RISK REPORT INCORPORATING THE BOARD ASSURANCE FRAMEWORK (BAF)

Author: Risk and Assurance Manager Sponsor: Medical Director Trust Board paper K

Executive Summary

Context

The Board Assurance Framework (BAF) is the key source of evidence that links strategic objectives to risks, controls and assurances, and the main tool that the Trust Board (TB) should use in seeking assurance that those internal control mechanisms are effective. This report provides the TB with the UHL 2015/16 BAF and action tracker as of 30th September 2015, notification of any new extreme or high risks opened during September 2015 and a summary of all high and extreme risks on the UHL risk register.

Questions

1. Does the BAF provide an accurate reflection of the principal risks to our strategic objectives?
2. Is sufficient assurance provided that the principal risks are being effectively controlled?
3. Have agreed actions been completed within the specified target dates?
4. Does the TB have knowledge of new significant risks reported within the reporting period?

Conclusion

1. Executive leads of each strategic objective have provided an accurate picture of our principal risks affecting the achievement of our objectives.
2. Many of our assurance sources are based on internal monitoring and some may benefit from external scrutiny (e.g. via internal audit) to provide additional assurance that controls are effective.
3. Six actions have been completed within timescales and 17 actions have had their deadline extended.
4. The TB are sighted to all new extreme and high risk that have been entered on the UHL risk register during September and, in addition, receive a summary of **all** extreme and high risks on the UHL organisational register.

Input Sought

We would welcome the board's input to consider the content of the BAF and

(a) Receive and note this report;
(b) review and comment upon this version of the 2015/16 BAF, as it deems appropriate;
(c) note the actions identified to address any gaps in either controls or assurances (or both);
(d) identify any areas which it feels that the Trust's controls are inadequate;
(e) identify any gaps in assurances about the effectiveness of the controls to manage the principal risks and consider the nature of, and timescale for, any further assurances to be obtained;

(f) identify any other actions necessary to address any 'significant control issues' in order to provide assurance on the Trust meeting its principal objectives

For Reference

Edit as appropriate:

1. The following objectives were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes]
Effective, integrated emergency care	[Yes]
Consistently meeting national access standards	[Yes]
Integrated care in partnership with others	[Yes]
Enhanced delivery in research, innovation & ed'	[Yes]
A caring, professional, engaged workforce	[Yes]
Clinically sustainable services with excellent facilities	[Yes]
Financially sustainable NHS organisation	[Yes]
Enabled by excellent IM&T	[Yes]

2. This matter relates to the following governance initiatives:

Organisational Risk Register	[Yes]
Board Assurance Framework	[Yes]

3. Related Patient and Public Involvement actions taken, or to be taken: [None]

4. Results of any Equality Impact Assessment, relating to this matter: [None]

5. Scheduled date for the next paper on this topic: [03/12/15]

6. Executive Summaries should not exceed 1 page. [My paper does comply]

7. Papers should not exceed 7 pages. [My paper does not comply]

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **5TH NOVEMBER 2015**

REPORT BY: **ANDREW FURLONG – MEDICAL DIRECTOR**

SUBJECT: **RISK REPORT INCORPORATING THE BOARD ASSURANCE FRAMEWORK (BAF)**

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1. INTRODUCTION

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

a) The UHL 2015/16 BAF and action tracker as of 30th September 2015.
b) Details of new extreme or high risks opened during September 2015.
c) Summary of all extreme or high risks currently on the UHL risk register as of 30th September 2015.

2. 2015/16 BAF POSITION 30TH SEPTEMBER 2015

2.1 A copy of the 2015/16 BAF is attached at appendix one with any changes highlighted in red text. A copy of the action tracker is attached at appendix two with changes also highlighted in red text for ease of reference.

2.2 In relation to the above, the TB is asked to note the following:

a. Two actions (3.3 and 7.2) have moved to a red RAG rating due to significant extensions to completion dates. The delay associated with 3.3 is due to the action to improve theatres *'in hours'* utilisation being a complex issue and will be a long-term action (potentially 2 to 3 years). The delay associated with 7.2 is related to the deferment of the Facilities Strategy paper to EWB until November.

b. There are 17 *'action due'* dates extended (reasons for extensions are included in the action tracker at appendix two). These are not felt to have a detrimental effect on the risk scores.

c. Six actions have completed during this reporting period. The executive leads will be asked to consider whether the relevant risk scores can be reduced in light of this.

d. There are no changes to any of the current risks scores during this reporting period.

2.3 The role of the Trust Board is to provide scrutiny and challenge in relation to the BAF ensuring that executive owners of each strategic objective have provided sufficient assurance that risks to the achievement of these are being effectively controlled. Given our difficult in year financial position it is proposed that the following objective is submitted for Trust Board scrutiny:

'**A financially sustainable NHS organisation'** (incorporating risks 15, 16 and 17).

3. EXTREME AND HIGH RISK REPORT.

3.1 To inform the TB of significant operational risks, a summary of all extreme and high risks (i.e. scoring 15 and above) as of 30th September 2015 is attached at appendix three. There are 45 risks on the UHL risk register scoring 15 and above.

3.2 Four new high risks opened during September 2015 as described below and the details of these risks are included at appendix three.

Risk ID	Risk Title	CMG
2609	Risks to the quality of Patient Cardiac Rehabilitation individual assessments due to new clinic location in LRI	RRC
2605	There is a risk that the Transplant Laboratory's IT database for managing patients and donors will experience a system 'crash'	RRC
2606	There is a risk that the Transplant Laboratory may not receive CPA accreditation damaging the reputation of the service	RRC

4. RECOMMENDATIONS

4.1 The Trust Board is invited to:

(a) Receive and note this report;

(b) review and comment upon this version of the 2015/16 BAF, as it deems appropriate;

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

(d) identify any areas which it feels that the Trust's controls are inadequate and do not effectively manage the principal risks to our objectives;

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

(f) identify any other actions necessary to address any 'significant control issues' in order to provide assurance on the Trust meeting its principal objectives;

Peter Cleaver
Risk and Assurance Manager
27th October 2015.

UHL BOARD ASSURANCE FRAMEWORK 2015/16

STRATEGIC OBJECTIVES

Objective	Description	Objective Owner(s)
a	**Safe, high quality, patient centred healthcare**	**Chief Nurse** /Medical Director
b	**An effective and integrated emergency care system**	**Chief Operating Officer/** Medical Director/ Chief Nurse
c	**Services which consistently meet national access standards**	**Chief Operating Officer**
d	**Integrated care in partnership with others**	**Director of Strategy**
e	**Enhanced delivery in research, innovation and clinical education**	**Medical Director**
f	**A caring, professional and engaged workforce**	**Director of Workforce and Organisational Development**
g	**A clinically sustainable configuration of services, operating from excellent facilities**	**Director of Strategy** / Director of Estates and Facilities
h	**A financially sustainable NHS Foundation Trust**	**Chief Financial Officer**
i	**Enabled by excellent IM&T**	**Chief Information Officer**

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

PERIOD: SEPTEMBER 2015

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 (QC).	CN	9	6
2.	**An effective and integrated emergency care system**	Demographic growth plus ineffective admission avoidance schemes may counteract any internal improvements in emergency pathway	COO	20	6
3.	**Services which consistently meet national access standards**	Failure to transfer elective activity to the community , develop referral pathways, and key changes to the cancer providers in the local health economy may adversely affect our ability to consistently meet national access standards	COO	9	6
4.	**Integrated care in partnership with others**	Existing and new tertiary flows of patients not secured compromising UHL's future more specialised status.	DS	15	10
5.		Failure to deliver integrated care in partnership with others including failure to: Deliver the Better Care Together year 2 programme of work Participate in BCT formal public consultation with risk of challenge and judicial review Develop and formalise partnerships with a range of providers (tertiary and local services) Explore and pioneer new models of care. Failure to deliver integrated care.	DS	15	10
6.	**Enhanced delivery in research, innovation and clinical education**	Failure to retain BRU status.	MD	9	6
7.		Clinical service pressures and too few trainers meeting GMC criteria may mean we fail to provide consistently high standards of medical education.	MD	9	4
8.		Insufficient engagement of clinical services, investment and governance may cause failure to deliver the Genomic Medicine Centre project at UHL	MD	9	6
9.		Changes in senior management/ leaders in partner organisations may adversely affect relationships / partnerships with universities.	MD	6	6
10	**A caring, professional and engaged workforce**	Gaps in inclusive and effective leadership capacity and capability , lack of support for workforce well- being, and lack of effective team working across local teams may lead to deteriorating staff engagement and difficulties in recruiting and retaining medical and non-medical staff	DWOD	16	8
11.	**A clinically sustainable configuration of services, operating from excellent facilities**	Insufficient estates infrastructure capacity and the lack of capacity of the Estates team may adversely affect major estate transformation programme	DS	20	10
12.		Limited capital envelope to deliver the reconfigured estate which is required to meet the Trust's revenue obligations	DS	12	8
13.		Lack of robust assurance in relation to statutory compliance of the estate	DS	12	8
14.		Failure to deliver clinically sustainable configuration of services	DS	12	8
15.	**A financially sustainable NHS Organisation**	Failure to deliver the 2015/16 programme of services reviews, a key component of service-line management (SLM)	DS	9	6
16		Failure to deliver UHL's deficit control total in 2015/16	CFO	15	10
17		Failure to achieve a revised and approved 5 year financial strategy	CFO	15	10
18	**Enabled by excellent IM&T**	Delay to the approvals for the EPR programme	CIO	16	6
19		Perception of IM&T delivery by IBM leads to a lack of confidence in the service	CIO	16	6

BAF Consequence and Likelihood Descriptors:

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 1	Lack of progress in implementing UHL Quality Commitment (QC).	**Overall level of risk to the achievement of the objective**	**Current score 3x3=9**	**Target score 3x2=6**
Executive Risk Lead(s)	Chief Nurse			
Link to strategic objectives	Provide safe, high quality, patient centred healthcare			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Corporate leads agreed for each goal and identified leads for each work stream of the Quality Commitment (QC). Recruitment strategies for medical/ nursing staff in place	3 monthly and / or 6 monthly progress reports to EQB and QAC. Nursing recruitment monitored via NET and Medical recruitment via the Medical Workforce Group			
KPIs agreed and monitored for all parts of the Quality Commitment. High level KPIs include: UHL SHMI =/< 100 by March 2016 Reduction in harm events by 5% Trust level F&FT score to 97% by March 2016 Targeted work based on 'Box Plots'	Monthly Q&P Report to TB. 3 monthly and / or 6 monthly progress reports to EQB and QAC. Exception reporting where KPIs/ outcomes not achieved External validation and benchmarking data including: Dr Foster Intelligence Copeland Risk adjusted barometer (CRAB) Hospital Evaluation data Benchmarking against peer Trusts SHMI score fallen from 106 to 99 Nationally reported infection rates show improvement 97% positive for inpatients friends and family test Currently not all deaths are screened Safety walkabout programme	(a) Currently not all deaths are screened and there is a requirement to move to 100%.	Audit support to be provided (1.3) Mortality database to be developed (1.5)	Oct 2015 MD Oct 2015 MD
Clear work plans agreed and monitored for all parts of the Quality Commitment.	Action plans reviewed regularly at EQB and as a minimum annually reported to QAC. Annual reports produced. Internal audit review during 2014/15 for each arm of			

	QC CQC inspection during 2015/16 Commissioner review of work plans/ progress via CQUIN. Internal Audit.			
Robust governance and committee structures in place to ensure delivery of the quality agenda	Regular committee reports. Annual reports. Achievement of KPIs. Senior accountable individuals with appropriate support			

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 2	Demographic growth plus ineffective admission avoidance schemes may counteract any internal improvements in emergency pathway	**Overall level of risk to the achievement of the objective**	**Current score 4x5=20**	**Target score 3x2=6**
Executive Risk Lead(s)	Chief Operating Officer			
Link to strategic objectives	An effective and integrated 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**
Agreed set of metrics that measure internal and external emergency care performance	Reported to UHL TB monthly Reported to EPB monthly Reported to UHL Emergency Quality Steering Group monthly Performance reported at UHL Gold Command meeting daily Reported to UCB and CCGs National benchmarking of emergency care data	Attendance and admissions continue to increase (+5% and (+7%).	UHL is working with LLR colleagues to identify a more effective way of reducing attendances and admissions. Plan to achieve this to be presented to UCB (2.2)	Nov 2015 COO
LLR Action plan to improve patient flow (i.e. admissions, reduction in discharge delays, making best use of existing ED capacity		(c) LLR action plan continues to be not fully implemented	Continue to implement and monitor progress of LLR action plan (2.1)	Nov 2015 COO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 3	Failure to transfer elective activity to the community , develop referral pathways, and key changes to the cancer providers in the local health economy may adversely affect our ability to consistently meet national access standards	**Overall level of risk to the achievement of the objective**	**Current score 3x3=9**	**Target score 3x2=6**
Executive Risk Lead(s)	Chief Operating Officer			
Link to strategic objectives	Services which consistently meet national access standards			

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**
Agreed set of metrics that measure referrals activity and waiting times	Reported to EPB quarterly Reported to Trust Board monthly Reported to UHL Access meeting – weekly Reported to RTT Board weekly (with representation from TDA & CCGs) Weekly diagnostics meeting Engaged with Intensive Support Team (specialist services) Now delivering Admitted, non-admitted and incomplete 18 week RTT standards Theatre Waiting list Initiatives have reduced from 180 per month to 30 in July	Have yet to implement tools and processes that allow us to improve our overall responsiveness through tactical planning (c) Currently not delivering the 62 day and 31 day cancer access standard (c) Anticipated failure of diagnostic 6 week standard in June due to endoscopy overdue planned patients	Theatre productivity improvements driven through the cross-cutting work stream. (3.3) Recovery of cancer standards - revised action plans with revised trajectory for 62 day compliance. (3.4) Recovery of diagnostic 6 week standard - Medinet (outsource company) to provide additional capacity (3.5)	2017 COO Oct 2015 COO Oct 2015 COO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 4	Existing and new tertiary flows of patients not secured compromising UHL's future more specialised status.	**Overall level of risk to the achievement of the objective**	**Current score 5x3=15**	**Target score 5x2=10**
Executive Risk Lead(s)	Director of Strategy			
Link to strategic objectives	Integrated care in partnership with others.			

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**
Appointment to Head of Tertiary Partnerships role to lead on formalising and securing existing pathways and developing new ones. UHL Partnership Board in place	Monthly reporting to ESB as part of Director of Strategy report.			
Children's and Cancer Collaborative Groups established with NUH.	Monthly reporting to ESB as part of Director of Strategy report.			
Memorandum of Understanding (MoU) between NUH and UHL signed in 2011.	Monthly reporting to ESB as part of Director of Strategy report.	(c) MoU was intended to support establishment of EMPATH and should include wider partnership opportunities.	MoU to be reviewed by both organisations. (4.2)	Oct 2015 DS
Partnership Board for Specialised Services established in Northamptonshire. Membership includes Northants CCGs; NHS England; KGH; NGH and UHL.				
Meetings in place and planned at Director level with other provider organisations (regional and national) to explore partnership opportunities.	Monthly reporting to ESB as part of Director of Strategy report.	None	None	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 5	**Failure to deliver integrated care in partnership with others including failure to:** Deliver the Better Care Together year 2 programme of work; Participate in BCT formal public consultation with risk of challenge and judicial review; Develop and formalise partnerships with a range of providers; Explore and pioneer new models of care. Failure to deliver integrated care.	**Overall level of risk to the achievement of the objective**	**Current score 3x5=15**	**Target score 2x5=10**
Executive Risk Lead(s)	Director of Strategy			
Link to strategic objectives	An effective and integrated emergency care system; Services which consistently meet national access standards; A clinically sustainable configuration of services, operating from excellent facilities; A 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**
PLANNING • BCT Programme five year directional plan developed and agreed in June 2014. • Two-year operational plan approved in April 2014. • LLR BCT Strategic Outline Case approved and submitted centrally December 2014.	LLR BCT Partnership Board bi-monthly, attended by the chief executive and medical director. Ad hoc updates from the chief executive to Trust Board as part of the chief executive report			
GOVERNANCE - Robust BCT and UHL/BCT project governance structure: • LLR BCT Partnership Board - overarching responsibility for setting, implementing and reporting the BCT Programme • UHL/BCT Programme Board	Monthly UHL/BCT Programme Board progress reports to Executive Strategy Board LLR wide performance monitoring report presented to Trust Board			
DELIVERY - Robust system wide project delivery structure and organisational specific delivery mechanisms • LLR project delivery through LLR Implementation Group • Organisational delivery (UHL/BCT Programme Board) Project specific delivery (UHL Beds/theatres/OP etc.)	Monthly project specific highlight reports considered at UHL/BCT Programme Board	(a)LLR wide dashboard required so that performance can be monitored	A BCT Programme Dashboard is to be established and agreed with the BCT PMO. Dashboard to be aligned and consolidated to the UHL Reconfiguration Dashboard highlighting	Nov 2015 DS

	Monthly project specific highlight reports	(a) Lack of Triangulation and assurance of plans at organisational and system wide level.	progress/risks against the eight BCT work streams (5.3) BCT PMO to facilitate triangulation process (5.4)	Review Nov 2015 DS
PUBLIC CONSULTATION • Update on plans for Public consultation considered and approved by LLR BCT Partnership Board in March 2015. • The programme will carry out an overarching consultation for the whole system change, paying specific attention to areas of particular public interest and is targeted to take place in autumn 2015.	Monthly reports are submitted to the LLR BCT Partnership Board, last one submitted March 2015	(c)No detailed plans for overall change. These will form the basis for the narrative for formal consultation.	Plan for consultation including a full governance roadmap to be completed. (5.8)	Oct 2015 DMC
EXPLORING PIONEERING NEW MODELS OF CARE TO SUPPORT THE DELIVERY OF INTEGRATED CARE Proposal for proof of concept for a single Integrated Frail Older Person Service (LPT/UHL/GE Finnamore) prepared Proposed establishment of an Institute of Frail Older People Services Programme management arrangements in place (early April, 2015)	Verbal update to Executive Strategy Board (April 2015) Progress reports are to be submitted to the Executive Strategy Board on a monthly basis	Project plan and early progress not yet developed	Integrated Frail Older Person Service project plan to be developed (5.9)	Oct 2015 DS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 6	Failure to retain BRU status.	**Overall level of risk to the achievement of the objective**	**Current score 3x3=9**	**Target score 3x2=6**
Executive Risk Lead(s)	Medical Director			
Link to strategic objectives	Enhanced reputation in research, innovation and clinical education			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Maintaining relationships with key partners to support joint NIHR/ BRU infrastructure	Joint BRU Board (bimonthly) Annual Report Feedback from NIHR for each BRU (annual) UHL R&D Executive (monthly) R&D Report to Trust Board (quarterly)	(c) Requirement to replace senior staff and increase critical mass of senior academic staff in each of the three BRUs.	BRUs to re-consider theme structures for renewal, identifying potential new theme leads. (6.1) BRUs to identify potential recruits and work with UoL/LU to structure recruitment packages. (6.2)	Dec 2015 MD Dec 2015 MD
	Athena Swan Silver Status by University of Leicester and Loughborough University. (The Athena Swan charter applies to higher education institutions)	(c) Athena Swan Silver not yet achieved by UoL and Loughborough University. This will be required for eligibility for NIHR awards	UoL and LU to ensure successful applications for Silver swan status. Individual medical school depts. will need to separately apply for Athena Swan Silver status. (6.4)	Mar 2016 MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 7	Clinical service pressures and too few trainers meeting GMC criteria may mean we fail 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**	
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 Oversight by Executive Workforce Board Bi-monthly UHL Medical Education Committee meetings (including CMG representation) Database of recognised Trainers required by GMC 2016 Appointment processes for Level 3 educational roles established Appraisal of Level 2 educational roles in UHL appraisal KPI are measured using the: • UHL Education Quality Dashboard • CMG Education Leads and stakeholder meetings • GMC Trainee Survey results • UHL trainee survey • HEEM accreditation visits	(c) Education facilities Identified as poor in external reports from HEEM and Leicester University c) Ineffective control of clinical service pressures, vacancies and loss of posts on rotas that adversely affect quality of training and added impact of	Continue to improve facilities i.e. to re-provide LRI Jarvis education centre in 1771 building, provide UHL Simulation facility and consider feasibility of Glenfield as an expanding training site (7.2) SPA time in job plans for training (7.5) CMG Education leads to develop action plans following findings from GMC National Trainee Survey and National Student	Nov 2015 MD Jan 2016 MD Aug 2016 MD

			Survey (7.6) All UHL trainers need to be recognised by GMC and included on a Trust database (7.7)	July 2016 MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 8	Insufficient engagement of clinical services, investment and governance may cause failure to deliver the Genomic Medicine Centre project at UHL	**Overall level of risk to the achievement of the objective**	**Current score 3x3=9**	**Target score 3x2=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**
Genomic Medicine Centre project manager for UHL in place Nominated UHL GMC lead, with UHL leads for both cancer and rare diseases Trust GMC Steering Committee in place	GMC Report to UHL R&I Executive (bimonthly) R&I minutes (inc. GMC report) to ESB bimonthly Weekly NHS England/Genomics England: Reports to UHL GMC Steering Committee via Cambridge GMC Update in R&I Report to Trust Board (quarterly) Trust GMC Steering Committee minutes Local delivery monitoring against recruitment trajectory KPI via R&I Office when project live Delivery monitoring against recruitment trajectory KPI by Lead GMC Partner when project live	(c) Workforce education around genomics (c) Transformation in clinical services (c) Transformation in public attitudes towards genomic medicine	Work with AHSN, HEEM and GMC Lead organisation to develop appropriate training for clinical and non-clinical staff (8.1) Support CMGs with transformation of GMC project into clinical services (8.2) Work with AHSN and centre for BME Health to coordinate public engagement activity aimed at (i) raising expectation of participating in the GMC project and (ii) benefits to patients of genomic medicine (8.3)	Mar 2016 MD Mar 2016 MD June 2016 MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 9	Changes in senior management/ leaders in partner organisations may adversely affect relationships / partnerships with universities.	**Overall level of risk to the achievement of the objective**	**Current score 3x2=6**	**Target score 3x2=6**
Executive Risk Lead(s)	Medical Director			
Link to strategic objectives	Enhanced reputation in research, innovation and clinical education			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Maintaining relationships with key academic partners. Developing relationships with key academic partners. Existing well established partners: • University of Leicester • Loughborough University Developing partnerships; • De Montfort University • University of Nottingham • University College London (Life Study) • Cambridge University (100k project)	Minutes of joint UHL/UoL Strategy meetings Minutes of Joint BRU Board Minutes of NCSEM Management Board Meetings of Joint UHL/UoL research office Life steering group meets monthly EM CLAHRC Management Board reports via R&D Exec to ESB	(c) Contacts with Universities could be developed more closely	Develop new 4 way strategy meeting with UHL, UoL, LU and DMU (9.2)	Mar 2016 MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 10	Gaps in inclusive and effective leadership capacity and capability , lack of support for workforce well-being, and lack of effective team working across local teams may lead to deteriorating staff engagement and difficulties in recruiting and retaining medical and non-medical staff	**Overall level of risk to the achievement of the objective**	**Current score 4x4 = 16**	**Target score 4x2 = 8**
Executive Risk Lead(s)	Director of Workforce and Organisational Development			
Link to strategic objectives	A caring, professional and engaged 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**
Organisational Development Plan	Reported to EWB quarterly Reported to Trust Board quarterly Internal Audit assurance via 2014/15 Programme Key Performance Indicators included within OD plan Progress against plan monitored monthly in CMGs			
LIA Programme	LIA Sponsor Group meet monthly Reported to EWB quarterly Reported to Trust Board quarterly (as part of the OD report).	(c) Analysis of LIA dataset has identified some key areas for improvement – coded as: Frustrations; Focus on Quality; Structures and leadership	Continue with the spread of LiA to enable staff to make contributions to changes and improvements at work (10.2)	Mar 2016 DWOD
Workforce Planning	Reported to EWB quarterly Reported to Trust Board quarterly (as part of OD plan) Key Performance Indicators included in organisational health dashboard and NTDA submission and include: Pay spend against plan Staff number (wte) against plan Safe staffing levels within clinical areas	(c) Affordability against workforce plan is an issue related to lack of substantive staff leading to increase in premium spend	CMGs to produce a trajectory of premium spend linked to recruitment with which will be monitored through the weekly CMG performance meetings and Cross Cutting Workforce Meeting. (10.3)	Mar 2016 DWOD

		(c) No national guidance currently in place in relation to nursing revalidation and therefore UHL plan based on draft/ consultation documents (c) Lack of resource for appraisals and third party confirmer processes and access to CPD for bank only nurses (c) registrants currently do not have time built into their shifts to complete revalidation requirements (approx. 8 hour per year per registrant required)	Once national guidance received we will need to identify the resources required to implement the nursing revalidation guidance and submit business cases for funding (10.13)	Mar 2016 CN
Medical Workforce Strategy Medical Workforce Group Medical Workforce Design and Recruitment group	Outputs reported to EWB (quarterly) and CQRG (bi-annually)	(c) Lack of effective processes for international recruitment. (c) Lack of a systematic approach to design by new teams around the patient. (c) Lack of clarity on gaps in junior Dr supply as a result of broadening foundation and redistribution	 Training for clinicians on role redesign and functional mapping (10.11) Work with HEEM to influence posts to be redistributed (10.12)	 Dec 2015 MD Mar 2016 MD
Leadership into Action Strategy	Reported to EWB quarterly	(c)Negative feedback	Improvements in	Mar 2016

	Reported to Trust Board quarterly (as part of OD plan) National staff survey responses Staff friends and family test responses LiA 'pulse check' responses East Midland Academy Board receives reports in relation to the monitoring of utilisation and quality of East Midlands Academy Board leadership programmes.	from surveys in relation to leadership issues	local leadership and the management of well led teams including holding to account for the basics (10.4)	DWOD
Equality Action Plan	Twice yearly progress report to Trust Board, EWB,EQB and Commissioners KPIs for monitoring are contained within the Public Sector Equality duty	(c) Low BME representation at band 7 or above	NED apprenticeship scheme to be implemented (10.5) Targeted interventions for BME band 5 and 6 to be developed and implemented (10.6)	Mar 2016 DMC Mar 2016 DMC
Compliance with national 'Freedom to Speak' standard including: 3636 concerns hotline Junior Dr 'gripe tool' Patients Safety walkabouts UHL intranet 'staff room' Clinical Senate Monthly 'Breakfast with the Boss' forums Whistleblowing' policy Anti-Bullying / harassment policy Director of Safety and Risk	Regular (quarterly) reporting to EQB in relation to 'whistleblowing 3636 hotline CQC Patient Safety Junior Dr 'gripe tool' Regular reports from Clinical senate	(c)Not yet appointed a 'Freedom to Speak' Guardian (a) No formal publication of actions taken as a consequence of concerns raised (c)Nominated managers for receipt of concerns not yet identified (c) Need better links with National helpline	CMGs to nominate appropriate managers (10.9) (This action to be revised following receipt of National guidance)	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 11	Insufficient estates infrastructure capacity and the lack of capacity of the Estates team may adversely affect major estate transformation programme	**Overall level of risk to the achievement of the objective**	**Current score** 5x4=20	**Target score** 5x2=10
Executive Risk Lead(s)	Director of Facilities			
Link to strategic objectives	A clinically sustainable configuration of services, operating from excellent facilities			

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**
Link the reconfiguration investment programme demands with current infrastructure, identifying future capacity requirements Current infrastructure details being gathered for all three acute sites identifying high risk elements of engineering and building infrastructure	Highlight reports developed monthly and reported to the UHL Reconfiguration Programme Board. Capital business cases meeting on a monthly basis which will ensure strategy/estates link and this group will feed into the reconfiguration board.	(c) A programme of infrastructure improvements is yet to be identified (c) Timescale issues for infrastructure works which could impact on the overall programme have not yet been identified and quantified in relation to risk	Assessment of current capacity being established (11.7) Develop a programme of works (11.2) Develop an operational risk register for the projects (11.3)	Jan 2016 DEF Mar 2016 DEF Mar 2016 DEF
Capital programme with ring fenced capital funding to support future infrastructure capacity demands	Capital Investments Monitoring Committee	(c) Currently no identified capital funding within 2015/16 programme and future years	Identification of investment required and allocation of capital funding (11.4)	Mar 2016 DEF/CFO
An established Estates and Facilities team with detailed knowledge of the estates and reconfiguration programme Estates work stream to support reconfiguration established which reports in UHL reconfiguration programme board to ensure alignment with all other reconfiguration projects.	Regular reports to Executive Performance Board (EPB) Monthly highlight reports completed and reported to EPB	(c) Conflicting responsibilities/roles of the estates and facilities team between UHL and the LLR estate	Define resource and skills gaps and agree an enhanced team structure to support the significant	Review Nov 2015 DEF

		and Facilities Management Collaborative	reconfiguration programme (11.5)	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 12	Limited capital envelope to deliver the reconfigured estate which is required to meet the Trust's revenue obligations	**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 Facilities			
Link to strategic objectives	A clinically sustainable configuration of services, operating from excellent facilities			

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**
Five year capital plan agreed with individual business cases identified to deliver reconfiguration. The capital plan and overarching programme for reconfiguration is regularly reviewed by the executive team.	Capital Investment Monitoring Committee will monitor the overall programme of capital expenditure and early warning to issues. Monthly reports to ESB and IFPIC on progress of reconfiguration capital programme.	(c) Availability of external capital funding	On-going discussions between executive team and NTDA. (12.4) Consideration to be given to other avenues for sources of funding. (12.5)	Review Nov 2015 DEF / DOS / CFO
There are a series of capital business cases supporting reconfiguration. Each business case under development has its own project board in place to manage and monitor detailed schemes. Business case development is overseen by the strategy directorate, with responsibility for the estates annex part in the estates directorate. Both directorates work closely to ensure activities are tracked and aligned.	Highlight reports produced for each project board. This is then aggregated with all work streams, to provide an overall assurance picture of the reconfiguration for estates (last report 17.7) Estates work stream reporting to the UHL Reconfiguration Programme Board	(c) 'road map' requires development to provide the full picture and deliverability of the programme of change	PMO holding estates workshop and followed by a joint estates and strategy workshop (12.3)	Nov 2015 DEF/DS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 13	Lack of robust assurance in relation to statutory compliance of the estate	**Overall level of risk to the achievement of the objective**	**Current score 4x3=12**	**Target score 4x2=8**
Executive Risk Lead(s)	Director of Facilities			
Link to strategic objectives	A clinically sustainable configuration of services, operating from excellent facilities			

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**
Outsourced facilities management contract performance managed by the Estates and Facilities Management Collaborative Defined KPI's which Interserve FM are measured against.	LLR FMC Board Monthly Contact Management Panel, and Service Review Meeting Assurance on IFM performance monitored via spot checks and deep dive analysis. In addition incident scenarios have been carried out to test IFM data, processes and systems the outcome of these are being reported to the Contract Management Panel with future scenarios planned bi-monthly On-going major incident scenarios developed and played out to identify any deficiencies in data, process and systems New Planet software system introduced by IFM in July now being populated	(a) A lack of electronic evidence by IFM on compliance (a) Limited contractual KPI's on compliance		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 14	**Failure to deliver clinically sustainable configuration of services**	**Overall level of risk to the achievement of the objective**	**Current score 4x3=12**	**Target score 4x2=8**
Executive Risk Lead(s)	Director of Strategy			
Link to strategic objectives	Clinically sustainable configuration of services, operating from excellent facilities			

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**
Business case approvals: • Strategic capital business case work stream established within UHL reconfiguration programme governance. • Detailed programme plan which identifies key milestones for delivery of the capital plan over the coming years; business cases are differentiated between external funding/approval and internal approval. • Monitoring of business case timescales for delivery via established governance structure	A monthly highlight report is submitted to the UHL Reconfiguration Programme Delivery Board. Monthly aggregate reporting to ESB, IFPIC and Trust Board. (Last reporting, July 15). Monthly meetings with the NTDA to discuss the programme of delivery and identify new cases coming up for approval	(c) Lack of capacity within the NTDA to resource each of the business cases	NTDA to look at providing a management and financial lead for each business case (14.1)	Feb 2016 DS
Availability of transitional support: Requirements identified to deliver key projects and this is overseen by programme management office (PMO) to ensure delivery and ensure progress as outlined in project plan. Projects focus on reconfiguration/service transformation to support achievement of the UHL two acute site model, via: • Models of care • Future Operating Model • Strategic business cases • Enablers Project resources identified against each project, particularly for business cases. A resource management process has been approved through the reconfiguration board to monitor spend against agreed budgets and available resources.	PMO in place to track and monitor overall UHL reconfiguration delivery. Overall programme resources identified and system in place to manage/track spend relating to reconfiguration. Business case team oversee, manage and deliver cases for approval, including report on spend. A report is submitted to the UHL Reconfiguration Programme Delivery Board on a monthly basis that tracks progress to date, including financial assurance, risks with mitigations. Summary report provided to ESB each month.	No gaps currently identified		

Consultation- • BCT Consultation programme established • Each of the appropriate BC have a consultation and engagement plans in place and work closely through the UHL communication and engagement lead to ensure continuity with the BCT Plan	The reconfiguration communication lead sits on key project boards and the BCT communications and engagement group. A monthly report is submitted to the UHL Reconfiguration Programme Delivery Board from the communication and engagement work stream. Last report Aug 15.			
A future operating model at speciality level which supports a two acute site footprint: Work stream exists to develop plans (bottom up) across beds, theatres, outpatients, diagnostics, and workforce with a series of workshops to map future capacity to inform reconfiguration.	Monthly reports submitted to UHL reconfiguration programme board. Models of care workshops set-up across the CMGs to further develop future state plans – led by Gino Distefano and Andrew Furlong as SRO. A work stream for the LGH has been established to support the estates delivery plan.	(a) Further work required, as part of future operating model, to look at the remaining acute services at the LGH to determine the gap in the current capital plan	Complete site survey at LGH and then to overlay future operating model outputs. (14.3). This will be done across estates/strategy to develop a future state delivery plan. Work stream established to support this.	Nov 15 DS
Ability to shift activity into out of hospital settings in order to support two site acute model: An out of hospital project has been established to develop and deliver plans to shift appropriate activity into the community.	Monthly reports submitted to UHL reconfiguration programme board. Last report Aug 15. Contract approved with transitional funding secured. Recruiting to positions (LPT lead) for an October phased start.	No gaps currently identified		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 15	Failure to deliver the 2015/16 programme of services reviews, a key component of service-line management (SLM)	**Overall level of risk to the achievement of the objective**	**Current score 3x3= 9**	**Target score 3x2=6**
Executive Risk Lead(s)	Director of Strategy			
Link to strategic objectives	A financially sustainable NHS Organisation			

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**
Overarching project plan for service reviews developed	Service Review Update and Roll Out Plan considered by ESB.			
Governance arrangements established which includes: - Monthly highlight reporting process embedded (includes progress, risks, issues, and mitigation) - Monthly updates / assurance reported to Integrated Finance, Performance and Investment Committee (IFPIC) and EPB as part of the Cost Improvement Programme paper.	Monthly reporting to IFPIC and EPB as part of CIP report.			
Capacity bolstered through the appointment of: - Programme Support Officer appointed to coordinate the programme of service reviews, provide support to service leads, and to engage key stakeholders in the process e.g. heads of service, transformation managers, operational managers etc. - Transformation managers within CMGs who will support the facilitation of service reviews	N/A			
Service reviews to be considered as part of the Clinical Strategy work stream which reports into the BCT UHL Delivery Board (and PMO) to ensure alignment with wider provision of data and intelligence designed to inform new models of care / ways of working	Monthly reporting to BCT UHL Delivery Board (PMO)	N/A	N/A	N/A

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 16	Failure to deliver UHL's deficit control total in 2015/16 (note this has officially changed by £2m to £34.1m)	**Overall level of risk to the achievement of the objective**	**Current score 5x3=15**	**Target score 5x2=10**
Executive Risk Lead(s)	Chief Financial Officer			
Link to strategic objectives	A financially sustainable NHS organisation			

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**
Completion and delegation of final, detailed income and expenditure control totals each CMG and Department within UHL Following excess spend, particularly on premium pay in Q1 and the NTDA revision of the Trust's control total to £34.1m, a recovery/improvement plan submitted to NTDA	Final agreed financial plan including detailed budget book to IFPIC (draft in April 2015) in early May 2015 Full devolution of budgets to CMGs and Departments, clarity achieved by robust integrated planning process in advance of April 2015 Monthly reporting via Exec Performance Board, IFPIC and Trust Board			
Sign off and agreement of contracts with CCGs and NHSE including activity plans for all areas and the terms and conditions attached to the contracts in 2015/16	Detail of the agreed contracts to IFPIC (draft in April 2015) in early May 2015 Full devolution of activity and performance plans to CMGs and Departments, clarity achieved by robust integrated planning process in advance of April 2015 Monthly reporting via Exec Performance Board, IFPIC and Trust Board			
Finance and CIP delivery by CMGs at UHL	Weekly reviews between CFO/COO and all CMGs, covering key areas of performance including finance and CIPs Monthly reporting via Exec Performance Board, IFPIC and Trust Board			
UHL service and financial strategy (as per SOC and LTFM)	Updates and reporting to the BCT UHL Monthly			

	Delivery Group (chaired by DS or CFO), reporting into Executive Strategy Board, IFPIC and Trust Board			
Identification and mitigation of excess cost pressures	Robust process involving the CEO to identify and fund where necessary any unavoidable cost pressures in advance of the start of 2015/16 Monthly reporting via Exec Performance Board, IFPIC and Trust Board			

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 17	Failure to achieve a revised and approved 5 year financial strategy	**Overall level of risk to the achievement of the objective**	**Current score 5x3=15**	**Target score 5x2=10**
Executive Risk Lead(s)	Chief Financial Officer			
Link to strategic objectives	A financially sustainable NHS organisation			

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**
Overall strategic direction of travel defined through Better Care Together	The pending approval of the Better Care Together Strategic Outline Case (SOC) by TDA and NHSE			
Financial Strategy fully modelled and agreed by all parties locally and nationally	2015/16 financial plan (as per existing LTFM) approved by both Trust Board and TDA LTFM being revised for review by Trust Board in mid-May Approval of the LTFM by the TDA will be sought late May into June depending on TDA governance process	(c)LTFM not yet approved	Liaise with TDA to agree process for LTFM submission and sign-off (17.3)	Review Nov 2015 CFO
Cash required for capital and existing deficit support	Trust Board have approved UHL's working capital strategy (in April 2015) In principle, TDA are supportive of the 5 year strategy and the cash/loan support that is required This will be formalised through TDA approval of BCT SOC and the revised LTFM	(c)SOC not yet formally approved (c)LTFM not yet approved	As above Explore options for other (non-NHS) sources of capital funding(17.4)	Nov 2015 CFO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 18	Delay to the approvals for the EPR programme	**Overall level of risk to the achievement of the objective**	**Current score 4x4 =16**	**Target score 2x3=6**
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**
Communications with key contacts throughout the external approvals chain	Weekly meeting to discuss progress and issues. Updates on the IM&T transformation Board, EPR programme Board and the joint Governance Board.	(c) Local TDA approval has been given and the project now sits with the Department of Health who are unable to give us a clear timetable	Further work with NTDA/DoH to progress a firm timetable to the ATP (18.1)	Dec 2015 CIO
Communications with key contacts throughout the Internal approvals chain	Weekly meeting to discuss progress and issues. Updates on the IM&T transformation Board, EPR programme Board and the joint Governance Board.	(c) Lack of confirmed planning, hindered by the external ATP steps, could lead to delays in the internal processing of the final FBC	Further work to expose the executive and the Trust board to the likely shape of the FBC and the required internal steps. (18.2)	Dec 2015 CIO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 19	Perception of IM&T delivery by IBM leads to a lack of confidence in the service	**Overall level of risk to the achievement of the objective**	**Current score 4x4=16**	**Target score 3x2=6**
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**
Review of contractual deliverable and quality of service	External reviews, PWC and ISO 27001 Audit in 2014 Monthly service delivery board, covering all aspects of service delivery			
Communication to end users of the performance of IBM and IM&T in service delivery	Monthly service delivery board, covering all aspects of service delivery Performance reports are available on InSite Project performance is reported quarterly through the trust executive	(a) Demonstration of the improved communications approach	Review of the new communications strategy and deliverables (19.7)	Dec 2015 CIO
End user's service meets their requirements	Liaison with the CMGs to ensure we are meeting their requirements Monitoring of complaints around the service and it's delivery	(c) No formal process, post the contract award, to test the delivery principles	Following LiA Event in June, monitoring of the performance indicators in the improvement plan (19.8)	Dec 2015 CIO

Appendix two

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
ACTION TRACKER FOR THE 2015/16 BOARD ASSURANCE FRAMEWORK (BAF)

Monitoring body (Internal and/or External):	UHL Executive Team
Reason for action plan:	Board Assurance Framework
Date of this review	**September 2015**
Frequency of review:	Monthly
Date of last review:	August 2015

REF	ACTION	BOARD LEVEL LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
1	**Lack of progress in implementing UHL Quality Commitment (QC).**					
1.2	Roll-out plan to be developed to move to 100% screening of deaths	MD	HOE	September 2015	**Complete.** Policy launched and roll out plan being implemented. Monitored by Mortality Review Committee.	5
1.3	Audit support to be provided.	MD	HOE	~~July 2015~~ October 2015	Funding approved. M&M Clerks and analyst recruitment process commenced. Job descriptions currently undergoing job panel evaluation. Further information requested for Job Evaluation purposes. Due for final review on 1st October. Temporary staff appointed in the meantime.	3
1.5	Mortality database to be developed.	MD/CN	HOE	~~Review July 2015~~ October 2015	Database scoping exercise being undertaken. Awaiting feedback from potential providers. Excel spread sheet database being used in the meantime. Demonstration of database to be given at the M&M Leads Forum in October with 'go live' date planned for end of October.	3
2	**Demographic growth plus ineffective admission avoidance schemes may counteract any internal improvements in emergency pathway**					

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

2.1	Continue to implement and monitor progress of LLR action plan	COO		~~Review September 2015~~ November 2015	Plan is reviewed through weekly EQSG and fortnightly UCB. The key problem remains inflow trend. Further conversations at UCB and board to board thinking day in Q3 Nov 2015. Timescale extended to reflect this	2
2.2	UHL is working with LLR colleagues to identify a more effective work of reducing attendances and admissions. Plan to achieve this to be presented to UCB in July	COO		~~June 2015~~ ~~July 2015~~ November 2015	Demand management is not proving to be as effective as had been hoped. Further conversations at UCB and board to board thinking day in Q3 Nov 2015. Timescale extended to reflect this	2
3	**Failure to transfer elective activity to the community , develop referral pathways, and key changes to the cancer providers in the local health economy may adversely affect our ability to consistently meet national access standards**					
3.3	Theatre productivity improvements driven through the cross-cutting work stream.	COO		~~July 2015~~ ~~September 2015~~ 2017	Theatre CCT is concentrating on reducing out of hours sessions at present. Waiting list initiatives reduced from 180 per month to 30 in July however disappointingly have now plateaued. The next stage of the action is to improve theatres in hours utilisation however this is a complex issue and will be a long-term action (potentially 2/3 years). Key milestones to be identified.	2
3.4	Recovery of cancer standards	COO	W Monaghan / C Carr	~~September 2015~~ October 2015	Revised tumour site plans and trajectory. Appointment of 3 band 7's to support key tumour sites underway. New weekly executive cancer board on Tuesday afternoons to progress with recovery to trajectory.	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

3.5	Recovery of diagnostic 6 week standard	COO	W Monaghan / C Carr	~~September 2015~~ October 2015	Main issue within endoscopy, clear action plan in place Endoscopy improving. Insufficient transfers to circle is reducing the effectiveness of the actions. Recovery plan timescale extended to reflect this.	3
4	**Existing and new tertiary flows of patients not secured compromising UHL's future more specialised status.**					
4.1	Consider options/benefits/risks of establishing UHL Partnership Board.	DS		~~July 2015~~ October 2015	**Complete.** Partnership Board established first meeting 14th September other dates in diary.	5
4.2	Memorandum of Understanding (MoU) to be reviewed by both organisations.	DS		~~July 2015~~ October 2015	MOU will need to be considered on a service by service basis. Tripartite CE meeting between UHL, NUH and ULH 5th October and work programme agreed.	3
5	**Failure to deliver RTT improvement plan. Failure to deliver integrated care in partnership with others including failure to: Deliver the Better Care Together year 2 programme of work; Participate in BCT formal public consultation with risk of challenge and judicial review; Develop and formalise partnerships with a range of providers; Explore and pioneer new models of care. Failure to deliver integrated care.**					

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

5.3	LLR wide business intelligence group established. UHL dashboard in draft to be used to inform LLR wide dashboard.	DS		~~May 2015~~ ~~July 2015~~ ~~August 2015~~ November 2015	A LLR dashboard has not yet been produced although the LLR BAF does include progress against largely process based objectives. To progress this the Head of Local Partnerships has met with the BCT PMO and respective work stream reps to look how the various sources of data already available can be brought together into a draft dashboard for the November TB. The BCT programme does produce a series of update reports; Detailed highlight reports for the clinical work streams, which focus on progress against key milestones, risks and mitigation. Once the pre-consultation business case and benefit realisation plan has been completed, the metrics will be incorporated into the monthly BCT Trust Board paper for monitoring purposes.	3
5.4	BCT PMO to facilitate triangulation process for plans at an organisational and system level	DS		~~May 2015~~ ~~July 2015~~ November 2015	Awaiting update from action owner. In progress – series of presentations going to the BCT delivery board in May June and July. Deadline extended to reflect the sequencing of presentations Work continues. This action to be reviewed again at the end of August 2015	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

5.8	Plan for consultation including a full governance roadmap to be completed.	DMC		~~July 2015~~ October 2015	Draft plan complete. Awaiting outcomes of BCT Work stream 'Lock ins' taking place during August in order to finalise. Likely that the plan and narrative will be reviewed by BCT partners in Sept / Oct. timescale extended to reflect this	3
5.9	Project plan to be developed Integrated Frail Older Person Service Project plan to be developed	DS		~~May 2015~~ ~~July 2015~~ ~~September~~ October 2015	The final report was presented to the August ESB, following ESB Chief Executive level discussions are to be taken with LPT before final agreement is reached. Discussions are on-going between UHL and LPT on how the work will be taken forward. Deadline extended to reflect this	3
6	**Failure to retain BRU status.**					
6.1	BRUs to re-consider theme structures for renewal, identifying potential new theme leads.	MD	Nigel Brunskill	~~June 2015~~ Dec 2015	On-going – Target date updated to align with schedule from NIHR	3
6.2	BRUs to identify potential recruits and work with UoL/ LU to structure recruitment packages.	MD	Nigel Brunskill	~~June 2015~~ Dec 2015	On-going – Target date updated to align with schedule from NIHR	3
6.4	University of Leicester (UoL) and Leicester University to ensure successful applications for Silver Swan status.	MD		March 2016	VC and President has re-constituted group leading Medical School Bid with appointment of new project manager.	4
7	**Clinical service pressures and too few trainers meeting GMC criteria may mean we fail to provide consistently high standards of medical education.**					
7.2	Continue to improve facilities i.e. to re-provide LRI Jarvis education centre in 1771 building, provide UHL Simulation facility and consider feasibility of Glenfield as an expanding training site	MD		~~Sept 2015~~ November 2015	Facilities strategy was scheduled to be presented to Executive Workforce Board August however this was deferred. The strategy is now tabled for the Executive Strategy Board on November 17th	2

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

7.5	SPA time in job plans for training	MD	Sue Carr	January 2016	Time for education roles remains to be reliably demonstrated in job plans and transparency of education expenditure is still an issue – CMGs will be visited over next 3 months	4
7.6	CMG Education leads to develop action plans following findings from GMC National Trainee Survey and National Student Survey.	MD	Sue Carr	August 2016	CMG Education leads have been asked to develop actions plan re learning culture and in particular giving feedback to trainees and students. We will take a trust wide approach to issues around learning culture, induction (Task & Finish group led by HR) and feedback. At present only 22.9% medical students choose Leicester as first choice for Foundation posts and discussions have been held with Leicester University about ways to improve this – a meeting will be held in October	4
7.7	All UHL trainers need to be recognised by GMC and included on a Trust database	MD	Sue Carr	July 2016	To continue to train medical students and trainee doctors all Consultants will need to be appropriately trained and details recorded on a UHL database of trainers. Consultants with education SPA activity will need to demonstrate competence as a trainer and record this at appraisal. The GMC will visit Leicester in Nov 2016 and will request this information.	4
8	**Insufficient engagement of clinical services, investment and governance may cause failure to deliver the Genomic Medicine Centre project at UHL**					
8.1	Develop appropriate training for clinical and non-clinical staff		Nigel Brunskill	March 2016		4
8.2	Support CMGs with transformation of GMC project into clinical services		Nigel Brunskill	March 2016		4

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

8.3	Coordinate public engagement activity aimed at (i) raising expectation of participating in the GMC project and (ii) benefits to patients of genomic medicine		Nigel Brunskill	June 2016		4
9	**Changes in senior management/ leaders in partner organisations may adversely affect relationships / partnerships with universities.**					
9.2	Develop regular meeting with Universities	MD	Nigel Brunskill	March 2016	Develop new 4 way strategy meeting with UHL, UoL, LU and DMU	4
10	**Gaps in inclusive and effective leadership capacity and capability , lack of support for workforce well-being, and lack of effective team working across local teams may lead to deteriorating staff engagement and difficulties in recruiting and retaining medical and non-medical staff**					
10.2	Continue with the spread of LiA to enable staff to make contributions to changes and improvements at work	DWOD	B Kotecha	March 2016	Progress on track against LiA Year 3 Plan	4
10.3	CMGs to produce a trajectory of premium spend linked to recruitment to be monitored through the CMG performance and Cross Cutting Workforce Meeting.	DWOD	B Kotecha	March 2016	Plans in place to reduce Premium Spend – implementation monitored by existing performance meetings (CIP/Workforce). Work is underway in populating the Workforce Modelling Tool with recruitment and workforce plans. Workforce tool is now being populated on a monthly basis and now plans are in place to monitor actions to reduce premium expenditure based on the DH toolkit. There are some challenges to accurate forecasting and a recommendation is to go to the Cross Cutting Theme Group on premium spend reports which are of most use to the CMGs and how information can be used to improve forecasting.	4
10.4	Improvements in local leadership and the management of well led teams including holding to account for the basics	DWOD	B Kotecha	March 2016	Progress on track against Trust Wide Action Plan	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

10.5	NED apprenticeship scheme to be implemented	DMC	D Baker	March 2016	Proposal drafted and discussed at the June NED meeting. Intention to report back on proposals at the September 2015 Board.	4
10.6	Targeted interventions for BME band 5 and 6 to be developed and implemented	DWOD	D Baker	March 2016	Graduate traineeship scheme under development focussed around recruitment at operational manager level. Communication Plan being developed in promoting leadership development opportunities to band 5 and 6 BME staff	4
10.7	Await national guidance in relation to the post of 'Freedom to Speak' Guardian	MD	DSR	September 2015	**Complete.** Guidance received	5
10.8	Undertake actions from 'Freedom to Speak' gap analysis	MD	DSR	September 2015	**Complete.**	5
10.9	CMGs to nominate appropriate managers to receive staff concerns. **Please note** In light of new national guidance this action needs revision.	MD	DSR	TBA	**Please note** In light of new national guidance this action requires revision.	
10.11	Training for clinicians on role redesign and functional mapping	MD	AMD	December 2015	Resource identified through Better Care Together Team. Pilot work being undertaken in RRC re 'How to Staff a Ward Differently'.	4
10.12	Work with HEEM to influence posts to be redistributed	MD	AMD	March 2016	Good clinical and education team engagement in discussions relating to redistribution.	4
10.13	Need to identify the resources required to implement the national nursing revalidation guidance and submit business cases for funding	CN		March 2016	Awaiting NMC decision on the implementation date and publication of final policy and guidance expected in October 2015	4
11	**Insufficient estates infrastructure capacity and the lack of capacity of the Estates team may adversely affect major estate transformation programme**					

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

11.2	Develop a programme of works for infrastructure improvements	DEF	Nigel Bond	~~September 2015~~ March 2016	Minor infrastructure works being carried out from 2015/16 Backlog programme. Full infrastructure programme subject to outcome of review identified in11.7	3
11.3	Develop an operational risk register for the projects	DEF	DEF	~~August 2015~~ ~~September 2015~~ March 2016	Work in progress. Subject to outcome of review identified in11.7	3
11.4	Identification of investment required and allocation of capital funding	DEF	Nigel Bond/ Richard Kinnersley	~~September 2015~~ March 2016	Work in progress. Subject to outcome of review identified in11.7	3
11.5	Define resource and skills gaps and agree an enhanced team structure to support the significant reconfiguration programme	DEF		~~September 2015~~ Review November 2015	Work around skills and resources for the estates element of the reconfiguration has commenced and additional resources have been engaged, but further work is required to understand what resources are required once the complexity of the programme is more detailed. Review action in November 2015	3
11.7	Assessment of current capacity of Estates infrastructure being established	DEF		~~September 2015~~ January 2016	The initial survey work and review is currently being carried out but has uncovered some complex technical issues which is taking longer to understand and address, than originally planned. Infrastructure review in progress which will inform 11.2, 11.3, and 11.4	3
12	**Limited capital envelope to deliver the reconfigured estate which is required to meet the Trust's revenue obligations**					

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12.3	PMO holding estates workshop and followed by a joint estates and strategy workshop to develop a 'road map' of deliverability and programme of change	DEF/DS		~~September 2015~~ Review November 2015	Workshop held on 30th September with agreed action being worked on. 'Road map of deliverability not yet developed. Estates work is progressing at pace and it is the volume of work that is extending the timescales Review again in November 2015.	3
12.4	On-going discussions between executive team and NTDA regarding availability of capital funding (this action now replaces previous 12.2)	DEF/ DOS/ CFO		~~September 2015~~ Review November 2015	CFO continues to liaise closely with NTDA regarding external capital funding and the ITFF. The financial solutions are still being discussed at Trust, NTDA and DH level with no agreed outcome at present.	3
12.5	Consideration to be given to other avenues for sources of funding.	DEF/ DOS/ CFO		~~September 2015~~ Review November 2015	Discussions have commenced between the Trust and PwC and (separately) between the Trust and IBM. The financial solutions are still being discussed at Trust, NTDA and DH level with no agreed outcome at present.	3
13	**Lack of robust assurance in relation to statutory compliance of the estate**					
13.2	Develop improved software dashboard reporting (CASS)	DEF	Mike Webster	September 2015	**Complete.** Software purchased and currently being populated. Staff training complete. on-going process to extend the knowledge base and assurance levels	5
14	**Failure to deliver clinically sustainable configuration of services**					

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14.1	NTDA to look at providing a management and financial lead for each of the business cases	DS		~~October 2015~~ February 2016	Initial meeting was held on the 12.05.15 with the NTDA where they recognised the need for NTDA resource. Follow-up meeting with NTDA lead to review business case schedule. Next business case for review is Childrens – February 2016. A lead will be identified before then.	3
14.3	Complete site survey at LGH and then to overlay future operating model outputs.	DS		November 2015	Work underway	4
15	**Failure to deliver the 2015/16 programme of services reviews, a key component of service-line management (SLM)**					
16	**Failure to deliver UHL's deficit control total in 2015/16**					
17	**Failure to achieve a revised and approved 5 year financial strategy**					
17.3	Liaise with TDA to agree process for LTFM submission and sign-off	CFO		~~July 2015~~ Review November 2015	Revised financial strategy and LTFM submitted to NTDA in early August 2015 as part of ITFF funding application. Awaiting NTDA feedback. Review in November 2015	3
17.4	Explore options for other (non-NHS) sources of capital funding	CFO		~~September~~ November 2015	Options are actively being considered for both EPR and aspects of our service reconfiguration programme. Update provided to IFPIC in September and October 2015.	3
18	**Delay to the approvals for the EPR programme**					
18.1	Further work with NTDA to progress a firm timetable to the ATP	CIO	E. Simons	~~May 2015~~ ~~June 2015~~ ~~August 2015~~ ~~October 2015~~ December 2015	Progress has been made with the NTDA and we are currently tracking the 15th of December as sign off. Deadline extended to reflect this.	2

Status key:									
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18.2	Further work to expose the executive and the Trust board to the likely shape of the FBC and the required internal steps.	CIO	E. Simons	~~July 2015~~ ~~August 2015~~ ~~October 2015~~ December 2015	Plan is currently being finalised for this action, as above 18.1	2
19	**Perception of IM&T delivery by IBM leads to a lack of confidence in the service**					
19.6	Develop Service Improvement Plan from contract review and LIA outputs	CIO	IM&T	September 2015	**Complete.**	5
19.7	Review of the new communications strategy and deliverables	CIO	IM&T	December 2015	On track.	4
19.8	Following LiA Event in June 2015, monitoring of KPIs in the improvement plan	CIO	IM&T	December 2015	On track.	4

Key

CEO	Chief Executive
CFO	Chief Financial Officer
MD	Medical Director
DoF	Director of Finance
DEF	Director of Estates and Facilities
DP&I	Director of Performance and Improvement
COO	Chief Operating Officer
DWOD	Director of Workforce and Organisational Development
DS	Director of Strategy
DMC	Director of Marketing and Communications
CIO	Chief Information Officer
CN	Chief Nurse
AMD (CE)	Associate Medical Director (Clinical Education)
HOE	Head of Outcomes and Effectiveness
DSR	Director of Safety and Risk
AMD	Associate Medical Director

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Risk ID	CMG	Risk Title	Current Risk Score	Target Risk Score	Risk Movement
2467	Emergency and Specialist Medicine	Outlying medical patients to ward 24 (Neurology) and into other CMG beds due to bed capacity	25	9	↔
2236	Emergency and Specialist Medicine	There is a risk of overcrowding due to the design and size of the ED footprint	25	16	↔
2445	Emergency and Specialist Medicine	There is a risk that SpR gaps on the ESM CMG Medical Rota could delay patient care	12	9	↓ (20)
2234	Emergency and Specialist Medicine	There is a medical staffing shortfall resulting in a risk of an understaffed Emergency Department impacting on patient care	20	6	↔
2557	ITAPS	There is a risk that consultant and jnr dr staffing levels in Glenfield ITU could impact on patient care	12	5	↓ (20)
2333	ITAPS	Lack of paediatric cardiac anaesthetists to maintain a WTD compliant rota leading to interuptions in service provision	20	8	↔
2415	ITAPS	There is a risk of loss of ITU facilities at the LGH resulting in a lack of Consultant cover for the Service	20	2	↔
510	Clinical Support and Imaging	There is a risk of staff shortages impacting on the Blood Transfusion Service at UHL	20	15	↔
2564	Clinical Support and Imaging	There is a risk that system issues with displaying past and present breast images could result in patient harm.	20	8	↔
2391	Women's and Children's	There is a risk of inadequate numbers of Junior Doctors to support the clinical services within Gynaecology & Obstetrics	20	8	↔
1042	Women's and Children's	Unavailability of USS and not meeting National Standards for USS in Maternity	20	6	↔
2553	Women's and Children's	There is a risk of spread of infection due to inadequate levels of cleaning on the Neonatal Unit (NNU) at LRI.	20	6	↔
2562	Women's and Children's	There is a risk that 2 vacant consultant paediatric neurology vacancies could impact sustainability of the service	20	4	↔
2403	Corporate Nursing	There is a risk changes in the organisational structure will adversely affect water management arrangements in UHL	20	4	↔
2404	Corporate Nursing	There is a risk that inadequate management of Vascular Access Devices could result in increased morbidity and mortality	20	8	↔
2471	CHUGS	There is a risk of Radiotherapy Tx on the Linac (Bosworth) being compromised due to poor Imaging capability of the machine.	16	4	↔
2422	CHUGS	There is a risk nurse staffing levels on SAU LRI could adverserly impact the quality of patient care delivered	16	4	↔
2609	RRC	Risks to the quality of Patient Cardiac Rehabilitation individual assessments due to new clinic location in LRI	16	12	NEW
2605	RRC	There is a risk that the Transplant Laboratory's IT database for managing patients and donors will experience a system 'crash'	16	4	NEW
2606	RRC	There is a risk that the Transplant Laboratory may not receive CPA accreditation damaging the reputation of the service	16	4	NEW
2591	Emergency and Specialist Medicine	Risk of increased demand in diabetes outpatient foot clinic leading to overbooked clinics which over run	16	8	↔
2388	Emergency and Specialist Medicine	There is risk of delivering a poor and potentially unsafe service to patients presenting in ED with mental health conditions	16	6	↔

Risk ID	CMG	Risk Title	Current Risk Score	Target Risk Score	Risk Movement
2466	Emergency and Specialist Medicine	There is a risk of Patient harm due to delays in timely review of results and Monitoring in Rheumatolgy	16	1	↔
2541	Musculoskeletal and Specialist Surgery	There is a risk of reduced theatre & bed capacity at LRI due to increased spinal activity	16	8	↔
2504	Musculoskeletal and Specialist Surgery	There is a risk that patients will wait for an unacceptable length of time for trauma surgery resulting in poor patient outcomes	16	8	↔
607	Clinical Support and Imaging	Failure of UHL BT to fully comply with BCSH guidance and BSQR in relation to traceability and positive patient identification	16	4	↔
2487	Clinical Support and Imaging	Maintaining the quality of the Nuclear Medicine service for PET, Cardiac MPI and general diagnostics	16	6	↔
2245	Clinical Support and Imaging	Staff vacancies and increased activity within the medical records departments is having an impact on service delivery	16	6	↔
2378	Clinical Support and Imaging	There is a risk that Pharmacy workforce capacity could result in reduced staff presence on wards or clinics	16	8	↔
1926	Clinical Support and Imaging	There is a risk that insufficient staffing to manage ultrasound referrals could impact Trust operations and patient safety	16	6	↔
2384	Women's and Children's	There is an increased risk in the incidence of babies being born with HIE (moderate & severe) within UHL	16	8	↔
2153	Women's and Children's	Shortfall in the number of all qualified nurses working in the Children's Hospital.	16	8	↔
2237	Medical Directorate	There is a risk of results of outpatient diagnostic tests not being reviewed or acted upon resulting in patient harm	16	8	↔
2338	Medical Directorate	There is a risk of patients not receiving medication and patients receiving the incorrect medication due to an unstable homecare	16	9	↔
2093	Medical Directorate	Athena Swan - potential Biomedical Research Unit funding issues.	16	4	↔
2318	EFMC	There is a risk of blocked drains causing leaks and localized flooding of sewage impacting on service provision	16	2	↔
2325	Corporate Nursing	There is a risk that security staff not assisting with restraint could impact on patient/staff safety	16	6	↔
2247	Corporate Nursing	There is a risk that a significant number of RN vacancies in UHL could affect patient safety	16	12	↔
1693	Operations	There is a risk of inaccuracies in clinical coding resulting in loss of income	16	8	↔
2316	Operations	There is a risk of flooding from fluvial and pluvial sources resulting in interuption to Services	16	12	↔
2561	Clinical Support and Imaging	Non specialist Provision of Vascular Access Services on the LGH/GGH site in comparison to the services offered at the LRI	15	4	↔
2496	Clinical Support and Imaging	Risks associated with implementation of an Electronic Blood Tracking and Traceability Management System within MHRA timescales	15	4	↔
2426	Clinical Support and Imaging	There is a risk that an increase in referrals could compromise safety for patients with complex nutritional requirements	15	3	↔
2278	Women's and Children's	There is a risk that the Leicester Fertility Centre could have its licence for the provision of treatment and services withdrawn	15	6	↔

Risk ID	CMG	Risk Title	Current Risk Score	Target Risk Score	Risk Movement
2601	Women's and Children's	There is a risk of delay in gynaecology patient correspondence due to a backlog in typing	15	6	↔
2402	Corporate Nursing	There is a risk that inappropriate decontamination practise may result in harm to patients and staff	15	3	↔
1551	Corporate Nursing	Failure to manage Category C documents on UHL Document Management system (Insite)	15	9	↔

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2467	Emergency and Specialist Medicine		Outlying medical patients to ward 24 (Neurology) and into other CMG beds due to bed capacity	12/03/2014	30/09/2015	There is a risk that owing to the increase in medical admissions that the bed base/Ward 24 will be insufficient resulting in the need to out lie into other speciality/CMG beds jeopardizing delivery of the RTT targets and poor quality of care. There is a requirement to outlie medical patients because of: o 8% increase in medical admissions and current insufficient medical bed capacity o Daily admission levels warranting the need to outlie ahead of the winter months - winter capacity needed o Discharge processes not as efficient as they should be internally impacting patient flow and patients waiting in ED for admission o Continued delayed transfers of care o On-going risks and potential harm to patients as a consequence of overcrowding in ED o OOH teams have to make decisions to use all available capacity to cope with pressures in ED The ability to open extra beds within the CMG is compounded by: o >100 Nursing vacancies o Medical staffing vacancies	Patients	* Review of capacity requirements throughout the day 4 X daily * Issues escalated at Gold command meetings and outlying plans executed as necessary taking into account impact on elective activity * Opportunities to use community capacity (beds and community services) promoted at site meetings. * Daily board rounds and conference calls to confirm and challenge requirements for patients who have met criteria for discharge and where there are delays * ICRS in reach in place . PCC roles fully embedded * Discharges before 11am and 1pm monitored weekly supported by review of weekly ward based metrics * Ward based discharge group working to implement new ways of delivering safe and early discharge *Explicit criteria for outliying in place supported by recent clarification from Assistant HON * Review of complaints and incidents * Safety rota developed to ensure there is an identified consultant to review outliers on non medical wards * Matron appointed to lead on discharge and focus on outliers. * Matron cover until 8pm Monday to Friday and 8 - 4pm at the weekend. * Enhanced UHL weekend senior Gold Support * Safety Rota daily Doctor identified for outliers * Matron identified for outliers	Extreme	Almost certain	25	Develop clear escalation plans supported by a decision tree for opening flex/buffer beds (CMG decision only) - 30/09/2015 Revised Emergency Quality Steering Group action plan - 30/09/2015 Maintain additional beds on ward 2 LGH (21 beds to 27 beds) - 30/09/2015 Raise staff awareness re winter plans and access to community resources to enable patients to be discharged in a timely manner - 30/09/2015 CMG to access and act on additional corporate support to focus on discharge processes - 30/09/2015	9	JE

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2236	Emergency and Specialist Medicine	ED	There is a risk of overcrowding due to the design and size of the ED footprint	10/04/2013	30/10/2015	Design and size of footprint in resus causes delay in definitive treatment, delay in obtaining critical care, risk of serious incidents, increased crowding in majors, risk to four hour target. Poorer quality care. Risk of rule 43. Lack of privacy and dignity. Increased staff stress. Design and size of majors causes delay in definitive treatment and medical care. Poor quality care. Lack of privacy and dignity. High number of patient complaints. Risk of deterioration. Difficulty in responding to unwell patient in majors. Risk of adverse media interest. Staff stress. Risk of serious incident. Inability to meet four hour target resulting in patient safety and financial consequences. High number of incidents. Increased staff stress. Infection control risk. Risk of rule 43. Design and size of footprint in paediatrics causes delay in being seen by clinician. Risk of deterioration. Risk of four hour target and local CQUINS. Lack of patient confidentiality. Increased violence and aggression. Design and size of assessment bay causes delay in time to assessment. Paramedics unable to reach turnaround targ Design and size of minors results in delay in receiving medi Design and size footprint in streaming rooms causes threat Design and size of footprint in EDU causes delay in access	Patients	The Emergency Care Action Team, which was established in spring 2013 aims to improve emergency flow and therefore reduce the ED crowding. The Emergency department is actively engaging in plans to increase the ED footprint via the 'hot floor' initiative, but in the shorter term to increase the capacity of assessment bay and resus. The Resus Bed area is being created. Dr Ian Sturges has been employed by the trust to work towards improving flow of patients from the emergency department to the assessment units and wards. Increase in Clinical Education staff, to assist with upskilling of Nursing Staff. Majors Floor has been marked out and numbered to prevent to many trolleys from blocking Majors and assessment Bay. Improving quality of care in the ED sessions open to staff, led by ED Consultant. Direct referrals from assessment bay to ambulatory clinic. CAD system went live highlighting nuber of ambulance patients on route to ED. SOP's completed for all areas.	Extreme	Almost certain	25	New ED plus associated hot floor rebuild approved by the trust and OBC (Outline Business Case) submitted and first phase of construction of new ED - due 31/12/15 . Update - Full business case signed by trust board, now submitted to NTDA Patients in ED referred to any service should be reviewed by respective services in ED - (update surgeons & ACB rv resus pts, ongoing work with ortho(ED referrals should have 30 min response time) - Completed For update with ED CG Lead on 17/06/2015, further update required Oct 2015 (Update from KA - this was completed following the Sturgess report. All specialitys were made aware during the woek completed by Ian Sturgess - Report attached in documents) There is to be a receptionist staffing paeds reception at all times - (Completed) Creation of "single front door" - all ambulatory ED arrivals now first seen in UCC, thereby reducing total ED attendances.(Completed) The number of toilets in majors is to be increased to 2 and shower facilities are to be installed(Completed) Side rooms 2 and 3 are to be converted into formal a 3 additional phone lines to be installed in assessmer	16	JDIX

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2234	Emergency and Specialist Medicine	ED	There is a medical staffing shortfall resulting in a risk of an understaffed Emergency Department impacting on patient care	10/04/2013	30/12/2015	Causes: Consultant vacancies and non ED medical consultants. Middle grade vacancies. Due to a National Shortage of available trainees. Trainee attrition. Trainees not wanting to apply for consultant positions. Reduced cohesiveness as a trainee group. Junior grade vacancies. Juniors defecting to other specialties. Paediatric medical staffing. Consequences: Poor quality care. Lack of retention. Stress, poor morale and staff burnout. Increased sickness absence. Increased clinical incidents (SUI's), claims and complaints. Inability to do the general work of the department, including breaches of 4 hour target. Financial impacts from fines. Reduced ability to maintain CPD commitments for consultants/medical staff with subspeciality interest. Reduced ability to train and supervise junior doctors. Deskilling of consultants without subspeciality interest. Suboptimals training.	Patients	The chief executive and medical director have met with senior trainees in Leicester ED to invite them to apply for consultant positions. The East Midlands Local Education and training board has recognised middle grade shortages as a workforce issues and has set up several projects aiming to attract and retain emergency medicine trainees and consultants. Advanced nurse practitioners and non-training CT1 grades have been employed in order to backfill the shortage of SHO grade junior doctors. There has been shared teaching sessions in which non ED consultants and ED consultants have shared skills, (i.e. ED consultants learning about collapse in the elderly and elderly medicine consultants doing ALS). The non ED consultants have been set up on a specific mailing list so that new developments and departmental 'mini-teaches' (= learning cases from incidents) can be shared. Only approved locum agencies are used for ED internal locums and their CVs are checked for suitability prior to appointing them. Locums receive a brief shop floor induction on arrival and also must sign the green locum induction Locum doctors are only placed in paeds ED in excep The grid paediatric trainees shift pattern has changed ED employs medical registrars to work night shifts in	Major	Almost certain	20	Deanery report actions, completed. Guidelines to be created governing minimum standards of locum doctor approval completed. An internal induction document to be produced for locum grade doctors, completed. Review of shift vs rota and the required number of juniors per shift, completed. Doctor In Induction' badges have now been ordered to distinguish staff who cannot yet make decisions, completed. New rota for August 2014 juniors with higher number of doctors at CT3 level. Although there are still gaps at the Senior Registrar levels ST4 and above, completed. R & R Package to be relaunched, completed. Increase Locum Rates of pay - update, refused by trust board, completed. Continue recruitment to pillar strategy - due 31/01/2016. Continuation of International Recruitment - due 31/01/2016. R & R for ST3 staff with a 2yr contract until July 15 with review & CESR programme in house to attract staff - due 31/01/2016	6	BTD

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2333	ITAPS	Anaesthesia	Lack of paediatric cardiac anaesthetists to maintain a WTD compliant rota leading to interuptions in service provision	17/04/2014	31/12/2015	Causes: Retirement of previous consultants Ill health of consultant Lack of applicants to replace substantively Consequences: Need for remaining paeds anaesthetists to work a 1:2 rota on-call Lack of resilience puts cardiac workload at risk May adversely affect the national reputation of GGH as a centre of excellence Current rota non complaint Working Time Directive (WTD) Patients requiring urgent paeds surgery may be at risk of having to be transferred to other centres Income stream relating to paeds cardiac surgery may be subsequently affected Risk of suboptimal patient treatment resulting in harm.	Quality	1:2 rota covered by experience colleagues 12 month locum appointed	Major	Almost certain	20	Due to no suitable applicants for substantive or locum Consultant posts which have been advertised twice a Specialist post is to be advertised and converted to locum Consultant for appropriate candidate - 31/01/16.	8	DTR
2415	ITAPS	Critical Care	There is a risk of loss of ITU facilities at the LGH resulting in a lack of Consultant cover for the Service	09/03/2014	30/12/2015	Causes: Trust strategy is to move services to LRI & GH to create centres of excellence and improve services. Consequences: There will be a loss of Consultant cover, services and capacity at the LGH ITU due to: - Planned move of services from the LGH site makes the recruitment of new Consultant Intensivists difficult -Impending retirement of some current Consultant Intensivists -Lack of Consultant cover reduces ability for other specialties (i.e. Urology/Renal/General Surgery/HPB) to undertake planned and emergency major surgery. -Crucial to now downgrade surgery at the LGH site. Management of some patient groups could be directed to the LRI site adding additional pressure to the emergency flow at LRI. - Move to a 1:8 rotas may add to further Consultant departures.	HR	Cross site cover from current Consultant workforce Recruitment campaign in progress Acting down on shifts to cover rotas deficits ITAPs leading change of ITU level and service moves across to the other 2 sites. Staff briefings to share plans and strategies.	Major	Almost certain	20	1. Commence Recruitment campaign for one Consultant Intensivist 30/09/15. 2. Cross site cover - Completed 3. Move to a 1:8 rota - Completed 4. Offer on call rota to general duties anaesthetists - Completed 5. ITAPs management team to work with the Trusts Strategy leads and specialty leads to start to plan timescale's, scope movement of services from the LGH site and scope required environmental and workforce impacts. 30/12/15 Recruit Consultant Intensivist - Reviewed 01/09/15 - On hold currently for 2 months whilst review rotas.	2	CAL

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
510	Clinical Support and Imaging	Blood Transfusion	There is a risk of staff shortages impacting on the Blood Transfusion Service at UHL	05/10/2006	30/11/2015	Causes: Staffing issues caused by turnover of staff (retirements / leavers). Post planning process poor - local and national shortages of qualified staff (BMS). Internal recruitment processes causing significant delay. Consequences: Possibility of temporary closure of satellite blood banks (LGH). Adverse impact on patient experience for patients requiring urgent transfusion (out of hours). Non-delivery of key acute services. Increased risk of claim /complaint. Adverse media attention / loss of reputation. Staff working extra shifts and more hours - fatigue;stress; non compliance with EWTD	HR	Full 24/7 rota implemented. Voluntary rota for spare sessions - sickness leave etc. Full rota has created additional sessions as satellite laboratories to comply with 24/7 working. Associate practitioners included in early and late roster sessions Associate practitioners to cover entire night at LRI Phased extended contractual hours 8 to 8 B.S & B.Transfusion Phased extended day B Transfusion to 23:00 Employed Bank/Locum BMS staff to cover short term deficiencies in rota Investigate additional lean working options to reduce pressure on laboratory staff. Introduced a forced rota Multi discipline staff to assist cover overnight B.S(24/7) at LRI Retrained Lab Manager One-off training Risk assessed the process of a "Plan B" 24/7 Rotas with voluntary sessions in place from May 2012 2 new BMS band 5 staff recruited 24/09/2012 - to complete local competecy training Feb 2013 Introduction of cross cover form NUH to support UHL BT Roster - limited cover at present (Oct 2013) Numerous meetings taken place with empath management team to raise acute risk of service failu	Extreme	Likely	20	Arrange full trial of DRP 31/12/15 Staff recruitment/replacement to appropriate levels - 2nd phase plus further replacements + cross training of staff - 31/12/15	15	AFE

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2564	Clinical Support and Imaging	Breast	There is a risk that system issues with displaying past and present breast images could result in patient harm.	25/06/2015	31/10/2015	Causes: Retrieval of prior imaging was updated for all of imaging in December 2014. Issues had been resolved for all but Breast Images. What should happen is that when the patient's details are barcode read on the PACS workstations the current images should appear on the top part of the screens, and the priors immediately below. What actually happens is that the current images appear and the priors do not or take excessive time to upload. The film readers are having to manually retrieve prior screening images from PACS, this is causing an unnecessary time and poses the risk of error. On many occasions no priors are available. Consequences: Potential harm to patients includes calling patients to return for additional appointment when actually not required causing anxiety to patients. Also additional ionisation radiation and intervention risks. Without access to this imaging early cancer changes could be missed. This failure of process will not be evident until a patients presents symptomatically with cancer between her screening rounds (3 year window). Impacts on service as significantly more time is required to Cases of repetitive strain experienced by staff (film readers)	Patients	All film readers aware of issues Extra caution being taken when retrieving and reviewing prior films escalation policy in place for film reading Additional paid film reading sessions are in place	Extreme	Likely	20	Fully resolved and working PAC system due 31/10/15.	8	AGO

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2391	Women's and Children's		There is a risk of inadequate numbers of Junior Doctors to support the clinical services within Gynaecology & Obstetrics	24/06/2014	31/12/2015	Causes: Currently there are not enough Junior Doctors on the rota to provide adequate clinical cover and service commitments within the specialties of Gynaecology & Obstetrics. Consequences: Failure to meet the Junior Drs training needs in accordance with the LETB requirements. Impact on key objectives and delivery of service. Potential to lose Junior Drs training within the CMG. Reduced training opportunities and inconsistencies in placements. Increased risk of Junior Doctors seeing complex patients in clinics unsupervised. On call rota gaps/ Increased requirement for locums to fill gaps. Potential for LETB to remove training accreditation within obstetrics and gynaecology. This will lead to the removal of training posts. Increased potential for mismanagement / delay in patients treatment/pathway.	Patients	Locums used where available. Specialist Nurses being used to cover the services where possible and appropriate.	Major	Almost certain	20	Business Case to be developed re. how to meet service commitments by backfilling with Consultants, Specialist Nurses, etc due 29/12/2015	8	ACURR

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
1042	Women's and Children's	Maternity	Unavailability of USS and not meeting National Standards for USS in Maternity	10/10/2008	28/10/2015	Failure to diagnose abnormality which we would normally expect to diagnose due to changes in National standards. The potential for other consequences are apparent.	Quality	Detailed scan pro-forma US performed by suitable trained staff Self audit Use of regular pre-booked agency sonographers Daily review of outstanding requests to monitor the situation Access to consultants for second opinion if suspicious re possible abnormality All ultrasound machines now of suitable specification and replaced 5 yearly Incident report forms Update 18.10.12 Continued use of Agency Sonographers; Continued 'extra' lists by Fetal Med Consultants; Additional u/s machine in place but next step is need for additional scan room - this is built in to the interim solution for Maternity (phase 1) and should be converted by April 2013.	Major	Almost certain	20	2 midwives to undertake 18 month scanning training Due 31/12/2015 Consultant to undertake growth and reduced fetal movement scans on MAU Due 31/12/2015	6	LHAR
2553	Women's and Children's	Neonatology	There is a risk of spread of infection due to inadequate levels of cleaning on the Neonatal Unit (NNU) at LRI.	06/09/2015	31/10/2015	Causes Reduction in the number of domestic (cleaning) hours by 4 hours PER DAY provided for the NNU, a very high risk area. Consequences 1.Unable to maintain an acceptable standard of cleanliness on NNU affeciting quality and safety of babies care. 2.Breach of national specifications for cleanliness in the NHS. 3.Risk of infection outbreak on NNU resulting in increased mortality and morbidity of babies. 4.Risk of damage to NNU and Trust reputation and possible litigation.	Patients	Daily meetings with Interserve from May 18th to review standards of cleanliness. Weekly ServiceTrack audits to be undertaken with Facilities and Infection prevention team.	Major	Almost certain	20	Reinstate cleaning hours to level to meet National Cleaning Standards - 31/10/2015 Undertake frequent ServiceTrack audits with facilities and IP team to monitor cleaning standards - due 31/10/15	6	JFO

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2562	Women's and Children's	Paediatrics	There is a risk that 2 vacant consultant paediatric neurology vacancies could impact sustainability of the service	18/06/2015	31/10/2015	Causes: National shortage of suitable candidates to fill vacant posts Substantive Consultant Staffing levels inadequate for continuity of service Consequences: Delayed access to Consultant Paediatric Neurologist for inpatient & outpatient consultations. Loss of continuity for patients, families and Consultants as a result of changing workforce. Potential for a negative reputation of the service.	Quality	We have 1 substantive appointment, 1 locum for 6 months and 1 Consultant General Paediatrician with an interest in Neurology on a 12 month NHS contract covered by Locum Agency and NHS fixed term contracts.	Major	Almost certain	20	Actively recruit to vacant posts - Due 31/12/2015 Guideline being written for General Paediatricians to ensure appropriate in-patient & out-patient referrals - Due 31/10/2015 To work with NUH on a regional solution to service delivery - Due 31/12/2015	4	JVI
2403	Corporate Nursing	IF&C	There is a risk changes in the organisational structure will adversely affect water management arrangements in UHL	19/08/2014	31/10/2015	Causes National guidance from the Health and Safety Executive advise that water management should fall under the auspices of hospital infection Prevention (IP) teams. Resources are not available within the UHL IP team to facilitate the above. Lack of clarity in UHL water management policy/plan. Since the award of the Facilities Management contract to Interserve the previous assurance structure for water management has been removed and a suitable replacement has not yet been implemented. Consequences Resources not identified at local (i.e. ward/ CMG) or corporate (e.g. Interserve /IPC) level to perform flushing of water outlets leading to infection risks, including legionella pneumophila and pseudomonas aeruginosa to patients, staff and visitors from contaminated water. Non-compliance with national standards and breeches in statutory duty including financial penalty and/or prosecution of the Chief Executive by the HSE Adverse publicity and damage to reputation of the Trust and loss of public confidence Loss/interruption to service due to water contamination Potential for increase in complaints and litigation cases	Quality	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	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. - Funding for additional IPN agreed with FMS. Job description to be finally agreed and recruitment to commence during September 2015 - 31/10/15 Review procedures and practices in other Trusts to ensure that UHL is reaching normative standards of practice - 31/10/15 Review & agree Water Safety Plan - Water Safety Plan agreed and will be submitted to the Trust Infection Prevention Committee with the Implemenation Plan on the 23rd Sept 2015 - 31/10/15	4	LCOL

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2404	Corporate Nursing	IF&C	There is a risk that inadequate management of Vascular Access Devices could result in increased morbidity and mortality	19/08/2014	31/10/2015	Causes There is currently no process for identifying patients with a centrally placed vascular access (CVAD) device within the trust. Lack of compliance with evidence based care bundles identified in areas where staff are not experienced in the management of CVAD's. There are no processes in place to assess staff competency during insertion and ongoing care of vascular access devices. Inconsistent compliance with existing policies. Consequences Increased morbidity, mortality, length of stay, cost of additional treatment non-compliance with epic-3 guidelines 2014, non-compliance with criteria 1, 6 and 9 of the Health and Social Care Act 2010 and non-compliance with UHL policy B13/2010 revised Sept 2013, and UHL Guideline B33/2010 2010, non-compliance with MRSA action plan report on outcomes of root cause analyses submitted to commissioners twice yearly	Quality	Policies are in place to minimise the risk to patients.	Major	Almost certain	20	CVAD's identified on Nerve Centre - 31/7/15. This is not possible so there remains no method of centrally identifying patients with these devices. For further discussion by the Vascular Access Committee - 31/10/15. Development of an education programme relating to on-going care of CVAD's - 31/10/15. Targeted surveillance in areas where low compliance identified via trust CVC audit - Yet to be established due to lack of staff required. For further review by the Vascular Access Committee - 31/10/15. Support the recommendations of the Vascular Access Committee action plans to increase the Vascular Access Team within the Trust in line with other organisations. Business Case to be submitted Sept by the CSI CMG 31/10/15.	8	LCOL

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2471	CHUGS		There is a risk of Radiotherapy Tx on the Linac (Bosworth) being compromised due to poor Imaging capability of the machine.	31/03/2016	12/05/2014	Causes: Poor quality images due to deterioration of the imaging panel make it difficult and occasionally impossible to compare planned and set-up positions using the acquired images. This could lead to a geographic miss i.e. incorrect area treated. Unavailability of online correction capability may result in acquisition of several high dose images in order to safely correct and check patient position. These high dose images are used since the ageing technology available on this machine does not support good quality low dose kilovoltage imaging. Consequences: Dependent upon dose and fractionation this could result in a significant amount of the intended dose being delivered to the wrong area with significant damage to the patient resulting in a reportable incident. Repeated high dose imaging due to deteriorating MV imaging panel increases the risk of exceeding current dose limits. If kV or cone beam imaging is required, patients will need transferring from Bosworth to Varian machines. This transfer process will entail patients missing treatment days to give staff time to produce back-up plans that are labour i There is a risk of increasing waiting times leading to potenti Restricted participation in National Clinical Trials, due to lac	Quality	Increase in imaging dose (up to 10 MU) to produce a usable image. This however restricts the number of times an image may be repeated (due to dose limits). N.B imaging dose of 1MU is used on the Varian treatment machines. Pre-selection of patients with a reduced imaging requirement are booked on Bosworth. However this list is getting fewer and fewer due to best practice and national guidelines. We have introduced long day working on Varian machines to absorb patients that cannot be treated on Bosworth due to imaging limitations Clear Set-Up instructions plus photographs are provided to treatment staff to aid set-up. These do not fully eliminate the risk due to variable patient stability and condition hence the need for on-treatment imaging.	Major	Likely	16	Replacement of Imaging panel to improve image quality and reduce imaging dose. However this does not solve the lack of online correction capability - complete Replacement of Linac - 31/3/16	4	LWI

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2422	CHUGS	General Surgery	There is a risk nurse staffing levels on SAU LRI could adverserly impact the quality of patient care delivered	29/09/2014	30/11/2015	Causes: The nurse staffing levels within the Surgical Assessment Unit at the LRI are at a critical level with poor retention of staff. Of the recruitment of 6 International nurses, 2 newly qualified nurses and a development band 6 nurse - 7 of these nurses have left or are leaving reporting high workload as the reason. Due to it being a busy, high activity area - it is difficult to get staff to work on the area from the nursing bank and agency. Consequences: Poor quality of care to patients including increasing patient harms, delays for treatment/care. High levels of complaints for the ward (seven complaints over the past 6 months). Poor Patient Experience (The Friends and Family Test score has been consistently low. (<55).	Patients	Shifts escalated to bank and agency at an early stage. Increased the numbers of Band 6's to provide leadership support. Agency contract in place for one nurse on day shift and night shift to increase nursing numbers.	Major	Likely	16	Continue to actively recruit to the area - 30/11/15. Review and continue agency contract until substantive numbers are at an acceptable level - 30/11/15.	4	GK

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2609	RRC	Cardiac Rehabilitation	Risks to the quality of Patient Cardiac Rehabilitation individual assessments due to new clinic location in LRI	09/09/2015	30/11/2015	Causes: New clinic location and consultation room based on the main corridor, level 0 (Victoria Building) is not suitable to carry out shuttle walking tests due to the safety hazards along a busy corridor. Reconfiguration works including demolition of Victoria wing have created access issues for patients attending an appointment (porters and Interserve staff) will not transport patients from or to Balmoral building main reception as they are not insured to take patients outside the building. Ambulance staff will drop off and pick up from Victoria building but because the patient is classed as being in a place of safety pick up is not a priority. Ambulance staff will organise taxis for patients (if they have been escalated) to be picked up but this is only at Balmoral reception only Consequences: Potential for patient injury, poor experience and increased waiting times because the service is unable to carry out the full comprehensive assessment as shuttle walking tests are not being completed. Risk of staff members injuring themselves and requiring time off work because of the requirement to transport some Verbal complaints received from patients concerned about t Limited availability of shuttle walking tests at the LRI is affec Evidence demonstrates that the longer a patient waits for ca Potential for adverse publicity impacting on the services exc	Quality	Cardiac patients who are invited to the cardiac rehabilitation clinic have a clinical diagnosis of Myocardial infarction, PCI+/- stent (s), unstable angina, angina, valve disease, heart failure, CABG/valve surgery and congenital surgery. Cardiac Rehab staff triage patients prior to booking clinic appointments to assign to an alternative site (LGH/GGH) if shuttle test is required on a temporary basis, however this is having an impact on the service at the LGH and GGH with increased waiting times. A wheelchair must be kept in the CR Dept at ALL times in case of the need to transfer a patient. Emergency equipment in place (cardiac arrest trolley, BM boxes). Ensure all patients attending the LRI site for assessment are aware of potential wait for ambulance pick up particularly patients with diabetes so that they can bring a snack & drink if needed, etc. Ensure patients are informed to bring their medications to avoid any delays in having their prescribed medications in the event of a delay in ambulance pick up.	Major	Likely	16	Review and develop case of need for alternative to shuttle walking test - chester step - 30/10/15 Work through the relocation process with the UHL Space Utilisation Group to seek suitable space to be able to carry out shuttle walking tests - 31/10/15	12	SBY

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2605	RRC	Renal Transplant	There is a risk that the Transplant Laboratory's IT database for managing patients and donors will experience a system 'crash'	09/04/2015	31/10/2015	Causes: Transplant Lab IT system is Filemaker Pro which is run from a number of Maintosh PCs. Filemaker updates patient status on Proton through a number of scripts. - Macintosh PCs are not supported by UHL IM&T; - Several of these Macintosh PCs crash during routine operation and have to be restarted; - Filemaker crashes during routine operation. Consequences: If the Laboratory experiences a 'crash' it is conceivable that valuable patient or donor data could be lost or corrupt. Loss of patient or donor data (typing, screening or crossmatching) could affect organ allocation or transplantation (i.e. wrong recipient chosen for organ transplantation). This could affect patient safety if acute rejection occurred.	Quality	A system 'crash' would mean Transplant Laboratory staff would have to search paperwork for patient / donor data and transcribe testing results which could be error prone. In the past the Laboratory's Filemaker System has been backed up by using CDs but this has not occurred for some time.	Major	Likely	16	Migration of data from current Filemaker System into Histotrac (a dedicated Tissue Typing IT System). Training of Transplant Laboratory staff in use of Histotrac - due 31/10/15. Evaluate and test Histotrac links to Empath's LIMs (Winpath) and Proton systems - due 31/10/15. Investigate options to procure a robust system - due 31/10/15 Discuss with UHL and EMPATH information management an IT safety plan for Transplant Lab. Empath current and planned IT systems (Haemonetics and Winpath) do not have Tissue Typing component but some commercial Tissue Typing IT systems (e.g. Histotrac) would be able to 'talk to' Empath IT systems - complete.	4	PDU

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2606	RRC	Renal Transplant	There is a risk that the Transplant Laboratory may not receive CPA accreditation damaging the reputation of the service	09/04/2015	31/10/2015	Causes: The Quality Management system (QMS) has not been fully maintained since the last CPA inspection and is in a 2 year period of transition finding a new Head of Laboratory. SOP and other documents not updated. Low staffing levels due to sickness absence. 'In house' IT systems are standalone and not supported by UHL IM&T. Consequences: If the Laboratory experiences a system 'crash' , it is conceivable that valuable patient and / or donor data could be lost or corrupt. Damage to the reputation of the H&I and Transplant Laboratory service may result in further external probity from other user organisations. Financial loss as tests are outsourced to other providers. Low staff morale - staff may decide to leave and vacancies may be difficult to recruit into.	Quality	Approved communication issued to Lab staff, Trust Senior Management (Medical Director, Director of Clinical Quality, HoN, HoS and HoO), UHL finance, NHSBT (under the EU directive on organ donation) and Commissioners w/c 15/06/15. QAC Board approved on 25th June 2015. Approval to appoint a temporary band 2 post (6 months) and a band 7 post.	Major	Likely	16	Loss of income and financial case worked up as part of interim cost measures. Finance team to review financial position following the outcome of the UKAS visit on 14th September - 31/10/15. Band 2 post to be appointed into - due 31/10/15. Band 7 post to be appointed into, awaiting start date from HR - 31/10/15.	4	PDU

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2591	Emergency and Specialist Medicine		Risk of increased demand in diabetes outpatient foot clinic leading to overbooked clinics which over run	24/08/2015	30/11/2015	Causes: Increased volume of patients referred in from primary care needing MDT assessment. Majority of referrals are urgent due to high risk nature of patients. No increase in staffing capacity, therefore clinics are overbooked and over run. Inability to urgently transfer systemically unwell patients to be admitted to ESM due lack of transport. Consequences: Risk of patient harm (ulceration/amputation/sepsis) due to lack of capacity to see high risk patients urgently. Risk of delays in clinics. Risk of breaching national guidelines. Increasing workload of MDT foot team leading to stress and risk of mistakes. Risk to patients and staff when patients have to wait for transport to LRI when being admitted.	Patients	The diabetes foot team follow NICE/FDUK Guidance for treating high risk foot patients Patients are triaged in accordance with LLR Diabetes Foot care Pathway. CCGs aware of increase in referrals from primary care Clinics are consistently over booked to attempt to accommodate increased demand Service review of Foot care undertaken including review of Podiatry SLA	Major	Likely	16	Recruitment of Diabetes Specialist Nurse - 30/11/15 Recruitment of Consultant - 30/11/15 Additional foot clinic to commence (inc additional podiatry session) - 30/11/15 Arrangement to be agreed to access urgent transport (Use of CMG specific ambulance being explored to transfer high risk patients in a timely manner) - 30/11/15	8	JSPI

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2388	Emergency and Specialist Medicine	ED	There is risk of delivering a poor and potentially unsafe service to patients presenting in ED with mental health conditions	29/10/2014	30/10/2015	Causes: An increase of over 20% in ED attendances relating to mental health conditions in the past 5yrs. Inappropriate referrals into the ED of patients with mental health conditions. Limited resources and experience of staff in the ED to manage mental health conditions. The number of security staff has not increased with the increase in patient numbers (and are unable to restrain patients currently- see associated risk). The facilities in which to manage this patient group are inadequate for this patient group as not currently staffed. Poor systems in place between UHL, LPT, Police & EMAS to manage this patient group. High workload issues in the ED overall and overcapacity. National shortage of mental health beds, leading to placement delays for patients requiring in patient mental health beds. CAMHS service is limited. (11/02/2015, several recent SI's highlighted) Consequences: Potentially vulnerable patients are able to leave the ED and are therefore at risk of coming to harm. There have been incidents reported where patients have been able to self harm whilst in the ED. Patients receive sub optimal care in terms of their mental he Increased and serious incidents reported regarding various Patients' privacy and dignity is adversely affected. Risk of staff physical and mental injury/harm.	Patients	Security staff allocated to ED via SLA agreement (can intervene if staff become at risk). Violence & Aggression policy. Staff in ED undergo training with regard to mental health. Staff attend personal awareness training. Mental health pathway and assessment process in place in ED. Mental health triage nurse based in MH assessment area of ED, covering UCC and ED. ED Mental Health Nurse Practitioner employed in ED. Medical lead for mental health identified in ED from Consultant body. 10/02/2015 update - Recent SI's related to CAHMS have been raised on the agenda of the Urgent Care Board. LLR System Urgent Care Board has agreed that they will commission an external independent investigation into the 3 recent Patient Safety Serious Incidents (SIs) relating to vulnerable children under the care of the CAMHs services. This process will follow the methodology set out for NHS organisations. Terms of reference agreed by John Adler. Urgent review across all agencies regarding people being detained in place of safety. Protocol being developed for management of younger people. Recent reports have been shared with the TDA UHL representation (JE) on the Health Economy Par There is a detailed action plan underpinning the mul	Major	Likely	16	Task & Finish group to review security arrangements in terms of Control & Restraint practice in ED - complete Missing persons process for ED to append to UHL Missing Patients Policy - complete Agreement of role of security staff in ED and agree service level agreement to reflect this - 30/10/15. Update requested from David Lord (11/06/2015) (Update 16/7/15, ED Education team sorting Band 7 & 6 training first. Venue still be arranged. ST4 Medics also being looked at for training. David Lord Discussing protocol with Police regards handover of patients) Training to be available for ED staff with regard to management of aggressive patients, to include breakaway techniques - Completed, Conflict resolution training now completed via E learning Roll out of Mental Health Study Day for ED staff during 2014/15 - Complete. Develop plans in line with Government's "Mandate" to ensure no one in crisis will be turned away by - Completed. UHL are signed up to the crisis care concordat. No patients are turned away. Partnership working group set up to include UHL, LPT, EMAS & Police to look at improving response t Violence Risk Assessment &Training needs analysis UPDATE, 1st Sept - Personal Safety Awareness trai	6	DMI

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2466	Emergency and Specialist Medicine	Rheumatology	There is a risk of Patient harm due to delays in timely review of results and Monitoring in Rheumatolgy	12/03/2014	31/12/2015	1. High Volume of paper results that need daily review by registered Nurse, 2. There is duplication of results as some patients will have results reported through DAWN database and some patients will not (patients on other immunosuppressant drugs); therefore nurses checking all paper copies 3. There is a gap in the nursing establishment 4. Only one person trained to input data on DAWN system; they have given notice and will finish end of November 5. Insufficient DAWN licences for number of patients required 6. DAWN is not used in real time by Clinicians Consequences 1. Risk of patient harm due to late or missed identification of drug toxicity 2. Risk of patient harm due to delays in decision making and poor communication within the department and with patients and GPs 3. Risk of breaching national guidelines 4. Financial impact due to duplication of blood tests 5. Increasing workload of nurse specialists leading to stress and risk of mistakes 6. Financial risk from commissioning due to inadequate tracking of compliance and drug monitoring	Patients	The Rheumatology Department follows the 'BSR/BHPR guideline for disease-modifying anti-rheumatic drug (DMARD) therapy in consultation with the British Association of Rheumatologists (2). This stipulates the type and frequency of blood test monitoring, as well as recommendations for actions if results are found to be abnormal. Service management team are negotiating more live patient licences with 4s Systems and more users as well as training requirements. Action plan in place to identify and act on further risks, process review supported by LiA programme.	Major	Likely	16	Site visit and further support from 4s systems requested to identify further monitoring of biologics patients - Complete LiA work stream to address risks and plan future working - 31/10/15 Every patient on DMARD to be on DAWN system and monitored in real time - 31/10/15 Business case for DAWN expansion with further licenses and more users - 31/10/15	1	GST

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2541	Musculoskeletal and Specialist Surgery		There is a risk of reduced theatre & bed capacity at LRI due to increased spinal activity	27/04/2015	30/09/2015	Causes: Increased spinal activity Workload exceeds capacity Insufficient theatre capacity Reduced bed capacity Insufficient consultant numbers to operate spinal on call rota Inadequate junior doctor numbers Increased activity from out of areas in line with proposal to be regional spinal service Consequences: Financial loss though increased LoS Adverse effect on other trauma theatre and bed capacity Inability to take advantage of increased tariff from #NOF BPT due to knock on effect on capacity Increased morbidity Risk to reputation Risk to CT training programme Claims risk Decreased efficiency from increased split site working Insufficient Orthogeriatric cover for increased activity	Patients	Weekly Monitoring of performance against BPT criteria Monitoring of morbidity at M&M meetings Trauma Coordinator role implemented Cross organisational meetings with commissioners Trauma business case accepted for increased staffing across wards/departments and theatres Trauma unit meeting reinstated	Major	Likely	16	Agree way forward for regional spinal service - Richard Power/Sarah Taylor - due Sept 2015 Employment of further staff to support the spinal on call rota - Richard power/ John Davison - from July to September 2015 Employment and training of further TNPs to bolster junior doctor gaps and facilitate more stable CT training - Kate Machin/Nicola Grant - due May 2018 Recruit to staffing agreed through the trauma business case - Kate Machin/Nicola Grant/John Davison/Nafisa Bhaya - due Sept 2015	8	CSK
2504	Musculoskeletal and Specialist Surgery	Trauma Orthopaedics	There is a risk that patients will wait for an unacceptable length of time for trauma surgery resulting in poor patient outcomes	03/12/2015	30/09/2015	Causes: Increased spinal activity; workload exceeds capacity; under utilised theatre capacity; insufficient capacity at the weekend; inadequate junior doctor numbers; insufficient Orthogeriatrician input across 7 days; absence / under-provision of senior anaesthetic ward pre-assessment. Consequences: Patient safety and patient experience; financial loss through increased LoS; inability to take advantage of increased tariff from #NOF BPT; increased morbidity; risk to reputation; risk to CT training programme; litigation risk.	Patients	Weekly monitoring of performance against BPT criteria Monitoring of morbidity at M&M meetings LiA Event taken place to identify problem areas and potential solutions Action plan in place and monitored monthly Trauma Coordinator role implemented Increased Orthogeriatrician Input Mandatory reporting to CQRG Trauma unit meeting reinstated	Major	Likely	16	Creation of escalation and response process to meet peaks in trauma demand - 30/09/15. Scoping and implementation of a more responsive data capture and scheduling database - 30/09/15. Complete LiA cycle and subsequent action plan - 30/09/15. Employment of further staff to support the service across 7 days as per the recent business case - 31/12/15. Employment and training of further TNPs to bolster junior doctor gaps and facilitate more stable CT training - 30/04/18.	8	CSK

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
607	Clinical Support and Imaging	Blood Transfusion	Failure of UHL BT to fully comply with BCSH guidance and BSQR in relation to traceability and positive patient identification	22/12/2006	31/10/2015	Causes: Failure to implement electronic tracking for blood and blood products to provide full traceability from donor to recipient At UHL blood is tracked electronically up to the point of transfer of blood from local fridge to patient with a manual system thereafter which is not 100% effective (currently approximately 1 - 2% (approx 1200 units) of all transfusion recording is non-compliant = 98% compliance). Non-compliance with blood transfusion policies resulting in incorrect identification processes resulting in sample identification and labeling error resulting in wrong blood cross-matched and / or provided for patient (last incident of ABO incompatibility by wrong transfusion approx 2008; approximately 6 near misses per year). New British Committee for Standards in Haematology (BCSH) guidelines state that unless a secure electronic PPI system is in place for the taking of blood transfusion samples, except in cases of acute clinical urgency, 2 samples on 2 separate occasions should be tested prior to blood issue. An electronic system would require only 1 sample. Critical report received from MHRA in October 2012 in relat Consequences:	Quality	Policies and procedures in place for correct patient identification and blood/ blood product identification to reduce risk of wrong transfusion. Paper system provides a degree of compliance with the regulations. Training and competency assessment for UHL staff involved in the transfusion process including e-learning and induction training with competency assessment for key staff groups. Regular monitoring and reporting system in relation to blood/ blood product traceability performance within department, to clinical areas and Transfusion Committee.	Major	Likely	16	Full implementation of LIMS ; Full implementation Blood Track - 31/10/15	4	AFE

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2487	Clinical Support and Imaging	Medical Physics	Maintaining the quality of the Nuclear Medicine service for PET, Cardiac MPI and general diagnostics	01/06/2015	31/03/2016	Causes: The lead clinician in Nuclear Medicine is on long term sick leave. He is the only PET ARSAC certificate holder in the Trust and the clinical lead for the service. The locum covering cardiac MPI is the only other experienced ARSAC certificate holder for MPI studies. His contract ends in Jan 2015. There are other ARSAC certificate holders who cover general Nucelar Medicine and paediatric work. Their time commitment to Nuclear Medicine is severely limited. There is only one Consultant Radiologist currently entitled to report PET images under the national contract. A second is experienced and has retained competence but requires some training and revalidation. There are a number of Consultant Radiologists who report MPI's and general Nuclear Medicine but none eligible or interested in gaining ARSAC certification Consequences: An ARSAC certificate holder for PET can be "borrowed" under the existing contract but the new contract will require a certificate holder within the Trust. This puts the plans for fixed PETCT at risk. Loss of MPI expertise will have a major impact on the servic Pressures on the consultant body to provide a comprehens The risks are that PET and MPI scanning are suspended, i	Quality	Imaging rotas re-arranged to increase reporting sessions from other Radiologists Consultants nominated as interim clinical leads - carol Newland and Yvonne Rees Take action to provide clinician cover for ARSAC, reporting and clinical supervision - 30/12/14 completed Undertake clinical review - 30/12/14 completed Produce business case - 1/3/15 - completed	Major	Likely	16	Appoint new clinician - 31/03/16	6	DPE

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2245	Clinical Support and Imaging	Medical Records	Staff vacancies and increased activity within the medical records departments is having an impact on service delivery	24/10/2013	31/10/2015	The Medical Records service should be working 14 days in advance for locating routinely requested records, current performance is 3 to 5 days. Many case notes are being located late or not at all with a consequent impact on patient care, causing delays in clinics and delayed decision making on wards in some instances. Causes (hazard) High level of turnover and vacancies, predominantly caused by the anticipated impact of the proposed Electronic Document Records Management project. Increase of 7.5% in activity over last 12 months and increasing month on month since February 2014 are also impacting service delivery Consequence (harm / loss event) Deterioration in service provided due to inability to deal with level of medical records requests leading to cancellation of these and failure to provide service. Patients appointments and elective surgery are being cancelled due to records not being available in some clinical areas with a potential adverse impact on patient care. Delays to emergency flow and extension of length of stay due to a lengthened decision making process (due to lack o Increase in daily internal complaints and Datix incidents and	HR	Use of A&C bank staff where possible, though very limited in supply. Use of overtime from remaining substantive staff (though dwindling due to length of time during recruitment process; staff are under pressure). Reduction / cancellation of staff attendance at mandatory training (though with clear consequent impact on this Trust deliverable target). Cancellation of non-clinical requests for case notes daily (e.g. audit) to minimise disruption to front line clinical need (though with clear consequent impact on other areas of service delivery). On going urgent recruitment to existing vacancies. A waiting list of suitable applicants has been created to minimise the risk of the current staffing levels reoccurring in the future. Medical records management supporting HRSS by chasing references and other checks. Daily review of staffing levels and management of requests with concentration of staffing in areas of greatest demand and clinical priority.	Major	Likely	16	Continuing review of short-term reduction in service for non-clinical requests for case notes located within specialty areas of UHL (records within library areas will continue to be located). Communication to affected clinical areas as required - Ongoing requirement. Monitoring and review of need for short-term agency usage (limited bank availability) to make library locations safe - 05/09/14 - decision not to use agency taken due to cost and training implications will continue with current plan of using substantive staff at weekends and evenings instead Continuation of substantive overtime and utilisation of bank staff if available - ongoing requirement. Monitoring storage capacity weekly in the libraries - ongoing requirement. Arrange meetings with CMG's to review notes processes to improve availability - started end August 2014 - ongoing will continue to liaise with specialties until problems have been resolved. LIA wave 4 workstream from January 2015 to work with all areas to improve notes availability by reviewing processes and identifying and solving issues that cr	6	DWAT

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2378	Clinical Support and Imaging	Pharmacy	There is a risk that Pharmacy workforce capacity could result in reduced staff presence on wards or clinics	19/06/2014	30/11/2015	Causes: High levels of vacancies and sickness High levels of activity Training requirements for newly recruited staff Consequences: There is a risk that arises because of pharmacy workforce capacity across multiple teams which will result in reduced staff presence on wards or clinics, as well as capacity for core functions. This will result in reduced prescription screening capacity and the ability to intervene to prevent prescribing errors and other medicines governance issues in a number of areas including some high risk.	HR	extra hours being worked by part time staff team leaders involved in increased 'hands' on delivery staff time focused on patient care delivery (project time, meeting attendance reduced) Prioritisation of specific delivery issues e.g. high risk areas and discharge prescriptions, chemo suite	Major	Likely	16	Increase band 4 technician training capacity - 30/10/15	8	CELL
1926	Clinical Support and Imaging	Ultrasound	There is a risk that insufficient staffing to manage ultrasound referrals could impact Trust operations and patient safety	04/10/2012	31/10/2015	Causes: Unfilled vacancies, out of hours inpatient lists and an increase in scanning time for nuchal screening Consequences: Patients waiting much longer for Imaging tests May affect ED 4 hour targets Negative effect on internal standard turnaround times for inpatients Further effect is to contribute towards Trust bed pressures; increased patient stays and breaches of targets (ED targets.) Radiology staff over stretched due to covering extra overtime continuously to meet targets and internal wait. Unsustainable service. Cost pressure from the use of agency staff and overtime payments	Patients	Staff volunteer to do overtime/extra duties . Agency and bank staff are being used to cover sessions	Major	Likely	16	Recruit to vacancies - 30/10/2015	6	CLA

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2384	Women's and Children's	Maternity	There is an increased risk in the incidence of babies being born with HIE (moderate & severe) within UHL	24/06/2014	31/10/2015	Causes: Increased incidence of Hypoxic Ischemic Encephalopathy (HIE) within UHL 2012 2.3/1000 (2013 - further increase - incidence not defined). Compared to Trent & Yorkshire incidence 1.4/1000 births. Decision-making/capacity /CTG interpretation Midwifery staffing levels/Capacity Medical staffing levels overnight @LGH Consequences: Mismanagement of patient care Litigation risk Adverse publicity	Patients	Interim solution to increase capacity Monthly figures of HIE to be included in W&C dashboard Mandatory training for CTG/CTG Masterclass Weekly session to discuss CTG interpretation with junior doctors Active recruitment process for midwifery staff	Major	Likely	16	Undertake a peer review visit to Birmingham Heartlands due 31/10/15. Development of a decision education package focusing on the management of the 2nd stage of labour due 31/10/15.	8	ACURR
2153	Women's and Children's	Paediatrics	Shortfall in the number of all qualified nurses working in the Children's Hospital.	03/05/2013	31/12/2015	Causes The Children's Hospital is currently experiencing a shortfall in the number of Children's registered nurses. This is due to high numbers of vacancies and staff on maternity leave and long term sickness. Consequences There is a short fall in the number of appropriately qualified children's nurses in the Children's Hospital which could impact on the quality of patient care.	HR	Where possible the bed base is flexed on a daily bases to ensure we are maintaining our nurse to bed ratios There is an active campaign to recruit nurses locally, national and internationally Additional health care assistance have been employed to support the shortfall of qualified nurses. Specialise Nurses are helping to cover ward clinical shifts. Cardiac Liaison Team cover Outpatient clinics Overtime, bank & agency staff requested Head of Nursing, Lead Nurse, Matron and ECMO Co-ordinator cover clinical shifts Adult ICU staff cover shifts where possible Recruitment and retention premium in place to reduce turn-off of staff Part time staff being paid overtime Program in place for international nurses in the HDU and Intensive Care Environment Second Registration for Adult nurses in place	Major	Likely	16	Weekly metrics related to staffing shortages reported to CMG team and action taken where identified - due 11/01/16 Complete staff safe levels daily and take action where required. Clear escalation process - Due 11/01/16 Matrons daily ward rounds - due 11/1/16 Second registration course to commence September 2015 and be evaluated - due 11/01/16 Completion of a period of perceptorship for new international qualified nurses - due 30/01/2016 Continue to recruit to remaining vacancies - due 30/01/16	8	HKI

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2237	Medical Directorate		There is a risk of results of outpatient diagnostic tests not being reviewed or acted upon resulting in patient harm	10/07/2013	31/10/2015	Causes Outpatients use paper based requesting system and results come back on paper and electronically. Results not being reviewed acknowledged on IT results systems due to; Volume of tests. Lack of consistent agreed process. IT systems too slow and 'lock up'. Results reviewed not being acted upon due to; No consistent agreed processes for management of diagnostic test results. Actions taken not being documented in medical notes due to; Volume of work and lack of capacity in relation to medical staff. Lack of agreed consistent process. Referrals for some tests still being made on paper with no method of tracking for receipt of referral, test booked or results. Poor communication process for communicating abnormal results back to referring clinician; Abnormal pathology results- cannot always contact clinician that requested test and paper copies of results not being sent to correct clinicians or being turned off to some areas. Suspicious imaging findings- referred to MDT but not always also communicated back to clinician that referred for test. Lack of standards or meeting standards for diagnostic tests	Patients	Abnormal pathology results escalation process Suspicious imaging findings escalated to MDTs Trust plan to replace iCM (to include mandatory fields requiring clinicians to acknowledge results).	Major	Likely	16	Implementation of Diagnostic testing policy across Trust - to ensure agreed specialty processes for outpatient management of diagnostic tests results - complete. Development IT work with IBM to improve results system for clinicians and Trust to develop EPR with fit for purpose results management system. - Jan 16	8	CER

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2338	Medical Directorate		There is a risk of patients not receiving medication and patients receiving the incorrect medication due to an unstable homecare	05/01/2014	30/09/2015	Causes: A major homecare company has left the Homecare market requiring remaining companies to take on large numbers of patients. These companies are now experiencing difficulties in maintaining their current levels of service. Consequences: Existing providers of homecare services are having difficulties achieving satisfactory level of deliveries UHL patients are now being affected and poor patient experience. Patients receiving incorrect medication or not receiving any medication via homecare Patients having difficulties in contacting homecare telephone helplines. Potential interruption in supply of chemotherapy agents from Bath ASU. Deliveries not arriving leading to missed doses and also issues with patients having to take time of work to accept the deliveries There are a significant number of patients, clinicians and pharmacy staff who have lost confidence in the homecare services provided on behalf of UHL. As UHL have had to purchase these drugs, there is a loss of the VAT benefits that were originally gained by the health community. Adverse impact on Trust reputation	Patients	UHL Homecare team liaising with homecare companies to try and resolve issues of which they are made aware. H@H high risk patients currently being repatriated to UHL. UHL procurement pharmacist in discussion with NHS England (statement due out soon - timeframe unsure), and with the CMU. Patient groups and peer group discussions also been had to support patient education and support during this uncertain period. Reviewing which medicines can be done through UHL out-patient provider or through UHL Discussions with Medical Director and CMG (CSI) and clinical speciality teams to ensure that any necessary clinical pathway changes are supported Repatriation of urgent drugs back to UHL out-patient provider Self - assessment against Hackett criteria against all homecare schemes	Major	Likely	16	Review of RPS stds across region - 30/09/2015 Review against Hackett - due 30/09/2015 Appt of homecare administrator post - 30/09/2015	9	CELL
2093	Medical Directorate	R&I	Athena Swan - potential Biomedical Research Unit funding issues.	08/08/2014	31/10/2015	The Athena SWAN Charter is a recognition scheme for UK universities and celebrates good employment practice for women working in science, engineering and technology (SET) departments. Standards required for next round of Biomedical Research Unit (BRU) submissions. Academic partners required to be at least Silver Status. Failure for the University to achieve this will result in UHL being unable to bid successfully for repeat funding of the BRUs. There is a very real possibility that UHL will loose ALL BRUs if this is not adequately addressed.	Economic	Every meeting with the University, Athena Swan is on the Agenda. Out of UHL control directly, but every avenue is being used to keep the emphasis high at the University. New high level process has been introduced at University of Leicester to drive and supervise the application.	Major	Likely	16	Medical school has submitted bid for Athena Swan Silver and will learn outcome in September 2015. Individual medical school departments are preparing separate bids for Athena Swan Silver that will be submitted in October 2015 if medical school bid unsuccessful - 31/10/2015	4	CMAL

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2318	EFMC		There is a risk of blocked drains causing leaks and localized flooding of sewage impacting on service provision	17/03/2014	30/12/2015	Causes: Aging infrastructure unable to cope with the volume of sewage due to restrictions and narrowing of the pipes Staff, visitors and patients placing materials other than toilet paper into the drainage system including wipes, sanitary towels and nappies. Back flow sink drains are unprotected resulting in foreign bodies Consequence: Blockages build up easier and the older pipes cannot cope with the additional pressure causing leaks of raw sewage into occupied areas. Pipes cannot cope with the non-degradable materials and flooding occurs Localised flooding of clinical areas often involving areas on the floors below Foreign bodies block the drains and cause back fill and overspill of sinks and other facilities Clinical areas and staff areas become contaminated with raw sewage. Patients contaminated with sewage from leaks in the ceilings above their bays/beds. Whilst repairs are underway it may become necessary to isolate and turn off showers, toilets and washing facilities elsewhere in the building. Potential media coverage (one request for information from Leicester Mercury during August 2014) which could result in Quality and safe delivery of care compromised in areas of s Risk to health and safety of staff from an unsafe working en	Targets	CCTV surveys of drains completed as far as possible in Balmoral, Windsor, Victoria and Modular Wards. Remedial works carried out in priority areas. New main drain being installed in Service level 2 to divert 19 drain stacks to external drain, this reduces pressure on drains below level 3. Business Continuity Plans for all CMGs Single choice patient wipes agreed at NET. Reporting of the number of blockages monitored by NHS Horizons and by Trust.	Major	Likely	16	Cost of replacement of stacks to be assessed by Nigel Bond - due 30/12/15 NHS Horizons to identify additional measures to reduce blockages - Nigel Bond 30/12/15	2	GLA

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2325	Corporate Nursing	Corporate Nursing	There is a risk that security staff not assisting with restraint could impact on patient/staff safety	04/03/2014	31/12/2015	Causes Interserve refusal to provide trained staff to carry out non-harmful physical intervention, holding and restraint skills, where patient control is necessary to deliver essential critical care to patients lacking capacity to consent to treatment. Insufficient UHL staff trained in use of non-harmful physical intervention and restraint skills to carry out patient control. Termination of Physical skills training contract with LPT provider in January 2014. Consequence Inability to deliver safe clinical interventions for patients lacking capacity who resist treatment and/or examination. Increased risk of Life threatening or serious harm to patients resisting clinical intervention Increased risk of injuries to patients due to physical interventions by inexperienced/untrained staff. Increased risk of injuries to untrained staff carrying out physical interventions. Increased risk of injuries to staff carrying out clinical procedures Requirement for increased staffing presence to carry out safe procedures Reduced quality of service due to diverted staff resources Increased risk of sick absence due to staff injury. Increased risk of complaints from patients and visitors Increased risk of failure to meet targets	Patients	UHL Nursing and Horizons colleagues have met with Interserve 12/03/14 and UHL have agreed to issue a temporary indemnity notice that will provide vicarious liability cover for Interserve staff in these situations (supported by our legal team). This was rejected by Interserve Management Cover with more UHL employed staff where there may be patients requiring this type of restraint; Staff must take risk assessed decisions about the use of restraint and ensure incidents are reported using the Trust's incident reporting database. In extreme cases staff should be aware that the police should be called Continue to communicate with all staff about the current position.	Major	Likely	16	Development and delivery of training programme in Physical Skills for clinical staff - 31/12/15	6	DLO

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2247	Corporate Nursing	Corporate Nursing	There is a risk that a significant number of RN vacancies in UHL could affect patient safety	30/10/2013	31/12/2015	Causes: Shortage of available Registered Nurses (RN) in Leicestershire. Nursing establishment review undertaken resulting in significant vacancies due to investment. Insufficient HRSS Capacity leading to delays in recruitment. Consequences: Potential increased clinical risk in areas. Increase in occurrence of pressure damage and patient falls. Increase in patient complaints. Reduced morale of staff, affecting retention of new starters. Risk to Trust reputation. Impact on Trust financial position due to premium rate staffing being utilised to maintain safety. Increased vacancies across UHL. Increased pay bill in terms of cover for establishment rotas prior to permanent appointments. HRSS capacity has not increased to coincide and support the increase in vacancies across the Trust. Delays in processing of pre employment checks due to increased recruitment activity. Delayed start dates for business critical posts. Benefits of bulk and other recruitment campaigns not being realised as effectively as anticipated and expected. Service areas outside of nursing being impacted upon due t	Patients	HRSS structure review. A temporary Band 5 HRSS Team Leader appointed. A Nursing lead identified. Recruitment plan developed with fortnightly meetings to review progress. Vacancy monitoring. Bank/agency utilisation. Shift moves of staff. Ward Manager/Matron return to wards full time.	Major	Likely	16	Over recruit HCAs. - 30/10/16 Utilise other roles to liberate nursing time - 30/04/17	12	MMC

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1693	Operations		There is a risk of inaccuracies in clinical coding resulting in loss of income	08/02/2011	31/12/2015	Causes: Casenote availability and casenote documentation. HISS/PatientCentre constraints (HRG codes not generated due to old version of Patient Administration System) High workload (coding per person above national average). Unable to recruit to trained coder posts (band 4/5) Inaccuracies / omissions in source documentation (e.g. case notes and discharge summaries may not include co-morbidities, high cost drugs may not be listed). Coding proformas/ ticklists designed (LiA scheme and previously) but not widely used. Electronic coding (Medicode Encoder) implemented February 2012 but not updated since (old versions of HRG). The system has no support model with IM&T, so errors are difficult to resolve. Mandatory training not undertaken for 3 years (the maximum span permitted) Consequences: Loss of income (PbR). Potential outlier for SHMI/HSMR data. Non- optimisation of HRG. Loss of Trust reputation.	Economic	Backlog of uncoded episodes actively managed from September 2014 and reduced from 11,000 to 4,000 (as at Dec 14). This has risen again to 8,000 in January due to Christmas Bank holidays, lack of agency coders and mandatory training for coders. When the backlog was reduced casenotes delivered to the coding offices, can be coded within 24 hours and work is underway again to reduce the backlog back to this level. Backlog reduction has increased coverage of coding from notes (rather than other electronic sources) and reduced the unnecessary movement of notes between departments. 4 Trainee coders commenced in Jan15 and have commenced comprehensive training in February (minimum of 21 days). Recruitment and retention strategy being developed with support of HR. Currently advertising for replacement band 6 site lead and band 5/6 coding trainer posts. Agency coders being used to backfill vacant positions. Medicode has been upgraded in the test environment but is failing to function correctly. The benefits of Medicode are being re-evaluated with a view to ensuring a comprehensive IT support model Lead clinicians identified to move coding closer to the Scorecard redevelopment to demonstrate improveme 3 year refresher training to be in place and funded re Regular updates to the Audit Committee	Major	Likely	16	Work with CMGs / ward clerks to maximise transfer of casenotes to Clinical Coding - 31/03/16 Appoint Coding trainer (Band 5/6) - 31/03/16 Establish comprehensive IT support model for Medicode - 31/03/16 Appoint replacement coding site lead (Band 6) - 30/04/16	8	JRO

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2316	Operations		There is a risk of flooding from fluvial and pluvial sources resulting in interuption to Services	03/06/2014	31/12/2015	Causes: Pluvial flooding (all sites) external and internally Fluvial flooding (at LRI) from the River Soar Heavy, prolonged rain fall Winter snow/ice melt Blocked drains Consequence: Loss of service areas/buildings/site To the full extent of the river soar flood plain the majority of the LRI would be flooded Sewage ingress Contamination of infrastructure Patient safety Loss of electrical supplies Loss of mains water and drainage Disruption to supply lines Staff difficulties getting in Staff difficulties getting home - staff car parks and vehicles flooded Reputation and publicity on the impact of flooding, the development of a site at risk from flooding, the response and recovery	Targets	Flood Plan - LRF and UHL Response teams IPC Policy Local Business Continuity Plans UHL Major Incident Plan UHL/Multi-agency communications plan Insurance Policy Cooperate with LRF partners to test the LRF plans	Major	Likely	16	Update UHL flood plan to identify services and equipment at risk and identify control measures - 31/12/15	12	PWA

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2561	Clinical Support and Imaging		Non specialist Provision of Vascular Access Services on the LGH/GGH site in comparison to the services offered at the LRI	22/07/2015	31/12/2015	Causes No specialist provision of vascular access on LGH/ GGH Service currently provided by clinicians non-specialised , unplanned and non patient focused (high specialist role - not likely to recruit staff with appropriate skill level). Staffing levels reduced due to retirement. Consequences Delays in provision of vascular access services cause harm to patients; delay in receiving appropriate treatment , failure of procedures , risk of infection and poor patient outcomes resulting in increased length of stay. Lack of cover to GGH/ LGH could possibly create discharge difficulties /failure to provide the most appropriate care delaying discharge.	Patients	Nationally recognised Vascular Access Service provision at the LRI, delivered at exceptionally high standards. Vascular access is provided in a planned , patient centred fashion by a very experienced team of nurse specialists. Service already offer out patient and direct access provision to prevent admission .	Moderate	Almost certain	15	Recruit to substantial posts following approval of the business case - 31/12/15	4	JHA

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2496	Clinical Support and Imaging	Blood Transfusion	Risks associated with implementation of an Electronic Blood Tracking and Traceability Management System within MHRA timescales	03/12/2015	31/10/2015	Causes: The training of clinical, laboratory and all other UHL staff in the use of system is inadequate leading to delay in implementation and the fate of the blood not being stored electronically. The procurement of an Electronic Blood Tracking and Traceability Management System which is not fit for purpose. The inability of the system to maintain and retain data storage (eg ward based data) for the minimum legal time. There is inadequate supplier, IT and laboratory support for a system that needs to run 24/7/365. Consequences: Having to ensure paper systems are maintained with associated costs. Not reaching 100% compliance in relation to traceability. Loss of opportunity to comply with additional recent transfusion recommendations eg positive patient ID on transfusion sampling. Loss of opportunity for patient safety improvements through the security of electronic monitoring and tracking of the vein to vein transfusion process. Lack of economies in patient blood component administration by only needing a single practitioner to transfuse a component augmented by electronic checking.	Statutory	1.Blood Transfusion Electronic Tracking Group Members and meeting - held fortnightly and consisting of multi-team specialists to address all aspects of procurement and implementation of the system 2.Business case for the Electronic Tracking System completed. Capital and Revenue Funds (PQQ) allocated for the purchase of the system - completed June 2014 3.Timeline and action plan for implementation of the Electronic Tracking System - active 4.Procurement process for the 'expressions of interest' for the Electronic system actioned and review of the expressions of interest presently being reviewed by Group Members 5.Defined specification of required Electronic system completed in preparation for the procurement process 6.Completion of scoring mechanism for system functionality and 'fit for purpose' being completed by Group members 7.IT specification for the non-functionality of the Electronic system requirements - members of the group collating system interfacing with UHL IT systems, data storage, training and equipment needs 8.Appointment of a project manager to support the in	Moderate	Almost certain	15	Appointment of additional staff to run and maintain the system once established 30/10/2015; Purchase and implementation of a Electronic Blood tracking and Tractability System to an agreed schedule for phase 1 courier - October 2015 Phase 2 , rest of TX system plus training roll out - Feb 2017	4	AFE

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2426	Clinical Support and Imaging	Dietetics	There is a risk that an increase in referrals could compromise safety for patients with complex nutritional requirements	28/10/2014	31/12/2015	Causes: Increased workload with greater number of patient referrals. Inability to staff the PN round daily due to shortage of staffing resource. Consequences: Increased length of stay, prescription errors, delays in reviewing patients, reduced quality of care, loss of patency of lines and reduced efficiency around checking patients' blood results. Delayed response to complex Home Parenteral Nutrition patients' contacts/referrals due to further increase in inpatient workload. Increased risk of prescribing errors due high workload and pressures to respond quickly. Insufficient nursing and dietetic cover to action promptly the increasing numbers of all referrals in-house and in the community, resulting in a number of patients receiving delayed reviews. Increased levels of stress amongst the team, which could result in increased sickness absence, which would further exacerbate the risks above. Risks to patient safety due to not being reviewed daily, particularly unstable patients. HIFNET bid will fail due to current staffing establishment. Loss of regional and national intestinal failure status. Loss of income from HIFNET bid. This will affect other services throughout the Trust (e.g. bari	Patients	Temporary controls following previous risk assessment December 2013, in the form of funding 1.0 WTE at Band 6 nurse and 0.21 at Band 8a nurse and 1.0 WTE Band 6 Dietitian, on a temporary basis, currently in place until 30/3/15.	Moderate	Almost certain	15	1. Review possibility of capping numbers of HPN referrals with the clinical teams. Review possibility of capping inpatient PN tailored bags - 30/11/15. 2. Consider converting temporary posts to permanent contracts to ensure continuity of staffing and training needs- complete. 3. Urgent review of the NST service to ascertain requirements for further uplift in staffing levels - 30/11/15. 4. Consider the option to Identify and facilitate professional checking by qualified pharmacist of the HPN prescriptions on a daily basis - complete. 5. Review current response times for enteral and HOS referrals, with a view to lengthening (current standard is within 24 hours) on a short term basis, to reduce pressure on the team - complete. 6. Complete stress risk assessments on all members of the nutrition nurse team and take any identified actions - 30/11/15. 7. Urgent review of job plans to all members of the NST to meet high risk priorities - 30/11/15. 8. Audit readmissions of HPN patients - complete. 9. To create and develop a specialist pharmacist post dedicated to nutrition in line with the current Ph	3	MSC

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2278	Women's and Children's	Family Planning	There is a risk that the Leicester Fertility Centre could have its licence for the provision of treatment and services withdrawn	17/12/2013	30/11/2015	Causes: Inadequate staffing levels and inappropriate quality systems in place. ISO 15189 accreditation would be an outcome if the service was adequately staffed with appropriate quality systems in place. Consequences: Patient safety and quality issues if unable to deliver service. Financial impact if patients choose to move elsewhere or NHS contracts not obtained. Risk to Trust reputation. Challenging external recommendations/improvement notice from HFEA - critical report received Feb 2013.	Statutory	1 full time trained Embryologist to a national recognised level. 3 part time trained Embryologist to a national recognised level. 1 0.8wte Band 6 BMS.	Moderate	Almost certain	15	Band 7 to be advertised & recruited to - due 30/11/2015	6	DMARS

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2601	Women's and Children's	Gynaecology	There is a risk of delay in gynaecology patient correspondence due to a backlog in typing	24/08/2015	31/10/2015	Causes: An increase in the number of referrals to gynaecology services. 1.0 wte vacancy of an audio typist. Bank and Agency staff being used to reduce typing backlog are not consistent especially during holiday periods. In addition delays can occur due to Consultants working cross-site and not accessing results promptly in order for the letters to be completed. Consequences: Delay in timely appointment letters to patients Delay in patients receiving results Delay in patients receiving follow up appointments Breach in the Trust standard for typing and sending out of patients letters (48 hours maximum time from date of dictation) As at 21/08/15 - there is a delay in gynaecology correspondence to the patient of: - 8 weeks following a general gynaecology appointment at LRI - 8 weeks for 1st appointment letters for Colposcopy at LRI - 1 week and 5 days for colposcopy result letters at LRI - 10 days for communication to GP with regards to the patient.	Quality	2 week wait clinics or any letters highlighted on Windscribe in red are typed as urgent. Weekly admin management meeting standing agenda item: typing backlog by site also by Colposcopy and general gynaecology. Using Bank & Agency Staff. Protected typing for a limited number of staff.	Moderate	Almost certain	15	Introduce template letters for 1st colposcopy appts - due 31/10/15 Clearance of backlog of letters - due 30/09/15 Introduction of new transcription service within gynaecology - due 31/10/15	6	DMAR

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2402	Corporate Nursing	Corporate Nursing	There is a risk that inappropriate decontamination practise may result in harm to patients and staff	19/08/2014	31/10/2015	Causes: Endoscope Washer Disinfector (EWD) reprocessing is undertaken in multiple locations within UHL other than the Endoscopy Units. These areas do not meet current guidelines with regard to a. Environment b. Managerial oversight c. Education and Training of staff There is decontamination of Trans Vaginal probes being undertaken within the Women's CMG and Imaging CMG according to historical practice, that is no longer considered adequate. Bench top sterilisers within Theatres continue to be used. The use of these sterilisers is monitored by an AED. Purchase of Equipment is not always discussed with the Decontamination Committee. Consequences: Lack of oversight of Decontamination practice across the Trust Equipment purchased may not be capable of adequate decontamination if not approved by Infection Prevention Current Endoscope Washer Disinfectors (EWD) re-processing locations (other than endoscopy units) are unsatisfactory. All of the above having the potential for inadequately decontaminated equipment to be used Patient harm due to increased risk of infection Risk to staff health either by infection or chemical exposure Reputational damage to the organisation Financial penalty	Patients	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 te	Moderate	Almost certain	15	Complete full review of decontamination practice within UHL and make recommendations for future practice - 31/12/2015 Review all education and training for staff involved in reprocessing reusable medical equipment - 31/10/15 Review the use of equipment and the appropriateness of their current placement according to national guidance - 31/10/15	3	LCOL

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1551	Corporate Nursing	Q&S	Failure to manage Category C documents on UHL Document Management system (Insite)	14/03/2011	31/12/2015	Causes: Lack of resource at CMG/directorate level to check review dates and enter local guidance onto the system in a timely manner. Lack of resource in CASE team effectively 'police' cat C documents Clinical guidelines very difficult to locate due to difficulties in navigating on InSite During migration from Sharepoint 2007 to Sharepoint 2010 searched documents displayed the titles of the files rather than the titles of documents. Consequences InSite may not contain the most recent versions of all category C documents. There may be duplication of documents with older versions being able to be accessed in addition to the most recent version. Staff may be following incorrect guidance (clinical or non-clinical) which could adversely impact on patient care.	Quality	Reports run from Sharepoint to show review dates of guidelines for each CMG A review date and author have now been assigned to each Cat C where this is possible.	Moderate	Almost certain	15	Make contact with lead authors in relation to out of review date documents - 31/12/15 Compile a list of local guidelines requiring review and send to CMGs for action - 31/12/15 CMGs to advise 'CRESPO' of any guidelines requiring urgent revision/ attention or that need to be removed from InSite - 31/12/15 Provide a message on InSite to inform staff that work to improve the system is ongoing and if necessary advise can be sought from Rebecca Broughton/ Claire Wilday - 31/12/15 Implement shared mailbox to receive responses from CMGs - 31/12/15 Ensure input from IM&T to make InSite more effective as a document library - 31/12/15 Continue work to assign review dates and authors to all CAT C documents 31/12/15	9	SH