University Hospitals of Leicester NHS
NHS Trust

To:	**Trust Board**
From:	**Rachel Overfield - Chief Nurse**
Date:	**25th September 2014**
CQC regulation:	Outcome 16 – Assessing and Monitoring the Quality of Service Provision

Trust Board paper L

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

Author/Responsible Director: Chief Nurse

Purpose of the Report:

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

a) A copy of the UHL BAF and action tracker as of 31st August 2014.

b) Notification of any new extreme or high operational risks opened during August 2014.

The Report is provided to the Board for:

Decision		Discussion	
Assurance	X	Endorsement	

Summary :

- In relation to the 2014/15 BAF the TB is asked to note the following:
  - The 'current' risk scores for principal risks 2 and 3 have increased from 12 to 16 to reflect current levels of ED performance.
  - At the August 2014 TB meeting (action item no. 9d) it was agreed that the monthly TB review of the BAF be structured so as to include all the principal risks relating to an individual strategic objective. Consequently, Objective C: *'Responsive services which people choose to use'* is suggested for review which will incorporate principal risks 5, 6, 7 and 8.
- To assist the TB in maintaining awareness of current operational risks scoring 15 or above (i.e. 'high' or 'extreme' risks), the TB is asked to note that 5 new high risks have opened on the organisational risk register during August 2014.
- In response to two actions raised at the TB meeting in August, section 4.1 of this report describes the levels of senior review and challenge concerning operational risks (action item no. 9c) and section 4.2 provides details of the two separate scoring systems for the BAF and the organisational risk register.

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 BAF to address any gaps in either controls or assurances (or both);

(c) identify any areas which it feels that the BAF 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 on the BAF and consider the nature of, and timescale for, any further assurances to be obtained;

(e) identify any other BAF 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 new operational risks scoring 15 or above opened on the organisational risk register during August 2014.

(g) note the risk scoring systems in place for the organisational risk register and the BAF (item no. 9c - TB meeting in August 2014).

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **UHL TRUST BOARD**

DATE: **25th SEPTEMBER 2014**

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

SUBJECT: **UHL RISK REPORT (INCLUDING THE BOARD ASSURANCE FRAMEWORK AND THE ORGANISATIONAL RISK REGISTER)**

---

1 INTRODUCTION

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

a) A copy of the revised UHL BAF as of 31st August 2014.
b) A BAF action tracker to monitor progress of actions.
c) Notification of any new extreme or high operational risks from the organisational risk register opened during August 2014.
d) A response to a query re risk scoring at Trust Board in August 2014.

2. 2014/15 BAF AS OF 31ST AUGUST 2014

2.1 A copy of the 2014/15 BAF is attached at appendix 1 with changes since the previous version highlighted in red text. A copy of the BAF action tracker is attached at appendix 2.

2.2 In relation to the BAF the TB is asked to note the following points:

a. In August 2014 (TB action item no. 9) the TB enquired that consideration be given to *'dividing principal risk 1 into UHL and LLR system-wide components'* reflecting the outcomes from the LLR review. The Chief Nurse and corporate risk team will review and advise as to whether this can be achieved or if an additional principal risk will need to be included on the BAF. Changes in relation to this will be reflected in the BAF report to the TB meeting in October 2014.

b. Principal risks 2 and 3 have had their 'current' risk scores increased from 12 – 16 in order to reflect current levels of ED performance. Following discussions at TB in August, principal risk 4 has had its 'current' risk score increased to 12.

c. At the TB meeting in August 2014 (action item no. 9d) it was agreed that the monthly TB review of the BAF be structured so as to include all the principal risks relating to an individual strategic objective. The following objective is therefore submitted to this TB for discussion and review:

- Objective C: *'Responsive services which people choose to use'*. This objective incorporates principal risk numbers 5, 6, 7 and 8.

3. EXTREME AND HIGH ORGANISATIONAL RISK REGISTER REPORT

3.1 To assist the TB in maintaining awareness of current operational risks scoring 15 or above (i.e. 'high' or 'extreme' risks), the TB is asked to note that 5 new high risks have opened during August 2014, as described in the table below. A full description for each of these risks is included at appendix 3, for information purposes.

3.2

Risk ID	Operational Risk Title	Score	CMG/Corporate Directorate
2402	Inappropriate Decontamination practise within UHL may result in harm to patients and staff	15	Corporate Nursing
2403	Changes in the organisational structure have adversely affected water management arrangements in UHL	20	Corporate Nursing
2404	Inadequate management of Vascular Access Devices resulting in increased morbidity and mortality	20	Corporate Nursing
2409	There is an insufficient number or middle-grade doctors, both registrars and SHO's to provide adequate service cover	20	Women's & Children's
2407	Failure to meet national non admitted target of 18 weeks	15	Women's & Children's

4.0 ACTION FROM TRUST BOARD MEETING IN AUGUST 2014

4.1 Responding to a question raised at Trust Board in August (action item no. 9c), the Board is asked to note the levels of senior review and challenge regarding content and scoring of operational risks is as follows:

1) Line manager to sign-off the assessment prior to submitting a copy to CMG Quality & Safety Board (or equivalent);
2) CMG / corporate director or deputy to approve the risk assessment for entry onto the organisational risk register;
3) The corporate risk team closely monitor new and open risks and where necessary will 'temporarily suspend' a risk if information is missing and notify the risk owner of the reasons;
4) The Executive Team via the weekly notification report of new risks scoring 15 and above, and also through the monthly reporting of high and extreme risks and the twice yearly reporting of moderate risks to EPB meetings.

4.2 The UHL use a 5 x 5 matrix to assign a risk rating between 1 and 25 for all types of risks, including local risks on the operational risk register and principal risks on the BAF. However, the scoring descriptors for these two processes are different and should not be confused. Operational risks are assigned a risk rating by using a nationally adapted framework which assesses the consequence to harm (of patients, staff and others), quality, human resources, statutory, reputation, business, economic and environment. A new scoring system has been developed for the BAF to assess the level of risk to the achievement of the relevant strategic objective. Where it is identified that an operational risk is of strategic significance and needs to be escalated onto the BAF the risk should be re-evaluated using the BAF scoring system to assess the impact on the achievement of the appropriate strategic objective. For completeness, all risk scores are calculated by consequence multiplied by likelihood. The Trust's Internal Auditors support this new approach to more clearly define the scoring descriptors for these two separate processes and this new method has been ratified at Audit Committee. A copy of the two scoring systems is attached as appendix 4, for information.

5. 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 BAF to address any gaps in either controls or assurances (or both);

(c) identify any areas which it feels that the BAF 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 on the BAF and consider the nature of, and timescale for, any further assurances to be obtained;

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

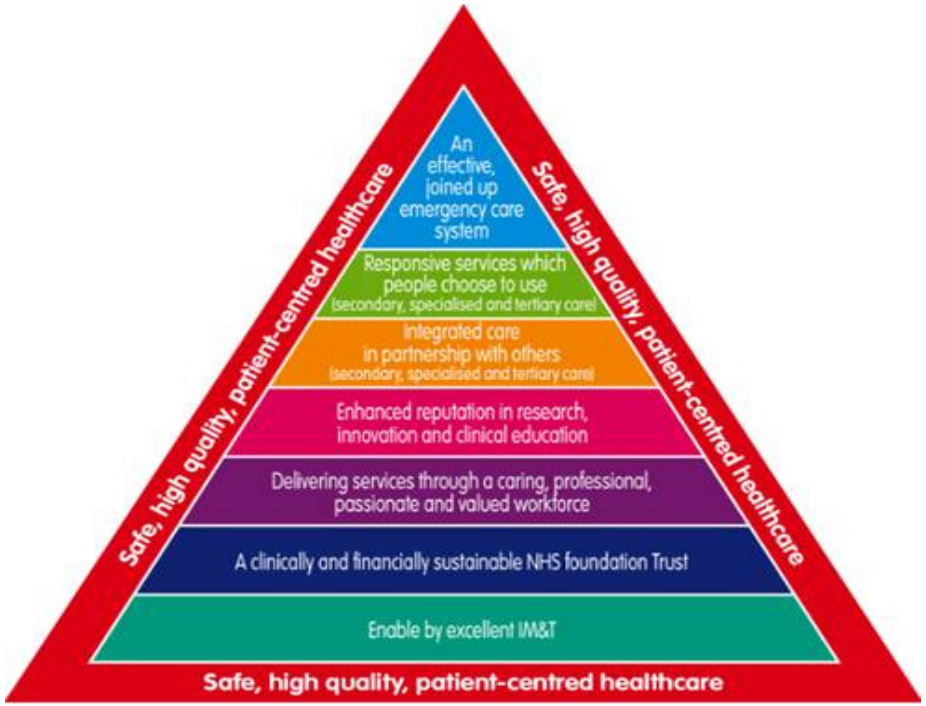
(f) note the new operational risks scoring 15 or above opened on the organisational risk register during August 2014.

(g) note the risk scoring systems in place for the organisational risk register and the BAF (item no. 9c - TB meeting in August 2014).

Richard Manton/Peter Cleaver
Risk and Assurance
18 September 2014

Appendix 1

UHL BOARD ASSURANCE FRAMEWORK 2014/15



UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Appendix 1

STRATEGIC OBJECTIVES

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Appendix 1

PERIOD: AUGUST 2014

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

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

BAF Consequence and Likelihood Descriptors:

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Appendix 1

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Corporate leads agreed for all component parts of the Quality Commitment.	Q&P Report. Reports to EQB and QAC.	(c) Quality Commitment not fully embedded within organisation	Corporate leads to embed QC into organisation (1.1)	September 2014 Chief Nurse
Objectives agreed for all parts of the Quality Commitment.	Reports to EQB and QAC based on key outcome/KPIs.	(a) KPIs for QC not fully developed	Corporate leads to develop KPIs (1.2)	September 2014 Chief Nurse
Clear action plans agreed for all parts of the Quality Commitment.	Action plans reviewed regularly at EQB and annually reported to QAC. Annual reports produced.	(c) Some action plans remain outstanding.	Corporate leads to complete action plans (1.3)	September 2014 Chief Nurse
Committee structure is in place to ensure delivery of key work streams – led by appropriate senior individuals with appropriate support.	Regular committee reports. Annual reports. Achievement of KPIs.	No gaps identified		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Appendix 1

Principal risk 2	Failure to implement LLR emergency care improvement plan.	**Overall level of risk to the achievement of the objective**	**Current score** 4 x 4 = 16	**Target score** 3 x 2 = 6
Executive Risk Lead(s)	Chief Operating Officer			
Link to strategic objectives	An effective joined up emergency care system			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Establishment of emergency care delivery and improvement group with named sub groups	Meetings are minuted with actions circulated each week. Trust Board emergency care report references the LLR steering group actions.			
Appointment of Dr Ian Sturgess to work across the health economy	Weekly meetings between Dr Sturgess, UHL CEO and UHL COO. Dr Sturgess attends Trust Board.	(c) Dr Sturgess is contracted to finish work here in mid-November 2014.	CEO and Dr Sturgess to agree plans to ensure legacy is sustainable (2.2)	Sep 2014 CE
Allocation of winter monies	Allocation of winter monies is regularly discussed in the LLR steering group			

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Appendix 1

Principal risk 3	Failure to effectively implement UHL Emergency Care quality programme.	**Overall level of risk to the achievement of the objective**	**Current score** 4 x 4 = 16	**Target score** 3 x 2 = 6
Executive Risk Lead(s)	Chief Operating Officer			
Link to strategic objectives	An effective joined up emergency care system			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Emergency care action team meeting has been remodelled as the 'emergency quality steering group' (EQSG) chaired by CEO and significant clinical presence in the group. Four sub groups are chaired by three senior consultants and chief nurse.	Trust Board are sighted on actions and plans coming out of the EQSG meeting.	(C) Progress has been made with actions outside of ED and we now need to see the same level of progress inside it	Subgroup to focus on the front end of the pathway to ensure progress within ED (3.1)	Sep 2014 COO
Reworked emergency plans are focussing on the new dashboard with clear KPIs which indicates which actions are working and which aren't	Dashboard goes to EQSG and Trust Board	(C) ED performance against national standards	As above	Sep 2014 COO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Appendix 1

Principal risk 4	Delay in the approval of the Emergency Floor Business Case.	**Overall level of risk to the achievement of the objective**	**Current score** 4 x 3 = 12	**Target score** 3 x 2 = 6
Executive Risk Lead(s)	Medical Director			
Link to strategic objectives	An effective joined up emergency care system			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Monthly ED project program board to ensure submission to NTDA as required Gateway review process Engagement with stakeholders	Monthly reports to Executive Team and Trust Board Gateway review	(c) Inability to control NTDA internal approval processes	Regular communication with NTDA (4.1)	Aug 2014 MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Appendix 1

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Fortnightly RTT meeting with commissioners to monitor overall compliance with plan	Trust Board receives a monthly report detailing performance against plan	(c) UHL is behind trajectory on its admitted RTT plan	Action plans to be developed in key specialities – general surgery and ENT to regain trajectory (5.1)	Sept 2014 COO
Weekly meeting with key specialities to monitor detailed compliance with plan	Trust Board receives a monthly report detailing performance against plan	(c) UHL is behind trajectory on its admitted RTT plan	As above	Sep 2014 COO
Intensive support team back in at UHL (July 2014) to help check plan is correct	IST report including recommendations to be presented to Trust Board	(a) Report has not been seen yet	Await publication of report and act on findings and recommendations (5.2)	Oct 2014 COO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Appendix 1

Principal risk 6	Failure to achieve effective patient and public involvement	**Overall level of risk to the achievement of the objective**	**Current score 4x3=12**	**Target score 4x2=8**
Executive Risk Lead(s)	Director of Marketing and Communications			
Link to strategic objectives	Responsive services which people choose to use (secondary, specialised and tertiary care)			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
1. PPI / stakeholder engagement Strategy Named PPI leads in all CMGs 2. PPI reference group meets regularly to assess progress against CMG PPI plans 3. Patient Advisors appointed to CMGs 4. Patient Advisor Support Group Meetings receive regular updates on PPI activity and advisor involvement 5. Bi-monthly Membership Engagement Forums 6. Health watch representative at UHL Board meeting 7. PPI input into recruitment of Chair / Exec' Directors 8. Quarterly meetings with LLR Health watch organisations, including Q's from public. 9. Quarterly meetings with Leicester Mercury Patient Panel	Emergency floor business case (Chapel PPI activity) PPI Reference group reports to QAC July Board Development session discussion about PPI resource. Health watch updates to the Board Patient Advisor Support Group and Membership Forum minutes to the Board.	PPI/ stakeholder engagement strategy requires revision Time available for CMG leads to devote to PPI activity Incomplete PPI plans in some CMGs PA vacancies (4) Single handed PPI resource corporately	Update the PPI/stakeholder engagement strategy (6.1) Revised PPI plan (6.2) OD team involvement to reenergise the vision and purpose of Patient Advisors (6.3)	Sep 2014 DMC Sept 14 DMC Oct 14 DMC

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Appendix 1

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**

Better Care Together Strategy:
• UHL actively engaged in the Better Care Together governance structure, from an operational to strategic level:
  ~~o~~ John Adler – member of the BCT Partnership Board (formerly the BCT Programme Board)
  o Kate Shields – Bed Reconfiguration lead for UHL
  o Kate Shields – SRO for Planned Care work stream
  o Mark Wightman – SRO for Comms & Engagement enabling work stream
  o Helen Seth – Workbook Lead for Long Term Conditions work stream
  ~~o~~ Paul Gowdridge – SRO for Finance / Activity Model enabling work stream
• Better Care Together plans co–created in partnership with LLR partners e.g. sub-acute project with LPT
• Better Care Together planning assumptions embedded in the Trust's 2015/16 planning round
	LLR Better Care Together Executive Summary (directional plan):
	• received and approved at the June 2014 UHL Trust Board meeting
	• BCT resource plan, identifying all work books named leads (SRO, Implementation leads and clinical leads agreed at the BCT Partnership Board (formerly the BCT Programme Board) meeting held on 21st August 2014
	• Workbooks for all 8 clinical work streams and 4 enabling groups underway –progress overseen by implementation group and the Strategy Delivery Group which reports to BCT Partnership Board.
		(c) Lack of detailed workbooks	Detailed work books to be developed (7.3)	Oct 2014
				DS

Effective partnerships with primary care and Leicestershire Partnership Trust (LPT):
1) Active engagement and leadership of the LLR Elective Care Alliance
2) LLR Urgent Care and Planned Care work streams in partnership with local GPs
3) A joint project has been established to test the concept of early transfer of sub-acute care to a community hospitals setting or home in partnership with LPT. The impact of this is reflected in UHLs, LPTs the LLR BCT 5 year plans.
	• Minutes of the June public Trust Board meeting:
	  o Trust Board approved the LLR BCT 5 year directional plan and UHLs 5 year directional plan on 16 June, 2014
	  o urgent care and planned care work streams reflected in both of these plans
	• BCT resource plan, identifying all work books
		(c) Lack of detailed workbooks	See action 7.3	Oct 2014
				DS

4) Mutual accountability for the delivery of shared objectives are reflected in the LLR BCT 5 year directional plan 5) Active engagement in the BCT LTC work stream. Mutual accountability for the delivery of shared objectives are reflected in the LLR BCT 5 year directional plan	named leads (SRO, Implementation leads and clinical leads agreed at the BCT Partnership Board (formerly the BCT Programme Board) meeting held on 21st August 2014 Workbooks for all 8 clinical work streams and 4 enabling groups underway – progress overseen by implementation group and the Strategy Delivery Group which reports to BCT Partnership Board.			

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Appendix 1

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
(i) Regional partnerships: UHL is actively engaging with partners with a view to: • establishing a Leicestershire Northamptonshire and Rutland partnership for the specialised service infrastructure in partnership with Northampton General Hospital and Kettering General Hospital • establishing a provider collaboration across the East Midland's as a whole • Developing an engagement strategy for the delivery of the long term vision for and East Midlands network for both acute and specialised services	Minutes of the April 2014 Trust Board meeting: ○ Paper presented to the April 2014 UHL Trust Board meeting, setting out the Trust's approach to regional partnerships Project Initiation Document (PID): ○ Developed as part of UHL's Delivering Care at its Best ○ Reviewed at the June 2014 Executive Strategy Board (ESB) meeting	(c) No Head of External Partnership Development or administrative support (c) Lack of Programme Plan	Appoint Head of Partnerships and admin support (8.2) Programme Plan to be developed (8.3)	Dec 2014 DS - Apr 2015 DS
(ii) Academic and commercial partnerships.		c) Lack of PID for commercial partnerships	PIDs to be developed and overarching highlight report to be presented at October ESB for sign off. (8.5)	Oct 2014 DMC
(iii) Local partnerships		(c) Lack of PID for local partnerships		
Specialised Services specifications: CMGs addressing Specialised Service derogation plans	Plans issued to CMGs in February 2014. Follow up meetings being convened for w/c 14th July 2014to identify progress to date.	(a) Currently no mechanism in place to monitor progress	Contracts Team to develop monthly reporting tool to track progress (8.4)	Sep 2014 DS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Appendix 1

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Directional 5 year Integrated Business Plan (IBP) submitted to the NHS Trust Development Authority (NTDA) defines three principle partnership networks to support the integration of services (Local, regional and academic). These will progress in a structured and methodical way. Clear lines of reporting have been established through the Executive Strategy Board (ESB) Delivering Care at its Best structure. Highlight reports will be presented to monitor progress.	Minutes of the April 2014 Trust Board meeting: o Paper presented to the April 2014 UHL public Trust Board meeting, describing the development of an East Midlands Provider Partnership Project Initiation Document (PID): o Developed as part of UHL's Delivering Care at its Best o Reviewed at the June 2014 ESB meeting			
Regional partnerships: UHL is actively engaging with partners with a view to: • establishing a Leicestershire Northamptonshire and Rutland partnership for the specialised service infrastructure in partnership with Northampton General Hospital and Kettering General Hospital • establishing a provider collaboration across the East Midland's as a whole • Developing an engagement strategy for the delivery of the long term vision for and East Midlands network for both acute and specialised services		(c) No Head of External Partnership Development or administrative support (c) Lack of Programme Plan	See action 8.2 See action 8.3	See action 8.2 See action 8.3
Academic and commercial partnerships		c) Lack of PID for commercial partnerships	See action 8.5	See action 8.5
Local partnerships		(c) Lack of PID for local partnerships		

Delivery of Better Care Together: • UHL actively engaged in the Better Care Together governance structure, from an operational to strategic level: o John Adler – member of the BCT Partnership Board (formerly the BCT Programme Board) o Kate Shields – Bed Reconfiguration lead for UHL o Kate Shields – SRO for Planned Care work stream o Mark Wightman – SRO for Comms & Engagement enabling work stream o Helen Seth – Workbook Lead for Long Term Conditions work stream o Paul Gowdridge – SRO for Finance / Activity Model enabling work stream • Better Care Together plans co–created in partnership with LLR partners e.g. sub-acute project with LPT Better Care Together planning assumptions embedded in the Trust's 2015/16 planning round	LLR Better Care Together Executive Summary (directional plan): • Received and approved at the June 2014 UHL Trust Board meeting • BCT resource plan, identifying all work books named leads (SRO, Implementation leads and clinical leads agreed at the BCT Partnership Board (formerly the BCT Programme Board) meeting held on 21st August 2014 Workbooks for all 8 clinical work streams and 4 enabling groups underway –progress overseen by implementation group and the Strategy Delivery Group which reports to BCT Partnership Board.	(C) Lack of detailed work books	See action 7.3	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Appendix 1

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Effective partnerships with LPT: A joint project has been established to test the concept of early transfer of sub-acute care to be delivered in community Hospitals or home in partnership with LPT for specific cohorts of patients e.g. frail older person The impact of this is reflected in UHLs, LPTs the LLR BCT 5 year plans.	Reflected in UHL directional 5 year plan presented to TB June 20 2014	(c) UHLs and LPTs 5 year plans yet to be reconciled and developed in enough detail to support operational delivery.	PID & draft Terms of Reference to be reviewed at the August 2014 ESB meeting. (10.1)	Oct 2014 DS/COO –
Effective partnerships with primary care: Elective Care Alliance established with agreed terms of reference for the Leadership Board and other sub groups thereby allowing structured engagement and partnership working with local GPs through the LLR Provider Company LTD. Joint business plan under development.	Minutes of the March 2014 Trust Board meeting: • establishment of the Alliance formally approved by Trust Board in March, 2014 • Minutes of ESB meetings: • Progress against plan is reported to the ESB	(c) Work Programme for the Alliance yet to be agreed	Work Programme for the Alliance to be developed (10.2)	Oct 2014 DS
Effective partnerships with primary care and LPT: Active engagement and leadership of the LLR Urgent Care and Planned Care work streams in partnership with local GPs. Mutual accountability for the delivery of shared objectives reflected in the LLR BCT 5 year plan.	Minutes of the June public Trust Board meeting: • Trust Board approved the LLR BCT 5 year directional plan and UHLs 5 year directional plan on 16 June, 2014 • urgent care and planned care work streams reflected in both of these plans • BCT resource plan, identifying all work books named leads (SRO, Implementation leads and clinical leads agreed at the BCT Partnership Board (formerly the BCT Programme Board) meeting held on 21st	(c) Respective plans not yet reconciled or detailed to support operational delivery.	Detailed work books to be developed by 19th September 2014 (10.4)	Oct 2014 DS

	August 2014 • Workbooks for all 8 clinical work streams and 4 enabling groups underway –progress overseen by implementation group and the Strategy Delivery Group which reports to BCT Partnership Board.			

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Appendix 1

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Appendix 1

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Appendix 1

Principal risk 13	Failure to provide consistently high standards of medical education.	**Overall level of risk to the achievement of the objective**	**Current score 3 x 3 = 9**	**Target score 2 x 2 = 4**
Executive Risk Lead(s)	Medical Director			
Link to strategic objectives	Enhanced reputation in research, innovation and clinical education			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Medical Education Strategy	Department of Clinical Education (DCE) Business Plan and risk register are discussed at regular DCE Team Meetings and information given to the Trust Board quarterly Medical Education issues championed by Trust Chairman Bi-monthly UHL Medical Education Committee meetings (including CMG representation) Oversight by Executive Workforce Board Appointment processes for educational roles established KPI are measured using the: • UHL Education Quality Dashboard • CMG Education Leads and stakeholder meetings • GMC Trainee Survey results • UHL trainee survey • Health Education East Midlands Accreditation visits	(c) Transparent and accountable management of postgraduate medical training tariff is not yet established (c) Transparent and accountable management of SIFT funding not yet identified in CMGs (proposal prepared for EWB) (c) Job Planning for Level 2 (SPA) Educational Roles not written into job descriptions (c) Appraisal not performed for Educational Roles	To work with Finance to address all funding issues (13.1) Ensure appropriate Consultant Job descriptions include job planning (13.2) Develop appraisal methodology for educational roles (13.3) Disseminate agreed	Oct 2014 MD Jan 2015 MD Jan 2015 MD Jan 2015

			appraisal methodology to CMG s (13.4)	MD
		Trainee Drs in community – anomalous location in DCE budgets	Work to relocate to HR as other Foundation doctor contracts (13.5)	Dec 2014 MD
UHL Education Committee	CMG Education Leads sit on Committee. Education Committee delivers to the Workforce Board twice monthly and Prof. Carr presents to the Trust Board Quarterly.	No system of appointing to College Tutor Roles	Develop more robust system of appointment and appraisal of disparate roles by separating College Tutor roles in order to be able to appoint and appraise as College Tutors	Jan 2015 MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Appendix 1

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Appendix 1

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
UHL Workforce Plan (by staff group)	Reduction in number of 'hotspots' for staff shortages across UHL reported as part of workforce plan update. Executive Workforce Board will consider progress in relation to the overarching workforce plan through highlight report from CMG action plans.	(c) Workforce planning difficult to forecast more than a year ahead as changes are often dependent on transformation activities outside UHL (e.g. social services/ community services and primary care and broad based planning assumptions around demographics and activity). (c) Difficulty in recruiting to hotspots as frequently reflect a national shortage occupation (e.g. nurses)	Develop an integrated approach to workforce planning with LPT so we can plan workforce to deliver the right care in right place at the right time. (15.1) Establish a joint group of strategy, finance and workforce leads to share plans and numbers (15.2) Establish Multi-professional new roles group to devise and monitor processes for creation of new roles (15.3) Develop Innovative	Oct 2014 DHR Oct 2014 DHR Oct 2014 CN Mar 2015 DHR

			approaches to recruitment and retention to address shortages. (15.4)	
Nursing Recruitment Trajectory and international recruitment plan in place for nursing staff	Overall nursing vacancies are monitored and reported monthly by the Board and NET as part of the Quality and Performance Report NHS Choices will be publishing the planned and actual number of nurses on each shift on every inpatient ward in England			
Development of an Employer Brand and Improved Recruitment Processes	Reports of the LIA recruitment project Reports to Executive Workforce Board regarding innovative approaches to recruitment	(c) Capacity to develop and build employer brand marketing (c) Capacity to build innovative approaches to recruitment of future service/ operational managers (c) capacity to build innovative approaches to consultant recruitment	Deliver our Employer Brand group to share best practice and develop social media techniques to promote opportunities at UHL (15.6) Development of internship model and potential management trainee model supported by robust education programme and education scheme. (15.7) Consultant recruitment review team to develop professional assessment centre approach to recruitment	Mar 2015 DHR Nov 2014 DHR April 2015 DHR

			utilising outputs to produce a development programme (15.8)	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Appendix 1

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Refreshed Organisational Development Plan (2014-16) including five work streams: 'Live our Values' by embedding values in HR processes including values based recruitment, implementing our Reward and Recognition Strategy (2014-16) and continuing to showcase success through Caring at its Best Awards	Quarterly reports to EWB and Trust Board and measured against implementation plan milestones set out in PID	(a) Improvements required in 'measuring how we are doing'	Team Health Dashboard to be developed – mock up to be presented to EWB at September Meeting (16.1)	Sep 2014 DHR
'Improve two-way engagement and empower our people' by implementing the next phase of Listening into Action (see Principal Risk 16), building on medical engagement, experimenting in autonomy incentivisation and shared governance and further developing health and wellbeing and Resilience Programmes.	Quarterly reports to and EWB and measured against Implementation Plan Milestones set out in PID	No gaps identified		
'Strengthen leadership' by implementing the Trust's Leadership into Action Strategy (2014-16) with particular emphasis on 'Trust Board Effectiveness', 'Technical Skills Development' and 'Partnership Working'	Quarterly reports to EWB and bi-monthly reports to UHL LETG. Measured against implementation Plan milestones set out in PID	No gaps identified		
'Enhance workplace learning' by building on training capacity and resources, improvements in medical education and developing new roles	Quarterly report to EQB, EWB and bi-monthly reports to UHL LETG and LLR WDC. Measured against implementation plan milestones set out in PID	(a) eUHL System requires significant improvement in centrally managing all development activity (c) Robust processes required in relation to e-learning development	eUHL system updates required to meet Trust needs (16.2) Robust ELearning policy and procedures to be developed (16.3)	Mar 2015 DHR Oct 2014 DHR
'Quality Improvement and innovation' by implementing quality improvement education, continuing to develop quality improvement	Quarterly reports to EQB and EWB and measured against implementation plan milestones set out in	No gaps identified		

networks and creating a Leicester Improvement and Innovation Centre	PID.			
Appraisal and Objective Setting in line with Strategic Direction	Appraisal rates reported monthly via Quality and Performance Report. Appraisal performance features on CMG/Directorate Board Meetings. Board/CMG Meetings to monitor the implementation of agreed local improvement actions	No gaps identified		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Appendix 1

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Year 2 Listening into Action (LiA) Plan (2014 to 2015) including five work streams: Work stream One: **Classic LiA** • Two waves of Pioneering teams to commence (with 12 teams per wave) using LiA to address changes at a ward/department/pathway level	Quarterly reports to Executive Workforce Board (EWB) and Trust Board Updates provided to LiA Sponsor group on success measures per team and reports on Pulse Check improvements Annual Pulse Check Survey conducted (next due in Feb 2015) Update reports provided to JSCNC meetings	(a Lack of triangulation of LiA Pulse Check Survey results with National Staff Opinion Survey and Friends and Family Test for Staff	Team Health Dashboard to be developed – mock up to be presented to EWB at September 2014 meeting (Please see Principal Risk 15) (17.1)	Mar 2015 DHR
Work stream Two: **Thematic LiA** • Supporting senior leaders to host Thematic LiA activities. These activities will respond to emerging priorities within Executive Directors' portfolios. Each Thematic event will be hosted and led by a member of the Executive Team or delegated lead.	Quarterly reports to Executive Workforce Board (EWB) and Trust Board Updates provided to LiA Sponsor group on each thematic activity Update reports provided to JSCNC meetings	No gaps identified		
Work stream Three: **Management of Change LiA** • LiA Engagement Events held as a precursor to change projects associated with service transformation and / or HR Management of Change (MoC) initiatives.	Quarterly reports to Executive Workforce Board (EWB) and Trust Board Updates provided to LiA Sponsor group on each thematic activity Update reports provided to JSCNC meetings	(c Reliant on IBM / HR to notify LiA Team of MoC activity	Ensure IBM aware of requirements. (17.2) HR Senior Team aware of need to include Engagement event prior to formal	Mar 2015 DHR Mar 2015 DHR

			consultation (with MoC impacting on staff – (more than 25 people) (17.3)	
Work stream Four: **Enabling LiA** • Provide support to delivering UHL strategic priorities (Caring At its Best), where employee engagement is required.	Quarterly reports to Executive Workforce Board (EWB) and Trust Board Updates provided to LiA Sponsor group on each thematic activity Update reports provided to JSCNC meetings	(C) Resource requirements in terms of people and physical resources difficult to anticipate from LiA activity linked to Caring at its Best engagement events	Include as regular agenda item on LiA sponsor group identifying activity and anticipated resources required (17.4)	Mar 2015 DHR
Work stream Five: **Nursing into Action (NiA)** • Support all nurse led Wards or Departments to host a listening event aimed at improving quality of care provided to patients and implement any associated actions.	Quarterly reports to Executive Workforce Board (EWB) and Trust Board Updates provided to LiA Sponsor group every 6 months on success measures per set and reports on Pulse Check improvements Update reports provided to JSCNC meetings Monthly updates to Nursing Executive Team (NET) meetings via Heads of Nursing per CMG	No gaps identified		
Annual National Staff Opinion and Attitude Survey	Annual Survey report presented to EWB and Trust Board Analysis of results in comparison to previous year's results and to other similar organisations presented to EWB and Trust Board annually Updates on CMG / Corporate actions taken to address improvements to National Survey presented to EWB Staff sickness levels may also provide an indicator of staff satisfaction and performance and are reported monthly to Board via Quality and Performance report Results of National staff survey and local patient	(a) Lack of triangulation of National Staff Survey results with local Pulse Check Results (Work stream One: Classic LiA / Work stream Five: NiA) and other indicators of staff engagement such as Friends and Family Test for Staff	Please see action 17.1	Mar 2015 DHR

	polling reported to Board on a six monthly basis. Improving staff satisfaction position.			
Friends and Family Test for NHS Staff	Quarterly survey results for Quarter 1, 2 and 4 to be submitted to NHS England for external publication: Submission commencing 28 July 2014 for quarter 1 with NHS England publication commencing September 2014 Local results of response rates to be CQUIN Target for 2014/15 – to conduct survey in Quarter 1 (achieved)	(a) Survey completion criteria variable between NHS organisations per quarter. Survey to include 'NHS Workers' and not restricted to UHL staff therefore creating difficulty in comparisons between organisations as unable to identify % response rates. No guidance available regarding how NHS England will present the data published in September 2014, i.e. same format at FFT for Patients or format for National Staff Opinion and Attitude Survey. Lack of triangulation of Friends and Family Test for Staff results with local Pulse Check Results (Work stream One: Classic LiA / Work stream Five: NiA) and other indicators of staff engagement such as National Staff Survey	National data on UHL workforce numbers to be used by NHS England to get a sense of how many staff completed the survey (Same calculations being used for all other Trusts so variables consistent nationally). (17.5) Develop draft internal reports in development in readiness for possible analysis methodology used by NHS England in September 2014. (17.6) Please see action 17.1	First report published by NHS England Sep 2014 Sep 2014 DHR Mar 2015 DHR

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Appendix 1

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Leadership into Action Strategy (2014:16) including six work streams: 'Providing Coaching and Mentoring' by developing an internal coaching and mentoring network, with associated framework and guidance which will be piloted in agreed areas (targeting clinicians at phase 1).	Quarterly Reports to Executive Workforce Board (EWB) as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.	Leadership into Action Strategy not yet approved UHL Coaching and Mentoring Framework requires development	Strategy to be reviewed by EWB (18.1) Improve internal coaching and mentoring training provision in collaboration with HEEM and at phase 1 establish process for assigning coaches and mentors to newly appointed clinicians (18.2)	September 2014 DHR December 2014 DHR
'Shadowing and Buddying' by creating shadowing opportunities and devising a buddy system for new clinicians or those appointed into new roles.	Quarterly Reports to Executive Workforce Board as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.	Buddying / Shadowing System Requires Development	System being developed in partnership with HEEM and Assistant Medical Director to ensure support provided to newly appointed Consultants at initial phase (18.3)	April 2015 DHR
'Improving local communications and 360 degree feedback' by	Quarterly Reports to Executive Workforce Board as	360 Feedback Tool not		

developing and implementing a 360 Degree feedback Tool for all leaders and developing nurse leaders to facilitate Listening Events in all ward and clinical department areas as set out in Risk 17.	part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16. Updates provided to LiA Sponsor group every 6 months on success measures Monthly updates to Nursing Executive Team (NET) meetings via Heads of Nursing per CMG	yet developed		
'Shared Learning Networks' by creating and supporting learning networks across the Trust, developing action learning sets across disciplines and initiating paired learning.	Quarterly Reports to Executive Workforce Board as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.	No gaps identified		
'Talent Management and Succession Planning' by developing a talent management and succession planning framework, reporting on talent profile across the senior leadership community, aligning talent activity to pay progression and ensuring succession plans are in place for business critical roles.	Quarterly Reports to Executive Workforce Board as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.	Talent Management and Succession Planning Framework requires development at regional and national level with alignment to the new NHS Health Care Leadership Model	Support national and regional Talent Management and Succession Planning Projects by National NHS Leadership Academy , EMLA and NHS Employers (18.5)	March 2015 DHR
'Leadership Management and Team Development' by developing leaders in key areas, team building across CMG leadership teams, tailored Trust Board Development and devising a suite of internal eLearning programmes	Quarterly Reports to Executive Workforce Board as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.	Improvement required in senior leadership style and approach as identified as part of Board Effectiveness Review (2014)	Board Coach (on appointment) to facilitate Board Development Session (18.6) Update of UHL Leadership Qualities and Behaviours to reflect Board Development, UHL 5 Year Plan and new NHS Healthcare Leadership Model (18.7)	October 2014 January 2015 CEO / DHR

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Appendix 1

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Delivering recurrent balance via effective management controls including SFIs, SOs and on-going Finance Training Programme Health System External Review has defined the scale of the financial challenge and possible solutions UHL Service & Financial Strategy including Reconfiguration/ SOC	Monthly progress reports to F&P Committee, Executive Board, & Trust Board Development Sessions TDA Monthly Meetings Chief Officers meeting CCGs/Trusts TDA/NHSE meetings Trust Board Monthly Reporting UHL Programme Board, F&P Committee, Executive Board & Trust Board	(C) Lack of supporting service strategies to deliver recurrent balance	Production of a FRP to deliver recurrent balance within six years (19.2)	Sep 2014 DDF
CIP performance management including CIP s as part of integrated performance management	Monthly reports to F&P committee and Trust Board. Formal sign-off documents with CMGs as part of agreement of IBPs	(C) CIP Quality Impact Assessments not yet agreed internally or with CCGs (c) PMO structure not yet in place to ensure continuity of function following departure of Ernst & Young	Expedite agreement (19.5) PMO Arrangements need to be finalised (19.6)	Review Sep 2014 DDF Oct 2014 DDF
Managing financial performance to deliver recurrent balance via SFI and SOs and utilising overarching financial governance processes	Monthly progress reports to Finance and Performance (F&P) Committee, Executive Board and Trust board.	(c) Finance department having difficulties in recruiting to finance posts leading to temporary staff being	Restructuring of financial management via MoC (19.8)	Oct 2014 DDF

		employed.		
Financially and operationally deliverable by contract signed off by UHL and CCGs and Specialised Commissioning on 30/6/14	Agreed contracts document through the dispute resolution process/arbitration Regular updates to F&P Committee, Executive Board, Escalation meeting between CEOs/CCG Accountable Officers			
Securing capital funding by linking to Strategy, Strategic Outline Case (SOC) and Health Systems Review and Service Strategy	Regular reporting to F&P Committee, Executive Board and Trust Board	(c) Lack of clear strategy for reconfiguration of services.	Production of Business Cases to support Reconfiguration and Service Strategy (19.10)	Review Sep 2014 DDF
Obtaining sufficient cash resources by agreeing short term borrowing requirements with TDA	Monthly reporting of cash flow to F&P Committee and Trust Board	(c) Lack of service strategy to deliver recurrent balance	Agreement of long-term loans as part of June Service and Financial plan (19.11)	Oct 2014 DDF

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Appendix 1

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
CIP performance management including CIP s as part of integrated performance management	Monthly reports to F&P committee and Trust Board. Formal sign-off documents with CMGs as part of agreement of IBPs	(c) CIP Quality Impact Assessments not yet agreed internally or with CCGs (c) PMO structure not yet in place to ensure continuity of function following departure of Ernst & Young	Please see action 19.5 Please see action 19.6	
Cross cutting themes are established.	Executive Lead identified. Monthly reports to F&P committee and Trust Board	(A) Not all cross cutting themes have agreed plans and targets for delivery	Agree plans and targets through the monthly cross cutting theme delivery board (20.1)	August 2014 COO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Appendix 1

Principal risk 21	Failure to maintain effective relationships with key stakeholders	**Overall level of risk to the achievement of the objective**	**Current score 5x3=15**	**Target score 5x2=10**
Executive Risk Lead(s)	Director of Marketing and Communications			
Link to strategic objectives	A clinically and financially sustainable NHS Foundation Trust			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Stakeholder Engagement Strategy	Annual Stakeholder surveys presented to the Board Feedback from stakeholders in Board 360 as part of Foresight review. BCT strategy and planning Regular meeting with: CCGs and GPs and Health watch(s) Mercury Panel MPs and local politicians TDA / NHSE	(a) Survey is quantative and therefore improvement actions harder to identify (c) No structured key account management approach to commercial relationships (c) Commissioner (clinical) relationships can be too transactional i.e. not creative / transformational.	Qualitative survey by Trust Internal Audit (PWC) (21.1) TBA with DoS / DoF (21.2) Create a platform to launch Clinical Task Group (21.3)	Oct 14 DMC TBA Sept 14 MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Appendix 1

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Capital Monitoring Investment Committee Chaired by the Director of Finance & Procurement – meets monthly. All capital projects are subject to robust monitoring and control within a structured delivery platform to provide certainty of delivery against time, cost and scope. Project scope is monitored and controlled through an iterative process in the development of the project from briefing, through feasibility and into design, construction, commissioning and Post Project Evaluation. Project budget is developed at feasibility stage to enable informed decisions for investment and monitored and controlled throughout design, procurement and construction delivery. Project timescale is established from the outset with project milestone aspirations developed at feasibility stage. Process to follow: • Business case development • Full business case approvals • TDA approvals • Availability of capital • Planning permission • Public Consultation • Commissioner support	Minutes of the Capital Monitoring Investment Committee meetings. Capital Planning & Delivery Status Reports. Minutes of the March 2014 public Trust Board meeting - Trust Board approved the 2014/15 Capital Programme. Project Initiation Document (PID) (as part of UHL's Delivering Care at its Best) and minutes of the May 2014 Executive Strategy Board (ESB) meeting. Estates Strategy - submitted to the NTDA on 20th June in conjunction with the Trust's 5 year directional plan.	(C) Lack of integrated governance framework for the delivery of a sustainable clinical services strategy	Reconfiguration Board (reporting to ESB) to be established (22.2) DoH Heath Gateway Team to carry out a Gateway 0 review of the reconfiguration project commencing 20th October, over 4 days	Oct 2014 DS Oct 2014 DS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Appendix 1

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Governance in place to manage the procurement of the solution	EPR project board with executive and Non-Executive members. Standard boards in place to manage IBM; Commercial board, transformation board and the joint governance board. UHL reports progress to the CCG IM&T Strategy Board			
Clinical acceptability of the final solution	Clinical sign-off of the specification. Clinical representation on the leadership of the project. The creation of a clinically led (Medical Director) EPR Board which oversees the management of the programme. Highlight reports on objective achievement go through to the Joint Governance Board, chaired by the CEO. The main themes and progress are discussed at the IM&T clinical advisory group.	(C) Not all clinicians can be part of the process	Continue to communicate with the wider/non-involved clinicians throughout the procurement process (23.6)	Oct2014 CIO
Transition from procurement to delivery is a tightly controlled activity	EPR board has a view of the timeline. Trust Board and ESB have had an outline view of the delivery timelines.	(c) No detailed plan is in place for the delivery phase of the project until the vendor is chosen	When the final vendor is chosen we will create and communicate the detail delivery plan	Sep 2014 CIO

			and its dependencies. (23.5)	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Appendix 1

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Project Management to ensure we are only proceeding with appropriate projects	Project portfolio reviewed by the ESB every two months. Agreements in place with finance and procurement to catch projects that are not formally raised to IM&T.	(C) Formal prioritisation matrix	Develop, disseminate and implement the new matrix (24.1)	Sep 2014 CIO
Ensure appropriate governance arrangements around the deliverability of IM&T projects	Projects managed through formal methodologies and have the appropriate structures, to the size of project, in place. KPIs are in place for the managed business partner and are reported to the IM&T service delivery board			
Signed off capital plan for 2014/15 and 2015/16	2 year plan in place and a 5 year technical in place highlighting future requirements - signed off by the capital governance routes	(A) In year requirements which could not be reasonable forecasted cause unsustainable pressure within existing resources	Please see action 24.1	Sep 2014 CIO
Formalised process for assessing a project and its objectives	All projects go through a rigorous process of assessment before being accepted as a proposal	(C) Lack of transparency of the process and unachievable delivery expectations based on the priority of the project	All CMGs to hold formal monthly meeting with IM&T service delivery lead where these issues can be solved	Sep 2014 CIO/CMGs

Appendix two

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

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
1	**Lack of progress in implementing UHL Quality Commitment.**					
1.1	Corporate leads to embed QC into organisation	CN	DCQ	September 2014	QC included in CEO brief September. QC reporting included in EQB work programme. QC included in CMG reviews.	4
1.2	Corporate leads to develop KPIs	CN	DCQ	September 2014	KPIs in place for most QC workstreams/committees. Expect to complete September 2014	4
1.3	Corporate leads to complete action plans	CN	DCQ	September 2014	On track – systematically being reviewed at EQB as part of EQB work programme.	4
2	**Failure to implement LLR emergency care improvement plan.**					
2.2	CEO and Dr Sturgess to agree plans to ensure his legacy is sustainable	Chief Executive		~~August 2014~~ September 2014	Likely contract for re-visits to ensure momentum is maintained. Expect to finalise arrangement by end of 09/14.	3
3	**Failure to effectively implement UHL Emergency Care quality programme.**					
3.1	Subgroup to focus on the front end of the pathway to ensure progress within ED	COO	M Ardron	September 2014		4
4	**Delay in the approval of the Emergency Floor Business Case.**					
4.1	Regular communication with NTDA	MD		August 2014	Update awaited	4
5	**Failure to deliver RTT improvement plan.**					
5.1	Action plans to be developed in key specialities – general surgery and ENT to regain trajectory	COO		September 2014		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

5.2	Await publication of IST report and act on findings and recommendations	COO		~~August~~ October 2014	IST report received. UHL plan to implement findings and recommendations to be developed by 10/14. Deadline extended to reflect this	4
6	**Failure to achieve effective patient and public involvement**					
6.1	Update the PPI/stakeholder engagement strategy	DMC		September 2014		4
6.2	Revised PPI plan	DMC	PPIMM	September 2014		4
6.3	OD team involvement to reenergise the vision and purpose of Patient Advisors	DMC	PPIMM	October 2014		4
7	**Failure to effectively implement Better Care together (BCT) strategy.**					
7.1	Work plan to be developed by the LLR BCT Strategy Delivery Group to be considered by the BCT Programme	DS		August 2014	**Complete.** BCT Partnership Board agreed the BCT resource plan, identifying all work books named leads at the meeting held on 21/8/14.	5
7.2	Work plans to be reconciled and developed by the LLR BCT Strategy Delivery Group to be considered by LLR BCT Programme	DS/COO		August 2014	**Complete.** BCT Partnership Board agreed the BCT resource plan, identifying all work books named leads at the meeting held on 21/8/14.	5
7.3	Detailed work books to be developed	DS		October 2014		4
8	**Failure to respond appropriately to specialised service specification.**					
8.1	Highlight report to be presented at the August 2014 ESB meeting for approval.	DS		August 2014	**Complete.** Highlight Report for Regional Partnerships presented at the 08/14 ESB meeting.	5
8.2	Appoint Head of External Partnership development and admin support	DS		December 2014	Head of External Partnerships to be advertised w/c 8/9/14.	4
8.3	Programme Plan to be developed	DS		April 2015		4
8.4	Contracts Team to develop monthly reporting tool to track progress	DS		September 2014		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

8.5	PIDs to be developed for academic, commercial and local partnerships and overarching highlight report to be presented at the August 2014 ESB for sign off.	DMC		~~August~~ October 2014	PID for Academic Partnerships presented at the 08/14 ESB meeting. Agreed at the 08/14 ESB, Local Partnerships to be captured within the Delivering Caring at its Best (DC@IB) PID for comms, engagement & marketing. PID for DC@IB comms engagement & marketing to be presented at the 10/14 ESB meeting. Deadline extended to reflect this	3
9	**Failure to implement network arrangements with partners.**					
	Actions 7.3, 8.1, 8.2, 8.3 and 8.5 also refer to risk 9, therefore refer above for progress					
9.2	*Action removed from BAF / action tracker by DS following further review of content of risk number 9.*	N/A		N/A		N/A
10	**Failure to develop effective partnership with primary care and LPT.**					
10.1	PID & draft Terms of Reference to be reviewed at the August 2014 ESB meeting.	DS/ COO		~~August~~ October 2014	Agreed at 08/14 ESB, Local Partnerships to be captured within the Delivering Caring at its Best (DC@IB) PID for comms, engagement & marketing. PID to be presented at the 10/14 ESB meeting. Deadline extended to reflect this	3
10.2	~~Business plan to be finalised prior to consideration by the ESB and then the Trust (10.2)~~ Work Programme for the Alliance to be developed (10.2). *Action reworded 10/9/14*	DS		~~August~~ October 2014	Alliance Work programme to be presented at the October Alliance Leadership Board. An Alliance Highlight Report will be presented at the 10/14 ESB meeting. 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

10.3	Work plan developed by the LLR BCT Strategy Delivery Group to be considered by the LLR BCT Programme Board.	DS		August 2014	**Complete.** BCT Partnership Board agreed the BCT resource plan, identifying all work books named leads at the meeting held on 21/8/14	5
10.4	Detailed work books to be developed by 19th September 2014	DS		October 2014		4
11	**Failure to meet NIHR performance targets.**					
12	**Failure to retain BRU status.**					
13	**Failure to provide consistently high standards of medical education.**					
13.1	To work with Finance to address all funding issues relating to medical training tariff	MD	AMD (CE)	October 2014		4
13.2	Ensure appropriate Consultant Job descriptions include job planning	MD	AMD (CE)	January 2015		4
13.3	Develop appraisal methodology for educational roles	MD	AMD (CE)	January 2015		4
13.4	Disseminate approved appraisal methodology to CMGs.	MD	AMD (CE)	December 2014		4
13.5	Work to relocate anomalous budgets to HR as other Foundation doctor contracts	MD	AMD (CE)	January 2015		4
14	**Lack of effective partnerships with universities.**					
15	**Failure to adequately plan the workforce needs of the Trust.**					
15.1	Develop an integrated approach to workforce planning with LPT in order that we can plan an overall workforce to deliver the right care in right place at the right time.	DHR		October 2014	Group has been established to link workforce, strategy and finance. Second meeting 26/8/14	4
15.2	Establish a joint group of strategy, finance and workforce leads to share plans and numbers	DHR		October 2014	See 15.1	4
15.3	Establish multi-professional new roles group to devise and monitor processes for the creation of new roles	CN		October 2014	Date set for first meeting. Terms of Reference drafted. Discussed with CMGs.	4

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

15.4	Develop Innovative approaches to recruitment and retention to address shortages.	DHR		March 2015	Medical Workforce Strategy in place which addresses mechanisms to improve recruitment and retention	4
15.6	Delivering our Employer Brand group to share best practice and development social media techniques to promote opportunities at UHL	DHR		March 2015	Webpage review planned for end of August	4
15.7	Development of internship model and potential management trainee model supported by robust education programme and education scheme	DHR		November 2014	Five internships planned to commence in 10/14 – advertisement in place. Trainee management proposal to be shared with Executive Workforce Board 16/9/14	4
15.8	Consultant recruitment review team to develop professional assessment centre approach to recruitment utilising outputs to produce a development programme	DHR		April 2015	Proposal prepared for review by DHR and MD	4
16	**Inability to recruit and retain staff with appropriate skills.**					
16.1	Team Health Dashboard to be developed – mock up to be presented to EWB at September Meeting	DHR		September 2014	Team Health Dashboard in development. Scoping meetings held with key stakeholders to consider potential data inclusion. Meeting with Asst. Director of Information booked to scope dashboard content and to ensure compliance with Trust format.	4
16.2	eUHL system updates required to meet Trust needs	DHR		March 2015	An eUHL System Replacement Specification will be delivered by the 20/814	4
16.3	Robust ELearning policy and procedures to be developed to reflect P&GC approach	DHR		October 2014	Draft document produced. This will form part of the Core Training Policy currently under development.	4
17	**Failure to improve levels of staff engagement**					
17.1	Team Health Dashboard to be developed – mock up to be presented to EWB at September 2014	DHR		March 2015	Please refer to Item 16.1	4

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

17.2	Ensure IBM aware of requirements.	DHR		March 2015	CIO aware of LiA MoC associated with IBM related projects. Meetings held with IBM representatives to coach and guide on LiA principles and approach. LiA process included in pilot phase of Managed Print roll out at Glenfield. Further plans to include LiA in pilot of Paediatric Areas for Electronic Document Record Management	4
17.3	HR Senior Team aware of need to include Engagement event prior to formal consultation (with MoC impacting on staff – more than 25 people)	DHR		March 2015	MoC (HR) including LiA as a precursor to formal consultation. A number of events have been concluded using LiA. A specific resource for LiA MoC has been developed	4
17.4	Include as regular agenda item on LiA sponsor group identifying activity and anticipated resources required	DHR		March 2015	Each of the LiA Work streams is included as standing items on LiA Sponsor Group meetings.	4
17.5	National data on UHL workforce numbers to be used by NHS England to get a sense of how many staff completed the survey	NHS England		September 2015		4
17.6	Develop draft internal reports in development in readiness for possible analysis methodology used by NHS England in September 2014.	DHR		September 2015	**Friends and Family Test for Staff:** Submission of first UNIFY report submitted to NHS England in compliance with deadline and CQUIN target. Internal analysis of free text themes being undertaken. UHL data to be included in CE Briefing. Awaiting information on how the data will be analysed and published by NHS England.	4
18	**Lack of effective leadership capacity and capability**					
18.1	Leadership into Action Strategy to be reviewed by Executive Workforce Board in September 2014	DHR		September 2014	Leadership into Action Strategy will be presented to the Executive Workforce Board on 14/9/14	4

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

18.2	Improve internal coaching and mentoring training provision in collaboration with HEEM and at phase 1 establish process for assigning coaches and mentors to newly appointed clinicians	DHR		December 2014	Mentoring / Coaching development programme in place. Bespoke Consultant Programme planned for 10/14 in partnership with HEEM	4
18.3	'Shadowing and Buddying' System being developed in partnership with HEEM and Assistant Medical Director to ensure support provided to newly appointed Consultants at initial phase (18.3)	DHR		April 2015	Consultant Forum in place	4
18.4	360 System Specification to be produced	DHR		August 2014	**Complete.** System tender document submitted by OCB Media and will be reviewed by Project Board on 3/9/14	5
18.5	Support national and regional Talent Management and Succession Planning Projects by National NHS Leadership Academy , EMLA and NHS Employers	DHR		March 2015	UHL staff nominated to access National Leadership Academy Programme based on talent conversations.	4
18.6	Board Coach (on appointment) to facilitate Board Development Session	DHR		October 2014	Board development session planned for 16/10/14. DHR in discussion with The Foresight Partnership on the appointment of Board 'Coach'. Sue Rubinstein has agreed to act as the Board Coach but is subject to agreement with the Trust Chairman.	4
18.7	Update of UHL Leadership Qualities and Behaviours to reflect Board Development, UHL 5 Year Plan and new NHS Healthcare Leadership Model	DHR/ CE		January 2015	As above, at the initial phase the Trust Board will discuss and agree : (a) the overall leadership model the Board and Executive Team are seeking to build; and (b) the Board culture that it is seeking to shape and exemplify.	4
19	**Failure to deliver financial strategy (including CIP).**					

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

19.2	Production of a FRP to deliver recurrent balance within three years	DDF		~~August~~ Review September 2014	On track, though the timescale is 6 years subject to TDA approval of the LTFM. Awaiting formal feedback from the TDA on the LTFM submitted on 20/6/14	3
19.5	Expedite agreement of CIP quality impact assessments with UHL and CCGs	DDF		~~August~~ Review September 2014	UHL continues to submit CIP quality impact statements to the CCGs. We have also requested quality impact statements from the CCGs for their QIPP plans	3
19.6	PMO Arrangements need to be finalised	DDF		~~August~~ October 2014	Whilst the structure is agreed we have extended the EY contract until the end of 10/14. Deadline extended to reflect this	3
19.8	Restructuring of financial management via MoC	DDF		~~July~~ ~~Review~~ ~~August~~ October 2014	MoC consultation ended 6/6/14; recruitment to vacant posts on-going. All senior posts have now been successfully recruited to – all will be in post by the end of 10/14. Deadline extended to reflect this	3
19.10	Business Cases to support Reconfiguration and Service Strategy	DDF		~~July~~ Review September 2014	The TDA have now confirmed that the previously submitted IBP/LTFM will act as the overall SOC. Individual business cases will be submitted to the Trust Board and TDA.	4
19.11	Agreement of long-term loans as part of June Service and Financial plan	DDF		~~June~~ ~~August~~ October 2014	The Trust is in receipt of a £29m cash loan in line with the Plan and trajectory submitted to the TDA. Application for further loans submitted on the 22/8/14 – on-going work with the TDA between now and 17/10/14 when the application will be formally reviewed by ITFF panel. Deadline extended to reflect this.	3
20	**Failure to deliver internal efficiency and productivity improvements.**					
20.1	Agree plans and targets for cross-cutting themes through the monthly cross cutting theme delivery board	COO		August 2014	Update awaited	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

21	**Failure to maintain effective relationships with key stakeholders**					
21.1	Qualitative survey by Trust Internal Audit (PWC)	DMC		October 2014		4
21.2	TBA			TBA		
21.3	Create a platform to launch Clinical Task Group	MD		September 2014		4
22	**Failure to deliver service and site reconfiguration programme and maintain the estate effectively**.					
22.1	Highlight report re PPI strategy to be presented at the August 2014 ESB meeting for sign off.	DS		August 2014	DC@IB Reconfiguration & major capital development Highlight Report presented at the 08/14 ESB meeting.	5
22.2	Reconfiguration Board (reporting to ESB) to be established – 1st meeting in Oct 2014	DS		October 2014		4
22.3	DoH Heath Gateway Team to carry out a Gateway 0 review of the reconfiguration project commencing 20th October, over 4 days	DS		October 2014		4
23	**Failure to effectively implement EPR programme**					
23.1	Work closely with finance, procurement and the NTDA to navigate the approvals process to submit OBC	CIO		August 2014	**Complete.** OBC presented to the Trust Board in 08/14. Finance have indicated that there is no requirement for only the FBC to go to the NTDA	5
23.5	When the final vendor is chosen we will create and communicate the detail delivery plan and its dependencies.	CIO		September 2014	Plans are being developed to take this forward	4
23.6	Continue to communicate with the wider/non-involved clinicians throughout the procurement process	CIO		October 2014		
24	**Failure to implement the IM&T strategy and key projects**					
24.1	Develop, disseminate and implement the new prioritisation matrix	CIO		~~August~~ September 2014	Document presented to the Executive Team in 08/14 and clarification is being given by the CMGs/Corporate leads as to the appropriateness of the scoring method. Timescale extended to reflect this delay	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

24.2	All IT projects requested by CMGs must be formally signed off through their governance structures	CIO		August 2014	**Complete.** Forms changed to reinforce this requirement. Additional checks will be made through the prioritisation matrix.	5
24.3	CMGs to hold formal monthly meeting with IM&T service delivery lead where issues can be solved	CIO		September 2014	Not yet in place for all CMGs	3

Key

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

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

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Consequence	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2409	Women's and Children's		There is an insufficient number or middle-grade doctors, both registrars and SHO's to provide adequate service cover	26/08/2014	26/09/2014	**Causes:** Historically there have been 4 funded SPR posts, 2 paediatric trainee SHO posts on rotation which are usually filled and 1 trust funded SHO post. As the service and demand has grown these posts have remained the same leaving the middle-grade cover inadequate. **Consequences:** In accordance with the European Working Time Directive on-call rotas should be 1 in 6. The shortfall in middle-grade staff means that 2/6 nights and weekends are not covered and the registrars are over worked during the day. The lack of SHO's also means they are unable to provide resident out-of-hours cover for ward 30 and that HDU patients cannot be managed on the ward. Consultants often have to take time away from their activity, which can often only be done by a consultant, to provide middle-grade cover which is inefficient use of time and resources.	Quality	Consultant cover. The workload is increasing and there is an inadequate number of consultants to provide ward level cover as required	Extreme	Likely	20	Funding for and recruitment of an additional 2 middle-grade registrars capable of covering due TBC Review of medical staffing arrangements due TBC	10	LCOW

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Consequence	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2403	Corporate Nursing	IPC	Changes in the organisational structure have adversely affected water management arrangements in UHL	19/08/2014	19/09/2014	**Causes** National guidance from the Health and Safety Executive advise that water management should fall under the auspices of hospital infection Prevention (IP) teams Resources are not available within the UHL IP team to facilitate the above. Lack of clarity in UHL water management policy/plan Since the award of the Facilities Management contract to Interserve the previous assurance structure for water management has been removed and a suitable replacement has not yet been implemented. **Consequences** Resources not identified at local (i.e. ward/ CMG) or corporate (e.g. Interserve /IPC) level to perform flushing of water outlets leading to infection risks, including legionella pneumophila and pseudomonas aeruginosa to patients, staff and visitors from contaminated water. Non-compliance with national standards and breeches in statutory duty including financial penalty and/or prosecution of the Chief Executive by the HSE Adverse publicity and damage to reputation of the Trust and loss of public confidence Loss/interruption to service due to water contamination Potential for increase in complaints and litigation cases	HR	Instruction re: the flushing of infrequently used outlets is incorporated into the Mandatory Infection Prevention training package for all clinical staff. Infection Prevention inbox receives all positive water microbiological test results and an IPN daily reviews this inbox and informs affected areas. This is to communicate/enable affected wards/depts to ensure Interserve is taking necessary corrective actions. Flushing of infrequently used outlets is part of the Interserve contract with UHL and this should be immediately reviewed to ensure this is being delivered by Interserve All Heads of Nursing have been advised through the Nursing Executive Team and via the widely communicated National Trust Development Action Plan (following their IP inspection visit in Dec 2013) that they must ensure that their wards and depts are keeping records of all flushing undertaken and this must be widely communicated Monitoring of flushing records has been incorporated into the CMG Infection Prevention Toolkit (reviewed monthly) and the Ward Review Tool (reviewed quarterly)	Major	Almost certain	20	UHL flushing awareness training and audit of flushing records- 30/9/14 Appointment of Authorising Engineer (Water Management)- 30/9/14 Request that Interserve and NHS Horizons provide robust evidence of that all processes and procedures identified in the contract as required to control water quality are being carried out - 30/9/14 Request that Interserve and NHS Horizons provide a list of all outstanding and prevailing 'faults' and their status of address - 30/9/14 Request that Interserve and NHS Horizons provide a proposed methodology and rationale of process of reporting the above to the Trust - 30/9/14 Submit business case for additional funding to provide sufficient resource to either the IP team or NHS Horizons to enable the trust to carry out the requirements of the statutory and regulatory documents, with potential for full introduction and management of the "compass" system. - 30/9/14 Review procedures and practises in other Trusts to ensure that UHL is reaching normative standards of practice - 30/9/14 To review and confirm sampling points for Legionella To review and agree Water Safety Plan - 30/9/14	4	LCOL

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Consequence	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2404	Corporate Nursing	IPC	Inadequate management of Vascular Access Devices resulting in increased morbidity and mortality	19/08/2014	19/09/2014	**Causes** There is currently no process for identifying patients with a centrally placed vascular access (CVAD) device within the trust Lack of compliance with evidence based care bundles identified in areas where staff are not experienced in the management of CVAD's There are no processes in place to assess staff competency during insertion and ongoing care of vascular access devices Inconsistent compliance with existing policies **Consequences** Increased morbidity, mortality, length of stay, cost of additional treatment non-compliance with epic-3 guidelines 2014, non-compliance with criteria 1, 6 and 9 of the Health and Social Care Act 2010 and non-compliance with UHL policy B13/2010 revised Sept 2013, and UHL Guideline B33/2010 2010, non-compliance with MRSA action plan report on outcomes of root cause analyses submitted to commissioners twice yearly	Quality	Policies are in place to minimise the risk to patients.	Major	Almost certain	20	CVAD's identified on Nerve Centre - TBC Development of an education programme relating to on-going care of CVAD's - 30/9/14 Targeted surveillance in areas where low compliance identified via trust CVC audit - TBC Support the recommendations of the Vascular Access Group action plans to reduce the risk of harm to patients and improve compliance with legislation and UHL policies - TBC	8	LCOL
2407	Women's and Children's		Failure to meet national non admitted target of 18 weeks	26/08/2014	30/09/2014	Recent increase in referrals - Increase in waiting time for appointment 18-30+ weeks 1.0 wte consultant gynaecologist vacancy - Failure to meet 95% performance target Failure to appoint to permanent post or locum position - Performance gone down since June, Possibility of 50% performance rate by August 2014	Patients	Letters sent to GP's advising them of waiting time delays and the need to prioritise the patients they refer Working with GP representative to ensure all GP's are aware Out of area referrals discontinued SpR on maternity leave to return 1 month early Cancer Geneticist increasing workload -assisting with 1 clinic per week	Moderate	Almost certain	15	Recruit into the consultant vacancy - due 31/01/2015 SpR to return early from maternity leave due 30/09/2014 Recruit into x2 associate specialist post - due 30/11/2014	3	DMARS

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Consequence	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2402	Corporate Nursing	IPC	Inappropriate Decontamination practise within UHL may result in harm to patients and staff	19/08/2014	19/09/2014	**Causes** Endoscope Washer Disinfector (EWD) reprocessing is undertaken in multiple locations within UHL other than the Endoscopy Units. These areas do not meet current guidelines with regard to a. Environment b. Managerial oversight c. Education and Training of staff There is decontamination of Trans Vaginal probes being undertaken within the Women's CMG and Imaging CMG according to historical practice, that is no longer considered adequate. Bench top sterilisers within Theatres continue to be used. The use of these sterilisers is monitored by an AED. Purchase of Equipment is not always discussed with the Decontamination Committee **Consequences** Lack of oversight of Decontamination practice across the Trust Equipment purchased may not be capable of adequate decontamination if not approved by Infection Prevention Current Endoscope Washer Disinfectors (EWD) re-processing locations (other than endoscopy units) are unsatisfactory. All of the above having the potential for inadequately decontaminated equipment to be used Patient harm due to increased risk of infection Risk to staff health either by infection or chemical exposur Reputational damage to the organisation Financial penalty	Strategy	Surgical instrument decontamination outsourced to third party provider. Joint management board and operational group oversee this contract. The endoscopy units undergo Joint Advisory Group on GI endoscopy (JAG) accreditation. This is an external review that includes compliance with decontamination standards. All units are currently compliant. Current policy in place for decontamination of equipment at ward level. Equipment cleanliness at ward level is audited as part of monthly environmental audits and an annual Trust wide audit is carried out. Benchtop sterilisers are serviced by a third party Endoscope washer disinfectors are serviced as part of a maintenance contract Infection prevention team are auditing current decontamination practice within UHL. Position paper sent to Trust Infection Prevention Assurance Committee in November 2013 Infection prevention team provide advice and support to service users if requested Endoscopy water test results monitored by IP team. Failed results sent to the team by Food and Water laboratory and these are followed up with relevant tea	Moderate	Almost certain	15	Complete full review of decontamination practice within UHL and make recommendations for future practice - 30/9/14 Review all education and training for staff involved in reprocessing reusable medical equipment - 31/12/14 Review the use of equipment and the appropriateness of their current placement according to national guidance - 30/9/14	3	LCOL

Appendix 4:

UHL *Board Assurance Framework* scoring matrix (consequence & likelihood):

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

	← Consequence →				
Likelihood	**1**	**2**	**3**	**4**	**5**
↓	**Insignificant**	**Minor**	**Moderate**	**Major**	**Extreme**
1 Rare Probability: Less than 20%	**1**	**2**	**3**	**4**	**5**
2 Unlikely Probability: 20% - 40%	**2**	**4**	**6**	**8**	**10**
3 Possible Probability: 41% - 60%	**3**	**6**	**9**	**12**	**15**
4 Likely Probability: 61% - 80%	**4**	**8**	**12**	**16**	**20**
5 Almost certain Probability: >81%	**5**	**10**	**15**	**20**	**25**

Appendix 4 (cont'd):

UHL *Organisational Risk Register* scoring matrix (consequence / impact):

Consequence / Impact score					
Risk Subtype	1	2	3	4	5
	Insignificant	**Minor**	**Moderate**	**Major**	**Extreme**
PATIENTS (Consequence on the safety of patients physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment. Not requiring first aid	Minor injury or illness, requiring minor intervention (including first aid, additional therapy and/ or medication) Increase in length of hospital stay by 1-3 days An event that consequences on 1 – 2 patients	Moderate increase in treatment defined as a return to surgery, unplanned readmission, prolonged episode of care (4-15 days), extra time as an outpatient, cancellation of treatment or transfer into hospital as a result of the incident. Moderate injury requiring professional intervention RIDDOR/agency reportable incident An event which Consequences on 3 -15 patients	Mismanagement of patient care with long-term effects Prolonged episode of care by >15 days An event that consequences on 16 – 50 patients	Incident leading to death Multiple permanent injuries or irreversible health effects An event which Consequences on a large number of patients (i.e. > 50)
INJURY Consequence on the safety of staff or public physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment. Not requiring first aid No time off work	Minor injury or illness, requiring minor intervention. Requiring first aid. Requiring time off work for <3 days	Moderate injury requiring professional intervention and / or counseling Requiring time off work for 4-14 days RIDDOR/agency reportable incident	Major injury leading to long-term incapacity/disability and / or counseling Requiring time off work for >14 days	Incident leading to death Multiple permanent injuries or irreversible health effects
QUALITY Quality/ complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/ inquiry	Overall treatment or service suboptimal verbal complaint Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness (written) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple, repeated complaints/ independent review Critical report	Totally unacceptable level or quality of treatment/ service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
HUMAN RESOURCES (Human resources/ organisational development/	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Ongoing low staffing level that reduces the service quality 75% – 95% staff attendance at mandatory training	Late delivery of key objective/ service Unsafe staffing level or competence 2-5 days) Low staff morale	Uncertain delivery of key objective/service Unsafe staffing level or competence (>5 days)	Non-delivery of key objective/service Ongoing unsafe staffing levels or competence

staffing/ competence)			Moderate / minor error due to poor staff attendance for mandatory/key training 50% -75% staff attendance at mandatory training due to the risk	Loss of key staff Very low staff morale Major/ serious error due to no staff attending mandatory/ key training 25%-50% staff attendance at mandatory training due to risk	Loss of several key staff Critical error due to no staff attending mandatory training /key training on an ongoing basis Less than 25% staff attendance at mandatory training due to the risk
STATUTORY (Statutory duty/ inspections)	No or minimal consequence or breech of guidance/ statutory duty. Small number of recommendations that focus on quality and safety improvement issues	Single breech of statutory duty Reduced performance rating if unresolved Minor recommendations that can be implemented by low level of management action	multiple breeches in statutory duty Challenging external recommendations/ improvement notice that can be addressed with appropriate action plan	Multiple breeches in statutory duty with subsequent enforcement action Improvement notices Critical report	Multiple breeches in statutory duty with subsequent prosecution Complete systems change required Severely critical report and subsequent prosecution
REPUTATION (Adverse publicity/ reputation)	Rumors Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
BUSINESS (Business objectives/ projects)	Insignificant cost increase/ or slippage of project but recoverable to original timescale	<5 per cent over project budget Slippage of project with uncertain recovery to original timescale	5–10 per cent over project budget Slippage of project affecting original timescale but within contingency plans	10–25 per cent over project budget Slippage of project affecting original timescale with uncertain recovery within contingency plans Key objectives not met	Incident leading >25 per cent over project budget Late delivery of project (outside of contingency limits). Key objectives not met
ECONOMIC (Finance including claims)	Loss of £1 - £999 Risk of claim remote	Loss of £1,000 - £9,999 Overspend or 0.1–0.25 per cent of budget Claim less than £10,000	Loss £10,000 – 50,000 Overspend of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Loss of £100,000 - £1 million Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Loss > £1 million Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
TARGETS (Service/ business interruption)	Loss/interruption to service of >1 hour	Loss/interruption to service of >8 hours	Loss/interruption to service of >1 day	Loss/interruption to service of >1 week	Permanent loss of service or facility
ENVIRONMENT (Environmental Consequence)	Minor on-sit release of substance No direct contact with patients, staff, members of the public.	On-site release of substance contained. Minor damage to Trust property <£10,000	On-site release with no detrimental effect Moderate damage to Trust property £10,000 – £50,000	Off-site release/ on-site release with potential for detrimental effect. Major damage to Trust property >£50,000	On-site/ off-site release with realised detrimental/ catastrophic effects Loss of building

Appendix 4 (cont'd):

UHL *Organisational Risk Register* scoring matrix (likelihood):

	← Consequence →				
Likelihood	**1**	**2**	**3**	**4**	**5**
↓	**Insignificant**	**Minor**	**Moderate**	**Major**	**Extreme**
6 Rare This will probably never happen/recur. Or Not expected to occur for years. Or Probability: <0.1%	**1**	**2**	**3**	**4**	**5**
7 Unlikely Do not expect it to happen/recur but it is possible it may do so. Or Expected to occur at least annually. Or Probability: 0.1-1%	**2**	**4**	**6**	**8**	**10**
8 Possible Might happen or recur occasionally. Or Expected to occur at least monthly. Or Probability: 1-10%	**3**	**6**	**9**	**12**	**15**
9 Likely Will probably happen/recur but it is not a persisting issue. Or Expected to occur at least weekly. Or Probability: 10-50%	**4**	**8**	**12**	**16**	**20**
10 Almost certain Will undoubtedly happen/recur, possibly frequently. Or Expected to occur at least daily. Probability: >50%	**5**	**10**	**15**	**20**	**25**