TRUST BOARD: RISK MANAGEMENT INFORMATION PACK

Author: Corporate Risk Team Trust Board Date: Thursday 4th February 2016 INFORMATION PACK

Executive Summary

Context

It is important that the Trust Board (TB) is sighted to the significant risks within the organisation and their mitigating controls. This information is provided on a monthly basis via the Board Assurance Framework (BAF) and an excerpt from the UHL risk register showing all risks rated extreme and high. The BAF is the key source of evidence that links strategic objectives to risks, controls and assurances, and the main tool that the will be used in seeking assurance that those internal control mechanisms are effective. The BAF and risk register discussion is captured in the Chief Executive's TB paper. This paper includes the full detail of the BAF (appendix 1) and risk register (appendix 2) as part of an information pack.

Questions

1. Does the BAF provide an accurate reflection of the principal risks to our strategic objectives?
2. Is sufficient assurance provided that the principal risks are being effectively controlled?
3. Have agreed actions been completed within the specified target dates?
4. Does the TB have knowledge of new significant risks opened within the reporting period?
5. What are the key themes in relation to the extreme and high risks on the UHL risk register

Conclusion

1. Executive leads of each strategic objective have provided an accurate picture of our principal risks which may affect the achievement of our Trust plan.
2. 'Reasonable assurance' ratings flagged amber or red may benefit from more quantitative KPIs and /or further external scrutiny (e.g. via internal audit) to provide additional assurance that control measures are effective.
3. All actions have been completed within specified deadlines.
4. The TB is sighted to all new extreme and high risks on the UHL risk register during December by reference to the extract in the Chief Executive's Trust Board paper.
5. The majority of risks with a rating of 15 and above are related to workforce capacity and capability which, should they occur, might impact on patient safety, quality of services and operational targets.

Input Sought

We would welcome the Trust Board's input to:

(a) Receive and note this report;
(b) Consider and challenge any areas where they feel risks are not being adequately controlled.

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:

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

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

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

5. Scheduled date for the next paper on this topic: [03/03/16]

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

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

Board Assurance Dashboard:		December 2015								
Objective	**Risk No.**	**Risk Description**	**Owner**	**Current Risk Rating**	**Target Risk Rating**	**Risk Movement**	**Reasonable Assurance Rating**	**Board Committee for Assurance**		
								Comm	**Date**	
Safe, high quality, patient centred healthcare	1	Lack of progress in implementing UHL Quality Commitment (QC).	CN	9	6	⟷	G	EQB/QAC		
An effective and integrated emergency care system	2	Emergency attendance/ admissions increase	COO	25	6	⟷	A	EPB/TB		
Services which consistently meet national access standards	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	COO	16	6	↑	G	EPB/IFPIC		
Integrated care in partnership with others	4	Existing and new tertiary flows of patients not secured compromising UHL's future more specialised status.	DS	12	8	↓	A	ESB/TB		
	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	16	10	↑	R	ESB/TB		
Enhanced delivery in research, innovation and clinical education	6	Failure to retain BRU status.	MD	15	6	⟷	A	ESB/TB		
	7	Clinical service pressures and too few trainers meeting GMC criteria may mean we fail to provide consistently high standards of medical education.	MD	12	4	⟷	A	EWB/TB		
	8	Insufficient engagement of clinical services, investment and governance may cause failure to deliver the Genomic Medicine Centre project at UHL	MD	16	6	⟷	A	ESB/TB		
A caring, professional and engaged workforce	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	DWOD	16	8	⟷	G	EWB/TB		
A clinically sustainable configuration of services, operating from excellent facilities	11	Insufficient estates infrastructure capacity and the lack of capacity of the Estates team may adversely affect major estate transformation programme	DS	20	10	⟷	A	ESB/IFPIC		
	12	Limited capital envelope to deliver the reconfigured estate which is required to meet the Trust's revenue obligations	DS	20	8	⟷	G	ESB/IFPIC		
	13	Lack of robust assurance in relation to statutory compliance of the estate	DS	16	8	⟷	A	ESB/IFPIC		
	14	Failure to deliver clinically sustainable configuration of services	DS	16	8	↑	A	ESB/IFPIC		
A financially sustainable NHS Organisation	15	Failure to deliver the 2015/16 programme of services reviews, a key component of service-line management (SLM)	DS	9	6	⟷	G	EPB/IFPIC		
	16	Failure to deliver UHL's deficit control total in 2015/16	CFO	15	10	⟷	G	EPB/IFPIC		
	17	Failure to achieve a revised and approved 5 year financial strategy	CFO	15	10	⟷	G	EPB/IFPIC		
Enabled by excellent IM&T	18	Delay to the approvals for the EPR programme	CIO	16	6	⟷	A	IMT/IFPIC		
	19	Perception of IM&T delivery by IBM leads to a lack of confidence in the service	CIO	16	6	⟷	G	IMT/IFPIC		

Board Assurance Framework:	Updated version as at:		Dec-15									
Principal risk 1:	Lack of progress in implementing UHL Quality Commitment								**Risk owner:**		Chief Nurse (CN)	
Strategic objective:	Safe, high quality, patient centred healthcare								**Objective owner:**		CN	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9			
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 'National guidance for Friends and family test' Clinical pathways of care Corporate leads agreed for work streams of the Quality Commitment (QC). **Detective Controls** Quarterly patient safety report highlighting number of 'harms' moderate and above Work programme of Mortality Review Committee to identify SHMI (=/< 100 by Mar 2016). Reported to Mortality and Morbidity Committee and TB, QAC via Q&P report. Friends and Family score (target 97% by March 2016) reported monthly via Q&P report to TB and QAC Quarterly QC report to EQB to monitor achievement of key milestones	UHL SHMI Apr14 - Mar 15 reduced to 98 (from 99) Achievement of 5% reduction in moderate and above 'harms' in Quarter 2 2015/16 Inpatient (inc D/C) 'friends and family' score for December ('caring' KPI C1) = 97% (1% up on previous reporting period) Achievement of key milestones within QC work plans monitored by relevant trust level committee.	Delivery against CQUIN schedule as per contract 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 and there is a requirement to move to 100%. (1.2) (1.3), (1.5)

Assurance rating:	G	**Comments on assurance**	Good range of assurance sources. Performance against KPIs within thresholds.

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
Roll out plan to be developed (1.2)	Sep-15	MD	**Complete.** Process drafted and incorporated into policy. Being launched at M&M Lead's forum on 18th May.	5

Audit support to be provided (1.3)	~~Oct - 15~~ Review ~~Nov - 15~~ Jan - 16	MD	Funding approved. Recruitment into substantive roles dependant upon the vacancy controls panel outcome. Deadline extended to reflect expected dates for roles to be filled. 31.12.15 Post approved. Adverts placed and interview dates arranged for Jan 16.	4
Mortality database to be developed (1.5)	~~Oct - 15~~ Review ~~Nov - 15~~ Jan - 16	MD	Database scoping exercise being undertaken. Awaiting feedback from potential providers. Excel spread sheet database being used in the meantime. Further changes to database required following feedback from M and M leads and excel spread sheet continues to be used. 31.12.15 Database due to go live early Jan 16	4
Pilot Copelands Risk adjusted Barometer (CRAB)	Mar-16	MD		4

Board Assurance Framework:	Updated version as at:	Dec-15										
Principal risk 2:	Emergency attendance/ admissions increase								**Risk owner:**	Chief Operating Officer		
Strategic objective:	An effective and integrated emergency care system								**Objective owner:**	COO		
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x5=20	4x5=20	4x5=20	4x5=20	4x5=20	4x5 = 20	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. Urgent Care Centre (UCC) now managed by UHL from 31/10/15 Admissions avoidance directory **Detective Controls** Q&P report monitoring ED 4-hour waits, ambulance handover >30 mins and >60 mins, total attendances / admissions. Comparative ED performance summaries showing total attendances and admissions	**ED 4 hour wait performance (threshold 95%)** 85.1% (3.4% increase since previous report). 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)** Attendance + 7% Admissions + 4.5% **Ambulance handover (threshold 0 delays over 30 mins)** Difficulties continue in accessing beds from ED leading to congestion in the assessment area and delayed ambulance handover. >30 - <60 mins delay 23%, >60mins 16%, **Bed Occupancy.** Monitored daily but not formally reported	National benchmarking of emergency care data Urgent Care Board fortnightly dashboard.	(c) Effectiveness of admissions avoidance plan (2.1) Lack of winter surge capacity (2.1)

Assurance rating:	A	**Comments on assurance**	Acceptable number of internal assurance sources. Limited number of external assurance sources identified at present. Performance against a number of the KPIs is below threshold.

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
LLR plan to reduce admissions (including access to Primary Care) (2.1)	~~01/11/2015~~ Review Dec 16	COO	Admissions and attendance continue to increase	2

Board Assurance Framework:	Updated version as at:	Dec-15									
Principal risk 3	Failure to transfer elective activity into community, develop referral pathways, and changes to cancer providers may affect ability to meet access standards								Risk owner:	COO	
Strategic objective:	Services which consistently meet national access standards								Objective owner:	COO	
Current risk rating (I x L):	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	4x3=12	4x3=12	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** Medinet providing w/e lists Patients transferred to Circle and Nuffield Additional lists by UHL consultants	**RTT Incomplete waiting times (threshold 92%).** Currently 93% (0.8% decrease) RTT backlog currently 3400 (up from 3000) **Cancer Access Standards (reported quarterly).** Current performance based on Nov actual figures as Dec data not available **2 ww for urgent GP referral (Threshold 93%).** 92.4% **2 ww for symptomatic breast patients (threshold 93%).** 89.4% **31 day wait for 1st treatment (threshold 96%).** 95.5% **31 day wait for 2nd or subsequent treatments (Drugs - threshold 98%).** 100% (**Surgery - threshold 94%**). 76.6% **(Radiotherapy - threshold 94%)**. 95% **62 day wait for 1st treatment (threshold 85%).**	Internal audit review on breast screening and cancer performance standards due Q2 2015/16. Internal audit review in relation to waiting times for elective care due in quarter 4 2015/16. NHS IQ to externally review endoscopy Cancer and RTT Board monthly meetings with CCGs and NTDA. Monthly performance call with NTDA NHS Intensive Support team visit Aug 2015	(c) Have yet to implement tools and processes that allow us to improve our overall responsiveness through tactical planning (3.3) (c) Failure of diagnostic 6 week standard due to endoscopy overdue planned patients (3.5) (c) Emerging gap in ability to meet Gastro outpatient demand (c) Lack of progress on 62 day backlog reduction due to ITU/HDU capacity.

		82.5%. **62 day wait for 1st treatment (CSS referral-threshold 90%).** 96.2% **Cancer wait 104 days (threshold TBC).** 17 **Diagnostics**	Cancer plan to regional tri-partite Oct 2015		
Assurance rating:	G	**Comments on assurance**	Acceptable number of assurance sources however 5 out of 11 KPIs are below threshold		

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

Board Assurance Framework:	Updated version as at:	Dec-15										
Principal risk 4:	Existing and new tertiary flows of patients not secured compromising UHL's future more specialised status								**Risk owner:**		Director of Strategy (DS)	
Strategic objective:	Integrated care in partnership with others								**Objective owner:**		DS	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	5x3=15	5x3=15	5x3=15	5x3=15	5x3=15	5x3=15	5x3=15	5x3=15	4x3 = 12			
Target risk rating (I x L):	4 x 2 = 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. Bipartite Partnership Working Group UHL/NUH. Memorandum of Understanding (MoU) between NUH and UHL Tripartite Working Group UHL/NUH/ULHT. **Detective/Corrective Controls** UHL Tertiary Partnerships Board.	UHL Tertiary Partnerships Board reporting to ESB Monthly on achievements in the last month, looking forward and new partnership areas.	Inclusion in acute services contract. Compliance with national service specifications. Strategic Clinical Network/Senate reviews.	(c) Absence of Tertiary Partnerships Strategy (4.1). (c): Lack of MoU for a number of work-streams. (4.4) (a) Detailed work plan required for major areas (4.2). (a) Lack of reporting on return on investment e.g. income (4.3).

Assurance rating:	A	**Comments on assurance**	Few 'hard KPIs' (i.e. quantitive assurances) identified. Number of gaps assurance may present some challenges to the effective management of this risk

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
Tertiary Partnerships Strategy to ESB (4.1)	Dec-15	DS	**Complete.** Approved by Trust Board 7 January 2015.	5
Detailed work plan to Partnership Board.(4.2)	~~Dec 2015~~ Jan 2016	DS	Paper to ESB 12 January 2015	3

Begin reporting on return on investment (4.3)	~~Jan 2016~~ Apr 2016	DS	ROI for specific areas identified but reporting mechanism not established.	3
Develop MoUs for work streams (4.4)	Dec-16	JC	1st MoU to ESB in December 2015. MOU for SEMOC due ESB Feb 2015.	4

Board Assurance Framework:	Updated version as at:	Dec-15										
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 (tertiary and local services) Explore and pioneer new models of care. Failure to deliver integrated care.								**Risk owner:**		Director of Strategy (DS)	
Strategic objective:	Integrated care in partnership with others								**Objective owner:**		DS	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3x5=15	3x5=15	3x5=15	3x5=15	3x5=15	3x5=15	3x5=15	3x5=15	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 Robust - BCT and UHL/BCT project governance structure including programme management arrangements BCT Programme five year directional plan Two-year operational plan LLR BCT Strategic Outline Case LLR BCT Partnership Board UHL/BCT Reconfiguration Programme Board System wide project delivery structure and organisational specific delivery mechanisms LLR project delivery through LLR Implementation Group **Detective Controls** Progress updates to LLR BCT Partnership Board Monthly UHL/BCT Programme Board progress reports to ESB LLR wide performance monitoring report presented to Trust Board Monthly BCT progress report to Trust Board Monthly project specific highlight reports	Av length of stay (10% improvement in 15/16) Reduction in emergency admissions with a length of stay of 0-6 hours. Rapid access HF clinic attendances from ED and CDU. Integrated medicine (elderly) av length of stay 3day + emergency patients. Respiratory av length of stay 3day + emergency patients. Cardiology av length of stay 3day + emergency patients. Patient experience Satisfaction of people who use services with their care and support. Increase in virtual appointments. ED unplanned re-attendance rate. SHMI reduced to 98. Increased treatments in community setting. Enhanced out of hospital ICS bed capacity (130 beds by the end of March 2016). +32 in place as of 1/12/15 Target bed occupancy 90%. Current 88-90%.	Internal audit review in relation to governance structures around hosted services i.e. Elective Care Alliance due Q2 2015/16. Head of Local Partnerships sits on BCT Delivery Board - escalates as required.	(a)Lack of LLR wide BCT outcome dashboard required so that performance can be monitored (5.1) (c) No detailed plans for overall change management/organisational development .These will form the basis for the narrative for formal consultation. (5.3 &5.5) (c) Project plan for Frail Older Person Service not yet developed (5.4)

considered at UHL/BCT Programme Board Draft LLR wide performance dashboard presented to Trust Board for use by UHL. BCT Implementation Board has completed triangulation and assurance process across the 8 clinical work streams	Av length of stay (10 days). Current < 10 days. Emergency admissions Delayed Transfer of Care		

Assurance rating:	R	**Comments on assurance**	Large number of internal assurances now with thresholds identified, however currently not all have the current performance listed. Without this detail it is unclear as to whether we are on track with our objective

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
A BCT Programme Dashboard to be established and agreed with the BCT PMO. (5.1)	~~Nov - 15~~ ~~Dec 15~~ Mar - 16	DS	Initial draft presented to Partnership Board November 2015. Further development required including agreement on KPI's and thresholds. BCT PMO advise that It is unlikely that thresholds will be agreed before March 2016. Deadline extended to reflect this	3
BCT PMO to facilitate triangulation process (5.2)	Review Nov 15	DS	**Complete.** Assurance process for each work stream being progressed via the BCT Implementation Group. Action on-going	5
Plan for consultation including a governance roadmap to be completed. (5.3)	~~Oct 15~~ Review ~~Nov 15~~ ~~Dec 15~~ Feb 2016	DS	Further work completed on PCBC following NHS England feedback. PCBC scheduled to go to CCG boards in February. Meetings in place to discuss 'wicked issues' and impact on overall programme.	3
Integrated Frail Older Person Service project plan to be developed (5.4)	~~Oct 15~~ Review ~~Nov 15~~ ~~Dec - 15~~ Feb 2016	DS	Discussion on-going between UHL/LPT at chief executive level. Date for completion TBC Update will be chased.	3

OD and change plan - For inclusion in revised PCBC narrative and project plans (5.3)	~~Dec 2015~~ Feb 2016	DS	Revised narrative agreed through the LLR HR &OD group. Head of Local Partnerships and Assistant Director of OD have met and discussed how OD and the 'UHL way' can be embedded into current and future reconfiguration projects and/or BCT projects. This will be reflected in the development and management of project plans. Due Feb 16 and deadline amended to reflect this	4

Board Assurance Framework:	Updated version as at:		Dec-15									
Principal risk 6:	Failure to retain BRU status								**Risk owner:**		Medical Director (MD)	
Strategic objective:	Enhanced delivery in research, innovation and clinical education								**Objective owner:**		MD	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	5x3=15	5x3=15			
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 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 (6.3) (c) Weak support from academic partners (6.1) (c) Unsuccessful application for Athena Swan 'silver' from UoL Medical School(6.2)

Assurance rating:	A	**Comments on assurance**	Few 'hard KPIs' (i.e. quantitive assurances) identified to monitor the effectiveness of controls

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

Closer joint working with Universities to provide successful Athena Swan (6.2) application.	Review ~~Jan 2016~~ Mar 2016	MD	Respiratory BRU & cardiovascular BRU have submitted applications for Athena Swan - awaiting outcome (NIHR have agreed with Athena Swan that applications from universities intending to apply for BRC status will be expedited).	3
Develop new 4-way strategy meeting with UHL, UoL, LU and DMU (6.1)	Mar-16	MD		4
Closer joint working with Universities to develop application (6.3)	Review Feb 2016	MD	NIHR call for applications released. Changes to previous application process - differentation between BRC and BRU	3

Board Assurance Framework:	Updated version as at:		Dec-15									
Principal risk 7:	Too few trainers meeting GMC criteria means we fail to provide consistently high standards of medical education								**Risk owner:**		Medical Director (MD)	
Strategic objective:	Enhanced delivery in research, innovation and clinical education								**Objective owner:**		MD	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	3x4=12	3x4=12	3x4=12			
Target risk rating (I x L):	2 x 2 = 4											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls Medical Education Strategy Operational guidance **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 65% • CSI: o Imaging 89% o Pathology 38% • ESM 70% • ITAPS 79% • MSS 90% • RRCV 49% • W&C: o Women's 97% o Children's 56% University Deans report to show % of fully recognised medical trainers in UHL. (threshold 100%) by July 2016. Current position = 75% (down from 76% previous period) UHL trainee survey	HEEM accreditation visits. GMC trainee survey results	(c & a) Accuracy of database uncertain (7.1) (c) EWB and CMG scrutiny / challenge of Medical Education issues is weak (7.2)

Assurance rating:	A	**Comments on assurance**	Until the issues around the accuracy of the database can be resolved then full assurance cannot be provided and may present some challenges to the management of this risk

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

Ensure engagement with CMGs to embed Medical Education Dashboard to ensure more robust data (7.1)	Jun-16	S Carr	Ongoing 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.	4
Medical Director to 'champion' scrutiny of Medical Education Committee minutes at EWB (7.2)	Mar-16	MD		4

Board Assurance Framework:	Updated version as at:		Dec-15									
Principal risk 8:	Insufficient engagement of clinical services, investment and governance may cause failure to deliver the Genomic Medicine Centre project at UHL								**Risk owner:**		Medical Director (MD)	
Strategic objective:	Enhanced delivery in research, innovation and clinical education								**Objective owner:**		MD	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	4x3=12	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 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 approximately 50% below trajectory and this is continuing to deteriorate. 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 (8.1)

Assurance rating:	A	**Comments on assurance**	Consideration should be given as to whether the current assurance sources are adequate to monitor the effectiveness of controls

Action tracker:	Due date	Owner	Progress update:	Status
Lead nurse and team of Clinical Research Assistants to be appointed.	Dec-15	DRI	**Complete** - research Nurse and CRAs in post	5
Additional Research Nurse to be appointed	Feb-16	DRI		4

Board Assurance Framework:	Updated version as at:	CLOSED IN OCT 2015										
Principal risk 9:	Changes in senior management/ leaders in partner organisations may adversely affect relationships / partnerships with universities.								**Risk owner:**		Medical Director (MD)	
Strategic objective:	Enhanced delivery in research, innovation and clinical education								**Objective owner:**		MD	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3x2=6	3x2=6	3x2=6	3x2=6	3x2=6	3x2=6	3x2=6					
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**	
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) Nigel/ David - Upon further discussion we wonder whether this is a 'stand alone' risk or whether it is in fact a 'cause' (ie weak support from academic partners) that would impact on the achievement of retention of BRUs? yes - I think thats a good way of looking at it (Nigel Brunskill)	Minutes of joint UHL/UoL Strategy meetings Minutes of Joint BRU Board Minutes of NCSEM Management Board Meetings of Joint UHL/UoL research office Life steering group meets monthly EM CLAHRC Management Board reports via R&D Exec to ESB		(c) Contacts with Universities could be developed more closely (9.1)

Assurance rating:	TBA	**Comments on assurance**	

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
Develop new 4 way strategy meeting with UHL, UoL, LU and DMU (9.1)	Mar-16	MD		

Board Assurance Framework:	Updated version as at:	Dec-15										
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								**Risk owner:**			Director of Workforce and Organisational Development (DWOD)
Strategic objective:	A caring, professional and engaged workforce								**Objective owner:**			DWOD
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x4=15	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16			
Target risk rating (I x L):	4 x 2 = 8											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls Organisational development (OD) Plan Listening into Action (LiA) Workforce planning Leadership into Action Strategy Equality Action plan 'Freedom to Speak' standard BCT Strategy Medical Workforce strategy **Detective Controls** Organisational health dashboard Q&P report 3636 concerns hotline Junior Dr 'gripe tool' Patients Safety walkabouts UHL intranet 'staff room' Clinical Senate Monthly 'Breakfast with the Boss' forums	Organisational health dashboard and Q&P report including: Friends and family staff survey (% of staff who would recommend UHL as a place to work). Jul - Sept = 55.7% (qtrly report. Note Q3 not completed as national survey carried out) Turnover rate 10% (monthly report - threshold =/< 11). Sickness absence rate = 4% (monthly report- threshold 3%) Annual appraisal rate = 92.7 % (monthly report - threshold 95%) Stat/ Man training = 93% (monthly report - threshold 95%) Corporate induction attendance for Nov = 92% (monthly report - threshold 95%)	Internal audit review of medical staffing due Q3 2015/16. Internal audit review of recruitment and retention of staff due Q2 2015/16.	(a) No threshold in place for F&F staff survey (10.1) (c) BCT Workforce Strategy Delivery Plan (10.2) (c) Workforce Plan (10.3)

Assurance rating:	G	Comments on assurance	No threshold currently in place for F&F staff survey for UHL to monitor performance

Action tracker:	Due date	Owner	Progress update:	Status
Develop threshold for F&F staff survey. (10.1)	~~Dec 15~~ Mar 2016	DWOD	Organisation now to adopt new Pulse Check which incorporates staff F&F as agreed with CEO, UHL Way Steering Group and CCG colleagues (in meeting staff governance/ satisfaction criteria). New Pulse Check thresholds to be discussed with EWB in March 2016 on presentation of first data set	3
Development of Workforce Plan aligned to BCT (10.2)	Mar-16	DWOD	Addressing priorities workshop held in Oct 15	4
Development of BCT Workforce Strategy (10.3)	~~Dec 15~~ Mar 2016	DWOD	Submission delayed to March 16. Document produced as part of BCT Pre-consultation Business Case (on BCT Delivery Board Agenda for approval in Feb 16 with the plan to submit to NHS England in March 16)	3

Board Assurance Framework:	Updated version as at:	Dec-15										
Principal risk 11:	Insufficient estates infrastructure capacity and the lack of capacity of the Estates team may adversely affect major estate transformation programme								**Risk owner:**	Director of Strategy (DS)		
Strategic objective:	A clinically sustainable configuration of services, operating from excellent facilities								**Objective owner:**	DS		
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	5x4=20	5x4=20	5x4=20	5x4=20	5x4=20	5x4=20	5x4=20	5x4=20	5x4=20			
Target risk rating (I x L):	5 x 2 = 10											

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 **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. **Corrective Control** Revised programme timescale approved by IFPIC	Capital expenditure and progress against reconfiguration programme monitored via Capital Investment committee. Major Capital - On track against revised schedule Annual programme - On track against revised schedule Space Management - Behind schedule Property Management - Behind schedule		(c) A programme of infrastructure improvements is yet to be identified (11.1) (c) Overall programme of works not yet identified and quantified in relation to risk (11.2) c) Currently no identified capital funding within 2015/16 programme and future years (11.3) (c) Conflicting responsibilities/roles of the estates and facilities team between UHL and the LLR estate and Facilities Management Collaborative. (11.4)

Assurance rating:	A	Comments on assurance	There may be benefit in considering whether a summary of performance via a RAG rating could be developed in order to provide an overall level of assurance to the Board via the BAF.

Action tracker:	Due date	Owner	Progress update:	Status
Assessment of current capacity being established (11.1)	~~Jan 2016~~ Feb 2016	DEF	In progress - delays due to additional surveys being requited to be undertaken, no ditrect inpact on capital programme due to general slow down in Cpaital funding.	3
Develop a programme of works (11.2)	Mar-16	DEF	In Progress - detailed folowing output of 11.1	4
Identification of investment required and allocation of capital funding 11.3)	Mar-16	DEF/CFO	In Progress	4
Define resource and skills gaps and agree an enhanced team structure to support the significant reconfiguration programme (11.4)	Review ~~Nov 15~~ Feb 2016	DEF	PMO light support engaged and additional project managers recruited (fixed term) in relation to transformation projects however clarity is still required around the future enhanced status of Estates/ IFM teams	3

Board Assurance Framework:	Updated version as at:	Dec-15										
Principal risk 12:	Limited capital envelope to deliver the reconfigured estate which is required to meet the Trust's revenue obligations								**Risk owner:**		Director of Strategy (DS)	
Strategic objective:	A clinically sustainable configuration of services, operating from excellent facilities								**Objective owner:**		DS	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x3=12	4x3=12	4x3=12	4x3=12	4x3=12	4x3=12	4x3=12	4x5=20	4x5=20			
Target risk rating (I x L):	4 x 2 = 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 of reconfiguration capital programme. Highlight reports produced for each project board. **Corrective Control** Revised programme timescale approved by IFPIC	Timescales for business case development - there is some delay to original timescales for three business cases due to internal delay and also BTC consultation.Revised programme timescale taken to ESB and approved - will go to IFPIC 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 monitored via highlight report including project timelines which are reviewed by the Major Business Case meeting and Reconfiguration Board.	Regular meetings with NDTA ITFF NHS England BCT Programme Board	(c) Uncertain availability of external capital funding. (12.1) (c) 'road map' requires development to provide the full picture and deliverability of the programme of change (12.2)

Assurance rating:	G	Comments on assurance	Range of assurance sources in place

Action tracker:	Due date	Owner	Progress update:	Status
On-going discussions between Exec team and NTDA (12.1)	Review ~~Nov 15~~ ~~Dec 16~~ Feb 2016	DEF/DS/ CFO	National announcements indicate a slowing of available capital which may impact on the current delivery plan, so have rephased and approved through ESB. Capital threshold has been set as £327m P. Traynor continues discussions with TDA regarding cash flow. Will know more for 16/17 in March16	3
Consideration given to other sources of funding (12.1)	Review ~~Nov 15~~ Feb 16	DEF/DS/ CFO	Piece of work underway led by CFO to explore other sources. This is an on-going action and will be reviewed again in February 2016.	3
PMO holding estates workshop and followed by joint Estates and Strategy workshop to provide the full picture and deliverability of the programme of change (12.2)	~~Nov 15~~ Feb 16	DEF/DS	Workshops held and. LGH work stream established to progress activities to refresh the 'route map' - outputs expected in Feb16	4

Board Assurance Framework:	Updated version as at:		Dec-15									
Principal risk 13:	Lack of robust assurance in relation to statutory compliance of the estate								**Risk owner:**		Director of Estates	
Strategic objective:	A clinically sustainable configuration of services, operating from excellent facilities								**Objective owner:**		Director of Strategy (DS)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x3=12	4x3=12	4x3=12	4x3=12	4x3=12	4x3=12	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**	
Directive Controls LLR FMC Board Outsourced facilities management contract performance managed by the Estates and Facilities Management Collaborative **Preventive/ Corrective Controls** On-going major incident scenarios developed and played out to identify any deficiencies in data, process and systems **Detective controls** Monthly defined KPI's which monitor Interserve FM (IFM) are reported to Contract Management Panel Assurance on IFM performance monitored via ad-hoc spot checks and deep dive analysis and reported to Contract Management Panel	In excess of 70 KPIs across 14 services to monitor the IFM contract. UHL are reporting major concerns around performance and delivery of the IFM contract	PLACE inspection performed in March 2015 and PLACE inspections planned for March - June 2016 3rd party independent auditing.	a) Lack of electronic evidence by IFM on compliance (a) Limited contractual KPI's in certain areas of compliance. (a) Uncertainty around adequacy of IFM response to critical failures of service (13.2)

Assurance rating:	A	**Comments on assurance**	Inadequacies in IFM data collection via electronic means and appropriateness of KPIs may present a challenge to providing effective assurance of IFM performance.

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
To increase the number of manual audits (13.1)		DEF	**Complete.** Manual audits being carried out including deep dive spot checks	5
Major failure scenarios being set with IFM (13.2)		DEF	**Complete.** Annual programme of testing failure scenarios being implemented with IFM	5

Board Assurance Framework:	Updated version as at:	Dec-15									
Principal risk 14:	Failure to deliver clinically sustainable configuration of services								**Risk owner:**		Director of Strategy (DS)
Strategic objective:	A clinically sustainable configuration of services, operating from excellent facilities								**Objective owner:**		DS
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x3=12	4x3=12	4x3=12	4x3=12	4x3=12	4x3=x12	4x3=12	4x3=12	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**	
Directive Controls UHL reconfiguration programme governance structure aligned to BCT Strategic capital business case work streams aligned to BCT Monthly meetings with the NTDA 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 the community. **Detective Controls** 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	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 NTDA NHS England BCT Programme Board	(c) Lack of capacity within the NTDA to resource each of the business cases (a) Further work required, as part of future operating model, to look at the remaining acute services at the LGH to determine the gap in the current capital plan (14.1) (c) Delay in BCT public consultation (14.2) (a)No thresholds in place to provide an objective view of the RAG rating in relation to reconfiguration programme progress (14.3)

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 Monitor spend against agreed budgets.			

Assurance rating:	A	**Comments on assurance**	Currently no thresholds identified to provide objective RAG rating for reconfiguration programme progress

Action tracker:	Due date	Owner	Progress update:	Status
Completed site survey at LGH to be used to further develop route map/ sequencing of moves. Will overlay future operating model outputs to enable refresh of DCP by estates (14.1)	~~Nov 15~~ Feb 16	DS	GH work stream established to complete planning for refresh of the route map and more granular plan for release of the LGH. Route map not due till Feb16.therefore timescale amended to reflect this	4
Develop a contingency address the delay (14.2)	Jan-16	DS	Impact of external influences (capital/consultation etc) is being considered with exec led actions to consider scenarios for review. Programme rephased to reflect current knowns and approved by ESB.	4
Develop clear thresholds to enable a more objective RAG rating for overall progress of reconfiguration programme (14.3)	Jan-16	DS	Work underway to agree measures	4

Board Assurance Framework:	Updated version as at:	Dec-15									
Principal risk 15:	Failure to deliver the 2015/16 programme of services reviews, a key component of service-line management (SLM)							**Risk owner:**	Director of Strategy (DS)		
Strategic objective:	A financially sustainable NHS Organisation							**Objective owner:**	DS		
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	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. **Detective Controls** Monthly reporting to IFPIC and EPB as part of CIP report. 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 updates (and reports) to ESB Regular updates to EPB and IFPIC as part of CIP paper (where schemes have a financial benefit) KPIs as agreed during each service review. Service Review Roll Out / Project Plan milestones monitored via the above governance structure - Currently slightly behind plan due to operational pressures impacting on clinical engagement.	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) (c) Improvement tools / change management techniques are under development (15.2)

Assurance rating:	G	**Comments on assurance**	Appropriate assurance sources available for each service review to measure against KPIs which are reported into Exec Team identifying any deteriorating trends e.g. clinical engagement, operational pressures, etc.

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

Revised Data Pack being scoped for discussion with BI leads. (15.1)	~~Dec 2015~~ Jan 2016	DS	Key stakeholders engaged in shaping new process (including ESB) which includes a revised data pack. Broad agreement reached with respect to what this will look like and how packs will need to be much more tailored going forward. BI Manager preparing an example. This will be ready before the end of January	3
Improvement tools (for use by clinical services) to be finalised (15.2)	~~Dec 15~~ Jan 2016	DS	Agreement at ESB that the 'UHL Way' change methodology will be embedded within service reviews. Work is underway with OD colleagues and representatives from the 'UHL Way' Steering Group (with input from stakeholders in the process) to: 1) Articulate the skills we think the process needs 2) Understand how these marry to the skill set we have across the team involved in the process 3) Get a feel for what is available that we can tap into ito adress gaps	3

Board Assurance Framework:	Updated version as at:	Dec-15										
Principal risk 16:	Failure to deliver UHL deficit control total in 2015/16								**Risk owner:**		CFO	
Strategic objective:	A financially sustainable NHS organisation								**Objective owner:**		CFO	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	5x3=15	5x3=15	5x3=15	5x3=15	5x3=15	5x3=15	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 2015/16 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 2015/16 **Detective Controls** Monthly finance reporting in relation to income and expenditure and CIP **Corrective Controls** Identification and mitigation of excess cost pressures Production of financial recovery plan submitted to NTDA	Variance to plan of £1.7m at M8 Improvement in pay premium spend in M8 CIP under-delivery of £1.3 million ytd. The detailed position was reviewed by the Executive Performance Board on 15/12/15, Integrated Finance, Performance & Investment Committee on 17/12/15 and Trust Board on 07/01/16 Run rates to achieve £34.1m in each area (pay, non-pay, CIP and income) updated for Months 9-12 and reported to Committees/Trust Board	Internal / external audit annual review of financial systems and processes due quarter 3 of 2015/16. TDA scrutiny monthly and quarterly with regional team	(c) Certain aspects of contract review in 2015/16 require negotiation with NHS England and CCGs. (c) Further actions are required to reduce premium medical pay spend in 2015/16 in line with recent national guidance. (16.1)

Assurance rating:	A	**Comments on assurance**	Good number of assurance sources

Reasonable assurance rating that risk is being managed:	**Due date**	**Owner**	**Progress update:**	**Status**
Review national guidance in relation to premium medical pay and develop strategy for reduction (16.1)	Review Feb 2016	CFO	Complete for nursing staff. Strategy in relation to medical and other staff still under consideration.	3

Board Assurance Framework:	Updated version as at:	Dec-15										
Principal risk 17:	Failure to achieve a revised and approved 5 year financial strategy								**Risk owner:**		Chief Finance Officer (CFO)	
Strategic objective:	A financially sustainable NHS organisation								**Objective owner:**		CFO	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	5x3=15	5x3=15	5x3=15	5x3=15	5x3=15	5x3=15	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. 2015/16 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 2015/16 plan - As at M8, the Trust is £1.7m adverse 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	Financial systems review due Q3 2015/16 Internal audit review of service line reporting processes due Q1 2015/16 NHS England and NTDA review of: BCT SOC BCT PCBC Financial strategy LTFM Individual business cases above a certain level	(c)LTFM not yet formally approved (17.1) (c)SOC not yet formally approved (17.2)

Assurance rating:	G	**Comments on assurance**	Good range of internal and external assurances

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
Liaise with TDA to agree process for LTFM submission and sign-off (17.1)	Review ~~Nov 15~~ Jan 16	CFO	Still awaiting NDTA feedback.	3

Liaise with TDA to agree process for SOC submission and sign-off (17.2)	Review ~~Nov 15~~ Jan 16	CFO	Still awaiting NDTA feedback.	3

Board Assurance Framework:	Updated version as at:		Dec-15									
Principal risk 18:	Delay to the approvals for the EPR programme								**Risk owner:**		Chief Information Officer (CIO)	
Strategic objective:	Enabled by excellent IM&T								**Objective owner:**		CIO	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16			
Target risk rating (I x L):	2 x 3 = 6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls Weekly communications with key contacts throughout the external approvals chain. EPR project plan. IM&T transformation Board EPR programme Board and the joint Governance Board **Detective Controls** Weekly meeting to discuss progress and issues - Milestones that relate to the EPR early works are monitored to ensure that all work, that can be, is progressing to time. **Corrective controls** We have a contingency plan in place for the provision of services to the new ED department if the plan has no realistic chance of meeting their timelines. Works that support the EPR project but could be used for an alternative, if approval was not forthcoming, have continued.	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	Internal audit review of implementation of gateway actions following review of EPR implementation due Q3 2015/16	(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. Currently we have further meetings planned into January 2016 but there is no timetable in place for approval at the moment.

Assurance rating:	A	**Comments on assurance**	Sole internal assurance source relates to the achievement of the key milestone leading to national approval for which there is currently no date set by NTDA.

Action tracker:	Due date	Owner	Progress update:	Status
Progress work with NTDA/DoH to progress a firm timetable (18.1)	~~Dec - 15~~ Review Jan 16	CIO	Currently we have further meetings planned into January 2016 but there is no timetable in place for NTDA approval at the moment. Deadline for review extended. We are unable to produce a timetable until after 7/1/2016	3

Board Assurance Framework:	Updated version as at:		Dec-15									
Principal risk 19:	Perception of IM&T delivery by IBM leads to a lack of confidence in the service								Risk owner:		Officer (CIO)	
Strategic objective:	Enabled by excellent IM&T								Objective owner:		CIO	
Current risk rating (I x L):	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	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	
Directive Controls IM&T monthly news letter Monthly service delivery board **Preventive Controls** UHL IM&T governance structure Service credit regime which seeks to incentivise delivery and has an escalating failure regime for repeat monthly failures **Detective Controls** Monitoring of contract deliverables and quality of service i.e. number of LANDesk incidents and requests, and the number of telephone calls to the IT service desk. Monitoring of performance via customer satisfaction surveys. Liaison with the CMGs to ensure we are meeting their requirements. **Corrective controls** LIA event to improve perception and staged improvement plan to be fully developed	There are 148 performance indicators in total. 23 have not met their SLA, including key areas such: as Business Intelligence/Data Warehouse Customer satisfaction (trajectory of 95%) is at 78% (September data as we report a month in arrears)	Internal audit review in relation to IT general controls and systems due Q3 2015/16 ISO 27001:2013 Audit in 2015, which was passed. We believe we are the first NHS trust to achieve this standard of service delivery	(a) Lack of an effective communications strategy (19.1) (c) No formal process, post the contract award, to test the delivery principles - (in the transfer of staff to IBM we extensively tested the gateways before we transferred services, now these are live with IBM we have limited contractual cover to test new processes other than good will) (19.2)

Assurance rating:	G	Comments on assurance	Good range of internal and external assurances

Action tracker:	Due date	Owner	Progress update:	Status
Review of the new communications strategy and deliverables (19.1)	Dec-15	CIO	**Complete.** Strategy has been created and is being internally reviewed. We are now producing a detailed plan and we will be recruiting (through IBM) a communications specialist in Jan 16	5
To monitor the performance indicators in the improvement plan and communicate results to end users (19.2)	Mar-16	CIO	Further meetings have taken place with staff groups to look at individual items of concern. Plan has been created and now has staged delivery until March 16	4

Reasonable assurance rating:

Green	G	Effective controls in place and appropriate assurances are available
Amber	A	Effective controls thought to be in place but assurances are uncertain / insufficient
Red	R	Effective controls may not be in place and 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
2236	Emergency and Specialist Medicine	ED	There is a risk of overcrowding due to the design and size of the ED footprint	10/04/2013	30/06/2016	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. Increased risk of patients being in the corridor on trolleys. Lack of dignity and privacy. Serious incident risk.	Patient safety	The Emergency Care Action Team, which was established in spring 2013 aims to improve emergency flow and therefore reduce the ED crowding. The Emergency department is actively engaging in plans to increase the ED footprint via the 'hot floor' initiative, but in the shorter term to increase the capacity of assessment bay and resus. The Resus Bed area is being created. Dr Ian Sturges has been employed by the trust to work towards improving flow of patients from the emergency department to the assessment units and wards. Increase in Clinical Education staff, to assist with upskilling of Nursing Staff. Majors Floor has been marked out and numbered to prevent to many trolleys from blocking Majors and assessment Bay. Improving quality of care in the ED sessions open to staff, led by ED Consultant. Direct referrals from assessment bay to ambulatory clinic. CAD system went live highlighting nuber of ambulance patients on route to ED. SOP's completed for all areas, including SOP's for specifically managing assessment bay at full capacity & for supporting an escalation area when the main ED is full. Actions in place from EQSG Emergency Floor actions. New ED floor working stream. Quality metric audits. - These are now daily rather than monthly. (15/12/2015) Escalation plans.	Extreme	Almost certain	25	Creation of SOP for resus crowding - due 18/01/2016. Assessment Bay SOP - Completed. Majors operational policy to be reviewed - 28/02/2016 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 31/01/16. Update - Full business case signed by trust board and approved by NTDA. Patients in ED referred to any service should be reviewed by respective services in ED - (update - surgeons & ACB review resus pts, ongoing work with ortho) - Completed (Update from KA - this was completed following the Sturgess report. All specialitys were made aware during the project completed by Ian Sturgess - Report attached in documents field for info). There is to be a receptionist staffing paeds reception at all times - Completed. Creation of "single front door" (UCC handed over to UHL in Nov 2015) - 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.	16	JDIX

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2762	Corporate Nursing		Ability to provide safe, appropriate and timely care to all patients attending the Emergency Department at all times.	21/12/2015	21/01/2016	Causes Failure to consistently undertake and record initial assessment by appropriately trained clinical staff within 15 minutes of presentation and document in real time. Failure to consistently ensure that all patients receive adequate care and treatment in accordance with Trust sepsis clinical pathway. Lack of ability to demonstrate we have an appropriate staffing skill mix in place on a shift by shift basis. Lack of recording of induction for temporary staff. Consequences Significant risk of patient harm Conditions placed on licence to practice Risk of CQC placing the Trust in Special Measures Risk of CQC imposing unlimited financial penalties Adverse media attention affecting reputation of the Trust Breaches in Statutory duty with subsequent criminal prosecution	Quality	CEO and executive leadership with clear responsibility and oversight in place. Programme management arrangements in place supported by trio of nursing, medical and operational leads with allocated time and objectives. This is supported by four oversight meetings per week. Internal reporting in relation to quality metrics (sepsis compliance, staffing, initial assessment within 15 mins) Weekly reporting to CQC on required metrics in place Sepsis Implementation of trust-wide single adult sepsis pathway supported by a programme of daily audit in ED. Supporting action plan in place including rollout of single paediatric pathway. Initial Assessment Standard Operating Procedure (Initial Assessment and Dynamic Priority Scoring - version 3 December 2015) revised and implemented to ensure ED patients are prioritised appropriately. Consistent real-time recording. Review of patient harm associated with delayed initial assessment (>15mins) at patient level.	Extreme	Almost certain	25	Overarching action plan to address all 3 of the CQC areas of non-compliance - complete Governance and PMO arrangements to be agreed - paper to Quality Assurance Committee - complete On-going assurance monitoring that controls and completed actions are effective - Reviewed weekly via CQC steering group	15	JSMI

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	ED	Emergency and Specialist Medicine	There is a medical staffing shortfall resulting in a risk of an understaffed Emergency Department impacting on patient care	10/04/2013	30/06/2016	Causes: Consultant vacancies and non ED medical consultants. Middle grade vacancies. Due to a National Shortage of available trainees. Trainee attrition. Trainees not wanting to apply for consultant positions. Reduced cohesiveness as a trainee group. Junior grade vacancies. Juniors defecting to other specialties. Paediatric medical staffing. Consequences: Poor quality care. Lack of retention. Stress, poor morale and staff burnout. Increased sickness absence. Increased clinical incidents (SUI's), claims and complaints. Inability to do the general work of the department, including breaches of 4 hour target. Financial impacts from fines. Reduced ability to maintain CPD commitments for consultants/medical staff with subspeciality interest. Reduced ability to train and supervise junior doctors. Deskilling of consultants without subspeciality interest. Suboptimals training.	Patient safety	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).	Major	Almost certain	20	Deanery report actions, completed. Guidelines to be created governing minimum standards of locum doctor approval completed. An internal induction document to be produced for locum grade doctors, completed. Review of shift vs rota and the required number of juniors per shift, completed. Doctor In Induction' badges have now been ordered to distinguish staff who cannot yet make decisions, completed. New rota for August 2014 juniors with higher number of doctors at CT3 level. Although there are still gaps at the Senior Registrar levels ST4 and above, completed. R & R Package to be relaunched, completed. Increase Locum Rates of pay - update, refused by trust board, completed. Continue recruitment to pillar strategy - due 31/03/2016. Continuation of International Recruitment - due 31/03/2016. R & R for ST3 staff with a 2yr contract until July 15 with review Completed CESR programme in house to attract staff - due 31/03/2016 Update on 29th Dec, new advert just gone out. (update on 13/10/2015 from RW. CESR Interviews on 03/11/15)	6	BTD
2333	ITAPS	Anaesthesia	Lack of paediatric cardiac anaesthetists to maintain a WTD compliant rota leading to interuptions in service provision	17/04/2014	30/06/2016	Causes: Retirement of previous consultants Ill health of consultant Lack of applicants to replace substantively Consequences: Need for remaining paeds anaesthetists to work a 1:2 rota on-call Lack of resilience puts cardiac workload at risk May adversely affect the national reputation of GGH as a centre of excellence Current rota non complaint Working Time Directive (WTD) Patients requiring urgent paeds surgery may be at risk of having to be transferred to other centres Income stream relating to paeds cardiac surgery may be subsequently affected Risk of suboptimal patient treatment resulting in harm.	Quality	1:2 rota covered by experience colleagues 12 month locum appointed	Major	Almost certain	20	Due to no suitable applicants for substantive or locum Consultant posts which have been advertised twice a Specialist post is to be advertised and converted to locum Consultant for appropriate candidate - 31/01/16. Due to no suitable applicants for substantive or locum Consultant posts which have been advertised twice a Specialist post is to be advertised and converted to locum Consultant for appropriate candidate.- Reviewed again 21/12/15 - Still disputing budget for Consultants, hoping to advertise in the near future	8	DTR

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
2415	ITAPS	Critical Care	There is a risk of loss of ITU facilities at the LGH rng in a lack of Consultant cover for the Service	09/03/2014	30/06/2016	Causes: Trust strategy is to move services to LRI & GH to create centres of excellence and improve services. Consequences: There will be a loss of Consultant cover, services and capacity at the LGH ITU due to: - Planned move of services from the LGH site makes the recruitment of new Consultant Intensivists difficult -Impending retirement of some current Consultant Intensivists -Lack of Consultant cover reduces ability for other specialties (i.e. Urology/Renal/General Surgery/HPB) to undertake planned and emergency major surgery. -Crucial to now downgrade surgery at the LGH site. Management of some patient groups could be directed to the LRI site adding additional pressure to the emergency flow at LRI. - Move to a 1:8 rotas may add to further Consultant departures.	HR	Cross site cover from current Consultant workforce Recruitment campaign in progress Acting down on shifts to cover rotas deficits ITAPs leading change of ITU level and service moves across to the other 2 sites. Staff briefings to share plans and strategies.	Major	Almost certain	20	Cross site cover - Completed Move to a 1:8 rota - Completed Offer on call rota to general duties anaesthetists - Completed 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 - complete Recruit Consultant Intensivist - due 30/06/16. Recruitment Consultant Intensivist - complete - recruitment taken place awaiting start dates	2	CAL

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
510	Clinical Support and Imaging	Blood Transfusion	There is a risk of staff shortages impacting on the Blood Transfusion Service at UHL	05/10/2006	10/02/2016	Causes: Staffing issues caused by turnover of staff (retirements / leavers). Post planning process poor - local and national shortages of qualified staff (BMS). Internal recruitment processes causing significant delay. Consequences: Possibility of temporary closure of satellite blood banks (LGH). Adverse impact on patient experience for patients requiring urgent transfusion (out of hours). Non-delivery of key acute services. Increased risk of claim /complaint. Adverse media attention / loss of reputation. Staff working extra shifts and more hours - fatigue;stress; non compliance with EWTD	HR	Full 24/7 rota implemented. Voluntary rota for spare sessions - sickness leave etc. Full rota has created additional sessions as satellite laboratories to comply with 24/7 working. Associate practitioners included in early and late roster sessions Associate practitioners to cover entire night at LRI Phased extended contractual hours 8 to 8 B.S & B.Transfusion Phased extended day B Transfusion to 23:00 Employed Bank/Locum BMS staff to cover short term deficiencies in rota Investigate additional lean working options to reduce pressure on laboratory staff. Introduced a forced rota Multi discipline staff to assist cover overnight B.S(24/7) at LRI Retrained Lab Manager One-off training Risk assessed the process of a "Plan B" 24/7 Rotas with voluntary sessions in place from May 2012 2 new BMS band 5 staff recruited 24/09/2012 - to complete local competecy training Feb 2013 Introduction of cross cover form NUH to support UHL BT Roster - limited cover at present (Oct 2013) Numerous meetings taken place with empath management team to raise acute risk of service 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	Arrange full trial of Disaster Recovery Plan (DRP) - 31/03/16 To review and re-asses capacity within depts, to move staff for multi disciplinary training - 31/03/16	15	AFE

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2391	Women's and Children's		There is a risk of inadequate numbers of Junior Doctors to support the clinical services within Gynaecology & Obstetrics	24/06/2014	31/12/2015	Causes: Currently there are not enough Junior Doctors on the rota to provide adequate clinical cover and service commitments within the specialties of Gynaecology & Obstetrics. Consequences: Failure to meet the Junior Drs training needs in accordance with the LETB requirements. Impact on key objectives and delivery of service. Potential to lose Junior Drs training within the CMG. Reduced training opportunities and inconsistencies in placements. Increased risk of Junior Doctors seeing complex patients in clinics unsupervised. On call rota gaps/ Increased requirement for locums to fill gaps. Potential for LETB to remove training accreditation within obstetrics and gynaecology. This will lead to the removal of training posts. Increased potential for mismanagement / delay in patients treatment/pathway.	Patient safety	Locums used where available. Specialist Nurses being used to cover the services where possible and appropriate.	Major	Almost certain	20	Business Case to be developed re. how to meet service commitments by backfilling with Consultants, Specialist Nurses, etc due 28/02/2016	8	ACURR
1042	Women's and Children's	Maternity	Unavailability of USS and not meeting National Standards for USS in Maternity	10/10/2008	19/04/2016	Failure to diagnose abnormality which we would normally expect to diagnose due to changes in National standards. The potential for other consequences are apparent.	Quality	Detailed scan pro-forma US performed by suitable trained staff Self audit Use of regular pre-booked agency sonographers Daily review of outstanding requests to monitor the situation Access to consultants for second opinion if suspicious re possible abnormality All ultrasound machines now of suitable specification and replaced 5 yearly Incident report forms Update 18.10.12 Continued use of Agency Sonographers; Continued 'extra' lists by Fetal Med Consultants; Additional u/s machine in place but next step is need for additional scan room - this is built in to the interim solution for Maternity (phase 1) and should be converted by April 2013.	Major	Almost certain	20	R/v of the implementation of the GROW package - Due 30/06/2016 Review the requirement of MW Sonographers - Due 30/06/2016	6	LHAR

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2667	Women's and Children's	Maternity	Emergency Buzzer & Call Bell not audible clearly on Delivery Suite which could result in MDT being delayed to an emergency	10/01/2015	28/02/2016	Cause: System not able to be repaired as now obsolete - so parts are no longer available. Consequences: When an emergency arises the team may not be aware, causing a delay in the response. This could result in a delay in Medical & Midwifery staff responding to such emergency situations as: Fetal Distress Post Partum Haemorrhage Maternal and/or Neonatal collapse Shoulder Dystocia Eclamptic Fits etc. Such delays could potentially lead to a catastrophic outcome with regards to mother and baby.	Quality	All staff are aware and reminded at the commencement of each shift to be extra vigilant.	Extreme	Likely	20	Formulate a business case to the Management Team to replace the call bell system - Due 28/02/2016	5	ABUC
2553	Women's and Children's	Neonatology	There is a risk of spread of infection due to inadequate levels of cleaning on the Neonatal Unit (NNU) at LRI.	06/09/2015	31/01/2016	Causes Reduction in the number of domestic (cleaning) hours by 4 hours PER DAY provided for the NNU, a very high risk area. Consequences 1.Unable to maintain an acceptable standard of cleanliness on NNU affeciting quality and safety of babies care. 2.Breach of national specifications for cleanliness in the NHS. 3.Risk of infection outbreak on NNU resulting in increased mortality and morbidity of babies. 4.Risk of damage to NNU and Trust reputation and possible litigation.	Patient safety	Daily meetings with Interserve from May 18th to review standards of cleanliness. Weekly ServiceTrack audits to be undertaken with Facilities and Infection prevention team.	Major	Almost certain	20	Reinstate cleaning hours to level to meet National Cleaning Standards - 31/01/2016	6	JFO
2562	Women's and Children's	Paediatrics	There is a risk that 2 vacant consultant paediatric neurology vacancies could impact sustainability of the service	18/06/2015	19/02/2016	Causes: National shortage of suitable candidates to fill vacant posts Substantive Consultant Staffing levels inadequate for continuity of service Consequences: Delayed access to Consultant Paediatric Neurologist for inpatient & outpatient consultations. Loss of continuity for patients, families and Consultants as a result of changing workforce. Potential for a negative reputation of the service.	Quality	We have 1 substantive appointment, 1 locum for 6 months and 1 Consultant General Paediatrician with an interest in Neurology on a 12 month NHS contract covered by Locum Agency and NHS fixed term contracts.	Major	Almost certain	20	Actively recruit to vacant posts - Due 31/03/2016 Guideline being written for General Paediatricians to ensure appropriate in-patient & out-patient referrals - Due 19/02/2016 To work with NUH on a regional solution to service delivery - Due 31/03/2016	4	JVI

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
2403	Corporate Nursing	INFEC	There is a risk changes in the organisational structure will adversely affect water management arrangements in UHL	19/08/2014	14/03/2016	Causes National guidance from the Health and Safety Executive advise that water management should fall under the auspices of hospital infection Prevention (IP) teams. Resources are not available within the UHL IP team to facilitate the above. Lack of clarity in UHL water management policy/plan. Since the award of the Facilities Management contract to Interserve the previous assurance structure for water management has been removed and a suitable replacement has not yet been implemented. Consequences Resources not identified at local (i.e. ward/ CMG) or corporate (e.g. Interserve /IPC) level to perform flushing of water outlets leading to infection risks, including legionella pneumophila and pseudomonas aeruginosa to patients, staff and visitors from contaminated water. Non-compliance with national standards and breeches in statutory duty including financial penalty and/or prosecution of the Chief Executive by the HSE Adverse publicity and damage to reputation of the Trust and loss of public confidence Loss/interruption to service due to water contamination Potential for increase in complaints and litigation cases	Quality	Instruction re: the flushing of infrequently used outlets is incorporated into the Mandatory Infection Prevention training package for all clinical staff. Infection Prevention inbox receives all positive water microbiological test results and an IPN daily reviews this inbox and informs affected areas. This is to communicate/enable affected wards/depts to ensure Interserve is taking necessary corrective actions. Flushing of infrequently used outlets is part of the Interserve contract with UHL and this should be immediately reviewed to ensure this is being delivered by Interserve All Heads of Nursing have been advised through the Nursing Executive Team and via the widely communicated National Trust Development Action Plan (following their IP inspection visit in Dec 2013) that they must ensure that their wards and depts are keeping records of all flushing undertaken and this must be widely communicated Monitoring of flushing records has been incorporated into the CMG Infection Prevention Toolkit (reviewed monthly) and the Ward Review Tool (reviewed quarterly)	Major	Almost certain	20	Submit business case for additional funding to provide sufficient resource to either the IP team or NHS Horizons to enable the trust to carry out the requirements of the statutory and regulatory documents, with potential for full introduction and management of the "compass" system. - Funding for additional IPN agreed with FMS. Job description to be finally agreed and recruitment to commence during September 2015 - 14/3/16 Review procedures and practices in other Trusts to ensure that UHL is reaching normative standards of practice - 14/3/16 Review & agree Water Safety Plan - Water Safety Plan agreed and will be submitted to the Trust Infection Prevention Committee with the Implemenation Plan on the 23rd Sept 2015 - 14/3/16	4	LCOL

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2404	Corporate Nursing	INFEC	There is a risk that inadequate management of Vascular Access Devices could result in increased morbidity and mortality	19/08/2014	14/03/2016	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 - This is not possible so there remains no method of centrally identifying patients with these devices. For further discussion by the Vascular Access Committee - 14/03/2016 Development of an education programme relating to on-going care of CVAD's - 14/03/2016 Targeted surveillance in areas where low compliance identified via trust CVC audit - Yet to be established due to lack of staff required. For further review by the Vascular Access Committee - 14/03/2016 Support the recommendations of the Vascular Access Committee action plans to increase the Vascular Access Team within the Trust in line with other organisations. Business Case to be submitted Sept by the CSI CMG 14/03/2016	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 the machine.	12/05/2014	31/03/2016	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	Replacement of Imaging panel to improve image quality and reduce imaging dose. However this does not solve the lack of online correction capability - complete Replacement of Linac - 31/3/16	4	LWI

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2671	CHUGS	Gastroenterology	There is a risk of delays to patients treatment in the Endoscopy Unit	31/01/2016	10/12/2015	Causes: Increase in referrals and workload through to Endoscopy; Inexperienced staff that have not had appropriate training and supervision; Vacancies in nursing and administration; Poor administration processes and unorganised working environment within the administration area (LGH); Backlog of patients on the Endoscopy Unit. Consequences: Referrals could go missing which may mean patients do not receive their procedure in a timely manner and a risk of harm due to delayed diagnosis; Lack of training and supervision means that staff are not following correct procedures to ensure that the waiting list is not an accurate reflection of numbers of patients waiting; Not meeting the RTT and Cancer targets; Vacancies within the nursing establishment mean that the staff are over stretched which means processes are not followed correctly and could result in staff phycological harm.	Patient safety	Matron appointed specifically to focus on nursing recruitment and management in Endoscopy only; Staffing model developed in line with neighbouring private & NHS providers and monitored by Matron. Waiting list management - patients now transferred to the active diagnostic waiting list 6 weeks after their due date (grace period as advised by TDA). Vacancies filled within the administration teams (either permanent or through bank). Weekly scheduling meetings with Sister/Deputy, Service Manager and A&C supervisor to ensure all lists are appropriately filled and to plan staffing levels for following week to reduce cancelled ops. 2WW patients offered an appointment by phone. Currently all other patients are sent an appointment with appropriate lead in time of three weeks. Endoscopy Manager has been appointed to review and change the clinical and administration processes within department; The administration area at the LGH has been cleared and there is senior presence on each of the three sites to supervise the staff; Administration SOP's developed to support the administration processes. Admin team time out afternoon to resolve problems and potential solutions and increase engagement.	Major	Likely	16	Additional activity being undertaken, (external , internal) - due 31/01/16; "Medinet - capacity for 300 cases in November. Circle - c.120 patients transferred in October. Nuffield - capacity for 20 cases in November. Internal UHL (Sundays) - 80 cases in November. Medinet lists hosted by Alliance - 40 cases in November. Your World Doctors - 20 cases in October. Exploring additional capacity in November. UHL has signed up to the national PMO agreement to outsource activity. However no additional capacity supplied through that route. PMO requesting weekly returns of activity outsourced to the IS via other routes." External support from NHSIQ (visit on 29/09/15) - awaiting report and recommendations which will focus on Endoscopy and rapid change cycles - review 31/01/16. IST visit in October - specific focus on capacity and demand processes with Endoscopy unit -- awaiting report and recommendations - review 31/01/16. Advertise for nursing posts via central recruitment - meaning 2nd room at the LGH becomes more operational - due 31/01/16. Clinical lead to review patients not on follow up surveillance to see if appropriate for another investigation, potential to release endoscopy capacity - there is some delay while scanning facilities and files are set up to put the referrals into a format where they can be accessed - 31/01/16.	6	MNA

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2621	CHUGS	General Surgery	There is a risk to patient safety & quality due to high nurse vacancy levels on Ward 22, LRI	20/10/2015	31/01/2016	Causes: During the last 6 months 7 nurses have left and 3 nurses have reduced their hours. Due to the high level of acuity of the patients and the number of daily ITU discharges at least 2-3 per day, it is difficult to get staff to work on the area from the nursing bank and agency. The levels of vacancies are 8 wte band 5. There are currently no nurses waiting to start as the recent international nurses 2.0 wte only stayed for 3 shifts due to the acuity of the area. Consequences: There is a risk to patient safety and quality due to the high nurse vacancy levels on ward 22, LRI and an increase in acuity due to the high levels of ITU discharges. Further impacts could include staff injury (stress), expense due to agency shifts.	Patient safety	Shifts escalated to bank and agency at an early stage; Increased the numbers of band 6's to provide leadership support. Agency contract in place for one nurse on day shift and night shift to increase nursing numbers. Staffing is reviewed on a day by day basis and staff are moved across the CMG to support the ward as required. Matron to work clinically on the ward for 2 days a week to provide support and increase nursing numbers. Matron to ensure daily matron ward rounds for leadership/ increased monitoring of care standards/accessibility to patients/relatives to discuss any concerns.	Major	Likely	16	Implement rotational shifts for staff across other surgical/GI med wards to increase attractiveness to staff - 31/01/16 Recruit via next cohort of international nurses and redirect 2.0 wte to ward 22 - 31/01/16	6	KJO
2422	CHUGS	General Surgery	There is a risk nurse staffing levels on SAU LRI could adverserly impact the quality of patient care delivered	29/09/2014	31/01/2016	Causes: The nurse staffing levels within the Surgical Assessment Unit at the LRI are at a critical level with poor retention of staff. Of the recruitment of 6 International nurses, 2 newly qualified nurses and a development band 6 nurse - 7 of these nurses have left or are leaving reporting high workload as the reason. Due to it being a busy, high activity area - it is difficult to get staff to work on the area from the nursing bank and agency. Consequences: Poor quality of care to patients including increasing patient harms, delays for treatment/care. High levels of complaints for the ward (seven complaints over the past 6 months). Poor Patient Experience (The Friends and Family Test score has been consistently low. (<55).	Patient safety	Shifts escalated to bank and agency at an early stage. Increased the numbers of Band 6's to provide leadership support. Agency contract in place for one nurse on day shift and night shift to increase nursing numbers.	Major	Likely	16	Continue to actively recruit to the area - 31/01/16. Review and continue agency contract until substantive numbers are at an acceptable level - 31/01/16.	4	GK

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2623	CHUGS	Urology	There is a risk of harm or death to a patient if scopes are not properly decontaminated.	21/09/2015	28/02/2016	Causes: We have not been able to determine the cause of the problem i.e. is it the reverse osmosis machine or the water supply that is at fault, therefore the problem is not fixed. We have not yet had a definitive advice with which the clinical team can perform a full risk assessment from the IP team and therefore have continued to use the equipment. We do however have a definitive statement on the risk in terms of UHL/IP policy (the Red Flag system). Consequences: The risk is that we cause harm or death to a patient if scopes are not properly decontaminated. If we remove the washers from service we will heavily impact patient outcomes, cancer and non-admitted pathways. There is a danger of causing infection and thus harm/cause death to a patient by using infected scopes. We continue to run a risk - as above - the problem remains unresolved.	Patient safety	UHL/IP policy (the Red Flag system) TVC Count is being checked regularly and discussions with theatres/endoscopy re use of their washers; medical staff informed prior to use.	Major	Likely	16	UHL Exec to agree long-term solution and funding thereof as appropriate - 28/02/16 SOP also to be agreed - 28/02/16 Emergency medical capital bid to be completed - complete.	2	LDAL

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
2617	RRCV		Shortfall in appropriately skilled nursing staff at Northamptons renal units	10/05/2015	31/12/2015	Causes: Failure to fund to nationally recommended staffing levels at budget setting. Increase in patient numbers attending unit. Increase in number of shifts to fill. Minimal access to bank staff/staff with specialist skills for the unit. Reduced ability to redeploy staff from within the CMG due to shortages. Existing staff are working additional/excess hours and some are not having the required break periods between shifts. Units are in 'stand-alone' locations and therefore accessibility issues. Increasing sickness & staff waiting to leave the unit. A high proportion of the staff have been in post for a short period so the skill set is currently dilute and many staff are still needing significant support from experienced staff Consequences: Reduced ability to respond to routine patient needs in timely manner Overall reduced patient experience due to increased waiting times Increased waiting times to commence and terminate HD affecting flow through the unit Reduced ability to respond in an emergency situation Increased potential for clinical incidents Potential delays in administration of medicines required during haemodialysis Patients will recognise skill deficit and potentially loose confidence in care delivery affecting reputation.	Patient safety	Core of appropriately skilled, competent and experienced staff Supporting policies and guidelines for clinical practice NMC code of professional conduct NMC Standards for Medicines Management Offering additional hours and overtime when required to meet minimum staffing Minimum suitable staffing requirements, in line with BRS staffing guidelines. CQC Registration completed recruitment & compliance with N/P ratios by September 2015 - declared compliant Regular communication with current staff to keep all updated with plans to support staffing Risk communicated to senior management by Conference call 13/8/15. Consideration to closing slots as they are vacated. Redeploy staff to support as able however there are limited options due to geographical area and unfamiliar HD machines are used in Northamptonshire. Matron/Sisters to work clinically on units as often as possible.	Major	Likely	16	Hold a time out day with HD matrons to review approach to staffing unit - complete Regular communication with current staff to keep all updated with plans to support staffing - complete Consider closing the night shift recognising that some patients may need to move to other units for HD. - complete Consider closing slots as they are vacated - complete Redeploy staff to support as able however there are limited options due to geographical area and unfamiliar HD machines are used in Northamptonshire. - complete Matron/Sisters to work clinically on units as often as possible - complete Present business paper to revenue and recruitment committee in Nov 2015 for funding to increase WTE establishment - Linked to piece of work to undertake a review of staffing in HD units in other networks, including visiting and literature review - 31/12/15 Advertise vacancies & recruit promptly & consider any previous candidates - due 31/12/15 Recruit substantively into maternity leave posts as low risk. - complete Utilise recruitment at LGH HD unit to support Northants - complete Enlist support of HR in processing recruitment once agreed - 31.12.15	8	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
2609	RRCV	Cardiac Rehabilitation	Risks to the quality of Patient Cardiac Rehabilitation individual assessments due to new clinic location in LRI	09/09/2015	31/03/2016	Causes: New clinic location and consultation room based on the main corridor, level 0 (Victoria Building) is not suitable to carry out shuttle walking tests due to the safety hazards along a busy corridor. Reconfiguration works including demolition of Victoria wing have created access issues for patients attending an appointment (porters and Interserve staff) will not transport patients from or to Balmoral building main reception as they are not insured to take patients outside the building. Ambulance staff will drop off and pick up from Victoria building but because the patient is classed as being in a place of safety pick up is not a priority. Ambulance staff will organise taxis for patients (if they have been escalated) to be picked up but this is only at Balmoral reception only Consequences: Potential for patient injury, poor experience and increased waiting times because the service is unable to carry out the full comprehensive assessment as shuttle walking tests are not being completed. Risk of staff members injuring themselves and requiring time off work because of the requirement to transport some patients from Balmoral main entrance, whilst building work is in place. Verbal complaints received from patients concerned about the service they receive.	Quality	Cardiac patients who are invited to the cardiac rehabilitation clinic have a clinical diagnosis of Myocardial infarction, PCI+/- stent (s), unstable angina, angina, valve disease, heart failure, CABG/valve surgery and congenital surgery. Cardiac Rehab staff triage patients prior to booking clinic appointments to assign to an alternative site (LGH/GGH) if shuttle test is required on a temporary basis, however this is having an impact on the service at the LGH and GGH with increased waiting times. A wheelchair must be kept in the CR Dept at ALL times in case of the need to transfer a patient. Emergency equipment in place (cardiac arrest trolley, BM boxes). Ensure all patients attending the LRI site for assessment are aware of potential wait for ambulance pick up particularly patients with diabetes so that they can bring a snack & drink if needed, etc. Ensure patients are informed to bring their medications to avoid any delays in having their prescribed medications in the event of a delay in ambulance pick up.	Major	Likely	16	Review and develop case of need for alternative to shuttle walking test - chester step - 31/03/16 Work through the relocation process with the UHL Space Utilisation Group to identify suitable space to be able to carry out shuttle walking tests - 31/03/16	8	SBY

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2591	Emergency and Specialist Medicine		Risk of increased demand in diabetes outpatient foot clinic leading to overbooked clinics which over run	24/08/2015	31/01/2016	Causes: Increased volume of patients referred in from primary care needing MDT assessment. Majority of referrals are urgent due to high risk nature of patients. No increase in staffing capacity, therefore clinics are overbooked and over run. Inability to urgently transfer systemically unwell patients to be admitted to ESM due lack of transport. Consequences: Risk of patient harm (ulceration/amputation/sepsis) due to lack of capacity to see high risk patients urgently. Risk of delays in clinics. Risk of breaching national guidelines. Increasing workload of MDT foot team leading to stress and risk of mistakes. Risk to patients and staff when patients have to wait for transport to LRI when being admitted.	Patient safety	The diabetes foot team follow NICE/FDUK Guidance for treating high risk foot patients Patients are triaged in accordance with LLR Diabetes Foot care Pathway. CCGs aware of increase in referrals from primary care Clinics are consistently over booked to attempt to accommodate increased demand Service review of Foot care undertaken including review of Podiatry SLA	Major	Likely	16	Recruitment of Diabetes Specialist Nurse - complete Recruitment of Consultant - complete Additional foot clinic to commence (inc additional podiatry session) - 31/01/16 Arrangement to be agreed to access urgent transport (Use of CMG specific ambulance being explored to transfer high risk patients in a timely manner) - 31/01/16	8	JSPI

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2388	Emergency and Specialist Medicine	ED	There is risk of delivering a poor and potentially unsafe service to patients presenting in ED with mental health conditions	29/10/2014	30/06/2016	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, CAHMS & 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.	Patient safety	Security staff allocated to ED via SLA agreement (can intervene if staff become at risk). Violence & Aggression policy. Staff in ED undergo training with regard to mental health. Staff attend personal awareness training. Mental health pathway and assessment process in place in ED. Mental health triage nurse based in MH assessment area of ED, covering UCC and ED. ED Mental Health Nurse Practitioner employed in ED. Medical lead for mental health identified in ED from Consultant body. 10/02/2015 update - Recent SI's related to CAHMS have been raised on the agenda of the Urgent Care Board. LLR System Urgent Care Board has agreed that they will commission an external independent investigation into the 3 recent Patient Safety Serious Incidents (SIs) relating to vulnerable children under the care of the CAMHs services. This process will follow the methodology set out for NHS organisations. Terms of reference agreed by John Adler.	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 - 31/01/16 (Update 16/7/15, ED Education team sorting Band 7 & 6 training first. Venue still be arranged. ST4 Medics also being looked at for training. David Lord Discussing protocol with Police regards handover of patients) Training to be available for ED staff with regard to management of aggressive patients, to include breakaway techniques - Completed, conflict resolution training now completed via E learning Roll out of Mental Health Study Day for ED staff - Complete. Develop plans in line with Government's "Mandate" to ensure no one in crisis will be turned away by - Completed. UHL are signed up to the crisis care concordat. No patients are turned away.	6	DMI

Risk ID	Specialty	CMG	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	Rheumatology	Emergency and Specialist Medicine	There is a risk of Patient harm due to delays in timely review of results and Monitoring in Rheumatolgy	31/03/2016	12/03/2014	1.□High Volume of paper results that need daily review by registered Nurse, 2.□There is duplication of results as some patients will have results reported through DAWN database and some patients will not (patients on other immunosuppressant drugs); therefore nurses checking all paper copies 3.□There is a gap in the nursing establishment 4.□Only one person trained to input data on DAWN system; they have given notice and will finish end of November 5.□Insufficient DAWN licences for number of patients required 6.□DAWN is not used in real time by Clinicians Consequences 1.□Risk of patient harm due to late or missed identification of drug toxicity 2.□Risk of patient harm due to delays in decision making and poor communication within the department and with patients and GPs 3.□Risk of breaching national guidelines 4.□Financial impact due to duplication of blood tests 5.□Increasing workload of nurse specialists leading to stress and risk of mistakes 6.□Financial risk from commissioning due to inadequate tracking of compliance and drug monitoring	Patient safety	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. Updated 12.10.15 ***New matron in post to establish current specialist nursing establishment job plans and skill mix ***Long standing spread sheet system remains in place - under review as move towards full DAWN implementation.	Major	Likely	16	Every patient on DMARD to be on DAWN system and monitored in real time - 31/03/16 Business case for DAWN expansion with further licenses and more users - 31/03/16	1	GST

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2541	Musculoskeletal and Specialist Surgery		There is a risk of reduced theatre & bed capacity at LRI due to increased spinal activity	27/04/2015	31/12/2015	Causes: Increased spinal activity Workload exceeds capacity Insufficient theatre capacity Reduced bed capacity Insufficient consultant numbers to operate spinal on call rota Inadequate junior doctor numbers Increased activity from out of areas in line with proposal to be regional spinal service Consequences: Financial loss though increased LoS Adverse effect on other trauma theatre and bed capacity Inability to take advantage of increased tariff from #NOF BPT due to knock on effect on capacity Increased morbidity Risk to reputation Risk to CT training programme Claims risk Decreased efficiency from increased split site working Insufficient Orthogeriatric cover for increased activity	Patient safety	Weekly Monitoring of performance against BPT criteria Monitoring of morbidity at M&M meetings Trauma Coordinator role implemented Cross organisational meetings with commissioners Trauma business case accepted for increased staffing across wards/departments and theatres Trauma unit meeting reinstated	Major	Likely	16	Agree way forward for regional spinal service - Business case to be presented to R&I Committee - due Dec 2015. Employment of further staff to support the spinal on call rota - completed. Employment and training of further TNPs to bolster junior doctor gaps and facilitate more stable CT training - Kate Machin/Nicola Grant - due May 2018	8	CSK
2504	Musculoskeletal and Specialist Surgery	Trauma Orthopaedics	There is a risk that patients will wait for an unacceptable length of time for trauma surgery resulting in poor patient outcomes	03/12/2015	30/03/2016	Causes: Increased spinal activity; workload exceeds capacity; under utilised theatre capacity; insufficient capacity at the weekend; inadequate junior doctor numbers; insufficient Orthogeriatrician input across 7 days; absence / under-provision of senior anaesthetic ward pre-assessment. Consequences: Patient safety and patient experience; financial loss through increased LoS; inability to take advantage of increased tariff from #NOF BPT; increased morbidity; risk to reputation; risk to CT training programme; litigation risk.	Patient safety	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	Employment of further staff to support the service across 7 days as per the recent business case - 31/03/16. Employment and training of further TNPs to bolster junior doctor gaps and facilitate more stable CT training - 30/04/18.	8	CSK

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
607	Clinical Support and Imaging	Blood Transfusion	Failure of UHL BT to fully comply with BCSH guidance and BSQR in relation to traceability and positive patient identification	22/12/2006	01/10/2016	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	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	Staff training required to extract data from 'Winpath Path Manager' 30-01-2016	4	AFE

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
182	Clinical Support and Imaging	General Pathology	POCT- Inappropriate patient Management due to inaccurate diagnostic results from Point Of Care Testing (POCT) equipment	13/05/2005	01/02/2016	Incorrect diagnostic results from POCT equipment due to: 1.□Lack of Standard Operating Procedures (Sop's) and Competency documentation for POCT devices/analysers, Risk assessment and COSHH documentation (requires a POCT Team to achieve compliance) 2.□Inadequate initial and on going training and competency assessment for users (requires a POCT Team to achieve compliance) 3.□POCT analysers/devices not being subject to the appropriate quality checks including: Internal quality control (IQC), External Quality Assurance (EQA), Maintenance and Calibration (requires a POCT Team to achieve compliance). 4.□Lack of standardisation of POCT equipment (particularly blood gas analysers) with associated lack of consistency of POCT results. 5.□Lack of standardisation regarding staff groups maintaining POCT equipment (particularly blood gas analysers). 6.□Limited POCT staff resources-exacerbated by the failure of the POCT Business Case to gain approval by the Trust Investment and Revenue Committee and POCT Manager post due to be vacant from October 2015. 7.□Lack of POCT IT Connectivity 8.□Some duties will not be performed during the interim period between current POCT Manager retiring and post being filled eg. Glucose and ketone EQA, contact with manufacturers / engineers or ward areas for POCT issues, reports to Trust committees, equipment audits to check maintenance and quality checks are being performed.	Quality	1. Committee for overseeing POCT trust wide is in place , 2.UHL Management of Point of Care Testing (POCT) Devices Policy	Major	Likely	16	Succession plan; Explore options for secondment post to replace POCT Manager vacancy ...31 Jan 2016; Update business case to include Medical devices training 31 Jan 2016; Resource funding for POCT team 02/03/2016; UHL Blood gas standardisation programme 02/06/2016	2	TSCR

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2654	Clinical Support and Imaging	Cellular Pathology	There is a risk of failure of delivering Breast Histopathology Services due to unplanned Consultant Pathologist sickness absence	22/09/2015	01/02/2016	Causes: Staff shortages - 3 out of 4 Consultant Histopathologists on long term sick leave at date of RA (one for >1 year). Increased workload with no additional staff resource - general 'creep' of work due to age extension of National Breast Cancer Screening program in 2013. data collected by the breast pathologists indicates that workload, measured as specimens/month has increased 17% in this time. Glenfield remains the largest Breast Cancer Unit in England with 800 cancers/year. Consequences: Staff morale Fatigue errors, incidents and failure to meet TAT's for diagnostic biopsies required to meet national Cancer Pathway targets. Remaining breast pathologist has had to stop reporting specimens of other pathology types, becoming a mono-specialist' reduced reporting capacity within other specialist teams 'similar knock on effects to consultants and quality of service provision in these teams.	HR	Staffing - Use of external pathology provider to process and report less urgent treatment resection specimens and enable remaining pathologist to concentrate on diagnostic specimens that remain at UHL. This option has cost and reputation consequences for empath. Other options have been extensively investigated via a Breast Service Resilience Action Plan. There are a number of options that will be beneficial in the medium to long term but none that offer an immediate increase in reporting capacity for the breast service.	Major	Likely	16	Review operation of breast team with particular emphasis on improving the training of junior pathologists to provide short term support for consultants and long term recruitment options 02/01/2016	4	MLANG

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2487	Clinical Support and Imaging	Medical Physics	Maintaining the quality of the Nuclear Medicine service for PET, Cardiac MPI and general diagnostics	01/06/2015	31/03/2016	Causes: The lead clinician in Nuclear Medicine is on long term sick leave. He is the only PET ARSAC certificate holder in the Trust and the clinical lead for the service. The locum covering cardiac MPI is the only other experienced ARSAC certificate holder for MPI studies. His contract ends in Jan 2015. There are other ARSAC certificate holders who cover general Nucelar Medicine and paediatric work. Their time commitment to Nuclear Medicine is severely limited. There is only one Consultant Radiologist currently entitled to report PET images under the national contract. A second is experienced and has retained competence but requires some training and revalidation. There are a number of Consultant Radiologists who report MPI's and general Nuclear Medicine but none eligible or interested in gaining ARSAC certification Consequences: An ARSAC certificate holder for PET can be "borrowed" under the existing contract but the new contract will require a certificate holder within the Trust. This puts the plans for fixed PETCT at risk. Loss of MPI expertise will have a major impact on the 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 - 31/03/16	6	DPE

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2245	Clinical Support and Imaging	Medical Records	Staff vacancies and increased activity within the medical records departments is having an impact on service delivery	24/10/2013	30/04/2016	The Medical Records service should be working 14 days in advance for locating routinely requested records, current performance is 3 to 5 days. Many case notes are being located late or not at all with a consequent impact on patient care, causing delays in clinics and delayed decision making on wards in some instances. Causes (hazard) High level of turnover and vacancies, predominantly caused by the anticipated impact of the proposed Electronic Document Records Management project. Increase of 7.5% in activity over last 12 months and increasing month on month since February 2014 are also impacting service delivery Consequence (harm / loss event) Deterioration in service provided due to inability to deal with level of medical records requests leading to cancellation of these and failure to provide service. Patients appointments and elective surgery are being cancelled due to records not being available in some clinical areas with a potential adverse impact on patient care. Delays to emergency flow and extension of length of stay due to a lengthened decision making process (due to lack of available clinical information in a timely manner).	HR	Use of A&C bank staff where possible, though very limited in supply. Use of overtime from remaining substantive staff (though dwindling due to length of time during recruitment process; staff are under pressure). Reduction / cancellation of staff attendance at mandatory training (though with clear consequent impact on this Trust deliverable target). Cancellation of non-clinical requests for case notes daily (e.g. audit) to minimise disruption to front line clinical need (though with clear consequent impact on other areas of service delivery). On going urgent recruitment to existing vacancies. A waiting list of suitable applicants has been created to minimise the risk of the current staffing levels reoccurring in the future. Medical records management supporting HRSS by chasing references and other checks. Daily review of staffing levels and management of requests with concentration of staffing in areas of greatest demand and clinical priority.	Major	Likely	16	Continuing review of short-term reduction in service for non-clinical requests for case notes located within specialty areas of UHL (records within library areas will continue to be located). 30.4.2016 Monitoring and review of need for short-term agency usage (limited bank availability) to make library locations safe - decision not to use agency taken due to cost (Sept 15). Will continue with current plan of using substantive staff at weekends and evenings instead - complete. Continuation of substantive overtime and utilisation of bank staff if available - 30.4.16 Monitoring storage capacity weekly in the libraries - due 30.4.16 Arrange meetings with CMG's to review notes processes to improve availability - started end August 2014 - ongoing will continue to liaise with specialties until problems have been resolved - complete. LIA wave 4 workstream from January 2015 to work with all areas to improve notes availability by reviewing processes and identifying and solving issues that cross cut all areas - due 30.4.16	6	DWAT
2378	Clinical Support and Imaging	Pharmacy	There is a risk that Pharmacy workforce capacity could result in reduced staff presence on wards or clinics	19/06/2014	28/02/2016	Causes: High levels of vacancies and sickness High levels of activity Training requirements for newly recruited staff Consequences: There is a risk that arises because of pharmacy workforce capacity across multiple teams which will result in reduced staff presence on wards or clinics, as well as capacity for core functions. This will result in reduced prescription screening capacity and the ability to intervene to prevent prescribing errors and other medicines governance issues in a number of areas including some high risk.	HR	extra hours being worked by part time staff team leaders involved in increased 'hands' on delivery staff time focused on patient care delivery (project time, meeting attendance reduced) Prioritisation of specific delivery issues e.g. high risk areas and discharge prescriptions, chemo suite	Major	Likely	16	recruitment of senior pharmacist vacancies - 31/3/2016	8	CELL

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1926	Clinical Support and Imaging	Ultrasound	There is a risk that insufficient staffing to manage ultrasound referrals could impact Trust operations and patient safety	04/10/2012	30/03/2016	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	Patient safety	Staff volunteer to do overtime/extra duties . Agency and bank staff are being used to cover sessions	Major	Likely	16	Recruit to vacancies - 30/03/2016	6	CLA
2384	Women's and Children's	Maternity	There is an increased risk in the incidence of babies being born with HIE (moderate & severe) within UHL	24/06/2014	31/01/2016	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	Patient safety	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	Development of a decision education package focusing on the management of the 2nd stage of labour due - 12/01/2016	8	ACURR

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2153	Women's and Children's	Paediatrics	Shortfall in the number of all qualified nurses working in the Children's Hospital.	03/05/2013	01/11/2016	Causes The Children's Hospital is currently experiencing a shortfall in the number of Children's registered nurses. This is due to high numbers of vacancies and staff on maternity leave and long term sickness. Consequences There is a short fall in the number of appropriately qualified children's nurses in the Children's Hospital which could impact on the quality of patient care.	HR	Where possible the bed base is flexed on a daily bases to ensure we are maintaining our nurse to bed ratios There is an active campaign to recruit nurses locally, national and internationally Additional health care assistance have been employed to support the shortfall of qualified nurses. Specialise Nurses are helping to cover ward clinical shifts. Cardiac Liaison Team cover Outpatient clinics Overtime, bank & agency staff requested Head of Nursing, Lead Nurse, Matron and ECMO Co-ordinator cover clinical shifts Adult ICU staff cover shifts where possible Recruitment and retention premium in place to reduce turn-off of staff Part time staff being paid overtime Program in place for international nurses in the HDU and Intensive Care Environment Second Registration for Adult nurses in place	Major	Likely	16	Weekly metrics related to staffing shortages reported to CMG team and action taken where identified - due 11/01/16 Complete staff safe levels daily and take action where required. Clear escalation process - Due 11/01/16 Matrons daily ward rounds - due 11/1/16 Second registration course to commence September 2015 and be evaluated - due 11/01/16 Completion of a period of perceptorship for new international qualified nurses - due 30/01/2016 Continue to recruit to remaining vacancies - due 30/01/16	8	HKI
2394	Communications		No IT support for the clinical photography database (IMAN)	07/04/2014	31/01/2016	Cause: IMAN stores the clinical photographs taken by the clinical photographers on behalf of clinical staff requesting them and form part of the patient's medical record. It contains >60,000 images of >9,000 patients since 2009. The hardware is supported by IM&T but is now out of warranty. The application software is no longer supported by its creator SEARCH Technologies (since April 2014). Consequence: If a fault were to occur with the database we cannot fix it. Clinicians would not be able to view the photographs of their patients. Patient safety will be jeopardised.	Patient safety	IM&T hardware support; IM&T Integration & Development team best endeavours to support the application software; separate backup of images on Apple server in Medical Illustration. Project brief published Nov 2014 for new database. Funding from IM&T agreed April 2015. Functional Specification for new system published Sep 2015. IM&T project and technical support sought Oct 2015. IM&T project manager appointed Nov 2015. IM&T Functional Spec complete Dec 2015. Tender issued Jan 2016?	Major	Likely	16	Seek Supplier responses to tender - 31/03/16	1	SAN

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
2237	Medical Directorate		There is a risk of results of outpatient diagnostic tests not being reviewed or acted upon resulting in patient harm	10/07/2013	31/01/2016	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.	Patient safety	Abnormal pathology results escalation process Suspicious imaging findings escalated to MDTs Trust plan to replace iCM (to include mandatory fields requiring clinicians to acknowledge results).	Major	Likely	16	Implementation of Diagnostic testing policy across Trust - to ensure agreed specialty processes for outpatient management of diagnostic tests results - complete. Development IT work with IBM to improve results system for clinicians and Trust to develop EPR with fit for purpose results management system. - Jan 16	8	ADOS

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
2338	Medical Directorate		There is a risk of patients not receiving medication and patients receiving the incorrect medication due to an unstable homecare	28/02/2016	05/01/2014	Causes: A major homecare company has left the Homecare market requiring remaining companies to take on large numbers of patients. These companies are now experiencing difficulties in maintaining their current levels of service. Consequences: Existing providers of homecare services are having difficulties achieving satisfactory level of deliveries UHL patients are now being affected and poor patient experience. Patients receiving incorrect medication or not receiving any medication via homecare Patients having difficulties in contacting homecare telephone helplines. Potential interruption in supply of chemotherapy agents from Bath ASU. Deliveries not arriving leading to missed doses and also issues with patients having to take time of work to accept the deliveries There are a significant number of patients, clinicians and pharmacy staff who have lost confidence in the homecare services provided on behalf of UHL. As UHL have had to purchase these drugs, there is a loss of the VAT benefits that were originally gained by the health community. Adverse impact on Trust reputation Potential breaches of patient confidentiality	Patient safety	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	Recruit to vacant homecare pharmacist post - March 2016 Agree income to support pharmacy homecare team with NHSE/CCGs - Feb 2016 Set up insourced subsidiary to allow repatriation of high risk patients - April 2016 Review of internal processes with rheumatology - March 2016	9	CELL
2093	Medical Directorate	R&I	Athena Swan - potential Biomedical Research Unit funding issues.	08/08/2014	31/03/2016	The Athena SWAN Charter is a recognition scheme for UK universities and celebrates good employment practice for women working in science, engineering and technology (SET) departments. Standards required for next round of Biomedical Research Unit (BRU) submissions. Academic partners required to be at least Silver Status. Failure for the University to achieve this will result in UHL being unable to bid successfully for repeat funding of the BRUs. There is a very real possibility that UHL will loose ALL BRUs if this is not adequately addressed.	Economic	Every meeting with the University, Athena Swan is on the Agenda. Out of UHL control directly, but every avenue is being used to keep the emphasis high at the University. New high level process has been introduced at University of Leicester to drive and supervise the application.	Major	Likely	16	Medical school has submitted bid for Athena Swan Silver. Individual medical school departments are preparing separate bids for Athena Swan Silver if medical school bid unsuccessful - 31/03/16	4	CMAL

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	EFMC		There is a risk of blocked drains causing leaks and localized flooding of sewage impacting on service provision	17/03/2014	31/03/2016	Causes: Aging infrastructure unable to cope with the volume of sewage due to restrictions and narrowing of the pipes Staff, visitors and patients placing materials other than toilet paper into the drainage system including wipes, sanitary towels and nappies. Back flow sink drains are unprotected resulting in foreign bodies Consequence: Blockages build up easier and the older pipes cannot cope with the additional pressure causing leaks of raw sewage into occupied areas. Pipes cannot cope with the non-degradable materials and flooding occurs Localised flooding of clinical areas often involving areas on the floors below Foreign bodies block the drains and cause back fill and overspill of sinks and other facilities Clinical areas and staff areas become contaminated with raw sewage. Patients contaminated with sewage from leaks in the ceilings above their bays/beds. Whilst repairs are underway it may become necessary to isolate and turn off showers, toilets and washing facilities elsewhere in the building. Potential media coverage (one request for information from Leicester Mercury during August 2014) which could result in a loss of reputation and patient satisfaction scores Quality and safe delivery of care compromised in areas of sewage leaks resulting in disruption to service	Quality	CCTV surveys of drains completed as far as possible in Balmoral, Windsor, Victoria and Modular Wards. Remedial works carried out in priority areas. New main drain being installed in Service level 2 to divert 19 drain stacks to external drain, this reduces pressure on drains below level 3. Business Continuity Plans for all CMGs Single choice patient wipes agreed at NET. Reporting of the number of blockages monitored by NHS Horizons and by Trust.	Major	Likely	16	Initail CCTV surveys carried out in 2015 has lead to further remedial works including: improved access for rodding and cctv to stack in area 2 Balmoral COMPLETE. Installation of a new main drain to area 4 Balmoral (service Level) used to divert stacks from level 3 and above to external manhole - Due 31/03/16	2	GLA

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2325	Corporate Nursing		There is a risk that security staff not assisting with restraint could impact on patient/staff safety	04/03/2014	31/03/2016	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	Patient safety	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 to be arranged in Brandon Unit - 31/03/16	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
2247	Corporate Nursing		There is a risk that a significant number of RN vacancies in UHL could affect patient safety	30/10/2013	31/03/2016	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.	Patient safety	HRSS structure review. A temporary Band 5 HRSS Team Leader appointed. A Nursing lead identified. Recruitment plan developed with fortnightly meetings to review progress. Vacancy monitoring. Bank/agency utilisation. Shift moves of staff. Ward Manager/Matron return to wards full time.	Major	Likely	16	Over recruit HCAs. - 30/10/16 Utilise other roles to liberate nursing time - 30/04/17	12	MMC

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1693	Operations		There is a risk of inaccuracies in clinical coding resulting in loss of income	08/02/2011	31/03/2016	Causes: Casenote availability and casenote documentation. HISS/PatientCentre constraints (HRG codes not generated due to old version of Patient Administration System) High workload (coding per person above national average). Unable to recruit to trained coder posts (band 4/5) Inaccuracies / omissions in source documentation (e.g. case notes and discharge summaries may not include co-morbidities, high cost drugs may not be listed). Coding proformas/ ticklists designed (LiA scheme and previously) but not widely used. Electronic coding (Medicode Encoder) implemented February 2012 but not updated since (old versions of HRG). The system has no support model with IM&T, so errors are difficult to resolve. Consequences: Loss of income (PbR). 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.	Major	Likely	16	Work with CMGs / ward clerks to maximise transfer of casenotes to Clinical Coding - 31/03/16 Appoint Coding trainer (Band 5/6) - 31/03/16 Establish comprehensive IT support model for Medicode - 31/03/16 Appoint replacement coding site lead (Band 6) - 30/04/16	8	JRO

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	EP&BC	There is a risk of flooding from fluvial and pluvial sources resulting in interuption to Services	03/06/2014	31/03/2016	Causes: Pluvial flooding (all sites) external and internally Fluvial flooding (at LRI) from the River Soar Heavy, prolonged rain fall Winter snow/ice melt Blocked drains Consequence: Loss of service areas/buildings/site To the full extent of the river soar flood plain the majority of the LRI would be flooded Sewage ingress Contamination of infrastructure Patient safety Loss of electrical supplies Loss of mains water and drainage Disruption to supply lines Staff difficulties getting in Staff difficulties getting home - staff car parks and vehicles flooded Reputation and publicity on the impact of flooding, the development of a site at risk from flooding, the response and recovery	Targets	Flood Plan - LRF and UHL Response teams IPC Policy Local Business Continuity Plans UHL Major Incident Plan UHL/Multi-agency communications plan Insurance Policy Cooperate with LRF partners to test the LRF plans	Major	Likely	16	Update UHL flood plan to identify services and equipment at risk and identify control measures - 28/02/2016	12	PWA

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2549	Musculoskeletal and Specialist Surgery	Orthodontics & Restorative Denistry	There is a known risk of excessive waiting times in the departments of Orthodontics and Restorative Dentistry	10/01/2015	31/01/2016	Causes: - Orthodontics - Treatment capacity reduced over the years (3 wte to 1.6 wte). No junior support (SpR, SAS grades) Poor OPD waiting list management with planned patients not being placed onto active waiting list when they are ready for treatment to begin. We are therefore not sighted to the true waiting time of the patients. - Restorative Dentistry - Increasing requirement for specialist work - particularly endodontic Capacity cannot keep up with the demand Consequences: - Orthodontics - 336 patients on the waiting list. Longest wait of 5.5 years - RTT start March 2010 Increasing number of complaints. Not able to provide an indication as to when they might start treatment. Psychological impact for the patient. - Restorative Dentistry - Closed to endodontic referrals - significantly reduced provision for this on the NHS within Leicester and Leicestershire. 20, 52 week breaches within August and September 2014. Affected the Trusts bottom line non-admitted performance. Increased complaints.	Patient safety	Endodontic waiting list closed to new referrals (Restorative Dentistry). Revised endodontic guidelines agreed and in place from 1.4.15. Managing the orthodontic patients in order by longest wait.	Moderate	Almost certain	15	Business case approved describing investment required to increase capacity - completed. Clinical and admin validation of orthodontic waiting list required. Public health to be involved - completed. Record all patients waiting times correctly on HISS - completed. Transfer patients to Nottingham - commissioner approval in place - completed. Transfer patients to Northampton - On progress, Northants are now only able to take 4 patients per month from dec 2015 - due 31/03/16. Recruitment of 2 locum consultant orthodontists (first advert did not elicit suitable candidates - re-advertised - due to lose mid October 15)□-31/01/16. □□ TDA to agree with NHSE for the IPT of patients - completed.□□	9	ARA

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
2673	Clinical Support and Imaging	Cytogenetics	Decommissioning of the cytogenetics laboratory service at UHL through the NHS England Review	14/10/2015	30/04/2016	Causes: NHS England has a requirement to save 20% of the national specialised service commissioning budget. Genetic laboratory service provision, which is part specialist commissioned and part of the E01 Medical Genetics specification, is to be reconfigured through a procurement process overseen by NHS England in autumn 2014. The specification is aimed at creating a world class resource in the use of genomics and genetic technologies within the NHS. An outline specification was published in April 2014 which gives more detail on the strategic context of this procurement (attached). NHS England commissioning intentions for 2015/16 for prescribed specialised services published on 30th September 2014 indicate that the new pattern of service delivery will be in place in 2016 with a current planned 'go live' date of January 2016. The service specification has been re-written and is due to be published with the joint PQQ/ITT w/c 26th October 2015. The evaluation phase is due to start w/c 7th December with potential provider interviews early January 2016. Award recommendations are due in February 2016. It is expected that the specification will be largely unchanged. Consequences: The cytogenetics laboratory at UHL will be unable to respond to the procurement specification as a stand alone laboratory on the basis of the outline specification. This is due to there being no molecular genetics laboratory within UHL that undertakes routine diagnostic clinical sequencing.	Targets	Empath procurement specification utilising exiting services within UHL and NUH pathology services. This includes Molecular genetics at NUH and Empath molecular diagnostics to ensure that all elements of the procurement be addressed. Public consultation period clarifying the scope and service specification requirements in autumn 2014. Plans to form a single genetic laboratory service for the east midlands under Empath which would be able to cover the expected requirement s of the service specification There is a verbal agreement to submit a joint response to the tender between UHL and NUH incorporating Empath services and genetics at NUH.	Extreme	Possible	15	Submit successful tender for provision of genetic laboratory services to the East Midlands. Empath response to procurement (with NUH) - April 2016	10	LCR

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2426	Clinical Support and Imaging	Dietetics	There is a risk that an increase in referrals could compromise safety for patients with complex nutritional requirements	28/10/2014	01/01/2016	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).	Patient safety	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 - 01/01/16 2. Consider converting temporary posts to permanent contracts to ensure continuity of staffing and training needs- complete. 3. Urgent review of the NST service to ascertain requirements for further uplift in staffing levels - 01/01/16 4. Consider the option to Identify and facilitate professional checking by qualified pharmacist of the HPN prescriptions on a daily basis - complete. 5. Review current response times for enteral and HOS referrals, with a view to lengthening (current standard is within 24 hours) on a short term basis, to reduce pressure on the team - complete. 6. Complete stress risk assessments on all members of the nutrition nurse team and take any identified actions - 01/01/16. 7. Urgent review of job plans to all members of the NST to meet high risk priorities - 01/01/16. 8. Audit readmissions of HPN patients - complete. 9. To create and develop a specialist pharmacist post dedicated to nutrition in line with the current Pharmacy workforce optimisation review - 01/01/16.	3	MSC

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2601	Women's and Children's	GY	There is a risk of delay in gynaecology patient correspondence due to a backlog in typing	24/08/2015	28/02/2016	Causes: An increase in the number of referrals to gynaecology services. 1.0 wte vacancy of an audio typist. Bank and Agency staff being used to reduce typing backlog are not consistent especially during holiday periods. In addition delays can occur due to Consultants working cross-site and not accessing results promptly in order for the letters to be completed. Consequences: Delay in timely appointment letters to patients Delay in patients receiving results Delay in patients receiving follow up appointments Breach in the Trust standard for typing and sending out of patients letters (48 hours maximum time from date of dictation) As at 21/08/15 - there is a delay in gynaecology correspondence to the patient of: - 8 weeks following a general gynaecology appointment at LRI - 8 weeks for 1st appointment letters for Colposcopy at LRI - 1 week and 5 days for colposcopy result letters at LRI - 10 days for communication to GP with regards to the patient.	Quality	2 week wait clinics or any letters highlighted on Windscribe in red are typed as urgent. Weekly admin management meeting standing agenda item: typing backlog by site also by Colposcopy and general gynaecology. Using Bank & Agency Staff. Protected typing for a limited number of staff.	Moderate	Almost certain	15	Clearance of backlog of letters - due 28/02/2016	6	DMAR

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	Corporate Nursing	INFEC	There is a risk that inappropriate decontamination practise may result in harm to patients and staff	19/08/2014	14/03/2016	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	Patient safety	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 - 14/03/2016 Review all education and training for staff involved in reprocessing reusable medical equipment - 14/03/2016 Review the use of equipment and the appropriateness of their current placement according to national guidance - 14/03/2016	3	LCOL

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1551	Corporate Nursing	QS	Failure to manage Category C documents on UHL Document Management system (Insite)	14/03/2011	31/03/2016	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 - complete Compile a list of local guidelines requiring review and send to CMGs for action - complete CMGs to advise 'CRESPO' of any guidelines requiring urgent revision/ attention or that need to be removed from InSite - 31/03/16 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 Stanley - complete Implement shared mailbox to receive responses from CMGs - complete Ensure input from IM&T to make InSite more effective as a document library - complete Continue work to assign review dates and authors to all CAT C documents 31/03/16 Recruitment approved for Band 3 P&G Administrator - interviews in Feb 2016. Appoint temporary staff to help address backlog of documents requiring review - complete.	9	RBROUG