INTEGRATED RISK REPORT INCORPORATING THE 2016/17 BOARD ASSURANCE FRAMEWORK – REPORTING PERIOD AS AT 30/6/16

Author: Risk and Assurance Manager Sponsor: Medical Director Date: Thursday 4th August 2016

Executive Summary Trust Board paper H

Context

The BAF is the key source of evidence that links strategic objectives to risks, controls and assurances, and the main tool that the Trust Board (TB) should use in seeking assurance that those internal control mechanisms are effective. The 2016/17 BAF has been developed with reference to the revised annual priorities and this report provides the TB with the 2016/17 BAF position to 30th June 2016. The report also provides a summary of new organisational risks scoring 15 or above, opened during the reporting period.

Questions

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

Conclusion

1. Executive leads of each strategic objective have provided an accurate picture of our principal risks affecting the achievement of our objectives. To ensure a clearer and more focussed approach in addressing gaps in control assurances, it is proposed that Risk 10 is separated into three entries as follows:-
   - *'Lack of supply and retention of the right staff, at the right time, in right place and with the right skills that operates across traditional organisational boundaries'.*
   - *'Lack of system wide consistency and sustainability in the way we manage change and improvement impacting on the way we deliver the capacity and capability shifts required for new models of care'.*
   - *'Failure to deliver an effective learning culture'.*
2. Many of our assurance sources are based on internal monitoring and some may benefit from external scrutiny (e.g. via internal audit) to provide additional assurance that controls are effective. Some entries have not yet identified an assurance rating and this will be resolved during the next round of executive boards in July.
3. All actions are currently on track. There are a small number of actions where the deadline for completion has been extended in recognition of delays being encountered. Narrative within the BAF 'action tracker' provides further detail.
4. The TB are sighted to all new risks scoring 15 or above opened on the operational risk register during June 2016.

Input Sought

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

(a) receive and note this report;

(b) review this version of the 2016/17 BAF noting:

- 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;
- the actions identified to address any gaps in either controls or assurances (or both);
- any areas which it feels that the Trust's controls are inadequate.

For Reference

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

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

2. This matter relates to the following **governance** initiatives:

a. Organisational Risk Register [Yes]

If YES please give details of risk ID, risk title and current / target risk ratings.

Risk ID	Operational Risk Title(s)	Current rating	Target rating	CMG
2870	Audit of DNACPR form have shown that the discussion with the patient or family is not consistently recorded	16	2	RRCV
2820	Risk that a timely VTE risk assessment is not performed on admission to CDU meaning that subsequent actions are not undertaken	16	3	RRCV
2878	There is a risk of cancer patients not being discussed at MDTs due to inadequate video conferencing facilities	16	4	Ops
2872	There is a risk of bedded bariatric patients being trapped compromising fire evacuation on ward 15 at GGH	15	6	RRCV

b. Board Assurance Framework [Yes]

If YES please give details of risk No.

Principal risks 1 – 19 – see BAF dashboard for details

3. Related Patient and Public Involvement actions taken, or to be taken: [None]
4. Results of any Equality Impact Assessment, relating to this matter: [None]
5. Scheduled date for the next paper on this topic: [01/09/16]
6. Executive Summaries should not exceed 1 page. [My paper does not comply]
7. Papers should not exceed 7 pages. [My paper does not comply]

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **UHL TRUST BOARD**

DATE: **4TH AUGUST 2016**

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

SUBJECT: **INTEGRATED RISK REPORT (INCORPORATING UHL BOARD ASSURANCE FRAMEWORK AS OF 30TH JUNE 2016)**

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1 INTRODUCTION

1.1 This integrated risk report will assist the Trust Board (TB) to discharge its responsibilities by providing:-

a. A 2016/17 BAF based on the revised annual priorities.
b. A summary of risks that are new and have increased in risk rating on the operational risk register with a score of 15 and above.

2. BAF AS OF 30TH JUNE 2016

2.1 Executive risk owners have updated their BAF entries to reflect the progress to achieve the annual priorities for 2016/17. A copy of the 2016/17 BAF is attached at appendix one with all changes highlighted in red text for ease of reference

2.2 The TB is asked to note:

a. An increase in the severity of risk (from 8 – 12) for principal risk two due to the fact that we are in the early days of transfer of staff and services back in house and the EQB wish to review the systems issues and the KPIs over the next few months before endorsing a risk reduction to the target score.

b. A reduction in risk scores associated with principal risks one and 13.

c. Following discussion at the EWB on 19th July 2016 and to ensure a clearer and more focussed approach in addressing gaps in control assurances, the EWB proposed that Risk 10 is separated into three entries as follows:-

- ***'Lack of supply and retention of the right staff, at the right time, in right place and with the right skills that operates across traditional organisational boundaries'.*** Primarily this risk will set out controls and actions to address gaps set out in medical and nursing supply/recruitment and retention strategies with key emphasis on addressing 'Brexit' workforce implications and developing a more inclusive and diverse workforce.

- ***'Lack of system wide consistency and sustainability in the way we manage change and improvement impacting on the way we deliver the capacity and capability shifts required for new models of care'.*** Primarily this risk will set out controls and actions to address gaps specific to the delivery of the Year 1 Implementation Plan for the UHL Way, ensuring an improved level of staff engagement and a consistent approach to change and improvement

- ***'Failure to deliver an effective learning culture'.*** Primarily this risk will set out controls and actions to address gaps specific to delivery of medical, clinical and non-clinical education incorporating elements of poor quality of training delivery and the need for significant improvement and modernisation of educational facilities

The EWB also recommend that for future versions of the BAF that principal risk eight is incorporated into *'Failure to deliver an effective learning culture'*.

Subject to Trust Board approval the revised BAF entries will be presented to the Trust Board at the September Meeting.

3. UHL RISK REGISTER SUMMARY AS OF 30TH JUNE 2016

3.1 At the end of the reporting period, there are 51 risks open on the operational risk register scoring 15 and above. Four new 'high' risks were entered during the reporting period and are described below with full details included in appendix two:

Datix ID	Risk Title	Risk Rating	CMG
2870	Audit of DNACPR form have shown that the discussion with the patient or family is not consistently recorded	16	RRCV
2820	Risk that a timely VTE risk assessment is not performed on admission to CDU meaning that subsequent actions are not undertaken	16	RRCV
2878	There is a risk of cancer patients not being discussed at MDTs due to inadequate video conferencing facilities	16	Ops
2872	There is a risk of bedded bariatric patients being trapped compromising fire evacuation on ward 15 at GGH	15	RRCV

Two risks have increased in rating during the reporting period and are described below with full details included in appendix two:

Datix ID	Risk Title	Risk Rating	CMG
2391	There is a risk of inadequate numbers of Junior Doctors to support the clinical services within Gynaecology & Obstetrics	16	W&C
2670	There is a risk to the Immunology & Allergy Services due to a Consultant Vacancy	20	RRCV

4 RECOMMENDATIONS

4.1 The TB is invited to:-

(a) receive and note this report;

(b) review this version of the 2016/17 BAF noting:

- any gaps in assurance 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;
- the actions identified to address any gaps in either controls or assurances (or both);
- any areas which it feels that the Trust's controls are inadequate.

(c) consider and endorse the proposal outlined in section 2.2 (c) prior to the corresponding BAF entries being updated.

UHL Corporate Risk Management Team
28th July 2016.

UHL Board Assurance Dashboard:		JUNE 2016						
Strategic Objective	**Risk No.**	**Principal Risk Description**	**Owner**	**Current Risk Rating**	**Target Risk Rating**	**Risk Movement**	**Assurance Rating**	**Executive Board Committee for Endorsement**
Safe, high quality, patient centred healthcare	1	Lack of progress in implementing UHL Quality Commitment.	CN	12	8	↓		EQB
	2	Failure to provide an appropriate environment for staff/ patients	DEF	12	8	↑		EQB
An excellent integrated emergency care system	3	Emergency attendance/ admissions increase without a corresponding improvement in process and / or capacity	COO	25	6	⇔		EPB
Services which consistently meet national access standards	4	Failure to deliver the national access standards impacted by operational process and an imbalance in demand and capacity.	COO	16	6	⇔		EPB
Integrated care in partnership with others	5	There is a risk that UHL will lose existing, or fail to secure new, tertiary referrals flows from partner organisations which will risk our future status as a teaching hospital. Failure to support partner organisations to continue to provide sustainable local services, secondary referral flows will divert to UHL in an unplanned way which will compromise our ability to meet key performance measures.	DoMC	12	8	⇔		ESB
	6	Failure to progress the Better Care Together programme at sufficient pace and scale impacting on the development of the LLR vision	DoMC	16	10	⇔		ESB
Enhanced delivery in research, innovation and clinical education	7	Failure to achieve BRC status.	MD	9	6	⇔		ESB
	8	Too few trainers meeting GMC criteria means we fail to provide consistently high standards of medical education	MD	12	6	⇔		EWB / EQB
	9	Insufficient engagement of clinical services, investment and governance may cause failure to deliver the Genomic Medicine Centre project at UHL	MD	12	6	⇔		ESB
A caring, professional and engaged workforce	10	Lack of system wide consistency and sustainability in the way we manage change and improvement in order to deliver the capacity and capability shifts required for new models of care	DWOD	16	8	⇔		EWB
	11	Ineffective structure to deliver the recommendations of the national 'freedom to speak up review	DWOD	16	8	⇔		EWB
A clinically sustainable configuration of services, operating from excellent facilities	12	Insufficient estates infrastructure capacity may adversely affect major estate transformation programme	CFO	16	12	⇔		ESB
	13	Limited capital envelope to deliver the reconfigured estate which is required to meet the Trust's revenue obligations	CFO	12	8	↓		ESB
	14	Failure to deliver clinically sustainable configuration of services	CFO	20	8	⇔		ESB
A financially sustainable NHS Trust	15	Failure to deliver the 2016/17 programme of services reviews, a key component of service-line management	CFO	9	6	⇔		ESB
	16	The Demand/Capacity gap if unresolved may cause a failure to achieve UHL deficit control total in 2016/17	CFO	15	10	⇔		EPB
	17	Failure to achieve a revised and approved 5 year financial strategy	CFO	15	10	⇔		EPB
Enabled by excellent IM&T	18	Delay to the approvals for the EPR programme	CIO	16	6	⇔		EIM&T
	19	Lack of alignment of IM&T priorities to UHL priorities	CIO	12	6	⇔		EIM&T

Board Assurance Framework:	Updated version as at:	Jun-16										
Principal risk 1:	Lack of progress in implementing 2016/17 UHL Quality Commitment								**Risk owner:**	CN / MD		
Strategic objective:	Safe, high quality, patient centred healthcare								**Objective owner:**	CN		
Annual Priorities	To reduce avoidable deaths and avoidable re-admissions . To reduce harm caused by unwarranted clinical variation through introduction of 4 key 7 DS clinical standards in core services; implement UHL EWS and eObs processes; and safe use of insulin. To use patient feedback to drive Improvements to services and care by ensuring patients are informed and involved in their care; better end of life planning and improve the experience of outpatients.								**Risk Assurance Rating**	Exec Board RAG Rating = EQB 7/6/16		
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x4=16	4x4=16	4x3=12									
Principal risk 1:	4x2=8											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Clinical Effectiveness **Directive controls** Screen all hospital deaths Sepsis screening tool and care pathway Implement daily PARR 30 report to direct specialised discharge planning and communication of risk with stakeholders **Detective controls** Hospital deaths screening tool findings % of deaths screened Case record review individual and thematic findings Dr Foster's Intelligence and HED data Audit of sepsis 6 interventions No of SIs in relation to deteriorating patient/ sepsis Readmission rates and findings of PARR30 tool **Patient Safety:**	**Clinical Effectiveness** SHMI scores reported to Mortality and Morbidity Committee and TB, QAC via Q&P report. Quarterly mortality report to ESB/QAC/TB 6 monthly TB report in relation to mortality parameters monthly review of mortality alerts reported to TB. UHL target SHMI <= 99 Current SHMI (Oct 14 - Sept 15) 96 Readmission rate to be < 8.5% Readmissions action plan progress reported monthly to Ward Programme Board Quarterly report to EQB Exception reports to EPB when rate over8.6% **Sepsis** % of patients where screening is used	Internal Audit mortality and morbidity review due Q3 2015/16. Internal audit review in relation to outpatient patient experience due Q4 2015/16.	(a) Currently not all deaths are screened. (1.1, 1.2 and 1.3) (c) Circa £4M funding gap to implement 7 day service standards. (1.4) (c) Workforce shortage may inhibit implementation of 7 day service standards (1.4) (a) No single measure to monitor performance of 7 day services (1.4) (c)Resource to support the implementation of the Insulin strategy not yet approved (1.5)

Patient Safety **Directive controls** 7 Day service standards (including implementation of 14 hour consultant review, diagnostics, professional standards and daily consultant review) Implement UHL EWS and e-obs Implement insulin safety strategy **Detective control** Quarterly patient safety report highlighting number of severe/ moderate harms % of deaths screened 7 DS NHSE audit returns Insulin related incidents reported via Datix **Patient Experience** **Directive Control** End of life care plans Use of the 5 questions **Detective Controls** EoLC audits of use of care plan % uptake of EoLc training Outpatient group monitoring data	% of patients where screening is used (threshold 100% of in patients) % of patients receiving antibiotics within 1 hour (threshold 90% of antibiotics within 60mins of recognition for admission units and 90 mins for base wards) **Patient experience** 6% improvement on patient involvement scores 10% improvement on care plan use and outpatient experience scores. Achieve 14 day correspondence standard.		strategy not yet approved (1.5) (c) EWS score to trigger sepsis care pathway in Nerve Centre not yet in place (1.6) (c)Many avoidable readmissions caused due to factors in the community beyond influence of UHL

Action tracker:	Due date	Owner	Progress update:	Status
Mortality database to be developed (1.1)	Jun 2016	MD	Database developed and currently in testing phase. Roll out anticipated June 2016.	3
UHL Medical Examiners as Mortality Screeners (1.2)	Jul 2016	MD	Roll out at LRI planned to go live 4th July 2016.	3
Participate in National retrospective case record review (1.3)	TBA	MD	No date for completion has been set nationally yet	1
Work with Nerve Centre to implement EWS score to trigger sepsis care pathway (1.6)	Sep-16	MD	On track	4
7-Day services gap analysis (1.4)	Jun-16	MD	On track	4
Scope resources require to deliver the Strategy for Insulin Safety (1.5)	Jul-16	MD	being considered by EQB 05/07/16	4
Incorporate PARR30 scores into ICE and Nerve Centre	TBA	MD	meeting with DOI 28.06.16	4
Release wte discharge sister to prioritise high risk discharge planning	TBA	MD	funding secured HoOE May 2016	4

Board Assurance Framework:	Updated version as at:		Jun-16									
Principal risk 2:	Failure to provide an appropriate environment for staff/ patients								**Risk owner:**		DEF	
Strategic objective:	Safe, high quality, patient centred healthcare								**Objective owner:**		CN	
Annual priorities	Develop a high quality in-house Estates and Facilities service								**Risk Assurance Rating**		Exec Board RAG Rating = (Date: xx/xx/xx)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4X3=12	4x2=8	4x3=12									
Target risk rating (I x L):	4x2=8											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Preventative Control Estates management infrastructure in place Including committee structure (e.g. Fire Safety Committee, Water Management Committee, Waste Committee, IP Committee, etc) **Detective Control** IT systems to control processes and performance manage. Review of Estates and facilities related incident reports Service user feedback (Staff) **Directive Control** Outline plan in place for developing Estates and Facilities Service: 0 - 3 months - Maintain safe services 0-9 months - Ensure compliance 0-18 months - Review, develop and optimise quality of services **Corrective Control** Escalation processes for deteriorating standards/ performance	Cleanliness audits PLANET SYSTEM providing data for Estates and 'soft' services SAFFRON system providing data for Patient feeding/ catering services. Annual ERIC return to benchmark efficiency against other organisations (due July 2016) Monthly performance reporting to EQB/ QAC and TB in relation to KPIs (beginning July 2016)	Annual 'PLACE' review (next due March 2017). Annual peer audit/ review (next due November 2016)	(c) Lack of detailed plans to deliver outline plan (2.1) (a) Some data not robust in relation to detailed KPIs (2.2)

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
Develop detailed plans to deliver the outline plan	Sep-16	DEF		4
KPIs to be reviewed	Sep-16	DEF		4

Board Assurance Framework:	Updated version as at:		Jun-16									
Principal risk 3:	Emergency attendance/ admissions increase without a corresponding improvement in process and / or capacity								**Risk owner:**		Sam Leak, Director of Emergency Care and ESM	
Strategic objective:	An effective and integrated emergency care system								**Objective owner:**		COO	
Annual Priorities	Reduce ambulance handover delays in order to improve patient experience, care and safety. Fully utilise ambulatory care to reduce emergency admissions and reduce length of stay (including ICS). Develop a clear understanding of demand and capacity to support sustainable service delivery and to inform plans for addressing any gaps. Diagnose and reduce delays in the in-patient process to increase effective capacity								**Risk Assurance Rating**		Exec Board RAG Rating = EPB: 28/06/16	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	5x5=25	5x5=25	5x5=25									
Target risk rating (I x L):	3x2=6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive / Preventative Controls NHS '111' helpline GP referrals Local/ National communication campaigns Winter surge plan Triage by Lakeside Health (from 3/11/15) for all walk-in patients to ED. (reduced resource by 50% May 2016 and ceases November 16) Urgent Care Centre (UCC) now managed by UHL from 31/10/15 Admissions avoidance directory Reworking of LLR urgent care RAP- as detailed in COO report **Detective Controls** Q&P report monitoring ED 4-hour waits, ambulance handover >30 mins and >60 mins, total attendances / admissions. UCB RAP progressed by Healtheconomy monthly Comparative ED performance summaries	ED 4 hour wait performance (threshold 95%) YTD 79.72% Poor performance continues to be primarily driven by record ED attendances and emergency admissions but has also been contributed to by staffing issues. Total attendances and admissions (compared to previous year) 1.6% increase in emergency admissions 5.7% increase in total A&E attendances. Ambulance handover (threshold 0 delays over 30 mins) 23.5% over 30mins 8.6% over 60mins, 1.5% over 120 mins Difficulties continue in accessing beds from ED leading to congestion in the assessment area and delayed ambulance handover. Handover delays have decreased (December 37% over 30 mins to 18% in June) however further improvements are essential especially in the long waits (over 2 hours in	National benchmarking of emergency care data ORG fortnightly board dashboard.	(c) Lack of effectiveness of admissions avoidance plan (3.1) (c)Lack of effectiveness of attendance avoidance plan Lack of winter surge capacity (3.1)

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
LLR plan to reduce admissions (including access to Primary Care) (3.1)	~~Review Jun 16~~ Sept-16	COO	Admissions and attendance continue to increase.	2
Expansion of Majors by moving minors to DVT and TIA (3.2)	Jul-16	SL	**Complete.** Updated at EQSG - on track	5
ORG action plan to decrease attendances (3.2)		ORG	**Complete.** Acton plan in place and progress against milestones managed via ORG	5
Increased medical base ward capacity (possibility of ward 7) (3.1)	Sep-16	SL / COO	Options paper for ward 7 being produced for decision	4
Ensure patients are conveyed to the most appropriate to access e.g. UCC, Assessment bay, AAU (amb and non amb) (3.2)		SL	**Complete.** SOP developed and audited on a regular basis	5
Move to new build (3.2)	Mar-17	SL / CF	Ensure pathway reconfiguration and workforce matches requirement to address this risk	4
Develop a detailed action plan demonstrating actions to impact on bed capacity	Aug-16	SL / COO	Actions to August IFPIC on 28.8.16	4
Bed capacity demand for 16/17 and 17/18 to be updated to show the bed gap by	Jul-16	COO	**Complete**	5

Board Assurance Framework:	Updated version as at:	Jun-16										
Principal risk 4	Failure to deliver the national access standards impacted by operational process and an imbalance in demand and capacity.								**Risk owner:**		Will Monaghan, Director Of Performance And Information	
Strategic objective:	Services which consistently meet national access standards								**Objective owner:**		COO	
Annual Priorities	Maintain 18-week RTT and diagnostic access standard compliance Deliver all cancer access standards sustainably								**Risk Assurance Rating**		Exec Board RAG Rating = EQB 28/6/16	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x4=16	4x4=16	4x4=16									
Target risk rating (I x L):	3 x 2 = 6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Detective Controls RTT incomplete waiting times, cancer access and diagnostic standards reported via Q&P report to TB **Corrective controls** Insourcing of external consultant staff to deliver additional sessions. Outsourcing of elective work to independent sector providers. Productivity improvements in-house. Additional premium expenditure work in house.	RTT Incomplete waiting times (threshold 92%). Currently 92.4%. Diagnostics: 0.7% (threshold 1%) Cancer Access Standards (reported quarterly). 2 ww for urgent GP referral (Threshold 93%). 90% forecasted 2 ww for symptomatic breast patients (threshold 93%). 96.2% 31 day wait for 1st treatment (threshold 96%). 89% 31 day wait for 2nd or subsequent treatments (Drugs - threshold 98%). 100% (Surgery - threshold 94%). 77.5% (Radiotherapy - threshold 94%). 96.4% 62 day wait for 1st treatment (threshold 85%). 75.9% 62 day wait for 1st treatment (CSS referral-threshold 90%). 70% Cancer wait 104 days (threshold TBC). 12	Cancer recovery action plan managed across the Trust, NHS Improvement and the CCG. Monthly performance call with NTDA. Internal audit review in relation to waiting times for elective care due in quarter 4 2015/16; initiated end January 2016. Elective IST have assured the action plans in Diagnostics and the Cancer plan.	(c) Lack of progress on 62 day backlog reduction due to ITU/HDU capacity and gaps in clinical capacity in key specialties (4.1). (c) Inability to manage the pressure through the ENT service (4.2).

Action tracker:	Due date	Owner	Progress update:	Status
Sustained achievement of 85% 62 day standard (4.1)	Sep-16	DPI	62 day backlog reduction currently off trajectory. Implementation of 'Next Steps' for cancer patients in key tumour sites to start end February 2016. The extension to deadline comes as part of our submission to the TDA for our sustainable transformation plans.	4
Development of ITU additional capacity plan including increased frequency of step downs. (4.1)	Sep-16	HoO ITAPS		4
Further insourcing of external consultant staff to deliver additional sessions (4.2)	Jul-16	DPI		5

Board Assurance Framework:	Updated version as at:	Jun-16										
Principal risk 5:	There is a risk that UHL will lose existing, or fail to secure new, tertiary referrals flows from partner organisations which will risk our future status as a teaching hospital. Failure to support partner organisations to continue to provide sustainable local services, secondary referral flows will divert to UHL in an unplanned way which will compromise our ability to meet key performance measures.								**Risk owner:**		Director of Marketing and Comms (DoMC)	
Strategic objective:	Integrated care in partnership with others								**Objective owner:**		DoMC	
Annual priorities	Develop new and existing partnerships with a range of partners, including tertiary and local service providers to deliver a sustainable network of providers across the region. Progress the implementation of the EMPATH strategic outline case								**Risk Assurance Rating**		Exec Board RAG Rating = (Date: xx/xx/xx)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x3=12	4x3=12	4x3=12									
Target risk rating (I x L):	4x2=8											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls NHS England Five Year Forward View sets out the national strategic direction. UHL Business Decision Process. UHL/NUH Children's Services Collaborative Group. Partnership Board for Specialised Services established in Northamptonshire. Membership includes Northants CCGs; NHS England; KGH; NGH and UHL. Tripartite Working Group UHL/NUH/ULHT. ULHT/UHL Urology Steering Group. SEMOC Steering Group. Memorandum of Understanding (MoU) for key work programmes.	ULHT/UHL Urology Steering Group and SEMOC Steering Group work programmes and risk registers reporting to UHL Tertiary Partnership Board. UHL Tertiary Partnerships Board reporting to ESB Monthly. Statistical Process Control (SPC) Reporting of performance developed (vascular only).	Inclusion in acute services contract. Compliance with national service specifications and standards, External service reviews (e.g. peer reviews).	(c) Lack of prioritised service level strategies and engagement plans. (5.1) (a) SPC Reporting required for other priority services. (5.3)

SLAs in place for all partnerships. Tertiary Partnership Strategy. Individual service strategies. **Detective/Corrective Controls** UHL Tertiary Partnerships Board. Tertiary partnership work-programme. Horizon scanning: NHS England (local and national); NICE; SCN; AHSN; NHS Networks			

Action tracker:	Due date	Owner	Progress update:	Status
(5.1) Apply criteria in Tertiary Partnership Strategy to prioritise service lines.	~~01/06/2016~~ Jul-16	JC	To report to the Tertiary Partnership Board in July. Deadline extended due to the already established meeting schedule.	3
(5.2) Present vascular reporting to Tertiary Partnership Board.	May-16	JC	**Complete.** Will continue and use as a template for other priority services.	5
(5.3) SPC Reporting to be developed for other priority services.	Sep-16	JC	To follow on from (5.1)	4

Board Assurance Framework:	Updated version as at:	Jun-16									
Principal risk 6:	Failure to progress the Better Care Together programme at sufficient pace and scale impacting on the development of the LLR vision								**Risk owner:**	Director of Marketing and Comms (DoMC)	
Strategic objective:	Integrated care in partnership with others								**Objective owner:**	DoMC	
Annual priorities	Work with partners to deliver year 3 of the Better Care Together programme to ensure we continue to make progress towards the LLR vision (including formal consultation).								**Risk Assurance Rating**	Exec Board RAG Rating = (Date: xx/xx/xx)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x4=16	4x4=16	4x4=16									
Target risk rating (I x L):	2x5=10											

Controls: (preventive, corrective, directive, detective)	Assurance on effectiveness of controls		Gaps in Control / Assurance
	Internal	**External**	
Directive Controls BCT 5 Year Plan. BCT Strategic Outline Case. BCT Project Initiation Document. BCT governance arrangements, including a programme management office, multi-agency boards (BCT Partnership Board, BCT Delivery Board, BCT Service Reconfiguration Board, LLR Chief Officers, and CCG Commissioning Collaborative Board) all of which inform an overall BCT Board Assurance Framework. BCT project delivery structure and organisational specific delivery mechanisms,	Monthly updates (including high level risks and mitigating actions) received and reviewed by a number of internal boards and committees, namely Trust Board, Executive Strategy Board, Reconfiguration Programme Board. UHL bed base aligned to BCT requirements	Healthwatch organisations across LLR and the PPI Group. Clinical Senate (external to the LLR Partnership). Externally commissioned Health checks (also known as Gateway Reviews). Pre-consultation business case (PCBC) considered and signed off by partner boards, including CCG Boards, provider boards, local authorities etc. Ultimate decision to go to consultation sits with NHS England - NHS	(a) Some early schemes may not be delivering the anticipated impact e.g. LRI UEC, ICS. BCT programme dashboard (used to track progress) lacks sufficient detail making it difficult to hold work stream leads to account (6.1)

including 8 integrated clinical work streams. UHL governance arrangements, including UHL Reconfiguration Programme Board and associated sub-committees / boards and work streams i.e. major capital business cases, estates, IM&T, Future Operating Model etc. **Detective Controls** Progress updates against pre-defined plans presented to both multi-agency boards and individual partner boards, including BCT Partnership Board, BCT Delivery Board, UHL Reconfiguration Board, UHL Executive Strategy Board and UHL Trust Board.		England lead the national (external) assurance process. NHS Improvement (formerly the Trust Development Authority) when reviewing and approving Trust plans.	

Action tracker:	Due date	Owner	Progress update:	Status
(6.1) A BCT Programme Dashboard to be established and agreed with the BCT PMO. BCT Delivery Board to review work stream plans to ensure there is sufficient stretch.	Sep-16	MW	All BCT work streams have revisited and updated plans apart of the STP development process, adding to plans where needed. The STP also describes the need to review and/or change governance and delivery mechanisms tonsure change is delivered at pace. The outcome of these(on-going) discussions will then frame the process we adopt for measuring delivery (i.e. a programme dashboard)	3
(6.2) Identifying how BCT (and associated cost improvement plans) will address the deficit requirements across LLR.	Jun-16	PT	**Complete** - this is included in the LLR STP	5

(6.3) Implement proposed changes (subject to public consultation) over a longer time frame while still delivering financial balance by 20/21 and the priority order in respect to capital plans for UHL, plus options for exploring alternative sources of capital.	Jun-16	PT	**Complete** - this is included in the LLR STP and our refreshed internal capital programme (pending confirmation from the Centre).	5

Board Assurance Framework:	Updated version as at:	Jun-16										
Principal risk 7:	Failure to achieve BRC status								**Risk owner:**		Nigel Brunskill, DoR&D	
Strategic objective:	Enhanced delivery in research, innovation and clinical education								**Objective owner:**		MD	
Annual Priorities	Deliver a successful bid for a Biomedical Research Centre								**Risk Assurance Rating**		Exec Board RAG Rating = (ESB 12/7/16)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3x3=9	3x3=9	3x3=9									
Target risk rating (I x L):	3x2=6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls Each BRU has a strategy document **Preventive Controls** UHL R&I supportive role to BRUs by meeting with Universities (Joint Strategic Meeting) Good working relationships between UHL and University partners Good track record of attracting subjects into studies Contracting and innovation team. Work with Medipex to commercialise our projects/ ideas. **Detective Controls** Financial monitoring of BRUs via Annual Report **Corrective controls** UHL to provide funding from external sources for targeted posts if necessary	Financial performance and academic output reported to UHL Joint Strategic meetings for assurance. In addition financial performance reported to each BRU Executive Board. Financial performance currently on plan. Highest recruiting Trust in the East Midlands and 7th nationally	NIHR monitor BRU performance University analysis of data	(c) NIHR national strategy not under UHL control (no local action can be taken) (c) Weak support from academic partners (7.1 and 7.2)

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
(7.1) Develop new 4-way strategy meeting with UHL, UoL, LU and DMU (7.1)	Jun-16	MD	On-going	4
(7.2) Closer joint working with Universities to develop application (7.2)	Jun-16	MD	**Complete.** Application submitted	5

Board Assurance Framework:	Updated version as at:	Jun-16										
Principal risk 8:	Too few trainers meeting GMC criteria means we fail to provide consistently high standards of medical education								**Risk owner:**		Sue Carr, Clinical Education	
Strategic objective:	Enhanced delivery in research, innovation and clinical education								**Objective owner:**		MD	
Annual priorities	Improve the experience of our medical students to enhance their training and improve retention, and help to introduce the new University of Leicester Medical Curriculum. Develop and implement our Commercial Strategy to deliver innovation and growth across both clinical and non-clinical opportunities. Launch the Leicester Academy for the Study of Ageing (LASA)								**Risk Assurance Rating**		Exec Board RAG Rating = EQB 07/06/16	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3x4=12	3x4=12	3x4=12									
Target risk rating (I x L):	3x2=6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls Medical Education Strategy Operational guidance EWB and CMG scrutiny / challenge of Medical Education issues **Detective Controls** Medical education database to show number of accredited trainers which feeds into Medical Education Quality dashboard. Reported to EWB via Medical Education Committee minutes. University Dean's report.	Medical Education Quality Dashboard shows the percentage of medical staff complying with GMC requirements (per CMG). Target 100%. Current position (per CMG) = • CHUGGS 76% • CSI: o Imaging 89% o Pathology 67% • ESM 68% • ITAPS 79% • MSS 88% • RRCV 73% • W&C: o Women's 96.5% o Children's 80% University Deans report to show % of fully recognised medical trainers in UHL (threshold 100%) by July 2016. Current position = 74% (down from 75% previous period). UHL trainee survey	HEEM accreditation visits. GMC trainee survey results.	(c & a) Accuracy of database uncertain (8.1)

Action tracker:	Due date	Owner	Progress update:	Status
Ensure engagement with CMGs to embed Medical Education Dashboard to ensure more robust data (8.1)	Jun-16	S Carr	**Complete.** On-going engagement with CMG Med ED leads. Extra provision of online supervisor training in place to improve accreditation rates among supervisors. Triangulation of internal and external data sources to improve database accuracy.	5

Board Assurance Framework:	Updated version as at:		Jun-16									
Principal risk 9:	Insufficient engagement of clinical services, investment and governance may cause failure to deliver the Genomic Medicine Centre project at UHL								**Risk owner:**		Nigel Brunskill, DoR&D	
Strategic objective:	Enhanced delivery in research, innovation and clinical education								**Objective owner:**		MD	
Annual priorities	Support the development of the Genomic Medical Centre and Precision Medicine Institute								**Risk Assurance Rating**		Exec Board RAG Rating = ESB 12/7/16	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x4=16	4x3=12	4x3=12									
Target risk rating (I x L):	3x2=6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls Director of R&I meets with key CMG managers to ensure engagement. Genomic Medicine Centre (GMC) CMG leads for Cancer and rare diseases New pathway for samples initiated with Genomic Medicine Centre at Cambridge (previously Nottingham). **Preventive Controls** **E**ngagement with CMGs via comms strategy including weekly national and local (i.e. UHL) news letters Contracting and innovation team Work with Medplex to help commercialise our projects ideas **Detective Controls** Research study subject recruitment trajectory (sufficient income depends upon meeting recruitment thresholds). Monitored by GMC Steering Committee and UHL Exec Team	Monthly and annual trajectory for recruitment into this project. Currently we are slightly below trajectory for rare diseases but this is improving. New pathway for samples initiated with Genomic Medicine Centre at Cambridge to resolve issues	Eastern England Genomic Centre monitoring against recruitment trajectory.	(c) Ineffective recruitment into studies attributable to lack of research staff (9.1)

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**

(9.1) Engagement of CMGs with process	~~01/06/2016~~ Sep - 16	MD DRI	DRI and MD leading on engagement programme. Meeting with Clinical Genetics and W&C CMG Management to discuss Clinical Genetics workforce plan.	3
(9.1) Appoint nurse to cover maternity leave in May	Jun-16	MD CRI	**Complete.**	5
(9.1) Recruitment against trajectories	~~01/06/2016~~ Sep - 16	DRI	Recruitment for rare diseases above trajectory for June. Focus on individual specialties to identify further potential legacy samples. Preparation to start recruitment for cancer in July.	3
Finalise IT plans	Jun-16	DRI	**Complete** - on-going service agreement in place.	5

Board Assurance Framework:	Updated version as at:	Jun-16										
Principal risk 10:	Lack of system wide consistency and sustainability in the way we manage change and improvement impacting on the way we deliver the capacity and capability shifts required for new models of care								**Risk owner:**		DoWD	
Strategic objective:	A caring, professional and engaged workforce								**Objective owner:**		DoWD	
Annual priorities	Develop an integrated workforce strategy to deliver a diverse and flexible multi-skilled workforce that operates across traditional organisational boundaries and enhances internal sustainability . Deliver the Year 1 Implementation Plan for the UHL Way, ensuring an improved level of staff engagement and a consistent approach to change and development. Develop training for new and enhanced roles, i.e. Physician's Associates, Advanced Nurse Practitioners, Clinical Coders Develop a more inclusive and diverse workforce to better represent the community we serve and to provide services that meet the needs of all patients								**Risk Assurance Rating**		Exec Board RAG Rating EWB 19/7/16	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**		**March**
	4x4=16	4x4=16	4x4=16									
Target risk rating (I x L):	4x2=8											

Principal risk 10:	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Develop Integrated Workforce Strategy **Directive Controls** LETC/BCT Programme Board BCT Workforce Implementation Group Workforce enabling group (strategic) New roles group **Detective Controls** Not yet agreed	No assurance sources available for development of integrated workforce strategy as key measures/ metrics have yet to be agreed.	Apprenticeship attraction strategy not yet in place	(a) No measures/ metrics to track progress of workforce enabling plan. 10.1 (c) Ineffective training for new and enhanced roles 10.2 (c) Strategy to be developed (10.4) (c) Internal reporting / Goverance structures yet to be finalised. 10.3
Deliver year 1 implementation of 'The UHL Way' **Directive controls** Executive Workforce Board UHL Way Steering Group UHL 'LiA' Sponsor group	Measures against schedule of activities for the 4 components: 1. Better engagement 2. Better teams 3. Better change 4. Academy	East Midlands Leadership Academy Leicestershire Improvement Innovation Patient Safety Forum	

Detective Controls Schedule of activities for each component of 'The UHL Way' **Develop a more inclusive and diverse workforce** **Directive controls** Quality and Diversity action Plan Monthly Diversity working group **Preventative controls** Working with external training providers (e.g. colleges of FE and private providers) Bi-monthly contract performance meetings with extreme providers	UHL Pulse Check National Staff Survey data Annual workforce report on quality and diversity reported to TB and published on UHL public website Achievement of milestones within Quality and diversity action plan - currently on track Workforce, Race and Equality Statement (WRES) report to NHS England		

Action tracker:	Due date	Owner	Progress update:	Status
Strategic Workforce Planning - Develop a view of capacity and capability changes across the system. 10.1	Mar-17	DoWD		4
Agree a delivery plan and measures/ metrics for strategic Workforce Planning group. 10.1	Jun-16	DoWD	**Complete**	5
Identify internal governance structure to implement 'The UHL Way'. 10.3	Jun-16	DoWD		4
Improve effectiveness of training via new roles group 10.2	Mar-17	DoWD		4
Develop an apprentice attraction strategy	Sep-16	DoWD		4

Board Assurance Framework:	Updated version as at:	Jun-16									
Principal risk 11:	Ineffective structure to deliver the recommendations of the national 'freedom to speak up review							**Risk owner:**	DoWD		
Strategic objective:	A caring, professional and engaged workforce							**Objective owner:**	DoWD		
Annual priorities	Deliver the recommendations of "Freedom to Speak Up" Review to further promote a more open and honest reporting culture							**Risk Assurance Rating**	Exec Board RAG Rating EWB on 19/7/16		
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x4=16	4x4=16	4x4=16									
Target risk rating (I x L):	4x2=8											

Controls: (preventive, corrective, directive, detective)	Assurance on effectiveness of controls		Gaps in Control / Assurance
	Internal	**External**	
Freedom to speak up **Directive controls** UHL Whistle blowing policy Freedom to speak up internal policy Executive Quality Board Executive Workforce Board Quality Assurance Committee **Detective controls** No. of whistleblowing reported issues (via 3636 / gripe tool etc) Project plan with milestones for freedom to speak up Casework monitoring (investigations)	No. UHL Whistleblowing reported cases for reporting period: X		(c) No internal governance structure to comply with national recommendations. 11.1 (c) No local Guardian (Freedom to speak up). 11.2 (c) Lack of resources for project (funding for Guardian). 11.3

Action tracker:	Due date	Owner	Progress update:	Status
Governance structure to be developed for Freedom to speak up. 11.1	Sep-16	DoWD		4
Local Guardian to be appointed (Freedom to speak up). 11.2	Mar-17	DoWD		4
Consideration of resources and potential business case to deliver the plan. 11.3	Sep-16	DoWD		4

Board Assurance Framework:	Updated version as at:		Jun-16									
Principal risk 12:	Insufficient estates infrastructure capacity may adversely affect major estate transformation programme								**Risk owner:**		DEF	
Strategic objective:	A clinically sustainable configuration of services, operating from excellent facilities								**Objective owner:**		CFO	
Annual priorities	Complete and open Phase 1 of the new Emergency Floor Deliver our reconfiguration business cases for vascular and level 3 ICU (and dependent services)								**Risk Assurance Rating**		Exec Board RAG Rating = (Date: xx/xx/xx)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x4=16	4x4=16	4x4=16									
Target risk rating (I x L):	4X3=12											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls UHL reconfiguration programme governance structure aligned to BCT Reconfiguration investment programme demands linked to current infrastructure. Estates work stream to support reconfiguration established Five year capital plan and individual capital business cases identified to support reconfiguration Property / Space Management - clinical and non clinical schedules in place **Detective Controls** Survey to identify high risk elements of engineering and building infrastructure. Monthly report to Capital Investment Monitoring committee to track progress against capital backlog and capital projects Regular reports to Executive Performance Board (EPB). Highlight reports developed monthly and reported to the UHL Reconfiguration Programme Board.	Major Capital - On track against revised schedule Annual programme - On track against revised schedule	Eric data Lord Carter review and recommendations Capita report	(c) A programme of infrastructure improvements is currently being identified (12.1) (c) Overall programme of works not yet identified and quantified in relation to risk (12.2)

Action tracker:	Due date	Owner	Progress update:	Status
Assessment of current capacity being established through a set of comprehensive technical/engineering site surveys for GGH and LRI (12.1)	~~01/06/2016~~ Jul-16	DEF	Surveys are nearing completion with report due by end of May 2016; ESB update July 2016. The draft report for GH has been received and is being reviewed by the estates capital team. The LRI report is due this month but it is now known that there is insufficient electrical data to fully inform the electrical review. This will impact upon the second stage report covering where do we want to be and how do we get there. See remedial action below.	3
Identification of investment required and allocation of capital funding to develop a programme of works (12.2)	TBA	DEF	Prioritisation of backlog capital once 2016/17 annual capital resources confirmed by IFPIC. Phasing options to be included with further programme to be developed once capital availability is confirmed. This date is now at risk. A revised timeline will be presented after the gap analysis	3
Remedial action. The estates capital team are currently carrying out a gap analysis. This will review each service, identifying gaps in information available, the impact of the lack of data on the validity of the second stage report and the cost benefit of acquiring the relevant data. Information relating to this will be included in the July update to ESB (12.2)	Jul-16	DEF		3
Capital plan C includes an allocation of £1.5m which will support the immediate	Jul-16	DEF	Capital availability will be clear end of Q1	4

Board Assurance Framework:	Updated version as at:	Jun-16										
Principal risk 13:	Limited capital envelope to deliver the reconfigured estate which is required to meet the Trust's revenue obligations								**Risk owner:**		CFO	
Strategic objective:	A clinically sustainable configuration of services, operating from excellent facilities								**Objective owner:**		CFO	
Annual priorities	Develop outline business cases for our integrated Children's Hospital, progress with the clinical scoping of other projects e.g. Women's Services and planned ambulatory care hub, theatres, beds and long term ICU								**Risk Assurance Rating**		Exec Board RAG Rating = (Date: xx/xx/xx)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x5=20	4x4=16	4x3=12									
Target risk rating (I x L):	4x2=8											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls/Preventive Controls Five year capital plan and individual capital business cases identified to support reconfiguration Business case development is overseen by the strategy directorate and business case project boards manage and monitor individual schemes. Capital plan and overarching programme for reconfiguration is regularly reviewed by the executive team. **Detective Controls** Capital Investment Monitoring Committee to monitor the programme of capital expenditure and early warning to issues. Monthly reports to ESB and IFPIC on progress	Capital expenditure and progress against reconfiguration programme monitored via Capital Investment committee ESB/ IFPIC/ TB. On track against revised schedule. Resource expenditure for development of business cases - on track/ monitored on a monthly basis Affordability of business cases (i.e. schemes within allocated budget envelope) - on track against revised programme. Individual projects capital expenditure monitored via highlight report which are reviewed by the Major Business Case meeting	UHL's Annual Operating Plan, as submitted to NHS Improvement, includes capital requirements for 2016/17 strategic programme (awaiting feedback). Monthly meetings with NHSI ensures Trust's capital priorities are clearly identified and known. Formal communication with Regional Director at NHSE and NHSI regarding the strategic capital requirements linked to BCT. LLR BCT (and now STP) include the external capital values as part of the system wide case for change	c) Limited capital funding within 2016/17 programme and future years (13.1 and 13.2) (c) ITU interim configuration has been delayed due to capital availability, this will not be confirmed until Q2 2016/17. Capital plan D has been developed which allows for the development of additional ward capacity at GH for HPB which is now necessary before the ICU interim move. Development of ICU construction will commence at the back end of 2016/17. In addition to capital

Monthly reports to LSB and IFPIC on progress of reconfiguration capital programme. Highlight reports produced for each project board. **Corrective Control** Revised programme timescale approved by IFPIC	reviewed by the Major Business Case meeting and Reconfiguration Board.	for change.	2016/17. In addition to capital there are risks to Trust capacity that may delay move further. Interim measures have been put in place to manage risks in short-term, these arrangements need to be reviewed if any further delays (13.3) (c) Clinical, financial and estates engagement to identify and evaluate alternate configuration options that may retain clinical sustainability but reduce capital

Action tracker:	Due date	Owner	Progress update:	Status
Consideration to be given to alternative sources of funding. (13.1)	~~01/06/2016~~ August 16	CFO	Exploratory discussions with expert PF2 advisors (Deloitte) regarding which capital schemes could potentially be suitable. Meeting with PFU in May 2016, options still being	3
Maintain dialogue with NHSI and NHSE regarding the pressing need for external capital to facilitate strategic change (13.2)	~~01/06/2016~~ August 16	CEO/CFO	Alongside recent correspondence and discussion regarding BCT and its capital requirements, the LLR STP represents a further opportunity to formalise and emphasise the requirement.	3
Capital plan C has identified best way to prioritise / progress all reconfiguration projects within a reduced funding allocation (13.3)	~~01/07/2016~~ Aug-16	CFO	Capital availability still unknown - it is hoped that this will be clear at the beginning of Q2. Informal discussions have been positive. Programme planning assumes availability from 01 September 16.	3
Clinical engagement and validation sessions of estate configuration scenarios planned for 6th and 28th July. (13.4)	Aug-16	CFO	Not due yet	4

Board Assurance Framework:	Updated version as at:		Jun-16									
Principal risk 14:	Failure to deliver clinically sustainable configuration of services								**Risk owner:**		CFO	
Strategic objective:	A clinically sustainable configuration of services, operating from excellent facilities								**Objective owner:**		CFO	
Annual priorities	Develop new models of care that will support the development of our services and our reconfiguration plan								**Risk Assurance Rating**		Exec Board RAG Rating = (Date: xx/xx/xx)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x5=20	4x5=20	4x5=20									
Target risk rating (I x L):	4x2=8											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls UHL reconfiguration programme governance structure aligned to BCT Strategic capital business case work streams aligned to BCT Monthly meetings with the NHSI to identify new business cases coming up for approval Detailed programme plan identifying key milestones for delivery of the capital plan. Project plans and resources identified against each project. A future operating model at speciality level which supports a two acute site footprint: Out of hospital contract approved and project established to shift appropriate activity into	Progress of all reconfiguration programme work streams is monitored via aggregated reporting to ESB/ IFPIC/ TB. Monthly updates via aggregated reporting (highlight reports) to ESB/ IFPIC/ TB. Overall reconfiguration programme is RAG rated. Currently reported as 'amber 'due to complexity of programme and risks associated with delivery.	Regular meetings with NHSI NHS England BCT Programme Board Gateway / Assurance review carried out Feb - 16	(c) Agreed that current capacity and demand management / left shift assumptions of a reduction in 462 beds which determines future size and configuration of services is very challenging, but will be modelled in the STP. (14.1) (a) Detailed bed capacity model/assumptions being reviewed as part of the BCT programme (14.2). (c)Development of plan for all services at the LGH to determine

established to shift appropriate activity into the community. **Detective Controls** Gateway / Assurance review A monthly highlight report to indicate RAG rating of reconfiguration programme submitted to the UHL Reconfiguration Programme Delivery Board. Monthly aggregate reporting to ESB, IFPIC and Trust Board. Monthly meetings with the NTDA to discuss the programme of delivery Monitoring of progress towards UHL two acute site model Monitoring of business case timescales for delivery. Requirements identified to deliver key projects overseen by PMO			services at the LGH to determine the gap in the current capital plan (14.3) (Roadmap exercise) (c) Delay in BCT public consultation - being managed by response to NHS Assurance panel (14.4)

Action tracker:	Due date	Owner	Progress update:	Status
Demand and capacity issue being fully modelled and then considered by BCT Delivery Board on June 13th. Conclusions need to feed into NHSE led assurance process in advance of public consultation and reconfiguration. Internal work with estates, clinical, finance and workforce teams continues throughout June and July to support implementation when plans are agreed. (14.1, 14.2, 14.3, 14.4)	~~01/06/2016~~ July 16	COO / CFO	STP will show the full reduction of beds of 400. This means that it has not addressed the initial risk and part of rationale for revisiting demand and capacity assumptions. Therefore an internal focus on delivery and building organisational confidence is required. Phase 1 of estates update of the estates strategy is complete showing no reduction in beds to give a possible range of scenarios, and now needs updating to reflect the STP once split of beds by specialty known. Workshop with CMGs on possible mitigations to reduce the capital impact to be held 6th July, will include discussion on clinical strategy and site locations in order to inform discussions around the STP . Phase 2 of the detailed estates strategy to be undertaken thereafter; showing moves by site location and programme. Estates strategy and Development Control	2

Board Assurance Framework:	Updated version as at:	Jun-16										
Principal risk 15:	Failure to deliver the 2016/17 programme of services reviews, a key component of service-line management (SLM)								**Risk owner:**		CFO	
Strategic objective:	A financially sustainable NHS Organisation								**Objective owner:**		CFO	
Annual priorities	Implement service line reporting through the programme of service reviews to ensure the on-going viability of our clinical services Deliver operational productivity and efficiency improvements in line with the Carter Report								**Risk Assurance Rating**		Exec Board RAG Rating = (Date: xx/xx/xx)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3x3=9	3x3=9	3x3=9									
Target risk rating (I x L):	3x2=6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls Governance arrangements established Overarching project plan for service reviews developed New structure / methodology agreed for capturing outputs in a consistent way, aligned to the IHI Triple Aim and UHL way New virtual team structure to support the intensive service reviews. Steering Group in place to monitor and provide assurance regarding the service review programme (all levels i.e. standard, enhance and intensive). **Detective Controls** SLM / Service Review Data Packs now to include a range of metrics, beyond finance Monthly updates required from services against pre-determined work programme. Measureable outcomes now embedded into the process via improved methodology - Where relevant, schemes with a financial benefit are added to the CIP Tracker	Regular update reports to ESB, EPB and IFPIC. Previous programme suspended. New programme being developed as agreed through ESB. Individual service reviews will report through to the Steering Group and the Steering Group will provide quarterly updates to ESB.	Internal Audit (PWC) October 2015 - Service Line Reporting	(c) BI capacity is (at times) limited which impacts on Data Pack production (15.1) (c) Clinical engagement can be variable (as is clinical capacity to get involved) (15.2) (c) Improvement tools / change management techniques are under development with the UHL Way better change Team (15.3) (a) Assurance that resources are placed with the services who need them the most (15.4)

Action tracker:	Due date	Owner	Progress update:	Status
Revised Data Pack being scoped for discussion with BI leads. (15.1)	~~01/06/2016~~ TBA	CFO	A sample data pack was circulated to the steering group on 11.5.16. Expert members to consider data for appropriateness. Steering Group suspended following instruction from ESB	3
Clinical engagement can be variable (as is clinical capacity to get involved) (15.2)	Jun-16	CFO	**Complete.** Time resources needed with clinicians has been reduced by amalgamating work streams together.	5
Improvement tools (for use by clinical services) to be finalised (15.3)	Jun-16	CFO	**Complete.** Improvement tools and templates agreed with Better Change Team.	5
Assurance that resources are placed with the services who need them the most (15.4)	~~01/06/2016~~ TBA	CFO	The plan involves: Stratification of services to determine the level of input required (Intensive, Standard and Enhanced). The priority order of services to be completed are dependant on their positioning in the Stratification matrix. This information will then be developed into a programme plan. The stratification matrix has been simplified by the Steering Group. Revised measures have been agreed and the data is being collected for the next steering group 22.6.16. Roll out paused	3

Board Assurance Framework:	Updated version as at:	Jun-16										
Principal risk 16:	The Demand/Capacity gap if unresolved may cause a failure to achieve UHL deficit control total in 2016/17								**Risk owner:**		CFO	
Strategic objective:	A financially sustainable NHS organisation								**Objective owner:**		CFO	
Annual priorities	Reduce our deficit in line with our 5-Year Plan Reduce our agency spend to the national cash target								**Risk Assurance Rating**		Exec Board RAG Rating = (Date: xx/xx/xx)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	5x3=15	5x3=15	5x3=15									
Target risk rating (I x L):	5x2=10											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls Agreed Financial Plan for 2016/17 (AOP) Standing Financial Instructions UHL Service and Financial strategy as per SOC and LTFM. **Preventative Controls** Sign-off and agreement of contracts with CCGs and NHS England CIP delivery plan for 2016/17 **Detective Controls** Monthly finance reporting in relation to income and expenditure and CIP Monthly performance reporting in relation to STF performance trajectories **Corrective Controls**	Contracts signed with both main commissioners. Robust internal process to set the financial plan for 2016/17 as agreed by IFPIC and TB. Favourable variance to plan of £20k at M3 with a year end forecast in-line with the revised I&E plan of a deficit of £31.7m (excluding STF). STF Funding of £5.9m recognised at M3 in line with STF rules. CIP within the year to date position has over-delivered against the plan of £6.4m by £1.1m.	Regular review of financial plan by NHS Improvement. Quarterly submission to NHS Improvement of STF Performance.	At the start of the 2016/17 year, there is unidentified/ invalidated CIP. (16.1)

Identification and mitigation of excess cost pressures Planned reduction in agency spend	The detailed position will be reviewed by the Executive Performance Board monthly Integrated Finance, Performance & Investment Committee and Trust Board monthly Run rates to achieve £31.7m in each area (pay, non-pay, CIP and income) updated for month 3 and reported to Committees/Trust Board alongside the financial and performance requirements to secure STF funding of £23.4m		

Reasonable assurance rating that risk is being managed:	Due date	Owner	Progress update:	Status
CIP gap needs to be resolved. (16.1)	Jun-16	COO	**Complete.** The CIP gap identified at the start of the year has been closed.	5
Outstanding cost pressure list (i.e. any remaining items from budget/contract setting exercise) requires final decisions to be made by CEO and Executive Team.	~~01/05/2016~~ ~~Jun-16~~ Jul -16	CFO	Initial meeting has taken place. Further refinement has been completed with the final options appraisal paper being considered by the Executive Directors. Conclusion to be reached by end of July 2016.	3

Board Assurance Framework:	Updated version as at:	Jun-16										
Principal risk 17:	Failure to achieve a revised and approved 5 year financial strategy								**Risk owner:**	CFO		
Strategic objective:	A financially sustainable NHS organisation								**Objective owner:**	CFO		
Annual priorities	Reduce our deficit in line with our 5-Year Plan Reduce our agency spend to the national cash target								**Risk Assurance Rating**	Exec Board RAG Rating = (Date: xx/xx/xx)		
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	5x3=15	5x3=15	5x3=15									
Target risk rating (I x L):	5x2=10											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls Overall strategic direction of travel defined through Better Care Together. Financial Strategy fully modelled and understood by all parties locally and nationally. UHL's working capital strategy in place. 2016/17 financial plan in place and monitored appropriately **Detective Controls** Monthly monitoring of performance against financial plan. IFPIC and TB receive half yearly updates in relation to financial strategy and LTFM **Corrective controls** Explore options for other (non-NHS) sources of capital funding	Monthly reporting against 2016/17 plan. - As at M2 the Trust is £172k favourable to plan. Half yearly review of LTFM to ensure fitness for purpose i.e. checking consistency with UHL's strategy and ensuring we have a deliverable recovery plan over the medium term. Strong links to overall BCT 5 year strategy and the financial consequences (revenue and capital) of the transformational business cases	NHS England and NTDA review of: BCT SOC BCT PCBC Financial strategy LTFM System-wide five-year 'place-based' sustainability and transformation plan (STP) Individual business cases above a certain level	(c)LTFM not yet formally approved (17.1) (c)SOC not yet formally approved (17.2) (c)STP still in production (17.3) (c) Currently seeking authority to proceed with public consultation

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
As per the annual work plan for IFPIC, UHL's LTFM and therefore its financial strategy is being refreshed. (17.1, 17.2)	~~01/06/2016~~ Aug-16	CFO	The LTFM is in the process of being updated in line with the STP submission.	3
UHL's financial strategy including the finalisation of the 2016/17 plan needs to be incorporated into the LLR STP financial model. (17.3)	Jun-16	CFO	**Complete. S**ubmitted as part of the STP submission at the end of June.	5

Board Assurance Framework:	Updated version as at:	Jun-16										
Principal risk 18:	Delay to the approvals for the EPR programme								**Risk owner:**		CIO	
Strategic objective:	Enabled by excellent IM&T								**Objective owner:**		CIO	
Annual priorities	Conclude the EPR business case and start implementation								**Risk Assurance Rating**		Exec Board RAG Rating (21/7/16)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4 x 4 = 16	4x4=16	4x4=16									
Target risk rating (I x L):	3 x 2 = 6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls Regular communications with key contacts throughout the external approvals chain. IM&T Programme Board. EPR programme Board and the joint Governance Board. **Detective Controls** Weekly meeting to discuss progress and issues with IBM and separately with NHSI **Corrective Controls** Plan B to provide a paperlite solution for the new EF Build has been approved Works that support the EPR project but could be used for an alternative, have been completed	Internal and external meetings about the FBC are being undertaken. Until National TDA approval is given we can't engage with our key partners to implement the system, however we continue to work to mitigate the impact of the delay. Upgrades are now taking place on our major IT systems including Clinicom, ORMIS and planning for EDIS to ensure they can be supported for a longer period prior to replacement by EPR or alternative.	Internal audit review of implementation of gateway actions following review of EPR implementation in Q3 2015/16. HSCIC have completed a health check review on the EPR Project in March 2016. Rated as amber/green and action plan in place in response to recommendations	(c)The NTDA have been unable to meet their timetable. This is due to the nationally deteriorating position around capital and is outside of the control of UHL (18.1).

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**

Progress work with NTDA/DoH to progress a firm timetable (18.1)	Review Jun-16	CIO	The business case was not added to the NTDA National Investment Committee for approval on the 10/03/16 due to issues with the capital resource limit (CRL). Further work is required on the financial model. The NTDA are supportive of the business case for EPR however due to financial constraints and capital limits the case currently exceeds the acceptable CRL and has not been forwarded onto the National Investment Committee for approval. Deadline extended to reflect this. Plans to upgrade our core systems to ensure services can be maintained are underway. This is likely to cost around £1m in the short term for software & hardware plus IT and organisational time and effort to implement over 6 month period.	2

Board Assurance Framework:	Updated version as at:	Jun-16										
Principal risk 19:	Lack of alignment of IM&T priorities to UHL priorities								**Risk owner:**		CIO	
Strategic objective:	Enabled by excellent IM&T								**Objective owner:**		CIO	
Annual priorities	Improve access to and integration of our IT systems								**Risk Assurance Rating**		Exec Board RAG Rating (21/7/16)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3 x 4 = 12	3x4=12	3x4=12									
Target risk rating (I x L):	3 x 2 = 6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls Prioritisation Group meets monthly. Standard operating procedure for bringing and authorising new work tasks. Progress updates reported to Executive IM&T board quarterly. UHL IM&T Governance Structure. **Detective Controls** Prioritisation matrix to define projects. Service Level Agreements. Weekly and monthly meetings to discuss issues and monitor progress.	Weekly reporting within IM&T Monthly Prioritisation meetings Reports to Executive IM&T board	Internal audit review (15/16) of UHL IM&T service delivery reporting methods and quality	(c) No link to UHL Operations directorate within the Prioritisation Group (19.1)

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
UHL COO to chair the Prioritisation Group on a quarterly basis (19.1)	Jun-16	CIO	**Complete**	5

Reasonable assurance rating:

Green	G	Effective controls in place and satisfactory outcomes of assurance received.
Amber	A	Effective controls thought to be in place but outcomes of assurances are uncertain / insufficient.
Red	R	Effective controls may not be in place and outcomes assurances are not available to the Board.

Risk rating criteria:

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%)

Action tracker status:

5	Complete
4	On-track
3	Some delay. Expected to be completed as planned
2	Significant delay. Unlikely to be completed as planned.
1	Not yet commenced.
0	Objective revised.

BAF Risk Rating Matrix:

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	Div/Exec Director	Strategic risk No.
2670	RRCV		There is a risk to the Immunology & Allergy Services due to a Consultant Vacancy	10/05/2015	31/07/2016	Causes Delayed recruitment to vacant post 2nd allergy consultant resigning leaving a gap in food allergy expertise This service is dependent on nursing support to assist with immunology therapies, skin prick and challenge tests. Band 6 vacancies only recently appointed and require extended training to confirm competence Band 7 Nurse Specialist for Asthma Immunology & Allergy vacancy There is a planned waiting list with a backlog of patients There is a back log of New and Follow up patients referrals Patients who are already been given appointments but not yet been seen who have had a subsequent hospital admission for anaphylaxis requiring adrenaline. Delay of patients receiving specific diagnosis and avoidance advice. Loss of income and activity Potential 52 week breaches adverse impact on timely review of the Immunology and Allergy patients. adverse impact on the appointment capacity , facilities available and nursing support. Immunology Specialist Nurse vacancy will impact on Services whilst recruitment is completed The speciality service requirements will increase the difficulty of replacing with a 'like for like' replacement. There will be a financial impact on the service The service will potentially require two posts one to maintain the Immunology service and one for the Allergy Risk to the patients who has an allergy condition which is are high priority condition Risk to service continuity	HR	Weekly Access Meeting (WAM) attendance for support and completion of actions. Review of patient referrals to identify the high risk patients and complete a trajectory plan. Advice and actions being agreed with the Head of Performance and Operations to ensure all patients waiting for sequential procedures have been identified and are allocated to the appropriate patient waiting list. Continued monitoring of these patient waiting list at Respiratory RTT meetings and escalation of concerns. To standardise referral and waiting list procedure to ensure all patients are recorded on the correct patient waiting list. Completion of Business Case and Risk Assessment to recruit an Allergy Consultant for the service. Respiratory Physicians to help maintain current and future Allergy Service. Route to Recruit and advert to be authorised ASAP to cover allergy gap(s). Further discussions of future model of Allergy and Immunology and identifying possible support from Consultant Dietitian.	Major	Almost certain	20	Incorporate regular meetings with Allergy Consultant to ensure monitoring of the patient backlog. - complete General Manager to attend weekly MDT sessions - complete Monitoring of patient backlog at Respiratory RTT meetings - complete Escalation of concerns to Head of Operations/Director of Performance - complete Appoint a 1WTE Allergy Consultant - 31.12.16 Standardise referral and patient waiting list procedure - IFPIC approved - complete Regular meetings with Senior Management, Head of Performance and Allergy Team to continue to monitor patient backlog and work through solutions. 30.12.16 Monitoring of patient backlog at Respiratory RTT meetings - 31.3.17 Escalation of concerns to Head of Operations/Director of Performance - 31.3.17 Appoint a 2 WTE Allergy Consultant - 31.12.16 Repiratory Physicians with allergy expertise to temporarily change job plans to support the allergy service and enable patient appointments to be booked – for a 6 month period - 31.12.16	6	SM		

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Div/Exec Director	Strategic risk No.
2870	RRCV		Audit of DNACPR form have shown that the discussion with the patient or family is not consistently recorded	27/06/2016	31/07/2016	Causes The DNACPR audit undertaken has shown that there is some poor documentation on the form and not fully compliant with the UHL DNACPR policy, which states specifically: All discussion around DNACPR decisions must be documented. If DNACPR decision is made, and there has been no discussion with the individual because the doctor considers that consultation would be distressful and such distress could cause physical or psychological harm, this must be documented in the clinical record. Any DNACPR decisions not made by either Consultant or Associate Specialist are verified within 24 hours. The date for review or no review required must be documented on the DNACPR form document rationale if no decision has taken place with patient and relative/carer. Consequences 1. Patients and relatives are not being informed according to Trust DNACPR policy. 2. Loss of confidence in the Consultant/Medical team/organisation 3. Litigation against trust 4. complaints	Quality	1. UHL DNACPR POLICY 2. Audit of policy	Major	Likely	16	Reminder email to inform all doctors by email of audit results and UHL guidance - 31.7.16 As above scheduled at 2 and 4 weeks, plus mention of re audit (see 5 below) - 19.7.16 Inform all ward nurses by cascase through ward sisters of audit results and UHL guidance - complete Schedule repeat audit - 1.8.16	2	EROBER		

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	Div/Exec Director	Strategic risk No.
2820	RRCV	CDU	Risk that a timely VTE risk assessment is not performed on admission to CDU meaning that subsequent actions are not undertaken	06/01/2016	31/07/2016	Causes of the risk: VTE risk assessment form not completed Lack of understanding or awareness of process to ensure VTE risk assessment form completed to the requirements of National Guidelines (http://guidance. nice.org.uk/CG92) Insufficient communication and reminders of process to relevant staff CDU Medical Clerking Proforma layout results in the VTE risk assessment being missed or delayed completion Consequences of the risk: Potential risk of patient developing VTE, resulting in prolonged length of stay and risk to health Financial loss to the CDU unit and UHL due to VTE risk assessment form not being recorded on patient centre and any Impact on delivery of monthly VTE target of 95% for UHL Impact on quality indicators and maintaining external standards and reputation	Patients	Interim solution to highlight the VTE risk assessment form on the CDU Medical Clerking proforma with a bold red/white sticker. Raise awareness at Junior Doctor Local Induction training. Close monitoring of the monthly VTE target with support from VTE nurse specialist. Complete ‘spot check’ audit at least once a month - complete	Major	Likely	16	Circulate information and reminder to all medical staff of the process and requirement to complete VTE. Including details of the interim solution to use the bold red/white sticker - complete Complete ‘spot check’ audit at least once a month - complete Escalation of concerns to Quality and Safety Board and other appropriate personnel - complete Review current CDU Medical Clerking proforma and agree changes through correct Trust procedures to ensure the VTE risk assessment form is prominent (12 months of old stock) - 1.10.16. Update Local Induction Documents for Junior Drs to ensure information is correct and clear VTE risk assessment document completed - complete	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	Div/Exec Director	Strategic risk No.
2391	Women's and Children's		There is a risk of inadequate numbers of Junior Doctors to support the clinical services within Gynaecology & Obstetrics	24/06/2014	31/08/2016	Causes: Currently there are not enough Junior Doctors on the rota to provide adequate clinical cover and service commitments within the specialties of Gynaecology & Obstetrics. Consequences: Impact on key objectives and delivery of service. Potential to lose Junior Drs training within the CMG. Reduced training opportunities and inconsistencies in placements. On call rota gaps/ Increased requirement for locums to fill gaps. Possibility for LETB to remove training accreditation within obstetrics and gynaecology. This will lead to the removal of training posts. Potential for mismanagement / delay in patients treatment/pathway.	Patients	Locums used where available. Specialist Nurses being used to cover the services where possible and appropriate. Update 17/2/16 All antenatal clinics have a Consultant Lead present Rota accomodated to address specific training needs of juniors Rota reviewed and monitored on a daily basis by Dr representative Consultants act down if required	Major	Likely	16	Recruitment of x2 wte NPI's overseas Drs via RCOG - due 31/8/16	8	CWIESE		

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	Div/Exec Director	Strategic risk No.
2878	Operations		There is a risk of cancer patients not being discussed at MDTs due to inadequate video conferencing facilities	27/06/2016	31/07/2016	Causes: Video conferencing facilities for cancer MDTs were 'upgraded' in April / May 2016 in Osborne seminar room and Glenfield Radiology rooms. The planning and installation of this project has not been managed and executed in a succinct way. There was no defined project plan with no clear ownership of the key elements of the project between IM&T / Imaging and the Cancer centre and third party technical companies. This has resulted in an unstable technical environment in the Osborne seminar room, with numerous and irregular faults in the new system. Consequences: No specific incidents of harm have yet been reported (as of May 2016), but there is considered to be a high risk of clinical error where the discussion of cancer patients is interrupted or omitted because of technical faults, such as loss of the ability to share and view radiology images between hospital sites , both uhl and other Trusts. The impact could be: Patient harm, wrong clinical decisions made. Patient harm, delay to decisions being made if clinical discussion is delayed. Organisational reputation, MDTS involve other organisations, poor video conferencing meeting experiences will reflect badly on UHL. Targets, delays to clinical discussion may impact on patient pathways re 62 day performance.	Patients	MDT clinicians make a case by case judgement on the day about whether cases can be discussed via the video conferencing system. Use of telephone conferencing as a back up facility	Major	Likely	16	Lock down of Osborne LRI and GH seminar room new kit to stop alterations happening - 31/07/16 Ongoing fault finding / responding to issues with LGH and Windsor rooms until new kit installed - 31/07/16 Agree and sign off support package with 3rd party supplier - 31/07/16	4	CCA		

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	Div/Exec Director	Strategic risk No.
2872	RRCV		There is a risk of bedded bariatric patients being trapped compromising fire evacuation on ward 15 at GGH	27/06/2016	31/07/2016	**Causes** The two final exit doors to fresh air do not have sufficient exit width in order to facilitate the movement of bedded bariatric patients. Also there is a gradient on both escape routes. There must not be excessive gradients on escape routes which would prevent the free and controlled movement of the bariatric patients on beds/trolleys/wheelchairs. The gradients on the two escape routes from the final exits to fresh air will be difficult to overcome as Ward 15 is located at lower ground floor level. If bedded bariatric patients cannot use the two final exit doors they will need to be evacuated via the lift provided which is located in the means of escape outside the Ward; however this lift does not meet the appropriate standard to be used as an evacuation or fire fighting lift. Due to the nature of the patients (Respiratory), evacuating them directly to fresh air is not an ideal method of evacuation; the majority of the patients may also be bedded. It is important that the impact of evacuating respiratory patients directly to fresh air, taking into account all weather conditions, is assessed for suitability in regards to clinical needs. The Ward is currently used for up to 30 Respiratory patients and can accommodate a maximum of three bariatric patients at any one time. **Consequences** Bedded bariatric patients not being evacuated to a place of safety in a fire situation. Injury to staff during attempted evacuation – smoke inhalation, manual handling. Gross failure of patient / staff safety if findings not acted on. Critical report from Fire Service (main inspecting body) and other inspectorate bodies. Non-compliance with statutory requirements in the RR Fire Safety Order. Adverse publicity and media coverage.	Injury - staff, others	Early warning fire detection system fitted (L1). The Ward is designed as a one hour fire compartment divided into four 30 minute sub-compartments; allowing a progressive horizontal phase evacuation within the Ward area. Staff awareness of the risk and staff attend annual fire safety training Fire evacuation plans in place for the Ward to include transfer of bedded bariatric patients to chairs where possible. LFRS Western Fire Brigade aware and have this included in their action cards when attending Glenfield site.	Extreme	Possible	15	Estates to provide quote to upgrade lift to a suitable dedicated evacuation lift to move bedded bariatric patients from the area - 30.7.16 Estates to provide quote to install a new fire escape in bay 2 - 30.7.16 Fire evacuation plan for Ward 15 at GGH to be communicated to Switchboard and fire response team to ensure appropriate action and response to an alarm. - 30.6.16 Personal evacuation plans to be prepared for bedded bariatric and other high risk patients - 30.6.16 Ward staff to perform practical Fire Evacuation training with the Fire Officer - 31.8.16 Fire Warden training to be completed by at least 2 members of staff and to ensure monthly fire safety checks are completed. - 31.7.16	6	SM		