

SUBJECT: **UHL RISK REPORT (INCORPORATING THE BOARD ASSURANCE FRAMEWORK) FOR THE PERIOD ENDING 31 JULY 2013**

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1. INTRODUCTION

1.1 This report provides the Board with:-

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

2. BAF POSITION AS OF 31 JULY 2013

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

2.2 The progress of actions associated with the BAF is monitored by reference to the action tracker attached at appendix two.

2.3 Risk numbers four and five on the BAF have achieved their target score and are now effectively closed. The Board are asked to note that risk number nine has also achieved its target score but remains open until final actions are completed and there is confidence that we have sustainable improvements in service delivery.

2.4 Following a recent presentation to the Board in relation to medical education and training at UHL it was agreed that a new entry on the BAF would be required to provide assurance that any associated risks are being adequately controlled. Risk number 13 on the BAF provides this detail.

2.5 The Board had previously agreed that risk two should contain the *'single front door'* model of care as a mitigating action (minute 200/13/1 refers), however the '*single front door'* is already implemented and is therefore already identified as one of the control mechanisms for this risk. The Board should seek assurance that this model of care is functioning effectively.

2.6 To provide an opportunity for more detailed review three BAF risks will be presented on a monthly basis for Board members to review against the areas listed in appendix four. Following discussion at the UHL Executive Team it was agreed that will be presented in numerical sequence and the risks below are presented for review:

- Risk six - Failure to achieve FT status (risk score 16).

- Risk seven - Failure to maintain productive and effective relationships (risk score 15).
- Risk eight - Failure to achieve and sustain quality standards (risk score 16).

3 EXTREME AND HIGH RISKS.

3.1 As described in the UHL Risk Management Policy, the Board will receive notification of any extreme/ high risks that have opened during the reporting period. The Board are therefore asked to note:

a. No new high risks have opened in July 2013, however an existing moderate risk in relation to a backlog in Imaging reporting has increased to high (from risk score 12 to 16) during the reporting period, the detail of which is attached at appendix five.

4. RECOMMENDATIONS

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

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

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

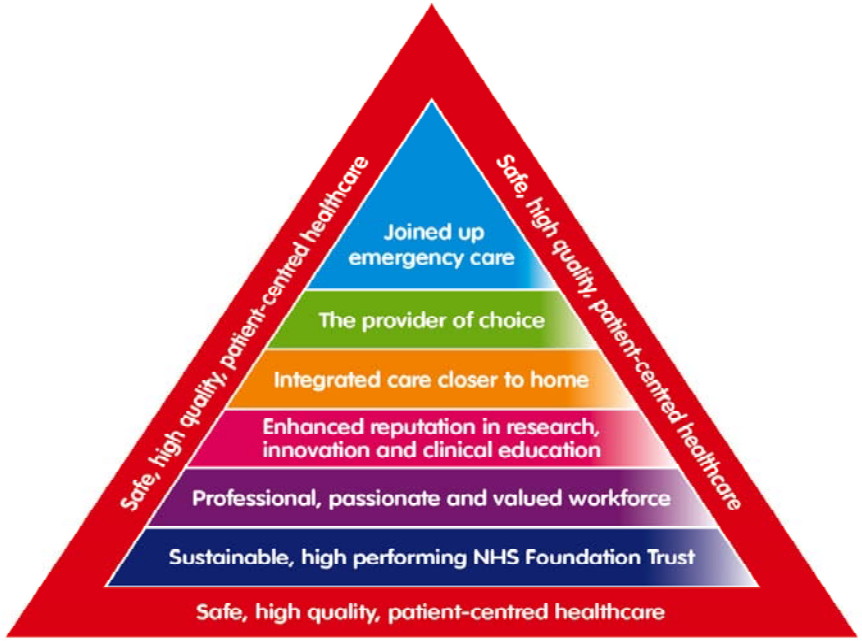
(c) identify any areas which it feels that the Trust's controls are inadequate and do not, therefore, effectively manage the principal risks to the organisation achieving its objectives;

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

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

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

Peter Cleaver,
Risk and Assurance Manager,
21 August 2013.


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

PERIOD: JULY 2013

RISK TITLE	STRATEGIC OBJECTIVE	CURRENT SCORE	TARGET SCORE
Risk 1 – Failure to achieve financial sustainability	g - To be a sustainable, high performing NHS Foundation Trust	25	12
Risk 2 – Failure to transform the emergency care system	b - To enable joined up emergency care	25	12
Risk 3 – Inability to recruit, retain, develop and motivate staff	f - To maintain a professional, passionate and valued workforce e - To enjoy an enhanced reputation in research, innovation and clinical education.	16	12
Risk 4 – Ineffective organisational transformation	a - To provide safe, high quality patient-centred health care c - To be the provider of choice d - To enable integrated care closer to home	12	12
Risk 5 – Ineffective strategic planning and response to external influences	a - To provide safe, high quality patient-centred health care c - To be the provider of choice g - To be a sustainable, high performing NHS Foundation Trust	12	12
Risk 6 – Failure to achieve FT status	g - To be a sustainable, high performing NHS Foundation Trust	16	12
Risk 7 – Failure to maintain productive and effective relationships	c - To be the provider of choice d - To enable integrated care closer to home f - To maintain a professional, passionate and valued workforce	15	10
Risk 8 – Failure to achieve and sustain quality standards	a - To provide safe, high quality patient-centred health care c - To be the provider of choice	16	12
Risk 9 – Failure to achieve and sustain high standards of operational performance	a - To provide safe, high quality patient-centred health care	12	12
Risk 10 – Inadequate reconfiguration of buildings and services	a - To provide safe, high quality patient-centred health care	12	9
Risk 11– Loss of business continuity	g - To be a sustainable, high performing NHS Foundation Trust	9	6
Risk 12 – Failure to exploit the potential of IM&T	a - To provide safe, high quality patient-centred health care d - To enable integrated care closer to home	9	6
Risk 13 - Failure to enhance education and training culture	e – To enjoy an enhanced reputation in research, innovation and clinical education	12	6

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

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to achieve financial sustainability including:	Overarching financial governance processes including PLICS process and expenditure controls. Revised variance analysis and reporting metrics especially for the ETPB Self-assessment and SLM baseline exercise completed and project manager identified On going discussions with the CCG, LAT, and NTDA as to regards Transformation and Strategic Transitional Funding	5X5=25	Monthly /weekly financial reporting to Exec Team Performance Board, F&P Committee and Board. Cost centre reporting and monthly PLICS reporting. Monthly confirm and challenge processes at CBU and Divisional level. Annual internal and external audit programmes. Monthly meetings with the NTDA and the CCG Contract Performance Meeting	(c) SLM programme not fully implemented	SLM Action plan is awaited. (1.9) Formal sign off of the Transformation bids (1.16)	4x3=12	Aug 2013 DFBS Aug 2013 DFBS
Failure to achieve CIP.	Strengthened CIP governance structure.		Progress in delivery of CIPs is monitored by CIP Programme Board (meeting fortnightly) and reported to ET and Board.	Under-delivery of CIP programme (C)	Refreshed CIP programme management arrangements (1.5)		Review Aug 2013 DFBS

Locum expenditure.	Workforce plan to identify effective methods to recruit to 'difficult to fill' areas Reinstatement of weekly workforce panel to approve all new posts. STAFFflow for medical locums saving £130k of every £1m expenditure Financial Recovery plans developed by Acute and Planned Care Non Contractual Payments are discussed at monthly Divisional meetings Confirm and Challenge Meetings All Divisions (by CBU) have produced premium spend trajectories and associated plans until March 2014 Weekly Staff Bank data reports are issued for medical and nursing (qualified and unqualified) staff Action plan to increase bank staff capacity and drive down agency nurse expenditure.		The use of locum staff in 'difficult to fill' areas is reported to the Board on a monthly basis via the Quality and Performance report. A reduction in the use of such staff would be an assurance of our success in recruiting substantive staff to 'difficult to fill' areas. Increase in substantive staff of 200wte to Oct 12. Saving in excess of £0.6m 5 weeks after 'go live' date Monthly Q&P report to TB Non contractual payments (premium spend) are reported monthly to the Finance and Performance Committee Weekly meetings with HoNs and DHR to monitor progress.	(c) Failure to reduce locum spend. 587 wte locum staff currently used. (c) recovery plans require more development	See action (1.15) Further iteration of Financial Recovery plans for Acute and Planned Care divisions to be agreed at August ET Performance Board (1.15)		Aug 2013 DFBS
Loss of income due to tariff/tariff changes (including referral rate for emergency admissions – MRET)	Contract meetings with Commissioners Negotiations with Commissioners concluded at a transactional level.		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board.	(c) Failing to manage marginal activity efficiently and effectively.	Ongoing discussions with commissioners about planned re-investment of the MRET deductions. (1.11)		Review Aug 2013

Ineffective processes for Counting and Coding.	Clinical coding project.		Ad-Hoc reports on annual counting and coding process. PbR clinical coding audit Jan 2013 (final report received 29 May 2013). IG toolkit audit (sample of 200 General Surgery episodes).	(c) Error rates in audit sample could be indicative of underlying process issues (c) Error rates identified as: Primary diagnoses incorrect 8.0% › Secondary diagnoses incorrect 3.6%. › Primary procedure incorrect 6.4% › Secondary procedure incorrect 4.5%.	Re-establishing clinical coding improvement team under John Roberts. Initial action plan in place (1.6)		Review Aug 2013 COO
Loss of liquidity.	Liquidity Plan.		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board. Cash management plans presented at June 2013 F&P committee				
Lack of robust control over pay and non-pay expenditure.	Pay and Non-pay recovery action plan in place and monitored monthly Catalogue control project.		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board. Non-pay management plan presented at July F&P committee Ongoing Monitoring via F&P Committee.	(c) Failing to control adverse trends in pay	See action (1.15)		
Commissioner fines against performance targets.	Contract meetings with Commissioners Negotiations with Commissioners concluded at a transactional level. Divisions have developed plans and trajectories to reduce admission rates that are monitored at monthly C&C meetings.		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board.	(c) Failing to reduce readmission trends.	Ongoing discussions with commissioners about planned re-investment of contract deductions and performance fines. (1.13)		Aug 2013 DFBS
Use of readmission monies.	Contract meetings with Commissioners Negotiations with Commissioners concluded at a transactional level Ownership of readmissions work streams in divisions clarified		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board.				

Ineffective organisational transformation.	See risk 4		See risk 4.	See risk 4.	See risk 4.		

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to transform emergency care system leading to demands on ED and admissions units continuing to exceed capacity.	Health Economy has submitted response plan to NHSE requirements for an Emergency Care system under the A&E Performance Gateway Reference 00062.	5x5=25	Once plan agreed with NTDA, it will be circulated to the Board	No gaps	No actions	4x3=12	
	Emergency Care Action Team formed. Chaired by Chief executive to ensure Emergency Care Pathway Programme actions are being undertaken in line with NHSE action plan and any blockages to improvement removed. Development of action plan to address key issues		Action Plan will be circulated to the Board on a monthly basis as part of the Report on the Emergency Access Target within the Quality and Performance Report	Gaps described below	Actions described below		
	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 Sep 2013 COO

	Formation of an EFU and AFU to meet increased demand of elderly patients		'Time to see consultant' metric included in National ED quarterly indicator.	No gaps	No actions		
	Maintenance of AMU discharge rate above 40%		Reported to Operational Board twice monthly and will be included in Emergency Care Update report in Quality and Performance Report.	No gaps	No actions		
	New daily MDT Board Rounds on all medical wards and medical plans within 24hrs of admission		Reported to Operational Board twice monthly and will be included in Emergency Care Update report in Quality and Performance Report.	No gaps	No actions		
	EDDs to be available on all patients within 24 hours of admission		Monitored and reported to Operational Board twice monthly and will be included in Emergency Care Update report in Quality and Performance Report.	(c) Provision of EDDs for all patients not yet achieved	Review required to check accuracy of EDDs. (2.11)		Aug 2013
	Maintain winter capacity in place to allow new process to embed		All winter capacity beds are to be kept open until the target is consistently met	No gaps	No actions		
	DTOCs to be kept to a minimal level		Forms part of the Report on Emergency Access in the Quality and Performance Report.	(c) Lack of availability of rehabilitation beds for increasing numbers of patients.	CCG/LPT to increase capacity by use of Intermediate Care Services (2.9)		Aug 2013 CO O

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

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

	Appraisal and objective setting in line with UHL strategic direction.		**Appraisal rates reported monthly to Board via Quality and Performance report. June 13 appraisal rate = 90.1% -**	(c) Appraisal rates below anticipated trajectory	Local actions and appraisal performance improvement trajectories to be agreed with Divisions and Directorates Boards (3.6)		Aug 2013 DHR
			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).	(a) Quality assurance findings not yet reported at local levels	**Appraisal quality assurance findings to be reported to Divisions / Directorates Boards and local staff engagement/experience action plans updated accordingly (3.7)**		Aug 2013 DHR
	Workforce plan to identify effective methods to recruit to 'difficult to fill areas). Divisions and Directorates 2013/14 Workforce Plans.		The use of locum staff in 'difficult to fill' areas is reported to the Board on a monthly basis via the Quality and Performance report. Reduction in the use of such staff would be an assurance of our success in recruiting substantive staff.	No gaps identified.	No actions required.		
	Reward /recognition strategy and programmes (e.g. salary sacrifice, staff awards, etc).			(a) Reward and recognition strategy requires revision to include how we will provide assurance that reward and recognition programmes are making a difference to staffing recruitment/ retention/ motivation.	Revise reward and recognition strategy. (3.1) **Development of Pay Progression Policy for Agenda for Change staff (3.3)** **Implementation of Recruitment and Retention Premia for ED staff (3.4)** **Ensure Statutory and Mandatory training is easy to access and complete with 75% compliance (3.5)**		Oct 2013 DHR Oct 2013 DHR **Sep 2013 DHR** **Mar 2014 DHR**

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

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

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

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

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

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

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

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

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	Current Score I x L	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	Target Score I x L	**Timescale** When will the action be completed?
Failure to achieve and sustain quality standards leading to failure to reduce patient harm with subsequent deterioration in patient experience/ satisfaction/ outcomes, loss of reputation and deterioration of NET promoter score.	Standardised M&M meetings in each speciality	4x4=16	Monitoring and CBU and Divisional Boards	(a) Routine analysis of out of hours/weekend mortality	Better use of routine data analysis tools including DFI and HED (8.1)	4x3=12	Sep 2013 MD
	Systematic speciality review of "alerts" of deterioration to address cause and agree remedial action. Corporate oversight via QPMG, QAC and by exception to ET and TB		Quality and Performance Report and National Quality dashboard presented to Exec and TB. Currently SMHI "within expected"	(a) UHL risk adjusted perinatal mortality rate below regional and national average.	Women's CBU to work with Dr Foster and other trusts to better understand risk adjustment model (8.2)		Jan 2014 MD
	Robust implementation of actions to achieve Quality Commitment (save 1000 extra lives in 3 years)		SHMI remains "within expected"	(a) LLR mortality review requires independent analysis	Analysis of mortality review by Public Health (8.9)		Sep 2013 MD
	Agreed patient centred care priorities for 2013-14: - Older people's care - Dementia care - Discharge Planning		Quality Action Group meets monthly – provides direction, pace and support and includes divisional representation Achievement against key objectives and milestones report to Trust board on a monthly basis	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		Divisional/CBU reporting on matron activity and implementation or supervisory practice	(c) Present vacancy levels prevent adoption of supervisory practice	Active recruitment to ward nursing establishment so releasing ward sister –for supervisory practice (8.5)		Sep 2014 ACN
	To promote and support older peoples champions network and new dementia champions network		Monthly monitoring of numbers and activity	No gaps identified	No action needed		

	Targeted development activities for key performance indicators - answering call bells - assistance to toilet - involved in care - discharge information		Monthly monitoring and tracking of patient feedback results Monthly monitoring of Friends and Family Test reported to the Trust board				
	Clinical staff development opportunities prioritised in CBUs/divisions						
	Appointment of carers advocacy post to lead carers involvement in care		Funding agreed for 12 months	No gaps identified	No action needed		
	Ensure completion of patient profile on every appropriate patient admitted		Audit results every 6 month	No gaps identified	No action needed		
	Agreed avoiding harm priorities: ➢ Falls ➢ Acting on results in ED ➢ Senior review, ward rounds, and notation.		Quality Action Group meets monthly – provides direction, pace and support and includes divisional representation Achievement against key objectives and milestones report to Trust board on a monthly basis	No gaps identified	No action needed		
	Relentless attention to 5 Critical Safety Actions (CSA) initiative to lower mortality		Q&P report to Trust Board showing outcomes for 5 CSAs. 4CSAs form part of local CQUIN monitoring. RAG rated green at end of quarter 2. M&M CSA removed from CQUIN monitoring due to full implementation	(c) Lack of a unified IT system in relation to ordering and receiving results means that many differing processes are being used to acknowledge/respond to results. Potential risk of results not being acted upon in a timely fashion.	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. Utilisation of CQUIN monies for 2013/14 to invest in data collection posts at ward level.		Monthly outcome report of '4 Harms' is reported to Trust board via Q&P report New DoH definitions may see an increase in harm attributed to UHL to encourage closer working between primary and secondary care.	a) There is a risk that some data may not be accurate due to complex DoH definitions of each harm in relation to whether it is community or hospital acquired.	Action to be identified.		

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.	Review of demand and capacity in key specialities using 'intensive support' tool	4x3=12	Key specialities will go onto weekly performance meetings with COO	(a) No external assurance of recovery plans	The Intensive Support team will be invited into UHL to provide assurance to recovery plans (9.9)	4x3=12	Sep 2013 COO
	Backlog plans to recover 18 week referral to treatment (RTT) target		Monthly Q&P report to Trust Board showing 18 week RTT rates Weekly monitoring of backlog numbers via Head of Performance Improvement.	(c) Backlog plans require further development in line with review of demand and capacity in key specialties. (c) Capacity issues created by emergency demand causes cancellations of operations.	Further development of backlog plans. (9.8) On-going work on ward processes in Acute to free up capacity. (9.1) Re-configuration of surgical beds to create a 'protected area' for surgical patients. (9.2)		Aug 2013 Aug 2013 COO Nov 2013 COO
	Referral pathways to decrease demand and ensure discharge to GP where appropriate.			(a) Lack assurance in relation to performance metrics to show activity versus number of patients deferred onto a different care pathway.	Development of key metrics at a local level. (9.3)		Review August 13 COO
	Transformational theatre project to improve theatre efficiency to 80 -90%.		Monthly theatre utilisation rates. Theatre Transformation monthly meeting. Transformation update to Board.	No gaps identified.	No actions required.		
	Emergency Care process redesign (phase 1) implemented 18 February 2013 to improve and sustain ED performance.		Monthly report to Trust Board in relation to Emergency Dept (ED) flow (including 4 hour breaches).	See risk number 2.	See risk number 2.		

	Each tumour site has developed action plans to achieve targets. (Expected that target of 85% to be delivered by April 2013)		Chief Operating Officer receives reports from Cancer Manager and information included within Monthly Q&P report to Trust Board. Monthly trajectory agreed and monitored at Board via exception report. Cancer 62 action plan agreed with CCG and reported and monitored at Executive Performance board.	(c) Gaps identified in Imaging (c) 62 day cancer target delivery below target	Action plan to resolve Imaging issues to be developed (9.7) Cancer Clinical lead, Cancer Centre Managers and Trackers to be recruited. (9.5)		Review Aug 2013 COO Aug 2013 COO
	Ongoing monitoring of key performance indicators.		Monthly Q&P report to Trust Board.	No gaps identified.	No actions required.		

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

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

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

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

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

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to integrate the IM&T programme into mainstream activities	Managed Business Partner for IM&T services to deliver IT that will be a key enabler for our clinical strategy. IM&T now incorporated into Improvement and Innovation Framework	3x3=9	IM&T Board in place. Quarterly reports to Trust Board	No gaps identified	No actions required	3x2=6	
	Engagement with the wider clinical communities (internal) including formal meetings of the newly created advisory groups/ clinical IT. Improved communications plan incorporating process for feedback of information		CMIO(s) now in place, and active members of the IM&T meetings The joint governance board monitors the level of communications with the organisation				
	Engagement with the wider clinical communities (External). UHL CMIOs are added as invitees to the meetings, as are the clinical (IM&T) leads from each of the CCGs		UHL membership of the wider LLR IM&B board	No gaps identified	No actions required		

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

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	Current Score I x L	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	Target Score I x L	**Timescale** When will the action be completed?
Failure to implement and embed an effective medical training and education culture with subsequent critical reports from commissioners, loss of medical students and junior doctors, impact on reputation and potential loss of teaching status.	Medical Education Strategy and Action Plan	4x3 = 12	Strategy approved by the Trust Board Strategy monitored by Operations Manager and reviewed monthly in Full team Meetings.	(c) Lack of engagement/awareness of the Strategy with CBUs.	Meetings to discuss strategy with CBUs (13.1)	3x2 = 6	Dec 2013 MD
	UHL Education Committee		Professor Carr reports to the Trust Board	(c) Attendance at the Committee could be improved. (c) Communication to trainees needs to be improved (c) Improved trainee representation on Trust wide committees	Relevance of the committee to be discussed at CBU Meetings (13.2) Doctors in Training Committee needs to be established along with terms of reference (13.3)		Dec 2013 MD Nov 2013 MD
	Education and Patient Safety		Reports submitted to the Education Committee Terms of reference and minutes of meetings	(c) Improve engagement with other patient safety activities/groups	Build relationships with CBU Quality Leads. Establish links with LEG/QAC and QPMG. (13.4)		Dec 2013 MD

	Quality Monitoring		Quality dashboard for education and training monitored monthly by Operations Manager, Quality Manager and Education Committee. Education Quality Visits to CBUs Monitor progress against the Education Strategy and GMC Training Survey results	(a) Information is from diverse sources – the collation of information needs to be established (a) Lack of engagement with CBUs to share findings from the dashboards (a) Do not currently ensure progress against strategic and national benchmarks (c) Inadequate educational resources	Introduce exit surveys for trainees Communicate feedback from the GMC training survey and LETB Visits via the Dashboard. (13.5) Attend CBU management meetings and liaise with CBUs. (13.6) Monitor UHL position against other trusts nationally. (13.7) New Library/learning facilities to be developed at the LRI .(13.8)		Dec 2013 MD Dec 2013 MD Review Sep 2013 Oct 2013 MD
	Educational project teams to lead on education transformation projects		Project team meets monthly	(c) Implementation of the project within Acute Medicine needs to be improved.	Dr Hooper in post for Acute Medicine to implement project. (13.9)		Feb 2014 MD
	Financial Monitoring		SIFT monitoring plan in place	(c) Poor engagement with CBUs in relation to implication of SIFT	Need to engage with the CBUs to help them understand the implication of SIFT and their funding streams. (13.10)		Dec 2013 MD

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	**July 2013**
Frequency of review:	Monthly
Date of last review:	June 2013

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
1	**Failure to achieve financial sustainability**					
1.3	Review of non-contractual pay controls	DHR		Review July 2013	**Complete.** Controls currently in place: Non contractual payments (premium spends) are reported monthly to the Finance and Performance Committee. Non Contractual Payments are discussed at monthly Divisional Confirm and Challenge Meetings. All Divisions (by CBU) have produced premium spend trajectories and associated plans until March 2014. Weekly Staff Bank data reports are issued for medical and nursing (qualified and unqualified) staff. Controls of non-contracted pay costs are in place within each Division. Action plan to increase bank staff capacity and drive down agency nurse expenditure. Weekly meetings with HoNs and DHR to monitor progress.	5

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
1.5	Refreshed CIP programme management arrangements.	DFBS	HTCIP	Review August 2013	Recently appointed (early May) interim Head of Trust Cost Improvement Programme to lead overall programme.	4
1.6	Re-establishing clinical coding improvement team under John Roberts. Initial action plan in place.	COO	ADI	Review August 2013	Change of action owner (previously DFBS). June update: New coding positions went before the panel in June, further work required on JDs to be submitted again in July. Actions being taken to expedite this. This will cause delay in recruitment to revised structure.	3
1.9	SLM Action plan is awaited.	DFBS		~~July~~ August 2013	SLM Development session now planned for 5 August 2013 therefore deadline extended.	3
1.10	Financial Recovery plans being developed by Acute and Planned Care divisions – to be agreed at ET Performance Board.	DFBS	DM Acute Care and Planned Care	July 2013	**Complete.** Recovery Plans submitted by Acute and Planned Care to the July EPB and F&P Committee. A further iteration is going to the August EPB.	5
1.11	Ongoing discussions with commissioners about planned re-investment of the MRET deductions.	DFBS		Review August 2013	Discussions ongoing.	4
1.12	Monthly monitoring of action plan to ensure financial recovery.	DFBS		Review July 2013	**Complete.** The financial recovery plan will be monitored monthly throughout the financial year at EPB and the F&P Committee. The NTDA will also receive a monthly update in line with their recently submitted standard format.	5
1.13	Ongoing discussions with commissioners about planned re-investment of contract deductions and performance fines.	DFBS		~~July~~ August 2013	A specific meeting with CCG colleagues is planned for August.	3
1.14	Ownership of readmissions work stream	DFBS	CD/DM	July 2013	Planned Care - Readmissions are	5

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
	at divisions to be clarified.				reported by CBU in the weekly divisional metrics and discussed at weekly Operational Delivery Group, the Divisional Executive Team meetings and the Quality Safety Board There are also specific pathway redesign projects that aim to also reduce readmissions. These streams of work have a project structure around them and will be picked up by the planned care steering group as areas for joint CCG/UHL pathway re-design. Acute - Readmissions form part of divisional dashboard and CBU Dashboard with performance reviewed on a weekly at the basis via divisional meeting and also at the CBU confirm and challenge. The Divisional Head of Nursing runs a Divisional re-admissions group.	
1.15	Further iteration of Financial Recovery plans for Acute and Planned Care divisions – to be agreed at August ET Performance Board.	DFBS	DM Acute Care and Planned Care	August 2013		4
1.16	Formal sign off of the Transformation bids.	DFBS		August 2013		4
2	**Failure to transform the emergency care system**					
2.6	CD for ED and GM will validate all data entry for quality metrics.	COO	CD and DM for ED	July 2013	**Complete** with ongoing review.	5

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
2.7	Continue with substantive appts until funded establishment within ED is achieved.	COO		Review Sep 2013	On track.	4
2.8	Roll out of actions from ECAT action plan.	COO		July 2013	**Complete.**	5
2.9	CCG/LPT to increase capacity by use of Intermediate Care Services.	COO		August 2013	DTOCs reduced but not at level required yet.	3
2.10	Risks from 'single front door' theme to be escalated via ECAT and raised with CCG Managing Director as required.	COO		August 2013	**Complete.**	5
2.11	Review required to check accuracy of EDDs to ensure provision of EDDs for all patients.	COO		August 2013	On track.	4
3	**Inability to recruit, retain, develop and motivate staff**					
3.1	Revise UHL reward and recognition strategy.	DHR		October 2013	On track.	4
3.2	Take baseline from January and measure progress in relation to the success of recruitment events now that there is a structured plan for bulk recruitment. Identify a lead from each professional group to develop and encourage the production of fresh and up to date material.	DHR		December 2013	On track.	4
3.3	Development of Pay Progression Policy for Agenda for Change staff.	DHR		October 2013	On track.	4
3.4	Implementation of Recruitment and Retention Premia for ED staff.	DHR		September 2013	On track.	4
3.5	Ensure Statutory and Mandatory training is easy to access and complete with 75% compliance	DHR		March 2014	On track.	4

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
3.6	Local actions and projected appraisal performance improvement trajectories to be agreed with Divisions and Directorates Boards.	DHR		August 2013	On track.	4
3.7	Appraisal quality assurance findings to be reported to Divisions / Directorates Boards and local staff engagement/experience action plans updated accordingly.	DHR		August 2013	On track.	4
4	**Ineffective organisational transformation**					
5	**Ineffective strategic planning and response to external influences**					
5.13	Establish Business Strategy Support Team.	CEO	MW	July 2013	**Complete.** Approved by ET and Trust Board. Moving to implementation.	5
5.14	Agree approach to gathering market intelligence and response via proposal from DMC.	CEO	MW	July 2013	**Complete.** Approved by ET and to be implemented by BSST.	5
5.15	Present ESB forward plan to reflect 12 month programme for approval to July meeting.	CEO		July 2013	**Complete.** Programme developed and to be agreed at ESB meeting on 6 August.	5
6	**Failure to achieve FT status**					
6.10	Director of Strategy to be Exec lead for BCT. Ad hoc cover to continue until appointment in place.	CEO		October 2013	Recruitment of DS in progress. Interim arrangements in place.	4

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
6.11	Action plans to be developed to address recommendations from independent reviews.	CEO	DCLA	~~Review July~~ September 2013	Document sourced from Sandwell and West Birmingham NHS Trust that will serve to complement our existing policy for responding to external recommendations and requirements. The Director of Clinical Quality will now work to merge these two documents and provide a revised UHL policy. Deadline extended to reflect the timeline for this work.	3
7	**Failure to maintain productive and effective relationships**					
7.2	Extend the surveys into wider group of stakeholders to complement the 'soft intel'.	DMC		September 2013	On target for plan caution over resource implications, maintain current RAG rating.	3
8	**Failure to achieve and sustain quality standards**					
8.1	Better use of routine data analysis tools including DFI and HED to assist in analysis of out of hour/ weekend mortality figures.	MD		September 2013		4
8.2	Women's CBU to work with Dr Foster and other trusts to better understand risk adjustment model related to the national quality dashboard.	MD		January 2014		4
8.3	Undertake LLR Mortality review.	MD		June /July 2013	**Complete.**	5
8.5	Active recruitment to ward nursing establishment so releasing ward sister for supervisory practice.	ACN		September 2014	On going recruitment process in place and is likely to take 12 -18months. Deadline extended to reflect this.	3
8.6	Prioritise clinical staff development opportunities in CBUs/Division.	ACN		July 2013	**Complete.**	5
8.9	Analysis of mortality review by Public Health.	MD		September 2013		4

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
8.10	Implementation of Electronic Patient Record (EPR)	CIO		2015		4
9	**Failure to achieve and sustain high standards of operational performance**					
9.1	On-going work on ward processes in Acute to free up capacity to recover RTT target.	COO		~~June 2013~~ ~~July 2013~~ August 2013	Plan in place to release a ward to Haematology to enable refurbishment although acute still occupy surgical ward. June update: The Haematology ward is planned to go to Odames on the 18th July. Remedial work to Odames has now started; project group is set up and have met twice to deal with the detail. On track- although completion date deferred to ensure COO has appropriate personal knowledge to confirm completion.	3
9.2	Re-configuration of surgical beds to create a 'protected area' for surgical patients.	COO	HO/DM Planned	November 2013	On track.	4
9.3	Development of key metrics at a local level to show number of patients deferred onto a different care pathway.	COO		Review ~~July~~ August 2013	On track- although completion date deferred to ensure COO has appropriate personal knowledge to confirm completion	3
9.5	Cancer Clinical lead, Cancer Centre Managers and Trackers to be recruited.	COO	DM Planned	~~June 2013~~ August 2013	Cancer clinical lead and trackers in post in June 2013. Cancer senior manager / nurse interview is arranged for the 9th July. On track- although completion date deferred to ensure COO has appropriate personal knowledge to confirm completion.	3
9.6	Continued monitoring of outpatient delivery plan to reduce cancellations.	COO	TT	Review June 2013	**Complete** with ongoing reviews.	5

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REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
9.7	Action plan to resolve Imaging issues to be developed.	COO		~~July~~ August 2013	This action to be reviewed during August 2013 to ensure COO has appropriate personal knowledge to confirm completion.	3
9.8	Further development of backlog plans in line with review of demand and capacity in key specialties.	COO		August 2013	On track.	4
9.9	The Intensive Support team will be invited into UHL to provide assurance to recovery plans.	COO		September 2013	On track.	4
10	**Inadequate reconfiguration of buildings and services**					
10.1	Key measures for gauging success of clinical strategy to be developed by specialties as part of their 'mini-IBPs' and will be monitored via divisional and directorate boards.	MD		December 2013	On track.	4
10.2	Ensure success of FT Application (see risk 6 for further detail).	CEO		April 2015	On track.	4
10.3	Secure capital funding to implement Estates Strategy.	DFBS		~~May 2013~~ December 2013	Work underway on capital planning around reconfiguration – SOC due for completion in Dec '13 / Jan '14 which will be the key vehicle to agree availability of capital funding.	4
11	**Loss of business continuity**					
11.1	Tailored training packages for service area based staff to ensure continued delivery of major incident training.	COO	EPO	~~July~~ August 2013	This action to be reviewed during August 2013 to ensure COO has appropriate personal knowledge to confirm completion.	3

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
11.2	Determine an approach to delivering a physical testing of the IT Disaster Recovery arrangements which have been identified as a dependency for critical services. Include assessment of the benefits of realistic testing of arrangements against the potential disruption of testing to operations.	COO	CIO	September 2013	On track	4
11.3	Assess our requirements of the critical suppliers and ensure that their response fulfils our requirements and include business continuity arrangements.	COO	EPO	September 2013	On track – currently reviewing all responses to develop benchmark criteria to assess resilience within suppliers.	4
11.6	Continue to engage with Interserve and service areas around development of Business Continuity Plans.	COO	EPO	September 2013	Still no dedicated lead in Interserve to oversee BCM.	3
11.7	Issues/lessons will feed into the development of local plans and training and exercising events to ensure lessons are learnt from incidents.	COO	EPO	September 2013	This will be a continual process and will feed into the first set of plans to be produced.	4
11.8	Further processes require development, particularly with the new Facilities and IM&T providers to ensure resilience is considered/ developed when implementing new systems, infrastructure and processes.	COO	EPO	~~July~~ August 2013	IM&T – Completed, Emergency Planning and Head of Ops are consulted as part of the change board approval process. Interserve – Process still to be agreed.	3
11.9	Emergency Planning Officer and Divisional BCM leads will ensure that business continuity plans developed are coordinated between service areas/CBUs/Divisions.	COO	EPO/ Divisional BCM leads	September 2013	This will be a continual process and will feed into the first set of plans to be produced.	4

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REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
11.10	Training and Exercising events to involve multiple CBUs/Divisions to validate plans to ensure consistency and coordination.	COO	EPO Divisional BCM leads	August 2014	BCM training and exercising programme has been developed.	4
12	**Failure to exploit the potential of IM&T**					
12.3	An improved communications plan for IM&T strategy to be presented to the JGB for approval.	CIO		July 2013	**Complete.** Communications is now a standing item on the JGB agenda and an improved plan will be presented in June.	5
12.5	Increased engagement and communications with the relevant departments to ensure that we capture requirements and communicate benefits of IM&T strategy.		CIO/ CMIO	August 2013	We have met with all divisions and produced a standard presentation. Key stakeholders have been identified and have had an initial engagement around requirements and benefits. Further activities are planned as part of specific projects or general communications. A new round of engagement activities with the CBUs has started.	4
12.6	Refine the proposal around benefits reporting to ensure we have a standard reporting methodology and that it is in line with trust expectations.	CIO		September 2013	Initial conversations have taken place with the IBM and benefits stakeholders. IBM has produced an approach to identification and realisation of benefits; this will need to be verified by the trust and amended to reflect our new "to-be" processes as part of the Innovation Framework.	4

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
12.7	Initial engagement with key members of the TDA to ensure there is sufficient understanding of technology roadmap and their involvement.	DFBS	CIO	August 2013	Initial conversations have happened, we now have their approvals paperwork and we are working through the implications.	4
13	**Failure to enhance education and training culture**					
13.1	To improve CBU engagement, facilitate meetings to discuss Medical Education Strategy and Action Plans with CBUs.	MD	AMD	December 2013	On track.	4
13.2	Relevance of the UHL Education Committee to be discussed at CBU Meetings in an effort to improve attendance.	MD	AMD	December 2013	On track.	4
13.3	'Doctors in Training' Committee needs to be established along with terms of reference to ensure more effective communication to Juniors.	MD	AMD	November 2013	On track.	4
13.4	Build relationships with CBU Quality Leads and establish links with LEG/QAC and QPMG in an effort to improve engagement with other patient safety activities/groups.	MD	AMD	December 2013	On track.	4
13.5	Introduce exit surveys for trainees and communicate feedback from the GMC training survey and LETB Visits via the Dashboard.	MD	AMD	December 2013	On track.	4
13.6	Attend CBU management meetings and liaise with CBUs in an effort to improve engagement of CBUs.	MD	AMD	December 2013	On track.	4
13.7	Monitor UHL position against other trusts nationally to ensure progress against strategic and national benchmarks.	MD	AMD	Review September 2013	On track.	4

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REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
13.8	New Library/learning facilities to be developed at the LRI to help resolve inadequate educational resources.	MD	AMD	October 2013	On track.	4
13.9	Dr Hooper in post for Acute Medicine to implement project and improve Acute Medicine progress.	MD	AMD	February 2014	On track.	4
13.10	Need to engage with the CBUs to help them understand the implication of SIFT and their funding streams.	MD	AMD	December 2013	On track.	4

Key to initials of leads

CEO	Chief Executive Officer
DFBS	Director of Finance and Business Services
MD	Medical Director
AMD	Assistant Medical Director
COO	Chief Operating Officer
DHR	Director of Human Resources
ACN	Acting Chief Nurse
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
DM	Divisional 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

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HoN	Head of Nursing
TT	Transformation Team

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

Appendix 3

UHL BOARD ASSURANCE FRAMEWORK SUMMARY REPORT – JULY 2013

Risk No	Risk Title	Current Risk Score (Jul 13)	Previous Risk Score (Jun 13)	Target Risk Score and Final Action Date	Risk Owner	Comment
1	Failure to achieve financial sustainability	25	25	12 – Aug 13	DFBS	Deadline extended.
2	Failure to transform the emergency care system	25	25	12 – review Sep 13	COO	
3	Inability to recruit, retain, develop and motivate staff	16	16	12 – Mar 14	DHR	Deadline extended to reflect the work required to ensure Statutory and Mandatory training is easy to access and complete with 75% compliance.
4	Ineffective organisational transformation	12	12	12	CEO	Target score achieved risk closed.
5	Ineffective strategic planning and response to external influences	12	16	12 – Jul 13	CEO	Target score achieved risk closed.
6	Failure to achieve FT status	16	16	12 – Oct 13	CEO	Deadline indicates completion of actions to enable a successful application NOT date of achievement of FT.
7	Failure to maintain productive and effective relationships	15	15	10 – Sep 13	DMC	
8	Failure to achieve and sustain quality standards	16	16	12 – 2015	ACN/MD	Deadline extended to reflect the improvements required in IT systems to fully implement 'Acting on results' critical safety action.
9	Failure to achieve and maintain high standards of operational performance	12	12	12 – Nov 13	COO	Target score achieved but risk remains open until final actions completed and confident of sustained performance improvements.
10	Inadequate reconfiguration of buildings and services	12	12	9 – Apr 15	DFBS	Deadline extended reflecting the fact that some reconfiguration will be dependent upon becoming successful FT.
11	Loss of business continuity	9	9	6 – Aug 14	COO	
12	Failure to exploit the potential of IM&T	9	9	6 – Sep 13	DFBS	
13	Failure to enhance education and training culture	12	n/a	6 – Feb 14	MD	New risk

Appendix 4

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?

Appendix 5

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

NEW RISKS SCORING 15 OR ABOVE FOR THE PERIOD ENDING 31/07/2013

REPORT PRODUCED BY: UHL RISK AND ASSURANCE MANAGER

Key

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

ACTION **Red text highlights where an action is outstanding (either an action has an elapsed action due date or there is no due date listed).**

Division	Directorate	Risk Title	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Movement	Div/Exec Director	Strategic risk No.
Acute	Imaging & Medical Physics	There is a risk of a backlog of unreported images	28/07/2009	**Causes** Backlog of unreported images on PAC'S (Plain Film, CT, MRI) which could lead to a major clinical risk incident and a potential for litigation and adverse media publicity. Royal College Radiologists guidelines state that all images should be reported IRMER require all images involving ionising radiation to be clinically evaluated **Consequences** Risk of suboptimal treatment Potential for patient dissatisfaction / complaint Potential for litigation	Patients	Ongoing reporting by radiologists and reporting radiographers Allocation of CT/MRI examinations to a intended radiologist or specialty group House keeping done by clerical and superintendents to ensure images are visible on PACS. Outsourcing overdue reporting to medica.	Major	Likely	16	An escalation policy to be developed - due 04/10/13	6	▲	PR/KB	3