INTEGRATED RISK REPORT

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

Executive Summary

Context

The BAF is the key source of evidence that links strategic objectives to risks, controls and assurances, and the main tool that the Trust Board (TB) should use in seeking assurance that those internal control mechanisms are effective. The 2016/17 BAF has been developed with reference to the revised annual priorities and this report provides the Trust Board with the position to 31st August 2016. The report also provides a summary of the organisational risk register for items scoring 15 or above.

Questions

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

Conclusion

1. Executive leads of each strategic objective have provided an accurate picture of our principal risks affecting the achievement of our objectives.
2. Many of our assurance sources are based on internal monitoring and some may benefit from external scrutiny (e.g. via internal audit) to provide additional assurance that controls are effective.
3. All actions are currently on track. There are a small number of actions where the deadline for completion has been extended in recognition of delays being encountered. Narrative within the BAF 'action tracker' provides further detail.
4. Two new operational risks scoring 15 and above have been opened during the month of August 2016 (There is a risk of delays to patient diagnosis and treatment which will affect the delivery of the national 62 day cancer target & Reduction in capital funding may lead to a failure to deliver the 2016/17 medical equipment capital replacement programme).

Input Sought

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

(a) receive and note this report;
(b) review this version of the 2016/17 BAF noting:
- any gaps in assurances about the effectiveness of the controls to manage the principal risks and consider the nature of, and timescale for, any further assurances to be obtained;
- the actions identified to address any gaps in either controls or assurances (or both);
- any areas which it feels that the Trust's controls are inadequate.

For Reference

Edit as appropriate:

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

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

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

a. Organisational Risk Register [Yes]

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

Datix Risk ID	Operational Risk Title(s) – add new line for each operational risk	Current Rating	Target Rating	CMG
	See appendix two			

If NO, why not? Eg. Current Risk Rating is LOW

b. Board Assurance Framework [Yes]

If YES please give details of risk No., risk title and current / target risk ratings.

Principal Risk	Principal Risk Title	Current Rating	Target Rating
	See appendix one		

3. Related **Patient and Public Involvement** actions taken, or to be taken: [N/A]

4. Results of any **Equality Impact Assessment**, relating to this matter: [N/A]

5. Scheduled date for the **next paper** on this topic: [03/11/16 Trust Board]

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **UHL TRUST BOARD**

DATE: **6TH OCTOBER 2016**

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

SUBJECT: **INTEGRATED RISK REPORT (INCORPORATING UHL BOARD ASSURANCE FRAMEWORK AS OF 31ST AUGUST 2016)**

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1 INTRODUCTION

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

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

2. BAF AS OF 31ST AUGUST 2016

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

2.2 The TB is asked to note:

a. Principal risk 19; reduction in risk score from 12 – 9.

3. UHL RISK REGISTER SUMMARY AS OF 31ST AUGUST 2016

3.1 At the end of the reporting period, there are 46 risks open on the operational risk register scoring 15 and above. Two new 'high' risks have been entered on the risk register during the reporting period. Noteworthy changes to other risks include four risks reducing to moderate ratings and one risk closing. Changes are described in the risk dashboard in appendix two.

3.2 Thematic analysis of risks scoring 15 and above on the risk register shows that the majority of risks relate to workforce capacity and capability with the potential to impact clinical quality and performance. A column to describe the thematic analysis is included in the dashboard in appendix two.

4 RECOMMENDATIONS

4.1 The TB is invited to:-

(a) receive and note this report;
(b) review this version of the 2016/17 BAF noting:

- any gaps in assurance about the effectiveness of the controls to manage the principal risks and consider the nature of, and timescale for, any further assurances to be obtained;
- the actions identified to address any gaps in either controls or assurances (or both);
- any areas which it feels that the Trust's controls are inadequate.

UHL Corporate Risk Management Team
28th September 2016.

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

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

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Clinical Effectiveness **Directive controls** Screen all hospital deaths Sepsis screening tool and care pathway Implement daily PARR 30 report to direct specialised discharge planning and communication of risk with stakeholders **Detective controls** Hospital deaths screening tool findings % of deaths screened Case record review individual and thematic findings Dr Foster's Intelligence and HED data Audit of sepsis 6 interventions No. of SIs in relation to deteriorating patient/ sepsis Readmission rates and findings of PARR30 tool **Patient Safety:**	**Clinical Effectiveness** SHMI scores reported to Mortality and Morbidity Committee and TB, QAC via Q&P report. Quarterly mortality report to ESB/QAC/TB 6 monthly TB report in relation to mortality parameters monthly review of mortality alerts reported to TB. UHL target SHMI <= 99 Current SHMI (Oct 14 - Sept 15) 96 Readmission rate to be < 8.5% Readmissions action plan progress reported monthly to Ward Programme Board Quarterly report to EQB Exception reports to EPB when rate over8.6% **Sepsis and deteriorating patient** % of EWS 3+ appropriately escalated %	Internal Audit mortality and morbidity review due Q3 2015/16. Internal audit review in relation to outpatient patient experience due Q4 2015/16.	(a) Currently not all deaths are screened. (1.1, 1.2 and 1.3) (c) Circa £4M funding gap to implement 7 day service standards. (1.4) (c) Workforce shortage may inhibit implementation of 7 day service standards(1.4) (a) No single measure to monitor performance of 7 day services (1.4) (c) Data quality and volume due to manual data audit collection (1.6)

Patient Safety **Directive controls** 7 Day service standards (including implementation of 14 hour consultant review, diagnostics, professional standards and daily consultant review) Implement UHL EWS and e-obs Implement insulin safety strategy **Detective control** Quarterly patient safety report highlighting number of severe/ moderate harms % of deaths screened 7 DS NHSE audit returns Insulin related incidents reported via Datix **Patient Experience** **Directive Control** End of life care plans Use of the 5 questions **Detective Controls** EoLC audits of use of care plan % uptake of EoLc training Outpatient group monitoring data	% of EWS 3+ appropriately escalated % of EWS 3+ screened for sepsis % of "red flag" sepsis patients receiving iv antibiotics within 1 hour (threshold 90% of antibiotics within 60mins) Harm reviews for patients >3 hours **7 Day Services** NHS E 7 DS quarterly self assessments **Patient experience** 6% improvement on patient involvement scores 10% improvement on care plan use and outpatient experience scores. Achieve 14 day correspondence standard.		(1.6) (c)Many avoidable readmissions caused due to factors in the community beyond influence of UHL (c) improvements in sepsis and the deteriorating patient trust wide are required (1.7)

Action tracker:	Due date	Owner	Progress update:	Status
Mortality database to be developed (1.1)	Oct 2016	MD	Database live and being used for capturing Medical Examiner screenings. Access to M&M Leads in progress	4
UHL Medical Examiners as Mortality Screeners (1.2)	Oct 2016 ~~Jul 2016~~	MD	Medical Examiner process up and running at the LRI and positive feedback to date. All deaths being screened including those where patients died in the Emergency Dept and also if died post discharge but not seen by their own GP. Plans to extend to LGH and Glenfield by end of October	4
Participate in National retrospective case record review (1.3)	TBA	MD	No date for completion has been set nationally yet	1
Work with Nerve Centre to implement EWS score to trigger sepsis care pathway (1.6)	Sep-16	MD	On track	4
7-Day services gap analysis (1.4)	Sep-16	MD	On track	4
Scope resources require to deliver the Strategy for Insulin Safety (1.5)	Jul-16	MD	Completed and Submitted to RIC	5

Incorporate PARR30 scores into ICE and Nerve Centre	Oct 2016	MD	Plan to incorporate PARR30 score NerveCentre as part of other integration and development works end Oct. CNIO discussing with NerveCentre team to confirm whether PARR30 is pulled through on a once daily basis or can be 'real-time'	4
Release wte discharge sister to prioritise high risk discharge planning	Aug-16	MD	Funding made available but due to competing priorities relating to the emergency flow and ED breaches, delays with releasing Discharge Sister to support PARR 30 project. Alternative interim solutions being considered, to include manual 'flagging' of readmission alert to relevant clinical team and part time input from discharge sister.	3
Develop a 6 month project plan to support the required improvements in sepsis	TBA	MD		4

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

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Preventative Control Estates management infrastructure in place Including committee structure (e.g. Fire Safety Committee, Water Management Committee, Waste Committee, IP Committee, etc) **Detective Control** IT systems to control processes and performance manage. Review of Estates and facilities related incident reports Service user feedback (Staff) **Directive Control** Outline plan in place for developing Estates and Facilities Service: 0 - 3 months - Maintain safe services 0-9 months - Ensure compliance 0-18 months - Review, develop and optimise quality of services **Corrective Control** Escalation processes for deteriorating standards/ performance	Cleanliness audits PLANET SYSTEM providing data for Estates and 'soft' services SAFFRON system providing data for Patient feeding/ catering services. Annual ERIC return to benchmark efficiency against other organisations (due July 2016) Monthly performance reporting to EQB/ QAC and TB in relation to KPIs (September 2016) Triangulation of audit data with external audits and user feedback. Internal Workforce targets.	Annual 'PLACE' review (next due March 2017). Annual peer audit/ review (next due November 2016) Compliance with all appropriate regulatory bodies requirements and audit (i.e. Environment Agency, Food Standards, HSE, etc.) CQC Inspections.	(c) Lack of detailed plans to deliver outline plan (2.1) (a) Some data not robust in relation to detailed KPIs (2.2) Quality of transition data related to staff details, work patterns, shifts, etc. (2.3) Vacancy levels, management structure. Lack of training of inherited staff. (2.4)

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
Develop detailed plans to cover 18 month review programme (2.1)	Dec-16	DEF	On-going. First draft being scoped.	4
Maintain critical patient facing services immediately post-transfer to create platform for future improvement	Aug-16	DEF	No critical system failures and delivery of patient services at	5
Clean up ELI data and evaluate shift patterns, rotas, etc. (2.3)	Sep-16	DEF	Major payroll/HR exercise undertaken. Minimal issues with pay - 3 clear months reviewed. All rotas evaluated - new proposals being prepared	4
KPI's to be developed for service delivery at 3 levels - National indicators; Trust (2.2)	Oct-16	DEF	Currently being discussed with Service Users, external partners, etc.	4
Comprehensive "on-boarding" events to be organised and training needs evaluated and planned (2.4)	On-going	DEF	Staff Road shows completed. Staff inductions c95% complete. LiA events scheduled for Sept 16. Training	4
Review compliance of service (2.2)	Dec-16	DEF	New System - CASS - introduced. DoH Premises Assurance Model completed. Desktop exercise on major hard FM services underway.	4
Recruit into vacancies, replace lost hours into cleaning/catering services, restructure management team. (2.4)	On-going	DEF	Recruitment campaign underway - dedicated events held. Staff offered hours back for cleaning/catering. Senior management team re-structure through MoC. Outline apprenticeship programme in development. Tiered management structures under development	4

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

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive / Preventative Controls NHS '111' helpline GP referrals Local/ National communication campaigns Winter surge plan Triage by Lakeside Health (from 3/11/15) for all walk-in patients to ED. (reduced resource by 50% May 2016 and ceases November 16) Urgent Care Centre (UCC) now managed by UHL from 31/10/15 Admissions avoidance directory Reworking of LLR urgent care RAP- as detailed in COO report **Detective Controls** Q&P report monitoring ED 4-hour waits, ambulance handover >30 mins and >60 mins, total attendances / admissions. UCB RAP being revised to ensure priority on decreasing attendance and admissions Comparative ED performance summaries showing total attendances and admissions.	ED 4 hour wait performance (threshold 95%) YTD 79.56% Poor performance continues to be primarily driven by record ED attendances and emergency admissions but has also been contributed to by staffing issues. (staff sickness and vacancies) Total attendances and admissions (compared to previous year) 1.6% increase in emergency admissions 5.7% increase in total A&E attendances. Ambulance handover (threshold 0 delays over 30 mins) 23.0% over 30mins 8.7% over 60mins, 1.5% over 120 mins Difficulties continue in accessing beds from ED leading to congestion in the assessment area and delayed ambulance handover. Handover delays have decreased (December 37% over 30 mins to 18% in June) however further improvements are essential especially in the long waits (over 2 hours in Dec	National benchmarking of emergency care data RAP review and progression in the new AE implementation group Start of new format SRG (AE recovery group) Chaired by J Adler in September ECIP 3 day gap analysis in July and 2 days in August to review ward processes. intensive support predicted end of Sept beginning of October (TBC)	(c) Lack of effectiveness of admissions avoidance plan (3.1) (c)Lack of effectiveness of attendance avoidance plan Lack of winter surge capacity (3.1)

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
New LLR AE recovery plan to be progressed (as per the action dates on the plan) through the new AE recovery board. (3.1)	~~Review Jun - 16~~ See plan	See plan	Plan has been produced Confirm and challenge session led by JA on 14.9.16	4
Expansion of Majors by moving minors to DVT and TIA (3.2)	Jul-16	SL	**Complete.** Updated at EQSG - on track	5
ORG action plan to decrease attendances (3.2)		ORG	**Complete.** Acton plan in place and progress against milestones managed via ORG	5
Increased medical base ward capacity (possibility of ward 7) (3.1)	~~01/09/2016~~ Oct-16	SL / COO	Ward 7 will be opened as increased bed capacity on the LRI site	4
Ensure patients are conveyed to the most appropriate to access e.g. UCC, Assessment bay, AAU (amb and non amb) (3.2)		SL	**Complete.** SOP developed and audited on a regular basis	5
Move to new build (3.2)	Mar-17	SL / CF	Ensure pathway reconfiguration and workforce matches requirement to address this risk	4
Develop a detailed action plan demonstrating actions to impact on bed capacity and	Aug-16	SL / COO	Actions to August IFPIC on 28.8.16	4
Bed capacity demand for 16/17 and 17/18 to be updated to show the bed gap by	Jul-16	COO	**Complete**	5
Revised LLR plan being developed focusing on key actions for AE recovery	Sept 16	CCG	Workshop 24.8.16 to agree and challenge plan	4

Board Assurance Framework:	Updated version as at:	Aug-16										
Principal risk 4	Failure to deliver the national access standards impacted by operational process and an imbalance in demand and capacity.								**Risk owner:**		Will Monaghan, Director Of Performance And Information	
Strategic objective:	Services which consistently meet national access standards								**Objective owner:**		COO	
Annual Priorities	Maintain 18-week RTT and diagnostic access standard compliance Deliver all cancer access standards sustainably								**Risk Assurance Rating**		Exec Board RAG Rating = EPB 27/7/16	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16							
Target risk rating (I x L):	3 x 2 = 6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Detective Controls RTT incomplete waiting times, cancer access and diagnostic standards reported via Q&P report to TB **Corrective controls** Insourcing of external consultant staff to deliver additional sessions. Outsourcing of elective work to independent sector providers. Productivity improvements in-house. Additional premium expenditure work in house.	RTT Incomplete waiting times (threshold 92%). Currently 92.1%. Diagnostics: 0.7% (threshold 1%) Cancer Access Standards (reported quarterly). 2 ww for urgent GP referral (Threshold 93%). 94.5% 2 ww for symptomatic breast patients (threshold 93%). 96.2% 31 day wait for 1st treatment (threshold 96%). 89% 31 day wait for 2nd or subsequent treatments (Drugs - threshold 98%). 100% (Surgery - threshold 94%). 77.5% (Radiotherapy - threshold 94%). 96.4% 62 day wait for 1st treatment (threshold 85%). 83.6% 62 day wait for 1st treatment (CSS referral-	Cancer recovery action plan managed across the Trust, NHS Improvement and the CCG. Monthly performance call with NTDA. Internal audit review in relation to waiting times for elective care due in quarter 4 2015/16; initiated end January 2016. Elective IST have assured the action plans in Diagnostics and the Cancer plan.	(c) Lack of progress on 62 day backlog reduction due to ITU/HDU capacity and gaps in clinical capacity in key specialties (4.1). (c) insufficient theatre staff to undertake additional sessions required to match growth (4.3). (c) Referral growth outmatching capacity growth (4.4).

	threshold 90%). 70% Cancer wait 104 days (threshold TBC). 12		

Action tracker:	Due date	Owner	Progress update:	Status
Sustained achievement of 85% 62 day standard (4.1)	Sep-16	DPI	62 day backlog reduction currently off trajectory. Implementation of 'Next Steps' for cancer patients in key tumour sites to start end February 2016. The extension to deadline comes as part of our submission to the TDA for our sustainable transformation plans.	4
Development of ITU additional capacity plan including increased frequency of step downs. (4.1)	Sep-16	HoO ITAPS		4
Further insourcing of external ENT consultant staff to deliver additional sessions (4.2)	Jul-16	DPI	**Complete**	5
Insourcing alternative suppliers of theatre staff (4.3)	Aug-16	DPI	complete but with on going risks	5
Serving Activity query Notices to the commissioners (4.4)	Oct-16	DPI		4

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

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

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

Action tracker:	Due date	Owner	Progress update:	Status
(5.1) Apply criteria in Tertiary Partnership Strategy to prioritise service lines.	~~01/06/2016~~ ~~Jul-16~~ ~~Aug-16~~ Sep-16	JC	To report to the Tertiary Partnership Board in July. Deadline extended due to the already established meeting schedule. Scope of work of work has extended to include NHS England QSIS returns and consequently report to September Tertiary Board/October ESB.	3
(5.3) SPC Reporting to be developed for other priority services.	Sep-16	JC	To follow on from (5.1)	4

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

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

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

Action tracker:	Due date	Owner	Progress update:	Status
(6.1) A BCT Programme Dashboard to be established and agreed with the BCT PMO. BCT Delivery Board to review work stream plans to ensure there is sufficient stretch.	~~01/09/2016~~ Oct-16	MW	Broader arrangements for Assurance (like this) will form part of the new governance arrangements put in place for STP Implementation.	3

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

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

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

Develop new 4-way strategy meeting with UHL, UoL, LU and DMU (7.1)	Sep-16	MD	On-going until we know the outcome of the application	4

Board Assurance Framework:	Updated version as at:	Aug-16										
Principal risk 8:	Failure to deliver an effective learning culture and to provide consistently high standards of medical education								**Risk owner:**		Sue Carr, Clinical Education /Louise Tibbert, Director of Workforce & OD	
Strategic objective:	Enhanced delivery in research, innovation and clinical education. A caring, professional and engaged workforce								**Objective owner:**		MD/DWOD	
Annual priorities	Improve the experience of our medical students to enhance their training and improve retention, and help to introduce the new University of Leicester Medical Curriculum. Develop and implement our Commercial Strategy to deliver innovation and growth across both clinical and non-clinical opportunities. Launch the Leicester Academy for the Study of Ageing (LASA). Develop training for New and Enhanced Roles i.e. Physician's Associates, Advanced Nurse Practitioners, Clinical Coders								**Risk Assurance Rating**		Exec Board RAG Rating = EQB 07/06/16 EWB 20/9/16	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3x4=12	3x4=12	3x4=12	3x4=12	3x4=12							
Target risk rating (I x L):	3x2=6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Delivery of Clinical, Non-Clinical and Medical Education **Directive Controls** Non-Medical Education Strategy Apprenticeship Attraction Strategy Medical Education Strategy Operational guidance EWB and CMG scrutiny / challenge of Medical Education issues **Detective Controls** Non-Medical Education Update Report Organisational Health Dashboard Medical education database to show number of accredited trainers which feeds into Medical Education Quality dashboard	Non-Medical Education Update Report update on New roles and funding Organisational Health Dashboard shows number of apprentices and assistant practitioners Medical Education Quality Dashboard shows the percentage of medical staff complying with GMC requirements (per CMG). Target 100%. Current position (per CMG) = • CHUGGS 76% • CSI: o Imaging 89% o Pathology 67% • ESM 68% • ITAPS 79% • MSS 88%	South Leicester College Quality Assurance Visits HEEM accreditation visits. GMC trainee survey results.	(c) Poor engagement with Medical Students and Junior Doctors impacting on reputation and recruitment and retention (8.1) (c & a) (a) Accuracy of GMC Trainer database uncertain (8.2), UHL appraisal of GMC recognised trainer roles (c) Poor quality training delivery (8.3) (feedback) (c) Lack of availability of Education/ training facilities (8.4)(c & a)

Education Quality dashboard: Reported to EWB via Medical Education Committee minutes. University Dean's report.	• MSS 88% • RRCV 73% • W&C: o Women's 96.5% o Children's 80% University Deans report to show % of fully recognised medical trainers in UHL (threshold 100%) by July 2016. Current position - WHAT PERIOD? = 74% (down from 75% previous period). UHL trainee survey		training facilities (8.4)(c & a) (c) Reduction in education funding (SIFT) (8.4) (c) Regional and National initiatives relating to redistribution of medical training posts (8.6)

Action tracker:	Due date	Owner	Progress update:	Status
Better engagement with Medical Students and Junior Doctors (8.1) - Summary in the LiA Action Plan	Dec-16	DME/UoL	The Trust and Leicester University held a joint LiA event to explore the issues and an action plan to address these issues was developed	4
Ensure engagement with CMGs to embed Medical Education Dashboard to ensure more robust data (8.2)	Jun-16	MD	**Complete.** On-going engagement with CMG Med ED leads. Extra provision of online supervisor training in place to improve accreditation rates among supervisors. Triangulation of internal and external data sources to improve database accuracy.	5
UHL Appraisal of GMC recognised trainer roles (8.2)	Aug-17	DME/ Appraisal Lead	**Complete.** Working with UHL Appraisal Lead Mary Mushambi - There is already written guidance, seminar sessions planned for this.	5
Implementation of Listening into Action Quick Wins and Longer Term Actions across Education Specific LiA Pioneering Programmes (8.3)	Mar-17	MD/ DWOD/ CN	Implementation monitored by Associated Sponsor Groups (including external partners such as the University of Leicester as appropriate) and progress reported to UHL LiA	4
Develop & Implement Education Facilities Business Case (8.4)	Mar-17	MD/ DWOD/ CN	Group established and work commenced on developing Business Case	4
Implementation of Enabling Work Programme for Future Education of Health and Social Care Provision / Workforce Attraction and Recruitment (8.4)	Mar-17	DWOD	Implementation monitored by newly established LWAB and LWAG at monthly intervals	4
Finance and CMG have identified SIFT funding and are aware of the reduction in the allocation (8.5)	Apr-16	MD	On-going engagement with the CMG Education Leads and Finance	5
New Medical Workforce Policy to be developed (8.6)	Mar-17	CF	Dr Catherine Free is responsible for working on the new Medical Workforce and reports to the Trust Board.	4

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

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

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

(9.1) Engagement of CMGs with process	~~01/06/2016~~ Sep - 16	MD DRI	DRI and MD leading on engagement programme. Meeting with Clinical Genetics and W&C CMG Management to discuss Clinical Genetics workforce plan.	3
(9.1) Recruitment against trajectories	~~01/06/2016~~ Sep - 16	DRI	Recruitment for rare diseases above trajectory for June. Focus on individual specialties to identify further potential legacy samples. Dry and wet sample runs completed and 2 patients recruited for the cancer arm.	3

Board Assurance Framework:	Updated version as at:		Aug-16									
Principal risk 10a:	Lack of supply and retention of the right staff, at the right time, in the right place and with the right skills that operates across traditional organisational boundaries								**Risk owner:**		DoWD	
Strategic objective:	A caring, professional and engaged workforce								**Objective owner:**		DoWD	
Annual Priorities	Develop an integrated workforce strategy to deliver a diverse and flexible multi-skilled workforce that operates across traditional organisational boundaries and enhances internal sustainability. Develop a more inclusive and diverse workforce to better represent the community we serve and to provide services that meet the needs of all patients								**Risk Assurance Rating**		Exec Board RAG Rating = EWB 20/9/16	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	New risk opened in July			4x4=16	4X4=16							
Target risk rating (I x L):	4x2=8											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Workforce planning including recruitment & retention			
Directive Controls	Review of monthly data sets	NHS I weekly reporting - Off trajectory	Lack of Resourcing strategy - (10a.1)
Executive Workforce Board	4 work streams (Medical, Nursing, AHP, other - WF bridges) - currently on track	Deanery & HEEM - National tariffs linked to funding	
New Roles Group	Workforce tool for forecast - currently on track	Local workforce Advisory Group	Lack of LLR Workforce plan (10a.2)
UHL Workforce Plan	6 pillars in place - monitoring against these.		
Nursing Task and Finish group	Work streams in place - currently on track		
Medical Workforce Strategy			
Resourcing Steering Board	Staff sickness, appraisal, mandatory training.		
	Monitoring vacancy position and recruitment activity		
Detective Controls			
Premium Pay Dashboard			
Organisational Health Dashboard			
Recruitment action plans	Annual workforce report on quality and diversity reported to TB and published on UHL public website		
Develop a more inclusive and diverse workforce			

Directive controls Quality and Diversity action Plan Monthly Diversity working group **Preventative controls** Working with external training providers (e.g. colleges of FE and private providers) Bi-monthly contract performance meetings with extreme providers **Detective controls** KPIs monitored via training providers **Address BREXIT workforce implications** **Directive controls** BREXIT Communication Plan **Detective controls** Exit Interviews Process	Achievement of milestones within Quality and diversity action plan - currently on track Currently on track with all KPIs Local staff support sessions in place Measuring no. of EU Nationals working / leaving UHL	Workforce, Race and Equality Statement (WRES) report to NHS England	Lack of National Guidance (10a.3) Take-up and response rate to exit interviews requires improvement (10a.4)

Action tracker:	Due date	Owner	Progress update:	Status
10a.1 - Resourcing strategy to be developed	Dec-16	DWOD	Being developed through the Resourcing Board. LLR Recruitment and Attraction group established - initial meeting took place in Sept 16 and actions agreed.	4
10a.2 - LLR workforce plan to be developed	Sep-16	DWOD	LLR workforce plan (high level) to be submitted. Work underway aligning to financial and activity planning.	4
10a.3 - Action unclear until informal negotiations have taken place once article 51 has been invoked.	TBC	DWOD	Awaiting national guidance - invoking of article 51 still to be invoked- FAQ's developed and shared to be clear on current status and position for individuals.	3
10a.4 Improve take up and response rate to exit interviews	Mar-17	DWOD	Promotion of take up being developed through CMG's.	4

Board Assurance Framework:	Updated version as at:	Aug-16										
Principal risk 10b:	Lack of system wide consistency and sustainability in the way we manage change and improvement impacting on the way we deliver the capacity and capability shifts required for new models of care								**Risk owner:**		DoWD	
Strategic objective:	A caring, professional and engaged workforce								**Objective owner:**		DoWD	
Annual priorities	Deliver the Year 1 Implementation Plan for the UHL Way, ensuring an improved level of staff engagement and a consistent approach to change and development. Develop training for new and enhanced roles, i.e. Physician's Associates, Advanced Nurse Practitioners, Clinical Coders								**Risk Assurance Rating**		Exec Board RAG Rating: EWB 20/9/16	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**		**March**
	4x4=16	4x4=16	4x4=16	4x4=16	4X4=16							
Target risk rating (I x L):	4x2=8											

Principal risk 10:	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Develop Integrated Workforce Strategy **Directive Controls** LWAB - Local Workforce Advisory Board LWAG - Local Workforce Advisory Group Workforce enabling group (strategic) Executive Workforce Board Local Education and Training Group New roles group **Detective Controls** Workforce Enabling Plan	5 work streams to measure workforce strategy. 1.Strategic Workforce Planning - Develop a view of capacity and capability changes; 2.Workforce Attraction and Recruitment; 3. Staff Mobility – Developing the ability to move people around the system; 4.Future Education of Health & Social Care Provision; and 5.Organisational Development and Change.		(c) Ineffective training for new and enhanced roles (10b.1) (c) Apprenticeship attraction strategy to be developed (10b.3)
Deliver year 1 implementation of 'The UHL Way' **Directive controls** Executive Workforce Board Internal Governance Structure established UHL Way Steering Group	Measures against schedule of activities for the 4 components: 1. Better engagement 2. Better teams 3. Better change 4. Academy	East Midlands Leadership Academy Leicestershire Improvement Innovation Patient Safety Forum	

UHL 'LiA' Sponsor group **Detective Controls** Schedule of activities for each component of 'The UHL Way'	UHL Pulse Check National Staff Survey data		

Action tracker:	Due date	Owner	Progress update:	Status
Implementation of Enabling Works Programmes (across the system):- Strategic Workforce Planning - Develop a view of capacity and capability changes; Workforce Attraction and Recruitment; Staff Mobility – Developing the ability to move people around the system; Future Education of Health & Social Care Provision; and Organisational Development and Change. (10b.1)	Mar-17	DoWD	Progress monitored by LLR Local Workforce Advisory Board and Local Workforce Advisory Group	4
LLR Apprenticeship Attraction Strategy to be developed (10b.3)	Sep-16	DoWD	Draft Strategy presented to Executive Workforce Board in July and scheduled to be presented to LLR Workforce Attraction and Recruitment Work stream in September 2016	4

Board Assurance Framework:	Updated version as at:	Aug-16										
Principal risk 11:	Ineffective structure to deliver the recommendations of the national 'freedom to speak up review'								**Risk owner:**	DoWD		
Strategic objective:	A caring, professional and engaged workforce								**Objective owner:**	DoWD		
Annual priorities	Deliver the recommendations of "Freedom to Speak Up" Review to further promote a more open and honest reporting culture								**Risk Assurance Rating**	Exec Board RAG Rating: EWB 20/9/16		
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x4=16	4x4=16	4x4=16	4x3=12	4X3=12							
Target risk rating (I x L):	4x2=8											

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

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
Governance structure to be developed for Freedom to speak up. 11.1	~~01/09/2016~~ Oct 16	DoWD	Action plan completed and in place identifying key actions with timescales - To QAC 25th August 2016	4
Local Guardian to be appointed (Freedom to speak up). 11.2	~~01/03/2017~~ Oct-16	DoWD	In progress being defined from engagement events running during Sept across all 3 sites - Advertisement by end of Sept /early October 16.	4

Consideration of resources and potential business case to deliver the plan. 11.3	Sep-16	DoWD	In progress - Task and finish group already established to meet to discuss feedback ad confirm decision making in Sept.	4

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

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls UHL reconfiguration programme governance structure aligned to BCT Reconfiguration investment programme demands linked to current infrastructure. Estates work stream to support reconfiguration established Five year capital plan and individual capital business cases identified to support reconfiguration Property / Space Management - clinical and non clinical schedules in place **Detective Controls** Survey to identify high risk elements of engineering and building infrastructure. Monthly report to Capital Investment	Major Capital - On track against revised schedule Annual programme - On track against revised schedule Corporate knowledge on infrastructure and risks now part of UHL E&F team. Various projects to establish revised capital delivery programme aligned to reconfiguration and demand and capacity.	Eric data Lord Carter review and recommendations Capita report Premises Assurance Model Capita Engineering Report in two phases - Phase 1: where are we now Phase 2 - where do we want to be and plan	Lack of data on critical infrastructure distribution loads, consumptions, plant redundancy, energy consumption, conditions, compliance and resilience. (12.1) Overall programme not yet identified to show options, costs and timescales in relation to risks. (12.2) Lack of clear agreed position on demand and capacity modelling which impacts upon infrastructure requirements. (12.3)

~~Monthly report to Capital Investment~~ Monitoring committee to track progress against capital backlog and capital projects Regular reports to Executive Performance Board (EPB). Highlight reports developed monthly and reported to the UHL Reconfiguration Programme Board.			Dedicated Infrastructure Project yet to be developed to sit alongside major reconfiguration business cases. (12.4, 12.5)

Action tracker:	Due date	Owner	Progress update:	Status
Assessment of current infrastructure capacity compliance and condition being established through a set of comprehensive technical/engineering site surveys for GGH and LRI Initial scope to be increased to include LGH. (12.1)	~~01/06/2016~~ ~~Jul-16~~ Oct-16	DEF	Surveys are on-going with report due by end of September 2016; ESB update Oct/Nov 2016. The draft report for GH has been received and is being reviewed by the estates capital team.	3
Identification of investment required and allocation of capital funding to develop a programme of works (12.2)	Oct/ Nov 2016	DEF	Prioritisation of backlog capital once 2016/17 annual capital resources confirmed by IFPIC. Phasing options to be included with further programme to be developed once capital availability is confirmed. This date is now at risk. A revised timeline will be presented after the gap analysis	3
Capital plan C /Includes an allocation of £1.5m which will support the reconfiguration infrastructure. (12.5)	TBA	DEF	Confirmation of programme Q2 expected. Work being scoped	3
Weekly Capital (Strategic and Operational) meeting to be arranged to align reconfiguration with infrastructure (12.4)	Aug-16	DEF	**Complete** - commenced July 2016	5
Rectification of any major non-compliance issues	on-going	DEF	Substitution as part of 2016/17 Capital Plan in place if required or covered by existing backlog allocation. Revenue rectifications undertaken by E&F Team	4

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

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

Monthly reports to LSB and IFPIC on progress of reconfiguration capital programme. Highlight reports produced for each project board. **Corrective Control** Revised programme timescale approved by IFPIC	reviewed by the Major Business Case meeting and Reconfiguration Board.	for change.	OBC has commenced. Development of ICU2016/17. Development of ICU construction will depend on approval of business cases. In addition to capital there are risks to Trust capacity that may delay move further. Interim measures have been put in place to manage risks in short-term, these arrangements need to be reviewed if any further delays (13.3)

Action tracker:	Due date	Owner	Progress update:	Status
Consideration to be given to alternative sources of funding. (13.1)	~~01/06/2016~~ August 16	CFO	Exploratory discussions with expert PF2 advisors (Deloitte) regarding which capital schemes could potentially be suitable. Meeting with PFU in May 2016, options still being	3
Maintain dialogue with NHSI and NHSE regarding the pressing need for external capital to facilitate strategic change (13.2)	~~01/06/2016~~ August 16	CEO/CFO	Alongside recent correspondence and discussion regarding BCT and its capital requirements, the LLR STP represents a further opportunity to formalise and emphasise the requirement.	3
Capital plan C has identified best way to prioritise / progress all reconfiguration projects within a reduced funding allocation (13.3)	~~01/07/2016~~ Aug-16	CFO	Capital availability still unknown - it is hoped that this will be clear at the beginning of Q2. Informal discussions have been positive. Programme planning assumes availability from 01 September 16.	3
~~Clinical engagement and validation sessions of estate configuration scenarios planned for 6th and 28th July. (13.4)~~	~~Aug-16~~	~~CFO~~	~~Not due yet~~	4
Estates Strategy Refresh - phase 2. The clinical design solution and capital plan for the two acute sites will be urgently reviewed in light of the approved STP bed numbers to understand impact.	Nov-16	CFO	Delayed due to STP bed numbers. Clinical checkpoints to validate phase 2 (development of the estates strategy in line with STP) set for end of September / start of October.	3

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

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

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

Action tracker:	Due date	Owner	Progress update:	Status
Demand and capacity issue being fully modelled and then considered by BCT/ STP Delivery Board to agree bed numbers in STP submission on 16th September. Conclusions need to feed into NHSE led assurance process in advance of public consultation and reconfiguration. Internal work with estates, clinical, finance and workforce teams continues to support implementation when plans are agreed. (14.1, 14.2, 14.3, 14.4)	~~01/06/2016~~ ~~July 16~~ Nov -16	COO / CFO	Draft STP showed the full reduction of beds of 400. This means that it has not addressed the initial risk and part of rationale for revisiting demand and capacity assumptions. There is now challenge on achievability of this bed reduction and work is on-going to agree appropriate bed capacity for LLR while maintaining financial balance. Phase 1 of the estates strategy update is complete showing no reduction in beds to give a possible range of scenarios, and will need updating to reflect the STP agreed bed numbers. Phase 2 of the detailed estates strategy to be undertaken showing moves by site location and programme. Estates strategy and Development Control plans to be updated thereafter	3

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

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

Action tracker:	Due date	Owner	Progress update:	Status
Revised Data Pack being scoped for discussion with BI leads. (15.1)	~~01/06/2016~~ TBC	CFO	A sample data pack was circulated to the steering group on 11.5.16. Expert members to consider data for appropriateness. Steering Group suspended following instruction from ESB	3
Assurance that resources are placed with the services who need them the most (15.4)	~~01/06/2016~~ TBC	CFO	The plan involves: Stratification of services to determine the level of input required (Intensive, Standard and Enhanced). The priority order of services to be completed are dependant on their positioning in the Stratification matrix. This information will then be developed into a programme plan. The stratification matrix has been simplified by the Steering Group. Revised measures have been agreed and the data is being collected for the next steering group 22.6.16. Roll out paused	3

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

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls Agreed Financial Plan for 2016/17 (AOP) Standing Financial Instructions UHL Service and Financial strategy as per SOC and LTFM. **Preventative Controls** Sign-off and agreement of contracts with CCGs and NHS England CIP delivery plan for 2016/17 **Detective Controls** Monthly finance reporting in relation to income and expenditure and CIP Monthly performance reporting in relation to STF performance trajectories **Corrective Controls**	Contracts signed with both main commissioners. Robust internal process to set the financial plan for 2016/17 as agreed by IFPIC and TB. Adverse variance to plan of £663k at M5 with a year end forecast in-line with the revised I&E plan of a deficit of £31.7m (excluding STF). STF Funding of £9.8m recognised at M4 in line with STF rules. CIP within the year to date position has over-	Regular review of financial plan by NHS Improvement. Quarterly submission to NHS Improvement of STF Performance.	No gaps identified

Identification and mitigation of excess cost pressures Planned reduction in agency spend The CIP gap identified at the start of the year has been closed.	delivered against the plan of £10.5m by £1.2m. The detailed position will be reviewed by the Executive Performance Board monthly Integrated Finance, Performance & Investment Committee and Trust Board monthly Run rates to achieve £31.7m in each area (pay, non-pay, CIP and income) updated for month 4 and reported to Committees/Trust Board alongside the financial and performance requirements to secure STF funding of £23.4m			

Reasonable assurance rating that risk is being managed:	Due date	Owner	Progress update:	Status
Outstanding cost pressure list (i.e. any remaining items from budget/contract setting exercise) requires final decisions to be made by CEO and Executive Team.	~~01/05/2016~~ ~~Jun-16~~ Jul -16	CFO	**Complete**	5
Financial recovery plans being developed for 4 CMGs plus Estates and Facilities	Sep-16	CFO	In progress	4

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

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls Overall strategic direction of travel defined through Better Care Together. Financial Strategy fully modelled and understood by all parties locally and nationally. UHL's working capital strategy in place. 2016/17 financial plan in place and monitored appropriately Sustainability and transformation plan (STP) **Detective Controls** Monthly monitoring of performance against financial plan. IFPIC and TB receive half yearly updates in relation to financial strategy and LTFM **Corrective controls** Explore options for other (non-NHS) sources of capital funding	Monthly reporting against 2016/17 plan - As at M5 the Trust is £663k adverse to plan. Half yearly review of LTFM to ensure fitness for purpose i.e. checking consistency with UHL's strategy and ensuring we have a deliverable recovery plan over the medium term. Strong links to overall BCT 5 year strategy and the financial consequences (revenue and capital) of the transformational business cases	NHS England and NTDA review of: BCT SOC BCT PCBC Financial strategy LTFM System-wide five-year 'place-based' sustainability and transformation plan (STP) Individual business cases above a certain level	(c)LTFM not yet formally approved (17.1) (c)SOC not yet formally approved (17.2) (c) STP not yet formally approved (c) Currently seeking authority to proceed with public consultation

Action tracker:	**Due date**	**Owner**	**(**	**Status**

As per the annual work plan for IFPIC, UHL's LTFM and therefore its financial strategy is being refreshed. (17.1, 17.2)	~~01/06/2016~~ Aug-16	CFO	**Complete.**	5
In accordance with the national deadline, complete LLR's STP by mid October 2016	Oct-16	CE/CFO	Draft submission made mid September 2016 with the final (full) document to be completed and signed off by 21st October 2016	4

Board Assurance Framework:	Updated version as at:	Aug-16										
Principal risk 18:	Delay to the approvals for the EPR programme								**Risk owner:**		CIO	
Strategic objective:	Enabled by excellent IM&T								**Objective owner:**		CIO	
Annual priorities	Conclude the EPR business case and start implementation								**Risk Assurance Rating**		Exec Board: EPB 27/09/16	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4 x 4 = 16	4x4=16	4x4=16	4x4=16	4x4=16							
Target risk rating (I x L):	3 x 2 = 6											

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

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

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

Board Assurance Framework:	Updated version as at:	Aug-16										
Principal risk 19:	Lack of alignment of IM&T priorities to UHL priorities								**Risk owner:**	CIO		
Strategic objective:	Enabled by excellent IM&T								**Objective owner:**	CIO		
Annual priorities	Improve access to and integration of our IT systems								**Risk Assurance Rating**	Exec Board: EPB 27/09/16		
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3 x 4 = 12	3x4=12	3x4=12	3x4=12	3x3=9							
Target risk rating (I x L):	3 x 2 = 6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls Prioritisation Group meets monthly. Standard operating procedure for bringing and authorising new work tasks. Progress updates reported to Executive IM&T board quarterly. UHL IM&T Governance Structure. **Detective Controls** Prioritisation matrix to define projects. Service Level Agreements. Weekly and monthly meetings to discuss issues and monitor progress	Weekly reporting within IM&T Monthly Prioritisation meetings Reports to Executive IM&T board	Internal audit review (15/16) of UHL IM&T service delivery reporting methods and quality	(c) No link to CMGs within the prioritisation process. (19.1) (c) Capital prioritisation plan to be developed (19.2)

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
To look at re-introduction of the CMG account management role within a restructure of IM&T resources (19.1)	Mar-17	CIO	The development of a costed plan to re-introduce this role to IM&T	4
Further work required with the Capital investment Board to define the priority areas for IM&T spend (19.2)	Oct-17	CIO	Production of a forward view of capital spend and the priority areas it addresses IT Strategy meeting, to look at prioritisation of resources, took place in September to refine the investment plan going forward	4

Reasonable assurance rating:

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

Risk rating criteria:

Current Risk Rating: A reasonable estimate of the likely occurrence and likely consequence with the current control measures in place

Target Risk Rating: A reasonable estimate of the likely occurrence and likely consequence with the current control measures and future actions applied
Risk target (also referred to as residual risk) is the amount of risk that is accepted or tolerated, or the level that has been decided to manage a risk dowr to in an ideal world.
As the BAF is focussed on the risks to achieving its most important annual objectives the risk target score should be achieved when all actions are applied or by year end (31st March).

Impact / Consequence			Likelihood of occurrence	
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.

Appendix 2 Risk Register Dashboard for period ending 31/08/16

Risk ID	CMG	HIGH & EXTREME RISKS: Risk Title - As at 31st Aug 2016	Current Risk Score	Target Risk Score	Risk Owner	Risk Movement	Elapsed risk deadline	Themes aligned with BAF
2236	ESM	There is a risk of overcrowding due to the design and size of the ED footprint & increased attendance to ED	25	16	Ian Lawrence	↔		Effective emergency care
2762	Corporate Nursing	Ability to provide safe, appropriate and timely care to all patients attending the Emergency Department at all times.	25	15	Julie Smith	↔		Effective emergency care
2670	RRCV	There is a risk to the Immunology & Allergy Services due to a Consultant Vacancy	20	6	Sue Mason	↔		Workforce capacity and capability
2354	RRCV	There is a risk of overcrowding in the Clinical Decisions Unit	20	9	Sue Mason	↔		Effective emergency care
2149	ESM	High nursing vacancies across the ESM CMG impacting on patient safety, quality of care and financial performance	20	6	Gill Staton	↔	X	Workforce capacity and capability
2804	ESM	Outlying Medical Patients into other CMG beds due to insuffient ESM inpatient bed capacity	20	12	Gill Staton	↔	X	Effective emergency care
2333	ITAPS	Lack of Paediatric cardiac anesthetists to maintain a WTD compliant rota leading to interruptions in service provision	20	8	Rachel Patel	↔		Workforce capacity and capability
2763	ITAPS	Risk of patient deterioration due to the cancellation of elective surgery as a result of lack of ICU capacity	20	10	Aimee Geary	↔		Workforce capacity and capability
182	CSI	POCT- Inappropriate patient Management due to inaccurate diagnostic results from Point Of Care Testing (POCT) equipment	20	2	Lianne Finnerty	↔		Workforce capacity and capability
2787	CSI	Failure of medical records service delivery due to delay in electronic document and records management (EDRM) implementation	20	4	Debbie Waters	↔		Workforce capacity and capability
2562	W&C	There is a risk that 2 vacant consultant paediatric neurology vacancies could impact sustainability of the service	20	4	J Visser	↔		Workforce capacity and capability
2403	Corporate Nursing	There is a risk changes in the organisational structure will adversely affect water management arrangements in UHL	20	4	Elizabeth Collins	↔		Estates and Facilities services
2404	Corporate Nursing	There is a risk that inadequate management of Vascular Access Devices could result in increased morbidity and mortality	20	16	Elizabeth Collins	↔		Safe, high quality, patient centred healthcare
2471	CHUGGS	There is a risk of poor quality imaging due to age of equipment resulting in suboptimal radiotherapy treatment.	16	4	Lorraine Williams	↔		Safe, high quality, patient centred healthcare
2823	CHUGGS	There is a risk of errors with patient medical review appointment and chemotherapy appointments due to gaps in admin workforce.	16	6	Kerry Johnston	↔		Safe, high quality, patient centred healthcare
2819	RRCV	Risk of lack of ITU and HDU capacity will have a detrimental effect on Vascular surgery at LRI	16	12	Paul Saunders	↔	X	Workforce capacity and capability
2791	RRCV	Broadening Foundation - Loss of F1 doctors	16	2	Sue Mason	↔	X	Workforce capacity and capability
2870	RRCV	Audit of DNACPR form have shown that the discussion with the patient or family is not consistently recorded	16	2	Elved Roberts	↔	X	Safe, high quality, patient centred healthcare
2905	RRCV	There is a risk of delays to patient diagnosis and treatment which will affect the delivery of the national 62 day cancer target	16	6	Karen Jones	NEW		Workforce capacity and capability
2820	RRCV	Risk that a timely VTE risk assessment is not performed on admission to CDU meaning that subsequent actions are not undertaken	16	3	Sue Mason	↔		Safe, high quality, patient centred healthcare
2193	ITAPS	There is a risk that the ageing theatre estate and ventilation systems coud result in an unplanned loss of capacity at the LRI	16	4	Gabby Harris	↔		Workforce capacity and capability
2759	MSK & SS	There is a risk that performance targets are not met due to a capacity gap within the ENT department	12	2	Patricia Bingley	↓ (16 to 12)		Workforce capacity and capability
2541	MSK & SS	There is a risk of reduced theatre & bed capacity at LRI due to increased spinal activity	16	8	Carolyn Stokes	↔		Workforce capacity and capability
2191	MSK & SS	There is a risk of lack of capacity within the service causing follow up backlogs and capacity issues in Ophthalmology	16	8	Clare Rose	↔		Workforce capacity and capability
2504	MSK & SS	There is a risk that patients will wait for an unacceptable length of time for trauma surgery resulting in poor patient outcomes	12	8	Carolyn Stokes	↓ (16 to 12)		Workforce capacity and capability
2687	MSK & SS	Lack of appropriate medical cover will clinically compromise care or ability to respond in Trauma Orthopaedics	16	9	Carolyn Stokes	↔		Workforce capacity and capability
1206	CSI	There is a risk that a backlog of unreported images in plain film chest and abdomen could result in a clinical incident	16	6	ARI	↔		Workforce capacity and capability
2378	CSI	There is a risk that Pharmacy workforce capacity could result in reduced staff presence on wards or clinics	16	8	Claire Ellwood	↔		Workforce capacity and capability
1926	CSI	There is a risk that insufficient staffing to manage ultrasound referrals could impact Trust operations and patient safety	16	6	Cathy Lea	↔		Workforce capacity and capability
2391	W&C	There is a risk of inadequate numbers of Junior Doctors to support the clinical services within Gynaecology & Obstetrics	16	8	Cornelia Wiesender	↔		Workforce capacity and capability
2153	W&C	Shortfall in the number of all qualified nurses working in the Children's Hospital.	16	8	HKI	↔		Workforce capacity and capability
2394	Comms	No IT support for the clinical photography database (IMAN)	16	1	Simon Andrews	↔		IM&T services
2338	Corporate Medical	There is a risk of patients not receiving medication and patients receiving the incorrect medication due to an unstable homecare	16	9	Claire Ellwood	↔		Workforce capacity and capability
2237	Corporate Medical	There is a risk of results of outpatient diagnostic tests not being reviewed or acted upon resulting in patient harm	16	8	Angie Doshani	↔	X	Workforce capacity and capability
2325	Corporate Medical	There is a risk that security staff not assisting with restraint could impact on patient/staff safety	16	6	Neil Smith	↔		Estates and Facilities services
2247	Corporate Nursing	There is a risk that a significant number of RN vacancies in UHL could affect patient safety	16	12	Maria McAuley	↔		Workforce capacity and capability
1693	Operations	There is a risk of inaccuracies in clinical coding resulting in loss of income	16	8	John Roberts	↔		Workforce capacity and capability
2878	Operations	There is a risk of cancer patients not being discussed at MDTs due to inadequate video conferencing facilities	16	4	Charlie Carr	↔		IM&T services
2872	RRCV	There is a risk of bedded bariatric patients being trapped compromising fire evacuation on ward 15 at GGH	15	6	Sue Mason	↔	X	Safe, high quality, patient centred healthcare
2836	ESM	There is a risk of single sex breaches on the Brain Injury Unit due to environmental design and inflow of patients.	15	2	Holly Bertalan	↔	X	Safe, high quality, patient centred healthcare
2837	ESM	There is a risk of delay in acting upon monitoring investigation results in patients with multiple sclerosis.	15	2	Ian Lawrence	↔		Safe, high quality, patient centred healthcare
2549	MSK & SS	There is a known risk of excessive waiting times in the departments of Orthodontics and Restorative Dentistry	9	3	Gaynor Webb	↓ (15 to 9)		Safe, high quality, patient centred healthcare
2769	MSK & SS	There is a risk of cross infection of MRSA as a result of unscreened emergency patients being cared for in the same ward bays	15	5	Kate Ward	↔		Workforce capacity and capability
1157	CSI	Lack of planned maintenance for medical equipment maintained by Medical Physics	9	6	Mark Norton	↓ (15 to 9)		Workforce capacity and capability
510	CSI	There is a risk of staff shortages impacting on the Blood Transfusion Service at UHL	15	15	AFE	↔		Workforce capacity and capability
2601	W&C	There is a risk of delay in gynaecology patient correspondence due to a backlog in typing	15	6	DMAR	↔		Workforce capacity and capability
2330	Corporate Medical	Risk of increased mortality due to ineffective implementation of best practice for identification and treatment of sepsis	15	6	JPARK	↔		Safe, high quality, patient centred healthcare
2925	Estates & Facilities	Reduction in capital funding may lead to a failure to deliver the 2016/17 medical equipment capital replacement programme	15	10	Darryn Kerr	NEW		Safe, high quality, patient centred healthcare
2402	Corporate Nursing	There is a risk that inappropriate decontamination practice may result in harm to patients and staff	15	3	Elizabeth Collins	↔		Safe, high quality, patient centred healthcare
2774	Operations	Delay in sending outpatient letters following consultations is resulting in a significant risk to patient safety & experience .	15	6	William Monaghan	↔		Workforce capacity and capability
1551	Corporate Nursing	Failure to manage Category C documents on UHL Document Management system (Insite)	CLOSED					IM&T services