INTEGRATED RISK REPORT AS AT 28TH FEBRUARY 2017

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

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) use in seeking assurance that those internal control mechanisms are effective. The 2016/17 BAF has been developed with reference to the revised annual priorities and this report provides the TB with the position to 28th February 2017. The report also provides a summary of the organisational risk register for items scoring 15 or above (i.e. current risk ratings of high and extreme).

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 on the BAF are being effectively controlled?
3. Have all agreed actions been completed within the specified target dates on the BAF?
4. Does the TB have knowledge of new significant organisational risks opened within the reporting period?

Conclusion

1. Executive leads have identified principal risks affecting the achievement of our objectives. All risks have been reviewed and endorsed at the relevant Exec Board during the reporting period.
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. Many of the risks are flagged with amber assurance ratings which suggest effective controls are believed to be in place but outcomes of assurances are uncertain / insufficient.
3. There are a 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. There have been no new organisational risks entered on the risk register, however one risk has increased from moderate to high (in relation to a Lack of capacity within the ophthalmology service) and four risks have reduced from high to moderate during the reporting period.

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 and assurances (or both).

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
All BAF risks	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: [04/05/17]

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 APRIL 2017**

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

SUBJECT: **INTEGRATED RISK REPORT (INCORPORATING UHL BOARD ASSURANCE FRAMEWORK & RISK REGISTER AS OF 28TH FEBRUARY 2017)**

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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 SUMMARY

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

2.2 The Board remains exposed to extreme risk in the following areas:

I. **Timely Access to emergency care services (principal risk 3: current rating 25)**; The new Emergency Floor has now been handed over to UHL and operational commissioning of the building is underway. Standard Operating Procedures are being developed to support new ways of working in the new Department, including escalation processes.

II. **Delivery of the national access standards (principal risk 4: current rating 25)**; Referral growth is outmatching capacity growth with a 7.4% YTD referral increase versus 2015/16. A number of standards were failed during February, including RTT Incomplete waiting times, Cancer Access: 31 day wait for 1st treatment; 62 day wait for 1st treatment.

III. **Achievement of the UHL deficit control total in 2016/17 (principal risk 16: current rating 25)**; Adverse variance to plan of £9.3m at M11 with a year-end forecast being adverse to Income & Expenditure plan by £6.9m of a deficit of £38.6m (excluding STF). During the reporting period, a deep dive exercise by NHSI into our financial planning process has been undertaken and we await the findings from the review.

IV. **Delivery of the EPR programme (principal risk 18: current rating 25)**; Further discussions are taking place with NUH NHS around sharing some of the development work to further mitigate risks/costs for the Nerve Centre model.

3. UHL RISK REGISTER SUMMARY

3.1 At the end of the reporting period, there are 37 organisational risks open on the risk register scoring 15 and above. A dashboard of these risks is attached in appendix two with full details included in appendix three.

3.2 There have not been any new risks scoring 15 and above entered on the risk register during February 2017.

3.3 Significant changes on the risk register during the reporting period include:

3.3.1 Current risk rating increased from moderate to high:

Datix ID	Risk Title	Risk Rating	CMG
2191	Lack of capacity within the ophthalmology service is causing delays that could result in serious patient harm.	20	MSS

3.3.2 Current risk ratings reduced from high to moderate:

Datix ID	Risk Title	Risk Rating	CMG
2870	Audit of DNACPR form have shown that the discussion with the patient or family is not consistently recorded	12	RRCV
2905	There is a risk of delays to patient diagnosis and treatment which will affect the delivery of the national 62 day cancer target	12	RRCV
2774	Delay in sending outpatient letters following consultations resulting in risk to patient safety & experience.	12	OPS
2541	There is a risk of reduced theatre & bed capacity at LRI due to increased spinal activity	9	MSK&SS

3.4 Thematic analysis of risks scoring 15 and above on the risk register continues to show the majority of risks relate to workforce capacity and capability with the potential to have an impact on harm and performance. A column to describe the thematic risk analysis, aligned to the BAF, is included in the risk register 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).

Report prepared by UHL Risk & Assurance Manager
30th March 2017

UHL Board Assurance Dashboard: 2016/17		FEBRUARY 2017						
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 centered 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	16	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	25	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. Status awarded on 13th September 2016 - RISK CLOSED SEPT 2016.	MD	6	6	CLOSED SEPT 2016		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	20	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	↔	Under review	ESB
	16	The Demand/Capacity gap if unresolved may cause a failure to achieve UHL deficit control total in 2016/17	CFO	25	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	25	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:	Feb-17										
Principal risk 1:	Lack of progress in implementing 2016/17 UHL Quality Commitment								**Risk owner:**	CN / MD		
Strategic objective:	Safe, high quality, patient centered 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 07/03/17		
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	4x3=12	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**	
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	**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 UHL SHMI Jun 15 - Jul 16: 101 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%	Internal Audit mortality and morbidity review completed. Internal audit review in relation to outpatient patient experience due completed.	Currently not all deaths are screened. (1.1, 1.2 and 1.3) Data quality and volume due to manual data audit collection (1.6) Many avoidable readmissions caused due to factors in the community beyond influence of UHL. The current blood glucose monitoring is not networked or linked to e - obs (1.8) Face to face training on the safe

Patient Safety **Directive controls** 7 Day service standards (including implementation of 14 hour consultant review, diagnostics, professional standards and daily consultant review) Tool for UHL EWS and e-obs Tool for 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	**Sepsis and deteriorating patient Audit** % 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.		use of insulin (1.9)	

Action tracker:	Due date	Owner	Progress update:	Status
Mortality database to be developed (1.1)	~~Nov 16~~ March 17	MD	Networked database proving slow and difficult to use. Plan is therefore for Medical Examiner module to be incorporated into the Bereavement Services Office database. UHL signed up to being an early implemented of the new National Mortality Review process, which will include submission of data to the National mortality database via Datix. In the meantime, outcomes from ME and Specialty mortality screenings/reviews are being collated and inputted into corporate Mortality database.	3

UHL Medical Examiners as Mortality Screeners (1.2)	~~July 16~~ ~~Nov 16~~ ~~March 17~~ May 17	MD	Medical Examiners screening all adult deaths at LRI. Additional cohort of Medical Examiners trained Dec 16 and 2 have now commenced in the role and are prinipally stabilising rota at LRI. Roll-out to LGH & GGH to follow subject to funding being agreed as per discusiions at Feb EQB.	3
Participate in National standardised mortality review process (1.3)	Apr-17	MD	UHL has registered as an early adopter and it is anticipated that this will start by April 2017. 6 clinicians have undergone training to be cascade trainers. Further national guidance meeting March 21st 2017	4
Implement EWS score to trigger sepsis care pathway and automate audit data collection for deteriorating patient (1.6)	~~Dec 16~~ ~~March 17~~ Aug 17	MD	E-Obs now on all in-patient wards. Plan to introduce into ED in March 2017 and to launch sepsis track & trigger tool at end of April 2017. Pilot to commence in RRCV of Nerve Centre automated data collection and reporting of EWS/sepsis performance with a plan for full roll out by end of August.	3
Incorporate PARR30 scores into ICE and Nerve Centre (1.6)	~~Dec 16~~ March 17	MD	PARR30 score where >45% being manually inputted into Nervecentre. Guideline out for consultantion with view to launch in April. Automation of the process in Nervecentre due end of March.	3
Release wte discharge sister to prioritise high risk discharge planning (1.6)		MD	Action now superseded by changed organisational priorities. Resource diverted to support Red 2 Green work. It was therefore agreed that whole project to be assimilated into discharge element of Red to Green	N/A
Develop a business case to support the implementation of networked blood glucose monitoring (1.8)	Mar-17	KH/JS	Case in development working with procurement and IT	4
In Q 3 commence face to face training on the safe use of insulin - targeted at areas with the highest no. of incidents (1.9)	Mar-17	KH	Plan to deliver to high incident areas in place	4

Board Assurance Framework:	Updated version as at:	Feb-17										
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 = EQB 07/03/17	
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	4x3=12	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	
Target risk rating (I x L):	4x2=8											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Preventative Control Estates management infrastructure in place including committee structure (e.g. Fire Safety Committee (Reviewed & Transformed), Water Management Committee (Reviewed & Consulted), Waste Committee (Reviewed & Transformed), IP Committee). Updated water policy in February 2017. **Detective Control** IT systems to control processes and performance manage. Review of Estates and facilities related incident reports. Service user feedback (Staff). Weekly audits carried out by Management. EHO inspections. Compliance KPI data monitored.	Cleanliness audits PLANET SYSTEM providing data for Estates and 'soft' services SAFFRON system providing data for Patient feeding/ catering services. Internal Statutory Compliance Audit from PWC in December 2016, report due in January 2017. 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. Refresher training for food handlers. Maintenance requests escalated.	Annual 'PLACE' review (next due March 2017). Annual peer audit/ review (next due November 2016). Compliance with all appropriate regulatory bodies statutory requirements and audit (i.e. Environment Agency, Environmental Health, Food Standards, HSE, etc.). Supporting CQC Inspection actions. Local Authority Environmental Health Officer (EHO inspections) - visit on 13th December 2016 and 5* rating achieved. Increased Trust EHO inspections.	~~(c) Lack of detailed plans to deliver outline plan (2.1)~~ ~~(a) Poor quality of transition data related to staff details, work patterns, shifts, etc. (2.3)~~ KPI's to be developed for service delivery at 3 levels - National indicators; Trust indicators; Internal Divisional targets (2.2) (c) Vacancy levels, management structure. Lack of training of inherited staff. (2.4) (c) Underfunding of the estates

Directive Control Outline plan in place for developing Estates and Facilities Service: 0 - 3 months - Maintain safe services 0-9 months - enhanced compliance and assurance systems and new structures developed and ready for implementation. 0-18 months - Review, develop and optimise quality of services. Refresher training for food handlers Maintenance requests escalated. **Corrective Control** Escalation processes for deteriorating standards/ performance	Weekly audits carried out by Management. Increased Trust EHO inspections. Annual compliance Audit programme developed for 2017/18 running from 1/04/2017 to 31/03/2018. This will support the Premises Assurance Model (PAM) and Estates Return Information Collection (ERIC) returns to the Department of Health.	Water Management Audit carried out in December 2016 by external specialists. Final report due in February 2017. External Piped Medical Gas audit completed in January 2017 by the Trust's Independent Authorising Engineer. This will be reported through MedOC.	and facilities revenue budget (2.5). **In terms of the significance of the impact of all the 'gaps' the potential funding shortfall carries the biggest influence on the risk score in terms of likelihood. The current level of underfunding can only be marginally mitigated through efficiencies.** Inherited sub-optimal systems and inconsistent information retention records (2.6).

Action tracker:	Due date	Owner	Progress update:	Status
Develop detailed plans to cover 18 month review programme (2.1)	~~Dec 16~~ Feb 17 Complete	DEF	E&F Compliance Team remodelled to incorporate TUPE staff. Compliance work plan, JDs and processes developed to maximise compliance output and assurance. Compliance Team structure, JD and processes remodelled and agreed and completed. MOC to commence once timesclaes agreed with HR	5
Clean up ELI data and evaluate shift patterns, rotas, etc. (2.3)	~~Sep 16~~ ~~Dec 16~~ Feb 17 Complete	DEF	Major payroll/HR exercise undertaken. Minimal issues with pay - 3 clear months reviewed. All rotas evaluated - new proposals being prepared. Data evaluations complete	5
KPI's to be developed for service delivery at 3 levels - National indicators; Trust indicators; Internal Divisional targets (2.2)	~~Oct 16~~ ~~Feb 17~~ June 17	DEF	Currently being discussed with Service Users, external partners, etc. Continuing work on KPI's. National indicators in place with Carter and ERIC Returns. Local Trusts and Divisional details being progressed but slower progress due to staff vacancies, recruitment and structure implementation.	3
Recruit into vacancies, replace lost hours into cleaning/catering services, restructure management team. (2.4)	Review ~~Jan 17~~ March 17	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. Key Estates Specialist Services staff identified and training plan underway.	3

Identify investment required to address fundamental issues with layout of equipment and equipment replacement/additions (2.5)	~~Sep 16~~ ~~Dec 16~~ Feb 17	DEF	Initial condition survey completed - further in-depth survey required to review insulation within walls. All minor works identified as requiring attention completed. New equipment now in place - i.e. refrigeration/oven. Final report on in depth survey to identify cause of condensation awaited. Revisit by local authority EHO on 13th December 2016 and 5* rating achieved. All minor works completed in December resulting in 5* Rating by EHO return visit. The only remaining item relates to tyhe wall condensation. Survey results complete and capital solution required to external walls, to be prioritised in 2017/18 capital programme once capital allocations agreed.	3
Inherited sub-optimal systems and inconsistent information retention records (2.6).	Review March 17	DEF	Task and finish group set up to review record management and retention and implement new systems.	4

Board Assurance Framework:	Updated version as at:	Feb-17										
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: 28/03/17	
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	5x5=25	5x5=25	5x5=25	5x5=25	5x5=25	5x5=25	
Target risk rating (I x L):	3x2=6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**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 Bed capacity demand for 16/17 and 17/18 updated to show the bed gap by month. Red to Green (R2G) to eliminate delays in our processes.	ED 4 hour wait performance (threshold 95%) Poor performance continues to be primarily driven by increased 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.% increase in emergency admissions 7% increase in total A&E attendances. Ambulance handover (threshold 0 delays over 30 mins) 29.0% over 30mins 12% over 60mins, 2.1% over 120 mins	National benchmarking of emergency care data New AE Delivery board chaired by CEO of UHL. RAP approved by NHSE and NHSI and being progressed by the new AE implementation group. New ECIP team started in November to support delivery over the next 12 months. In-depth ECIP review 12 & 13 January, including external ED consultant System-wide ambulance handover improvement plan in place.	(c)Lack of effectiveness of attendance avoidance plan & winter surge capacity / Discharge plan (3.1) Lack of capacity to operate (3.2) Standard Operating Procedures (SOPs) to be created to support new ways of working in the new ED, including escalation processes (3.3)

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.	Difficulties continue in accessing beds from ED leading to congestion in ED and delayed ambulance handover.		

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)	See plan	See plan	Plan has been produced New AE implementation group started 12.10.16 Recovery plan updated fortnightly by SROs, and monitored via EQSG fortnightly. New high impact actions to be confirmed, focusing on 4 key areas for delivery. RAP to continue as an improvement action plan.	4
Move to new build (3.2)	~~March 17~~ 24/04/17	LG / CF	Operational plan for moving the service to new build now in place. Building now handed over to UHL; operational commissioning of the building has now begun. On-going discussions with work stream leads, including workforce and HR, to ensure pathways are updated and staff engaged in new processes prior to opening.	3
Standard Operaing Procedures (SOPs) to be created to support new ways of working in the new ED, including escalation processes (3.3)	Apr-17	LG / CF		4

Board Assurance Framework:	Updated version as at:	Feb-17										
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: 28/03/17	
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	4x5=20	4x5=20	4x5=20	4x5=20	5x5=25	5x5=25	
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%). 91.2% (Feb 17) standard failed. Diagnostics (threshold 1%): 0.86% (Feb 17) position achieved. Cancer Access Standards (reported monthly). 2WW for urgent GP referral (Threshold 93%). 94.3% Achieved. 31 day wait for 1st treatment (threshold 96%). 94.5% Failed. 31 day wait for 2nd or subsequent treatments: (Drugs - threshold 98%). 98% Achieved. (Surgery - threshold 94%). 88.5% Failed. (Radiotherapy - threshold 94%). 94% Achieved. 62 day wait for 1st treatment (threshold 85%). 80.5% Failed. Cancer wait 104 days. 3	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. Demand management plan with CCG's	(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. 7.4% YTD referral increase versus 2015/16 (4.4).

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

Sustained achievement of 85% 62 day standard (4.1)	Review ~~Nov 16 Jan 17~~ March 17	DPI	62 day backlog reduction currently off trajectory. Implementation of 'Next Steps' for cancer patients in key tumour sites to start end February 2016. Sustainable ability to meet the 62 day standard will not be achieved until the Trust has 2 consecutive months with no outliers. Actions below and mitigating steps outlined to support in achieving this. Continued medical outliers over winter in January, 62 day performance improved continue to improve in January. Adjusted backlog at 40 The trust has not yet achieved 2 consecutive months without any outliers. Cancer activity continues to be prioritised with the backlog continunig at its lowest rate.	3
Development of ITU additional capacity plan including increased frequency of step downs. (4.1)	Review ~~Sept 16 Jan 17~~ March 17	HofOps ITAPS	Daily escalation of predicted surgical and medical step down at Gold Command to aid discharges. Plan to open additional physical beds pending nurse staffing recruitment. Continuing to actively pursue recruitment opportunities for both medical and nursing to get additional beds open at the LRI. Cancellations for February at 15 compared to year to date average of 22	3
Development of plan for closing the known theatre capacity Gap in 16/17 (4.3)	Review ~~Jan 17 Feb 17~~ March 17	COO to allocate	Trust wide decision to cease all WLI's that do not result in financial balance to support Trust financial delviery. Top down plan to adress gap to reduce backlog being worked through with CMG HoOPS. Plan to incorperate the 2017/18 D&C currently being formalised and worked through.	3
Serving Activity query Notices to the commissioners (4.4)	Review ~~Nov 16~~ Apr 17	DPI	Reviewed at Monthly Cancer RTT board with commissioners. New Planned Care Delivery Group chaired by DPI to start from January 2017. Aim of demand management, Referral Management Hub – including the use of PRISM. Low Priority Treatments left shift – to maximise community facilities. Reduced referrals resulting from demand management will have a downstream impact unlikely to realised until start of 2017/18.	3

Board Assurance Framework:	Updated version as at:	Feb-17										
Principal risk 5:	There is a risk that UHL will lose existing, or fail to secure new, tertiary referral 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). Updates by John Currington	
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**		ESB RAG Rating = (Date: 14/03/17)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x3=12	4x3=12	4x3=12	4x3=12	4x3=12	4x3=12	4x3=12	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. SLAs in place for all partnerships. Tertiary Partnership Strategy. Individual service strategies. service level strategies and engagement plans	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). Quarterly Review of Specialised Services (ROSS).	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) Review Children's services (5.4)

prioritised. **Detective/Corrective Controls** UHL Tertiary Partnerships Board. Tertiary partnership work-programme. Horizon scanning: NHS England (local and national); NICE; SCN; AHSN; NHS Networks. SPC reporting. Quarterly review of specialised services (ROSS). Systematic review of the children's services.				

Action tracker:	Due date	Owner	Progress update:	Status
(5.1) Apply criteria in Tertiary Partnership Strategy to prioritise service lines.	~~Feb 17~~ April 17	JC	The first priority strategy area is Cardiac Surgery with others to follow. Cardiac strategy to go to the CMG Board in March 2017; then to ESB.	4
(5.4) Complete a systematic review of the children's services portfolio against set criteria, prioritise and allocate each service into one of three groups: provided by both Trusts; one Trust to lead; neither Trust to provide.	Sep-17	JC	Process started	4

Board Assurance Framework:	Updated version as at:	Feb-17										
Principal risk 6:	Failure to progress the Better Care Together programme at sufficient pace and scale impacting on the development of the LLR vision, now captured within the STP								**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**		ESB RAG Rating = (Date: 14/03/17)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	
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 Draft STP Plan for 20/21, which builds on the BCT 5 Year Plan. New governance arrangements, including a new System Leadership Team (SLT) as a joint programme board with membership from the five NHS partner organisations and the three upper tier local authorities, a programme management office, and multi-agency boards (that include senior UHL representation) to progress each work stream of the STP (i.e. Integrated Teams Programme Board) A new System Stakeholder Forum (SSF) will be open to all members of Trust and CCG Boards, the Health and Wellbeing Boards for LLR, the Clinical Leadership Group, HealthWatch organisations within LLR, and PPI leads.	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. Plans and assumptions for UHL bed base aligned to STP (in terms of demand and capacity, finance and capital, and workforce)	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 England lead the national (external) assurance process. NHS Improvement when reviewing and approving Trust plans.	(a) Some early schemes may not be delivering the anticipated impact on demand, which is a significant risk for UHL. The STP currently lacks a programme dashboard (used to track progress) making it difficult to hold work stream leads to account (6.1). (c) Lack of visibility and engagement (of STP work streams / programmes) across the wider CMG leadership teams (6.3) (c) Lack of funding in the STP for either transitional or transformational costs (6.4) (c) the LLR system is not in equilibrium, which is not fully

UHL governance arrangements include a 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. Downside scenario ("excess demand") has been worked up to ensure stakeholders - internal and external - are sighted to the risks of 'demand outstripping our capacity'		New STP governance arrangements will strengthen controls - a more collaborative set of delivery and leadership arrangements have been established across the LLR health and care community.	equilibrium, which is not fully reflected in the STP (6.6)

Action tracker:	Due date	Owner	Progress update:	Status
(6.1) Finalise governance and reporting arrangements once STP work programmes are suitably developed - there is a need for a clear, detailed implementation plan, to operationalise the STP.	~~Sept 16~~ ~~Nov 16~~ ~~Dec 16~~ Apr 2017	MW	There will be a highlight report and dashboard that will go to SLT following the Programme Delivery Panel which will be the vehicle to supportively challenge and understand work stream delivery. The STP PMO is working on a dashboard, which will be available to organisations after it has gone to Board.	3
(6.3) Undertake mapping exercise of governance arrangements (specifically the various meetings, internal and external, now in place) relating to STP Delivery in order to check we have the right representation and necessary alignment to emerging priorities i.e. integration	~~Feb 17~~ March 17	MW	The majority of external meetings have now been mapped but this has only demonstrated the scale of the programme - work is ongoing to outline how we will best manage and support the emerging governance arrangements (paper expected for April ESB).	3
(6.4) Continue to lobby for the 'transformation' element of STF monies to be released as soon as possible given the requirement for investment	Mar-17	JA & PT	UHL (and commissioners) have continued to raise this centrally.	4
(6.6) Work with partners to bolster existing plans as well as looking at new possibilities, particularly around the integration agenda	Apr-17	MW	Integration Proposal is on the March ESB Agenda.	4

Board Assurance Framework:	Updated version as at:	RISK CLOSED SEPT 2016										
Principal risk 7:	Failure to achieve BRC status. The Trust was awarded BRC status 13/09/2016 therefore achieving this status is no longer a risk.								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 11/10/16)	
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	3x2=6	Risk mitigated to target rating and this risk closed on BAF in Sept					
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	

Action tracker:	Due date	Owner	Progress update:	Status
All actions complete - BRC status achieved				

Board Assurance Framework:	Updated version as at:	Feb-17										
Principal risk 8:	Failure to deliver an effective learning culture and to provide consistently high standards of medical education								**Risk owner:**		Sue Carr, Medical 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 training for New and Enhanced Roles i.e. Physician's Associates, Advanced Nurse Practitioners, Clinical Coders								**Risk Assurance Rating**		Exec Board RAG Rating = EQB 07/03/17	
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	3x4=12	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** Medical Education Strategy Non-Medical Education Strategy Apprenticeship Attraction Strategy Operational guidance TB, EWB & EPB scrutiny / challenge of Medical Education issues Medical Workforce Strategy Medical Education Committee Medical Workforce Policy. NED - Colonel (Retd) Iain Crowe has been appointed to support Clinical Education. Quality Improvement Plan for Undergraduate and Postgraduate Education and Training.	Medical Education Quality Dashboard. GMC Trainer recognition dashboard. Safe Learning Environment. Support and Development of Trainees. Trainer/Mentor Support. Funding Streams.	HEEM accreditation visits. GMC National trainee survey results - general improvement but some areas of concern raised. Leicester Medical School feedback (National Student Survey) - poor performance in National Student Survey 2016. GMC visit in Dec 2016 - formal report due early 2017. UK Foundation Programme - 19% of Leicester medical students chose LNR as their first choice for Foundation training and that of the 70% LNR Foundation year 2 doctors who progressed directly to speciality training – only 29% of those chose to stay in LNR.	(c & a) UHL appraisal of GMC recognised trainer roles (8.2) (c) Poor quality training delivery (8.3) (feedback) (c) Lack of availability of Education/ training facilities (8.4) (c) Reduction in education funding (SIFT) (8.4)

Detective Controls Medical Education Quality Dashboard mapped to GMC Promoting Excellence Standards UHL trainee surveys. CMG Medical Education Leads meetings and reports University Dean's report. Department of Clinical Education risk register.			

Action tracker:	Due date	Owner	Progress update:	Status
UHL Appraisal of GMC recognised trainer roles (8.2)	Aug-17	DME/ Appraisal lead	Working with UHL Appraisal Lead Mary Mushambi - framework and education sessions developed already	4
Implementation of Listening into Action Quick Wins and Longer Term Actions across Education Specific LiA Pioneering Programmes - LiA Summary (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 Sponsor Group	4
Develop & Implement Education Facilities Business Case (8.4)	Mar-17	MD/ DWOD/ CN	Project Group established, SRO and Project Manager appointed. 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

Board Assurance Framework:	Updated version as at:	Feb-17										
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, DoRaD	
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**		ESB Board RAG Rating = (Date: 14/03/17)	
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	4x3=12	4x3=12	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	~~June 16~~ ~~Sep - 16~~ ~~Dec 16~~ March 17	MD DRI	DRI and MD leading on engagement programme. Conference arranged for mid March; to bring together clinicians, senior managers, academics and patients/public.	3
(9.1) Recruitment against trajectories	~~June 16~~ ~~Sep - 16~~ ~~Dec 16~~ March 17	DRI	Recruitment for Rare diseases running 8% over trajectory. Overall recritment to Cancer arm is on trajectory - good recruitment in breast, renal and endometrial cancers. Preparations to launch recruitment in lung, haematological and colorectal cancers.	3

Board Assurance Framework:	Updated version as at:		Feb-17									
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**		EPB RAG Rating = 28/03/17		
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	4X4=16	4X4=16	4X4=16	4X4=16	4X4=16	4X4=16	
Target risk rating (I x L):	4x2=8											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**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	~~Need greater clarity regarding models of care outputs from STP Clinical Work streams to inform the workforce requirements (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	New workforce Board established March 2017 to give overview of workforce efficiency etc.		
Resourcing Steering Board	New Medical Agency dashboard and more detailed NHSI reporting and governance structure implemented.		
LLR workforce plan	Staff sickness, appraisal, mandatory training.		
Detective Controls	Monitoring vacancy position and recruitment		Workforce plans for 17/18 being developed in CMGs based on outturn (10a.5).
Premium Pay Dashboard			
Organisational Health Dashboard			
Recruitment action plans			

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

Action tracker:	Due date	Owner	Progress update:	Status
10a.1 - Resourcing strategy to be developed	~~Dec 16~~ March 16	DWOD	Being developed through the Resourcing Board. LLR Recruitment and Attraction group established - Action plan agreed and in place. Developing overarching framework for LLR Strategy to ensure alignment at UHL.	3
10a. 2 - LWAG time out to clearly define workforce OD role on Clinical Work streams	Feb-17	DWOD	Attended time out on 11 Jan 2017 and pack and role descriptors being put together. STP Lab Event planned for 9 February 2017 in setting out next steps. Role description for Clinical Workstream link developed. DWOD to determine appropriate nominees during March 17.	5
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.	4

10a.4 Improve take up and response rate to exit interviews	Mar-17	DWOD	Promotion of take up being developed through CMG's and incorporated within Monthly IFPIC Report.	4
Develop Workforce plans for 17/18 in CMGs based on outturn (10a.5).	Review April 2017	DWOD		4

Board Assurance Framework:	Updated version as at:	Feb-17										
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**		EPB RAG Rating = 28/03/17	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x4=16	4x4=16	4x4=16	4x4=16	4X4=16	4X4=16	4X4=16	4x4=16	4x4=16	4x4=16	4x4=16	
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 Apprenticeship attraction strategy LLR Apprenticeship Attraction Strategy **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)
Deliver yr1 implementation 'The UHL Way' **Directive controls** Executive Workforce Board Internal Governance Structure established UHL Way Steering Group UHL 'LiA' Sponsor group **Detective Controls** Schedule of activities for each component of 'The UHL Way'	Measures against schedule of activities for the 4 components: 1. Better engagement 2. Better teams 3. Better change 4. Academy UHL Pulse Check National Staff Survey data	East Midlands Leadership Academy. Leicestershire Improvement Innovation Patient Safety Forum.	

Action tracker:	Due date	Owner	Progress update:	Status
10b.1 - 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.	Apr-17	DoWD	Progress monitored by LLR Local Workforce Advisory Board and Local Workforce Advisory Group. Work completed on interdependencies between enabling and clinical work streams. Next LWAG meeting scheduled to take place on 07 April 2017. STP workforce plan underway as part of STP Assurance process.	4

Board Assurance Framework:	Updated version as at:	Feb-17										
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**		EPB RAG Rating = 28/03/17	
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	4X3=12	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**	
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 Resources agreed and business case to deliver the plan in place. Local Guardian appointed (Freedom to speak up). **Detective controls** No. of whistleblowing reported issues (via 3636 / gripe tool etc) Project plan with milestones for freedom to speak up Casework monitoring (investigations)	Detailed F2SU metrics: No. UHL Whistleblowing reported cases for reporting period: TBA		(c) No internal governance structure to comply with national recommendations (11.1).

Action tracker:	Due date	Owner	Progress update:	Status

Governance structure to be developed for Freedom to speak up. 11.1	~~Sep 16~~ ~~Oct 16~~ ~~March 17~~ April 17	DoWD	Review of Whistle Blowing policy will take place once new guardian in role to fully determine governance requirements. Guardian now commenced (March 2017) - Policy to be submitted to PGC in April 2017.	3

Board Assurance Framework:	Updated version as at:	Feb-17										
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 (Occupation date 26 April 2017) Deliver our reconfiguration business cases for vascular and level 3 ICU (and dependent services)								**Risk Assurance Rating**		ESB RAG Rating = (ESB 14/3/17)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	
Target risk rating (I x L):	4X3=12											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls UHL reconfiguration programme governance structure aligned to BCT Reconfiguration investment programme demands linked to current infrastructure. Estates work stream to support reconfiguration established Five year capital plan and individual capital business cases identified to support reconfiguration Property / Space Management - clinical and non clinical schedules in place **Detective Controls** Survey to identify high risk elements of engineering and building infrastructure. Monthly report to Capital Investment Monitoring committee to track progress against capital backlog and capital projects Regular reports to Executive Performance Board (EPB). Highlight reports developed monthly and reported to the UHL Reconfiguration Programme Board. Weekly Capital (Strategic and Operational) to align reconfiguration with infrastructure.	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 modelling where possible.	Eric data Lord Carter review and recommendations Premises Assurance Model Capita Engineering Report in two phases - Phase 1: where are we now - Received and under review by E&F Specialists. Phase 2 - where do we want to be and plan. Water management audit carried out in December 2017, the audit report was received 21/02/2017 and has been reviewed by a sub-group of the UHL Water Safety Group, who will report back to the UHL Water Safety Group 16 March 2017. Internal Statutory Compliance audit by PWC in December 2016, report received and presented to UHL Audit Committee March 2017.	Overall programme not yet identified to show options, costs and timescales in relation to risks. (12.2) Dedicated Infrastructure Project yet to be developed to sit alongside major reconfiguration business cases (12.5)

Action tracker:	Due date	Owner	Progress update:	Status
Identification of investment required and allocation of capital funding to develop a programme of works (12.2)	See Phase I & II below	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. A paper was presented to Reconfiguration Board on 2 November 2016 where it was agreed to form an Infrastructure Project Board supported by technical work streams. These work streams will prioritise the development of an investment strategy linked to the refresh of the DCP's which is currently underway. Work still in progress to develop capital investment strategy	4
Programme of works phase I (12.2)	~~Feb 17~~ March 17	DEF	Phase 1 - Review of infrastructure requirements following outputs from refreshed DCP. Draft programme being consolidated to include additional information.	3
Programme of works phase II (12.2)	Jun-17	DEF	Phase II - Identify areas of investment and develop high level costs to develop an OBC	4
Capital plan C /D Includes an allocation of £1.5m which will support the reconfiguration infrastructure. (12.5)	TBA	DEF	Confirmation of programme Q2 expected. Work being scoped. It is now unlikely that any funding for plan D will be forthcoming this financial year. Attention has now switched to firm up capital requirements for next financial year. Investment programme timescale will be influenced by availability of capital finding i.e. CRL or External Funding	3
Rectification of any major non-compliance issues	Review monthly to March 17	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. The Capita reports make a number of investment recommendations associated with condition and compliance. These will be evaluated and prioritised by the infrastructure technical work streams and included in the capital investment plans for 2017/18.	4

Board Assurance Framework:	Updated version as at:	Feb-17										
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**		ESB RAG Rating = (ESB 14/3/17)	
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	4x4=16	4x4=16	4x4=16	4x4=16	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/Preventive Controls Five year capital plan and individual capital business cases identified to support reconfiguration Business case development is overseen by the strategy directorate and business case project boards manage and monitor individual schemes. Capital plan and overarching programme for reconfiguration is regularly reviewed by the executive team. **Detective Controls** Capital Investment Monitoring Committee to monitor the programme of capital expenditure and early warning to issues. Monthly reports to ESB and IFPIC on progress of reconfiguration capital programme. Highlight reports produced for each project and submitted to the Reconfiguration Programme Board. **Corrective Control** Revised programme timescale approved by IFPIC on a monthly basis.	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. Capital expenditure against the agreed capital plan for reconfiguration is monitored via the monthly financial update to the Reconfiguration Board.	UHL's Annual Operating Plan, as submitted to NHS Improvement, includes capital requirements for 2017/18 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 (13.3). (c) development of the DCP estates strategy in line with STP (13.4). (c) development of the SOC (13.5)

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

Consideration to be given to alternative sources of funding. (13.1)	~~June 16~~ ~~Aug 16~~ ~~Dec 16~~ ~~Feb 17~~ March 17	CFO	STP submitted in October, assuming the use of PF2 for Women's and PACH projects. Exploratory discussions with expert PF2 advisors (Deloitte) regarding which capital schemes could potentially be suitable. Meeting with PFU in May 2016, options still being explored. A paper recommending PF2 use for the Women's and PACH projects was approved at the September 2016 Reconfiguration Board. Meeting held with the PFI & Transaction team and HMT - on-going discussions around the suitability of PF2 for retained estate elements of projects. A paper was presented to the Trust Board Thinking Day in February. Follow up meeting with DH & Treasury will take place 20th March.	3
Maintain dialogue with NHSI and NHSE regarding the pressing need for external capital to facilitate strategic change (13.2)	~~June 16~~ ~~Aug 16~~ ~~Dec 16~~ ~~Feb 17~~ March 17	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. Meeting held with local NHSI representatives to discuss PF2 and the new national guidance for business cases (including SOCs).	3
Capital plan C has identified best way to prioritise / progress all reconfiguration projects within a reduced funding allocation (13.3)	~~June 16~~ ~~Aug 16~~ ~~Dec 16~~ ~~Feb 17~~ March 17	CFO	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. ICU construction will commence once capital funding becomes available. Interim measures have been put in place to manage risks in short-term in terms of capacity, these mitigations need to be reviewed if any further delays. Priorisation of projects for internal CRL in 2017/18 has commenced.	3
DCP 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 (13.4)	~~Nov 16~~ ~~Dec 16~~ ~~Feb 17~~ March 17	CFO	Detailed work on the DCP refresh has commenced and discussion is on-going to validate the revised capital costs. Following a workshop in February a detailed action plan is now in place working to the end of March. This has caused a delay to the DCP refresh programme. Changes to this DCP may require the STP to be fine tuned, therefore discussions with Niki Bridge are ongoing regarding progress and programme.	3

Reconfiguration Programme are currently developing a Strategic Outline Case (SOC); which will articulate how the programme is affordable overall, reflecting the STP and the DCP refresh. This will then form the basis for subsequent Outline Business Cases (OBC) and Full Business Cases (FBC) for individual projects (13.5).	~~Feb 17~~ July 2017	CFO	The new NHSI guidance outlines that the SOC cannot be submitted without the pre-consultation business case and the outcome of consultation. Consultation cannot commence until the STP has been refreshed to reflect the Operating Plan and the refreshed DCPs. There is therefore a significant delay to the SOC development programme.	3

Board Assurance Framework:	Updated version as at:	Feb-17										
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**		ESB RAG Rating = (ESB 14/3/17)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x5=20	4x5=20	4x5=20	4x5=20	4x5=20	4x5=20	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 new STP governance and interdependencies to be reported to ESB monthly identifying potential risks and issues affecting delivery. Strategic capital business case work streams aligned to new STP governance. A Reconfiguration Programme Strategic Outline Case (SOC) is planned, which will reflect the STP submission, the revised Development Control Plans and the outcome of public consultation. This SOC will demonstrate affordability of the programme as a whole; and therefore pave the way for approval of individual project Outline Business Cases (OBC). Monthly meetings with 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.	Progress of the reconfiguration programme is monitored via aggregated reporting 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 - STP PMO and Leadership team - NHS Improvement - NHS England	(a) Detailed bed capacity model/assumptions have been included as part of the latest STP submission. Discussions are underway to agree the bed reduction plan over the 5 year period, to reflect the agreed 17/18 and 18/19 contract , to reflect the agreed end point of 1,697 beds in 2021 (14.1). (c) Indicative breakdown of beds, theatres and outpatients per speciality have been developed and will inform the revised Development Control Plans for UHL's reconfiguration programme. This will provide a detailed plan showing how UHL's sites will be reconfigured over the 5 year period, and will confirm the value of each project within the overall capital plan identified in

A future operating model at speciality level which supports a two acute site footprint. **Detective Controls** A monthly report outlining progress with the reconfiguration programme is submitted to the UHL Reconfiguration Programme Board. Monthly aggregate reporting to ESB, IFPIC and Trust Board. Monthly meetings with NHSI to discuss the programme of delivery. Monitoring of progress towards UHL two acute site model including interdependencies between projects. Monitoring of business case timescales for delivery. Requirements identified to deliver key projects overseen by PMO. Monitor spend against agreed budgets.			the STP. This plan will be reviewed in light of the Operating plan. (14.2). (c) The STP has delayed the ability of the PMO to gain approval of the pre-consultation business case. This has resulted in a delay to consultation. There has been minimal impact on the development of the PACH and Women's business cases since capital funding is not available this financial year to progress design work. In the meanwhile, detailed models of care and patient pathways are being worked up (14.3).

Action tracker:	Due date	Owner	Progress update:	Status
The demand and capacity discussions concluded with the agreement that 200 beds would be added back into the UHL bed base within the STP; 2 new build wards at GH and the remainder at LRI within refurbished estate and the community. Impact on capital programme, Estates Strategy and DCPs is currently being worked up. 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)	~~June 16~~ ~~July 16~~ ~~Dec 16~~ ~~Jan 17~~ ~~Feb 17~~ March 17	COO / CFO	Phase 1 of the DCP refresh is complete to give a possible range of scenarios. Phase 2 of the DCP refresh is currently being undertaken utilising the final bed split by specialty identified in the STP, and will show moves by site location and programme. The lack of bed reductions in years 1 and 2 of the STP need to be reflected in the DCP once programmed. Discussion is on-going to validate the revised capital costs. Following a workshop in February a detailed action plan is now in place working to the end of March. This has caused a delay to the DCP refresh programme. This, along with the refreshed STP and the outcome of public consultation, will inform the Reconfiguration Programme Strategic Outline Case. Estates strategy to be updated thereafter.	3

Board Assurance Framework:	Updated version as at:	Feb-17										
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 = TBA following corporate restructure	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	
Target risk rating (I x L):	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	Service Review programme has now been discontinued (15.5).

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

Current Service review programme winding down due to duplication of effort (in engaging CMGs in service redesign / improvement) and any resources going into this process will be diverted into a wider transformation programme that will be defined over the coming months (15.5).	~~Jan 17~~ March 17	CFO	Haematology coming to end of review ready for presenting to JA. Gynaecology has some on-going work to be transferred through the Theatre reconfiguration programme. Ophthalmology have pulled out of their service review due to current pressures. Despite this process / programme winding to a close, the risk score has not been changed due to the limited savings generated by the process when it was live.	3

Board Assurance Framework:	Updated version as at:	Feb-17										
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**		EPB RAG Rating = EPB (Date: 28/03/17)	
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	5x4=20	5x4=20	5x4=20	5x5=25	5x5=25	5x5=25	
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** The detailed position will be reviewed by the Executive Performance Board monthly Integrated Finance, Performance & Investment Committee and Trust Board monthly. Monthly finance reporting in relation to income and expenditure and CIP Monthly performance reporting in relation to STF performance trajectories. **Corrective Controls** Identification and mitigation of excess cost pressures Planned reduction in agency spend The CIP gap identified at the start of the year	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 £9.3m at M11 with a year end forecast being adverse to I&E plan by £6.9m of a deficit of £38.6m (excluding STF). STF Funding of £11.4m recognised at M11 in line with STF rules at Q3. This is adverse to plan by £10m and becomes a cash pressure for the Trust in the remaining months of the year. CIP within the year to date position has over delivered against the plan of £32m by £0.2m. Run rates that deliver the £38.6m in each area (pay, non-pay, CIP and income) updated for month 11 and reported to Committees/Trust Board alongside the financial and performance	Regular review of financial plan by NHS Improvement. Quarterly submission to NHS Improvement of STF Performance. Two day deep dive by NHSI into our financial planning process has been undertaken with meetings held to discuss and provide insight into the areas highlighted by NHSI in advance of the deep-dive. Waiting Report on findings of review.	(c) Significant deterioration in the financial performance within month 8. The additional organisational wide responses are defined and are required to ensure achievement of the mitigated revised forecast year end deficit position (16.1). (c) STF cannot be recognised based on Q3 and Q4 financial forecast. A cash pressure exists that requires additional cash support. (16.2).

has been closed.	position of STF funding.			

Reasonable assurance rating that risk is being managed:	Due date	Owner	Progress update:	Status
(16.1) Additional organisational wide responses are required to ensure achievement of the planned deficit.	~~Sept 16~~ ~~Dec 16~~ Review monthly	CFO	Action plan developed and being reported at relevant Executive Team Meetings.	3
(16.2) as 16.1. Additional organisational wide responses are required to ensure achievement of the planned deficit	Review monthly	CFO	STF cannot be recognised for Q3 or Q4 based on current forecast deficit position. The cash impact is being funded through the utilisation of the Revovling Working Capital Facility.	3

Board Assurance Framework:	Updated version as at:	Feb-17										
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**	EPB RAG Rating = EPB (Date: 28/03/17)		
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	5x3=15	5x3=15	5x3=15	5x3=15	5x3=15	5x3=15	5x3=15	5x3=15	5x3=15	5x3=15	5x3=15	
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) LTFM & SOC approved. **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 M10 the Trust is £8.7m adverse to plan. Half yearly review of LTFM to ensure fitness for purpose i.e. checking consistency with UHL's strategy and ensuring we have a deliverable recovery plan over the medium term. Strong links to overall BCT 5 year strategy and the financial consequences (revenue and capital) of the transformational business cases	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) Currently seeking authority to proceed with public consultation of STP (17.2) (c) The Trust is currently experiencing significant pressures within it's ability to achieve its obligations under the Better Payment Practice Code (BPPC). This pressure is being driven by a shortage of cash. (~~17.3 and~~ 17.4)

Action tracker:	**Due date**	**Owner**	**Progress with actions**	**Status**
(17.2) Currently seeking authority to proceed with public consultation	~~Oct 16~~ March-17	CE/CFO	Public consultation to follow approval of STP.	3

(17.3) Assurance over cash forecasting and working capital management completed by PWC.	~~Oct-16~~ ~~Dec-16~~ Feb-17 Complete	CE/CFO	Draft report received with further actions identified and being addressed within agreed timeframes and to be finalised by 30 November 2016. Final report and letter of support received.	5
(17.4) External cash injection required to resolve current working capital requirements.	~~Oct-16~~ ~~Dec-16~~ ~~Feb-17~~ March 17	CE/CFO	Process for working capital loan application yet to be defined by NHSI Treasury team. Once defined the Trust will make an appropriate application. Cash is currently being accessed through the revolving working capital facility with the final drawdown being made to the Trust's approved limit in January 2017.	3

Board Assurance Framework:	Updated version as at:	Feb-17										
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: EMI&T 28/03/17	
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	4x4=16	4x4=16	5x5 = 25	5x5 = 25	5x5 = 25	5x5 = 25	
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	NHSI have confirmed that they are not in a position to support the proposal and their proposed cost envelope would mean that an integrated solution, UHLs preferred option, is no longer achievable (18.1). Propose SOC for paper lite EPR solution (18.3)

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
Progress work with NTDA/DoH to progress a firm timetable (18.1)		CIO	*** This action can not be supported by NHSI*** Initial work has been undertaken to review our options and produce an alternative solution - see 18.3	

Propose Strategic Outline Case for the development of a Paper Lite EPR solution (18.3)	~~March 2017~~ May 2017	CIO	First phase will be to revisit the work undertaken as part of the FBC for the Cerer EPR solution Initial reviews have shown we can start to achieve some of the paper-lite benefits of EPR through limited investments in the NC product, with the work being generic enough to support any of the future models. This will enable us to move forward. Further conversations have happened with NUH around sharing some of the development work to further mitigate risks/costs for the NC model	4

Board Assurance Framework:	Updated version as at:	Feb-17										
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: EMI&T 28/03/17	
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	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	
Target risk rating (I x L):	3 x 2 = 6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls 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. Capital prioritisation plan in place. **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)

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
To review the deliverables in line with the EPR re-work to ensure the new programme accelerate the delivery of key items, such as desktop refresh (19.1)	Mar-17	CIO	The impact of the EPR re-work is causing concern with the approach to desktop refresh as different approaches have different needs	4
To review the urgent requirments for equipment refresh in clinincal areas (19.1)	Mar-17	CIO	Funds from 17/18 have been identified to start this work and a plan to create a procurement is in place for Aug 17	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 down 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 taking into consideration that the objectives and principal risks will be refreshed on an annual basis (annual period 1st April to 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.

BAF Matrix

		Consequence				
		1 Insignificant	2 Minor	3 Moderate	4 Major	5 Extreme
Likelihood	1 Rare	1	2	3	4	5
	2 Unlikely	2	4	6	8	10
	3 Possible	3	6	9	12	15
	4 Likely	4	8	12	16	20
	5 Almost Certain	5	10	15	20	25

Appendix 2 Risk Register Dashboard as at 28 Feb 17

Risk ID	CMG	Risk Title	Current Risk Score	Target Risk Score	Risk Owner	Risk Movement	Elapsed risk deadline	Themes aligned with Trust Objectives
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
2566	CHUGGS	There is risk of delays to planning patient treatment due to the age of the Toshiba Aquilion CT scanner in the Radiotherapy Dept	20	1	Lorraine Williams	↔		Safe, high quality, patient centred healthcare
2354	RRCV	There is a risk of overcrowding in the Clinical Decisions Unit	20	9	Sue Mason	↔		Effective emergency care
2670	RRCV	There is a risk to the Immunology & Allergy Services due to a Consultant Vacancy	20	6	Karen Jones	↔		Workforce capacity and capability
2886	RRCV	LGH Water Treatment Plant risk of downtime, resulting from equipment failure of the water plant impacting on HD patients	20	8	Geraldine Ward	↔		Safe, high quality, patient centred healthcare
2931	RRCV	Increasing frequency of Cardiac Monitoring System on CCU failing to operate	20	4	Judy Gilmore	↔		Safe, high quality, patient centred healthcare
2804	ESM	Outlying Medical Patients into other CMG beds due to insufficient ESM inpatient bed capacity	20	12	Gill Staton	↔		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	↔		Workforce capacity and capability
2333	ITAPS	Lack of Paediatric cardiac anesthetists to maintain a WTD compliant rota leading to interruptions in service provision	20	8	Chris Allsager	↔		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	Chris Allsager	↔		Workforce capacity and capability
2191	MSK & SS	Lack of capacity within the ophthalmology service is causing delays that could result in serious patient harm.	20	8	Clare Rose	↑		Workforce capacity and capability
2940	W&C	Risk that paed cardiac surgery will cease to be commissioned in Leicester with consequences for intensive care & other services	20	8	Nicola Savage	↔		Safe, high quality, patient centred healthcare
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

Risk ID	CMG	Risk Title	Current Risk Score	Target Risk Score	Risk Owner	Risk Movement	Elapsed risk deadline	Themes aligned with Trust Objectives
2471	CHUGGS	There is a risk of poor quality imaging due to age of equipment resulting in suboptimal radiotherapy treatment.	16	4	Lorraine Williams	↔		Workforce capacity and capability
2264	CHUGGS	Risk to the quality of care and safety of patients due to reduced staffing in GI medicine/Surgery and Urology at LGH and LRI	16	6	Georgina Kenney	↔		Safe, high quality, patient centred healthcare
2870	RRCV	Audit of DNACPR form have shown that the discussion with the patient or family is not consistently recorded	12	2	Elved Roberts	↓		Workforce capacity and capability
2819	RRCV	Risk of lack of ITU and HDU capacity will have a detrimental effect on Vascular surgery at LRI	16	12	Sarah Taylor	↔		Workforce capacity and capability
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	12	6	Karen Jones	↓		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	Karen Jones	↔		Workforce capacity and capability
2193	ITAPS	There is a risk that the ageing theatre estate and ventilation systems could result in an unplanned loss of capacity at the LRI	16	4	Gaby Harris	↔		Safe, high quality, patient centred healthcare
2541	MSK & SS	There is a risk of reduced theatre & bed capacity at LRI due to increased spinal activity	9	8	Carolyn Stokes	↓		Workforce capacity and capability
2687	MSK & SS	Lack of appropriate medical cover will clinically compromise care or ability to respond in Trauma Orthopaedics	**CLOSED**					Workforce capacity and capability
2955	CSI	If system faults attributed to EMRAD are not expediently resolved, Then we will continue to expose patient to the risk of harm	16	4	Cathy Lea	↔		Safe, high quality, patient centred healthcare
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
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	Communications	No IT support for the clinical photography database (IMAN)	16	1	Simon Andrews	↔		Workforce capacity and capability

Risk ID	CMG	Risk Title	Current Risk Score	Target Risk Score	Risk Owner	Risk Movement	Elapsed risk deadline	Themes aligned with Trust Objectives
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	↔		Workforce capacity and capability
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	Shirley Priestnall	↔		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	Vicky Osborne	↔		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	↔		Workforce capacity and capability
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	**CLOSED**					Workforce capacity and capability
1196	CSI	No comprehensive out of hours on call rota and PM cover for consultant Paediatric radiologists	15	2	Rona Gidlow	↔		Workforce capacity and capability
510	CSI	There is a risk of staff shortages impacting on the Blood Transfusion Service at UHL	**CLOSED**					Safe, high quality, patient centred healthcare
2787	CSI	Failure of medical records service delivery due to delay in electronic document and records management (EDRM) implementation	15	4	Debbie Waters	↔		Workforce capacity and capability
2965	CSI	If we do not address Windsor pharmacy storage demands, then we may compromise clinical care and breach statutory duties	15	6	Claire Ellwood	↔		Safe, high quality, patient centred healthcare
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
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	↔		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 .	12	6	William Monaghan	↓		Workforce capacity and capability

Apendix 3 **UHL Risk Register as at 28 Feb 17**

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2236	CMG 3 - Emergency & Specialist Medicine (ESM)	Emergency Department	There is a risk of overcrowding due to the design and size of the ED footprint & increased attendance to ED	04/Oct/13	31/05/2017	Design and size of footprint in resus causes delay in definitive treatment, delay in obtaining critical care, risk of serious incidents, increased crowding in majors, risk to four hour target. Poorer quality care. Risk of rule 43. Lack of privacy and dignity. Increased staff stress. Design and size of majors causes delay in definitive treatment and medical care. Poor quality care. Lack of privacy and dignity. High number of patient complaints. Risk of deterioration. Difficulty in responding to unwell patient in majors. Risk of adverse media interest. Staff stress. Risk of serious incident. Inability to meet four hour target resulting in patient safety and financial consequences. High number of incidents. Increased staff stress. Infection control risk. Risk of rule 43. Design and size of footprint in paediatrics causes delay in being seen by clinician. Risk of deterioration. Risk of four hour target and local CQUINS. Lack of patient confidentiality. Increased violence and aggression. Design and size of assessment bay causes delay in time to assessment. Paramedics unable to reach turnaround targets. Inability to meet CQUIN targets. Risk of patient deterioration. Delay in diagnosis and treatment. Increased staff stress. Patient complaints. Increased risk of patients being in the corridor on trolleys. Lack of dignity and privacy. Serious incident risk.	Patients (Clinical/Safety)	The Emergency Care Action Team, was established in spring 2013 with aims to improve emergency flow and therefore reduce the ED crowding. This has now been changed to Emergency Quality Steering Group(EQSG) meetings. The Emergency department is actively engaging in plans to increase the ED footprint via the emergency floor initiative, but in the shorter term to increase the capacity of assessment bay and resus. The Resus Bed area has been created. Increase in Clinical Education staff, to assist with upskilling of Nursing Staff. Majors Floor has been marked out and numbered to prevent to many trolleys from blocking Majors and assessment Bay. Improving quality of care in the ED sessions open to staff, led by ED Consultant. Direct referrals from assessment bay and UCC to ambulatory clinic/GPAU. CAD system went live highlighting number of ambulance patients on route to ED. SOP's completed, including SOP's for managing assessment bay at full capacity & for supporting an escalation area when the main ED is full. Actions in place from EQSG Emergency Floor New ED floor working stream.	Extreme	Almost certain	25	Creation of SoP for resus crowding (SoP is actually 4 discreet small procedures relating to Resus, including Resus entry assessment, board rounds, escalation and Resus step down) - due 31/03/17 - Dr A Millet leading. New build will be complete April 2017. 30/04/17 Resus board rounds, discussions, escalation to be commenced - this has been submitted for consultation with joint sisters and consultants meeting - final version due 31/03/2017 Resus step down process to be developed 31/03/2017 Escalation process re, occupancy, length of stay, staffing 31/03/17 Launch and implementation of additional patient on ward process (SAFER placement) Red to Green in process through trust, ongoing review 30/06/17	16	Ian Lawrence

Risk ID	CMG	Specialty	Risk Title	Review Date	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2762	Corporate Nursing		Ability to provide safe, appropriate and timely care to all patients attending the Emergency Department at all times.	21/12/2015	28/02/2017	Causes Failure to consistently undertake and record initial assessment by appropriately trained clinical staff within 15 minutes of presentation and document in real time. Failure to consistently ensure that all patients receive adequate care and treatment in accordance with Trust sepsis clinical pathway. Lack of ability to demonstrate we have an appropriate staffing skill mix in place on a shift by shift basis. Lack of recording of induction for temporary staff. Consequences Significant risk of patient harm Conditions placed on licence to practice Risk of CQC placing the Trust in Special Measures Risk of CQC imposing unlimited financial penalties Adverse media attention affecting reputation of the Trust Breaches in Statutory duty with subsequent criminal prosecution	Quality	CEO and executive leadership with clear responsibility and oversight in place. Programme management arrangements in place supported by trio of nursing, medical and operational leads with allocated time and objectives. This is supported by four oversight meetings per week. Internal reporting in relation to quality metrics (sepsis compliance, staffing, initial assessment within 15 mins) Weekly reporting to CQC on required metrics in place Sepsis Implementation of trust-wide single adult sepsis pathway supported by a programme of daily audit in ED. Supporting action plan in place including rollout of single paediatric pathway. Initial Assessment Standard Operating Procedure (Initial Assessment and Dynamic Priority Scoring - version 3 December 2015) revised and implemented to ensure ED patients are prioritised appropriately. Consistent real-time recording. Review of patient harm associated with delayed initial assessment (>15mins) at patient level.	Extreme	Almost certain	25	Risk is under review and to be replaced with a deteriorating patient risk assessment - currently undergoing scrutiny at Executive Team prior to being entered on the risk register - review position as at end of Feb 2017	15	Julie Smith

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2566	CMG 1 - Cancer, Haematology, Urology, Gastroenterology & Surgery (CHUGGS)	Oncology	There is risk of delays to planning patient treatment due to the age of the Toshiba Aquilion CT scanner in the Radiotherapy Dept	30/Jun/17 26/06/2015	The current Toshiba scanner is 9 years old with an expected 10 year life cycle. It is the only scanner in the department, scanning provision would need to be provided at either another Radiotherapy department or possibly in radiology in the event of a prolonged or permanent period of downtime. The likelihood of such an event significantly increases towards the end of its life cycle. Consequences would be: - Patients wouldn't be able to have their treatment planned having an impact on the cancer waiting time targets and outcomes of the patients treatment; - There is a risk to patients being planned for treatment in a timely manner due to availability of alternative scanning capacity; Consequences of using radiology (or another radiotherapy dept) scanner - Slice position numbering may differ between scanner and planning computer which could cause positioning errors; - Inconvenience to patients having to go to different dept for scan, possibly on a separate date to other apts in radiotherapy; radiotherapy staff would need to be allocated sessions working in radiology/another radiotherapy dept to scan radiotherapy patients; - A specific couch top is required for planning radiotherapy treatment, the existing couch top doesn't fit the diagnostic scanner in the radiology dept. The cost of a new couch top is approx £28k and would also require a modification to the table top. The modification to table top would take approx a day;	Patients (Clinical/Safety)	Limited arrangements for planning palliative patients only (unable to treat radical patients) Comprehensive Service Contract with Toshiba for scanner up until May 2016.	Extreme	Likely	20	Contingency plan for instances of breakdown of the Toshiba scanner using another radiotherapy departments scanner - 31 Aug 17 Agreement for monthly 1/2 day physics QA sessions on radiology scanner during periods of Toshiba breakdown to ensure continued compability between scanner and planning system - 31 Aug 17 Purchase of compatible couch top for use with CT scanners - 31 Aug 17 Service level agreement with radiology for scanner capacity for radiotherpay patients in the case of long term breakdown of scanner - 31 Aug 17 Contingency plan for instances of breakdown of the Toshiba scanner using radiology scanner - 31 Aug 17 Awaiting formal business case for the propsoed replacemnent - 31 Dec 17	1	Lorraine Williams

Risk ID	CMG	Specialty	Risk Title	Review Date	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2354	CMG 2 - Renal, Respiratory, Cardiac & Vascular (RRCV)		There is a risk of overcrowding in the Clinical Decisions Unit	31/03/2017	28/05/2014	Causes of the risk (hazard) 1.CDU originally designed to take in a 24 hour period 25-30 patients, on average it is now taking 60-70 patients/24 hr period. Despite the extension of the triage area the foot print of the unit still remains inadequate to cope with this increase number of patients. There is not the physical space to see/examine/review the number of patients that are currently presenting to CDU, particularly in the afternoon and evening. 2.The workforce on CDU (medical, nursing, therapy, admin/clerical) has increased since 2014 in accordance with the increase in the number of patients that require processing in the department, however at times the processing capacity of the staff available does not match demand. 3.Increasing risk to the compliance of CDU Quality Performance Indicators; patients being triaged within 15 minutes from arrival to CDU and seen by a Doctor within 60 minutes. 4.Due to the pressures within the Emergency Department at the LRI the level 1 diverts are enacted on occasions, compounding the overall processing power within CDU and impacting on bed capacity. 5.The out of hour's provision from support services such as pharmacy, radiology and pathology does not match the requirements of an increasing emergency take at the GH.	Patients (Clinical/Safety)	Respiratory Consultant on CDU 5 days/week 0800-20 00 hrs Respiratory Consultant on CDU at weekends and bank holidays 0800-1200 hrs and on call thereafter Cardiology Consultant assigned on CDU 5 days a week (shared rota) Cardio Respiratory Streaming flow, including referral criteria and acceptance Short stay ward adjacent to CDU Discharge Lounge utilised GH duty Manager present 24/7 Bed co-ordinator and Flow co-ordinator, providing 7 day cover CDU dash board – performance indicators UHL bed state and triage times includes CDU data Daily nurse staffing review with plan to ensure safe staffing levels on CDU EDIS operational on CDU Daily patient discharge conference calls for all wards Matron of the day - rota covers 7 day working Daily board rounds across all wards Primary Care Co-ordinators and increased community support Escalation plans Implementation of triage audit CDU Operations Meeting Monitoring of patient triage times and other quality performance indicators at monthly CDU ops meeting with appropriate representation from all staff groups	Major	Almost certain	20	Review additional resources as part of strategic transfer of vascular services in 2016/17 - run ambulatory GP model over winter months - additional resources identified and low risk ambulatory clinic will run until March 2017	9	Sue Mason

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2670	CMG 2 - Renal, Respiratory, Cardiac & Vascular (RRCV)		There is a risk to the Immunology & Allergy Services due to a Consultant Vacancy	31/03/2017 05/Oct/15	Causes of the risk (hazard) Consultant Immunologist/Allergist Vacancy The post has been vacant since 22nd June 2015 and the funding for this Consultant role sits within CSI CMG (empath, Pathology). Delayed recruitment to vacant post due to failure to appoint on at least two occasions (availability of candidates with the necessary speciality expertise) - risk added 12/05/16 From July 2016, an allergy consultant will be resigning from their post and this will leave a gap in food allergy expertise - risk added 12/05/16 Nurse Staffing Resource This service is dependent on nursing support to assist with immunology therapies, skin prick and challenge tests. Band 6 vacancies have only recently been appointed and due to the speciality requirements, extended training programmes are needed to confirm competence Band 7 Nurse Specialist for Asthma Immunology & Allergy vacancy from 12th May 2016 due to a resignation - risk added 12/05/16 Patient backlog and RTT risk There is a planned waiting list with a backlog of patients who are waiting for sequential procedures e.g. skin prick and/or challenges to help support and manage their health condition. Patient backlog of New and Follow Up Patients There is a back log of New and Follow up patients referrals due to the original vacancy gap and this will continue to increase when the second allergy consultant leaves the Trust. On 12/05/2016 backlog is 638 patients	Human Resources	Weekly Access Meeting (WAM) attendance for support and completion of actions. Review of patient referrals to identify the high risk patients and complete a trajectory plan. Advice and actions being agreed with the Head of Performance and Operations to ensure all patients waiting for sequential procedures have been identified and are allocated to the appropriate patient waiting list. Continued monitoring of these patient waiting list at Respiratory RTT meetings and escalation of concerns. To standardise referral and waiting list procedure to ensure all patients are recorded on the correct patient waiting list. Completion of Business Case and Risk Assessment to recruit an Allergy Consultant for the service. Respiratory Physicians to help maintain current and future Allergy Service. Route to Recruit and advert to be authorised ASAP to cover allergy gap(s). Further discussions of future model of Allergy and Immunology and identifying possible support from Consultant Dietitian. Clinical Immunology/Allergy Consultant commenced 9.10.16 - Consultant will support an additional allergy clinic due to allergy consultant has been appointed started on the 3.10.16 - complete	Major	Almost certain	20	Appoint a 1WTE Allergy Consultant - Failed no candidates, but we appointed a trust grade medical doctor, who should commence working by the end of March 2017 Monitoring of patient backlog at Respiratory RTT meetings - 31Mar 17 Escalation of concerns to Head of Operations/Director of Performance - 31 Mar 17 WLI will continue to support backlog and respiratory consultants will continue to back fill until 31.3.17	6	Karen Jones

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2886	CMG 2 - Renal, Respiratory, Cardiac & Vascular (RRCV)		LGH Water Treatment Plant risk of downtime, resulting from equipment failure of the water plant impacting on HD patients	10/Mar/17 29/06/2016	Causes (hazard) 1.The existing Water Treatment Plant that currently provides the LGH Haemodialysis Unit adjacent to the Haemodialysis Unit LGH site. with all of its treated water requirements for dialysis, has now exceeded its expected service life, (some parts dating back 42years) with the most recent addition dating back 20years. 2Failure of the exiting ring main RO systems 3Out-dated design without intergural disinfection capabilities RISK TO PATIENTS •There is a risk that downtime resulting from equipment failure of the water plant impacts directly on the clinical treatment offered to all haemodialysis patients receiving dialysis therapy at the LGH Renal Unit. This may result in patients having to travel to other units. •Risk from both long and short term complication to patients due to unacceptable bacterial contamination of water that supplies the Haemodialysis unit. •Emergency business continuity plans would need to be activated this would have an associated impact on other support services transport, community services etc). •Risk of a rise in clinical incident, complaints, litigation (staff stress, patient injury and clinical negligence) •Risk of reduced public confidence and subsequent media attention.	Quality	Discussion to be reached on the future model for LGH Haemodialysis Unit 1. Capital Purchase). Initial £200K Capital purchase and annual maintenance costs of approximately £10K per annum. To replace the ring main and complete water treatment system. LGH technical team will potentially organise internally to undertake weekly chemical disinfections – UHL Infection informed. Discontinue HDF therapy Samples for Endotoxin testing will continue on a weekly bases. Non-payment of invoices in January 17 has resulted in no chemical disinfect being undertaken by Veola in February 17. This will have an affect on the type of treatment provided to some patients.	Extreme	Likely	20	Replacement options paper to be compiled for submission to the Renal and CMG board before submitting to capital and investment committee - Capital Purchase - Initial £165K Capital purchase and annual maintenance costs of approximately £10K per annum. To replace the ring main and complete water treatment system. Business Case to be presented at the Capital & Investment Committee Meeting on 14.10.16 for decision. Decision made by the Capital Investment Committee to replace Water Treatment Plant. Funding to come from 17/18 capital expenditure. Weekly water sampling will continue. Scoping exercised commenced in January 17 and contract to be awared in April 17. Work should then commence on the installation of a new water treatment plant.	8	Geraldine Ward

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2931	CMG 2 - Renal, Respiratory, Cardiac & Vascular (RRCV)		Increasing frequency of Cardiac Monitoring System on CCU failing to operate	30/04/2017 05/Sep/16	Causes (hazard) Cardiac Monitoring system failure due to age, obsolescence, replacement parts not available, no GE service contract/support. System includes bedside, central, telemetry. Vital signs inc O2 sats, Bp, Pacemaker checks. 12 lead ECG's. Event history ie. Arrhythmia review Consequence (harm / loss event) 19 bedded, direct admitting CCU would not be able to safely admit critically unwell, unstable people through EMAS with, STEMI, nSTEMI, OoHCA, Arrhythmias etc Critically ill patients could not be safely transferred internally post Cardiac Arrest, TAVI, IABP insertion post procedure, ITU transfers, transfers from other sites, E/D, other trusts LLNR would not have functioning CCU available to population of over 1 million Cardiac arrests not detected, life threatening arrhythmia not seen/treated Delayed delivery of care Out of Hospital Cardiac Arrests, could not be safely admitted to the GH site Entire GH site affected operationally inc. ITU blocking LRI E/D detrimentally affected due to increased activity/delays in transferring Reduces operational capacity of the unit to safely admit monitored patients Potential risk to wider population and the reputation of UHL as impacts on emergency bed base Cancelled procedures/surgery eg. PCI/TAVI Loss of revenue Increased expenditure as staffing levels would need to be increased	Patients (Clinical/Safety)	Medical physics called for assistance and make contact with GE Matron, bleep holder and manager on call informed Nursing Rounds Escalated Nurses to be based at bedside/bay Escalation policy via duty manager to senior team Doctors based on CCU to review all patients Ensure capacity is available on the other clinical areas which have functioning central monitoring If bedside monitors available then parameter alarms set to max audible Patient review by cardiologist Datix completed by NiC Patients prioritised and moved to available ward beds or more visible beds Bleep holder/Matron/Senior team to assess numbers of staff across RRCV and acuity, monitored patients and potentially reallocate staff Identify through senior team/shift co's/Medical team/med physics and reallocate stand-alone bedside systems to most appropriate patients Escalated to Director/Gold command Business case submitted to Medical Equipment replacement board and to capital investment committee in September 2016.	Extreme	Likely	20	Replace obsolete monitoring system in its entirety including service contract - implementation plan being developed to install in April 17 - 30.4.17	4	Judy Gilmore

Risk ID	CMG	Specialty	Risk Title	Review Date Opened		Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2804	CMG 3 - Emergency & Specialist Medicine (ESM)		Outlying Medical Patients into other CMG beds due to insufficient ESM inpatient bed capacity	06/May/16	30/04/2017	There is a risk that if ongoing pressures in medical admissions continue that the Emergency and Specialist Medicine CMG medicine bed base will be insufficient resulting in the need to out lie into other speciality/CMG beds jeopardizing delivery of the RTT targets and affecting quality and safety of patient care. There is a requirement to outlie medical patients because of: o8% increase in medical admissions and current insufficient medical bed capacity oDischarge processes not as efficient as they should be internally impacting patient flow and patients waiting in ED for admission oContinued delayed transfers of care oOn-going risks and potential harm to patients as a consequence of overcrowding in ED oOOH teams have to make decisions to use all available capacity to cope with pressures in ED The ability to open extra beds within the CMG is compounded by: o>100 Nursing vacancies o3 Geriatrician vacancies oHigh patient acuity oHigh inflow of patients being admitted oNo available bed capacity on the LRI site	Patients (Clinical/Safety)	Review of capacity requirements throughout the day 4 X daily. Issues escalated at Gold command meetings and outlying plans executed as necessary taking into account impact on elective activity. Opportunities to use community capacity (beds and community services) promoted at site meetings. Daily board rounds and conference calls to confirm and challenge requirements for patients who have met criteria for discharge and where there are delays ICS/ICRS in reach in place. PCC roles fully embedded. Discharges before 11am and 1pm monitored weekly supported by review of weekly ward based metrics. Ward based discharge group working to implement new ways of delivering safe and early discharge. Explicit criteria for outlying in place supported by recent clarification from Assistant HON. Review of complaints and incidents data. Safety rota developed to ensure there is an identified consultant to review outliers on non-medical wards. Access to community resources to enable patients to be discharged in a timely manner. CMG to access and act on additional corporate support to focus on discharge processes. Matron for discharge appointed to provide consistent care for patients needing to be outlied.	Major	Almost certain	20	New Red to Green initiative being rolled December to March to reduce delays feedback due after this period. 30 April 2017	12	Gill Staton

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2149	CMG 3 - Emergency & Specialist Medicine (ESM)		High nursing vacancies across the ESM CMG impacting on patient safety, quality of care and financial performance	30/04/2017 21/02/2013	Many clinical areas are currently experiencing low levels of staffing to manage effectively the current numbers of patients. Often the nurse to bed ratio falls below that identified as the funded establishment, and therefore the required level of staffing to appropriately meet patient need. In addition within most of the clinical areas there is high bank and agency use further increasing the risk to the quality of care delivered. In addition we are required to staff the old TIA clinic and look after ambulance patients in ED corridors and provide support to outlying patients which further depletes numbers and nursing skills. Causes - "Large Number Vacant Nursing posts, "Lack of appropriately trained nursing staff to manage specialised patients, "Poor Agency and bank fill rates, " High level of maternity leave/sick leave, " Outlying of patients, " TIA Clinic, " Ambulance cohorting in the corridor protocol. Consequences - "Delays with Patient care, "Patient medications not being completed in a timely manner, "Patient buzzers not being answered in a timely manner, "Patient safety compromised, "Increased risk of patient pressure ulcer formation, "Increased risk of patient falls, "Increased risk of incidents due to lack of familiarity with treatment regimes, "Inability to deliver quality care to different patient groups, "Decreased patient satisfaction/ quality of care, "Delays in treatment and appropriate referral, "Increase in complaints, "Increase in incident reporting,	Patients (Clinical/Safety)	"Staffing Escalation policy, "Staffing Bleep Holder / Matron support ,Site Manager and Duty Manager, "Incident reporting, "Complaints monitoring, " Daily Staffing Meetings, " TIA rota, "Monitor staffing levels, "Monitoring recruitment and retention, "Monitoring sickness levels, "Provision of nursing support from other base wards, "Support from the Outreach Team, "Support from Education & Development Team, "Support from Matrons and Deputy/ Head of Nursing, Moving staff between clinical areas as a means to balance risk. Agency and bank as a means to increase nursing numbers- agreed contracts to block book allowing temporary staff to get use to environment and standards within the workplace. A 'job card' designed to ensure temporary staff understand the expectation of their shift and high quality of clinical management required. Orientation to each of the clinical areas for agency/bank staff -(green book compliance). Clinical matron/senior nurse available daily to ensure clinical risk is mitigated and managed. Bed management meeting at 8.00, 12.00 16.00 and 18.00 to review bed demands and staffing issues across the Trust. Forum agrees the strategic plan for the 24/7 with on-call director and Senior on a daily basis. Active recruitment strategies to reduce vacancies. Matron visibility on wards Monday to Friday 8 - 8pm and 8 - 4pm at weekends.	Major	Almost certain	20	Enhanced rate of pay now in place for 3 months period and due for ongoing regular reviews. New staff to be appointed from Philippines and India.	6	Gill Staton

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2333	CMG 4 - Intensive Care, Theatres, Anaesthesia, Pain Management & Sleep	Anaesthesia	Lack of Paediatric cardiac anesthetists to maintain a WTD compliant rota leading to interruptions in service provision	17/04/2014	30/05/2017	Causes: Retirement of previous consultants Ill health of consultant Lack of applicants to replace substantively Following NHS England announcement that Paeds Cardiac will close one consultant has resigned leaving the sustainability of the service until closure in April 17 in doubt. Consequences: Need for remaining paeds anaesthetists to work a 1:2 rota on-call Lack of resilience puts cardiac workload at risk May adversely affect the national reputation of GGH as a centre of excellence Current rota non complaint Working Time Directive (WTD) Patients requiring urgent paeds surgery may be at risk of having to be transferred to other centres Income stream relating to paeds cardiac surgery may be subsequently affected Risk of suboptimal patient treatment resulting in harm.	Quality	1:2 rota covered by experience colleagues 12 month locum appointed Fellow appointed in July 2016 (however following announcement by NHS England one consultant has resigned leaving ability to appoint a suitable locum and sustainability of business model in doubt).	Major	Almost certain	20	**Although all actions are completed ITAPS wish this risk to remain open in particular because following NHS England announcement that Paeds Cardiac will close one consultant has resigned leaving the sustainability of the service until closure in April 17 in doubt.** Pead Consultant interviews end of February to hopefully result in post being appointed 2 as experienced candidate applied.	8	Chris Allsager

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2763	CMG 4 - Intensive Care, Theatres, Anaesthesia, Pain Management & Sleep	Critical Care	Risk of patient deterioration due to the cancellation of elective surgery as a result of lack of ICU capacity	22/01/2016	30/04/2017	Causes: Lack of capacity (beds) within ICU cross-site. Lack of base ward bed for ICU patients to be discharged. Lack of nursing staff to manage ICU patients. Delays with discharging ICU patients to Wards. Consequences: Deterioration in condition with the potential for patients to become too unwell to have surgery when re-booked or worse case scenario patient dies waiting for surgery. Impacts to quality of service through failure to meet treatment targets. Also, potential for increase in complaints from patients/family. Breach in contract. Reputation amongst other CMGs as an inability to provide a service. Potential to attract media interest. Potential for financial penalties due to inability to meet national targets.	Patients (Clinical/Safety)	Identify patients ready for discharge from ICU in previous 24 hours Highlight potential cancellations to consultant on call Electronic bed booking system to identify potential issues with electives Highlight to General Managers potential cancellations Regular discussions cross-site with Consultants to balance the elective lists. Moving staff from between sites to maximise ITU capacity on all. Reviewing booking into ICU daily and for the week ahead to identify any risks or special requirements. Monitoring of cancellation rates on a monthly/ weekly basis including cancer cases. Identification of discharges for next day the night before to allow ring-fencing of beds on wards where possible.	Extreme	Likely	20	Risk paper discussed the key elements of opening Annex at LRI for a trial and was rejected by ITAPS Anaesthetics leads due to increased risk to UHL. SD development to support ITU1 Registrar rota and further recruitment to ITU2 rota with a view to support annex capacity. Four of the 7 required for SD rota have been offered however two at risk due to more attractive relocation packages at other Trust - recruitment to middle grade rota is the focus in order to open Annex safely - review 30/4/17 Increase additional capacity (6 beds at LRI). Not agreed by board.	10	Chris Allsager

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2191	CMG 5 - Musculoskeletal & Specialist Surgery (MSK & SS)	Ophthalmology	Lack of capacity within the ophthalmology service is causing delays that could result in serious patient harm.	30/04/2017 12/Jun/13	Causes: Nationally Ophthalmology services have severe capacity constraints. Lack of capacity within our services due to: Lack of Consultant work force Junior Doctor decision makers resulting in increased follow-ups. The current infrastructure is not fit for purpose Follow-ups not protocol led. Consultant annual leave booking adhoc Clinic cancellation process unclear, inadequate communication and escalation. Overbooking of Clinics that are not deliverable as per the template and medical availability Consequences: Backlog of outpatients to be seen, which continues to grow. Risk of high risk patients not being seen/delayed. Poor patient outcomes. Increased complaints and potential for litigation, including SUI's that evidence harm. Reputation damaged PPI compromised Low morale of the whole work force Increased scrutiny from the CQC and CCG's	Patients (Clinical/Safety)	Outpatient efficiency work ongoing. Further education and information to admin team regarding booking outpatient booking process No further overbooking of clinics all patients to be added to the outpatient waiting listened reviwed weekly by the GM and HOOP. Full recovery plan for improvements to Ophthalmology service are in place . EED Breaches monitored daily via text.	Major	Almost certain	20	Post Code Analysis for LTFU adn RTT Incompletes for transfer to Alliance - 1 Apr 17	8	Clare Rose

Risk ID	CMG	Specialty	Risk Title	Review Date	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2940	CMG 7 - Women's and Children's (W&C)	Paediatrics	Risk that paed cardiac surgery will cease to be commissioned in Leicester with consequences for intensive care & other services	30/09/2016	14/03/2017	Consequences of the risk (harm / loss event): Many Children and families within the East Midlands will have to travel further to their nearest paediatric cardiac surgical centre during the most stressful episode of their care. This is particularly difficult when mothers have just given birth and the baby's condition is complex. 12 Paediatric Intensive Care Unit (PICU) beds at Glenfield Hospital will be lost. The loss of a specialist PICU will mean that the children's intensive care will cease to be as attractive a place for our clinical teams to work; we are at risk of losing existing staff and find it harder to attract new staff. The above scenario poses the risk of not being able to sustain a children's intensive care service in Leicester with a subsequent domino effect on other specialist paediatric services including children's general surgery, ear nose and throat surgery, metabolic medicine, fetal and respiratory medicine (for long term ventilated children), children's cancer and the neonatal units. Neighbouring hospitals currently supported by the specialist teams in Leicester are at risk of no longer be able to look for support for their more complex patients from within the East Midlands. These include hospitals in Burton, Coventry, Kettering, Northampton and Peterborough. Paediatric ECMO services cannot be delivered without the specialist expertise of the paediatric cardiac surgical team and although adult ECMO may be sustainable in the short term there will be need to be adjustments to that service to make it sustainable in the long term as staff who currently work with both children and adults may not chose to work in an adult only service.	Enonomic/Property loss	Weekly staff communications briefings. Regular staff 'open' meetings to provide opportunity for concerns to be raised. Dedicated EMCHC project manager recruited. Dedicated project campaign resourced. Data manager employed to monitor EMCHC KPIs and performance. Legal advice instructed (Sharing the same legal team with Brompton Hospital). Opening additional ward capacity to meet the commissioning cardiac standards. UHL performance recognised by the Care Quality Commission who, in their initial feedback letter following their inspection in June 2016, reported: "We noted the excellent clinical outcomes for children following cardiac surgery at Glenfield Hospital. EMCHC website developed High priority activity strategy to meet the standard of 375 cases per year Trust Board led challenge to reject the NHSE decision by way of a signed letter by the CEO (05/07/16). NHS England visit to Leicester QC to brief the legal options to the TB in Oct 2016 Expansion of Ward 30 to open an extra 7 beds Liaising with East Midlands MP's	Extreme	Likely	20	Preparation ahead of the public consultation - due 21 Apr 17 Invitation for cardiac referrals to network hospitals - due 24 Apr 17	8	Nicola Savage

Risk ID	CMG	Specialty	Risk Title	Review Date	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2403	Corporate Nursing	Infection prevention	There is a risk changes in the organisational structure will adversely affect water management arrangements in UHL	19/08/2014	30/Jun/17	Causes National guidance from the Health and Safety Executive advise that water management should fall under the auspices of hospital infection Prevention (IP) teams. Lack of clarity in UHL water management policy/plan since the award of the Facilities Management contract to Interserve and the previous assurance structure for water management has been removed had meant that a suitable replacement has not yet been implemented. As of May 2016 Interserve no longer provide Facilities Management Services for UHL. The systems and process for water management are being reviewed. This review is expected to be complete by February 2017 Consequences Resources not identified at local (i.e. ward/ CMG) or corporate (e.g. Interserve /IPC) level to perform flushing of water outlets leading to infection risks, including legionella pneumophila and pseudomonas aeruginosa to patients, staff and visitors from contaminated water. Non-compliance with national standards and breeches in statutory duty including financial penalty and/or prosecution of the Chief Executive by the HSE Adverse publicity and damage to reputation of the Trust and loss of public confidence Loss/interruption to service due to water contamination Potential for increase in complaints and litigation cases	Quality	Instruction re: the flushing of infrequently used outlets is incorporated into the Mandatory Infection Prevention training package for all clinical staff. Infection Prevention inbox receives all positive water microbiological test results and an IPN daily reviews this inbox and informs affected areas. This is to communicate/enable affected wards/depts to ensure Interserve is taking necessary corrective actions. Flushing of infrequently used outlets is part of the Interserve contract with UHL and this should be immediately reviewed to ensure this is being delivered by Interserve All Heads of Nursing have been advised through the Nursing Executive Team and via the widely communicated National Trust Development Action Plan (following their IP inspection visit in Dec 2013) that they must ensure that their wards and depts are keeping records of all flushing undertaken and this must be widely communicated Monitoring of flushing records has been incorporated into the CMG Infection Prevention Toolkit (reviewed monthly) and the Ward Review Tool (reviewed quarterly). Senior Infection Prevention Nurse working with Facilities.	Major	Almost certain	20	Senior infection prevention nurse working with Facilities around water management arrangements. Backfill funding for this post has been agreed. Recruitment to the infection prevention nursing post due 31/3/17 Revised Water Management Policy and Water Safety Plan approved by the Trust Infection Prevention Committee. Implementation programme to be confirmed by Facilities colleagues - 31/3/17	4	Elizabeth Collins

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2404	Corporate Nursing	Infection prevention	There is a risk that inadequate management of Vascular Access Devices could result in increased morbidity and mortality	19/08/2014	30/Jun/17	Causes: There is currently no process for identifying patients with a centrally placed vascular access (CVAD) device within the trust. Lack of compliance with evidence based care bundles identified in areas where staff are not experienced in the management of CVAD's. There are no processes in place to assess staff competency during insertion and ongoing care of vascular access devices. Inconsistent compliance with existing policies. Consequences: Increased morbidity, mortality, length of stay, cost of additional treatment non-compliance with epic-3 guidelines 2014, non-compliance with criteria 1, 6 and 9 of the Health and Social Care Act 2010 and non-compliance with UHL policy B13/2010 revised Sept 2013, and UHL Guideline B33/2010 2010, non-compliance with MRSA action plan report on outcomes of root cause analyses submitted to commissioners twice yearly	Quality	UHL Policies are in place to minimise the risk to patients that staff are required to adhere too. A revised data report is being produced for the January 2017 Trust Infection Prevention Assurance Committee that will provide greater transparency with regard to audit results and allow Clinical Management Group boards and Senior staff the insight into areas that require actions to address poor performance	Major	Almost certain	20	CVAD's identified on Nerve Centre - There has been discussion with the Nervecentre team developers and this may now be possible. Further discussion to take place - 31/3/17 Development of an education programme relating to on-going care of CVAD's - 31/3/17 Targeted surveillance in areas where low compliance identified via trust CVC audit - Yet to be established due to lack of staff required. For further review by the Vascular Access Committee - 31/3/17 Develop the recommendations of the Vascular Access Committee action plans to increase the Vascular Access Team within the Trust in line with other organisations. Business Case to be submitted within the organisation by the CSI CMG with support from the Assistant Medical Director appointed by the Medical Director to oversee this objective - 31/3/17	16	Elizabeth Collins

Risk ID	CMG	Specialty	Risk Title	Review Date	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2471	CMG 1 - Cancer, Haematology, Urology, Gastroenterology & Surgery		There is a risk of poor quality imaging due to age of equipment resulting in suboptimal radiotherapy treatment.	05/Dec/14	30/04/2017	Causes: Using equipment beyond the recommended replacement age. Bosworth was 10 years old in November 2015, national guidance as well as the radiotherapy service specification recommends that LinearAccelerators are replaced after 10 years. Machines older than this are considered technically outdated, less accurate and increasingly unreliable. Manufacturer support is usually withdrawn after about 10 years with serious risk of a major breakdown which may not be repairable due to obsolescence of spare parts. Poor quality images due to deterioration of the imaging panel make it difficult and occasionally impossible to compare planned and set-up positions using the acquired images. This could lead to a geographic miss i.e. incorrect area treated. Unavailability of online correction capability may result in acquisition of several high dose images in order to safely correct and check patient position. These high dose images are used since the ageing technology available on this machine does not support good quality low dose kilovoltage imaging.	Quality	Increase in imaging dose (up to 10 MU) to produce a usable image. This however restricts the number of times an image may be repeated (due to dose limits). N.B imaging dose of 1MU is used on the Varian treatment machines. Pre-selection of patients with a reduced imaging requirement are booked on Bosworth. However this list is getting fewer and fewer due to best practice and national guidelines. We have introduced long day working on Varian machines to absorb patients that cannot be treated on Bosworth due to imaging limitations Clear Set-Up instructions plus photographs are provided to treatment staff to aid set-up. These do not fully eliminate the risk due to variable patient stability and condition hence the need for on-treatment imaging. Regular update meetings to check on progress of building works	Major	Likely	16	Replacement of Linac - 30/4/17; Building works underway prior to installation of the new Linac all on schedule. Linac due to be delivered at the end of January 2017. Linac due to be clinical from end of April 2017 following commissioning. NHS England's chief executive Simon Stevens, announced on 6th Dec 2016 that Leicester's Hospitals will receive a new linear accelerator (LINAC) as well as the chance to access a share of £200m of NHS England funding over two years to improve local cancer services. Leicester's Hospitals are part of the first wave of 15 NHS Trusts to benefit from a major national investment in NHS radiotherapy machines.	4	Lorraine Williams

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2264	CMG 1 - Cancer, Haematology, Urology, Gastroenterology & Surgery (CHUGGS)		Risk to the quality of care and safety of patients due to reduced staffing in GI medicine/Surgery and Urology at LGH and LRI	30/03/2017 03/Dec/13	There is a risk to the quality and safety of patients through poor staffing levels in GI medicine surgery & urology at the LGH & LRI. Causes Bank not filling shifts resulting in ward running below minimum safe numbers regularly. Agency contracts for some wards but not always filled and at times nurses do not turn up. Existing staff sickness rates increasing. No duty manager for support during the day at LGH and there have been several occasions in the last few weeks where there has been no night duty manager. Consequences Difficult to release sister or deputies for non clinical duties due to pt care being priority. Despite existing controls, some shifts manned with one RN from area and 1 borrowed from other wards or agency, leading to acute care being prioritised and other jobs being left. Best Shot and repositioning not completed in timely fashion. All documentation not being completed. IV's being given late. Patients waiting in triage and poor communication regarding progress with beds. . Appraisal rate low, Over due Datix forms Need to close triage due to difficulty in staffing area leading to lack of capacity for emergencies. Triage being regularly opened due to lack of beds which puts extra workload on already minimal staffing levels.	Patients (Clinical/Safety)	-Staffing levels checked on daily basis and staff movement from other areas decided by Matron on site/bleep holder. Head of Nursing and Deputy Head of Nursing available at weekends to advise about staffing moves. -All shifts required out to bank and agency contract due to lack of fill from Staff bank for some areas, other wards adhoc. -Over time offered to all staff in advance. -Reassurance and support from Matron where possible to pick up non clinical duties and sickness management, bank requests etc	Major	Likely	16	CHUGGS Participation in all international recruitment during 2016; Deputy Head of Nursing to meet with HR Shared Services on a monthly basis; Active recruitment to Assistant Practitioner posts - due 31/01/17; Closed 26/Jan/2017. Participate in recruitment from Philippines and India; Pilot increased bank rates of pay on all GI, Medicine and Surgery and Urology wards at LRI and LGH CHUGGS Participation in all international recruitment during 2016 - 30 Mar 17 Participate in recruitment from Philippines and India - 30 Mar 17 Trainee associate nurses to be recruited as part of LLR pilot - 30 Mar 17 Corporate HCA recruitment to be a priority for CHUGGS - 30 Mar 17 Realignment of bedbase between G22 and G20 to support reduced staffing on G22 - 30 Mar 17 Matrons to work adhoc clinical shifts to support wards with high vacancies - 30 Mar 17 Shifts for ward 22 at LRI/LGH and SAU's on both sites going to third tier two weeks in advance - 30 Mar 17	6	Georgina Kenney

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2819	CMG 2 - Renal, Respiratory, Cardiac & Vascular (RRCV)		Risk of lack of ITU and HDU capacity will have a detrimental effect on Vascular surgery at LRI	25/04/2016	01/Jun/17	Causes Lack of beds in ITU and HDU available to Vascular Surgery causing delays to complex, high-risk surgery at LRI. Consequences Mental, emotional and physical impact on patients of having their surgery cancelled at very short notice. Clinical risk associated with rupture of the AAA. Negative impact on RTT performance. Loss of income if patient is transferred to another hospital. Negative effect on the reputation/morale of the Department. Risk of incurring financial penalties resulting from potential 28-day breaches following same-day cancellation. Potential to hinder strategic move to secure complex, Level 1 activity from other Trusts in East Midlands (discussions with some Trusts are underway). Waste of Consultant and Theatre Team resource. Vascular Surgery deals with patients who have critical limb ischaemia, aneurysm disease and symptomatic carotid disease and left untreated the outcomes in these patients would be worse than patients with cancer. Patients with these diagnoses are on par with those that have cancer. Vascular Surgery has to achieve the national AAA target which is designed to improve quality of patient care.	Quality	Highlighting of ITU bed requirement day before to Gold Meeting attendee by text via Operational Manager Book ITU bed requirement as soon as the need is identified and await confirmation No business continuity plan - patients would need to be sent to another hospital	Major	Likely	16	Daily monitoring and escalation from Vascular Surgeons to GOLD if no ITU bed available - 31.5.17 Monthly monitoring of ITU cancellations via Operational Planning Group - 31.5.17 Monthly reporting of ITU cancellations to CMG quality and safety performance meetings (with Exec) - 31.5.17	12	Sarah Taylor

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2820	CMG 2 - Renal, Respiratory, Cardiac & Vascular (RRCV)	Clinical Decisions Unit	Risk that a timely VTE risk assessment is not performed on admission to CDU meaning that subsequent actions are not undertaken	01/Jun/16 31/03/2017	Causes of the risk: VTE risk assessment form not completed Lack of understanding or awareness of process to ensure VTE risk assessment form completed to the requirements of National Guidelines (http://guidance. nice.org.uk/CG92) Insufficient communication and reminders of process to relevant staff CDU Medical Clerking Proforma layout results in the VTE risk assessment being missed or delayed completion Consequences of the risk: Potential risk of patient developing VTE, resulting in prolonged length of stay and risk to health Financial loss to the CDU unit and UHL due to VTE risk assessment form not being recorded on patient centre and any Impact on delivery of monthly VTE target of 95% for UHL Impact on quality indicators and maintaining external standards and reputation	Patients (Clinical/Safety)	Interim solution to highlight the VTE risk assessment form on the CDU Medical Clerking proforma with a bold red/white sticker. Raise awareness at Junior Doctor Local Induction training. Close monitoring of the monthly VTE target with support from VTE nurse specialist. Complete ‘spot check’ audit at least once a month - complete	Major	Likely	16	Review current CDU Medical Clerking proforma and agree changes through correct Trust procedures to ensure the VTE risk assessment form is prominent (12 months of old stock) - 1.10.16. - emailed Caroline Baxter for a response - 18.11.16 - An SpR has been identified to review the CDU medical clerking proforma - 31.3.17	3	Karen Jones

Risk ID	CMG	Specialty	Risk Title	Review Date	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2193	CMG 4 - Intensive Care, Theatres, Anaesthesia, Pain Management & Sleep (ITAPS)	Theatres	There is a risk that the ageing theatre estate and ventilation systems could result in an unplanned loss of capacity at the LRI	31/03/2017	28/06/2013	Causes: The Theatre and Recovery estate and supporting plant(s) are old, unsupported from a maintenance perspective and not fit for purpose. There is recent history of unplanned loss of surgical functionality at the LRI site due to plant failure, problems with sluice plumbing and ventilation. In addition, the poor quality of the floors, walls, doors, fittings and ceilings mean an unfit working environment from a working life, infection prevention and patient experience perspectives. There is insufficient electricity and medical gas outlets per bed. Aged electrical sockets resulting in actual and potential electrical faults - fire in theatres at LRI (Theatre 4) in July 2013. There have been occasions where the cooling system has failed. There are issues with leaking roofs in the theatre estate. Consequences: Periodic failure of the theatre estate (ventilation etc) so elective operating has to cease. Risk of complete failure of the theatre estate so elective and emergency operating has to stop. Increase risk of patient infections. Poor staff morale working in an aged and difficult working environment. Difficulty in recruiting and retaining specialised staff (theatre and anaesthetic) due to poor working environment.	Quality	Regular contact with plant manufacturers to ensure any possible maintenance is carried out. Use of limited charitable funds available to purchase improvements such as new staff room chairs and anaesthetic stools - improve staff morale. TAA building work completed. Recovery area rebuild completed. Compliance with all IP&C recommendations where estate allows. Purchase of new disposable curtains for recovery area, reducing infection risk and improving look of environment. A minor refurbishment programme has taken place which included replacement of doors and seals and repair or replacement of balancing flaps - this has had a minor beneficial effect on the performance of the systems. Low air change rates in some Theatres and Anaesthetic rooms - assurance to address safety concerns to patients and staff from issues such as potential dangerous anaesthetic gases, an independent survey was conducted on a worst case basis (Theatre 16) during 2016. The report stated the following: The exposures measured in this study are not so high as to cause significant concern in relation to the Workplace Exposure Limit for nitrous oxide. On the basis of these results, it is reasonable to assert that staff exposure to nitrous oxide and the anaesthetic agents in the areas in which monitoring took place was compliant with the COSHH Regulations 2002.	Major	Likely	16	Ventilation audit actions to be undertaken as per Trust wide working party - Staged approach - short, medium and long term actions to be monitored monthly. Some remedial works completed in LRI Theatres and some floors and doors repaired and replaced. Higher risk areas have had remedial actions to improve ventilation flow and await results. Higher risk anaesthetic room (TH 16) has been tested for nitrous oxide and volatile gases and results demonstrated no risk to patients or staff. On going works and funding to be finalised. Review progress of refurbishment of LRI theatres - 31/03/17 Further update 08/02/17 - Provisional plan once capital agreed to use Theatre 7 and place back into service Theatre 18 to enable rolling programme of maintenance for theatre ventilation works and required upgrades.	4	Gaby Harris

Risk ID	CMG	Specialty	Risk Title	Review Date	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2955	CMG 6 - Clinical Support & Imaging (CSI)		If system faults attributed to EMRAD are not expediently resolved, Then we will continue to expose patient to the risk of harm	31/03/2017	17/01/2017	Causes: Slow and unresponsive radiology reporting system. Unavailability of reports associated with old films / scans. Inability to hold and compare multiple images or use integral work lists. Breast Care Services lost 50% of previous images due to integration failure between breast system (IDI) and GE PACS. Increased system navigation steps has reduced productivity by 50% in some modalities. Inability to use imaging sharing function across consortium. Consequences: Delays to the delivery of clinical diagnosis, treatment and ultimately discharged arrangements due to slow image retrieval system. Unavailability of previous images to be viewed concurrently with recent images enhances the likelihood misdiagnosis on a daily basis. Unable to meet PHE 5 day reporting targets (currently at 12 days) which could result in PHE ceasing UHL screening programme. Cancellation of clinics. UHL delivering a substandard service due to pending a resolution from developers on the reported system faults.	Patients (Clinical/Safety)	Use of out sourcing in order to make up for reduced service efficiency Conference calls with GE to ensure system faults are expediently brought to their attention for a swift resolution in order to minimise service impact. Continued meetings with GE and IMT to obtain solutions and deadline dates to restore service efficiency. Log of system faults recorded and monitored to ensure developers are finding resolutions in a timely manner.	Major	Likely	16	1. Review Meeting to be held with GE of all outstanding system issues. 2. GE to provide breakdown of reported issues with the EMRAD system and feedback on their resolution (with timescales - although GE have stated some items they will not be able to provide timescale) - 18th Mar 17. 3. GE to upgrade eRC to version 6.05 to rectify performance issues and crashes (to resolve issues with reporting examinations) - Currently due March (GE currently updating timescales as this was originally scheduled for December) - 31 Mar 17 4. GE to resolve pulling of prior images and integration of IDI with UVWEB for loading mammography images - Ongoing and GE have not provided resolution timeframe. - Awaiting confirmation of dates 5. Review and resolution of system reference data processes and management of central reference data that impacts on patient care - Due to discuss with IT 18th Mar 17, no resolution date agreed. - 18 Mar 17	4	Cathy Lea

Risk ID	CMG	Specialty	Risk Title	Review Date	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
1206	CMG 6 - Clinical Support & Imaging (CSI)	Cross Sectional Imaging (CT/MRI)	There is a risk that a backlog of unreported images in plain film chest and abdomen could result in a clinical incident	31/03/2017	28/07/2009	Causes Backlog of unreported images on PAC'S (Plain Film, CT, MRI) which could lead to a major clinical risk incident and a potential for litigation and adverse media publicity. Royal College Radiologists guidelines state that all images should be reported IRMER require all images involving ionising radiation to be clinically evaluated Consequences Risk of suboptimal treatment Potential for patient dissatisfaction / complaint Potential for litigation	Patients (Clinical/Safety)	Ongoing reporting by radiologists and reporting radiographers Allocation of CT/MRI examinations to a intended radiologist or specialty group House keeping done by clerical and superintendents to ensure images are visible on PACS. Outsourcing overdue reporting to medica.	Major	Likely	16	Housekeeping of unreported work by Superintendents - 30/Mar/2017 Use external company for plain xray - 30/Mar/2017	6	ARI
2378	CMG 6 - Clinical Support & Imaging (CSI)	Pharmacy	There is a risk that Pharmacy workforce capacity could result in reduced staff presence on wards or clinics	31/03/2017	19/06/2014	Causes: High levels of vacancies and sickness High levels of activity Training requirements for newly recruited staff Consequences: There is a risk that arises because of pharmacy workforce capacity across multiple teams which will result in reduced staff presence on wards or clinics, as well as capacity for core functions. This will result in reduced prescription screening capacity and the ability to intervene to prevent prescribing errors and other medicines governance issues in a number of areas including some high risk.	Human Resources	extra hours being worked by part time staff, payment for weekend commitment / toil and reduction in extra commitments where possible team leaders involved in increased 'hands' on delivery staff time focused on patient care delivery (project time, meeting attendance reduced) Prioritisation of specific delivery issues e.g. high risk areas and discharge prescriptions, chemo suite . Reduced presence at non direct patient focused activities e.g. CMG board/ Q&S and delay projects / training where possible. Revised rotas in place to provide staff/ service based on risk Recruit 8A pharmacists to replace those promoted to 8B Release band 3 staff to support onc/haem satellite	Major	Likely	16	Review methotrexate from LRI and move onto chemocare - 31/03/2017 payment offered for additional slots to cover weekend and late night gaps - until 31/3/2017 Recruitment of band 5 and band 7 to vacancies - 30/4/2017	8	Claire Elwood

Risk ID	CMG	Specialty	Risk Title	Review Date	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2391	CMG 7 - Women's and Children's (W&C)		There is a risk of inadequate numbers of Junior Doctors to support the clinical services within Gynaecology & Obstetrics	24/06/2014	30/Jun/17	Causes: Currently there are not enough Junior Doctors on the rota to provide adequate clinical cover and service commitments within the specialties of Gynaecology & Obstetrics. Consequences: Impact on key objectives and delivery of service. Potential to lose Junior Drs training within the CMG. Reduced training opportunities and inconsistencies in placements. On call rota gaps/ Increased requirement for locums to fill gaps. Possibility for LETB to remove training accreditation within obstetrics and gynaecology. This will lead to the removal of training posts. Potential for mismanagement / delay in patients treatment/pathway.	Patients (Clinical/Safety)	Locums used where available. Specialist Nurses being used to cover the services where possible and appropriate. Update 17/2/16 All antenatal clinics have a Consultant Lead present Rota accomodated to address specific training needs of juniors Rota reviewed and monitored on a daily basis by Dr representative Consultants act down if required X2 wte MTI to be recruited from overseas via RCOG	Major	Likely	16	Appoint to Trust Grade Post Due 30/06/2017	8	Cornelia Wiesender

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2153	CMG 7 - Women's and Children's (W&C)	Paediatrics	Shortfall in the number of all qualified nurses working in the Children's Hospital.	05/Mar/13	31/Aug/17	Causes The Children's Hospital is currently experiencing a shortfall in the number of Children's registered nurses. This is due to high numbers of vacancies and staff on maternity leave and long term sickness. Consequences There is a short fall in the number of appropriately qualified children's nurses in the Children's Hospital which could impact on the quality of patient care.	Human Resources	Where possible the bed base is flexed on a daily bases to ensure we are maintaining our nurse to bed ratios There is an active campaign to recruit nurses locally, national and internationally Additional health care assistance have been employed to support the shortfall of qualified nurses. Specialise Nurses are helping to cover ward clinical shifts. Cardiac Liaison Team cover Outpatient clinics Overtime, bank & agency staff requested Head of Nursing, Lead Nurse, Matron and ECMO Co-ordinator cover clinical shifts Adult ICU staff cover shifts where possible Recruitment and retention premium in place to reduce turn-off of staff Part time staff being paid overtime Program in place for international nurses in the HDU and Intensive Care Environment Second Registration for Adult nurses in place	Major	Likely	16	Continue to recruit to remaining vacancies - due 31/08/17 Second Registration cohort to complete course - due Sep 2017	8	HKI
2394	Communications		No IT support for the clinical photography database (IMAN)	04/Jul/14	21/Mar/17	Cause: IMAN stores the clinical photographs taken by the clinical photographers on behalf of clinical staff requesting them and form part of the patient's medical record. It contains >60,000 images of >9,000 patients since 2009. The hardware is supported by IM&T but is now out of warranty. The application software is no longer supported by its creator SEARCH Technologies (since April 2014). Consequence: If a fault were to occur with the database we cannot fix it. Clinicians would not be able to view the photographs of their patients. Patient safety will be jeopardised.	Patients (Clinical/Safety)	IM&T hardware support; IM&T Integration & Development team best endeavours to support the application software; separate backup of images on Apple server in Medical Illustration. Project brief published Nov 2014 for new database. Funding from IM&T agreed April 2015. Functional Specification for new system published Sep 2015. IM&T project support Oct 2015. IM&T project manager appointed Nov 2015. IM&T Functional Spec complete Dec 2015. Tender prepared Feb 2016. Supplier demos held Nov 2016. Supplier chosen Dec 2016.	Major	Likely	16	Tender document issued July 2016. Supplier responses received in Aug 2016. IM&T support agreed Oct 2016. Supplier demos completed by end Nov 2016. Preferred supplier chosen Dec 2016. Final costs being agreed Jan-Feb 2017. Funding sought from IM&T/RIC Jan-Mar 2017.	1	Simon Andrews

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2237	Corporate Medical		There is a risk of results of outpatient diagnostic tests not being reviewed or acted upon resulting in patient harm	30/04/2017 07/Oct/13	Causes Outpatients use paper based requesting system and results come back on paper and electronically. Results not being reviewed acknowledged on IT results systems due to; Volume of tests. Lack of consistent agreed process. IT systems too slow and 'lock up'. Results reviewed not being acted upon due to; No consistent agreed processes for management of diagnostic test results. Actions taken not being documented in medical notes due to; Volume of work and lack of capacity in relation to medical staff. Lack of agreed consistent process. Referrals for some tests still being made on paper with no method of tracking for receipt of referral, test booked or results. Poor communication process for communicating abnormal results back to referring clinician; Abnormal pathology results- cannot always contact clinician that requested test and paper copies of results not being sent to correct clinicians or being turned off to some areas. Suspicious imaging findings- referred to MDT but not always also communicated back to clinician that referred for test. Lack of standards or meeting standards for diagnostic tests in imaging for time to test and time to report.	Patients (Clinical/Safety)	Abnormal pathology results escalation process Suspicious imaging findings escalated to MDTs Trust plan to replace iCM (to include mandatory fields requiring clinicians to acknowledge results). Diagnostic testing policy approved.	Major	Likely	16	Awaiting ICE upgrade and implementation in outpatients - Update, Delivery date for ICE pilot roll out in TBC in near future Dr Steve Jackson and Ann Hall Project Manager will keep corporate risk management team aware - 30/04/17	8	Angie Doshani

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2247	Corporate Nursing	Corporate Nursing	There is a risk that a significant number of RN vacancies in UHL could affect patient safety	30/10/2013	30/04/2017	Causes: Shortage of available Registered Nurses (RN) in Leicestershire. Nursing establishment review undertaken resulting in significant vacancies due to investment. Insufficient HRSS Capacity leading to delays in recruitment. Consequences: Potential increased clinical risk in areas. Increase in occurrence of pressure damage and patient falls. Increase in patient complaints. Reduced morale of staff, affecting retention of new starters. Risk to Trust reputation. Impact on Trust financial position due to premium rate staffing being utilised to maintain safety. Increased vacancies across UHL. Increased pay bill in terms of cover for establishment rotas prior to permanent appointments. HRSS capacity has not increased to coincide and support the increase in vacancies across the Trust. Delays in processing of pre employment checks due to increased recruitment activity. Delayed start dates for business critical posts. Benefits of bulk and other recruitment campaigns not being realised as effectively as anticipated and expected. Service areas outside of nursing being impacted upon due to emphasis on nursing roles.	Patients (Clinical/Safety)	HRSS structure review. A temporary Band 5 HRSS Team Leader appointed. A Nursing lead identified. Recruitment plan developed with fortnightly meetings to review progress. Vacancy monitoring. Bank/agency utilisation. Shift moves of staff. Ward Manager/Matron return to wards full time.	Major	Likely	16	We have reviewed the recruitment process for HCA, recruited 125 to commence November 28th with a further plan to over recruit. Vacancies for HCAs in December 2016 were reported as 12wte We are not only recruiting nurses from EU, but are now going to India and the Philippines also, this recruitment has commenced, with all interviews completed, over 200wte nurses offered posts. These nurses will commence in post and impact on the vacancies from August 2017. TRAC is being implemented across the organisation to support streamlined recruitment Review 30/04/17	12	Maria McAuley

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1693	Operations		There is a risk of inaccuracies in clinical coding resulting in loss of income	30/04/2017 02/Aug/11	Causes: Casenote availability and casenote documentation. High workload (coding per person above national average). Unable to recruit enough staff to trained coder posts (band 4/5) Inaccuracies / omissions in source documentation (e.g. case notes and discharge summaries may not include co-morbidities, high cost drugs may not be listed). Coding proformas/ tick lists designed (LiA scheme and previously) but not widely used. Electronic coding (Medicode Encoder) implemented February 2012 but has no support model with IM&T. Consequences: Loss of income (PbR) £2-3 million potential (as at 31st May 2016). Non- optimisation of HRG. Loss of Trust reputation.	Enonomic/Property loss	As at Feb2017 - 5 Trainee Coders have completed their 21 Day Standards course. 3 of the 4 new trainees who commenced in 2015 have moved into trained Coder role (band 4). A Trainee Trainer has been appointed who will train to become our in-house Qualified Coding Trainer in March 2017. A further Accredited trainer has also been appointed to commence in Apr 2017.These posts are responsible for increasing clinical engagement with Coding as well as dedicated support to the new Trainees. Additional accommodation at LGH has been found and this is currently being refurbished ready for the next 4 trainees who will start in April 2017. Additional accommodation at GH is urgently needed. An audit cycle is established. Coding backlog is being currently at approximately <7 days (5500 cases uncoded). Reduced backlog minimises inefficiencies of multiple casenote transfers. Medicode (the Encoder interfaced to PAS) has been upgraded to the current version. An apprentice Coding runner has been employed to help with transfer of casenotes to the Coders for specific wards. Agency Coders are being used to backfill some of our vacant posts, but we are unable to adhere to the capped agency rates. An enhanced sessional weekend rate for our own trained Coders encourages additional weekend working.	Major	Likely	16	Provision of accommodation for expanded Coding Team - 31/03/17 Work with CMGs / ward clerks to maximise transfer of casenotes to Clinical Coding - 31/03/17 Establish comprehensive IT support model for Medicode - 31/03/17 Discontinue use of Agency Coders - 31/07/17	8	Shirley Priestnall

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2872	CMG 2 - Renal, Respiratory, Cardiac & Vascular (RRCV)		There is a risk of bedded bariatric patients being trapped compromising fire evacuation on ward 15 at GGH	27/06/2016	31/03/2017	Causes The two final exit doors to fresh air do not have sufficient exit width in order to facilitate the movement of bedded bariatric patients. Also there is a gradient on both escape routes. There must not be excessive gradients on escape routes which would prevent the free and controlled movement of the bariatric patients on beds/trolleys/wheelchairs. The gradients on the two escape routes from the final exits to fresh air will be difficult to overcome as Ward 15 is located at lower ground floor level. If bedded bariatric patients cannot use the two final exit doors they will need to be evacuated via the lift provided which is located in the means of escape outside the Ward; however this lift does not meet the appropriate standard to be used as an evacuation or fire fighting lift. Due to the nature of the patients (Respiratory), evacuating them directly to fresh air is not an ideal method of evacuation; the majority of the patients may also be bedded. It is important that the impact of evacuating respiratory patients directly to fresh air, taking into account all weather conditions, is assessed for suitability in regards to clinical needs. The Ward is currently used for up to 30 Respiratory patients and can accommodate a maximum of three bariatric patients at any one time.	Patients (Clinical/Safety)	Early warning fire detection system fitted (L1). The Ward is designed as a one hour fire compartment divided into four 30 minute sub-compartments; allowing a progressive horizontal phase evacuation within the Ward area. Staff awareness of the risk and staff attend annual fire safety training Fire evacuation plans in place for the Ward to include transfer of bedded bariatric patients to chairs where possible. Personal Emergency Evacuation Plans for patients considered to be at risk (in conjunction with the UHL Fire safety officer). LFRS Western Fire Brigade aware and have this included in their action cards when attending Glenfield site.	Extreme	Possible	15	Estates to provide quote to upgrade lift to a suitable dedicated evacuation lift to move bedded bariatric patients from the area - 31.3.17 Estates to provide quote to install a new fire escape in bay 2 - 31.12.16 - Update 18 Jan 2017 - Risk Owner has sent an email to estates and facilities requesting a progress update on the two remaining actions. Update 13.2.17 - We have received the Compliance Analyses Report from our consultants and there many areas highlighted that indicate unsuitability for hosting Bariatric Patients on this ward. The report highlights not just fire risk/evacuation concerns but also health and safety issues for staff/patients and patients. There also clinical operational issues that indicate the area unsuitable for these patients at this time according to the relevant compliance documentation. Taking guidance from this report, to bring the Ward into a condition fit for this category of patient will require a considerable capital outlay and an exdended period of works both in and around the ward area.	6	Vicky Osborne

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2837	CMG 3 - Emergency & Specialist Medicine (ESM)		There is a risk of delay in acting upon monitoring investigation results in patients with multiple sclerosis.	09/May/16	31/03/2017	Causes All results are sent as a paper copy to the named consultant's in-tray. There is duplication of workload as results are sent to the same consultant more than once in the space of 2 months even if a result has been noted, acted upon, a letter dictated and filed. The number of patients with multiple sclerosis on disease modifying therapies (DMT) requiring monitoring has significantly increased year on year to now around 500 patients. The number of disease modifying therapies available has increased by 4 in the past year to 12 different options. Each of these disease modifying therapies have varying frequency of blood test and other monitoring investigations. The resulting complexity of monitoring requirements and number of tests sent in the internal post as paper results to be checked by the MS team (2 consultant neurologists and 1.6 WTE MS nurses) increases the risk of results being mislaid or an unacceptable delay in reviewing and acting upon results.	Patients (Clinical/Safety)	"Paper results for blood, urine tests and MRI scans are sent to consultant. "Face-to-face outpatient clinic reviews by doctors or MS nurses.	Extreme	Possible	15	Dawn on hold until additional; MSSN Business Case has been approved by RIC. Plan to review DAWN progress due 31/03/2017	2	Ian Lawrence

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1196	CMG 6 - Clinical Support & Imaging (CSI)		No comprehensive out of hours on call rota and PM cover for consultant Paediatric radiologists	30/03/2017	29/06/2009	Causes: There are Consultant Radiologists on call however there are not sufficient numbers to provide an on call service. Registrars are available but they have variable experience. Lack of cover for PM work Consequences: Delays for patients requiring Paediatric radiological investigations. Sub-optimal treatment. Paediatric patients may have to be sent outside Leicester for treatment. Potential for patient dissatisfaction / complaints. Consultants are called in when they are not officially on call and they take lieu time back for this, resulting in loss of expertise during the normal working day. Delays in reports for Pathology and Coroner	Patients (Clinical/Safety)	To provide as much cover as possible within the working time directive. Registrars cover within the capability of their training period. Other Radiologists assist where practical however have limited experience and are unable to give interventional support. Locums are used when available.	Moderate	Almost certain	15	Review out of hours provision for EM. 30 Mar 2017	2	Rona Gidlow

Risk ID	CMG	Specialty	Risk Title	Review Date	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2787	CMG 6 - Clinical Support & Imaging (CSI)	Medical Records	Failure of medical records service delivery due to delay in electronic document and records management (EDRM) implementation	17/02/2016	30/04/2017	Causes: Insufficient staffing to manage current levels of activity. Since 2013 all vacancies have been filled with fixed term contracts due to EDRM project. Paediatric EDRM rollout with failure of UHL staff to follow correct new business change processes - has not resulted in the expected reduction in activity. Delay in Adult EDRM rollout. Consequences: large-scale cancellation of requests, late availability of case notes and subsequent impact to patients including cancellation of procedures and appointments. Insufficient staffing to support the Access to Health records service leading to breaches of statutory compliance to government targets in relation to access requests. Also breeches or internal and external timescale for litigation and inquest cases which could result in financial penalties. Insufficient staffing leading to non-compliance with health & safety requirements due to overcrowded library storage areas. Also this increases the potential for increased staff long-term sickness due to musculoskeletal injuries as a result of working environment. increase in complaints about the service.	Patients (Clinical/Safety)	Use of A&C bank staff where possible, though very limited in supply. Use of overtime from remaining substantive staff (though dwindling due to duration of the EDRM project and subsequent delays); staff are tired and under pressure. Cancellation of non-clinical requests for case notes daily (e.g. audit) to minimise disruption to front line clinical need (though with clear consequent impact on other areas of service delivery). On going urgent recruitment to existing vacancies. A waiting list of suitable applicants has been created to minimise the risk of the current staffing levels reoccurring in the future. Medical records management supporting HRSS by chasing references and other checks. Daily review of staffing levels and management of requests with concentration of staffing in areas of greatest demand and clinical priority.	Moderate	Almost certain	15	- Exec team approved additional staffing to support pause in paediatric EDRM - interviews in July 16, awaiting start dates for new starters, waiting list exhausted back out to interview 13/9/16 - 30/11/16 - new starters now coming in during December and January 2017 - 9 new starters Jan/Feb 2017 so small recruitment gap now - Weekly monitoring of patients TCI cancelled due to notes availability undertaken by med recs management, reported and discussed with each CMG to aid learning with monthly report to CSI exec as part of assurance process - 30/04/17 EDRM for paeditrics given go ahead Feb 2017 - awaiting update and timeline from IM&T - DW to chase - 31/03/17	4	Debbie Waters

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2965	CMG 6 - Clinical Support & Imaging (CSI)	Pharmacy	If we do not address Windsor pharmacy storage demands, then we may compromise clinical care and breach statutory duties	23/12/2016	31/03/2017	Causes: Insufficient floor space within Windsor pharmacy - unable to adequately provide secure storage to meet pharmaceutical demands for the LRI site. There are acute issues with accommodating new treatments or changes to medications that require an increase in storage demands. Insufficient cold storage for pharmaceuticals - Fridges over capacity. Year on year increase in requirements for storage/fridge/freezer space due to changing product lines- this is not a new issue, but significant increase in scale and frequency of issue within Q3 and rapidly worsening position. Consequences: Increased likelihood of patients missing doses due to stock outs as inadequate quantities of some lines being kept. Delay or denial of new treatments due to insufficient suitable storage capacity. Inability to switch to preparations that are safer for patients e.g. ready made injectables due to requirement for increased storage space-this has contributed to an 'Never event'. Potential for statutory breaches resulting in improvement notices and critical reports from General Pharmaceutical Council. Increased wastage of drugs due to poor storage conditions/fridge failure. Economic impact with procuring more expensive drugs that have to be stored at room temperature. Inability to clean the walk-in cold store due to lack of decant facilities.	Patients (Clinical/Safety)	Reduction/removal of non-pharmaceutical products to other areas. Transfer of non-pharmaceutical consumables to external storage containers. Additional fridges purchased to maximum capacity. Direct delivery of IV fluids to ward areas where possible. Regular pest control visits with reports monitored.	Moderate	Almost certain	15	Complete Phase 2 of aseptic unit/pharmacy stores redevelopment as per existing business case and 17/18 capital plan - March 2018 Review fridge capacity and where necessary purchase additional fridges once space available through redevelopment (identified within 17/18 plans) - March 2018 Review stockholding-pilot of managed stockholding reduction - Feb 2017 Identify additional stockholding area external to pharmacy (SUP request submitted and response awaited) Identify items that can be stored out of dept and/or on an alternative site to release capacity - March 2017 Implement identified plans to maximise fridge capacity to temporarily mitigate -scope opportunities for further fridges within current space and temporarily use of fridges designated for clinical trials use - March 2017	6	Claire Ellwood

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2601	CMG 7 - Women's and Children's (W&C)	Gynaecology	There is a risk of delay in gynaecology patient correspondence due to a backlog in typing	31/03/2017	24/08/2015	Causes: An increase in the number of referrals to gynaecology services. 1.0 wte vacancy of an audio typist. Bank and Agency staff being used to reduce typing backlog are not consistent especially during holiday periods. In addition delays can occur due to Consultants working cross-site and not accessing results promptly in order for the letters to be completed. Consequences: Delay in timely appointment letters to patients Delay in patients receiving results Delay in patients receiving follow up appointments Breach in the Trust standard for typing and sending out of patients letters (48 hours maximum time from date of dictation) As at 21/08/15 - there is a delay in gynaecology correspondence to the patient of: - 8 weeks following a general gynaecology appointment at LRI - 8 weeks for 1st appointment letters for Colposcopy at LRI - 1 week and 5 days for colposcopy result letters at LRI - 10 days for communication to GP with regards to the patient.	Quality	2 week wait clinics or any letters highlighted on Windscribe in red are typed as urgent. Weekly admin management meeting standing agenda item: typing backlog by site also by Colposcopy and general gynaecology. Using Bank & Agency Staff. Protected typing for a limited number of staff.	Moderate	Almost certain	15	Clearance of backlog of letters - due 31/3/2017	6	DMAR

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2925	Estates & Facilities		Reduction in capital funding may lead to a failure to deliver the 2016/17 medical equipment capital replacement programme	25/08/2016	28/May/17	Causes Reduction in capital funding due to the requirement to deliver the UHL deficit control total for 2016/17 Consequences Failure to replace all capital medical equipment items previously agreed for the 2016/17 plan Increased risk of patient harm if equipment becomes unsafe Delays to treatment and potential adverse impact on RTT targets/ waiting times Unanticipated expenditure due to increased frequency of equipment breakdown or requirement for urgent replacement if beyond economic repair Equipment becomes technologically inadequate Risk of adverse media attention and loss of reputation	Quality	Emergency contingency funds are maintained by the Medical equipment executive (MEE) - but funding is limited Supplier maintenance contracts are in place for key equipment some of them including the facility for emergency loan for breakdowns Medical physics also maintain some items of medical equipment not on contract	Extreme	Possible	15	Agree Capital funding for 2016/17 - 31/12/16 Prioritise emergency bids and rolling replacement plans 31/3/17	10	Darryn Kerr

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2402	Corporate Nursing	Infection prevention	There is a risk that inappropriate decontamination practice may result in harm to patients and staff	19/08/2014	30/Jun/17	Causes: Endoscope Washer Disinfector (EWD) reprocessing is undertaken in multiple locations within UHL other than the Endoscopy Units. These areas do not meet current guidelines with regard to a.Environment b.Managerial oversight c.Education and Training of staff There is decontamination of Trans Vaginal probes being undertaken within the Women's CMG and Imaging CMG according to historical practice, that is no longer considered adequate. Bench top sterilisers within Theatres continue to be used. The use of these sterilisers is monitored by an AED. Purchase of Equipment is not always discussed with the Decontamination Committee. Consequences: Lack of oversight of Decontamination practice across the Trust Equipment purchased may not be capable of adequate decontamination if not approved by Infection Prevention Current Endoscope Washer Disinfectors (EWD) re-processing locations (other than endoscopy units) are unsatisfactory. All of the above having the potential for inadequately decontaminated equipment to be used Patient harm due to increased risk of infection Risk to staff health either by infection or chemical exposure Reputational damage to the organisation Financial penalty Risk of litigation	Patients (Clinical/Safety)	Surgical instrument decontamination outsourced to third party provider. Joint management board and operational group oversee this contract. The endoscopy units undergo Joint Advisory Group on GI endoscopy (JAG) accreditation. This is an external review that includes compliance with decontamination standards. Current policy in place for decontamination of equipment at ward level. Equipment cleanliness at ward level is audited as part of monthly environmental audits and an annual Trust wide audit is carried out. Benchtop sterilisers are serviced by a third party Endoscope washer disinfectors are serviced as part of a maintenance contract Lead for Decontamination and Infection prevention team are auditing current decontamination practice within UHL. The responsibility for Decontamination within UHL is shared by the ITAPS Head of Operations and the Director of Infection Prevention (Chief Nurse) A Lead for Decontamination has been appointed a who will report to the CMG Head of Operations/DIPAC and be supported in this role by the Lead for Infection Prevention and the Infection Prevention Team.	Moderate	Almost certain	15	Review all education and training for staff involved in reprocessing reusable medical equipment - 31/3/17	3	Elizabeth Collins