# TRUST BOARD: RISK MANAGEMENT INFORMATION PACK

Author: Corporate Risk Team Sponsor: Medical Director Trust Board Date: Thursday 5th May 2016

## 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 principal risks, controls and assurances, and the main tool that the will be used in seeking assurance that those internal control mechanisms are effective. The risk register captures operational risks from CMGs and Corporate directorates to provide the bottom-up section of the process. The BAF and risk register discussion is captured in the Chief Executive's TB paper, along with summary documents for the reporting period. This paper includes the full detail of the BAF (appendix 1) and the 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. Does the TB have knowledge of all risks on the organisational risk register scoring 15 and above including new risks entered during this reporting period?
4. 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. The TB is sighted to all extreme and high risks on the UHL risk register by reference to the extract in the Chief Executive's Trust Board paper and the detail included in appendix two of this paper.
4. Analysis reveals that the majority of organisational risks with a rating of 15 and above continue to have a cause related to workforce capacity and capability which, should they occur, could impact on patient safety, quality of services and ability to meet performance targets.

### Input Sought

The Trust Board is invited to receive and note this information pack (and 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: [02/06/16]

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

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

| UHL Board Assurance Dashboard: | MARCH 2016 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **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 | |
| An effective and integrated emergency care system | 2 | Emergency attendance/ admissions increase | COO | 25 | 6 | ⇔ | R | EPB | |
| 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 | |
| Integrated care in partnership with others | 4 | Existing and new tertiary flows of patients not secured compromising UHL's future more specialised status. | DoMC | 12 | 8 | ⇔ | A | ESB | |
| | 5 | Failure to deliver integrated care in partnership with others including failure to:<br>Deliver the Better Care Together year 2 programme of work<br>Participate in BCT formal public consultation with risk of challenge and judicial review<br>Develop and formalise partnerships with a range of providers (tertiary and local services)<br>Explore and pioneer new models of care. Failure to deliver integrated care. | DoMC | 16 | 10 | ⇔ | R | ESB | |
| Enhanced delivery in research, innovation and clinical education | 6 | Failure to retain BRU status. | MD | 9 | 6 | ⇔ | A | ESB | |
| | 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 | |
| | 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 | |
| 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 | |
| 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 | CFO | 20 | 10 | ⇔ | A | ESB | |
| | 12 | Limited capital envelope to deliver the reconfigured estate which is required to meet the Trust's revenue obligations | CFO | 20 | 8 | ⇔ | A | ESB | |
| | 13 | Lack of robust assurance in relation to statutory compliance of the estate | CFO | 16 | 8 | ⇔ | A | ESB | |
| | 14 | Failure to deliver clinically sustainable configuration of services | CFO | 20 | 8 | ⇧ | A | ESB | |
| A financially sustainable NHS Organisation | 15 | Failure to deliver the 2015/16 programme of services reviews, a key component of service-line management (SLM) | CFO | 9 | 6 | ⇔ | G | EPB | |
| | 16 | Failure to deliver UHL's deficit control total in 2015/16 | CFO | 10 | 10 | ⇩ | G | EPB | |
| | 17 | Failure to achieve a revised and approved 5 year financial strategy | CFO | 15 | 10 | ⇔ | G | EPB | |
| Enabled by excellent IM&T | 18 | Delay to the approvals for the EPR programme | CIO | 16 | 6 | ⇔ | A | EIM&T | |
| | 19 | Perception of IM&T delivery by IBM leads to a lack of confidence in the service | CIO | 6 | 6 | ⇩ | G | EIM&T | |

| Board Assurance Framework: | Updated version as at: | Mar-16 | |
|---|---|---|---|
| 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 | 3x3=9 | 3x3=9 | |
| Target risk rating (I x L): | 3 x 2 = 6 | | | | | | | | | | | |

| Controls: (preventive, corrective, directive, detective) | Assurance on effectiveness of controls: Internal | Assurance on effectiveness of controls: External | Gaps in Control / Assurance |
|---|---|---|---|
| **Directive Controls**<br>'National guidance for Friends and family test'<br>Clinical pathways of care<br>Corporate leads agreed for work streams of the Quality Commitment (QC).<br><br>**Detective Controls**<br>Quarterly patient safety report highlighting number of 'harms' moderate and above<br>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.<br>Friends and Family score (target 97% by March 2016) reported monthly via Q&P report to TB and QAC<br>Quarterly QC report to EQB to monitor achievement of key milestones | UHL SHMI Jul14 - Jun 15 reduced to 95 (from 98)<br><br>Achievement of 5% reduction in moderate and above 'harms' in Quarter 2 2015/16<br><br>Inpatient (inc D/C) 'friends and family' score for January ('caring' KPI C1) = 97% (1% up on previous reporting period)<br><br>Achievement of key milestones within QC work plans monitored by relevant trust level committee. | Delivery against CQUIN schedule as per contract<br><br>Internal Audit mortality and morbidity review due Q3 2015/16<br><br>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) (1.6) |

| 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 in May. | 5 |

| | | | | |
|---|---|---|---|---|
| Audit support to be provided (1.3) | ~~Oct - 15~~<br>~~Nov -15~~<br>~~Jan - 16~~ | MD | **Complete.** All posts successfully recruited to. All staff will be in post by end of March 16 | 5 |
| Mortality database to be developed (1.5) | ~~Oct - 15~~<br>Review<br>~~Nov - 15~~<br>~~Jan - 16~~<br>~~Mar 2016~~<br>Jun 2016 | MD | Database developed and currently in testing phase. Roll out anticipated June 2016. Deadline extended to reflect this | 3 |
| Pilot Copelands Risk adjusted Barometer (CRAB) | Mar-16 | MD | Complete. Decision taken that this tool will not be used. | 5 |
| Scoping of Medical Examiners as Mortality Screeners (1.6) | ~~31/03/2016~~<br>Jul 2016 | MD | 21 clinicians have expressed interest. Evening event planned for May and day long training session scheduled for May.<br>Peter Furness appointed as UHL Lead Medical Examiner. Roll out at LRI anticipated July 2016. Deadline extended to reflect this. | 3 |

| Board Assurance Framework: | Updated version as at: | Mar-16 |
|---|---|---|
| **Principal risk 2:** | Emergency attendance/ admissions increase | |

| | | | |
|---|---|---|---|
| **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 | 5x5=25 | 5x5=25 | 5x5=25 |
| **Target risk rating (I x L):** | 3x2=6 | | | | | | | | | | | |

| Controls: (preventive, corrective, directive, detective) | Assurance on effectiveness of controls – Internal | Assurance on effectiveness of controls – External | Gaps in Control / Assurance |
|---|---|---|---|
| **Directive / Preventative Controls**<br>NHS '111' helpline<br>GP referrals<br>Local/ National communication campaigns<br>Winter surge plan<br>Triage by Lakeside Health (from 3/11/15) for all walk-in patients to ED.<br><br>Urgent Care Centre (UCC) now managed by UHL from 31/10/15<br><br>Admissions avoidance directory<br>Reworking of LLR urgent care RAP- as detailed in COO report<br>**Detective Controls**<br>Q&P report monitoring ED 4-hour waits, ambulance handover >30 mins and >60 mins, total attendances / admissions.<br><br>Comparative ED performance summaries showing total attendances and admissions. | **ED 4 hour wait performance (threshold 95%)**<br>77% in March and 3% lower for the year compared to the year below. (A further deterioration since previous report). Poor performance continues to be primarily driven by record ED attendances and emergency admissions but has also been contributed to by staffing issues.<br>**Total attendances and admissions (compared to previous year)**<br>Attendance + 6.8%<br>Admissions + 5.6%<br>**Ambulance handover (threshold 0 delays over 30 mins)**<br>**There has been a recent improvement in ambulance handover times as detailed in the COO emergency care TB report.**<br>**Difficulties continue in accessing beds from ED leading to congestion in the assessment area and delayed ambulance handover.**<br>**Bed Occupancy.**<br>**Monitored daily but not formally reported** | National benchmarking of emergency care data<br><br>Urgent Care Board fortnightly dashboard. | (c) Lack of effectiveness of admissions avoidance plan (2.1)<br>(c )Lack of effectiveness of attendance avoidance plan<br>Lack of winter surge capacity (2.1) |

| **Assurance rating:** | R | **Comments on assurance** | Performance is the poorest it has ever been, at a time when we are seeing the highest ever sustained period of attendance and admissions. The gaps in assurance - clear attendance and admission avoidance plans are key to resolving this. |
|---|---|---|---|

| Action tracker: | Due date | Owner | Progress update: | Status |
|---|---|---|---|---|
| LLR plan to reduce admissions (including access to Primary Care) (2.1) | ~~01/11/2015~~ Review Apr - 16 | COO | Admissions and attendance continue to increase. | 1 |

| Board Assurance Framework: | Updated version as at: | Mar-16 | |
|---|---|---|---|
| **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 | 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 – Internal | Assurance on effectiveness of controls – External | Gaps in Control / Assurance |
|---|---|---|---|
| **Detective Controls**<br>RTT incomplete waiting times, cancer access and diagnostic standards reported via Q&P report to TB<br><br>**Corrective controls**<br>Medinet providing w/e lists for endoscopy.<br>Patients transferred to Circle and Nuffield<br>Additional lists by UHL consultants<br><br>Gastro position improving through use of corrective controls. | **RTT Incomplete waiting times (threshold 92%).** Currently 93.2% (predicted)<br>RTT backlog currently 3400 (up from 3000)<br>**Cancer Access Standards (reported quarterly).**<br>Current performance based on Feb data<br>**2 ww for urgent GP referral (Threshold 93%).**<br>93.2%<br>**2 ww for symptomatic breast patients (threshold 93%).** 96.2%<br>**31 day wait for 1st treatment (threshold 96%).**<br>91.4%<br>**31 day wait for 2nd or subsequent treatments (Drugs - threshold 98%).** 100%<br>(**Surgery - threshold 94%**). 77.5%<br>**(Radiotherapy - threshold 94%).** 96.4%<br>**62 day wait for 1st treatment (threshold 85%).**<br>74.5%<br>**62 day wait for 1st treatment (CSS referral- threshold 90%).** 77.3%<br>**Cancer wait 104 days (threshold TBC).** 24<br>**Diagnostics** 1.3% | Internal audit review on breast screening and cancer performance standards due Q2 2015/16. Report received and actions implemented<br><br>Internal audit review in relation to waiting times for elective care due in quarter 4 2015/16; initiated end January 2016<br><br>NHS IQ to externally review endoscopy; now implementing agreed changes<br><br>Cancer and RTT Board monthly meetings with CCGs and NTDA. Recovery action plan in place<br><br>Monthly performance call with NTDA<br><br>NHS Intensive Support team visit Aug 2015 and additional advice re cancer management January 2016 | (c) Volume of elective cancellations associated with emergency pressure.<br><br>(c) Volume of cancellation for cancer treatment due to emergency pressure.<br><br>(c) Failure of diagnostic 6 week standard due to endoscopy overdue planned patients (3.5)<br><br>(c ) Emerging gap in ability to meet Gastro outpatient demand (3.4)<br><br>(c) Lack of progress on 62 day backlog reduction due to ITU/HDU capacity and gaps in clinical capacity in key specialties (3.6) |

| Assurance rating: | G | Comments on assurance | Acceptable number of assurance sources however 4 out of 11 KPIs are below threshold |
|---|---|---|---|

| Action tracker: | Due date | Owner | Progress update: | Status |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| Diagnostics / endoscopy recovery of <1% Threshold over 6 weeks (3.5) | Mar-16 | DPI | Reduction of number over 6 weeks progressing as planned, confident of meeting target date | 4 |
| Sustained achievement of 85% 62 day standard (3.6) | Sep-16 | DPI | 62 day backlog reduction currently off trajectory. Implementation of 'Next Steps' for cancer patients in key tumour sites to start end February 2016. The extension to deadline comes as part of our submission to the TDA for our sustainable transformation plans. | 3 |

| **Board Assurance Framework:** | Updated version as at: | Mar-16 | | |
|---|---|---|---|---|
| **Principal risk 4:** | Existing and new tertiary flows of patients not secured compromising UHL's future more specialised status | | **Risk owner:** | Director of Marketing and Comms (DoMC) |
| **Strategic objective:** | Integrated care in partnership with others | | **Objective owner:** | DoMC |

| **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 | 4x3=12 | 4x3=12 | 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**<br>NHS England Five Year Forward View sets out the national strategic direction.<br>UHL Business Decision Process.<br>UHL/NUH Children's Services Collaborative Group.<br>Partnership Board for Specialised Services established in Northamptonshire. Membership includes Northants CCGs; NHS England; KGH; NGH and UHL.<br>Bipartite Partnership Working Group UHL/NUH.<br>Memorandum of Understanding (MoU) between NUH and UHL<br>Tripartite Working Group UHL/NUH/ULHT.<br>SLAs in place for all partnerships<br>**Detective/Corrective Controls**<br>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.<br>Compliance with national service specifications.<br>Strategic Clinical Network/Senate reviews. | (c) Absence of Tertiary Partnerships Strategy (4.1).<br>(c )MoU/SLA to be put in place for the work-streams as detailed in the tertiary partnerships work programme. (4.4)<br>(a) Detailed tertiary partnerships work programme required (4.2).<br>(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~~<br>~~Jan – 16~~ | DS | **Complete.** Paper to ESB 12 January 2015 | 5 |

| | | | | |
|---|---|---|---|---|
| Begin reporting on return on investment (4.3) | ~~Jan 2016~~<br>Apr-16 | DS | ROI for specific areas identified but reporting mechanism not established. Partnership Board 18 Jan identified following measures to be considered: Numbers of joint posts and "partnership" clinical sessions; balance sheet; business case objectives. Unintended consequences could also be considered.<br>To progress after the contract process and year end is complete | 3 |
| Develop MoUs for work streams (4.4) | ~~01/12/2016~~<br>Apr-16 | JC | The MOU for South East Midlands Oncology Collaboration (SEMOC) was approved at ESB in April. The next MOU is focussing on Urology and the partnership with Lincolnshire | 3 |

| Board Assurance Framework: | Updated version as at: | Mar-16 | | |
|---|---|---|---|---|
| **Principal risk 5:** | Failure to deliver integrated care in partnership with others including failure to:<br>Deliver the Better Care Together year 2 programme of work<br>Participate in BCT formal public consultation with risk of challenge and judicial review<br>Develop and formalise partnerships with a range of providers (tertiary and local services)<br>Explore and pioneer new models of care. Failure to deliver integrated care. | | **Risk owner:** | Director of Marketing and Comms (DoMC) |
| **Strategic objective:** | Integrated care in partnership with others | | **Objective owner:** | DoMC |

| **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 | 4x4=16 | 4x4=16 | 4x4=16 |
| **Target risk rating (I x L):** | 2x5=10 | | | | | | | | | | | |

| Controls: (preventive, corrective, directive, detective) | Assurance on effectiveness of controls: Internal | Assurance on effectiveness of controls: External | Gaps in Control / Assurance |
|---|---|---|---|
| **Directive Controls**<br>Robust - BCT and UHL/BCT project governance structure including programme management arrangements.<br>BCT Programme five year directional plan.<br>Two-year operational plan.<br>LLR BCT Strategic Outline Case.<br>LLR BCT Partnership Board.<br>UHL Reconfiguration Programme Board.<br>LLR project delivery structure and organisational specific delivery mechanisms, including 8 integrated clinical work streams.<br>LLR project delivery through revised LLR BCT Delivery Board.<br>LLR BCT Service Reconfiguration Board.<br>CCG Commissioning Collaborative Board.<br>**Detective Controls**<br>Progress updates to LLR BCT Partnership Board.<br>Monthly UHL Reconfiguration Programme Board progress reports to ESB.<br>Monthly BCT progress report to Trust Board.<br>Monthly project specific highlight reports | Assurance in respect of the PCBC is secured via the Board<br>Av length of stay (10% improvement in 15/16)<br>Reduction in emergency admissions with a length of stay of 0-6 hours.<br>Rapid access HF clinic attendances from ED and CDU (by March 2016).<br>Integrated medicine (elderly) av length of stay 3day + emergency patients. Respiratory av length of stay 3day + emergency patients.<br>Cardiology av length of stay 3day + emergency patients.<br>Patient experience<br>Satisfaction of people who use services with their care and support.<br>Increase in virtual appointments.<br>ED unplanned re-attendance rate.<br>SHMI reduced to 95.<br>Increased treatments in community setting.<br>Enhanced out of hospital ICS bed capacity (130 beds to open by the end of March 2016). | Internal audit review in relation to governance structures around hosted services i.e. Elective Care Alliance due Q2 2015/16.<br>Head of Strategic Development sits on BCT Delivery Board - escalates as required.<br><br>PCBC is considered by partner boards including CCG Boards UHL and LPT Trust Boards, Local Authorities etc. Ultimate decision to go to consultation sits with NHS England | (a)Lack of LLR wide BCT outcome dashboard required so that performance can be monitored (5.1)<br><br>(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)<br><br>(c) Project plan for Frail Older Person Service not yet developed (5.4)<br><br>(c ) LLR Board requires stronger clinical leadership and Commissioner engagement (5.6)<br><br>(a)Draft LLR BCT Dashboard prepared for use in UHL |

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|---|---|---|---|
| considered at UHL/BCT Reconfiguration Programme Board.<br>Draft LLR wide performance dashboard presented to Trust Board for use by UHL.<br>LLR Chief Officers Group. | Target bed occupancy 90%. Current 84%.<br>Av length of stay (10 days). Current < 10 days.<br>Emergency admissions<br>Delayed Transfer of Care | | however further detail has been requested by the Board (5.7)<br><br>(c) The scope of services requiring consultation in the revised PCBC is greater than expected in particular specialised services e.g. congenital, vascular (5.8) |

| **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~~<br>~~Dec-15~~<br>~~Mar - 16~~<br>TBC | DS | High level milestones identified for all BCT Clinical Work streams with quarterly deliverables to promote transparency and to bolster accountability arrangements. This will be used to develop a dashboard - timescales being considered by the BCT PMO and Delivery Board - to be confirmed | 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~~<br>~~Review~~<br>~~Nov 15~~<br>~~Dec 15~~<br>~~Feb 2016~~ | DS | **Complete.** Further work completed on PCBC following NHS England feedback. PCBC went through CCG Board in February 2016 and to UHL Trust Board in March have supported the direction of travel described but noted the need for capacity and demand assumptions to be regularly revisited given levels of prevailing demand being experienced | 5 |
|---|---|---|---|---|
| Integrated Frail Older Person Service project plan to be developed (5.4) | ~~Oct 15~~<br>Review<br>~~Nov 15~~<br>~~Dec - 15~~<br>Feb 2016 | DS | **Complete.** BCT Clinical Work stream draft plan has been developed - this is now being led by Carmel O'Brien, Joint SRO, Frail Older People & Dementia, West Leicestershire CCG | 5 |
| OD and change plan - For inclusion in revised PCBC narrative and project plans (5.3) | ~~Dec 2015~~<br>~~Feb 2016~~ | DS | **Complete.** 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. The UHL Way Implementation Plan for 2016/17 has been presented to and approved by the Executive Workforce Board (March 16) and Trust Board (April 16). A 2 Year Workforce Enabling Plan has been created to address a number of workforce / OD challenges including ensuring effective management of change and development of the 'system' culture. | 5 |
| Membership and terms of reference of the LLR Service Reconfiguration Board are currently under review | ~~01/03/2016~~<br>May 2016 | DS | Revised draft ToR discussed at March BCT Delivery Board but further revisions are required, which will now be overseen by Richard Mitchell and Rachel Bilsborough as the new joint SROs. | 4 |
| Incorporate LLR BCT dashboard with UHL reconfiguration dashboard (5.7) | ~~Mar-16~~ | | **Complete.** | 5 |
| | | | | |

<table>
<tr><td>Board Assurance Framework:</td><td colspan="3">Updated version as at:</td><td colspan="9">Mar-16</td></tr>
<tr><td>Principal risk 6:</td><td colspan="8">Failure to attain BRC status</td><td colspan="2">Risk owner:</td><td colspan="2">Medical Director (MD)</td></tr>
<tr><td>Strategic objective:</td><td colspan="8">Enhanced delivery in research, innovation and clinical education</td><td colspan="2">Objective owner:</td><td colspan="2">MD</td></tr>
<tr><td rowspan="2">Current risk rating (I x L):</td><td>April</td><td>May</td><td>June</td><td>July</td><td>August</td><td>Sept</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>March</td></tr>
<tr><td>3x3=9</td><td>3x3=9</td><td>3x3=9</td><td>3x3=9</td><td>3x3=9</td><td>3x3=9</td><td>3x3=9</td><td>5x3=15</td><td>5x3=15</td><td>3x3=9</td><td>3x3=9</td><td>3x3=9</td></tr>
<tr><td>Target risk rating (I x L):</td><td colspan="12">3 x 2 = 6</td></tr>
<tr><td colspan="2" rowspan="2">Controls: (preventive, corrective, directive, detective)</td><td colspan="8">Assurance on effectiveness of controls</td><td colspan="3" rowspan="2">Gaps in Control / Assurance</td></tr>
<tr><td colspan="4">Internal</td><td colspan="4">External</td></tr>
<tr><td colspan="2">Directive Controls<br>Each BRU has a strategy document<br><br>Preventive Controls<br>UHL R&I supportive role to BRUs by meeting with Universities (Joint Strategic Meeting)<br>Good working relationships between UHL and University partners<br>Good track record of attracting subjects into studies<br>Contracting and innovation team.<br>Work with Medipex to commercialise our projects/ ideas.<br><br>Detective Controls<br>Financial monitoring of BRUs via Annual Report<br><br>Corrective controls<br>UHL to provide funding from external sources for targeted posts if necessary</td><td colspan="4">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.<br><br>Highest recruiting Trust in the East Midlands and 7th nationally</td><td colspan="4">NIHR monitor BRU performance<br>University analysis of data</td><td colspan="3">(c) NIHR national strategy not under UHL control (6.3)<br>(c ) Weak support from academic partners (6.1)</td></tr>
<tr><td>Assurance rating:</td><td>A</td><td colspan="2">Comments on assurance</td><td colspan="9">Few 'hard KPIs' (i.e. quantitive assurances) identified to monitor the effectiveness of controls</td></tr>
<tr><td colspan="5">Action tracker:</td><td>Due date</td><td>Owner</td><td colspan="5">Progress update:</td><td>Status</td></tr>
</table>

| | | | | |
|---|---|---|---|---|
| Closer joint working with Universities to provide successful Athena Swan application.(6.2) | ~~Review Jan 2016~~ ~~Mar 2016~~ | MD | **Complete.** Both Respiratory and Cardiovascular BRUs have successfully attained Athena Swan Silver status. | 5 |
| Develop new 4-way strategy meeting with UHL, UoL, LU and DMU (6.1) | ~~01/03/2016~~ Jun 2016 | MD | On-going | 3 |
| Closer joint working with Universities to develop application (6.3) | ~~Review Feb 2016~~ Review Apr-16 | MD | Director and theme leads agreed, academic partners agreed. Pre qualifying questionnaire submitted - outcome expected April 16. Work underway towards full application. Progress discussed at Joint BRU Board and R&I Exec - application process very competitive and final decision making external to UHL. | 4 |

| Board Assurance Framework: | Updated version as at: | | Mar-16 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 | 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 – Internal | Assurance on effectiveness of controls – External | Gaps in Control / Assurance |
|---|---|---|---|
| **Directive Controls**<br>Medical Education Strategy<br>Operational guidance<br><br>**Detective Controls**<br>Medical education database to show number of accredited trainers which feeds into Medical Education Quality dashboard.<br>Reported to EWB via Medical Education Committee minutes<br>University Dean's report | Medical Education Quality Dashboard shows the percentage of medical staff complying with GMC requirements (per CMG). Target 100%.<br>Current position (per CMG) =<br>• CHUGGS 76%<br>• CSI:<br>o Imaging 89%<br>o Pathology 67%<br>• ESM 68%<br>• ITAPS 79%<br>• MSS 88%<br>• RRCV 44%<br>• W&C:<br>o Women's 96.5%<br>o Children's 80%<br>University Deans report to show % of fully recognised medical trainers in UHL. (threshold 100%) by July 2016. Current position = 74% (down from 75% previous period)<br>UHL trainee survey | HEEM accreditation visits.<br>GMC trainee survey results | (c & a) Accuracy of database uncertain (7.1)<br><br>(c ) EWB and CMG scrutiny / challenge of Medical Education issues is weak (7.2) |

| Assurance rating: | A | Comments on assurance | Good range of internal assurances now in place however until the issues around the accuracy of the database can be resolved then full assurance cannot be provided. |
|---|---|---|---|

| 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 | On-going engagement with CMG Med ED leads. Extra provision of online supervisor training in place to improve accreditation rates among supervisors. Triangulation of internal and external data sources to improve database accuracy. | 4 |
| Medical Director to 'champion' scrutiny of Medical Education Committee minutes at EWB (7.2) | Mar-16 | MD | **Complete** | 5 |

<table>
<tr><td colspan="2">Board Assurance Framework:</td><td colspan="3">Updated version as at:</td><td colspan="9">Mar-16</td></tr>
<tr><td colspan="2">Principal risk 8:</td><td colspan="8">Insufficient engagement of clinical services, investment and governance may cause failure to deliver the Genomic Medicine Centre project at UHL</td><td colspan="2">Risk owner:</td><td colspan="2">Medical Director (MD)</td></tr>
<tr><td colspan="2">Strategic objective:</td><td colspan="8">Enhanced delivery in research, innovation and clinical education</td><td colspan="2">Objective owner:</td><td colspan="2">MD</td></tr>
<tr><td colspan="2" rowspan="2">Current risk rating (I x L):</td><td>April</td><td>May</td><td>June</td><td>July</td><td>August</td><td>Sept</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>March</td></tr>
<tr><td>3x3=9</td><td>3x3=9</td><td>3x3=9</td><td>3x3=9</td><td>3x3=9</td><td>3x3=9</td><td>4x3=12</td><td>4x4=16</td><td>4x4=16</td><td>4x4=16</td><td>4x4=16</td><td>4x4=16</td></tr>
<tr><td colspan="2">Target risk rating (I x L):</td><td colspan="12">3 x 2 = 6</td></tr>
<tr><td colspan="3" rowspan="2">Controls: (preventive, corrective, directive, detective)</td><td colspan="8">Assurance on effectiveness of controls</td><td colspan="3" rowspan="2">Gaps in Control / Assurance</td></tr>
<tr><td colspan="4">Internal</td><td colspan="4">External</td></tr>
<tr><td colspan="3">Directive Controls<br>Director of R&I meets with key CMG managers to ensure engagement.<br>Genomic Medicine Centre (GMC) CMG leads for Cancer and rare diseases<br>New pathway for samples initiated with Genomic Medicine Centre at Cambridge (previously Nottingham).<br><br>Preventive Controls<br>Engagement with CMGs via comms strategy including weekly national and local (i.e. UHL) news letters<br>Contracting and innovation team<br>Work with Medplex to help commercialise our projects ideas<br><br>Detective Controls<br>Research study subject recruitment trajectory ( sufficient income depends upon meeting recruitment thresholds). Monitored by GMC Steering Committee and UHL Exec Team</td><td colspan="4">Monthly and annual trajectory for recruitment into this project.<br><br>Currently we are slightly below trajectory for rare diseases but this is improving. New pathway for samples initiated with Genomic Medicine Centre at Cambridge to resolve issues</td><td colspan="4">Eastern England Genomic Centre monitoring against recruitment trajectory.</td><td colspan="3">(c ) Ineffective recruitment into studies attributable to lack of research staff (8.1)</td></tr>
<tr><td colspan="2">Assurance rating:</td><td>A</td><td colspan="2">Comments on assurance</td><td colspan="9">Consideration should be given as to whether the current assurance sources are adequate to monitor the effectiveness of controls</td></tr>
</table>

| Action tracker: | Due date | Owner | Progress update: | Status |
|---|---|---|---|---|
| Lead nurse and team of Clinical Research Assistants to be appointed. (8.1) | ~~Dec-15~~ | DRI | **Complete** - research Nurse and CRAs in post | 5 |
| Additional Research Nurse to be appointed (8.1) | ~~Feb-16~~ | DRI | **Complete** | 5 |
| Engagement of CMGs with process (8.1) | Jun-16 | MD DRI | DRI and MD leading on engagement programme. Meeting with Clinical Genetics and W&C CMG Management to discuss Clinical Genetics workforce plan. | 4 |
| Appoint nurse to cover maternity leave in May | Jun-16 | MD CRI | Out to advert | 4 |
| Appoint Project Manager (replacement post) (8.1) | Mar-16 | DRI | **Complete** | 5 |
| Recruitment against trajectories (8.1) | Jun-16 | DRI | Rare Diseases: currently exceeding trajectory – catching up with ground lost previously Cancer: start recruitment - sample pathways through labs needs full engagement and buy in from pathology and theatres – this is underway | 4 |
| Finalise IT plans | Jun-16 | DRI | Ensure UoL team deliver CiVi CRM to timelines | 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 – Internal | Assurance on effectiveness of controls – External | Gaps in Control / Assurance |
|---|---|---|---|
| Maintaining relationships with key academic partners. Developing relationships with key academic partners.<br><br>Existing well established partners:<br><br>• University of Leicester<br>• Loughborough University<br><br>Developing partnerships;<br>• De Montfort University<br>• University of Nottingham<br>• University College London (Life Study)<br>• Cambridge University (100k project)<br><br>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<br>Minutes of Joint BRU Board<br>Minutes of NCSEM Management Board<br>Meetings of Joint UHL/UoL research office<br><br>Life steering group meets monthly<br>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: | Mar-16 |
|---|---|---|
| **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 | 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** – **Internal** | **Assurance on effectiveness of controls** – **External** | **Gaps in Control / Assurance** |
|---|---|---|---|
| **Directive Controls**<br>Organisational development (OD) Plan<br>Listening into Action (LiA)<br>Workforce planning<br>Leadership into Action Strategy<br>Equality Action plan<br>'Freedom to Speak' standard BCT Strategy<br>Medical Workforce strategy<br><br>**Detective Controls**<br>Organisational health dashboard<br>Q&P report<br>3636 concerns hotline<br>Junior Dr 'gripe tool'<br>Patients Safety walkabouts<br>UHL intranet 'staff room'<br>Clinical Senate<br>Monthly 'Breakfast with the Boss' forums | Organisational health dashboard and Q&P report including:<br>Friends and family staff survey (% of staff who would recommend UHL as a place to work).<br>Feb 16 = 69.4%<br><br>Turnover rate 9.87% for Mar 2016 (monthly report - threshold =/< 11).<br><br>Sickness absence rate = 4.55% for Feb 2016 (Mar data not available)(monthly report- threshold 3%)<br><br>Annual appraisal rate = 90.7% for March 2016 (monthly report - threshold 95%)<br><br>Stat/ Man training = 93% for March (monthly report - threshold 95%)<br><br>Corporate induction attendance for Mar = 98% (monthly report - threshold 95%) | Internal audit review of medical staffing due Q3 2015/16.<br><br>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)<br>(c) BCT Workforce Strategy Delivery Plan (10.2)<br>(c) Workforce Plan (10.3) |

| Assurance rating: | G | Comments on assurance | |
| --- | --- | --- | --- |

| Action tracker: | Due date | Owner | Progress update: | Status |
| --- | --- | --- | --- | --- |
| Develop threshold for F&F staff survey. (10.1) | ~~Dec 15~~<br>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 | 5 |
| Development of Workforce Plan aligned to BCT (10.2) | Mar-16 | DWOD | Addressing priorities workshop held in March 16. Work progressing in collaboration with BCT partners on development of an LLR workforce plan. Work to be undertaken by Whole Systems Partnership which will link activity changes to workforce changes at a macro level. | 5 |
| Development of BCT Workforce Strategy (10.3) | ~~Dec 15~~<br>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). BCT plan issued to Trust Board in Feb 2016 | 5 |

<table>
<tr><th>Board Assurance Framework:</th><td colspan="3">Updated version as at:</td><td colspan="9">Mar-16</td></tr>
<tr><th>Principal risk 11:</th><td colspan="8">Insufficient estates infrastructure capacity and the lack of capacity of the Estates team may adversely affect major estate transformation programme</td><td colspan="2">Risk owner:</td><td colspan="2">Chief Financial Officer (CFO)</td></tr>
<tr><th>Strategic objective:</th><td colspan="8">A clinically sustainable configuration of services, operating from excellent facilities</td><td colspan="2">Objective owner:</td><td colspan="2">CFO</td></tr>
<tr><th rowspan="2">Current risk rating (I x L):</th><td>April</td><td>May</td><td>June</td><td>July</td><td>August</td><td>Sept</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>March</td></tr>
<tr><td>5x4=20</td><td>5x4=20</td><td>5x4=20</td><td>5x4=20</td><td>5x4=20</td><td>5x4=20</td><td>5x4=20</td><td>5x4=20</td><td>5x4=20</td><td>5x4=20</td><td>5x4=20</td><td>5x4=20</td></tr>
<tr><th>Target risk rating (I x L):</th><td colspan="12">5 x 2 = 10</td></tr>
</table>

| **Controls: (preventive, corrective, directive, detective)** | **Assurance on effectiveness of controls**<br>**Internal** | <br>**External** | **Gaps in Control / Assurance** |
|---|---|---|---|
| **Directive Controls**<br>UHL reconfiguration programme governance structure aligned to BCT<br>Reconfiguration investment programme demands linked to current infrastructure.<br>Estates work stream to support reconfiguration established<br>Five year capital plan and individual capital business cases identified to support reconfiguration<br><br>**Detective Controls**<br>Survey to identify high risk elements of engineering and building infrastructure.<br>Monthly report to Capital Investment Monitoring committee to track progress against capital backlog and capital projects<br>Regular reports to Executive Performance Board (EPB).<br>Highlight reports developed monthly and reported to the UHL Reconfiguration Programme Board.<br><br>**Corrective Control**<br>Revised programme timescale approved by IFPIC | Capital expenditure and progress against reconfiguration programme monitored via Capital Investment committee.<br>Major Capital - On track against revised schedule<br>Annual programme - On track against revised schedule<br>Space Management - Behind schedule<br>Property Management - Behind schedule | | (c) A programme of infrastructure improvements is yet to be identified (11.1)<br><br>(c) Overall programme of works not yet identified and quantified in relation to risk (11.2)<br><br>c) Currently no identified capital funding within 2015/16 programme and future years (11.3)<br><br>(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~~ May 2016 | DEF | In progress - delays due to additional surveys being requited to be undertaken, no direct impact on capital programme due to general slow down in Capital funding. We are continuing to gather data which has required the installation of various metering devices. As a result of this the Capita Infrastructure Report will not be available until the end of May 2016 | 3 |
| Develop a programme of works (11.2) | ~~01/03/2016~~ Jun 2016 | DEF | In Progress - detailed following output of 11.1 | 4 |
| Identification of investment required and allocation of capital funding 11.3) | ~~01/03/2016~~ Jun 2016 | DEF/CFO | Prioritisation of backlog capital once 2016/17 annual capital resources confirmed bu IFPIC | 4 |
| Define resource and skills gaps and agree an enhanced team structure to support the significant reconfiguration programme (11.4) | Review ~~Nov 1~~5 ~~Feb 2016~~ ~~May 16~~ Jul 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. Following transfer of IFM estates and facilities operational services to in-house on the 1st May 2016, a review will take place on skill gaps and overal resources of the team, followed by potential recriument programe and MOC | 3 |

| Board Assurance Framework: | Updated version as at: | Mar-16 | |
|---|---|---|---|
| Principal risk 12: | Limited capital envelope to deliver the reconfigured estate which is required to meet the Trust's revenue obligations | Risk owner: | Chief Financial Officer (CFO) |
| 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 | 4x5=20 | 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**<br>Five year capital plan and individual capital business cases identified to support reconfiguration<br>Business case development is overseen by the strategy directorate and business case project boards manage and monitor individual schemes.<br>Capital plan and overarching programme for reconfiguration is regularly reviewed by the executive team.<br><br>**Detective Controls**<br>Capital Investment Monitoring Committee to monitor the programme of capital expenditure and early warning to issues.<br>Monthly reports to ESB and IFPIC on progress of reconfiguration capital programme.<br>Highlight reports produced for each project board.<br><br>**Corrective Control**<br>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<br><br>Resource expenditure for development of business cases - on track/ monitored on a monthly basis<br><br>Affordability of business cases (i.e. schemes within allocated budget envelope) - on track against revised programme.<br><br>Individual projects monitored via highlight report including project timelines which are reviewed by the Major Business Case meeting and Reconfiguration Board. | Regular meetings with<br>NDTA<br>ITFF<br>NHS England<br>BCT Programme Board | (c) Uncertain availability of external capital funding. (12.1)<br><br>(c) 'road map' requires development to provide the full picture and deliverability of the programme of change (12.2) |

| Assurance rating: | A | 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<br>~~Nov 15~~<br>~~Dec 16~~<br>~~Feb 2016~~<br>Mar 2016 | DEF/DS/<br>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. Capital plan updated based on likely outcome, however capital funding confirmation not expected until end Q1. | 3 |
| Consideration given to other sources of funding (12.1) | Review<br>~~Nov 15~~<br>~~Feb 16~~<br>~~Apr 16~~<br>Jun 2016 | DEF/DS/<br>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. Action still on-going - due to report to ESB June 16 | 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~~<br>~~Feb 16~~<br>~~Apr 16~~<br>Jun 2016 | DEF/DS | Workshops held and. LGH work stream established to progress activities to refresh the 'route map' - outputs expected in Feb16. Draft roadmap presented to ESB with further detail to be added now service reconfiguration plans have been firmed up - work on-going interim update to ESB in April 16, further update in June 16. Deadline extended to reflect this. | 3 |

| Board Assurance Framework: | Updated version as at: | Mar-16 | | |
|---|---|---|---|---|
| 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: | Chief Financial Officer (CFO) |

| 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 | 4x4=16 | 4x4=16 | 4x4=16 |
| Target risk rating (I x L): | 4x2=8 | | | | | | | | | | | |

| Controls: (preventive, corrective, directive, detective) | Assurance on effectiveness of controls – Internal | Assurance on effectiveness of controls – External | Gaps in Control / Assurance |
|---|---|---|---|
| **Directive Controls**<br>LLR FMC Board<br>Outsourced facilities management contract performance managed by the Estates and Facilities Management Collaborative<br><br>**Preventive/ Corrective Controls**<br>On-going major incident scenarios developed and played out to identify any deficiencies in data, process and systems<br><br>**Detective controls**<br>Monthly defined KPI's which monitor Interserve FM (IFM) are reported to Contract Management Panel<br>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.<br><br>UHL are reporting major concerns around performance and delivery of the IFM contract<br><br>Current IFM senior management and operational structures will be assimilated into the Estates and Facilities Directorate | PLACE inspection performed in March 2015 and PLACE inspections planned for March - June 2016<br>3rd party independent auditing. | a) Lack of electronic evidence by IFM on compliance<br><br>(a) Limited contractual KPI's in certain areas of compliance.<br><br>(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. From the 1st May a period of review will take place to identify gaps in compliance and identification of a programme for correction | 5 |
| Terminate the IFM Contract as of 30th April 2016 and to transfer all FM services back in-house hosted by UHL to deliver services to UHL and across LLR to LPT and NHS PS Transfer services on the 1st May 2016 (13.1/13.2 | May-16 | DEF | FM Repatriation Board formed with inaugural meeting on the 4th March. Work streams reporting to Board with progress and risk registers<br>Phase 1 - FM repatriation plans on track for confirmed 1st May transfer date Phase 2 - Review of current service, risk and issues and develop plans to reform FM service. Carry out quick wins<br>Phase 3 - Implement changes identified in phase2 | 4 |

| Board Assurance Framework: | Updated version as at: | Mar-16 | | |
|---|---|---|---|---|
| **Principal risk 14:** | Failure to deliver clinically sustainable configuration of services | | **Risk owner:** | Chief Financial Officer (CFO) |
| **Strategic objective:** | A clinically sustainable configuration of services, operating from excellent facilities | | **Objective owner:** | CFO |

| **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 | 4x4=16 | 4x4=16 | 5x4=20 |
| **Target risk rating (I x L):** | 4x2=8 | | | | | | | | | | | |

| **Controls: (preventive, corrective, directive, detective)** | **Assurance on effectiveness of controls** | | **Gaps in Control / Assurance** |
|---|---|---|---|
| | **Internal** | **External** | |
| **Directive Controls**<br>UHL reconfiguration programme governance structure aligned to BCT<br>Strategic capital business case work streams aligned to BCT<br>Monthly meetings with the NTDA to identify new business cases coming up for approval<br>Detailed programme plan identifying key milestones for delivery of the capital plan.<br>Project plans and resources identified against each project.<br>A future operating model at speciality level which supports a two acute site footprint:<br>Out of hospital contract approved and project established to shift appropriate activity into the community.<br><br>**Detective Controls**<br>Gateway / Assurance review<br>A monthly highlight report to indicate RAG rating of reconfiguration programme submitted to the UHL Reconfiguration Programme Delivery Board.<br>Monthly aggregate reporting to ESB, IFPIC and Trust Board. | Progress of all reconfiguration programme work streams is monitored via aggregated reporting to ESB/ IFPIC/ TB.<br><br>Monthly updates via aggregated reporting (highlight reports) to ESB/ IFPIC/ TB.<br><br>Overall reconfiguration programme is RAG rated. Currently reported as 'amber 'due to complexity of programme and risks associated with delivery. | Regular meetings with<br>NTDA<br>NHS England<br>BCT Programme Board<br>Gateway / Assurance review carried out Feb - 16 | (c) Lack of capacity within the NTDA to resource each of the business cases<br>c) changes to capacity and demand management / left shift assumptions will determine future size and configuration of services. If this differs from current plan it may have significant cost implications (14.1)<br>(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)<br><br>(c ) Delay in BCT public consultation (14.2)<br><br>(a)No thresholds in place to provide an objective view of the RAG rating in relation to reconfiguration programme progress (14.3) |

| | | | |
|---|---|---|---|
| Monthly meetings with the NTDA to discuss the programme of delivery<br>Monitoring of progress towards UHL two acute site model<br>Monitoring of business case timescales for delivery.<br>Requirements identified to deliver key projects overseen by PMO<br>Monitor spend against agreed budgets. | | | (c) ITU interim configuration has been delayed due to capital availability, this will not be confirmed until Q1 2016/17. In addition to capital there are risks to Trust capacity that may delay move further. Interim measures have been put in place to manage risks in short-term, these arrangements need to be reviewed if any further delays (14.4) |

| **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~~<br>~~Feb 16~~<br>Jun - 16 | CFO | First iteration of road-map shared in February 16 as planned. Further version to reflect all sites, inter-dependencies and sequencing now underway. Due to present back to ESB in June 16 as it will be impacted upon by overall programme timeframes. Action still on-going. | 3 |
| Develop a contingency address the delay (14.2) | ~~Jan 16~~ | CFO | **Complete** Impact of external influences (capital/consultation etc) is being considered with exec led actions to consider scenarios for review. Programme rephased to reflect current known and approved by ESB. Further updates planned at key dates - expected capital funding confirmation expected end Q1. | 5 |
| Develop clear thresholds to enable a more objective RAG rating for overall progress of reconfiguration programme (14.3) | ~~Jan 2016~~<br>~~Mar - 16~~<br>Jun 2016 | CFO | Programme reporting processes being reviewed as part of Gateway review action plan - this will include development of KPIs and RAG parameters. Due date extended to reflect this process. | 3 |
| Review interim arrangements to manage risk if further delays to ITU reconfiguration | ~~01/06/2016~~<br>Jul 2016 | CFO | Action only required if further delays are introduced. | 4 |

| Board Assurance Framework: | Updated version as at: | Feb-16 | | |
|---|---|---|---|---|
| **Principal risk 15:** | Failure to deliver the 2015/16 programme of services reviews, a key component of service-line management (SLM) | | **Risk owner:** | Chief Financial 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 3x3=9 | 3x3=9 | 3x3=9 | 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: Internal | Assurance on effectiveness of controls: External | Gaps in Control / Assurance |
|---|---|---|---|
| **Directive Controls**<br>Governance arrangements established<br>Overarching project plan for service reviews developed<br>New structure / methodology agreed for capturing outputs in a consistent way, aligned to the IHI Triple Aim.<br>New virtual team structure to support the intensive service reviews. New Project Steering Group to be set up using the 'virtual team' membership<br>**Detective Controls**<br>Monthly reporting to IFPIC and EPB as part of CIP report.<br>SLM / Service Review Data Packs now to include a range of metrics, beyond finance<br>Monthly updates required from services against pre-determined work programme.<br>Measurable outcomes now embedded into | Regular updates (and reports) to ESB<br>Regular updates to EPB and IFPIC as part of CIP paper (where schemes have a financial benefit)<br>KPIs as agreed during each service review.<br><br>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)<br><br>(c) Clinical engagement can be variable (as is clinical capacity to get involved)<br><br>(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~~<br>~~Jan 2016~~<br>~~Mar 2016~~<br>May 2016 | CFO | The plan involves:<br>1) the development of a Stratification Dashboard to summarise how specialities are performing across a range of indicators. This is work in progress, due end of April<br>2) the allocation of specialties to standard, enhanced and intensive service reviews depending on what level of support is required to be complete once the matrix is completed.<br>3) the development of a new data pack. A mock-up is being finalised so that a draft pack can be produced. This has been delayed due to lack of resources. | 3 |
| Improvement tools (for use by clinical services) to be finalised (15.2) | ~~Dec 15~~<br>~~Jan 2016~~<br>~~Mar 2016~~<br>~~Apr-16~~<br>May 2016 | CFO | Approach agreed.<br>An Intensive Service Review will be piloted in 3 services have been identified and need to be agreed with operational teams , commencing in March 2016. Due date extended to reflect this. The roll out of the new approach in line with the UHL Way (Better Change Methodology). Working with the UHL better change group on developing the right improvement tools to be available in the UHL Way 'Tool Box' which is expected to be rolled across the Trust in May 2016. | 3 |

<table>
<tr><td>Board Assurance Framework:</td><td colspan="3">Updated version as at:</td><td colspan="9">Mar-16</td></tr>
<tr><td>Principal risk 16:</td><td colspan="8">Failure to deliver UHL deficit control total in 2015/16</td><td colspan="2">Risk owner:</td><td colspan="2">CFO</td></tr>
<tr><td>Strategic objective:</td><td colspan="8">A financially sustainable NHS organisation</td><td colspan="2">Objective owner:</td><td colspan="2">CFO</td></tr>
<tr><td rowspan="2">Current risk rating (I x L):</td><td>April</td><td>May</td><td>June</td><td>July</td><td>August</td><td>Sept</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>March</td></tr>
<tr><td>5x3=15</td><td>5x3=15</td><td>5x3=15</td><td>5x3=15</td><td>5x3=15</td><td>5x3=15</td><td>5x3=15</td><td>5x3=15</td><td>5x3=15</td><td>5x3=15</td><td>4x3=12</td><td>5x2=10</td></tr>
<tr><td>Target risk rating (I x L):</td><td colspan="12">5x2=10</td></tr>
</table>

| **Controls: (preventive, corrective, directive, detective)** | **Assurance on effectiveness of controls**<br>**Internal** | <br>**External** | **Gaps in Control / Assurance** |
|---|---|---|---|
| **Directive Controls**<br>Agreed Financial Plan for 2015/16<br>Standing Financial Instructions<br>UHL Service and Financial strategy as per SOC and LTFM.<br><br>**Preventative Controls**<br>Sign-off and agreement of contracts with CCGs and NHS England<br>CIP delivery plan for 2015/16<br><br>**Detective Controls**<br>Monthly finance reporting in relation to income and expenditure and CIP<br><br>**Corrective Controls**<br>Identification and mitigation of excess cost pressures<br>Production of financial recovery plan submitted to NTDA | Variance to plan of £1.5m at M11 with a year end forecast in-line with the revised I&E plan of a deficit of £34.1m.<br><br>Month 11 showed a favourable variance to plan of £0.7m.<br><br>CIP over-performance within the month by £0.2m has reduced the year to date under-performance to £0.9m.<br><br>The detailed position will be reviewed by the Executive Performance Board in March, Integrated Finance, Performance & Investment Committee and Trust Board in April 2016.<br><br>Run rates to achieve £34.1m in each area (pay, non-pay, CIP and income) updated for months 11 & 12 and reported to Committees/Trust Board.<br><br>Settlements reached with both main commissioning bodies.<br><br>Draft accounts produced which demonstrate achievement of the £34.1m control total | Internal audit annual review of financial systems and processes completed within quarter 3 of 2015/16. External audit annual review of financial systems and processes due to be completed as part of the interim audit work within quarter 4 of 2015/16.<br><br>TDA scrutiny monthly and quarterly with regional team<br><br>External audit of accounts | |

| Assurance rating: | A | Comments on assurance | Good number of assurance sources | | |
|---|---|---|---|---|---|
| **Action tracker** | | | | | |

| Action tracker | Due date | Owner | Progress update: | Status |
|---|---|---|---|---|
| Review national guidance in relation to premium medical pay and develop strategy for reduction (16.1) | Review March 2016 | CFO | Complete for nursing staff. Strategy in relation to medical and other staff still requires further development through the premium pay cross-cutting work stream. Now linked to 2016/17 plan and delivery of sub £21.6m target. | 3 |

| Board Assurance Framework: | Updated version as at: | Feb-16 | | |
|---|---|---|---|---|
| **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 | 5x3=15 | 5x3=15 | 5x3=15 |
| **Target risk rating (I x L):** | 5x2=10 | | | | | | | | | | | |

| Controls: (preventive, corrective, directive, detective) | Assurance on effectiveness of controls: Internal | Assurance on effectiveness of controls: External | Gaps in Control / Assurance |
|---|---|---|---|
| **Directive Controls**<br>Overall strategic direction of travel defined through Better Care Together.<br>Financial Strategy fully modelled and understood by all parties locally and nationally.<br>UHL's working capital strategy in place.<br>2015/16 financial plan in place and monitored appropriately<br><br>**Detective Controls**<br>Monthly monitoring of performance against financial plan.<br>IFPIC and TB receive half yearly updates in relation to financial strategy and LTFM<br>**Corrective controls**<br>Explore options for other (non-NHS) sources of capital funding | Monthly reporting against 2015/16 plan - As at M10, the Trust is £1.5m adverse to plan.<br>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.<br><br>Strong links to overall BCT 5 year strategy and the financial consequences (revenue and capital) of the transformational business cases | Internal audit annual review of financial systems and processes completed within quarter 3 of 2015/16. External audit annual review of financial systems and processes due to be completed as part of the interim audit work within quarter 4 of 2015/16.<br><br>Internal audit review of service line reporting processes completed within Q3 2015/16.<br><br>NHS England and NTDA review of:<br>BCT SOC<br>BCT PCBC<br>Financial strategy<br>LTFM<br>System-wide five-year 'place-based' sustainability and transformation plan (STP)<br>Individual business cases above a certain level | (c)LTFM not yet formally approved (17.1)<br><br>(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<br>~~Nov 15~~<br>March 16 | CFO | Still awaiting NDTA feedback. | 3 |
| Liaise with TDA to agree process for SOC submission and sign-off (17.2) | Review<br>~~Nov 15~~<br>March 16 | CFO | Original BCT SOC remains but more detailed work to support proceeding to public consultation supersedes. | 3 |

| **Board Assurance Framework:** | Updated version as at: | Mar-16 | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **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 | 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** – **Internal** | **Assurance on effectiveness of controls** – **External** | **Gaps in Control / Assurance** |
|---|---|---|---|
| **Directive Controls**<br>Weekly communications with key contacts throughout the external approvals chain.<br>EPR project plan.<br>IM&T transformation Board<br>EPR programme Board and the joint Governance Board<br><br>**Detective Controls**<br>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.<br><br>**Corrective controls**<br>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.<br>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.<br><br>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<br><br>Upgrades are now taking place on our major IT systems including Clinicom, ORMIS and planning for EDIS to ensure they can be supported for a longer period prior to replacement by EPR or alternative. | Internal audit review of implementation of gateway actions following review of EPR implementation due Q3 2015/16<br><br>HSCIC are undertaking a health check review on the EPR Project during March 2016. | (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. |

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

| Board Assurance Framework: | Updated version as at: | Mar-16 | | |
|---|---|---|---|---|
| **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 | 4x3=12 | 4x3=12 | 3x2=6 |
| **Target risk rating (I x L):** | 3 x 2 = 6 | | | | | | | | | | | |

| Controls: (preventive, corrective, directive, detective) | Assurance on effectiveness of controls – Internal | Assurance on effectiveness of controls – External | Gaps in Control / Assurance |
|---|---|---|---|
| **Directive Controls**<br>IM&T monthly news letter<br>Monthly service delivery board<br><br>**Preventive Controls**<br>UHL IM&T governance structure<br>Service credit regime which seeks to incentivise delivery and has an escalating failure regime for repeat monthly failures<br><br>**Detective Controls**<br>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.<br>Monitoring of performance via customer satisfaction surveys.<br>Liaison with the CMGs to ensure we are meeting their requirements.<br><br>**Corrective controls**<br>LIA event to improve perception and staged improvement plan to be fully developed | There are 148 performance indicators in total.<br>4 KPIs were failed in February<br><br>Customer satisfaction (trajectory of 95%) is 80% for March Data<br><br>Additional resourcing from IBM and NTT has now arrived at UHL to better deliver the services | Internal audit review in relation to IT general controls and systems due Q3 2015/16<br><br>ISO 27001:2013 Audit in 2015, which was passed. We believe we are the first NHS trust to achieve this standard of service delivery<br><br>The digital maturity index, published by the Department of Health in Jan 16, puts UHL in the upper quartile in terms of performance against the delivery areas.<br><br>Audit work by PwC on the service delivery metrics found no substantial issues withthe reporting of he delivery services. | |

| 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 | **Complete** | 5 |

**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.<br><br>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.<br><br>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.<br><br>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.<br><br>Design and size of minors results in delay in receiving medical assessment and treatment. Patient complaints. Four hour target. Increased violence and aggression.<br><br>Design and size footprint in streaming rooms causes threat to CQUIN target and four hour target. Staff stress. Delay in diagnosis and management. Injury to staff and patients. Increased risk of violence and aggression.<br><br>Design and size of footprint in EDU causes delay in | Patient safety | The Emergency Care Action Team, which was established in spring 2013 aims to improve emergency flow and therefore reduce the ED crowding.<br>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.<br>The Resus Bed area is being created.<br>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.<br>Increase in Clinical Education staff, to assist with upskilling of Nursing Staff.<br>Majors Floor has been marked out and numbered to prevent to many trolleys from blocking Majors and assessment Bay.<br>Improving quality of care in the ED sessions open to staff, led by ED Consultant.<br>Direct referrals from assessment bay to ambulatory clinic.<br>CAD system went live highlighting nuber of ambulance patients on route to ED.<br>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.<br>Actions in place from EQSG Emergency Floor actions.<br>New ED floor working stream.<br>Quality metric audits. - These are now daily rather than monthly. (15/12/2015)<br>Escalation plans.<br>Cohorting of ED patients in Escalation Area (TIA Clinic) and ED corridor as per agreed protocols.<br>CMG weekly meetings following CQC notice.<br>Weekly update / report form the Chief Exec to CQC. | Extreme | Almost certain | 25 | New ED plus associated hot floor rebuild approved by the trust and OBC (Outline Business Case) submitted and first phase of construction of new ED - due 31/05/16. Update - Full business case signed by trust board and approved by NTDA. NEW BUILD ON PLAN<br>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).<br>Creation of "single front door" (UCC handed over to UHL in Nov 2015) - Completed.<br>Resus space to be increased to 8 bays - Completed.<br>Bays to be allocated and staffed appropriately in majors to act as resus step-down bays for when space in resus is at a premium and some patients are well enough to be moved to majors with the appropriate level of observation - Completed.<br>Hourly Intentional Rounds by Area Nurse - Completed.<br>Traffic light system to ED doors awaiting commissioning following a visit to Addenbrookes - completed.<br>Creation of SOP for resus crowding - due 31/05/2016.<br>Assessment Bay SOP - Completed.<br>Majors operational policy to be reviewed - Completed. | 16 | IL |

| 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 | 28/04/2016 | Causes<br>Failure to consistently undertake and record initial assessment by appropriately trained clinical staff within 15 minutes of presentation and document in real time.<br>Failure to consistently ensure that all patients receive adequate care and treatment in accordance with Trust sepsis clinical pathway.<br>Lack of ability to demonstrate we have an appropriate staffing skill mix in place on a shift by shift basis.<br>Lack of recording of induction for temporary staff.<br><br>Consequences<br>Significant risk of patient harm<br>Conditions placed on licence to practice<br>Risk of CQC placing the Trust in Special Measures<br>Risk of CQC imposing unlimited financial penalties<br>Adverse media attention affecting reputation of the Trust<br>Breaches in Statutory duty with subsequent criminal prosecution | Quality | CEO and executive leadership with clear responsibility and oversight in place.<br>Internal reporting in relation to quality metrics (sepsis compliance, staffing, initial assessment within 15 mins)<br>Weekly reporting to CQC on required metrics in place<br><br>Sepsis<br>Implementation of trust-wide single adult sepsis pathway supported by a programme of daily audit in ED.<br>Supporting action plan in place including rollout of single paediatric pathway.<br><br>Initial Assessment<br>Standard Operating Procedure (Initial Assessment and Dynamic Priority Scoring - version 3 December 2015) revised and implemented to ensure ED patients are prioritised appropriately.<br>Consistent real-time recording.<br>Review of patient harm associated with delayed initial assessment (>15mins) at patient level.<br><br>Staffing/ skill mix<br>Shift by shift real-time reporting template looking at overall staffing numbers (e.g. nurse in charge, number of agency staff utilised) monitored by 'gold' command four times daily.<br>" Safe staffing overview by 'gold' command four times daily. | Extreme | Almost certain | 25 | Overarching action plan to address all 3 of the CQC areas of non-compliance - complete<br><br>Governance and PMO arrangements to be agreed - paper to Quality Assurance Committee - complete<br><br>On-going assurance monitoring that controls and completed actions are effective - Reviewed weekly via CQC steering group - monthly reviews - next due 14/4/16 | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2354 | RRCV | | There is a risk of overcrowding in the Clinical Decisions Unit | 28/05/2014 | 30/04/2016 | Causes of the risk (hazard)<br><br>Consequences of the risk (harm / loss event)<br>1. Significant delays in patients being assessed and treated due to inadequate workforce resource to meet demand. This compounds the space issue as patients are not being assessed and treated in an efficient manner. This is evidence by the current triaged times:<br>% triaged within 15 minutes – 60% (in recent weeks has improved to 90%)<br>% seen by doctor in 60 minutes – 40%<br><br>2. Overcrowded department leads to inefficiencies ie no physical space to review or examine patients; therefore there are delays in them being assessed and receiving treatment.<br><br>3. Facilities and environment of the CDU has limited additional space to accommodate friends and family who may accompany the patient<br><br>4. Patients dissatisfied with their experience: CDU patient survey results/Friends and Families Score reflect the long waits patients are experiencing. Current FFT figures is 92%, the detractors all relate to wait times, overcrowding whilst waiting and inappropriate conditions ie. Waiting in a chair, with patients reporting waiting 8 to 10 hours. This is particularly exacerbated when patients have already waited some considerable time in the Emergency Department.<br><br>5. Increasing delays to ambulance attendees and transfer of patients from the LGH and LRI | Patient safety | Controls in place: What processes are already in place to control the risk? (Copy & paste to add rows where necessary)<br>.<br>1. Respiratory Consultant on CDU 5 days/week 0800-20 00 hrs<br>2. Respiratory Consultant on CDU at weekends and bank holidays 0800-1200 hrs and on call thereafter<br>3. Cardiology Consultant assigned on CDU 5 days a week (shared rota)<br>4. Cardio Respiratory Streaming flow, including referral criteria and acceptance<br>5. Short stay ward adjacent to CDU<br>6. Discharge Lounge utilised<br>7. GH duty Manager present 24/7<br>8. Patient flow Coordinator 7 days/week daytime<br>9. CDU dash board<br>10. UHL bed state details CDU current status as well as ED<br>11. Daily nurse staffing review with plan to ensure safe staffing levels on CDU<br>12. EDIS operational on CDU<br>13. Daily patient census conference calls<br>14. Daily board rounds across all wards<br>15. Primary Care Co-ordinators and increased community support<br>16. Escalation plans<br>17. CDU Operations Meeting | Major | Almost certain | 20 | Introduction of patient flow coordinator role on CDU - complete<br>Catherine Free is supporting further work on the staffing model for CDU - 30/4/2016<br>Appoint Respiratory CDU Consultant - 30/04/16<br>Ambulatory Care Area supported by Cardiac and Respiratory Nurse and utilising the AMBS score - 30/04/16<br>Monitoring of patient triage times and other quality performance indicators at monthly CDU ops meeting with appropriate representation from all staff groups - 30/04/16 | 9 | SM |

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| 2149 | Emergency and Specialist Medicine | | High Nursing vacancies across the ESM CMG impacts on patient safety, quality and care continuity and financial performance | 21/02/2013 | 30/06/2016 | Many clinical areas are currently experiencing low levels of staffing to manage effectively the current numbers of patients. Often the nurse to bed ratio falls below that identified as the funded establishment, and therefore the required level of staffing to appropriately meet patient need. In addition within most of the clinical areas there is high bank and agency use further increasing the risk to the quality of care delivered. In addition we are required to staff the old TIA clinic and look after ambulance patients in ED corridors and provide support to outlying patients which further depletes numbers and nursing skills.<br><br>Causes<br>" Large Number Vacant Nursing posts<br>" Lack of appropriately trained nursing staff to manage specialised patients<br>" Poor Agency and bank fill rates<br>" High level of maternity leave/sick leave<br>" Outlying of patients<br>" TIA Clinic<br>" Ambulance cohorting in the corridor protocol<br><br>Consequences<br>" Patient safety compromised - Delays with Patient care<br>" Patient medications not being completed in a timely manner<br>" Increased risk of patient pressure ulcer formation<br>" Increased risk of patient falls<br>" Increased risk of incidents due to lack of familiarity with treatment regimes<br>" Inability to deliver quality care to different patient groups<br>" Decreased patient satisfaction/ quality of care<br>" Delays in treatment and appropriate referral<br>" Increase in complaints / " Increase in incident reporting | Patient safety | " Staffing Escalation policy<br>" Staffing Bleep Holder / Matron support ,Site Manager and Duty Manager<br>" Incident reporting<br>" Complaints monitoring<br>" Monitor staffing levels<br>" Monitoring recruitment and retention<br>" Monitoring sickness levels<br>" Provision of nursing support from other base wards<br>" Support from the Outreach Team<br>" Support from Education & Development Team<br>" Support from Matrons and Deputy/ Head of Nursing<br>Moving staff between clinical areas as a means to balance risk<br>Agency and bank as a means to increase nursing numbers- agreed contracts to block book allowing temporary staff to get use to environment and standards within the workplace<br>A 'job card' designed to ensure temporary staff understand the expectation of their shift and high quality of clinical management required<br>Orientation to each of the clinical areas for agency/bank staff -(green book compliance)<br>Clinical matron/senior nurse available daily to ensure clinical risk is mitigated and managed.<br>Bed management meeting at 8.00, 12.00 16.00 and 18.00 to review bed demands and staffing issues across the Trust. Forum agrees the strategic plan for the 24/7 with on-call director and Senior on a daily basis. | Major | Almost certain | 20 | Aim to recruit over and above establishment to minimise risk of vacancies<br>Active recruitment days, supporting easy, safe and timely recruitment of staff, minimizing recruitment time - completed.<br>Block book contracts with agency to improve fill rate and allow orientation of temporary nurses becoming familiar with the clinical areas - Completed<br>Plan to close wards in response to RPC by improving assessment process and reducing the demands for impatient beds - Completed.<br>Job cards to be written to ensure that temporary staff understand the role they have and the impact of quality in the clinical area - completed<br>Workstreams established which will help support the effective management of improved simple & complex discharge to support nursing staff in minimizing patient say reducing LOS & supporting potential closure of beds reducing demands on nurse staffing - completed.<br>Design dashboard for each ward to monitor quality to enable early detection of any deterioration and early action to include net promoter, thermometer and harms - Completed<br>Undertake regular stress assessments and manage according to outcome - Completed<br>Acuity review to be completed - due 30/04/16.<br>Continue to participate in overseas recruitment - 30/06/16. | 6 | GST |

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| 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:<br>Retirement of previous consultants<br>Ill health of consultant<br>Lack of applicants to replace substantively<br><br>Consequences:<br>Need for remaining paeds anaesthetists to work a 1:2 rota on-call<br>Lack of resilience puts cardiac workload at risk<br>May adversely affect the national reputation of GGH as a centre of excellence<br>Current rota non complaint Working Time Directive (WTD)<br>Patients requiring urgent paeds surgery may be at risk of having to be transferred to other centres<br>Income stream relating to paeds cardiac surgery may be subsequently affected<br>Risk of suboptimal patient treatment resulting in harm. | Quality | 1:2 rota covered by experience colleagues<br>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 - 30/06/16 | 8 | DTR |
| 2763 | ITAPS | Critical Care | Risk of patient deterioration due to the cancellation of elective surgery as a result of lack of ICU capacity | 22/01/2016 | 30/04/2016 | Causes:<br>Lack of capacity (beds) within ICU cross-site.<br>Lack of base ward bed for ICU patients to be discharged.<br>Lack of nursing staff to manage ICU patients.<br>Delays with discharging ICU patients to Wards.<br><br>Consequences:<br>Deterioration in condition with the potential for patients to become too unwell to have surgery when re-booked or worse case scenario patient dies waiting for surgery.<br>Impacts to quality of service through failure to meet treatment targets. Also, potential for increase in complaints from patients/family.<br>Breach in contract.<br>Reputation amongst other CMGs as an inability to provide a service. Potential to attract media interest.<br>Potential for financial penalties due to inability to meet national targets. | Patient safety | Identify patients ready for discharge from ICU in previous 24 hours<br>Highlight potential cancellations to consultant on call<br>Electronic bed booking system to identify potential issues with electives<br>Highlight to General Managers potential cancellations<br>Regular discussions cross-site with Consultants to balance the elective lists. | Extreme | Likely | 20 | Increase capacity (6 beds) - 25/05/16<br>Use of agency staff - 25/05/16 | 10 | AGE |

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| 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 | 15/04/2016 | Causes:<br>Staffing issues caused by turnover of staff (retirements / leavers).<br>Post planning process poor - local and national shortages of qualified staff (BMS).<br>Internal recruitment processes causing significant delay.<br><br>Consequences:<br>Possibility of temporary closure of satellite blood banks (LGH).<br>Adverse impact on patient experience for patients requiring urgent transfusion (out of hours).<br>Non-delivery of key acute services.<br>Increased risk of claim /complaint.<br>Adverse media attention / loss of reputation.<br>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.<br>Full rota has created additional sessions as satellite laboratories to comply with 24/7 working.<br>Associate practitioners included in early and late roster sessions<br>Associate practitioners to cover entire night at LRI<br>Phased extended contractual hours 8 to 8 B.S & B.Transfusion<br>Phased extended day B Transfusion to 23:00<br>Employed Bank/Locum BMS staff to cover short term deficiencies in rota<br>Investigate additional lean working options to reduce pressure on laboratory staff.<br>Introduced a forced rota<br>Multi discipline staff to assist cover overnight B.S(24/7) at LRI<br>Retrained Lab Manager<br>One-off training<br>Risk assessed the process of a "Plan B"<br>24/7 Rotas with voluntary sessions in place from May 2012<br>2 new BMS band 5 staff recruited 24/09/2012 - to complete local competecy training Feb 2013<br>Introduction of cross cover form NUH to support UHL BT Roster - limited cover at present (Oct 2013)<br>Numerous meetings taken place with empath management team to raise acute risk of service failure (August 2013 to Jan 2014 & ongoing).<br>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 | Recrruitment of additional/replacement staff to maintain Service 15/06/2016<br><br>To review and re-asses capacity within depts, to move staff for multi disciplinary training - 30/04/16 | 15 | AFE |

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| 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 | 15/04/2016 | Incorrect diagnostic results from POCT equipment due to:<br>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)<br>2. Inadequate initial and on going training and competency assessment for users (requires a POCT Team to achieve compliance)<br>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).<br>4. Lack of standardisation of POCT equipment (particularly blood gas analysers) with associated lack of consistency of POCT results.<br>5. Lack of standardisation regarding staff groups maintaining POCT equipment (particularly blood gas analysers).<br>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.<br>7. Lack of POCT IT Connectivity<br>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.<br>1. Unreliable diagnostic results potentially leading to mismanagement of patients leading to long term effects or death | Quality | 1. Committee for overseeing POCT trust wide is in place ,<br>2.UHL Management of Point of Care Testing (POCT ) Devices Policy | Major | Almost certain | 20 | Explore options for secondment post to replace POCT Manager vacancy - April.2016;<br>Update business case to include Medical devices training Apr 2016;<br>Resource funding for POCT team April 2016;<br>UHL Blood gas standardisation programme 02/06/2016;<br>To review interim arrangements for POCT provision April2016 | 2 | LFI |

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| 2787 | Clinical Support and Imaging | Medical Records | Failure of medical records service delivery due to delay in electronic document and records management (EDRM) implementation | 17/02/2016 | 30/04/2016 | Causes:<br>Insufficient staffing to manage current levels of activity.<br>Since 2013 all vacancies have been filled with fixed term contracts due to EDRM project.<br>Paediatric EDRM rollout with failure of UHL staff to follow correct new business change processes - has not resulted in the expected reduction in activity.<br>Delay in Adult EDRM rollout.<br><br>Consequences:<br>Potential for large-scale cancellation of requests, late availability of case notes and subsequent impact to patients including cancellation of procedures and appointments.<br>Insufficient staffing to support the Access to Health records service leading to breaches of statutory compliance to government targets in relation to access requests. Also breeches or internal and external timescale for litigation and inquest cases which could result in financial penalties.<br>Insufficient staffing leading to non-compliance with health & safety requirements due to overcrowded library storage areas. Also this increases the potential for increased staff long-term sickness due to musculoskeletal injuries as a result of working environment.<br>Potential for increase in complaints about the service. | Patient safety | Use of A&C bank staff where possible, though very limited in supply.<br>Use of overtime from remaining substantive staff (though dwindling due to duration of the EDRM project and subsequent delays); staff are tired and under pressure.<br>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).<br>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.<br>Daily review of staffing levels and management of requests with concentration of staffing in areas of greatest demand and clinical priority. | Major | Almost certain | 20 | Review current activity and staffing levels with a view to increasing staffing short term until adult EDRM go live accepting financial pressures - 30/04/16.<br>Escalate issues and chase for full rollout of EDRM to adults - 30/04/16. | 4 | DWAT |

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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 | 29/04/2016 | Cause:<br>System not able to be repaired as now obsolete - so parts are no longer available.<br><br>Consequences:<br>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:<br>Fetal Distress<br>Post Partum Haemorrhage<br>Maternal and/or Neonatal collapse<br>Shoulder Dystocia<br>Eclamptic Fits etc.<br>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 | Installation of new bell system Due 29/04/2016 | 5 | ABUC |
| 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 | 28/04/2016 | Causes:<br>National shortage of suitable candidates to fill vacant posts<br>Substantive Consultant Staffing levels inadequate for continuity of service<br><br>Consequences:<br>Delayed access to Consultant Paediatric Neurologist for inpatient & outpatient consultations.<br>Loss of continuity for patients, families and Consultants as a result of changing workforce.<br>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 16/05/2016<br>To work with NUH on a regional solution to service delivery - Due 31/08/2016 | 4 | JVI |

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| 2403 | Corporate Nursing | IPC | There is a risk changes in the organisational structure will adversely affect water management arrangements in UHL | 19/08/2014 | 30/06/2016 | Causes<br>National guidance from the Health and Safety Executive advise that water management should fall under the auspices of hospital infection Prevention (IP) teams.<br>Resources are not available within the UHL IP team to facilitate the above.<br>Lack of clarity in UHL water management policy/plan.<br>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.<br><br>Consequences<br>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.<br>Non-compliance with national standards and breeches in statutory duty including financial penalty and/or prosecution of the Chief Executive by the HSE<br>Adverse publicity and damage to reputation of the Trust and loss of public confidence<br>Loss/interruption to service due to water contamination<br>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.<br>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.<br>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<br>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<br>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 the IP team and Facilities Teams 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 and associated systems and processes, to effectively manage the water systems within the trust - Additional IPN approved within a paper presented to the Executive Quality Board by the Director of Facilities. Job description for Facilities IPN has been agreed and forwarded to the Facilites Team for approval. Awaiting confirmation of funding - 30/06/16<br><br>Review procedures and practices in other Trusts to ensure that UHL is reaching normative standards of practice - 31/06/16<br><br>Revised Water Management Policy and Water Safety Plan approved by the Trust Infection Prevention Committee. Implementation programme to be confirmed by Facilities colleagues when the Interserve contract ceases in May 2016 - 31/06/16 | 4 | LCOL |

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| 2404 | Corporate Nursing | IPC | There is a risk that inadequate management of Vascular Access Devices could result in increased morbidity and mortality | 19/08/2014 | 30/06/2016 | Causes:<br>There is currently no process for identifying patients with a centrally placed vascular access (CVAD) device within the trust.<br>Lack of compliance with evidence based care bundles identified in areas where staff are not experienced in the management of CVAD's.<br>There are no processes in place to assess staff competency during insertion and ongoing care of vascular access devices.<br>Inconsistent compliance with existing policies.<br><br>Consequences:<br>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 - There has been discussion with the Nervecentre team developers and this may now be possible. Furhter discussion to take place - 30/06/16<br>Development of an education programme relating to on-going care of CVAD's - 30/06/16<br>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 - 30/06/16<br>Develop 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 within the organisation by the CSI CMG with support from the Assistant Medical Director appointed by the Medical Director to oversee this objective - 30/06/16 | 16 | LCOOL |

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| 2471 | CHUGS | | There is a risk of poor quality imaging due to age of equipment resulting in suboptimal radiotherapy treatment. | 12/05/2014 | 31/07/2016 | Causes:<br>Using equipment beyond the recommended replacement age.<br>Consequences:<br>In the event of a major breakdown patients would need to be transferred to another radiotherapy centre resulting in inconvenience to the patient with the nearest centre over 30 miles away, and loss of income in the region of £1 million per annum to the trust.<br>Loss of reputation with patients and commissioners using equipment over 10 years old<br>Increased risk of CQC reportable incident due to poor imaging capabilities of the machine.<br>Arrangement to be made with other radiotherapy centres to transfer patients<br>Inability to develop new techniques which have the potential to bring in extra income<br>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.<br>Repeated high dose imaging due to deteriorating MV imaging panel increases the risk of exceeding current dose limits.<br>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<br>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.<br>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.<br><br>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.<br><br>We have introduced long day working on Varian machines to absorb patients that cannot be treated on Bosworth due to imaging limitations<br><br>Clear Set-Up instructions plus photographs are provided to treatment staff to aid set-up. These do not fully eliminate the risk due to variable patient stability and condition hence the need for on-treatment imaging. | Major | Likely | 16 | Develop business plan for replacement of treatment machine. Briefing paper to be submitted to the Investment Committee Meeting.<br><br>Replacement of Imaging panel to improve image quality and reduce imaging dose. However this does not solve the lack of online correction capability - This action is no longer going ahead as the Linac machine itself will be eventually replaced<br><br>Restriction of patient numbers to be treated on Bosworth. - Complete<br><br>Replacement of Linac - 31/3/17; Monitor progress of the replacement Linac on a quarterly basis through to the CMG Board | 4 | LWI |

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| 1149 | CHUGS | | There is a risk to patient diagnosis and treatment due to a failure to deliver the cancer waiting time targets | 16/04/2009 | 31/05/2016 | Causes:<br>Competing priorities between RTT and Cancer targets, patient compliance, capacity and administration processes.<br><br>Consequence:<br>Delays in patient diagnosis and treatment due to the non delivery of 2ww, 62 day and 31 day cancer targets | Patient safety | Attendance at the weekly Cancer Action Board meeting by tumour site representatives to review PTL and review cross speciality and department barriers to delivering the patient pathways.<br>Attendance of the CMG at the monthly CMG Cancer Action Board to review and refine the cancer action plans for the tumour sites and review performance.<br>Local PTL meetings within the individual tumour sites with Cancer tracking staff and General Managers/Service Managers to ensure that at an individual patient level, they are receiving care and treatment in line with the Cancer pathway timelines<br>Review overall performance at the CMG Board Meeting and review local action plans;<br>Attendance of Clinicians and Managers at the monthly Cancer Board to review patient pathways.<br>Attendance at Weekly Access Meeting (WAM) to manage RTT admitted and non admitted performance.<br><br><br>to escalate to CMG Head of Operations any issues<br>-UHL Cancer Board. | Major | Likely | 16 | General Managers to highlight delays and issues to the senior CMG Management Team - 31/05/16;<br>Review of local tumour site action plans monthly;<br>Ensure continued attendance at CAB; Performance to be monitored at CMG Board | 6 | MNA |

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| 2565 | CHUGS | | There is a risk of delays in patient treatment due to failure to deliver non admitted and admitted RTT targets | 06/03/2015 | 31/05/2016 | Cause:<br>There are delays in patient treatment due to the failure to deliver national targets in General Surgery, Gastro and Urology; due to increased referrals and lack of capacity to deliver the targets.<br><br>Consequences:<br>Patient safety implications including some appointments being cancelled at short notice. This means that some patients in these specialties are waiting longer for surgery, particularly those requiring an inpatient stay.<br><br>Potential for non-compliance with national standards with significant risk to patients if unresolved.<br><br>Potential for adverse media coverage (local/national) with an effect on public expectation. | Patient safety | Regular monitoring of the PTLs and activity levels by the speciality management teams. Review of position on a weekly basis within the services as well as at a corporate level.<br>All services are putting on extra sessions as well as utilising independent sector partners to ensure patients are treated as soon as possible.<br><br>While General Surgery continues to have a high backlog of patients waiting for surgery, their non-admitted performance is improving and is now at 40% of the level it was at the end of October. | Major | Likely | 16 | RTT Position to be monitored by speciality teams on a daily basis and corrective actions put in place. Ensure validation is on-going and completed timely. Ensure issues are raised with corrective actions within the CMG. Review of RTT Position weekly with corporate team - due 31/3/16. Ongoing issues relating to RTT to be escalated to CMG Senior Management Team | 6 | JFA |

| 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 |
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| 2671 | CHUGS | Gastroenterology | There is a risk of potential harm to patients due to delays in diagnostic and treatment procedures in the Endoscopy Unit | 10/12/2015 | 31/05/2016 | Causes:<br>Increase in referrals and workload through to Endoscopy;<br>Inexperienced staff that have not had appropriate training and supervision;<br>Vacancies in nursing and administration;<br>Poor administration processes and unorganised working environment within the administration area (LGH);<br>Backlog of patients on the Endoscopy Unit.<br><br>Consequences:<br>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;<br>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;<br>Not meeting the RTT and Cancer targets;<br>Vacancies within the nursing establishment mean that the staff are over stretched which means processes are not followed correctly and could result in staff psychological harm. | Patient safety | Matron appointed specifically to focus on nursing recruitment and management in Endoscopy only;<br>Staffing model developed in line with neighbouring private & NHS providers and monitored by Matron.<br>Waiting list management - patients now transferred to the active diagnostic waiting list 6 weeks after their due date (grace period as advised by TDA).<br>Vacancies filled within the administration teams (either permanent or through bank).<br>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.<br>2WW patients offered an appointment by phone.<br>Currently all other patients are sent an appointment with appropriate lead in time of three weeks.<br>Endoscopy Manager has been appointed to review and change the clinical and administration processes within department;<br>The administration area at the LGH has been cleared and there is senior presence on each of the three sites to supervise the staff;<br>Administration SOP's developed to support the administration processes.<br>Admin team time out afternoon to resolve problems and potential solutions and increase engagement.<br>All staff to be reminded of their individual responsibility to follow Trust policy on incident reporting where they consider harm has occurred due to delay to patient treatment. | Major | Likely | 16 | Production of electronic referrals internal - 30/06/16<br>Document and implement a standard process for managing requests and booking appointments irrespective of which clinician is required to undertake the procedure - 30/06/16<br>Investigate the possibility of moving to electronic requesting for endoscopy to speed up the process and remove reliance on paper forms, which need to be transferred between sites - 30/06/16.<br>KPIs should be reviewed at the Endoscopy Users Committee and remedial actions agreed as required - Sept 16;<br>Develop a range of indicators that support the clinical and operational needs of the Endoscopy service, examples include KPIs to monitor quality, productivity, efficiency, utilisation and waiting time performance Sept 16;<br>Documents terms of reference for the Endoscopy User Committee and develop a standing agenda to include waiting time performance and waiting list management issues - June 16;<br>Monitor the time from the request form being completed to the patient being added to the waiting list to provide assurance this is within the Trust standard - 30/06/16. | 6 | MNA |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2621 | CHUGS | General Surgery | There is a risk to patient safety & quality due to poor skill mix on Ward 22, LRI | 20/10/2015 | 31/05/2016 | Causes:<br>During the last 12 months 10 nurses have left and 3 nurses have reduced their hours.<br>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.<br>The levels of vacancies are 8 wte band 5. The continuous high acuity of patients also means that we have difficulty recruiting high caliber, experienced nurses to that ward.<br><br>Consequences:<br>There is a risk to patient safety and quality due to the numbers of inexperienced trained nurses on ward 22 at LRI and an increase in acuity due to the high levels of ITU discharges.<br>Further impacts could include staff injury (stress), inexperienced agency nurses and expense due to agency shifts.<br>Inconsistent skill mix and continuity for patients on a shift by shift basis which may result in higher staff movement across CHUGGS wards. | Patient safety | Shifts escalated to bank and agency at an early stage; Increased the numbers of band 6's to provide leadership support.<br>Agency contract in place for one nurse on day shift and night shift to increase nursing numbers.<br>Staffing is reviewed on a day by day basis and staff are moved across the CMG to support the ward as required.<br>Matron to work clinically on the ward for 2 days a week to provide support and increase nursing numbers.<br>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 - completed<br>Ongoing recruitment of international nurses - 31/05/16;<br>Daily mitigation of staffing skill mix by matron and ward sister - 31/5/16; Training needs analysis of all registered nurses and action plan developed - 30/4/16. | 6 | KJO |
| 2623 | CHUGS | Urology | There is a risk of potential harm due to scopes not being appropriately decontaminated. | 21/09/2015 | 30/04/2016 | Causes:<br>Failure of an RO machine to appropriately process the water supply.<br><br>Consequences:<br>The risk is that we could cause harm 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.<br>There is a danger of causing infection and thus harm/cause death to a patient by using infected scopes.<br>We continue to run a risk - as above - the problem remains unresolved. | Patient safety | UHL/IP policy (the Red Flag system)<br>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 - complete; Paper to be presented to Capital Investment Committee as to the way forward for decontamination across the Trust; Final solution to be worked-up through the decontamination group - 30/4/16<br>SOP also to be agreed - 30/04/16<br>Emergency medical capital bid to be completed - complete. | 2 | LDAL |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2193 | ITAPS | Theatres | There is a risk that the ageing theatre estate and ventilation systems coud result in an unplanned loss of capacity at the LRI | 28/06/2013 | 30/06/2016 | Causes:<br>The Theatre and Recovery estate and supporting plant(s) are old, unsupported from a maintenance perspective and not fit for purpose. There is recent history of unplanned loss of surgical functionality at the LRI site due to plant failure, problems with sluice plumbing and ventilation.<br>In addition, the poor quality of the floors, walls, doors, fittings and ceilings mean an unfit working environment from a working life, infection prevention and patient experience perspectives.<br>There is insufficient electricity and medical gas outlets per bed.<br>Aged electrical sockets resulting in actual and potential electrical faults - fire in theatres at LRI (Theatre 4) in July 2013.<br><br>Consequences:<br>Periodic failure of the theatre estate (ventilation etc) so elective operating has to cease.<br>Risk of complete failure of the theatre estate so elective and emergency operating has to stop.<br>Increase risk of patient infections.<br>Poor staff morale working in an aged and difficult working environment.<br>Difficulty in recruiting and retaining specialised staff (theatre and anaesthetic) due to poor working environment.<br>Poor patient experience - our most vulnerable patients arrive and are recovered in a dated environment, which does not promote confidence in the service, a sense of professionalism or safety.<br>May impair delivery of life support technologies. | Quality | 1. Regular contact with plant manufacturers to ensure any possible maintenance is carried out<br>2. Use of limited charitable funds available to purchase improvements such as new staff room chairs and anaesthetic stools - improve staff morale.<br>3. TAA building work completed.<br>4. Plan to develop full business case for new recovery build 2013 - start 2014 - Completed<br>5. Compliance with all IP&C recommendations where estate allows<br>7. Purchase of new disposable curtains for recovery area, reducing infection risk and improving look of environment - Completed | Major | Likely | 16 | Recovery re-build - complete<br>Capital investment and refurbishment of LRI theatres - 30/06/16.<br>Ventilation audit actions to be undertaken as per Trust wide working party - 28/02/17. Staged approach - short, medium and long term actions to be monitored. | 4 | PWA |

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| 2505 | Musculoskeletal and Specialist Surgery | | There is a risk of medical patients being outlied into the day surgical unit due to lack of beds within the trust. | 13/03/2015 | 31/05/2016 | Allocating Medical, Oncology or Haematology inpatients to the day surgery unit at the LRI when there is a shortage of inpatient beds for patients will result in additional risk for patients:<br>1. The Day surgery unit is a purpose built area for patients undergoing a variety of day case surgical procedures. It currently has a mixture of adults, and community dentals patients on a daily basis.<br>2. Day surgery unit is currently open and staffed as follows: 07:30 am Monday (24hrs) until Saturday 8pm<br>3. It is not suitable for inpatient care with dependant patients staying overnight due to the lack of basic facilities<br>4. The inability to operate day case surgery and then patients being cancelled when the environment is occupied with in patients, and the risk of same sex breaches due to mixing inpatients/day case patients in the same ward environment<br>5. The day case unit is currently not open on a Saturday and Sunday, and due to the high level of vacancies we would therefore need to rely on temporary staff to cover the outstanding shifts. Education and support would be required for the existing staff on the ward as they are not used to looking after this group of patients.<br>1. The day ward has been opened sporadically for medical and other speciality inpatients due to lack of beds within the trust.<br>2. Increased infection control risk for surgical patients as they are nursed in close proximity to medical patients.<br>3. Lack of medical cover for the day ward and not co-located to the medical wards/oncology wards.<br>4. Lack of privacy and dignity due to inpatients being nurse in the same environment as day case procedures and minor operations. | Patient safety | The day surgery unit to be used only when the trust has exhausted all other options available within UHL to accommodate the additional emergency patients.<br><br>Senior decision makers within medicine are able to assess which patients are most suitable to be outlied to the day surgery unit based on the following nursing and medical criteria:<br><br>Patients who are the most medically stable and meet the following criteria:<br>" Ambulant patients<br>" Do not score on EWS<br>" Low falls risk<br>" No Dementia or confusion<br>" Patients near to discharge awaiting results<br>" No high risk mental health patients | Major | Likely | 16 | Matron/NIC to ensure that all patients meet the agreed criteria to be outlied. Medical matron to visit the area whilst inpatients remain on the day surgical unit to offer support and advice - 31/5/16<br>Safe staffing levels to be monitored and escalated by the NIC/Matron to ensure there is adequate staff to care for the extra patients on the day case unit - 31/4/16<br>Levels of privacy and dignity should be monitored at all times by the allocated staff - 31/5/16<br>NIC/Matron should ensure that patients and relatives are kept fully informed - 31/5/16<br>General Manager /CMG manager to explore the possibility of patient having their day case procedures on inpatient wards within the CMG prior to being cancelled - On-going<br>Daily review of elective patients to proactively manage flow or cancel, discussed at daily Gold meeting - 31/5/16 | 6 | MAT |

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| 2541 | Musculoskeletal and Specialist Surgery | | There is a risk of reduced theatre & bed capacity at LRI due to increased spinal activity | 27/04/2015 | 30/04/2016 | Causes:<br>Increased spinal activity<br>Workload exceeds capacity<br>Insufficient theatre capacity<br>Reduced bed capacity<br>Insufficient consultant numbers to operate spinal on call rota<br>Inadequate junior doctor numbers<br>Increased activity from out of areas in line with proposal to be regional spinal service<br><br>Consequences:<br>Financial loss though increased LoS<br>Adverse effect on other trauma theatre and bed capacity<br>Inability to take advantage of increased tariff from #NOF BPT due to knock on effect on capacity<br>Increased morbidity<br>Risk to reputation<br>Risk to CT training programme<br>Claims risk<br>Decreased efficiency from increased split site working<br>Insufficient Orthogeriatric cover for increased activity | Patient safety | Weekly Monitoring of performance against BPT criteria<br>Monitoring of morbidity at M&M meetings<br>Trauma Coordinator role implemented<br>Cross organisational meetings with commissioners<br>Trauma business case accepted for increased staffing across wards/departments and theatres<br>Trauma unit meeting reinstated | Major | Likely | 16 | Agree way forward for regional spinal service - Business case to be presented to R&I Committee - due April 2016.<br>Protocol developed with NUH - complete<br>Employment of further staff to support the spinal on call rota - completed.<br>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 |
| 2758 | Musculoskeletal and Specialist Surgery | Otorhinolaryngology/ENT | There is a risk that patients have not been treated / informed of test results in a timely manner in ENT | 13/04/2015 | 31/03/2016 | Causes:-<br>Increased number of virtual appointments for managing the results process in ENT.<br>Admin staffing levels not adequate after previous A&C review to manage the core elements required - prepping and sitting clinics, making appointments.<br>Virtual appointments not managed on a weekly basis.<br><br>Consequences:-<br>Backlog of virtual appointments - circa 800. Dating back to November 2014.<br>Patients not informed of test result.<br>GP's not informed of test results.<br>Delays in patient's treatment.<br>Delays in next appointments.<br>Poor recording of 18 week pathways and virtual appointments.<br>Increased number of complaints. | Patient safety | Use of staff from other departments to deal with the backlog of virtuals.<br>Radiology made aware weekly of results required.<br>Hearing centre made aware weekly of balance test and hearing tests required.<br>Secretaries prioritising typing of virtuals. | Major | Likely | 16 | Business case describing investment required to increase admin support across key areas in ENT - Complete & approved<br>Begin recruitment once all approvals in place - recruitment underway - still have 1.0wte vacancy - 31/03/16<br>Induction programme for all new starters - programme in place - under review - 30/04/16<br>Introduce new structure - 31/03/16<br>Balance virtuals managed within the balance centre - Complete<br>Identify 1 member of ENT team to take on virtuals until new structure implemented - Complete | 2 | ARA |

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| 2759 | Musculoskeletal and Specialist Surgery | Otorhinolaryngology/ENT | There is a risk that performance targets are not met due to a capacity gap within the ENT department | 18/11/2015 | 30/04/2016 | Causes:-<br>Increasing referral rate - both routine and 2ww<br>Increasing sub-specialisation<br>Vacancies at consultant and fellow level - no suitable applicants for posts<br>Changing complexity of casemix - particularly in head and neck non cancer workload<br>Physical space constraints in theatres and ENT OPD<br>Paediatric bed pressures<br>Process issues within theatres reducing numbers of patients through lists<br><br>Consequences:-<br>Delays in patient's treatment.<br>Not achieving cancer or RTT performance Delays in next appointments.<br>Repeated cancellation of appointments.<br>Increased number of complaints.<br>Not achieving activity plan | Patient safety | WLI for both IP and OPD work<br>Use of independent sector<br>Individual tracking of cancer patients to ensure prioritisation of most urgent cases | Major | Likely | 16 | Recruitment plans:<br>- H&N consultant - 30/04/16<br>- H&N fellow - 31/03/16<br>- Research fellows - Complete<br><br>OPD actions:<br>Implement tinnitus pathway - 30/04/16<br>Implement audiology grommet led FU's - 30/04/16<br>Develop business case for nurse practitioners - 31/03/16<br><br>IP actions:<br>Increase in week theatre sessions - 30/04/16<br>Designate paed only theatres - 31/03/16<br>Designate service only lists - 31/03/16<br>Full capacity and demand review across ENT. To clearly show capacity gaps in terms of manpower, theatre and OPD space - Complete | 2 | ARA |
| 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 | 31/03/2016 | Causes:<br>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.<br><br>Consequences:<br>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<br>Monitoring of morbidity at M&M meetings<br>LiA Event taken place to identify problem areas and potential solutions<br>Action plan in place and monitored monthly<br>Trauma Coordinator role implemented<br>Increased Orthogeriatrician Input<br>Mandatory reporting to CQRG<br>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.<br>Employment and training of further TNPs to bolster junior doctor gaps and facilitate more stable CT training - 30/04/18. | 8 | CSK |

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| 1206 | Clinical Support and Imaging | CT/MRI | There is a risk that a backlog of unreported images in CT/MRI and plain film could result in a clinical incident | 28/07/2009 | 30/04/2016 | Causes<br>Backlog of unreported images on PAC'S (Plain Film, CT, MRI) which could lead to a major clinical risk incident and a potential for litigation and adverse media publicity.<br>Royal College Radiologists guidelines state that all images should be reported<br>IRMER require all images involving ionising radiation to be clinically evaluated<br><br>Consequences<br>Risk of suboptimal treatment<br>Potential for patient dissatisfaction / complaint<br>Potential for litigation | Patient safety | Ongoing reporting by radiologists and reporting radiographers<br>Allocation of CT/MRI examinations to a intended radiologist or specialty group<br>House keeping done by clerical and superintendents to ensure images are visible on PACS.<br>Outsourcing overdue reporting to medica. | Major | Likely | 16 | Train more reporting radiographers - due 30/11/2016<br>Housekeeping of unreported work by Superintendents - 30.11.16 | 6 | ARI |

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| 2487 | Clinical Support and Imaging | Medical Physics | Maintaining the quality of the Nuclear Medicine service for PET, Cardiac MPI and general diagnostics | 01/06/2015 | 30/04/2016 | Causes:<br>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.<br>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<br><br>Consequences:<br>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.<br>Loss of MPI expertise will have a major impact on the service and on Imaging and MR throughput.<br>Pressures on the consultant body to provide a comprehensive imaging service are high.<br>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<br>Consultants nominated as interim clinical leads - carol Newland and Yvonne Rees<br>Take action to provide clinician cover for ARSAC, reporting and clinical supervision - 30/12/14 completed<br>Undertake clinical review - 30/12/14 completed<br>Produce business case - 1/3/15 - completed | Major | Likely | 16 | Appoint new clinician - 30/06/16 | 6 | DPE |

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| 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 | 31/07/2016 | Causes:<br>High levels of vacancies and sickness<br>High levels of activity<br>Training requirements for newly recruited staff<br><br>Consequences:<br>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<br>team leaders involved in increased 'hands' on delivery<br>staff time focused on patient care delivery ( project time, meeting attendance reduced)<br>Prioritisation of specific delivery issues e.g. high risk areas and discharge prescriptions, chemo suite | Major | Likely | 16 | recruitment of senior pharmacist vacancies - complete<br>Newly recruited 8B pharmacists to commence new roles - 31/07/16.<br>Recruit 8A pharmacists to replace those promoted to 8B - 31/07/16.<br>Develop and implement staff development and engagement plan in conjunction with senior clinical pharmacists - 31/10/16 | 8 | CELL |
| 1926 | Clinical Support and Imaging | Ultrasound | There is a risk that insufficient staffing to manage ultrasound referrals could impact Trust operations and patient safety | 04/10/2012 | 30/04/2016 | Causes:<br>Unfilled vacancies, out of hours inpatient lists and an increase in scanning time for nuchal screening<br><br>Consequences:<br>Patients waiting much longer for Imaging tests<br>May affect ED 4 hour targets<br>Negative effect on internal standard turnaround times for inpatients<br>Further effect is to contribute towards Trust bed pressures; increased patient stays and breaches of targets (ED targets.)<br>Radiology staff over stretched due to covering extra overtime continuously to meet targets and internal wait.<br>Unsustainable service.<br>Cost pressure from the use of agency staff and overtime payments | Patient safety | Staff volunteer to do overtime/extra duties .<br>Agency and bank staff are being used to cover sessions | Major | Likely | 16 | Recruit to vacancies - 30/06/2016 | 6 | CLA |

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| 2153 | Women's and Children's | Paediatrics | Shortfall in the number of all qualified nurses working in the Children's Hospital. | 03/05/2013 | 05/12/2016 | Causes<br>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.<br><br>Consequences<br>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<br>There is an active campaign to recruit nurses locally, national and internationally<br>Additional health care assistance have been employed to support the shortfall of qualified nurses.<br>Specialise Nurses are helping to cover ward clinical shifts.<br>Cardiac Liaison Team cover Outpatient clinics<br>Overtime, bank & agency staff requested<br>Head of Nursing, Lead Nurse, Matron and ECMO Co-ordinator cover clinical shifts<br>Adult ICU staff cover shifts where possible<br>Recruitment and retention premium in place to reduce turn-off of staff<br>Part time staff being paid overtime<br>Program in place for international nurses in the HDU and Intensive Care Environment<br>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 11/01/17<br>Complete staff safe levels daily and take action where required. Clear escalation process - Due 11/01/17<br>Matrons daily ward rounds - due 11/1/17<br>Second registration course to commence September 2015 and be evaluated - due 11/01/17<br>Completion of a period of perceptorship for new international qualified nurses - due 30/01/2017<br>Continue to recruit to remaining vacancies - due 30/01/17 | 8 | HKI |
| 2809 | The Alliance | | There is a risk that there will be no capital funding in 2016/17 | 23/03/2016 | 30/04/2016 | Cause: The Alliance receives capital funding via CCG's. NHS England have stated there will be no capital in 2016/17.<br>Effect: A lack of capital funding will impact on the Alliance's ability to purchase / replace essential medical equipment at all sites and could have an adverse impact on delivery of activity, RTT performance and patient experience.<br>In addition the new Market Harborough Hospital requires a new radiology machine (and other essential equipment), without the capital funding the hospital will not open on time. The Alliance is dependant on this facility to provide radiology and other services. | Quality | High risk essential equipment has been identified.<br>There are no further controls at this time. | Major | Likely | 16 | Escalate issue within CCG's - COMPLETE<br>Discuss with Leadership Board - COMPLETE<br>Develop contingency plan for high risk equipment - SS 30/04/16 | 8 | SSU |

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| 2394 | Communications | | No IT support for the clinical photography database (IMAN) | 07/04/2014 | 30/04/2016 | Cause:<br>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).<br>Consequence:<br>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.<br>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 support Oct 2015. IM&T project manager appointed Nov 2015. IM&T Functional Spec complete Dec 2015. Tender issued Feb 2016. | Major | Likely | 16 | Tender document not yet issued at April 2016. No capital funding agreed. Seeking clarification from CIO and Procurement as to progress with this. | 1 | SAN |
| 2338 | Medical Directorate | | There is a risk of patients not receiving medication and patients receiving the incorrect medication due to an unstable homecare | 05/01/2014 | 31/05/2016 | Causes:<br>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.<br><br>Consequences:<br>Existing providers of homecare services are having difficulties achieving satisfactory level of deliveries<br>UHL patients are now being affected and poor patient experience.<br>Patients receiving incorrect medication or not receiving any medication via homecare<br>Patients having difficulties in contacting homecare telephone helplines.<br>Potential interruption in supply of chemotherapy agents from Bath ASU.<br>Deliveries not arriving leading to missed doses and also issues with patients having to take time of work to accept the deliveries<br>There are a significant number of patients, clinicians and pharmacy staff who have lost confidence in the homecare services provided on behalf of UHL.<br>As UHL have had to purchase these drugs, there is a loss of the VAT benefits that were originally gained by the health community.<br>Adverse impact on Trust reputation | Patient safety | UHL Homecare team liaising with homecare companies to try and resolve issues of which they are made aware.<br><br>H@H high risk patients currently being repatriated to UHL.<br><br>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.<br>Reviewing which medicines can be done through UHL out-patient provider or through UHL<br>Discussions with Medical Director and CMG (CSI) and clinical speciality teams to ensure that any necessary clinical pathway changes are supported<br>Repatriation of urgent drugs back to UHL out-patient provider<br>Self - assessment against Hackett criteria against all homecare schemes | Major | Likely | 16 | Re-advertise 8A Homecare pharmacist post and develop business case and job description for 8B regional pharmacist post in view of failure to recruit 31/05/16.<br>Agree income to support pharmacy homecare team with NHSE/CCGs - 31/05/16<br>Set up insourced subsidiary to allow repatriation of high risk patients - 31/07/16<br>Review of internal processes with rheumatology - 30/06/16 | 9 | CELL |

| 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 |
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| 2237 | Medical Directorate | | There is a risk of results of outpatient diagnostic tests not being reviewed or acted upon resulting in patient harm | 10/07/2013 | 30/06/2016 | Causes<br>Outpatients use paper based requesting system and results come back on paper and electronically.<br>Results not being reviewed acknowledged on IT results systems<br><br>Consequences<br>Potential for mismanagement of patients to include:<br>Severe harm or death to patient.<br>Suboptimal treatment.<br>Delayed diagnosis.<br>Increased potential for incidents, complaints, inquests and claims.<br>Risk of adverse publicity to UHL leading to loss of good reputation.<br>Financial consequences to include:<br>Potential increase in NHSLA contributions.<br>Potential increased LOS. | Patient safety | Abnormal pathology results escalation process<br>Suspicious imaging findings escalated to MDTs<br>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.<br><br>Development IT work with IBM to improve results system for clinicians and Trust to develop EPR with fit for purpose results management system. - 30/06/16 | 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 |
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| 2325 | Medical Directorate | | There is a risk that security staff not assisting with restraint could impact on patient/staff safety | 04/03/2014 | 30/06/2016 | Causes<br>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.<br>Insufficient UHL staff trained in use of non-harmful physical intervention and restraint skills to carry out patient control.<br>Termination of Physical skills training contract with LPT provider in January 2014.<br><br>Consequence<br>Inability to deliver safe clinical interventions for patients lacking capacity who resist treatment and/or examination.<br>Increased risk of Life threatening or serious harm to patients resisting clinical intervention<br>Increased risk of injuries to patients due to physical interventions by inexperienced/untrained staff.<br>Increased risk of injuries to untrained staff carrying out physical interventions.<br>Increased risk of injuries to staff carrying out clinical procedures<br>Requirement for increased staffing presence to carry out safe procedures<br>Reduced quality of service due to diverted staff resources<br>Increased risk of sick absence due to staff injury.<br>Increased risk of complaints from patients and visitors<br>Increased risk of failure to meet targets<br>Adverse publicity | Patient safety | UHL Nursing and Horizons colleagues have met with Interserve and 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.<br>Cover with more UHL employed staff where there may be patients requiring this type of restraint.<br>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<br>Continue to communicate with all staff about the current position. | Major | Likely | 16 | Development and delivery of training programme in Physical Skills for clinical staff - 30/06/16 | 6 | DLO |
| 2093 | Medical Directorate | R&I | Athena Swan - potential Biomedical Research Unit funding issues. | 08/08/2014 | 20/04/2016 | 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.<br>New high level process has been introduced at University of Leicester to drive and supervise the application. | Major | Likely | 16 | Risk to be reviewed and closed in April 2016 | 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 |
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| 2318 | EFMC | Business Continuity | There is a risk of blocked drains causing leaks and localized flooding of sewage impacting on service provision | 17/03/2014 | 31/05/2016 | Causes:<br>Aging infrastructure unable to cope with the volume of sewage due to restrictions and narrowing of the pipes<br>Staff, visitors and patients placing materials other than toilet paper into the drainage system including wipes, sanitary towels and nappies.<br>Back flow sink drains are unprotected resulting in foreign bodies<br>Consequence:<br>Blockages build up easier and the older pipes cannot cope with the additional pressure causing leaks of raw sewage into occupied areas.<br>Pipes cannot cope with the non-degradable materials and flooding occurs<br>Localised flooding of clinical areas often involving areas on the floors below<br>Foreign bodies block the drains and cause back fill and overspill of sinks and other facilities<br>Clinical areas and staff areas become contaminated with raw sewage.<br>Patients contaminated with sewage from leaks in the ceilings above their bays/beds.<br>Whilst repairs are underway it may become necessary to isolate and turn off showers, toilets and washing facilities elsewhere in the building.<br>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<br>Quality and safe delivery of care compromised in areas of sewage leaks resulting in disruption to service<br>Risk to health and safety of staff from an unsafe working environment resulting in contamination, slips and falls<br>Increased risk of infections | Quality | CCTV surveys of drains completed as far as possible in Balmoral, Windsor, Victoria and Modular Wards. Remedial works carried out in priority areas. 14/01/16 - Initail CCTV surveys carried out in 2015 this 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. COMPLETION 31/03/16<br>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.<br>Business Continuity Plans for all CMGs<br>Single choice patient wipes agreed at NET.<br>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.<br><br>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 31/05/16 | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2247 | Corporate Nursing | | There is a risk that a significant number of RN vacancies in UHL could affect patient safety | 30/10/2013 | 31/07/2016 | Causes:<br>Shortage of available Registered Nurses (RN) in Leicestershire.<br>Nursing establishment review undertaken resulting in significant vacancies due to investment.<br>Insufficient HRSS Capacity leading to delays in recruitment.<br>Consequences:<br>Potential increased clinical risk in areas.<br>Increase in occurrence of pressure damage and patient falls.<br>Increase in patient complaints.<br>Reduced morale of staff, affecting retention of new starters.<br>Risk to Trust reputation.<br>Impact on Trust financial position due to premium rate staffing being utilised to maintain safety.<br>Increased vacancies across UHL.<br>Increased pay bill in terms of cover for establishment rotas prior to permanent appointments.<br>HRSS capacity has not increased to coincide and support the increase in vacancies across the Trust.<br>Delays in processing of pre employment checks due to increased recruitment activity.<br>Delayed start dates for business critical posts.<br>Benefits of bulk and other recruitment campaigns not being realised as effectively as anticipated and expected.<br>Service areas outside of nursing being impacted upon due to emphasis on nursing roles. | Patient safety | HRSS structure review.<br>A temporary Band 5 HRSS Team Leader appointed.<br>A Nursing lead identified.<br>Recruitment plan developed with fortnightly meetings to review progress.<br>Vacancy monitoring.<br>Bank/agency utilisation.<br>Shift moves of staff.<br>Ward Manager/Matron return to wards full time. | Major | Likely | 16 | Over recruit HCAs. - 30/10/16<br><br>Utilise other roles to liberate nursing time - 30/04/17 | 12 | MMC |

| 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 |
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| 1693 | Operations | | There is a risk of inaccuracies in clinical coding resulting in loss of income | 08/02/2011 | 30/06/2016 | Causes:<br>Casenote availability and casenote documentation.<br>HISS/PatientCentre constraints (HRG codes not generated due to old version of Patient Administration System)<br>High workload (coding per person above national average).<br>Unable to recruit to trained coder posts (band 4/5)<br>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.<br>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.<br><br>Consequences:<br>Loss of income (PbR).<br>Non- optimisation of HRG.<br>Loss of Trust reputation. | Economic | As at Feb 2016 -4 newly trained Coders are in place. An audit cycle is established and coding backlog is being maintained at approximately 1 week (7000 spells uncoded). A Coding Workstream has commenced with CMG Head of Ops involvement to maximise availability of casenotes and quality documentation for Coding<br>When notes are required urgently for other purposes, coding is undertaken with a "same day" turnaround. Reduced backlog minimises inefficiencies of multiple casenote transfers. An apprentice Coding runner has been employed to help with transfer of casenotes to the Coders for specific wards.<br>Further trainees will commence in 2016.<br>Dec15 - Currently attempting recruitment of Band 4,5 and 6 Coders in the wake of capped agency rates. A band 6 trainee Trainer has been appointed and is expected to commence in mid March 2016.<br>Appointment of trained Coders continues to be challenging.<br>Agency Coders are being used to backfill some of our vacant posts. An enhanced sessional weekend rate for our own trained Coders was introduced from May 2015 which encourages additional weekend working.<br>Formal system support by the MBP for the Medicode encoder has been requested and requirements are currently being assessed. Medicode has still not been upgraded as at since installation 4 years ago which frustrates the realisation of full system benefits. Upgrade is expected immediately after the intended upgrade to PatientCentre early in 2016.<br>3 year refresher training for all Coders is in place | Major | Likely | 16 | Work with CMGs / ward clerks to maximise transfer of casenotes to Clinical Coding - 31/03/17<br>Appoint Coding trainer (Band 5/6) - 30/06/16<br>Establish comprehensive IT support model for Medicode - 30/09/16<br>Appoint replacement coding site lead (Band 6) - 30/09/16 | 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 | Business Continuity | There is a risk of flooding from fluvial and pluvial sources resulting in interuption to Services | 03/06/2014 | 31/10/2016 | Causes:<br>Pluvial flooding (all sites) external and internally<br>Fluvial flooding (at LRI) from the River Soar<br>Heavy, prolonged rain fall<br>Winter snow/ice melt<br>Blocked drains<br><br>Consequence:<br>Loss of service areas/buildings/site<br>To the full extent of the river soar flood plain the majority of the LRI would be flooded<br>Sewage ingress<br>Contamination of infrastructure<br>Patient safety<br>Loss of electrical supplies<br>Loss of mains water and drainage<br>Disruption to supply lines<br>Staff difficulties getting in<br>Staff difficulties getting home - staff car parks and vehicles flooded<br>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<br>Response teams<br>IPC Policy<br>Local Business Continuity Plans<br>UHL Major Incident Plan<br>UHL/Multi-agency communications plan<br>Insurance Policy<br>Cooperate with LRF partners to test the LRF plans | Major | Likely | 16 | Update UHL flood plan to identify services and equipment at risk and identify control measures - 31/10/2016 | 12 | PWA |
| 2769 | Musculoskeletal and Specialist Surgery | | There is a risk of cross infection of MRSA as a result of unscreened emergency patients being cared for in the same ward bays | 02/01/2016 | 31/03/2016 | Cause:<br>Emergency patients being admitted to the wards and a lack of capacity to segregate screened and unscreened patients.<br>Cross infection due to MRSA.<br><br>Consequence:<br>Patient could acquire MRSA infection/bacteraemia. | Patient safety | 1. Screening on admission for all emergency surgical admissions.<br>2. Topical MRSA suppression treatment for all patients (antibacterial daily wash and antibacterial nasal ointment).<br>3. Standard UHL precautions - hand hygiene/decontamination of equipment.<br>4. Prompt identification of known MRSA carriers to initiate isolation precautions | Extreme | Possible | 15 | 1. Review screening processes for emergency patients/elective patients - 31/03/16<br>2. Education of staff on expected processes - 31/03/16<br>3. Review hand hygiene and servistrack audits and improve compliance where necessary - 31/03/16<br>4. Work with Microbiology on business case for PCR faster MRSA screening results for emergency patients - 31/03/16<br>5. Prompt screening and support IP processes across wards - 31/03/16<br>6. Process in place for nursing screening and unscreened patients separately - 31/03/16. | 5 | KWR |

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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 | 31/07/2016 | Causes:<br>- Orthodontics -<br>Treatment capacity reduced over the years (3 wte to 1.6 wte).<br>No junior support (SpR, SAS grades)<br>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.<br><br>- Restorative Dentistry -<br>Increasing requirement for specialist work - particularly endodontic<br>Capacity cannot keep up with the demand<br><br>Consequences:<br>- Orthodontics -<br>336 patients on the waiting list.<br>Longest wait of 5.5 years - RTT start March 2010<br>Increasing number of complaints.<br>Not able to provide an indication as to when they might start treatment.<br>Psychological impact for the patient.<br><br>- Restorative Dentistry -<br>Closed to endodontic referrals - significantly reduced provision for this on the NHS within Leicester and Leicestershire.<br>20, 52 week breaches within August and September 2014.<br>Affected the Trusts bottom line non-admitted performance.<br>Increased complaints. | Patient safety | Endodontic waiting list closed to new referrals (Restorative Dentistry).<br>Revised endodontic guidelines agreed and in place from 1.4.15.<br>Managing the orthodontic patients in order by longest wait.<br>Closed orthodontic waiting list to new patients<br>The treatment of the backlog of patients is under way with a number of different providers providing their services :<br>Nottingham NHS Trust<br>Lincoln Hospital<br>Derby NHS Trust<br>Northampton NHS Trust<br>6 X local Pathway Providers<br>1 x Specialist Provider - Leamington Spa<br>Patients notes have been clinically reviewed and patients have been triaged to the most appropriate provider - patients have been sent a letter from the Trust explaining that we are unable to treat the patient and offering a choice of providers. Patients details / apt are being updated on a central database and HISS.<br>Reporting on the responses / allocation of patients / backlog to Senior Trust Managers , NHS England and the TDA on a weekly basis.<br>Clinical and admin validation of orthodontic waiting list (Public health involved). | Moderate | Almost certain | 15 | Recruitment of 2 locum consultant orthodontists (two failed attempts to recruit and the posts will be re-advertised following an external review and meeting with the Trust CEO) - Review date 31/07/16. | 1 | GW |

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| 2673 | Clinical Support and Imaging | Cytogenetics | Decommissioning of the cytogenetics laboratory service at UHL through the NHS England Review | 14/10/2015 | 15/04/2016 | Causes:<br>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.<br><br>Consequences:<br>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. Decommissioning of part of the cytogenetics laboratory repertoire within the remit of the procurement could destabilise the elements of the service that are out with of the specification which in turn could destabilise other services within UHL for example the HMDL service. Loss of a local laboratory would result in all samples being sent to other laboratories for analysis and may adversely affect patient care. Reduction in repertoire may result in loss of highly specialised clinical scientists and other technical staff. | 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.<br>Public consultation period clarifying the scope and service specification requirements in autumn 2014.<br>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<br>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) - 15 April 2016 | 10 | LCR |

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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 | 30/04/2016 | Causes:<br>An increase in the number of referrals to gynaecology services.<br>1.0 wte vacancy of an audio typist.<br>Bank and Agency staff being used to reduce typing backlog are not consistent especially during holiday periods.<br>In addition delays can occur due to Consultants working cross-site and not accessing results promptly in order for the letters to be completed.<br><br>Consequences:<br>Delay in timely appointment letters to patients<br>Delay in patients receiving results<br>Delay in patients receiving follow up appointments<br>Breach in the Trust standard for typing and sending out of patients letters (48 hours maximum time from date of dictation)<br><br>As at 21/08/15 - there is a delay in gynaecology correspondence to the patient of:<br>- 8 weeks following a general gynaecology appointment at LRI<br>- 8 weeks for 1st appointment letters for Colposcopy at LRI<br>- 1 week and 5 days for colposcopy result letters at LRI<br>- 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.<br>Weekly admin management meeting standing agenda item: typing backlog by site also by Colposcopy and general gynaecology.<br>Using Bank & Agency Staff.<br>Protected typing for a limited number of staff. | Moderate | Almost certain | 15 | Clearance of backlog of letters - due 30/04/2016 | 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 |
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| 2330 | Medical Directorate | | Risk of increased mortality due to ineffective implementation of best practice for identification and treatment of sepsis | 04/11/2014 | 30/04/2016 | Causes<br>Failure of clinical staff to consistently recognise and act on early indicators of sepsis.<br>Inconsistent timely recognition of patients with severe sepsis.<br>Inconsistent screening for sepsis in patients at risk.<br>Incomplete timely treatment of severe sepsis (i.e. deliver sepsis six within 1 hour of developing severe sepsis)<br><br>Consequences<br>Increased avoidable morbidity and mortality in adults and children.<br>Serious incidents relating to delayed recognition or treatment.<br>Risk of increased complaints, claims or adverse coroner inquest findings.<br>Financial costs to UHL - Additional estimated £4000 per patient for incomplete delivery of treatment and subsequent increased morbidity. Loss of income related to poor performance in National CQUIN for sepsis.<br>Adverse media attention, risk of reduced reputation following external visits by bodies such as CQC. | Patient safety | Appointed sepsis lead, sepsis nurse and sepsis working party. Regular reports to Adult Critical and Augmented Care Board and on to Executive Quality Board as required.<br>Network of sepsis champions across UHL, delivering face to face training to >2000 staff. Simulation based training in sepsis to all FY 1&2 staff. Ad hoc training to specialist areas.<br>Standardised sepsis pathway for adults and children across whole of UHL. Standardised early warning system.<br>Deployment of sepsis boxes with standard antibiotic regimen across whole trust.<br>Continuous audits of adherence to pathway and screening via UHL Quality Commitment and National CQUIN on sepsis. | Extreme | Possible | 15 | Embed timely use of sepsis pathway, including revised 2016 definitions into all clinical areas, prioritising high incidence areas such as ED and admission units - 30/04/16.<br>Reinforce usage of existing sepsis boxes in clinical areas - 30/04/16.<br>Coordinated relaunch of sepsis publicity via trust communications - 30/04/16.<br>Ensure all clinical staff receive education package relating to sepsis, face to face or via trust induction (for new starters) - 31/08/16.<br>Setup automated prompts for sepsis as NEWS and e-obs introduced into UHL - 31/08/16.<br>Appointment of 6 nurses, externally funded from the NHSLA (for 12 months) to support management of the deteriorating patient/sepsis care in ED & assessment areas. To sit within the Critical Care Outreach Team - 30/06/16.<br>Trial system for providing feedback to clinical staff of patient management prior to ICU admission, focusing on sepsis - 30/04/16. | 6 | JPARK |

| 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 | IPC | There is a risk that inappropriate decontamination practise may result in harm to patients and staff | 19/08/2014 | 30/04/2016 | Causes:<br>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<br>a. Environment<br>b. Managerial oversight<br>c. Education and Training of staff<br>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.<br>Bench top sterilisers within Theatres continue to be used. The use of these sterilisers is monitored by an AED.<br>Purchase of Equipment is not always discussed with the Decontamination Committee.<br><br>Consequences:<br>Lack of oversight of Decontamination practice across the Trust<br>Equipment purchased may not be capable of adequate decontamination if not approved by Infection Prevention<br>Current Endoscope Washer Disinfectors (EWD) re-processing locations (other than endoscopy units) are unsatisfactory.<br>All of the above having the potential for inadequately decontaminated equipment to be used<br>Patient harm due to increased risk of infection<br>Risk to staff health either by infection or chemical exposure<br>Reputational damage to the organisation<br>Financial penalty<br>Risk of litigation<br>Additional cost to the organisation when further equipment must be purchased | Patient safety | Surgical instrument decontamination outsourced to third party provider. Joint management board and operational group oversee this contract.<br>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.<br>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.<br>Benchtop sterilisers are serviced by a third party<br>Endoscope washer disinfectors are serviced as part of a maintenance contract<br>Infection prevention team are auditing current decontamination practice within UHL.<br>Position paper sent to Trust Infection Prevention Assurance Committee in November 2013<br>Infection prevention team provide advice and support to service users if requested<br>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 - 30/04/16<br>Review all education and training for staff involved in reprocessing reusable medical equipment - 30/04/16<br>Review the use of equipment and the appropriateness of their current placement according to national guidance -30/04/16 | 3 | LCOOL |

| 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 |
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| 1551 | Corporate Nursing | | Failure to manage Category C documents on UHL Document Management system (Insite) | 14/03/2011 | 31/05/2016 | Causes:<br>Lack of resource at CMG/directorate level to check review dates and enter local guidance onto the system in a timely manner.<br>Lack of resource in CASE team effectively 'police' cat C documents<br>Clinical guidelines very difficult to locate due to difficulties in navigating on InSite<br>During migration from Sharepoint 2007 to Sharepoint 2010 searched documents displayed the titles of the files rather than the titles of documents.<br><br>Consequences<br>InSite may not contain the most recent versions of all category C documents.<br>There may be duplication of documents with older versions being able to be accessed in addition to the most recent version.<br>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<br>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<br>Compile a list of local guidelines requiring review and send to CMGs for action - complete<br>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<br>Implement shared mailbox to receive responses from CMGs - complete<br>Ensure input from IM&T to make InSite more effective as a document library - complete<br>Continue work to assign review dates and authors to all CAT C documents 31/05/16<br>Recruitment approved for Band 3 P&G Administrator - 31/05/16.<br>Appoint temporary staff to help address backlog of documents requiring review - complete. | 9 | RBROUG |

| 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2774 | Operations | | Delay in sending outpatient letters following consultations is resulting in a significant risk to patient safety & experience . | 25/01/2016 | 30/04/2016 | Causes:<br>Variability in the systems and processes for generating and sending letters.<br>Lack of monitoring processes and oversight when performance falls below standard expectations.<br>Problems with access to equipment in clinics making it more challenging for clinicians to dictate and e-approve letters in a timely way.<br>Insufficient administrative and clerical staffing to support outpatient letter processes.<br>Sub-optimal training for medical and administrative staff on how to use Dictate/Winscribe.<br><br>Consequences:<br>Backlog and potential lost letters i.e. in Winscribe. A sustained backlog will create a delay in patient prognosis.<br>Affects the continuity of care of patients in a primary healthcare setting.<br>Information about new/changed medication and patient results not getting to GPs.<br>Prevents patients from having an insight into their condition and could also cause their condition to deteriorate. | Patient safety | Third party electronic systems i.e. Dictate IT, Winscribe.<br>Upgrading electronic system versions i.e. Dictate IT in order to help support improved outcomes.<br>Differing performance monitoring mechanisms by managers and administrative teams within each CMG. | Moderate | Almost certain | 15 | Review the current state of electronic systems used for generating outpatient letters within the Trust. Identify opportunities to implement a coordinated approach to systems within CMGs in order to improve turnaround times and reduce backlogs - due 30/04/16<br><br>Investigate processes currently used for monitoring electronic systems, turnaround times and the adherence to the UHL policy of 'letters within 10 days' within CMGs with the view to implement a standardised monitoring process for all - due 30/04/16<br><br>Ensuring for each CMG the most appropriate electronic system is chosen which is sufficient to meet the needs of its services; includes having the ability to outsource if required - due 30/06/16<br><br>Once decisions have been made on which electronic system will be used within CMG's, ensuring there is sufficient training processes for medical and administrative staff in place - due 30/06/16 | 6 | WMONAG |

| Risk ID | CMG | Specialty | RISK REGISTER REPORT: MODERATE RISKS AS AT 31/03/16<br>Risk Title | Current Risk Score | Target Risk Score | Risk Owner |
|---|---|---|---|---|---|---|
| 2798 | CHUGS | Gastroenterology | There is a risk of harm to patients due to reduced junior doctor cover on the gastro wards | 12 | 6 | JFA |
| 2722 | CHUGS | General Surgery | There is a risk of cross infection of MRSA as a result of unscreened pts being nursed in bays with screened pts | 12 | 5 | KJO |
| 2723 | CHUGS | Clinical Haematology | Clinical Oncologist support for Haematology MDTs | 12 | 1 | JFA |
| 2726 | CHUGS | Clinical Haematology | Radiologist Attandance at Haematology MDTs | 12 | 1 | JFA |
| 2771 | CHUGS | Clinical Haematology | There is a risk to quality of patient care due to insufficient clinical oncologist PAs for radiotherapy treatments &Haem MDTs | 12 | 8 | DPEEL |
| 2566 | CHUGS | Oncology | There is risk of delays to planning patient treatment due to the age of the Toshiba Aquilion CT scanner in the Radiotherapy Dept | 12 | 1 | LWI |
| 2617 | RRCV | | Shortfall in appropriately skilled nursing staff at Northamptons renal units | 12 | 8 | SM |
| 2670 | RRCV | | There is a risk to the Immunology & Allergy Services due to a Consultant Vacancy | 12 | 4 | SM |
| 2792 | RRCV | | Lincoln Water Treatment risk of failure & impact on patients | 12 | 6 | GWARD |
| 2605 | RRCV | Renal Transplant | There is a risk that the Transplant Laboratory's IT database for managing patients and donors will experience a system 'crash' | 12 | 4 | PDU |
| 2619 | RRCV | Vascular | Reduced nursing staff levels on ward 21 at LRI | 12 | 6 | CSISS |
| 2590 | Emergency and Specialist Medicine | | There is a risk that patients may come to harm due to significant gaps in the medical workforce rota at the LRI | 12 | 9 | SLO |
| 2552 | Emergency and Specialist Medicine | | There is a risk of an omission of insulin in inpatients with diabetes due to the clinical system (ePMA) | 12 | 9 | JSPI |
| 2656 | Emergency and Specialist Medicine | | There is a risk that a lack of resources in Dermatology service will impact on level and quality of service | 12 | 6 | SLO |
| 2256 | Emergency and Specialist Medicine | ED | There is a risk of harm to patients, staff and the four hour target due to inadequate paed nurse staffing/seniority levels. | 12 | 6 | LLA |
| 2234 | Emergency and Specialist Medicine | ED | There is a medical staffing shortfall resulting in a risk of an understaffed Emergency Department impacting on patient care | 12 | 6 | RW |
| 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 | 12 | 6 | MWIL |
| 2530 | ITAPS | | Vacant Consultant post in pain management resulting in backlog of new and follow up patients | 12 | 9 | AGE |
| 2557 | ITAPS | | There is a risk that consultant and jnr dr staffing levels in Glenfield ITU could impact on patient care | 12 | 5 | WBE |
| 2532 | ITAPS | Critical Care | Poor Physical Environment at the LRI and LGH ITUs | 12 | 8 | RVA |
| 2415 | ITAPS | Critical Care | There is an inability to support level 3 activity going forward at the LGH ITU as a result of lack of Consultant cover . | 12 | 2 | CAL |
| 2194 | ITAPS | Theatres | There is a risk that lack of nurse staffing could result in unplanned loss of theatre, recovery or Critical Care capacity in UHL | 12 | 4 | JHOL |
| 2542 | Musculoskeletal and Specialist Surgery | | There is a risk to the quality and safety of patients due to an increase in nursing vacancies on the Kinmonth Unit, LRI | 12 | 9 | MAT |
| 2558 | Musculoskeletal and Specialist Surgery | | There is a risk that the nightingale style wards could result in a Mixed-Sex Accommodation breach | 12 | 6 | TEL |
| 2768 | Musculoskeletal and Specialist Surgery | | There is a risk to the quality and safety of patients due to an increase in nursing vacancies on the Ambulatory Surgery Unit (fo | 12 | 6 | PED |

| Risk ID | CMG | Specialty | RISK REGISTER REPORT: MODERATE RISKS AS AT 31/03/16<br>Risk Title | Current Risk Score | Target Risk Score | Risk Owner |
|---|---|---|---|---|---|---|
| 2076 | Musculoskeletal and Specialist Surgery | Otorhinolaryngology/ENT | There is a risk of elective surgery cancellations due to emergency operations and lack of beds | 12 | 6 | STA |
| 2191 | Musculoskeletal and Specialist Surgery | Ophthalmology | There is a risk of lack of capacity within outpatient services causing follow up backlogs and capacity issues in Ophthalmology | 12 | 8 | STA |
| 2687 | Musculoskeletal and Specialist Surgery | Trauma Orthopaedics | Lack of appropriate medical cover will clinically compromise care or ability to respond in Trauma orthopaedics | 12 | 9 | CSK |
| 2575 | Clinical Support and Imaging | | Risk to patients due to a delay in Image reporting as there is a lack of reporting capacity in neuroradiology | 12 | 4 | ARIC |
| 2576 | Clinical Support and Imaging | | There is a risk due to lack of qualified & experienced radiographers to the quality of the service provided to patients | 12 | 4 | CLA |
| 2555 | Clinical Support and Imaging | | There is a risk of insufficient provision of clinical support services to adult ITU (all sites), resulting in increased clinical | 12 | 6 | CSH |
| 2603 | Clinical Support and Imaging | | There is a risk that CSI CMG will not deliver its full recurrent CIP target in 2015/16 | 12 | 6 | CSH |
| 2380 | Clinical Support and Imaging | | There is a risk of breach of Same Sex Accommodation Legislation in Imaging | 12 | 3 | JHA |
| 2607 | Clinical Support and Imaging | Clinical Microbiology | There is a risk that the provision of an out of hours Virology "On-call" service may not be sustained due to insufficient numb | 12 | 6 | JBOWSK |
| 2615 | Clinical Support and Imaging | Clinical Microbiology | Integrity and capacity of containment level 3 laboratory facility in Clinical Microbiology | 12 | 2 | JBOWSK |
| 2780 | Clinical Support and Imaging | Dietetics | Risk of suboptimal and unsafe Adult Nutrition and Dietetic Service provision to Adult Cancer patients | 12 | 1 | CSTE |
| 2781 | Clinical Support and Imaging | Dietetics | Suboptimal and unsafe Paediatric Nutrition and Dietetic Service to Paediatric Cardiology | 12 | 2 | CSTE |
| 1536 | Clinical Support and Imaging | General Pathology | Inability to deliver major Pathology Transformation | 12 | 6 | PSH |
| 1238 | Clinical Support and Imaging | Cellular Pathology | Tissue Retention Following Post Mortem Examination | 12 | 6 | AMCG |
| 2810 | Clinical Support and Imaging | Immunology | Inability to provide a robust on call service due to a reduction in number of staff participating in on-call rota | 12 | 4 | BDI |
| 2248 | Clinical Support and Imaging | Medical Physics | Lack of IR(ME)R training records held across the Trust | 12 | 4 | MNO |
| 2179 | Clinical Support and Imaging | Medical Physics | Non-medical stress for myocardial perfusion imaging | 12 | 6 | MNO |
| 2136 | Clinical Support and Imaging | Medical Physics | There is a risk that ageing asset base could result in infusion pump obsolescence | 12 | 4 | MNO |
| 2554 | Clinical Support and Imaging | Medical Physics | There is a risk that Radiopharmacy may not be able to operate due to the Production Manager leaving UHL | 12 | 4 | MNO |
| 2362 | Clinical Support and Imaging | Pharmacy | There is a risk the Pharmacy medicines storage facilities could increase infection rates | 12 | 1 | CELL |
| 2808 | Clinical Support and Imaging | Special Haematology | There is a risk that high ambient temperatures in the Sp.Haematology Lab will affect service provision and development | 12 | 2 | BDI |
| 2690 | Clinical Support and Imaging | Stem Cell | Failure of Stem Cell Laboratory Clean (SCL) Suite, due to age of facility, leading to inability to process stem cells | 12 | 4 | AFS |
| 2570 | Clinical Support and Imaging | Ultrasound | Risk of being unable to meet the national standard for the Image quality reviews for Nuchal Translucency and CRLs | 12 | 6 | CLA |
| 2419 | Women's and Children's | | ECMO Specialist Competency - Maintenance of minimum pump hours (70 per year), attendance at meetings (50% per year) & yearly wat | 12 | 1 | GF |
| 2391 | Women's and Children's | | There is a risk of inadequate numbers of Junior Doctors to support the clinical services within Gynaecology & Obstetrics | 12 | 8 | CWIESE |
| 2578 | Women's and Children's | GY | Scans undertaken in GAU & Gynaecology clinic cannot be archived | 12 | 2 | LGW |
| 1042 | Women's and Children's | Maternity | Unavailability of USS and not meeting National Standards for USS in Maternity | 12 | 6 | LHAR |

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|---|---|---|---|---|---|---|
| 593 | Women's and Children's | Neonatology | There is a risk of inadequate neonatal nursing staff /skill mix levels to meet clinical requirements | 12 | 6 | JFO |
| 1367 | Women's and Children's | Neonatology | Lack of Capacity in the Neonatal Service | 12 | 8 | JCC |
| 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. | 12 | 6 | JFO |
| 2597 | The Alliance | | Lack of monthly environment audits means there is no assurance that appropriate cleaning standards are being achieved | 12 | 4 | AHE |
| 2710 | The Alliance | | Failure to effectively move endoscopy out of UHL in to the community may adversely affect the health economy | 12 | 8 | ND |
| 2730 | The Alliance | | Failure to develop CIP plans for 2016/17. | 12 | 4 | SSU |
| 2732 | The Alliance | | Low staff moral caused by a lack of engagement with staff. | 12 | 8 | SJENNI |
| 2733 | The Alliance | | The current nursing management structure is not appropriate | 12 | 4 | ND |
| 2738 | The Alliance | | There is a delay in typing up and sending out patient letters. | 12 | 3 | ATY |
| 2739 | The Alliance | | Failure to pay invoices within required timescale specifically for payment of clinical sessions delivered. | 12 | 4 | SSU |
| 2740 | The Alliance | | Coverage of the Friends and Family test is inadequate in Outpatients. | 12 | 3 | ATY |
| 2741 | The Alliance | | Friends and Family Test for Outpatients and Imaging is poor. | 12 | 3 | ATY |
| 2794 | The Alliance | | There is a risk of a loss of income as a result more financial disputes being raised by the new contracting team. | 12 | 8 | LWALL |
| 2751 | The Alliance | | Insufficient capacity to support the implementation of business cases. | 12 | 3 | SSU |
| 2752 | The Alliance | | The supply of clincians (from UHL and other providers) does not meet activity levels. | 12 | 4 | SSU |
| 2735 | The Alliance | | Failure to achieve the appraisal target (95%). | 12 | 6 | ND |
| 2736 | The Alliance | | Some of our staff do not have the competency to support the future models of care in a community setting. | 12 | 4 | ND |
| 2743 | The Alliance | | The process for managing Subject Access Request is not fully robust. with no specific Alliance resource | 12 | 3 | ND |
| 2744 | The Alliance | | The operational management structure is no longer fit for purpose. | 12 | 3 | SSU |
| 2746 | The Alliance | | Failure to have signed pillar contracts in place. | 12 | 3 | LWALL |
| 2747 | The Alliance | | Failure to ensure SLA's are in place for the support services supplied to the Alliance. | 12 | 3 | LWALL |
| 2749 | The Alliance | | High level of dependancy of independant practitioners / companies | 12 | 8 | SSU |
| 2421 | The Alliance | Loughborough | There is a risk that inadequate air volume & frequency of air changes in the prep room of Loughborough impacting patient safety | 12 | 1 | THAM |
| 2712 | The Alliance | Hinckley | There is a risk of injury to staff resulting from the decontamination sinks being at a fixed low level. | 12 | 2 | HFL |
| 2713 | The Alliance | Hinckley | There is a risk that staff will incur damage to their hearing and well-being related to the level of noise in endoscopy | 12 | 2 | HFL |
| 2593 | The Alliance | Hinckley | There is a risk of cross infection and non compliance with JAG due to inadequate design of the endoscopy decontamination dept | 12 | 2 | MTIC |
| 2594 | The Alliance | Hinckley | Lack of appropriate storage facilities may cause damage to sterile theatre consumables | 12 | 1 | AHE |
| 2154 | Communications | | There is a risk that a lack of engagement with PPI processes by CMGs and Directorates could affect legal obligations | 12 | 8 | KMAY |
| 1888 | Communications | | There is a risk that poor GP relationships could affect public reputation | 12 | 4 | MWIG |

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| 2210 | Medical Directorate | | There is a risk that results of inpatient diagnostic tests are not being reviewed or acted upon resulting in patient harm. | 12 | 8 | ADOS |
| 2211 | Medical Directorate | | Risk of essential patient information not being handed over by doctors at shift changes resulting in patient harm. | 12 | 8 | CSU |
| 2212 | Medical Directorate | | Risk of patients not receiving a review from a senior clinician with associated documentation resulting in patient harm. | 12 | 8 | JJAME |
| 2196 | EFMC | | Estates & Facilities Service delivery issues due to technical difficulties with Computer Aided Facilities Management software | 12 | 4 | GLA |
| 1181 | EFMC | | LRI Water quality risks | 12 | 2 | GLA |
| 1336 | EFMC | | DDA Access Priority Review | 12 | 2 | ADM |
| 1612 | EFMC | | Foul water drain blockages - Glenfield | 12 | 2 | NBO |
| 568 | EFMC | | Electrical Infrastructure - LRI | 12 | 2 | GLA |
| 1179 | EFMC | | LRI electrical infrastructure | 12 | 3 | GLA |
| 2672 | EFMC | | There is a risk of fall from height from a window | 12 | 1 | GLA |
| 2608 | EFMC | | Micad Asbestos Register | 12 | 4 | GLA |
| 2775 | Finance | Business Continuity | There is a risk that the lack of availability of critical goods will impact on clinical service provision. | 12 | 6 | BSHAW |
| 2395 | IM&T | Privacy | Photographs of patients being taken by clinicians in contravention of the UHL Consent Policy | 12 | 4 | RSMI |
| 2267 | Corporate Nursing | IPC | Risk of reduced compliance with DoH requirements in relation to adherence to antimicrobial prescribing policy | 12 | 3 | KDA |
| 2528 | Operations | | If cancer MDT video conferencing equipment is not supported it could introduce delays for cancer patient pathways | 12 | 1 | MWA |
| 2728 | Operations | Business Continuity | Lack of cover due to industrial action by Junior Doctors may result in harm to patients | 12 | 12 | AVO |
| 2317 | Operations | Business Continuity | Influenza Type Disease Pandemic causing disruption to services | 12 | 12 | PWA |
| 2315 | Operations | Business Continuity | There is a risk of no notice loss of telecommunications accross UHL | 12 | 8 | PWA |
| 2609 | RRCV | Cardiac Rehabilitation | Risks to the quality of Patient Cardiac Rehabilitation individual assessments due to new clinic location in LRI | 10 | 1 | SBY |
| 2235 | Emergency and Specialist Medicine | ED | There is a risk of harm to patients during inter and intra hospital transfers | 10 | 8 | LLA |
| 2531 | Clinical Support and Imaging | | A shortage of suitably qualified Breast Radiology Consultant cover in Breast Imaging service | 10 | 4 | ARIC |
| 2551 | Clinical Support and Imaging | | A shortage of suitably qualified MSK and Head & Neck Consultant cover to provide adequate levels of service provision. | 10 | 4 | ARIC |
| 2444 | Clinical Support and Imaging | Medical Physics | Implementation of the medical equipment libraries (LRI and LGH), providing equipment fit for purpose to clinical areas | 10 | 5 | MNO |
| 2571 | Clinical Support and Imaging | Ultrasound | A shortage of suitably qualified Oncology Consultant cover within Imaging to provide adequate levels of service | 10 | 4 | CLA |
| 2409 | Women's and Children's | | There is an insufficient number or middle-grade doctors, both registrars and SHO's to provide adequate service cover in W&C CMG | 10 | 10 | LCOW |
| 2604 | Women's and Children's | GY | Lack of continuity in patient care due to Consultant cross site working | 10 | 6 | QD |
| 2381 | Women's and Children's | Paediatrics | Risk of a child falling from the 4th floor window in the Children's ward due to the gap between the single & secodary glazing | 10 | 1 | VBA |

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| 2454 | Medical Directorate | | Harm to patients/Trust resulting from supply / admin of medicines by non-medical professionals operating under expired PGDs | 10 | 1 | CELL |
| 2489 | EFMC | | Risk of micro-organism contamination of water supply from water tanks containing hollow struts leading to adverse health effects | 10 | 1 | GLA |
| 2414 | CHUGS | Gastroenterology | There is a risk to patients privacy & dignity and the decontamination process for endoscopes at LGH Endoscopy Unit | 9 | 4 | GK |
| 2620 | RRCV | | Reduced nursing skills set on W28, GH | 9 | 4 | SM |
| 2757 | RRCV | | Risk of infection to patients undergoing open chest cardiac procedure that require cardiopulmonary bypass | 9 | 3 | JGI |
| 2057 | RRCV | Cardiac Investigations | There is a risk that Insufficient Echo provision cross-site could impact on planned referrals | 9 | 1 | MCA |
| 2475 | RRCV | Satellite Units | There is a risk of an increase in the number of inpatients requiring haemodialysis within Lincolnshire Hospitals | 9 | 3 | JPR |
| 2591 | Emergency and Specialist Medicine | | Risk of Delay in Providing Timely Assessment and Treatmentto Outpatients with Diabetic Foot Ulcers | 9 | 6 | JSPI |
| 742 | Emergency and Specialist Medicine | Older people's services | Non secured ward entrance doors are a risk to wandering and confused patients on some wards. | 9 | 4 | SBURT |
| 2466 | Emergency and Specialist Medicine | Rheumatology | There is a risk of Patient harm due to delays in timely review of results and Monitoring in Rheumatolgy | 9 | 1 | JSPI |
| 2721 | Emergency and Specialist Medicine | Stroke Services | There is a risk that the limited establishment of Stroke Therapeutics could impact on stroke performance targets | 9 | 3 | SPIZZE |
| 2023 | ITAPS | Critical Care | There is a risk that the continued rise in critcal care occupancy could mean insufficient Staffed Level 3 Critical Care Beds | 9 | 6 | JHOL |
| 2478 | ITAPS | Theatres | Risk of reduced ODP cover for a second obstetric theatre opens out of hours. | 9 | 4 | JHOL |
| 2686 | Musculoskeletal and Specialist Surgery | Trauma Orthopaedics | Trauma orthopaedic surgery including spinal and hemi arthroplastics being carried out in non laminar flow theatres | 9 | 9 | CSK |
| 2496 | Clinical Support and Imaging | Blood Transfusion | Risks associated with implementation of an Electronic Blood Tracking (Phase 2) | 9 | 4 | AFE |
| 2293 | Clinical Support and Imaging | Dietetics | Risk of shortfall in nutritional intake in 'at risk' patients if reliant on meal provision without supplement. | 9 | 6 | CSTE |
| 2162 | Clinical Support and Imaging | Cellular Pathology | Cellular Pathology - Failure to meet TATs - Quality ; Patient Safety &HR risk | 9 | 6 | MLANG |
| 1157 | Clinical Support and Imaging | Medical Physics | Lack of planned maintenance for medical equipment maintained by Medical Physics | 9 | 6 | MNO |
| 2346 | Clinical Support and Imaging | Medical Physics | Lack of a scientific lead in EDS | 9 | 3 | MNO |
| 2364 | Women's and Children's | Maternity | Electronic Access to EMPath | 9 | 3 | LHAR |
| 337 | Women's and Children's | Neonatology | Medication prescribing and administration errors on NNU | 9 | 6 | JFO |
| 2452 | The Alliance | | Lack of Outpatient Follow Up Appointments | 9 | 6 | ATY |
| 2592 | The Alliance | | There is a risk of reduced Health Care Assistant staffing levels due to the introduction of the National Care Certificate. | 9 | 4 | RSUMNE |
| 2595 | The Alliance | | There is a risk that nurse staffing levels may fall due to staff being unable to revalidate. | 9 | 6 | ND |
| 2742 | The Alliance | | There is a risk of under reporting of incidents | 9 | 3 | ND |
| 2737 | The Alliance | | There is a risk that we cannot meet all clinical governance requirements within the existing structure. | 9 | 3 | ND |
| 2596 | The Alliance | Hinckley | There is a risk of reduced theatre activity as new anaesthetists are unhappy about working with cylinder supplied medical gases | 9 | 1 | ND |

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|---|---|---|---|---|---|---|
| 2777 | Communications | | That fundraising targets for the new Children's Hospital are greater than the amount held by the UHL fundraising dept. | 9 | 4 | SAN |
| 2327 | Communications | | Poor Stakeholder Relationships | 9 | 4 | KMAY |
| 2776 | EFMC | | Fire signal between panel and switchboard at LGH | 9 | 1 | GLA |
| 2266 | HR | | There is a risk that HR processes to recruit, retain, develop and motivate staff may not be fully embedded | 9 | 4 | KBR |
| 2314 | Operations | Business Continuity | National road fuel shortage impacting on ability to provide services | 9 | 6 | PWA |
| 2468 | CHUGS | | There is a risk of staff not reading, following and reviewing policies and protocols resulting in detriment to patient safety | 8 | 4 | MTI |
| 2310 | CHUGS | | There is a risk the SAU triage areas may be used as a bedded area with potential impacts on safety to patients and staff | 8 | 4 | GK |
| 2264 | CHUGS | | Risk to the quality of care and safety of patients due to reduced staffing in GI medicine/Surgery and Urology at LGH and LRI | 8 | 6 | GK |
| 2536 | RRCV | | Risk that patient safety may be compromised due to staffing shortages in the Renal Technical Dept | 8 | 3 | DW |
| 2755 | RRCV | | Water Control Warning System | 8 | 1 | GWARD |
| 2529 | ITAPS | Anaesthesia | Risk of vacancies on junior doctor on-call rota resulting in greater use of agency staff | 8 | 8 | CAL |
| 2560 | Clinical Support and Imaging | | Demolition and construction capital works for the ED impacting on genetics centre | 8 | 6 | LCR |
| 607 | Clinical Support and Imaging | Blood Transfusion | Failure of UHL BT to fully comply with BCSH guidance and BSQR | 8 | 4 | AFE |
| 2779 | Clinical Support and Imaging | Dietetics | Risk of suboptimal and unsafe Paediatric Nutrition and Dietetic Service provision to the Paediatric Cardiology Service | 8 | 2 | CSTE |
| 2307 | Clinical Support and Imaging | Special Biochemistry | The Forensic Toxicology service will fail resulting in a substantial loss of income and prestige for the Department/empath | 8 | 4 | BDI |
| 2782 | Women's and Children's | Family Planning | If ISO 15189 accreditation is not achieved there is a risk that the Leicester Fertility Centre licence may be withdrawn | 8 | 6 | DMARS |
| 2753 | The Alliance | | There are no leases in place for the premises used by the Alliance. | 8 | 2 | SSU |
| 2754 | The Alliance | | Failure to report diagnostic performance accurately (during 2015/16) | 8 | 8 | SSU |
| 2745 | The Alliance | | There is a risk that Hinkley Hospital is no longer fit for purpose. | 8 | 6 | SSU |
| 2750 | The Alliance | | The Project Manager contracts will end in March 2016 which may adversely effect community shift if staff leave before contract | 8 | 4 | SJENNI |
| 2795 | The Alliance | | Delays with receiving, reviewing and disseminating NICE guidance may result in recommended guidance not being followed | 8 | 4 | ND |
| 2602 | The Alliance | Loughborough | There is a risk of endoscopy procedures being cancelled if the endoscopy drying cabinets fail | 8 | 4 | AHE |
| 2688 | The Alliance | Hinckley | Contracted SLA session in Hinckley day case theatre for General Anaesthesia procedures | 8 | 4 | ALOWE |