University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper N

TRUST BOARD – 7th MAY 2015

UHL RISK REPORT INCORPORATING THE BOARD ASSURANCE FRAMEWORK

DIRECTOR:	ANDREW FURLONG – MEDICAL DIRECTOR
AUTHOR:	PETER CLEAVER – RISK AND ASSURANCE MANAGER
DATE:	7TH MAY 2015
PURPOSE:	This report provides the Trust Board (TB) with:- This report provides the Trust Board (TB) with:- a) The UHL 2014/15 BAF and action tracker as of 31ST March 2015. b) A draft version of the UHL BAF for 2015/16. c) Notification of new extreme or high risks opened during March 2015. d) Summary of all UHL extreme and high risks on the UHL risk register. The TB is invited to: • Receive and note this report; • review and comment upon the March 2015 iteration of the 2014/15 BAF and the draft version of the 2015/16 BAF, as it deems appropriate; • note the actions identified to address any gaps in either controls or assurances (or both); • identify any areas which it feels that the Trust's controls are inadequate and do not effectively manage the principal risks to our objectives; • 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; • identify any other actions necessary to address any 'significant control issues' in order to provide assurance on the Trust meeting its principal objectives;
PREVIOUSLY CONSIDERED BY:	**UHL Executive team**
Objective(s) to which issue relates *	[X] 1. Safe, high quality, patient-centred healthcare [Y] 2. An effective, joined up emergency care system [Y] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [Y] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [Y]

	5. Enhanced reputation in research, innovation and clinical education [Y] 6. Delivering services through a caring, professional, passionate and valued workforce [Y] 7. A clinically and financially sustainable NHS Foundation Trust [Y] 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	N/A
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	N/A
Strategic Risk Register/ Board Assurance Framework *	[ ] **Organisational Risk Register** [✓] **Board Assurance Framework** [ ] **Not Featured**
ACTION REQUIRED *	For decision [ ] For assurance [✓] For information [✓]

• We treat people how we would like to be treated • We do what we say we are going to do
• We focus on what matters most • We are one team and we are best when we work together
• We are passionate and creative in our work

* tick applicable box

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **7th MAY 2015**

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

SUBJECT: **UHL 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 2014/15 BAF and action tracker as of 31ST March 2015.
b) A draft version of the UHL BAF for 2015/16.
c) Notification of new extreme or high risks opened during March 2015.
d) Summary of all UHL extreme and high risks

2. 2014/15 BAF POSITION AS OF 31st MARCH 2015

2.1 A copy of the 2014/15 BAF is attached at appendix one with changes since the previous version highlighted in red text. A copy of the 2014/15 BAF action tracker is attached at appendix two with changes also highlighted in red. The TB is asked to note the following points:

a. Actions 16.2 and 16.3 are deemed to be operational in nature and have been removed from the BAF to be transferred to the UHL risk register under the ownership of the HR directorate and monitored to completion via the local risk review process.

b. A significant number of actions to close gaps in control and assurance have been completed and the TB is asked to consider reducing the current risk score to the target level for risk numbers 4, 5, 6, 7, 10, 16, 17, 18, 21 and 22.

c. Actions 18.6 and 18.7 are closed (as opposed to completed) and we may not return to these until at least the second half of 2015/16 (if at all) by which time the Board should be composed of substantive post holders.

2.2 It is proposed that the strategic objective below is discussed and reviewed:

- *'Responsive services which people choose to use' (incorporating* principal risk numbers 5, 6, 7 and 8).

3. DEVELOPMENT OF THE UHL 2015/16 BAF

3.1 The (TB) has previously requested a draft version of the 2015/16 BAF and to this end executive leads have populated the attached draft BAF at appendix three. The TB will note that final version will be submitted for sign-off in June 2015. The final version will be accompanied an action tracker to track the progress of actions.

3.2 It is important to recognise that the BAF should reflect only the 'high level' strategic issues and not drill down into operational details and should also contain sufficient detail in relation to how the TB receives assurance that our controls to achieve our strategic objectives are effective.

3.3 Some entries within this draft 2015/16 BAF may benefit from more challenge and scrutiny in particular around the identification of assurance sources and risk scoring. Where necessary this challenge will be provided by the corporate risk team with feedback being provided to the executive leads. This, in addition to any comments received from TB will enable a final version of the 2015/16 BAF to be produced.

4. EXTREME AND HIGH RISK REPORT.

4.1 To inform the TB of significant operational risks, a summary of all extreme and high risks (i.e. 15 and above) open as of 31st March 2015 is attached at appendix four. There are 46 risks on the organisational risk register scoring 15 and above.

4.2 Two new high risks have opened during March 2015 as described below. The details of these risks are included at appendix four for information

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Risk ID	Risk Title	Risk Score	CMG/ Directorate
2504	Patients will wait for an unacceptable length of time for trauma surgery resulting in poor outcomes and patient satisfaction	MSS	2504
2496	The Implementation of an Electronic Blood Tracking and Traceability Management System across UHL Hospital sites will not occur within the time scales agreed with the MHRA	CSI	2496

5. RECOMMENDATIONS

5.1 The TB is invited to:

(a) Receive and note this report;

(b) review and comment upon the March 2015 iteration of the 2014/15 BAF and the draft 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);

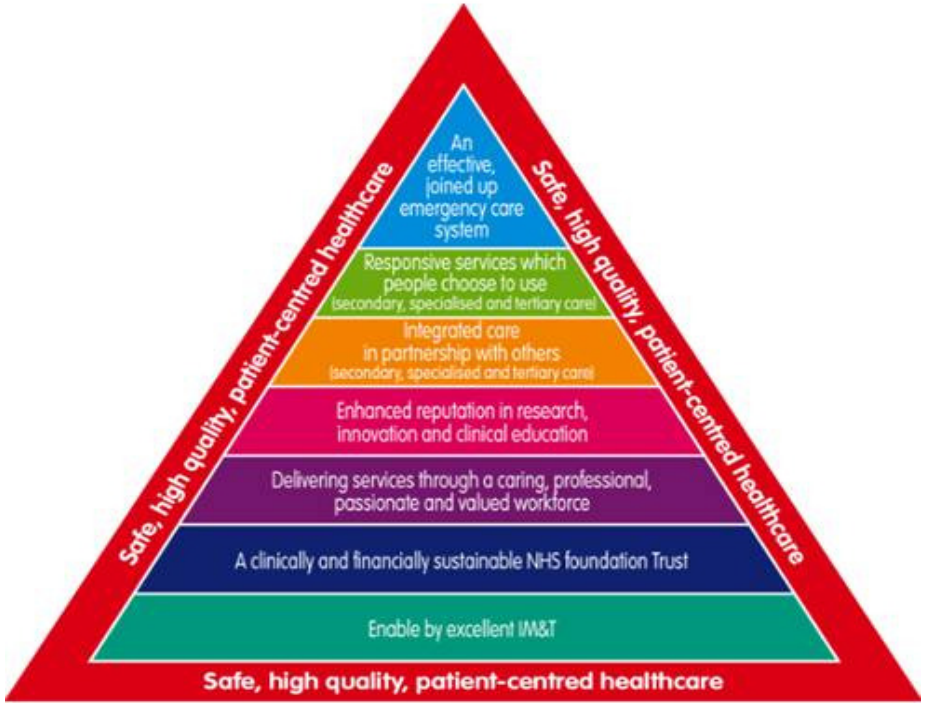
(d) identify any areas which it feels that the Trust's controls are inadequate and do not effectively manage the principal risks to our objectives;

(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,
30th April 2015.

UHL BOARD ASSURANCE FRAMEWORK 2014/15



UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

STRATEGIC OBJECTIVES

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

PERIOD: MARCH 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.	CN	12	8
2.	An effective joined up emergency care system	Failure to implement LLR emergency care improvement plan.	COO	20	6
3.		Failure to effectively implement UHL Emergency Care quality programme	COO	16	6
4.		Delay in the approval of the Emergency Floor Business Case.	MD	12	6
5.	Responsive services which people choose to use (secondary, specialised and tertiary care)	Failure to deliver RTT improvement plan.	COO	16	6
6.		Failure to achieve effective patient and public involvement	DMC	12	8
7.		Failure to effectively implement Better Care together (BCT) strategy.	DS	12	8
8.		Failure to respond appropriately to specialised service specification.	DS	15	8
	Integrated care in partnership with others (secondary, specialised and tertiary care)	Failure to effectively implement Better Care together (BCT) strategy.**(See 7 above)**	DS		
9.		Failure to implement network arrangements with partners.	DS	8	6
10.		Failure to develop effective partnership with primary care and LPT.	DS	12	8
11.	Enhanced reputation in research, innovation and clinical education	Failure to meet NIHR performance targets.	MD	6	6
12.		Failure to retain BRU status.	MD	9	6
13.		Failure to provide consistently high standards of medical education.	MD	9	4
14.		Lack of effective partnerships with universities.	MD	9	6
15.	Delivering services through a caring, professional, passionate and valued workforce	Failure to adequately plan workforce needs of the Trust.	DHR	12	8
16.		Inability to recruit and retain staff with appropriate skills.	DHR	12	8
17.		Failure to improve levels of staff engagement.	DHR	9	6
18	A clinically and financially sustainable NHS Foundation Trust	Lack of effective leadership capacity and capability	DHR	9	6
19		Failure to deliver the financial strategy (including CIP).	DF	15	10
20		Failure to deliver internal efficiency and productivity improvements.	COO	16	6
21.		Failure to maintain effective relationships with key stakeholders	DMC	15	10

22.		Failure to deliver service and site reconfiguration programme and maintain the estate effectively.	DS	10	5
23.	Enabled by excellent IM&T	Failure to effectively implement EPR programme.	CIO	15	9
24.		Failure to implement the IM&T strategy and key projects effectively	CIO	9	9

BAF Consequence and Likelihood Descriptors:

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Corporate leads agreed for each goal and identified leads for each work stream of the Quality Commitment.	Q&P Report. Reports to EQB and QAC.			
KPIs agreed for all parts of the Quality Commitment.	Reports to EQB and QAC based on key outcome/KPIs.	No gaps identified		
Clear work plans agreed for all parts of the Quality Commitment.	Action plans reviewed regularly at EQB and annually reported to QAC. Annual reports produced. Summary report scheduled for EQB February 2015			
Committee structure is in place to oversee delivery of key work streams – led by appropriate senior individuals with appropriate support.	Regular committee reports. Annual reports. Achievement of KPIs.	No gaps identified		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 2	Failure to implement LLR emergency care improvement plan.	**Overall level of risk to the achievement of the objective**	**Current score 4 x 5 = 20**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Chief Operating Officer			
Link to strategic objectives	An effective joined up emergency care system			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Establishment of emergency care delivery and improvement group with named sub groups	Meetings are minuted with actions circulated each week. Trust Board emergency care report references the LLR steering group actions.	(C) Emergency admissions are not reducing (C) Discharges are not increasing and delayed discharge rate has not changed Acceptance through U C B that attendance avoidance and admission avoidance schemes have not worked. LLR partners are aiming for a 5% reduction in 2015-16.		
Appointment of Dr Ian Sturgess to work across the health economy	Weekly meetings between Dr Sturgess, UHL CEO and UHL COO. Dr Sturgess attends Trust Board.			
Allocation of winter monies	Allocation of winter monies is regularly discussed in the LLR steering group	None	N/A	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Emergency care action team meeting has been remodelled as the 'emergency quality steering group' (EQSG) chaired by CEO and significant clinical presence in the group. Four sub groups are chaired by three senior consultants and chief nurse.	Trust Board are sighted on actions and plans coming out of the EQSG meeting.	C) Emergency admissions are not reducing (C) Discharges are not increasing and delayed discharge rate has not changed Acceptance through U C B that attendance avoidance and admission avoidance schemes have not worked. LLR partners are aiming for a 5% reduction in 2015-16.		
Reworked emergency plans are focussing on the new dashboard with clear KPIs which indicates which actions are working and which aren't	Dashboard goes to EQSG and Trust Board	(C) ED performance against national standards		
Further change leadership support has been identified to help embed the required clinically led changes	Trust Board are sighted on actions and plans coming out of the EQSG meeting.	C) Emergency admissions are not reducing (C) Discharges are not increasing and delayed discharge rate has not changed		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 5	Failure to deliver RTT improvement plan.	**Overall level of risk to the achievement of the objective**	**Current score 4x4=16**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Chief Operating Officer			
Link to strategic objectives	Responsive services which people choose to use (secondary, specialised and tertiary care)			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Weekly RTT meeting with commissioners to monitor overall compliance with plan	Trust Board receives a monthly report detailing performance against plan	(c) There is a revised admitted trajectory which is awaiting agreement with TDA and CCG. UHL is in line with the revised trajectory.		
Weekly meeting with key specialities to monitor detailed compliance with plan	Trust Board receives a monthly report detailing performance against plan	(c) As above		
Intensive support team back in at UHL (July 2014) to help check plan is correct	IST report including recommendations to be presented to Trust Board			

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Better Care Together (BCT) Strategy: • UHL actively engaged in the Better Care Together governance structure, from an operational to strategic level • Better Care Together plans co–created in partnership with LLR partners • Final approval of the 5 year strategic plan, Programme Initiation Document (PID – 'mobilises' the Programme) and SOC to be made at the Partnership Board of 20th November 2014 • Better Care Together planning assumptions embedded in the Trust's 2015/16 planning round	• BCT resource plan, identifying all work books named leads. Workbooks for all 8 clinical work streams and 4 enabling groups • Feedback from September 2014 Delivery Board and Clinical Reference Group workshops • LLR BCT refreshed 5 year strategic plan approved by the BCT Partnership Board • Minutes and Action Log from the BCT Programme Board			
Effective partnerships with primary care and Leicestershire Partnership Trust (LPT): 1) Active engagement and leadership of the LLR Elective Care Alliance 2) LLR Urgent Care and Planned Care work streams in partnership with local GPs 3) A joint project has been established to test the concept of early transfer of sub-acute care to a community hospitals setting or home in partnership with LPT. The impact of this is reflected in UHLs, LPTs the LLR BCT 5 year plans 4) Mutual accountability for the delivery of shared objectives are reflected in the LLR BCT 5 year directional plan 5) Active engagement in the BCT LTC work stream. Mutual accountability for the delivery of shared objectives are reflected in the LLR BCT 5 year directional plan	• Minutes of the public Trust Board meeting: o Trust Board approved the LLR BCT 5 year directional plan and UHLs 5 year directional plan on 16 June, 2014 o Urgent care and planned care work streams reflected in both of these plans • BCT resource plan, identifying all work books named leads (SRO, Implementation leads and clinical leads agreed at the BCT Partnership Board (formerly the BCT Programme Board) meeting held on 21st August 2014 Workbooks for all 8 clinical work streams and 4 enabling groups underway – progress overseen by implementation group and the Strategy Delivery Group which reports to BCT Partnership Board.			

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
(i) Regional partnerships: UHL is actively engaging with partners with a view to: • establishing a Leicestershire Northamptonshire and Rutland partnership for the specialised service infrastructure in partnership with Northampton General Hospital and Kettering General Hospital • establishing a provider collaboration across the East Midland's as a whole • Developing an engagement strategy for the delivery of the long term vision for and East Midlands network for both acute and specialised services	Minutes of the April 2014 Trust Board meeting: o Paper presented to the April 2014 UHL Trust Board meeting, setting out the Trust's approach to regional partnerships Project Initiation Document (PID): o Developed as part of UHL's Delivering Care at its Best (DC@IB) o Reviewed at the June 2014 Executive Strategy Board (ESB) meeting o Updates (DC@IB Highlight Report reviewed at ESB meetings	(c) Lack of Programme Plan	Programme Plan to be developed (8.3)	Apr 2015 DS
(ii) Academic and commercial partnerships.	Project Initiation Document (PID): o Developed as part of UHL's Delivering Care at its Best (DC@IB) o Reviewed at the August 2014 Executive Strategy Board (ESB) meeting o Updates (DC@IB Highlight Report reviewed at ESB meetings			
(iii) Local partnerships				
Specialised Services specifications: CMGs addressing Specialised Service derogation plans	Plans issued to CMGs in February 2014. Follow up meetings being convened for w/c 14th July 2014to identify progress to date.			

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Regional partnerships	See risk 8	See risk 8	See risk 8	See risk 8
Academic and commercial partnerships	See risk 8	See risk 8	See risk 8	See risk 8
Local partnerships	See risk 8	See risk 8	See risk 8	See risk 8
Delivery of Better Care Together:	See risk 7	See risk 7	See risk 7	See risk 7

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Effective partnerships with LPT	See risk 7	See risk 7	See risk 7	
Effective partnerships with primary care	See risk 7			

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 12	Failure to retain BRU status.	**Overall level of risk to the achievement of the objective**	**Current score 3 x 3 = 9**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Medical Director			
Link to strategic objectives	Enhanced reputation in research, innovation and clinical education			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Maintaining relationships with key partners to support joint NIHR/ BRU infrastructure	Joint BRU Board (bimonthly) Annual Report Feedback from NIHR for each BRU (annual) UHL R&D Executive (monthly) R&D Report to Trust Board (quarterly) Athena Swan Silver Status by University of Leicester and Loughborough University. (The Athena Swan charter applies to higher education institutions)	(c) Requirement to replace senior staff and increase critical mass of senior academic staff in each of the three BRUs. (c) Athena Swan Silver not yet achieved by UoL and Loughborough University. This will be required for eligibility for NIHR awards	BRUs to re-consider theme structures for renewal, identifying potential new theme leads. (12.1) UoL and LU to ensure successful applications for Silver swan status and. Individual medical school depts will need to separately apply for Athena Swan Silver status. (12.4)	Jun 2015 MD Mar 2016 MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Medical Education Strategy	Department of Clinical Education (DCE) Business Plan and risk register are discussed at regular DCE Team Meetings and information given to the Trust Board quarterly Medical Education issues championed by Trust Chairman Bi-monthly UHL Medical Education Committee meetings (including CMG representation) Oversight by Executive Workforce Board Appointment processes for educational roles established KPI are measured using the: • UHL Education Quality Dashboard • CMG Education Leads and stakeholder meetings • GMC Trainee Survey results • UHL trainee survey • Health Education East Midlands Accreditation visits Trainee Survey results • UHL trainee survey Health Education East Midlands			

	Accreditation visits			
UHL Education Committee	CMG Education Leads sit on Committee. Education Committee delivers to the Workforce Board twice monthly and Prof. Carr presents to the Trust Board Quarterly.	(c) No system of appointing to College Tutor Roles (c) UHL does not support College Tutor roles	Develop more robust system of appointment and appraisal of disparate roles by separating College Tutor roles in order to be able to appoint and appraise as College Tutors (13.6)	Jun2015 MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 14	Lack of effective partnerships with universities.	**Overall level of risk to the achievement of the objective**	**Current score 3 x 3=9**	**Target score 3 x 2= 6**
Executive Risk Lead(s)	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 100k genome and Life study reports to ESB monthly. Joint meetings held with R&D team for NUH - reported through R&D Exec minutes to ESB. EM CLAHRC Management Board reports via R&D Exec to ESB	(c) New relationships need to be developed and nurtured with the new VC and President for UHL. New Dean of Medical School expected 2015.	LU strategy to be discussed at joint BRU board. (14.2)	May 2015

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
UHL Workforce Plan (by staff group) including an integrated approach to workforce planning with LPT.	Reduction in number of 'hotspots' for staff shortages across UHL reported as part of workforce plan update. Executive Workforce Board will consider progress in relation to the overarching workforce plan through highlight report from CMG action plans.			
Nursing Recruitment Trajectory and international recruitment plan in place for nursing staff	Overall nursing vacancies are monitored and reported monthly by the Board and NET as part of the Quality and Performance Report NHS Choices will be publishing the planned and actual number of nurses on each shift on every inpatient ward in England			
Development of an Employer Brand and Improved Recruitment Processes	Reports of the LIA recruitment project Reports to Executive Workforce Board regarding innovative approaches to recruitment	(c) Capacity to develop and build employer brand marketing	Deliver our Employer Brand group to share best practice and develop social media techniques to promote opportunities at UHL (15.6)	Jun 2015 DHR

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Refreshed Organisational Development Plan (2014-16) including five work streams: 'Live our Values' by embedding values in HR processes including values based recruitment, implementing our Reward and Recognition Strategy (2014-16) and continuing to showcase success through Caring at its Best Awards	Quarterly reports to EWB and Trust Board and measured against implementation plan milestones set out in PID			
'Improve two-way engagement and empower our people' by implementing the next phase of Listening into Action (see Principal Risk 16), building on medical engagement, experimenting in autonomy incentivisation and shared governance and further developing health and wellbeing and Resilience Programmes.	Quarterly reports to and EWB and measured against Implementation Plan Milestones set out in PID	No gaps identified		
'Strengthen leadership' by implementing the Trust's Leadership into Action Strategy (2014-16) with particular emphasis on 'Trust Board Effectiveness', 'Technical Skills Development' and 'Partnership Working'	Quarterly reports to EWB and bi-monthly reports to UHL LETG. Measured against implementation Plan milestones set out in PID	No gaps identified		
'Enhance workplace 'development and learning' by building on training capacity and resources, improvements in medical education and developing new roles	Quarterly report to EQB, EWB and bi-monthly reports to UHL LETG and LLR WDC. Measured against implementation plan milestones set out in PID			
'Quality Improvement and innovation' by implementing quality improvement education, continuing to develop quality improvement networks and creating a Leicester Improvement and Innovation Centre	Quarterly reports to EQB and EWB and measured against implementation plan milestones set out in PID.	No gaps identified		
Appraisal and Objective Setting in line with Strategic Direction	Appraisal rates reported monthly via Quality and Performance Report. Appraisal performance features on CMG/Directorate Board Meetings. Board/CMG Meetings to monitor the implementation of agreed local improvement	No gaps identified		

	actions			

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Year 2 Listening into Action (LiA) Plan (2014 to 2015) including five work streams: Year 3 Listening into Action (LiA) Plan (2015 to 2016) to be developed in March 2015 for next 12 months. To include continued work with five work streams: Work stream One: **Classic LiA** • Two waves of Pioneering teams to commence (with 12 teams per wave) using LiA to address changes at a ward/department/pathway level	Quarterly reports to Executive Workforce Board (EWB) and Trust Board Updates provided to LiA Sponsor group on success measures per team and reports on Pulse Check improvements Annual Pulse Check Survey to be conducted March 2015 Update reports provided to JSCNC meetings			
Work stream Two: **Thematic LiA** • Supporting senior leaders to host Thematic LiA activities. These activities will respond to emerging priorities within Executive Directors' portfolios. Each Thematic event will be hosted and led by a member of the Executive Team or delegated lead.	Quarterly reports to Executive Workforce Board (EWB) and Trust Board Updates provided to LiA Sponsor group on each thematic activity Update reports provided to JSCNC meetings			
Work stream Three: **Management of Change LiA** • LiA Engagement Events held as a precursor to change projects associated with service transformation and / or HR Management of Change (MoC) initiatives.	Quarterly reports to Executive Workforce Board (EWB) and Trust Board Updates provided to LiA Sponsor group on each thematic activity Update reports provided to JSCNC meetings			

Work stream Four: **Enabling LiA** • Provide support to delivering UHL strategic priorities (Caring At its Best), where employee engagement is required.	Quarterly reports to Executive Workforce Board (EWB) and Trust Board Updates provided to LiA Sponsor group on each thematic activity Update reports provided to JSCNC meetings			
Work stream Five: **Nursing into Action (NiA)** • Support all nurse led Wards or Departments to host a listening event aimed at improving quality of care provided to patients and implement any associated actions.	Quarterly reports to Executive Workforce Board (EWB) and Trust Board Updates provided to LiA Sponsor group every 6 months on success measures per set and reports on Pulse Check improvements Update reports provided to JSCNC meetings Monthly updates to Nursing Executive Team (NET) meetings via Heads of Nursing per CMG			
Annual National Staff Opinion and Attitude Survey	Annual Survey report presented to EWB and Trust Board Analysis of results in comparison to previous year's results and to other similar organisations presented to EWB and Trust Board annually Updates on CMG / Corporate actions taken to address improvements to National Survey presented to EWB Staff sickness levels may also provide an indicator of staff satisfaction and performance and are reported monthly to Board via Quality and Performance report Results of National staff survey and local patient polling reported to Board on a six monthly basis. Improving staff satisfaction position.			
Friends and Family Test for NHS Staff	Quarterly survey results for Quarter 1, 2 and 4 to be submitted to NHS England for external publication:			

	Submission commencing 28 July 2014 for quarter 1 with NHS England publication commencing September 2014 Local results of response rates to be CQUIN Target for 2014/15 – to conduct survey in Quarter 1 (achieved)			
Workforce Sickness Absence levels	Attendance management policy and procedures available to staff and managers. Compliance reports via Workforce Informatics Manager sent to CMGs monthly to support management of individual cases. ESR recording of attendance. Monthly reports available to CMGs / Corporate Divisions HR CMG Teams support front line managers to manage staff in line with policy Sickness levels reported via CE Briefings per month Sickness levels incorporated into Organisational Health Dashboard monthly reporting via EWB quarterly meetings and available to CMG HR Leads via SharePoint Sickness absence rates reported to UHL Leadership Community via CE Briefings per month			
Mutuals in Health Pathfinder Programme	Submitted application to Cabinet Office (CO) and Department of Health (DH) to participate in the programme as one of the Trusts nationally. Selected to participate in the Pathfinder Programme – 1st January 2015 – 31 March 2015 Mutuals Programme Board established – January 2015 chaired by CEO. Programme Lead identified (Assistant Director of OD & Learning) to work with the assigned external partners (Hempsons, Stepping Out & Albion) Monthly update reports to Executive Team. Progress Report to be presented to EWB in March 2015 Programme of work relates to delivery of 3 pillars			

	identified for UHL – 1. Exploring organisational forms with whole Trust 2. Autonomous Incentivised Teams – elective orthopaedics & trauma team 3. Improving engagement within UHL Production of a Feasibility Report (Business Case) to DH/CO by 31 March 2014 Attendance at national workshops to learn from other Trusts – knowledge transfer. Organise internal workshops on each of the 3 pillars and encourage appropriate attendance by CMG Managers and nominated staff. Pathfinder Programme Risk Register to be managed by external partners with CO/DH.			

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Leadership into Action Strategy (2014:16) including six work streams: 'Providing Coaching and Mentoring' by developing an internal coaching and mentoring network, with associated framework and guidance which will be piloted in agreed areas (targeting clinicians at phase 1).	Quarterly Reports to Executive Workforce Board (EWB) as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.			
'Shadowing and Buddying' by creating shadowing opportunities and devising a buddy system for new clinicians or those appointed into new roles.	Quarterly Reports to Executive Workforce Board as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.			
'Improving local communications and 360 degree feedback' by developing and implementing a 360 Degree feedback Tool for all leaders and developing nurse leaders to facilitate Listening Events in all ward and clinical department areas as set out in Risk 17.	Quarterly Reports to Executive Workforce Board as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16. Updates provided to LiA Sponsor group every 6 months on success measures Monthly updates to Nursing Executive Team (NET) meetings via Heads of Nursing per CMG			
'Shared Learning Networks' by creating and supporting learning networks across the Trust, developing action learning sets across disciplines and initiating paired learning.	Quarterly Reports to Executive Workforce Board as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.			
'Talent Management and Succession Planning' by developing a talent management and succession planning framework, reporting on talent	Quarterly Reports to Executive Workforce Board as part of Organisational Development Plan and Learning, Education and Development Update as set			

profile across the senior leadership community, aligning talent activity to pay progression and ensuring succession plans are in place for business critical roles.	out in Risk 16.			
'Leadership Management and Team Development' by developing leaders in key areas, team building across CMG leadership teams, tailored Trust Board Development and devising a suite of internal eLearning programmes	Quarterly Reports to Executive Workforce Board as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.	(c) Improvement required in senior leadership style and approach as identified as part of Board Effectiveness Review (2014)		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Delivering recurrent balance via effective management controls including SFIs, SOs and on-going Finance Training Programme Health System External Review has defined the scale of the financial challenge and possible solutions UHL Service & Financial Strategy including Reconfiguration/ SOC	Monthly progress reports to F&P Committee, Executive Board, & Trust Board Development Sessions TDA Monthly Meetings Chief Officers meeting CCGs/Trusts TDA/NHSE meetings Trust Board Monthly Reporting UHL Programme Board, F&P Committee, Executive Board & Trust Board	(c) Required development of service strategies which integrate with the financial strategy (via LTFM) to deliver recurrent financial balance'	Production of a revised financial strategy to accelerate the recovery programme (19.2)	Jun 2015 DF
CIP performance management including CIP s as part of integrated performance management	Monthly reports to F&P committee and Trust Board. Formal sign-off documents with CMGs as part of agreement of IBPs CIP Quality Impact assessments			
Managing financial performance to deliver recurrent balance via SFI and SOs and utilising overarching financial governance processes	Monthly progress reports to Finance and Performance (F&P) Committee, Executive Board and Trust board.			
Financially and operationally deliverable by contract signed off by UHL and CCGs and Specialised Commissioning on 30/6/14	Agreed contracts document through the dispute resolution process/arbitration Regular updates to F&P Committee, Executive Board,			

	Escalation meeting between CEOs/CCG Accountable Officers			
Securing capital funding by linking to Strategy, Strategic Outline Case (SOC) and Health Systems Review and Service Strategy	Regular reporting to F&P Committee, Executive Board and Trust Board	(c) Lack of clear strategy for reconfiguration of services.	Production of Business Cases to support Reconfiguration and Service Strategy (19.10)	On-going action - Review monthly DF
Obtaining sufficient cash resources by agreeing short term borrowing requirements with TDA	Monthly reporting of cash flow to F&P Committee and Trust Board	(c) Lack of service strategy to deliver recurrent balance	Agreement of long-term loans as an outcome of submission of SOC/ business cases (19.11)	On-going action – Review March 2015 DF

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
CIP performance management including CIP s as part of integrated performance management	Monthly reports to F&P committee and Trust Board. Formal sign-off documents with CMGs as part of agreement of IBPs	c) Not all PMO posts have been recruited to	Recruit substantive staff to vacant posts (20.2)	Apr 2015 COO
Cross cutting themes are established.	Executive Lead identified. Monthly reports to F&P committee and Trust Board			

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Stakeholder Engagement Strategy (including a clinical task force to drive the improvements that come out of learning lessons to improve care)	Annual Stakeholder surveys presented to the Board Feedback from stakeholders in Board 360 as part of Foresight review. BCT strategy and planning Regular meeting with: CCGs and GPs and Health watch(s) Mercury Panel MPs and local politicians TDA / NHSE On-going review of effectiveness of clinical task force via EQB and QAC	(c) No structured key account management approach to commercial relationships (c) Commissioner (clinical) relationships can be too transactional i.e. not creative / transformational.		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Governance in place to manage the procurement of the solution	EPR project board with executive and Non-Executive members. Standard boards in place to manage IBM; Commercial board, transformation board and the joint governance board. UHL reports progress to the CCG IM&T Strategy Board	EPR Board now needs to be re-shaped from procurement to delivery		
Clinical acceptability of the final solution	Clinical sign-off of the specification. Clinical representation on the leadership of the project. The creation of a clinically led (Medical Director) EPR Board which oversees the management of the programme. Highlight reports on objective achievement go through to the Joint Governance Board, chaired by the CEO. The main themes and progress are discussed at the IM&T clinical advisory group.			
Transition from procurement to delivery is a tightly controlled activity	EPR board has a view of the timeline. Trust Board and ESB have had an outline view of the delivery timelines.	EPR Board now needs to be re-shaped from procurement to delivery		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 24	Failure to implement the IM&T strategy and key projects effectively *Note: Projects are defined, in IM&T, as those pieces of work, which require five or more days of IM&T activity.*	**Overall level of risk to the achievement of the objective**	**Current score 3x3 = 9**	**Target score 3 x 3 = 9**
Executive Risk Lead(s)	Chief Information Officer			
Link to strategic objectives	Enabled by excellent IM&T			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Project Management to ensure we are only proceeding with appropriate projects	Project portfolio reviewed by the ESB every two months. Agreements in place with finance and procurement to catch projects not formally raised to IM&T.			
Ensure appropriate governance arrangements around the deliverability of IM&T projects	Projects managed through formal methodologies and have the appropriate structures, to the size of project, in place. KPIs are in place for the managed business partner and are reported to the IM&T service delivery board			
Signed off capital plan for 2014/15 and 2015/16	2 year plan in place and a 5 year technical in place highlighting future requirements - signed off by the capital governance routes			
Formalised process for assessing a project and its objectives	All projects go through a rigorous process of assessment before being accepted as a proposal			

Appendix two

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

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
1	**Lack of progress in implementing UHL Quality Commitment.**					
1.5	Discussion at EQB March re 15/16 priorities and report to QAC	CN		March 2015	Refresh of QC complete, agreed at QAC March 2016 and included in strategic priorities and quality commitment	5
2	**Failure to implement LLR emergency care improvement plan.**					
2.4	Review effectiveness of specific LLR improvement actions to deliver a reduction in admissions and increase in discharges	COO / LLR MD		Review ~~December 2014~~ February 2015	Acceptance through Urgent Care Board that attendance avoidance and admission avoidance schemes in 2014-15 have not worked. LLR partners are aiming for a 5% reduction in 2015-16.	2
2.5	Arrangements for IS to return for a two week in January 2015 (2.5)	COO		~~January 2015~~ March 2015	IS attended for eight days in March. He identified progress and areas for improvement. Now awaiting letter.	5
3	**Failure to effectively implement UHL Emergency Care quality programme.**					
3.1	Review effectiveness of specific LLR improvement actions to deliver a reduction in admissions and increase in discharges. **NB:** *Original action reworded by COO – Dec 2014*	COO		February 2015	Acceptance through Urgent Care Board that attendance avoidance and admission avoidance schemes in 2014-15 have not worked. LLR partners are aiming for a 5% reduction in 2015-16.	2
4	**Delay in the approval of the Emergency Floor Business Case.**					
4.1	Regular communication with NTDA	MD		March 2015	**Complete.** Communication will continue until the submission dates and beyond to keep the NTDA on track.	5

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

5	**Failure to deliver RTT improvement plan.**					
5.2	Act on findings from recently published IST report	COO		~~August October 2014~~ March 2015	**Complete.** Improvements implemented. Compliant with two out of three measures. Aim is for the third to be compliant in April/ May 2015	5
6	**Failure to achieve effective patient and public involvement**					
7	**Failure to effectively implement Better Care together (BCT) strategy.**					
8	**Failure to respond appropriately to specialised service specification.**					
8.3	Programme Plan to be developed	DS		April 2015		4
8.7	PID for Local Partnerships to be developed by the Head of Local Partnerships	DS		~~December 2014 February 2015~~ March 2015	**Complete.** The PID is complete and is to go to ESB in May under the delivering care at its best work stream.	5
9	**Failure to implement network arrangements with partners.**					
10	**Failure to develop effective partnership with primary care and LPT.**					
11	**Failure to meet NIHR performance targets.**					
12	**Failure to retain BRU status.**					
12.1	BRUs to re-consider theme structures for renewal, identifying potential new theme leads. (12.1)	MD	DR&D	June 2015	Awaiting National Guidance on structure required for future bids	4
12.2	BRUs to identify potential recruits and work with UoL/LU to structure recruitment packages.	MD	DR&D	June 2015	**Complete.** Potential candidate for Respiratory BRU identified with UoL Offers of appointments made by LU for candidates to work with Lifestyle BRU	5
12.3	UHL to use RCF to pump prime appointments if possible and LU planning new academic appointments to support lifestyle BRU.	MD	DR&D	June 2015	**Complete.** RCF will be used to pump prime appointment in support Respiratory BRU. Clinical component of funding being agreed with RRC CMG	5
12.4	UoL and LU to ensure successful applications for Silver swan status and. Individual medical school depts will need to separately apply for Athena Swan Silver status.	MD	DR&D	March 2016	VC and President has re-constituted group leading Medical School Bid with appointment of new project manager.	4

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

12.5	Special meeting of Joint BRU Board: planning to secure BRU funding at the next NIHR competition. Further meetings planned.	MD	DR&D	March 2015	**Complete.** A schedule of meetings has been planned.	5
13	**Failure to provide consistently high standards of medical education.**					
13.6	Develop more robust system of appointment and appraisal of disparate roles by separating College Tutor roles in order to be able to appoint and appraise as College Tutors	MD	AMD (CE)	~~January 2015~~ ~~April 2015~~ June 2015	We have a role description agreed between UHL and HEEM – however unlike other Trusts UHL does not support College Tutor roles. A paper is being prepared for the April UHL Executive team to address this issue. Timescale for completion extended to reflect this	3
14	**Lack of effective partnerships with universities.**					
14.2	LU strategy to be discussed at joint BRU board.	MD	DR&D	~~March~~ 2015 May 2015		3
14.3	UHL membership of NCSEM management board	MD	DR&D	March 2015	Kevin Harris to attend for UHL and Nigel Brunskill to attend for UoL	5
14.4	Meeting with LU VC, UHL MD, UHL DRD and BRU Director to discuss strategy	MD	DR&D	June 2015	Breakfast meeting held in March 15 – further meetings planned as required and dictated by availability of National Guidance for future BRUs	5
14.5	Develop regular meeting with DMU	MD	DR&D	June 2015	Regular meetings established at Exec level – relevant subgroups established	5
15	**Failure to adequately plan the workforce needs of the Trust.**					
15.4	Develop Innovative approaches to recruitment and retention to address shortages.	DHR		June 2015	**Complete.** Medical Workforce Strategy to be updated following feedback from HEEM quality visit and the Clinical Senate. and incorporated into a Workforce Board Thinking Session in May or June Timescale for completion extended to reflect this Services are developing a portfolio to reflect provision in better attracting consultant to services	5

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

15.6	Delivering our Employer Brand group to share best practice and develop social media techniques to promote opportunities at UHL	DHR		~~March 2015~~ June 2015	Service areas need to provide an overview of the future of their services for use when advertising consultant posts. The timescales for developing this must link with plans for confirmation of CMG future operating models. These are scheduled to be completed by June 2015. Timescale extended to reflect this.	3
15.8	Consultant recruitment review team to develop professional assessment centre approach to recruitment utilising outputs to produce a development programme	DHR		April 2015	**Complete.** Consultant recruitment process has been improved to incorporate unseen presentations. This started in January 2015 and will be evaluated	5
15.9	Develop new roles that address competency and skill gaps in service delivery areas	DHR		~~March 2015~~ June 2015	**Complete.** UHL New Roles Group with the remit of delivering new roles in Assistant Practitioner, Advanced Practitioner and Physician Assistant. .	5
15.10	Refine the workforce elements of the Operational Planning cycle to ensure robust workforce plans to support organisational transformation, activity and finance	DHR		April 2015	**Complete.** Final submission of workforce plan was March 31 2015. The NTDA submission was made on 7 April 2015. The changes have been triangulated with finance and activity	5
16	**Inability to recruit and retain staff with appropriate skills.**					
16.2	eUHL system updates required to meet Trust needs. This action is operational in nature and is being removed from the BAF and will be transferred to the UHL HR risk register	DHR		March 2015	**Action transferred to organisational risk register**. Business Case presented to the Capital Investment Committee on 13 March 2015 and further work underway on understanding the procurement options, intellectual property and future sales.	N/A

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

16.3	Robust ELearning policy and procedures to be developed to reflect P&GC approach This action is operational in nature and is being removed from the BAF and will be transferred to the UHL HR risk register	DHR		~~February 2015~~ May 2015	**Action transferred to organisational risk register** Policy consultation will take place during April 2015 prior to revised policy submission to PGC during May 15. Timescale extended to reflect this	N/A
17	**Failure to improve levels of staff engagement**					
17.10	Success outcomes to be shared with nursing workforce via new annual Nursing Conference –scheduled for April 2015. To be transferred to organisational register	DHR/ CN		March 2016	**Complete.** Nursing Conference being planned.	5
17.11	Workshop on 2014 survey results priorities and actions to be shared via management forums and CE Briefing	DHR		~~March 2015~~ April 2015	**Complete.** National results known and have been analysed and compared to the previous year. A paper will be submitted to the Trust Board in April 2015. Timescale for completion extended to reflect this.	5
17.13	Workshop outputs to lead to 2015/16 engagement plan for the Trust – to be shared via appropriate management forums and CE Briefing (March & April 2015). TB and ET Paper for March 2015.	DHR		March 2016	**Complete.** Awaiting the outputs from the second workshop (TBC – March 2015)	5
17.15	Annual performance target set with CMG breakdown available per month for CMG Board Meetings.	DHR		March 2016	**Complete.** Performance targets are being rolled forward for 2015/16 and will be reviewed annually thereafter.	5
17.16	Workforce KPIs included in Quarterly CMG Workforce meetings from January 2015 – to be attended by HR CMG Leads and Workforce Development Manager	DHR		March 2016	**Complete.** HR Leads identified to attend Workforce KPI Quarterly meetings.	5

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

17.17	Premium spend / pay group to be established in February 2015 as part of the CIP Workforce Charter to review use of premium pay and reasons for use – to support CMGs to identify links to, for example, sickness absence, recruitment, & increased activities during 2015/16.	DHR		March 2016/17	**Complete.**	5
17.18	Feasibility Report by 31 March 2015 with Trust Board approval. To be presented to TB in March and EWB in March 2015	DHR		March 2015	**Complete.** Update to be provided on Mutuals in Health pathfinder Programme at EWB and TB in March 2015	5
18	**Lack of effective leadership capacity and capability**					
18.3	'Shadowing and Buddying' System being developed in partnership with HEEM and Assistant Medical Director to ensure support provided to newly appointed Consultants at initial phase (18.3)	DHR		April 2015	**Complete.** Consultant Forum in place and key development identified to support the newly appointed consultants Three day Mentoring Programme initially for Consultants, but second and third pilot Programmes are Multi-Professional. Pilot concluded in March 2015. Quality Assurance Standards being developed. Quarterly Mentoring Forum arranged. To build UHL capacity to provide Mentoring Training Faculty.	5
18.4	Present update on Learner Management System developments and NHS Healthcare Leadership Model Resources to support the provision of 360 Feedback	DHR		~~February 2015~~ March 2015	**Complete.** Healthcare Leadership Model recommended and standards sent to EWB for comment – responses to be received before the end of April 2015	5

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

18.5	Support national and regional Talent Management and Succession Planning Projects by National NHS Leadership Academy , EMLA and NHS Employers	DHR		March 2015	**Complete.** UHL staff nominated to access National Leadership Academy Programme based on talent conversations. Report on talent profile of Senior Leadership Community presented to Executive Workforce Board during March 2015 and an update provided to the Remuneration Committee on 2nd April 2015	5
18.6	Board Coach (on appointment) to facilitate Board Development Session	DHR		~~October 2014~~ ~~February 2015~~ March 2015	**Closed.** This action longer applicable until such time that a full Board is appointed and we may not return to this until at least the second half of 2015/16 (if at all) by which time the Board should be composed of substantive post holders.	N/A
18.7	Update of UHL Leadership Qualities and Behaviours to reflect Board Development, UHL 5 Year Plan and new NHS Healthcare Leadership Model	DHR/ CE		~~January 2015~~ March 2015	**Closed** This action longer applicable until such time that a full Board is appointed and we may not return to this until at least the second half of 2015/16 (if at all) by which time the Board should be composed of substantive post holders.	N/A
19	**Failure to deliver financial strategy (including CIP).**					
19.2	Development of service strategies which integrate with the financial strategy (via LTFM) to deliver recurrent financial balance. Reworded by Director of Finance (April)	DF		~~August Review September 2014~~ ~~February 2015~~ June 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

19.10	Business Cases to support Reconfiguration and Service Strategy	DF		~~July Review September 2014~~ On-going as per individual business case timeline	BCT SOC approved by UHL and all LLR partners. SOC submitted to TDA and NHS England and are awaiting approval. Individual business cases will be submitted to the Trust Board and TDA as per the overall reconfiguration strategy	4
19.11	Agreement of long-term loans as an outcome of submission of SOC/ business cases	DF		~~June August~~ On-going action – review March 2015	Trust received a £29m cash loan in line with the Plan and trajectory submitted to the TDA. Application for further loans (via SOC/business cases)to be submitted as necessary	4
20	**Failure to deliver internal efficiency and productivity improvements.**					
20.2	Recruit substantive staff to vacant posts to ensure continuity of function of PMO	COO		~~February 2015~~ April 2015	One vacancy out of eight remains, with national advert currently out. Timescale extended to reflect this	3
21	**Failure to maintain effective relationships with key stakeholders**					
22	**Failure to deliver service and site reconfiguration programme and maintain the estate effectively**.					
23	**Failure to effectively implement EPR programme**					
24	**Failure to implement the IM&T strategy and key projects**					

Key

CEO	Chief Executive
DF	Director of Finance
MD	Medical Director
AMD	Assistant Medical Director
COO	Chief Operating Officer
DHR	Director of Human Resources
DDHR	Deputy Director of Human Resources
DS	Director of Strategy
DR&D	Director of R&D
DMC	Director of Marketing and Communications
DCQ	Director of Clinical Quality

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

CIO	Chief Information Officer
CMIO	Chief Medical Information Officer
CD	Clinical Director
CMGM	Clinical Management Group Manager
DDF	Deputy Director Finance
CN	Chief Nurse
AMD (CE)	Associate Medical Director (Clinical Education)
PPIMM	PPI and Membership Manager

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

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 Human Resources**
g	**A clinically sustainable configuration of services, operating from excellent facilities**	**Director of Strategy** / Director of Facilities
h	**A financially sustainable NHS Foundation Trust**	**Director of Finance**
i	**Enabled by excellent IM&T**	**Chief Information Officer**

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

PERIOD: APRIL 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	DHR	12	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		
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	DF	15	10
17		Failure to achieve a revised and approved 5 year financial strategy	DF	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).	3 monthly and / or 6 monthly progress reports to EQB and QAC.	Vacancies within clinical staff will affect implementation of QC	Nurse and medical workforce recruitment strategies (1.1)	Milestone review Jul 2015 MD&CN
KPIs agreed and monitored for all parts of the Quality Commitment.	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	Currently only 30% of deaths are screened and there is a requirement to move to 100%. Vacancies within clinical staff grades may adversely affect our ability to implement this.	Roll out plan to be developed Audit support to be provided Monitor uptake Mortality database to be developed As action 1.1	Sep 2015 MD July 2015 MD Milestone review Jul 2015 MD&CN Milestone review Jul 2015 MD&CN
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	(a) Internal audit review awaited	Implement actions from review as required	June 2015 CN

	Commissioner review of work plans/ progress via CQUIN.			
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**
Agree 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			
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 not fully implemented	Continue to implement and monitor progress of LLR action plan	Review Sep 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)	(c) Currently not delivering the three 18 week RTT access standards. (c)Currently not delivering the three key Cancer access standards. (c) Currently not delivering the diagnostics access standards Have yet to implement tools and processes that allow us to improve our overall responsiveness through tactical planning	Develop performance improvement framework for failing specialties driven by the DP&I. Development and implementation of intelligence led recovery plan and trajectories. Theatre productivity improvements driven through the cross-cutting work stream.	May 2015 DP&I Jul 2015 DP&I Jul 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 15**	**Target score 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.	Monthly reporting to ESB as part of Director of Strategy report.	(c) Significant amount of partnership work being taken through ESB.	Considering options/benefits/risks of establishing UHL Partnership Board. (4.1)	Jul 2015 DS
Children's and Cancer Collaborative Groups established with NUH.	Monthly reporting to ESB as part of Director of Strategy report.	(c) Significant amount of partnership being taken through ESB.	As action 4.1	As action 4.1
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.	Jul 2015 DS
Partnership Board for Specialised Services established in Northamptonshire. Membership includes Northants CCGs; NHS England; KGH; NGH and UHL.		(a) Does not feed into UHL Governance Structure.	Future minutes to be included DS report to ESB.	Jul 2015 DS
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 15**	**Target score 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	(c) LLR Master Project Plan required to monitor progress	BCT PMO to establish plan (5.1)	May 2015 DS
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	(a) Regular LLR wide performance monitoring report required for presentation to Trust Board	BCT PMO establishing a master plan	Jun 2015 DS
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 Monthly project specific highlight reports	(a)LLR wide dashboard required so that performance can be monitored (a) Lack of Triangulation and assurance of plans	LLR wide business intelligence group established. UHL dashboard in draft to be used to inform LLR wide dashboard. BCT PMO to facilitate	May 2015 DS May 2015 DS

		at organisational and system wide level.	triangulation process	
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.	Work to outline the scope and target date for consultation project by project Results of the engagement programme will be summarised and used to inform the Consultation planning. Analysis to be provided to partnership Board. Plan for consultation including a full governance roadmap to be completed.	Apr 2015 DMC May 2015 DMC May 2015 DMC Jul 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	Project plan to be developed	May 2015

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. BRUs to identify potential recruits and work with UoL/LU to structure recruitment packages. UHL to use RCF to pump prime appointments if possible and LU planning new academic appointments to support lifestyle BRU.	Jun 2015 MD Jun 2015 MD Jun 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	UoL and LU to ensure successful applications for Silver swan status.	Mar 2016 MD

		required for eligibility for NIHR awards	Individual medical school depts will need to separately apply for Athena Swan Silver status.	

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	(c) Medical Education issues not championed by Non-Executive Director	Discuss NED lead with Chairman	TBA
	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	(c) Education facilities Identified as poor in external reports from HEEM and Leicester University	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	TBA
	KPI are measured using the: • UHL Education Quality Dashboard • CMG Education Leads and stakeholder meetings • GMC Trainee Survey results • UHL trainee survey • Health Education East Midlands	(a) Lack of accountability and transparency of educational funding income and expenditure	Engagement with CMGs in ensuring education expenditure matches income	TBA

	Accreditation visits	(c) Ineffective control of clinical service pressures, vacancies and loss of posts on rotas that adversely affect quality of training and added impact of	Medical education quality dashboard, SPA time in job plans for training, support for CMG Medical Education leads and local faculty groups (College Tutors etc)	TBA

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 (?best reporting route – ?via W&C CMG board) 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) Need for sufficient funding to CMG to support delivery of recruitment trajectory (c) Need for key staff to consent/recruit/data entry (c) Need UHL IT solution to deliver and monitor recruitment trajectory – under development (c) Need to increase awareness of GMC project amongst UHL staff	'The 100,000 Genomes Project' paper presented to Executive Strategy Board 'The 100,000 Genomes Project' paper with detailed costing to go to Revenue and Investment Committee Targeted use of Research Capability Funding Work with comms team to produce weekly UHL GMC newsletter	Apr 2015 MD May 2015 MD Apr/May 2015 MD Apr 2015 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 6**	**Target score 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) New relationships need to be developed and nurtured with the new VC and President for UoL and. New Dean of UoL Medical School expected 2015. (c) Contacts with DMU could be developed more closely	New UHL Associate MD for academic partnerships to be in place Develop regular meeting with DMU	Apr 2015 MD Jun 2015 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 12**	**Target score 8**
Executive Risk Lead(s)	Director of Human Resources			
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	Lack of scrutiny of the organisational health dashboard at CMG level	Scrutinise at CMG level the organisational health dashboard at quarterly intervals	Sep 2015 DHR
LIA Programme	LIA Sponsor Group meet monthly Reported to EWB quarterly Reported to Trust Board quarterly (as part of the OD report).	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	Mar 2016 DHR
Workforce Plan	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	Affordability against 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 Monday CMG performance meets and Cross Cutting Workforce Meeting.	Mar 2016 DHR

Leadership into Action Strategy	Reported to EWB quarterly 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.	(c)Negative feedback from surveys in relation to leadership issues	Improvements in local leadership and the management of well led teams including holding to account for the basics	Mar 2016 DHR
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 Targeted interventions for BME band 5 and 6 to be developed and implemented	Mar 2016 DHR Mar 2016 DHR

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** 5 x 4 = 20	**Target score** 5 x 2 = 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		(a) Effective governance arrangements for oversight and scrutiny of this work are yet to be agreed (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	PMO support to be engaged Develop a programme of works Develop an operational risk register for the projects	TBA Sep 2015 DoF Sep 2015 DoF
Capital programme with ring fenced capital funding to support future 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	Sep 2015 DoF/DF

An established Estates and Facilities team with detailed knowledge of the estates and reconfiguration programme	Regular reports to Executive Performance Board (EPB)	c) Conflicting responsibilities/roles of the estates and facilities team between UHL and the LLR estate and Facilities Management Collaborative	Define resource and skills gaps and agree an enhanced team structure to support the significant reconfiguration programme	Sep 2015 DoF

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**
Individual project boards in place to manage and monitor schemes Merging of strategic clinical change projects into the Estates an Facilities Directorate	Project boards report to UHL Better Care Together (BCT) working group via monthly highlight reports Estates work stream reporting to the UHL – BCT Programme Board	(c) lack of Overall programme management function for the estates work stream	Additional resource support to be identified and implemented	May 2015 DoF
5 year plan agreed with individual annual programmes developed each year	Capital Investment Monitoring Committee will monitor the overall programme of capital expenditure and early warning to issues	(c) Lack of Contingency funding	Discussions between D. Kerr and P. Traynor to identify funding	Sep 2015 DoF

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** TBA	**Target score** TBA
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	(a) A lack of electronic evidence by IFM on compliance (a) Limited contractual KPI's on compliance	Additional assurance to be identified through spot checks and deep dive analysis Develop improved software dashboard reporting (CASS)	July 2015 DoF TBA

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 12**	**Target score 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**
Agreed capital programme with NTDA identified what resources the NTDA need to commence their approval processes	Monthly meetings with the NTDA to discuss the whole programme of delivery and identify new cases coming up for approval A monthly highlight report is submitted to the BCT-UHL Programme Delivery Board.	(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 of the business cases	TBA
UHL structure and resources identified for delivery of the key projects • ITU • Vascular • Emergency Floor • Planned Treatment Centre • Maternity • Children's Hospital • Theatres • Beds • multi-storey car park Business Case Project resources identified against each project	A report is submitted to the BCT-UHL Programme Delivery Board on a monthly basis that tracks progress to date, including financial assurance, risks with mitigations	(a) Further work required looking at the remaining acute services at the LGH to determine the gap in the current capital plan	Work stream to be established to identify gaps	Sep 2015 DS
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 communication lead for the business cases for women's sits on the wider BCT consultation work stream. This is led by UHL Director of Communications and Marketing. A monthly report is submitted to the BCT-UHL Programme Delivery Board from the communication and engagement work stream.	(c) Dedicated communication and engagement lead required for the reconfiguration programme	Appoint to post	May 2015 DS

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 Finance			
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.	(c) Alignment with CIP and future operating model.	Discuss with the Director of CIP the Future Operating Model and that through this we will cement delivery	Jul 2015 DS
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.	(a) Monthly updates to ESB	High level updates to be included in the Director of Strategy's monthly report for ESB.	May 2015 DS
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	(c) Capacity (within central and operational teams)and level of clinical engagement determines when service reviews can happen and how many can run at any given time	Approach and scheduling of service reviews to be reviewed to ensure process remains viable and/or to identify resource requirement.	July 2015 DS
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	**Overall level of risk to the achievement of the objective**	**Current score 5 x 3 = 15**	**Target score 5 x 2 = 10**
Executive Risk Lead(s)	Director of Finance			
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	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 DoF/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 DoF), 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 5 x 3 = 15**	**Target score 5 x 2=10**
Executive Risk Lead(s)	Director of Finance			
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	(c) SOC not yet approved	Approval currently being sought	CEO Date TBA
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	Production of revised LTFM and submission for approval to Trust Board and TDA	DF June 2015
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 approved (c)LTFM not yet approved	As above	

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 16**	**Target score 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) No final approvals date can be given	Further work with NTDA to progress a firm timetable to the ATP	May 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.	July 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 16**	**Target score 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	(a) VfM review	Engage third party, as per contract, to asses and review VfM	Aug 2015 CIO
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	(c) Communication about successes is not sufficiently robust	Production of a 2014/15 annual review Production of a quarterly newsletter available to all staff	May 2015 CIO Aug 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	LiA event to surface any issues with the service delivery and the delivery model	Jun 2015 CIO

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 Extra Capacity - Winter months	30/04/2015 03/12/2014		There is a risk that owing to the increase in medical admissions that the bed base over winter months will be insufficient resulting in the need to out lie into other speciality/CMG beds jeopardizing delivery of the RTT targets. 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 (200 nursing vacancies in the CMG this time last year) o□3 Geriatrician and 2.4 Acute Physician vacancies o□Junior medical staffing shortages	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 * FJW and Ward 2 capacity increased/flexed before patients are outlied * ICRS in reach in place . PCC roles fully embedded * Plans in place for a phased opening of modular wards supported by a surge plan to use "buffer/flex" beds - Papers presented to Executive Team and Emergency Quality Steering Group * 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	Extreme	Almost certain	25	Develop clear escalation plans supported by a decision tree for opening flex/buffer beds (CMG decision only) - 30/04/15 Revised Emergency Quality Steering Group action plan - 30/04/15 Maintain additional beds on ward 2 LGH (21 beds to 27 beds) - 30/04/15 Raise staff awareness re winter plans and access to community resources to enable patients to be discharged in a timely manner - 30/04/15 CMG to access and act on additional corporate support to focus on discharge processes - 30/04/15	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	04/10/2013	31/05/2015	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 targets. Inability to meet CQUIN targets. Risk of patient deterioration. Delay in diagnosis and treatment. Increased staff stress. Patient complaints. Lack of dignity and privacy. Serious incident risk. Design and size of minors results in delay in receiving medical assessment and treatment. Patient complaints. Four hour target. Increased violence and aggression. Design and size footprint in streaming rooms causes threat to CQUIN target and four hour target. Staff stress. Delay in diagnosis and management. Injury to staff and patients. Increased risk of violence and aggression. Design and size of footprint in EDU causes delay in	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.	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) - 31/05/2015 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 assessment bays. (Completed) 3 additional phone lines to be installed in assessment bay(Completed) The trips and falls hazard in children's ED is to be removed by changing the layout of the minors work area(Completed) See and treat rooms being made into extra Paeds bays(Completed) Allocated nurse (and doctor when numbers permit), for patients placed in Majors middle(Completed) Resus space to be increased to 8 bays(Completed) The resus viewing room is to be made into a fully equipped resus bay (Completed) Bays to be allocated and staffed appropriately in majors to act as resus step-down bays for when space in resus is at a premium and some patients are well enough to be moved to majors with the appropriate level of observation(Completed)	16	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
2354	RRC		Overcrowding in the Clinical Decisions Unit	28/05/2014	30/06/2015	CAUSES 1. CDU originally designed to take in a 24 hour period 25-30 patients, on average it is now taking 50-60 patients/24 hr period. Therefore the foot print of the unit is inadequate to cope with this number of patients. There is not the physical space to see/examine/review the number of patients that are currently presenting to CDU, particularly in the afternoon and evening. 2. The workforce on CDU (medical, nursing, therapy, admin/clerical) has not increased in accordance with the increase in the number of patients that require processing in the department. 3. Due to the pressures within the Emergency Department at the LRI the level 1 and 2 diverts are enacted on a regular basis, compounding the overall processing power within CDU and impacting on bed capacity. 4. The out of hour's provision from support services such as pharmacy, radiology and pathology does not match the requirements of an increasing emergency take at the GH. CONSEQUENCES 1. Significant delays in patients being assessed and treated due to inadequate workforce resource to meet demand. This compounds the space issue as patients are not being assessed and treated in an efficient manner. 2. Overcrowded department leads to inefficiencies ie no physical space to review or examine patients; therefore there are delays in them being assessed and receiving treatment. 3. Patients dissatisfied with their experience: CDU patient survey results/Friends and Families Score reflect the long	Patients	1. Respiratory Consultant on CDU 5 days/week 0800-20 00 hrs 2. Respiratory Consultant on CDU at weekends and bank holidays 0800-1200 hrs and on call thereafter 3. Cardio Respiratory Streaming flow, including referral criteria and acceptance 4. Short stay ward adjacent to CDU 5. Discharge Lounge utilised 6. GH duty Manager present 24/7 7. Patient flow Coordinator 7 days/week daytime 8. CDU dash board 9. UHL bed state details CDU current status as well as ED 10. Daily nurse staffing review with plan to ensure safe staffing levels on CDU 11. EDIS operational on CDU 12. Daily patient census conference calls 13. Daily board rounds across all wards	Major	Almost certain	20	Increase registered nurse staffing level on CDU - 30/06/15 Introduction of patient flow coordinator role on CDU - 30/06/15 Implement revised triage process - 30/06/15 CDU element of whole hospital response has been drafted and is being reviewed at EQSG - 30/06/15 Continue the implementation of the LIA project - 30/06/15	3	SM

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
2445	Emergency and Specialist Medicine		SpR gaps on the ESM CMG Medical Rota	31/05/2015 04/11/2014		Causes: These vacancies are caused by a national shortage of trainees applying for specialties which have a general medicine component. This is further compounded by sickness and unexpected absence which makes the rotas very vulnerable to short notice absences. Given the high number of vacancies the CMG is unable to fill these all with locum and agency staff. Consequences: There is a delay in assessing patients admitted to the assessment units out of hours or overnight. This may result in delays in recognising severity of illness or initiation of treatment which in may cause harm (death, longer LoS). Delays in decision making which means patients cannot be moved from the assessment unit to base ward beds. This may have the knock on effect of causing crowding in the ED which endangers patients there (see overcrowding in ED risk - number 2236). There is a risk to patients coming to harm on the base wards if there are insufficient senior medical staff to assess unwell patients both in assessment units and on the wards. Staff are unable to take rest breaks which may impact on their ability to take safe decisions and work within their specified working regulations. There is a risk that trainees will be removed from UHL by HEEM if we cannot ensure that they have a manageable workload when on call which will further compound the	Patients	All known vacancies are out to locum bookers - the CMG actively recruits locum and agency staff and works closely with locum bookers and Maria McAuley in order to maximise fill rates. Fortnightly recruitment meetings for medical vacancies (all grades) with HR and service managers to proactively manage vacancies. Recruitment into non training grade positions from international graduates in order to fill gaps in the SpR rota. 8 day in advance schedule for on call rota produced daily and reviewed by senior manager to ensure gaps are cited and acted upon issued daily. 2 weekly advance scheduling shared with base wards to identify short falls and promote action. Monitoring in line with Trust requirements undertaken across key periods during the working year. Maintain advanced look forward for requests to maximise fill of gaps and ensure that all request are a minimum 6 weeks in advance for known vacancies. Daily review of skill mix and reallocation of SpRs following risk and dependency assessments across the CMG.	Major	Almost certain	20	Continue to progress recruitment actively and monitor deanery allocations - 30/06/15. Actively engage medical director for education (Sue Carr) and HEEM to ensure all mid and long term solutions to attracting and retaining SpRs are pursued - 31/05/15. Creative short term appointments offering fixed term opportunities within specialities to maximise interest within the local market - 31/05/15. Continue and progress the allocation of LAS doctors into the Acute rota - replacing the intended LGH team of Trust registrars (all to be in post by mid December) - 31/05/15. Trust to explore other ways of staffing medical rotas (ANPs etc) - 31/05/15.	9	CFRE

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	30/05/2015 04/10/2013		Causes: Consultant vacancies. 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. Non ED medical consultants. Locums. Increased consultant workload. Lack of uniformity. Paediatric medical staffing. Poorer quality care for paediatric population. Consequences: Poor quality care. Lack of retention. Stress, poor morale and burnout. Increased sickness. Increased incidents (SUI's), claims and complaints. Inability to do the general work of the department, including breaches of 4 hour target. Financial impacts. 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 book, which introduces trust policies such as hand hygiene. Locums work only in a supervised environment (either by an ED consultant or a substantive middle grade). There is a specific consultant who is concerned with locum issues as per their job plan (Ashok Kumar). Poorly performing locums are not permitted to continue working and this is fed back to their agencies. Locum doctors are only placed in paeds ED in exceptional circumstances. Consultants have been allocated specific time in paediatrics on the consultant rota.	Extreme	Likely	20	Deanery report actions, completed 01/10/2013. Guidelines to be created governing minimum standards of locum doctor approval completed 01/09/2013. An internal induction document to be produced for locum grade doctors, completed 01/09/2013 Review of shift vs rota and the required number of juniors per shift, completed 30/04/2014. Doctor In Induction' badges have now been ordered to distinguish staff who cannot yet make decisions, completed 02/07/2014. 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 31/08/2014. R & R Package to be relaunched (30/04/2015) Increase Locum Rates of pay being agreed (30/04/2015) Continue recruitment to pillar stategy (31/01/2016) Continuation of International Recruitment (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
2488	ITAPS		Risk of vacancies on resident on call rotas being unfilled resulting in increased use of locums and Consultant acting down	31/08/2015	14/01/2015	Causes: We are currently running with 11 junior doctor vacancies across the on call rotas on all three sites This is due to failure to recruit, maternity leave and sick leave. The options for filling these gaps are 1)□Use of internal locums but due to the number of gaps it is often difficult to find an internal locum who is available. 2)□Use of appropriate external locum via locum bookers but these are also often not available. 3)□Use of consultants acting down 4)□As a last resort the non-resident consultant on call becomes resident and the rota is run with one less person available. Consequences: Increase in Consultant Acting Down payments - Increased risk of on-call consultants becoming resident which will impact on elective activity the following day - Increased risk of trainee/consultant sick leave due to workload Increased risk of clinical incidents due to the use of external locums who are unfamiliar with UHL Decreased ability to manage emergency situations if there are less people available on call	Business	Locum Bookers contacted for available doctors Internal Trainees approached for extra shifts Ongoing recruitment in process Cross site cover explored	Major	Almost certain	20	Continue pro-active recruitment to specialty doctor jobs - 31/8/15 Expand fellowship jobs to support the rotas - 31/8/15 Recruit ICM trainees - 31/8/15 Plan to recruit non trainees to a level to ensure that all rotas are fully filled - 31/8/15 Robust escalation process understood and adhered to - Completed Monthly recruitment update at Board meeting - 28/8/15 Ensure core members attend recruitment meetings - 31/8/15	12	MTI

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	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 service disruption and loss of resilience	30/05/2015 17/04/2014	Causes: 1. Retirement of previous consultants 2. Ill health of consultant 3.lack of applicants to replace substantively Consequence: 4.need for remaining paeds anaesthetists to work a 1:2 rota oncall 5.Lack of resilience puts cardiac workload at risk 6. May adversely affect the national reputation of GGH as a centre of excellence 7.current rota non complaint WTD 8. patients requiring urgent paeds surgery may be at risk of having to be transferred to other centres 9. Income stream relating to paeds cardiac surgery may be subsequently affected 10. risk of suboptimal treatment	Quality	1. 1:2 rota covered by experience colleagues 2. 12 month locum appointed	Major	Almost certain	20	1. Continue with substantive recruitment strategy - Interview 15/01/15 - Recruit by 31/03/15. Interview held 12.01.15 and candidate offered post & accepted. Start date TBC. 6. Substantive Consultant to undertake recruitment processes and start by end of May 2015	8	DTR
2415	ITAPS	Critical Care	There is a risk of loss of ITU facilities at the LGH site	30/06/2015 03/09/2014	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 (Urology/Renal/General Surgery/HPB) to undertake planned and emergency major surgery. -Crucial to now down grade 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.	Patients	- Cross site cover from current Consultant workforce -Recruitment campaign - Acting down on shifts to cover rotas deficits - ITAPs leading change of ITU level and service moves across to the other 2 sites.	Major	Almost certain	20	1. Commence Recruitment campaign for one Consultant Intensivist 31/03/15. 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	2	CAL

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510	Clinical Support and Imaging	Blood Transfusion	Staff shortages impacting on the Blood Transfusion Service at UHL	10/05/2006	31/05/2015	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). Impact to acute services who may need to transfer admissions of acute cases between sites. Increased risk of claim /complaint. Adverse media attention / loss of reputation.	Patients	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 failure (August 2013 to Jan 2014 & ongoing). Approval in principle agreed to replace vacancies and also create 12 month secondment role to band 8a for additional managerial support. Also to consolidate 3 x band 5 bank staff into fixed term contracts.	Extreme	Likely	20	Staff recruitment/replacement to appropriate levels - 2nd phase 01.06.2015 Develop Disaster Recovery Plan (including operational escalation plan) & treatment algorithm (design for Obstetrics but should be blue print for other services) - due 30/04/15. Investigate and option appraisal for internal Transfusion transport service - 30/04/15.	15	KJON

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
698	Clinical Support and Imaging	Pharmacy	Risk to the production of aseptic pharmaceutical products	03/05/2007	05/05/2015	Causes Provision of aseptically prepared chemotherapy is being undertaken from a temporary rental unit. Temporary nature and age of facility indicates high probability of failure. Arrangements for segregation of in-process and completed items is inadequate leading to high possibility of error. Current temporary unit is outside the range of the department's temperature monitoring system. Failure of refrigerated storage will remain undetected outside working hours, and has already occurred. Planning permission for temporary unit only valid until August 2012 Contingency arrangements are insufficient and could only provide for the very short term. Project is already 6 months behind schedule Storage, receipts and dispensing facility for dose-banded chemotherapy and other outsourced items purchased. Alternative arrangements will need to be found when unit is refurbished Consequences Failure of Current Temporary Facility; Inability to provide 50% of current chemotherapy products for adult services. Inability to provide chemotherapy for paediatric services. Substantial delay in re-establishing service provision from alternative supplier Limitations of treatments that can be sourced from an alternative supplier. Inability to support research where aseptic compounding required. High cost of sourcing required products from alternative supplier at short notice. Increase in datix incidents pertaining to the Aseptic Unit.	Targets	Planned servicing & maintenance of temporary facility being undertaken. Constant environmental monitoring of facility in place. Contingency arrangement for supply from external source currently being pursued. Business Case for new unit (refurbishment of facility within the Windsor building) has been presented and approved by the commercial exec board in 2011. Facilities are working with Pharmacy and commercial architects in order to finalise plans and get refurbishment started. Project to refurbish the aseptic unit has now started - nov 2013	Extreme	Likely	20	New unit in operation - due 5/52015	3	GH

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
2409	Women's and Children's		There is an insufficient number or middle-grade doctors, both registrars and SHO's to provide adequate service cover	26/08/2014	23/05/2015	Causes: Historically there have been 4 funded SPR posts, 2 paediatric trainee SHO posts on rotation which are usually filled and 1 trust funded SHO post. As the service and demand has grown these posts have remained the same leaving the middle-grade cover inadequate. Consequences: In accordance with the European Working Time Directive on-call rotas should be 1 in 6. The shortfall in middle-grade staff means that 2/6 nights and weekends are not covered and the registrars are over worked during the day. The lack of SHO's also means they are unable to provide resident out-of-hours cover for ward 30 and that HDU patients cannot be managed on the ward. Consultants often have to take time away from their activity, which can often only be done by a consultant, to provide middle-grade cover which is inefficient use of time and resources.	Quality	Consultant cover. The workload is increasing and there is an inadequate number of consultants to provide ward level cover as required	Extreme	Likely	20	Reviewing out of hours medical cover to ward 30 - GH due 23/05/2015	10	LCOW

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		Inadequate numbers of Junior Doctors to support the clinical services within Gynaecology & Obstetrics	24/06/2014	31/05/2015	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. 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 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 29/06/2015 CMG to pursue overseas recruitment of Drs - 31/05/15 Further development of robust training programme for Junior Drs by Clinical Tutor & Programme Director due 29.06.15	8	ACURR
2330	Medical Directorate		Risk of increased mortality due to ineffective implementation of best practice for identification and treatment of sepsis	11/04/2014	31/05/2015	Causes Failure of clinical staff to consistently recognise and act on early indicators of sepsis Lack of system to 'red flag' early indicators of sepsis. Complex anti-microbial prescribing guidance. Consequences Sub-optimal care/ death of patients (2 x SUI reports of death related to sepsis) Potential for increased complaints and claims/ inquests Additional costs to the organisation (estimated additional cost of £4k per patient if best practice is not consistently applied). Risk of adverse media attention and questions in the house in relation to sepsis deaths	Patients	UHL Sepsis working group including representatives from clinical areas Education and training Regular sepsis audits Early Warning scores Regular reporting to Executive Quality Board Sepsis rates monitored via CQUIN performance monitoring Sepsis Care Package	Major	Almost certain	20	Develop sepsis scoring methodology and incorporate into EWS observations - 31/05/15 Increased visibility of sepsis care pathway - 31/05/15	6	JPARK

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2403	Nursing	IPC	Changes in the organisational structure have adversely affected water management arrangements in UHL	19/08/2014	31/05/2015	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	HR	Instruction re: the flushing of infrequently used outlets is incorporated into the Mandatory Infection Prevention training package for all clinical staff. Infection Prevention inbox receives all positive water microbiological test results and an IPN daily reviews this inbox and informs affected areas. This is to communicate/enable affected wards/depts to ensure Interserve is taking necessary corrective actions. Flushing of infrequently used outlets is part of the Interserve contract with UHL and this should be immediately reviewed to ensure this is being delivered by Interserve All Heads of Nursing have been advised through the Nursing Executive Team and via the widely communicated National Trust Development Action Plan (following their IP inspection visit in Dec 2013) that they must ensure that their wards and depts are keeping records of all flushing undertaken and this must be widely communicated Monitoring of flushing records has been incorporated into the CMG Infection Prevention Toolkit (reviewed monthly) and the Ward Review Tool (reviewed quarterly)	Major	Almost certain	20	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. - 31/05/15 Review procedures and practices in other Trusts to ensure that UHL is reaching normative standards of practice - 31/05/15	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	Nursing	IPC	Inadequate management of Vascular Access Devices resulting in increased morbidity and mortality	19/08/2014	31/05/2015	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 - 31/05/15. Development of an education programme relating to on-going care of CVAD's - 31/05/15. Targeted surveillance in areas where low compliance identified via trust CVC audit - 31/05/15. Support the recommendations of the Vascular Access Group action plans to reduce the risk of harm to patients and improve compliance with legislation and UHL policies - 31/05/15.	8	LCOL

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2471	CHUGS		There is a risk of Radiotherapy Tx on the Linac (Bosworth) being compromised due to poor Imaging capability of this machine.	31/05/2015	05/12/2014	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 intensive. "□There is a risk of increasing waiting times leading to potential breaches in cancer waiting time targets since all complex treatments requiring advanced imaging cannot be performed on Bosworth. "□Restricted participation in National Clinical Trials, due to lack of current imaging technologies such as cone beam CT.	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	Develop business plan for replacement of treatment machine. Briefing paper to be submitted to the Investment Committee Meeting - 31/05/15. Replacement of Imaging panel to improve image quality and reduce imaging dose. However this does not solve the lack of online correction capability -31/05/15. Restriction of patient numbers to be treated on Bosworth. This will have a large impact on the departments waiting times and potential breach patients - 31/05/15.	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 to patient safety and quality due to the nurse staffing levels on SAU LRI	29/09/2014	31/05/2015	Causes: The nurse staffing levels within the Surgical Assessment Unit at the Leicester Royal Infirmary 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. The levels of vacancies are 1 band 6 7wte band 5. We include the recruitment with 2 band 5 waiting to start who will require support an supernumerary time. 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).	Quality	1. Shifts escalated to bank and agency at an early stage. 2. Increased the numbers of Band 6's to provide leadership support. 3. Agency contract in place for one nurse on day shift and night shift to increase nursing numbers.	Major	Likely	16	Increase the number of Deputy Sister posts on the ward for operational leadership on each shift - 31/05/15. Review the possibility of rotational shifts for staff across other surgical/GI med wards to increase attractiveness to staff - 31/05/15. Review established nurse staffing levels for the ward and complete case of need to increase nurse staffing in line with other SAU's - 31/05/15. Continue to actively recruit to the area - 31/05/15.	4	GK

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2057	RRC	Cardiac Investigations	Insufficient Echo provision cross-site impacting on planned referrals	07/08/2012	30/06/2015	Causes: Insufficient BSE accredited Cardiac Physiologists for level of current/increasing demand. Challenging recruitment programme due to national shortage. Consequences: Failure to meet National Diagnostic Target for New referrals - loss of reputation; financial penalties. Failure to meet internal standard (<48hrs) for I/P (New) referrals - increased LOS; delays for further treatment/intervention Failure to perform Planned workload - hampers clinicians to manage patient's care effectively for this group of patient's who are at an increased risk of a significant clinical event. Increased risk of RSI's for Physiologists. Staff retention & recruitment issues - due to very limited training (including Mandatory); essential development in routine/advanced techniques; low staff morale; loss of key staff.	HR	Cardiac physiologists working additional hours to avoid National Target breeches for New referrals. SAC (some slots available on same day as O/P consultant visit) for Planned referrals not performed prior to OP appointment. Clinicians also able to re refer and change planned referral to New referral if Echo not performed prior to OP appointment. All new referrals attract 5 wk target. Waiting list initiative implemented (only outside of department standard working hours). Locum staff employed to support with the planned workload.	Major	Likely	16	Recruit 1.0 WTE BSE Cardiac Physiologists - 30/06/2015.	1	MCA

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
2423	RRC	Respiratory Medicine	Outstanding clinic letters and inability to act on results impacting on patient safety in respiratory services	30/09/2014	31/05/2015	Causes: Cardiology and Respiratory medicine have a significant number of secretarial and typist vacancies. Staff are leaving their posts due to work pressures, low morale and the decrease in secretarial staff. Much of the decrease of staff has been caused by the on-going Management of Change, which is still to reach resolution and has left new recruits on a different banding to existing ones, reducing staff morale further. The planned support to manage these known reductions was due to be undertaken by Audio Typists and Dictate IT. Increased use of ICE was meant to reduce the administrative workload associated with generating individual letters. However, difficulties in recruiting Audio Typists, continuous delay / poor performance of Dictate IT and lack of ICE support have placed unprecedented pressures on the existing staff. Core business functions in the departments of respiratory medicine and cardiology (communication, documentation, acting on results) are no longer deliverable. Consequences: 1. A large typing backlog The backlog within the Respiratory (as at 23/09/14) is 1795 letters and the oldest letter waiting to be typed is 24/07/14 (8 weeks old). 78% of the outstanding letters are greater than 10 days old and there is a risk that both the backlog figure and the figure in excess of ten days will increase further throughout the summer. Cardiology (as at 23/09/14) has 2356 letters in the back log, 43% are over 10 days and the oldest letter is 19/08/14. 2. Patients are at risk of significant harm/injury due to the delay in receipt of treatment/care plan information, including medication changes. 3. Patients are also at risk due to the limited availability of timely clinic letters (which include diagnostic ,treatment and referral information) to GPs and other health care professionals involved in the treatment of the patient. 4. Consultants are no longer able to reliably act on results	Quality	1. Recruitment for Audio typists. These roles have been advertised for a third time and so far 2 WTE have started. 2. Overtime offered to all secretarial and audio typing staff 3. Continued attempt to get cover through bank/recruitment agency staff. 4. Additional typing support through Ops Manager, Team Leader and PA's. 5. Clinical Immunology & Renal secretaries have been offered typing overtime to support Respiratory. 6. Secretarial staff have been asked to concentrate on the oldest typing first, regardless of whether the dictating Clinician is one they would normally provide administrative support to 7. Recruitment of Support Secretaries from Cardiology has been undertaken to help cover the shortfall 8. Use the Dictation service DICT8 to eradicate the typing backlog, 9. Recruited two Agency Audio Typists for minimum 8 weeks 10. Other CMG staff working overtime to help manage the backlog of letters - topping and tailing DICT8 files.	Major	Likely	16	Ensure named IM&T support for ICE implementation - complete Employ personal user voice recognition software to fill ICE templates - 30/4/15 Recruitment of two WTE secretary - complete. Recruitment of two WTE Audio Typists - Complete. Stress Risk assessment to be carried out - 31/5/15.	6	AGIB

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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	31/05/2015	29/10/2014	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 health needs. Increased and serious incidents reported regarding various aspects of care of mental health patients. 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 Mental Health 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 Partnership Group There is a detailed action plan that links into the concordat that UHL has signed up to to improve things for MH patients in crisis in response to CQC visit in 2014.	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 - 31/05/15. 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 - 31/05/15. Partnership working group set up to include UHL, LPT, EMAS & Police to look at improving response times and access to assessment for people with MH issues. Local area will have its own crisis care declaration including a joint statement which demonstrates the Concordat principles - completed. Violence Risk Assessment &Training needs analysis to be completed to identify appropriate training needs- 31/05/2015 Urgent review of MH pathway, particularly time in ED - 31/0/2015 Development of protocol for management of younger people - 30/06/2015 An external independent investigation into incidents relating to vulnerable children under the care of the CAMHs services by LLR - 30/06/2015	6	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
2466	Emergency and Specialist Medicine	Rheumatology	Risk of Patient Harm due to delays in timely review of results and Monitoring in Rheumatolgy	03/12/2014	31/07/2015	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	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 - This is an action until support from 4s is in place. LiA work stream to address risks and plan future working - 31/08/15 Every patient on DMARD to be on DAWN system and monitored in real time - 31/07/15.	1	GST
2191	Musculoskeletal and Specialist Surgery	Ophthalmology	Follow up backlogs and capacity issues in Ophthalmology	12/06/2013	31/05/2015	Causes: Lack of capacity within outpatient services. Junior Doctor decision makers resulting in increased follow-ups. Follow-ups not protocol led. No partial booking. Non adherence to 6/52 leave policy. Clinic cancellation process unclear, inadequate communication and escalation. Consequences: Backlog of outpatients to be seen. Risk of high risk patients not being seen/delayed. Poor patient outcomes. Increased complaints and potential for litigation.	Patients	Outpatient efficiency work ongoing. Full recovery plan for improvements to ophthalmology service are in process . Outsourcing of follow up patients to Newmedica (IS) has been agreed. All overdue patients will be triaged by them, with the company following up the appropriate patients. The company have agreed to flag high risk patients to us for follow up that do not meet their criteria	Major	Likely	16	Monitor and review impact of NEW MEDICA - 31/05/15. Implement clinic utilisation work - 31/05/15 Continued review of Newmedica - 31/05/15	8	DTR

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2504	Musculoskeletal and Specialist Surgery	Trauma Orthopaedics	Patients will wait for an unacceptable length of time for trauma surgery resulting in poor outcomes and patient satisfaction	12/03/2015	30/04/2015	Causes: increased spinal activity; workload exceeds capacity; underutilised 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 - 30/0415. Scoping and implementation of a more responsive data capture and scheduling database - 30/04/15. Complete LiA cycle and subsequent action plan - 30/04/15. Formulation of capacity plan across the region to make plans for increased spinal activity - 30/06/15. 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	MMCM

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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	02/04/2015	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 relation to UHL having no credible strategy for compliance with Blood Safety Regulations. Consequences: Potential loss of blood bank licence (via MHRA) with severe impact on surgery and transfusion dependent patients served by UHL. Financial penalty for non-compliance due to increased number of inspections Delay in timely supply of blood and blood components for new surgical and transfusion clinic patients. Increased potential for 'Never event' (i.e. wrong transfusion) leading to increased morbidity /mortality. Potential loss of Trust's good reputation via publication of critical reports.	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	Develop LIMS (Laboratory Information Management System) the IT system which interfaces the laboratory analysers with the Trust system. Implementation plan 02.05.2015; Full implementation of LIMS 31.05.15; Full implementation Blood Track 31.10.15.	4	KJON

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2487	Clinical Support and Imaging	Medical Physics	Maintaining the quality of the Nuclear Medicine service for PET, Cardiac MPI and general diagnostics	30/05/2015	06/01/2015	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 elgibile or interested in gaining ARSAC certification The consequences are severe. 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 service and on Imaging and MR throughput. Pressures on the consultant body to provide a comprehensive imaging service are high. The risks are that PET and MPI scanning are suspended, impacting on patients and business.	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 - 1/6/15	6	DPE

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2378	Clinical Support and Imaging	Pharmacy	Pharmacy workforce capacity	19/06/2014	30/05/2015	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. High levels of vacancies and sickness High levels of activity Training requirements for newly recruited staff	Patients	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	Implement recruitment and retention criteria at key grades and monitor impact - 31/05/15 Explore potential for overseas recruitment - 30/05/15 Ensure exit interviews completed for all staff and review outcome - 31/05/15 Recruit additional band 6 pharmacists - 31/05/15 Increase band 4 technician training capacity - 30/09/15 Recruit externally at 8a - 31/05/15	8	CELL
1926	Clinical Support and Imaging	Ultrasound	Risk to Trust operations and patient safety due to insufficient staffing to manage the ultrasound referrals	10/04/2012	30/06/2015	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 - 30/06/2015	6	JGI

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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	30/04/2015	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 Sheffield due 30/04/15. Review of Consultant working patterns and extension of presence on the DS and MAU due 30/04/15. Development of a decision education package focusing on the management of the 2nd stage of labour due 30/04/15. Further review of times of day when babies with HIE are born due 30/04/15.	8	ACURR

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2153	Women's and Children's	Paediatrics	Shortfall in the number of qualified nurses in Children's Hospital including ECMO staffing and Capacity	05/03/2013	30/04/2015	Causes The Children's Hospital is currently experiencing a shortfall in the number of appropriately qualified Children's nurses. This is in part due to the increased numbers of staff on maternity leave and the issues with recruiting Children's trained nurses. The demand for PICU beds currently outweighs capacity. There is an establishment of 6.5 beds but due to vacancies and long-term sickness/maternity leave the unit is currently only able to run at maximum capacity of 6 beds and on specific days only 5 beds (depending on the overall ECMO activity across adults and children). In addition to NHS activity the Trust has contracted to provide cardiac surgery for a cohort of Libyan children. At the time that the contract was developed (Nov-December 2012) it was assessed that there would be sufficient capacity to operate on one child per week without impacting on NHS Activity. However, the current staffing and long-term profile of patients on PICU has resulted in pressures on both NHS work and the delivery of the Libyan contract. Currently there are vacancies for 5.82 wte qualified and 1 wte unqualified nurse within the Children's cardio respiratory services, which cover PICU, ward 30 and the COPD. The ECMO services have vacancies for qualified staff. Consequences There is a short fall in the number of appropriately qualified children's nurses in the Children's Hospital which could impact on patient care. Balancing the demand for PICU beds between NHS contracted activity, emergency cases and Libyan private patients increases the risk of cancellations and increased waiting times. Unsafe staffing levels, therefore unable to provide the recommended nurse to bed ratios in an intensive environment. Staff from PICU are moved to cover ward shifts to ensure minimum nurse to bed requirement. Consequently this	HR	The bed base in Leicester Royal infirmary has been reduced. There is an active campaign being undertaken to recruit new nurses from around the country. Additional health care assistance have been employed to support the shortfall of qualified nurses. No further Libyan patients are being operated on until agency staff can be recruited to support their PICU stay or until the patient flow changes on PICU to allow week-end operating which does not compromise week-day operating or access to PICU. Active Recruitment in progress Educational team cover clinical shifts Cardiac Liaison Team cover Outpatient clinics Overtime, bank & agency staff requested Lead Nurse, Matron and ECMO Co-ordinator cover clinical shifts Children's Hospital & Adult ICU staff cover shifts The beds on Ward 30 have been reduced from 13 to 10 PICU beds are closed where necessary	Major	Likely	16	Continue to recruit to remaining 5wte vacancies - due 30/4/2015 Completion of a period of perceptorship for newly qualified nurses - due 30/4/2015 Completion of a period of perceptorship for new international qualified nurses - due 30/6/15	8	EA

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2237	Medical Directorate		Risk of results of outpatient diagnostic tests not being reviewed or acted upon resulting in patient harm.	07/10/2013	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 in imaging for time to test and time to report. Consequences Potential for mismanagement of patients to include: Severe harm or death to patient. Suboptimal treatment. Delayed diagnosis. Increased potential for incidents, complaints, inquests and claims. Risk of adverse publicity to UHL leading to loss of good	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 speciality processes for outpatient management of diagnostic tests results. June 15 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	01/05/2014	31/05/2015	A major homecare company has left the Homecare market requiring remaining companies to take on large numbers of patients. These companies are now experiencing difficulties in maintaining their current levels of service. UHL patients are now being affected. One homecare supplier has changed their compounding to Bath ASU causing concerns about UHL supply of chemotherapy drugs over the next few weeks. Healthcare at Home (H@H) 1)H@H have changed their logistics provider (to Movianto). There are IT incompatibilities between both providers resulting in a large number of failed deliveries. Patients have not been able to get through to H @H via their telephone helpline. 2) H@H no longer accepting new referrals for CF, respiratory and haemophilia patients who need to be repatriated to UHL urgently. There are also patients in whom homecare has been agreed and they are now referring back 3) H@H have changed their compounding to Bath ASU. This has resulted in Bath ASU not having enough capacity to carry out their routine production. UHL is a large user of dose banded chemotherapy. Bath ASU usually have a 5 day lead time on this, currently this has been increased to 2 weeks. Bath ASU are prioritising hospitals that do not have the facility to manufacture their own dose banded chemotherapy. Currently we do not have the facility to compound all of our dose banded chemotherapy, and there are concerns about supply over the next few weeks. Alcura 1)Experiencing difficulties that have resulted in failed deliveries and possible breaches of patient confidentiality. 2)There are on-going issues with invoicing. No invoices for Alcura have been paid since November from UHL. This is a national issue and there is a concern that the company may experience a cash-flow problem resulting in closure. Consequences	Quality	UHL Homecare team liaising with homecare companies to try and resolve issues of which they are made aware. H@H high risk patients currently being repatriated to UHL. UHL procurement pharmacist in discussion with NHS England (statement due out soon - timeframe unsure), and with the CMU. Patient groups and peer group discussions also been 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 - 30/4/2015 review against Hackett - due 31/5/2015 appt of homecare administrator post - 31/5/2015	9	CELL

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2093	Medical Directorate	R&D	Athena Swan - potential Biomedical Research Unit funding issues.	31/08/2015	08/08/2014	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	Add Athena Swan to every agenda at Leicester & Loughborough Universities attended by UHL R&D Personnel	4	CMAL

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2247	Nursing		There are significant numbers of RN vacancies in UHL leading to a deterioration in service/ adverse effect on financial position	30/10/2013	30/06/2015	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 to emphasis on nursing roles.	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	CRIB

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2325	Nursing		Risk to patient/staff safety due to security staff not assisting with restraint	03/04/2014	30/04/2015	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 Adverse publicity	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 - 30/04/15	6	DLO

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
1693	Operations		Risk of inaccuracies in clinical coding	02/08/2011	30/06/2015	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 is developed. When upgraded, Medicode will provide an audit functionality to facilitate regular audit of coding. In the short term an in-house audit tool has been developed by the Head of Information and routine randomised audit has commenced. Lead clinicians identified to move coding closer to the clinician. "Codebreaker" system has been developed by Respiratory Medicine (enabling clinicians to record diagnostic coding in real time) and implementation has the support of the coding department. A trust Clinical Coding policy is under development. Scorecard redevelopment to demonstrate improvements and benchmark against other Trusts. 3 year refresher training to be in place and funded recurrently	Major	Likely	16	Minimise backlog of coding, monitoring coding quality, appointing to substantive posts to reduce reliance on agency coders - 30/06/15	8	JRO

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
2316	Operations	Business Continuity	Flooding from fluvial and pluvial sources	06/03/2014	30/06/2015	Causes (hazard) Pluvial flooding (all sites) external and internally Fluvial flooding (LRI) from the River Soar Heavy, prolonged rain fall Winter snow/ice melt Blocked drains Consequence (harm / loss event) 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 Business Continuity Plans 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 - 30/06/15	12	PWA

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
2318	Operations	Business Continuity	Blocked drains causing leaks and localized flooding of sewage	17/03/2014	30/06/2015	Causes (hazard) Aging infrastructure that can no longer 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 Staff placing non maceratorable items in the macerators causing breakages and loss of containment Back flow sink drains are unprotected resulting in foreign bodies Consequence (harm / loss event) Blockages build up easier and the older pipes cannot cope with the additional pressure causing leaks of raw sewage into occupied areas. Approximately 250 calls a month are being received by LRI estates relating to blockages 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, ED 21st September, 12th August EDU 25th September, Ward 8 23rd August, ITU and CT 5th August. 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 of showers, toilets and washing facilities elsewhere in the building. Potential media coverage (one request for information from Leicester Mercury during August) which could result in a loss of reputation and patient satisfaction scores Quality and safe delivery of care will be compromised in areas of sewage leaks resulting in suspension/scaled back delivery of services Risk to health and safety of staff from an unsafe working environment resulting in contamination, slips and falls Increased risk of infections and patient safety	Statutory	Interserve and Hospital response teams. Awareness raised at local inductions. Business Continuity Plans. Communications and awareness with staff - poster campaign (launched September 2013). Approval for drain survey (Kensington and Balmoral Building). single choice patient wipes Surveys done in Kensington and Balmoral Jet washing pipes Reporting of the number of blockages	Major	Likely	16	Cost of replacement of stacks to be assessed. Nigel Bond - due 30/06/15. NHS Horizons to identify additional measures to reduce blockages - Nigel Bond 30/06/15	2	PWA

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2328	ITAPS	Anaesthesia	Risk of inadvertent wrong route administration of anaesthetic medicines during epidural and regional anaesthesia.	30/11/2016 16/04/2014	Causes Continued use of Luer fitting syringes, needles etc increases the risk of anaesthetic medicines being administered via the wrong route. Distractions during anaesthetic procedure. Consequences Permanent injury on irreversible health effects. Death of patient Adverse publicity affecting reputation of the Trust and its staff Litigation leading to medical negligence claim	Patients	Labelling of syringes to indicate content Two people to check drugs during 'drawing up' procedure wherever possible. Training	Extreme	Possible	15	Use of Non-Luer syringes for all LA injections(following introduction of ISO standard) - 31/10/16. Introduction of Non-Luer giving sets(following introduction of ISO standard) - 31/10/16. Introduction of Non-Luer connector to epidural filter (following introduction of ISO standard) - 31/10/16.	5	CAL
1196	Clinical Support and Imaging		No comprehensive out of hours on call rota and PM cover for consultant Paediatric radiologists	30/06/2015 29/06/2009	Causes There are Consultant Radiologists on call however there are not sufficient numbers to provide an on call service. Registrars are available but they have variable experience. Lack of cover for PM work Consequences Delays for patients requiring Paediatric radiological investigations. Sub-optimal treatment. Paediatric patients may have to be sent outside Leicester for treatment. Potential for patient dissatisfaction / complaints. Consultants are called in when they are not officially on call and they take lieu time back for this, resulting in loss of expertise during the normal working day. Delays in reports for Pathology and Coroner	Patients	To provide as much cover as possible within the working time directive. Registrars cover within the capability of their training period. Other Radiologists assist where practical however have limited experience and are unable to give interventional support. Locums are used when available.	Moderate	Almost certain	15	Recruit to Consultants vacancies - due 30/06/2015	2	RG

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
2380	Clinical Support and Imaging		Imaging - Risk of breach of Same Sex Accommodation Legislation	23/06/2014	30/04/2015	Causes: Inpatients and outpatients of the opposite sex have to wait together whilst wearing gowns/nightwear. Consequences: Breach of Same Sex Accommodation statutory legislation. Reduction in privacy and dignity for patients. Potential for increasing complaints. Potential for psychological harm/distress to patients. Repeated failure of internal standards around Same Sex Accommodation. Public expectations around Same Sex Accommodation and privacy and dignity not being met.	Patients	Imaging staff can provide patients with wrap-around gowns (or two gowns, one worn backwards) to reduce exposure, but this practice is inconsistent. Patients can be offered the opportunity to wait in the cubicles (where available) if preferred, but again this practice is inconsistent. Portable screens are available in CT waiting area for use when inpatients overflow into this area. (LRI)	Moderate	Almost certain	15	Glenfield Action Plan:- due 30/04/15 * Explore options around redesigning the cubicles and waiting area in the MRI and CT zone. LGH Action Plan:- due 30/04/15. Where feasible, implement appropriate changes, based on business case, costings approval and planning. Options to consider include: * Increasing numbers of cubicles * Provision of solid doors on cubicles instead of curtains * Investigate possibility of single sex sessions, i.e. males in the morning, females in the afternoon, for both inpatients and outpatients * Creating single sex recovery areas * Area D: utilise chair area for dressed patients only. Undressed patients could wait in the cubicles. Trolley area could have cubicles and chairs removed so that curtained area can be created to accommodate 1 trolley patient, allowing maximum of 2 patients in this area at a time. If opposite sex, one could be curtained behind the screened area.	3	JHA

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
2496	Clinical Support and Imaging	Blood Transfusion	Risks associated with implementation of an Electronic Blood Tracking and Traceability Management System within MHRA timescales	12/03/2015	30/06/2015	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 implementation and dissemination of the Electronic Tracking system to service areas/users within UHL	Moderate	Almost certain	15	Purchase and implementation of a Electronic Blood tracking and Tractability System to an agreed schedule - October 2015	4	KJON

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	Compromised safety for patients with complex nutritional requirements	28/10/2014	31/03/2015	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. bariatric services).	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 - 31/03/15. 2. Consider converting temporary posts to permanent contracts to ensure continuity of staffing and training needs- 31/03/15. 3. Urgent review of the NST service to ascertain requirements for further uplift in staffing levels - 31/03/15. 4. Consider the option to Identify and facilitate professional checking by qualified pharmacist of the HPN prescriptions on a daily basis - 31/03/15. 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 - 31/03/15. 6. Complete stress risk assessments on all members of the nutrition nurse team and take any identified actions - 31/03/15. 7. Urgent review of job plans to all members of the NST to meet high risk priorities - 31/03/15. 8. Audit readmissions of HPN patients - 31/03/15. 9. To create and develop a specialist pharmacist post dedicated to nutrition in line with the current Pharmacy workforce optimisation review - 31/03/15.	3	MSC

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2278	Women's and Children's	Family Planning	Risk that the Leicester Fertility Centre could have its licence for the provision of treatment and services withdrawn	17/12/2013	30/04/2015	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 fulltime 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 6 to be advertised & recruited to - due 30/04/2015 Overhaul of specimen request, collection and delivery procedures - due 30/04/2015	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
2402	Nursing		Inappropriate Decontamination practise within UHL may result in harm to patients and staff	19/08/2014	31/05/2015	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 Risk of litigation Additional cost to the organisation when further equipment must be purchased	Statutory	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 teams to ensure actions have been taken.	Moderate	Almost certain	15	Complete full review of decontamination practice within UHL and make recommendations for future practice - 31/05/15 Review all education and training for staff involved in reprocessing reusable medical equipment - 31/05/15 Review the use of equipment and the appropriateness of their current placement according to national guidance - 31/05/15	3	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
1551	Nursing	Safety	Failure to manage Category C documents on UHL Document Management system (Insite)	14/03/2011	30/06/2015	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 - 30/06/15 Compile a list of local guidelines requiring review and send to CMGs for action - 30/06/15 CMGs to advise 'CRESPO' of any guidelines requiring urgent revision/ attention or that need to be removed from InSite - 30/06/15 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 - 30/06/15 Implement shared mailbox to receive responses from CMGs - 30/06/15 Ensure input from IM&T to make InSite more effective as a document library - 30/06/15 Continue work to assign review dates and authors to all CAT C documents 30/06/15	9	SH

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
2501	Clinical Support and Imaging	Physiotherapy	The Proposal to relocate the Womens Health Physiotherapy Service to the LGH and to review the ward cover on LRI/LGH sites	26/05/2014	31/05/2015	Causes- Moving the Womens Health Physiotherapy Service from a two site service to a one site service (LGH) and changes to service provision. The team will cease to provide routine postnatal ward cover and will develop postnatal classes and an SOS service for women with continence and musculoskeletal conditions. Consequences- The possibility that some patients at LRI may not be treated because there are no Womens Health staff on the LRI site. The types of patient would be antenatal and postnatal patients on the delivery suite with chest problems, orthopaedic outliers on the Gynae Assessment Unit, Antenatal patients admitted with musculoskeletal problems and surgical mobility patients.	Patients	The controls that would be put in place would be: - Patients with respiratory problems and those with mobility concerns would be assessed and treated by the respiratory/surgical physiotherapy teams who are based at LRI - Orthopeadic outliers would be seen by the Trauma Physiotherapy Team - Antenatal patients who could be discharged (aprox 4 patients a month) would be given an urgent outpatient appointment (within 5 working days) - Antenatal patients who could not be discharged until they were seen by a Physiotherapist would be assessed by a member of the Womens Health Physiotherapy team as this staff member would travel to the LRI to see them. - The numbers of any of these patients are very small and can vary according to the time of year (e.g. Orthopeadic outliers)	Moderate	Almost certain	15	To liaise with Womens Patient Advisor - 28/08/15. To liaise with medical staff within the maternity unit - 28/08/15. To decide if the proposal is achievable - 28/08/15. To discuss and get approval at COG - 28/08/15. To liaise with other teams to understand the level of support they can give - 28/08/15. To decide if the proposal is achievable - 28/08/15.	2	LCOO