RISK REPORT INCORPORATING THE BOARD ASSURANCE FRAMEWORK (BAF)

Author: Risk and Assurance Manager Sponsor: Acting Medical Director Date: Thursday 6 August 2015 PAPER N

Executive Summary

Context

The Board Assurance Framework (BAF) is the key source of evidence that links strategic objectives to risks, controls and assurances, and the main tool that the Trust Board should use in seeking assurance that internal control mechanisms are effective. This report provides the Trust Board (TB) with:-

a) The UHL 2015/16 BAF and action tracker as of 30th June 2015.
b) Notification of any new extreme or high risks opened during 30th June 2015.
c) Summary of all extreme and high risks on the UHL risk register

Questions

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

Conclusion

1. Input from Executive owners of each strategic objective should have provided an accurate picture of our principal risks affecting the achievement of our objectives.
2. Many of our assurance sources are based on internal monitoring and some may benefit from external scrutiny (e.g. via internal audit) to provide additional assurance that controls are effective.
3. No actions have breached their due dates however there are six actions where the original timescale for completion has been extended due to delays.
4. The board is provided with a quarterly summary of all UHL extreme and high risk that have been entered on the risk register

Input Sought

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

(a) note the actions identified to address any gaps in either controls or assurances (or both);

(b) identify any areas which it feels that the Trust's controls are inadequate and do not effectively manage the principal risks to our objectives;

(c) identify 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;

(d) identify any other actions necessary to address any 'significant control issues' in order to provide assurance on the Trust meeting its principal objectives;

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:

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

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

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

5. Scheduled date for the next paper on this topic: [03/09/15]

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: **TRUST BOARD**

DATE: **6th AUGUST 2015**

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

SUBJECT: **RISK REPORT INCORPORATING THE BOARD ASSURANCE FRAMEWORK (BAF)**

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1. INTRODUCTION

1.1 This report provides the Trust Board (TB) with:-

a) The UHL 2015/16 BAF and action tracker as of 30th June 2015.
b) Details of new extreme or high risks opened during June 2015.
c) Summary of all extreme or high risks currently on the UHL risk register.

2. 2015/16 BAF POSITION AS OF 30TH JUNE 2015

2.1 A copy of the 2015/16 BAF is attached at appendix one with any changes highlighted in red text. A copy of the action tracker is attached at appendix two with changes also highlighted in red text for ease of reference.

2.2 In relation to the above, the TB is asked to note the following points:

a. All principal risks have been updated by their owners and no action plans have elapsed due dates for this reporting period.

b. Six actions (2.2 – Chief Operating Officer, 5.3 – Director of Strategy, 6.1, 6.2 & 7.2 – Acting Medical Director and 18.2 – Chief Information Officer) have moved to an amber rating in response to delays affecting the completion dates.

c. Four actions have been completed during this reporting period, relating to principle risks five (5.2), six (6.3), seventeen (17.2) and nineteen (19.4) and the EPB is asked to consider whether the completion of these actions has closed the associated gaps.

d. In relation to principle risk eight, regarding insufficient engagement of clinical services, investment and governance to deliver the Genomic Medicine Centre project at UHL, three new actions have been identified to address the gaps in control.

e. There have been no changes to any of the current risks scores during this reporting period.

2.3 The role of the TB is to provide scrutiny and challenge in relation to the BAF to ensure that executive owners of each strategic objective have provided sufficient assurance that risks to the achievement of these are being effectively controlled. Following discussion at the July TB it was recommended that the following objective was submitted for scrutiny:
'A clinically sustainable configuration of services, operating from excellent facilities'

Particular emphasis will be placed on scrutiny of the Estates elements (i.e. principal risks 11, 12 and 13) and the Director of Facilities will therefore be in attendance for this agenda item.

3. EXTREME AND HIGH RISK REPORT.

4.1 To inform the TB of significant operational risks, a summary of all extreme and high risks (i.e. scoring 15 and above) as of 30th June 2015 is attached at appendix three. There are 47 risks on the UHL risk register scoring 15 and above.

4.2 Four new high risks have opened during June 2015 as described below and, for information, the details of these risks are included at appendix four.

Risk ID	Risk Title	Risk Score	CMG/ Directorate
2557	There is a risk that consultant and Jr Dr staffing levels in Glenfield ITU could impact on patient care	ITAPS	2557
2564	There is a risk that system issues with displaying past and present breast images could result in patient harm.	CSI	2564
2553	There is a risk of spread of infection due to inadequate levels of cleaning on the Neonatal Unit (NNU) at LRI.	W&C	2553
2562	There is a risk that 2 vacant consultant paediatric neurology vacancies could impact sustainability of the service	W&C	2562

4. RECOMMENDATIONS

4.1 The Trust Board is invited to:

(a) Receive and note this report;

(b) review and comment upon this version of the 2015/16 BAF, as it deems appropriate;

(c) note the actions identified to address any gaps in either controls or assurances (or both);

(d) identify any areas which it feels that the Trust's controls are inadequate and do not effectively manage the principal risks to our objectives;

(e) identify 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;

(f) identify any other actions necessary to address any 'significant control issues' in order to provide assurance on the Trust meeting its principal objectives;

Peter Cleaver
Risk and Assurance Manager

UHL BOARD ASSURANCE FRAMEWORK 2015/16

STRATEGIC OBJECTIVES

Objective	Description	Objective Owner(s)
a	**Safe, high quality, patient centred healthcare**	**Chief Nurse** /Medical Director
b	**An effective and integrated emergency care system**	**Chief Operating Officer/** Medical Director/ Chief Nurse
c	**Services which consistently meet national access standards**	**Chief Operating Officer**
d	**Integrated care in partnership with others**	**Director of Strategy**
e	**Enhanced delivery in research, innovation and clinical education**	**Medical Director**
f	**A caring, professional and engaged workforce**	**Director of Human Resources**
g	**A clinically sustainable configuration of services, operating from excellent facilities**	**Director of Strategy** / Director of Estates and Facilities
h	**A financially sustainable NHS Foundation Trust**	**Director of Finance**
i	**Enabled by excellent IM&T**	**Chief Information Officer**

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

PERIOD: JUNE 2015

Risk No.	Link to objective	Risk Description	Risk owner	Current Score	Target Score
1.	**Safe, high quality, patient centred healthcare**	Lack of progress in implementing UHL Quality Commitment (QC).	CN	9	6
2.	**An effective and integrated emergency care system**	Demographic growth plus ineffective admission avoidance schemes may counteract any internal improvements in emergency pathway	COO	20	6
3.	**Services which consistently meet national access standards**	Failure to transfer elective activity to the community , develop referral pathways, and key changes to the cancer providers in the local health economy may adversely affect our ability to consistently meet national access standards	COO	9	6
4.	**Integrated care in partnership with others**	Existing and new tertiary flows of patients not secured compromising UHL's future more specialised status.	DS	15	10
5.		Failure to deliver integrated care in partnership with others including failure to: Deliver the Better Care Together year 2 programme of work Participate in BCT formal public consultation with risk of challenge and judicial review Develop and formalise partnerships with a range of providers (tertiary and local services) Explore and pioneer new models of care. Failure to deliver integrated care.	DS	15	10
6.	**Enhanced delivery in research, innovation and clinical education**	Failure to retain BRU status.	MD	9	6
7.		Clinical service pressures and too few trainers meeting GMC criteria may mean we fail to provide consistently high standards of medical education.	MD	9	4
8.		Insufficient engagement of clinical services, investment and governance may cause failure to deliver the Genomic Medicine Centre project at UHL	MD	9	6
9.		Changes in senior management/ leaders in partner organisations may adversely affect relationships / partnerships with universities.	MD	6	6
10	**A caring, professional and engaged workforce**	Gaps in inclusive and effective leadership capacity and capability , lack of support for workforce well- being, and lack of effective team working across local teams may lead to deteriorating staff engagement and difficulties in recruiting and retaining medical and non-medical staff	DHR	16	8
11.	**A clinically sustainable configuration of services, operating from excellent facilities**	Insufficient estates infrastructure capacity and the lack of capacity of the Estates team may adversely affect major estate transformation programme	DS	20	10
12.		Limited capital envelope to deliver the reconfigured estate which is required to meet the Trust's revenue obligations	DS	12	8
13.		Lack of robust assurance in relation to statutory compliance of the estate	DS	12	8
14.		Failure to deliver clinically sustainable configuration of services	DS	12	8
15.	**A financially sustainable NHS Organisation**	Failure to deliver the 2015/16 programme of services reviews, a key component of service-line management (SLM)	DS	9	6
16		Failure to deliver UHL's deficit control total in 2015/16	DF	15	10
17		Failure to achieve a revised and approved 5 year financial strategy	DF	15	10
18	**Enabled by excellent IM&T**	Delay to the approvals for the EPR programme	CIO	16	6
19		Perception of IM&T delivery by IBM leads to a lack of confidence in the service	CIO	16	6

BAF Consequence and Likelihood Descriptors:

Impact/Consequence			**Likelihood**	
5	Extreme	Catastrophic effect upon the objective, making it unachievable	5	Almost Certain (81%+)
4	Major	Significant effect upon the objective, thus making it extremely difficult/ costly to achieve	4	Likely (61% - 80%)
3	Moderate	Evident and material effect upon the objective, thus making it achievable only with some moderate difficulty/cost.	3	Possible (41% - 60%)
2	Minor	Small, but noticeable effect upon the objective, thus making it achievable with some minor difficulty/ cost.	2	Unlikely (20% - 40%)
1	Insignificant	Negligible effect upon the achievement of the objective.	1	Rare (Less than 20%)

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 1	Lack of progress in implementing UHL Quality Commitment (QC).	**Overall level of risk to the achievement of the objective**	**Current score 3x3=9**	**Target score 3x2=6**
Executive Risk Lead(s)	Chief Nurse			
Link to strategic objectives	Provide safe, high quality, patient centred healthcare			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Corporate leads agreed for each goal and identified leads for each work stream of the Quality Commitment (QC).	3 monthly and / or 6 monthly progress reports to EQB and QAC.	Vacancies within clinical staff will affect implementation of QC	Nurse and medical workforce recruitment strategies (1.1)	Milestone review July 2015 MD&CN
KPIs agreed and monitored for all parts of the Quality Commitment.	Monthly Q&P Report to TB. 3 monthly and / or 6 monthly progress reports to EQB and QAC. Exception reporting where KPIs/ outcomes not achieved External validation and benchmarking data including: Dr Foster Intelligence Copeland Risk adjusted barometer (CRAB) Hospital Evaluation data	Currently only 30% of deaths are screened and there is a requirement to move to 100%. Vacancies within clinical staff grades may adversely affect our ability to implement this.	Roll out plan to be developed (1.2) Audit support to be provided (1.3) Monitor uptake (1.4) Mortality database to be developed (1.5) As action 1.1	Sep 2015 MD July 2015 MD Review July 2015 MD&CN July 2015 MD As action 1.1
Clear work plans agreed and monitored for all parts of the Quality Commitment.	Action plans reviewed regularly at EQB and as a minimum annually reported to QAC. Annual reports produced. Internal audit review during 2014/15 for each arm of			

	QC CQC inspection during 2015/16 Commissioner review of work plans/ progress via CQUIN. Internal Audit.			
Robust governance and committee structures in place to ensure delivery of the quality agenda	Regular committee reports. Annual reports. Achievement of KPIs. Senior accountable individuals with appropriate support			

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 2	Demographic growth plus ineffective admission avoidance schemes may counteract any internal improvements in emergency pathway	**Overall level of risk to the achievement of the objective**	**Current score 4x5=20**	**Target score 3x2=6**
Executive Risk Lead(s)	Chief Operating Officer			
Link to strategic objectives	An effective and integrated emergency care system			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Agreed set of metrics that measure internal and external emergency care performance	Reported to UHL TB monthly Reported to EPB monthly Reported to UHL Emergency Quality Steering Group monthly Performance reported at UHL Gold Command meeting daily Reported to UCB and CCGs National benchmarking of emergency care data	Attendance and admissions continue to increase (+5% and (+7%).	UHL is working with LLR colleagues to identify a more effective work of reducing attendances and admissions. Plan to achieve this to be presented to UCB (2.2)	July 2015-COO
LLR Action plan to improve patient flow (i.e. admissions, reduction in discharge delays, making best use of existing ED capacity		(c) LLR action plan not fully implemented	Continue to implement and monitor progress of LLR action plan (2.1)	Review Sep 2015 COO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 3	Failure to transfer elective activity to the community , develop referral pathways, and key changes to the cancer providers in the local health economy may adversely affect our ability to consistently meet national access standards	**Overall level of risk to the achievement of the objective**	**Current score 3x3=9**	**Target score 3x2=6**
Executive Risk Lead(s)	Chief Operating Officer			
Link to strategic objectives	Services which consistently meet national access standards			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Agreed set of metrics that measure referrals activity and waiting times	Reported to EPB quarterly Reported to Trust Board monthly Reported to UHL Access meeting – weekly Reported to RTT Board weekly (with representation from TDA & CCGs) Weekly diagnostics meeting Engaged with Intensive Support Team (specialist services) Now delivering Admitted, non-admitted and incomplete 18 week RTT standards	Have yet to implement tools and processes that allow us to improve our overall responsiveness through tactical planning (c) Currently not delivering the 62 day and 31 day cancer access standard (c) Anticipated failure of diagnostic 6 week standard in June due to endoscopy overdue planned patients	Theatre productivity improvements driven through the cross-cutting work stream. (3.3) Recovery of cancer standards - revised action plans with revised trajectory for 62 day compliance. (3.4) Recovery of diagnostic 6 week standard - Medinet (outsource company) to provide additional capacity (3.5)	Jul 2015 COO September 2015 COO September 2015 COO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 4	Existing and new tertiary flows of patients not secured compromising UHL's future more specialised status.	**Overall level of risk to the achievement of the objective**	**Current score 5x3=15**	**Target score 5x2=10**
Executive Risk Lead(s)	Director of Strategy			
Link to strategic objectives	Integrated care in partnership with others.			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Appointment to Head of Tertiary Partnerships role to lead on formalising and securing existing pathways and developing new ones.	Monthly reporting to ESB as part of Director of Strategy report.	(c) Significant amount of partnership work being taken through ESB.	Considering options/benefits/risks of establishing UHL Partnership Board. (4.1)	Jul 2015 DS
Children's and Cancer Collaborative Groups established with NUH.	Monthly reporting to ESB as part of Director of Strategy report.	(c) Significant amount of partnership being taken through ESB.	As action 4.1	As action 4.1
Memorandum of Understanding (MoU) between NUH and UHL signed in 2011.	Monthly reporting to ESB as part of Director of Strategy report.	(c) MoU was intended to support establishment of EMPATH and should include wider partnership opportunities.	MoU to be reviewed by both organisations. (4.2)	Jul 2015 DS
Partnership Board for Specialised Services established in Northamptonshire. Membership includes Northants CCGs; NHS England; KGH; NGH and UHL.		(a) Does not feed into UHL Governance Structure.	Future minutes to be included DS report to ESB. (4.3)	Jul 2015 DS
Meetings in place and planned at Director level with other provider organisations (regional and national) to explore partnership opportunities.	Monthly reporting to ESB as part of Director of Strategy report.	None	None	

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Principal risk 5	**Failure to deliver integrated care in partnership with others including failure to:** Deliver the Better Care Together year 2 programme of work; Participate in BCT formal public consultation with risk of challenge and judicial review; Develop and formalise partnerships with a range of providers; Explore and pioneer new models of care. Failure to deliver integrated care.	**Overall level of risk to the achievement of the objective**	**Current score 3x5=15**	**Target score 2x5=10**
Executive Risk Lead(s)	Director of Strategy			
Link to strategic objectives	An effective and integrated emergency care system; Services which consistently meet national access standards; A clinically sustainable configuration of services, operating from excellent facilities; A financially sustainable NHS Foundation Trust			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
PLANNING • BCT Programme five year directional plan developed and agreed in June 2014. • Two-year operational plan approved in April 2014. • LLR BCT Strategic Outline Case approved and submitted centrally December 2014.	LLR BCT Partnership Board bi-monthly, attended by the chief executive and medical director. Ad hoc updates from the chief executive to Trust Board as part of the chief executive report			
GOVERNANCE - Robust BCT and UHL/BCT project governance structure: • LLR BCT Partnership Board - overarching responsibility for setting, implementing and reporting the BCT Programme • UHL/BCT Programme Board	Monthly UHL/BCT Programme Board progress reports to Executive Strategy Board LLR wide performance monitoring report presented to Trust Board			
DELIVERY - Robust system wide project delivery structure and organisational specific delivery mechanisms • LLR project delivery through LLR Implementation Group • Organisational delivery (UHL/BCT Programme Board) Project specific delivery (UHL Beds/theatres/OP etc.)	Monthly project specific highlight reports considered at UHL/BCT Programme Board	(a)LLR wide dashboard required so that performance can be monitored	A BCT Programme Dashboard is to be established and agreed with the BCT PMO. Dashboard to be aligned and consolidated to the UHL Reconfiguration Dashboard highlighting	Aug 2015 DS

	Monthly project specific highlight reports	(a) Lack of Triangulation and assurance of plans at organisational and system wide level.	progress/risks against the eight BCT work streams (5.3) BCT PMO to facilitate triangulation process (5.4)	Jul2015 DS
PUBLIC CONSULTATION • Update on plans for Public consultation considered and approved by LLR BCT Partnership Board in March 2015. • The programme will carry out an overarching consultation for the whole system change, paying specific attention to areas of particular public interest and is targeted to take place in autumn 2015.	Monthly reports are submitted to the LLR BCT Partnership Board, last one submitted March 2015	(c)No detailed plans for overall change. These will form the basis for the narrative for formal consultation.	Plan for consultation including a full governance roadmap to be completed. (5.8)	Jul 2015 DMC
EXPLORING PIONEERING NEW MODELS OF CARE TO SUPPORT THE DELIVERY OF INTEGRATED CARE Proposal for proof of concept for a single Integrated Frail Older Person Service (LPT/UHL/GE Finnamore) prepared Proposed establishment of an Institute of Frail Older People Services Programme management arrangements in place (early April, 2015)	Verbal update to Executive Strategy Board (April 2015) Progress reports are to be submitted to the Executive Strategy Board on a monthly basis	Project plan and early progress not yet developed	Integrated Frail Older Person Service project plan to be developed (5.9)	Jul 2015 DS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 6	Failure to retain BRU status.	**Overall level of risk to the achievement of the objective**	**Current score 3x3=9**	**Target score 3x2=6**
Executive Risk Lead(s)	Medical Director			
Link to strategic objectives	Enhanced reputation in research, innovation and clinical education			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Maintaining relationships with key partners to support joint NIHR/ BRU infrastructure	Joint BRU Board (bimonthly) Annual Report Feedback from NIHR for each BRU (annual) UHL R&D Executive (monthly) R&D Report to Trust Board (quarterly)	(c) Requirement to replace senior staff and increase critical mass of senior academic staff in each of the three BRUs.	BRUs to re-consider theme structures for renewal, identifying potential new theme leads. (6.1) BRUs to identify potential recruits and work with UoL/LU to structure recruitment packages. (6.2)	Dec 2015 MD Dec 2015 MD
	Athena Swan Silver Status by University of Leicester and Loughborough University. (The Athena Swan charter applies to higher education institutions)	(c) Athena Swan Silver not yet achieved by UoL and Loughborough University. This will be required for eligibility for NIHR awards	UoL and LU to ensure successful applications for Silver swan status. Individual medical school depts will need to separately apply for Athena Swan Silver status. (6.4)	Mar2016 MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 7	Clinical service pressures and too few trainers meeting GMC criteria may mean we fail to provide consistently high standards of medical education.	**Overall level of risk to the achievement of the objective**	**Current score 3 x 3 = 9**	**Target score 2 x 2 = 4**
Executive Risk Lead(s)	Medical Director			
Link to strategic objectives	Enhanced reputation in research, innovation and clinical education			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	
Medical Education Strategy	Department of Clinical Education (DCE) Business Plan and risk register are discussed at regular DCE Team Meetings and information given to the Trust Board quarterly Oversight by Executive Workforce Board Bi-monthly UHL Medical Education Committee meetings (including CMG representation) Database of recognised Trainers required by GMC 2016 Appointment processes for Level 3 educational roles established Appraisal of Level 2 educational roles in UHL appraisal KPI are measured using the: • UHL Education Quality Dashboard • CMG Education Leads and stakeholder meetings • GMC Trainee Survey results • UHL trainee survey • Health Education East Midlands	(c) Education facilities Identified as poor in external reports from HEEM and Leicester University (a) Lack of accountability and transparency of educational funding income and expenditure (c) Ineffective control of clinical service pressures, vacancies and loss of posts on rotas that adversely	Continue to improve facilities i.e. to re-provide LRI Jarvis education centre in 1771 building, provide UHL Simulation facility and consider feasibility of Glenfield as an expanding training site (7.2) Engagement with CMGs in ensuring education expenditure matches income (7.3) Medical education quality dashboard, SPA time in job plans for training, support for CMG	Nov 2015 MD Aug 2015 MD Aug 2015 MD

	Accreditation visits	affect quality of training and added impact of	Medical Education leads and local faculty groups (College Tutors etc) (7.4)	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 8	Insufficient engagement of clinical services, investment and governance may cause failure to deliver the Genomic Medicine Centre project at UHL	**Overall level of risk to the achievement of the objective**	**Current score 3x3=9**	**Target score 3x2=6**
Executive Risk Lead(s)	Medical Director			
Link to strategic objectives	Enhanced reputation in research, innovation and clinical education			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Genomic Medicine Centre project manager for UHL in place Nominated UHL GMC lead, with UHL leads for both cancer and rare diseases Trust GMC Steering Committee in place	GMC Report to UHL R&I Executive (bimonthly) R&I minutes (inc. GMC report) to ESB bimonthly Weekly NHS England/Genomics England: Reports to UHL GMC Steering Committee via Cambridge GMC Update in R&I Report to Trust Board (quarterly) Trust GMC Steering Committee minutes Local delivery monitoring against recruitment trajectory KPI via R&I Office when project live Delivery monitoring against recruitment trajectory KPI by Lead GMC Partner when project live	(c) Workforce education around genomics (c) Transformation in clinical services (c) Transformation in public attitudes towards genomic medicine	Work with AHSN, HEEM and GMC Lead organisation to develop appropriate training for clinical and non-clinical staff (8.1) Support CMGs with transformation of GMC project into clinical services (8.2) Work with AHSN and centre for BME Health to coordinate public engagement activity aimed at (i) raising expectation of participating in the GMC project and (ii) benefits to patients of genomic medicine (8.3)	March 2016 MD March 2016 MD June 2016 MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 9	Changes in senior management/ leaders in partner organisations may adversely affect relationships / partnerships with universities.	**Overall level of risk to the achievement of the objective**	**Current score 3x2=6**	**Target score 3x2=6**
Executive Risk Lead(s)	Medical Director			
Link to strategic objectives	Enhanced reputation in research, innovation and clinical education			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Maintaining relationships with key academic partners. Developing relationships with key academic partners. Existing well established partners: • University of Leicester • Loughborough University Developing partnerships; • De Montfort University • University of Nottingham • University College London (Life Study) • Cambridge University (100k project)	Minutes of joint UHL/UoL Strategy meetings Minutes of Joint BRU Board Minutes of NCSEM Management Board Meetings of Joint UHL/UoL research office Life steering group meets monthly EM CLAHRC Management Board reports via R&D Exec to ESB	(c) Contacts with Universities could be developed more closely	Develop new 4 way strategy meeting with UHL, UoL, LU and DMU (9.2)	March 2016 MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 10	Gaps in inclusive and effective leadership capacity and capability , lack of support for workforce well-being, and lack of effective team working across local teams may lead to deteriorating staff engagement and difficulties in recruiting and retaining medical and non-medical staff	**Overall level of risk to the achievement of the objective**	**Current score 4x4 = 16**	**Target score 4x2 = 8**
Executive Risk Lead(s)	Director of Human Resources			
Link to strategic objectives	A caring, professional and engaged workforce			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Organisational Development Plan	Reported to EWB quarterly Reported to Trust Board quarterly Internal Audit assurance via 2014/15 Programme Key Performance Indicators included within OD plan	(a) Lack of scrutiny of the Organisational Health Dashboard at CMG level	Scrutinise at CMG level the organisational health dashboard at quarterly intervals (10.1)	Sep 2015 DHR
LIA Programme	LIA Sponsor Group meet monthly Reported to EWB quarterly Reported to Trust Board quarterly (as part of the OD report).	(c) Analysis of LIA dataset has identified some key areas for improvement – coded as: Frustrations; Focus on Quality; Structures and leadership	Continue with the spread of LiA to enable staff to make contributions to changes and improvements at work (10.2)	Mar 2016 DHR
Workforce Planning	Reported to EWB quarterly Reported to Trust Board quarterly (as part of OD plan) Key Performance Indicators included in organisational health dashboard and NTDA submission and include: Pay spend against plan Staff number (wte) against plan Safe staffing levels within clinical areas	(c) Affordability against workforce plan is an issue related to lack of substantive staff leading to increase in premium spend	CMGs to produce a trajectory of premium spend linked to recruitment with which will be monitored through the weekly CMG performance meetings and Cross	Mar 2016 DHR

			Cutting Workforce Meeting. (10.3)	
		(c) No national guidance currently in place in relation to nursing revalidation and therefore UHL plan based on draft/ consultation documents (c) Lack of resource for appraisals and third party confirmer processes and access to CPD for bank only nurses (c) registrants currently do not have time built into their shifts to complete revalidation requirements (approx. 8 hour per year per registrant required)	Once national guidance received we will need to identify the resources required to implement the nursing revalidation guidance and submit business cases for funding (10.13)	Mar 2016 CN
Medical Workforce Strategy Medical Workforce Group Medical Workforce Design and Recruitment group	Outputs reported to EWB (quarterly) and CQRG (bi-annually)	(c) Lack of effective processes for international recruitment. (c) Lack of a systematic approach to design by new teams around the patient. (c) Lack of clarity on gaps in junior Dr supply as a result of	Training for clinicians on role redesign and functional mapping (10.11) Work with HEEM to influence posts to be redistributed	Dec 2015 MD Mar 2016 MD

		broadening foundation and redistribution	(10.12)	
Leadership into Action Strategy	Reported to EWB quarterly Reported to Trust Board quarterly (as part of OD plan) National staff survey responses Staff friends and family test responses LiA 'pulse check' responses East Midland Academy Board receives reports in relation to the monitoring of utilisation and quality of East Midlands Academy Board leadership programmes.	(c)Negative feedback from surveys in relation to leadership issues	Improvements in local leadership and the management of well led teams including holding to account for the basics (10.4)	Mar 2016 DHR
Equality Action Plan	Twice yearly progress report to Trust Board, EWB,EQB and Commissioners KPIs for monitoring are contained within the Public Sector Equality duty	(c) Low BME representation at band 7 or above	NED apprenticeship scheme to be implemented (10.5) Targeted interventions for BME band 5 and 6 to be developed and implemented (10.6)	Mar 2016 DMC Mar 2016 DMC
Compliance with national 'Freedom to Speak' standard including: 3636 concerns hotline Junior Dr 'gripe tool' Patients Safety walkabouts UHL intranet 'staff room' Clinical Senate Monthly 'Breakfast with the Boss' forums Whistleblowing' policy Anti-Bullying / harassment policy Director of Safety and Risk	Regular (quarterly) reporting to EQB in relation to 'whistleblowing 3636 hotline CQC Patient Safety Junior Dr 'gripe tool' Regular reports from Clinical senate	(c)Not yet appointed a 'Freedom to Speak' Guardian (a) No formal publication of actions taken as a consequence of concerns raised (c)Nominated managers for receipt of concerns not yet identified (c) Need better links with National helpline	Await national guidance in relation to this post (10.7) Undertake actions from 'Freedom to Speak' gap analysis (10.8) CMGs to nominate appropriate managers (10.9) TBA	Sep 2015 MD Sep 2015 MD Sep 2015 MD TBA MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 11	Insufficient estates infrastructure capacity and the lack of capacity of the Estates team may adversely affect major estate transformation programme	**Overall level of risk to the achievement of the objective**	**Current score** 5x4=20	**Target score** 5x2=10
Executive Risk Lead(s)	Director of Facilities			
Link to strategic objectives	A clinically sustainable configuration of services, operating from excellent facilities			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Link the reconfiguration investment programme demands with current infrastructure, identifying future capacity requirements Current infrastructure details being gathered for all three acute sites identifying high risk elements of engineering and building infrastructure	Highlight reports developed monthly and reported to the Programme Board	(a) Effective governance arrangements for oversight and scrutiny of this work are yet to be agreed. PMO developing reporting format	Plans being developed and liaison between Estates and Strategy team programmed (11.6)	July/ August 2015 DEF/DS
		(c) A programme of infrastructure improvements is yet to be identified	Assessment of current capacity being established (11.7)	Sep 2015 DEF
		(c) Timescale issues for infrastructure works which could impact on the overall programme have not yet been identified and quantified in relation to risk	Develop a programme of works (11.2)	Aug 2015 DEF
			Develop an operational risk register for the projects (11.3)	Sep 2015 DEF
Capital programme with ring fenced capital funding to support future capacity demands	Capital Investments Monitoring Committee	(c) Currently no identified capital funding within 2015/16	Identification of investment required and	Sep 2015 DEF/DoF

		programme and future years	allocation of capital funding (11.4)	
An established Estates and Facilities team with detailed knowledge of the estates and reconfiguration programme	Regular reports to Executive Performance Board (EPB)	(c) Conflicting responsibilities/roles of the estates and facilities team between UHL and the LLR estate and Facilities Management Collaborative	Define resource and skills gaps and agree an enhanced team structure to support the significant reconfiguration programme (11.5)	Sep 2015 DEF

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 12	Limited capital envelope to deliver the reconfigured estate which is required to meet the Trust's revenue obligations	**Overall level of risk to the achievement of the objective**	**Current score** 4 x 3 = 12	**Target score** 4 x 2 = 8
Executive Risk Lead(s)	Director of Facilities			
Link to strategic objectives	A clinically sustainable configuration of services, operating from excellent facilities			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Individual project boards in place to manage and monitor schemes Merging of strategic clinical change projects into the Estates an Facilities Directorate	Project boards report to UHL Better Care Together (BCT) working group via monthly highlight reports Estates work stream reporting to the UHL – BCT Programme Board	(c) 'road map' requires development to provide the full picture and deliverability of the programme of change	PMO holding estates workshop and followed by a joint estates and strategy workshop (12.3)	August 2015 DEF/DS
5 year plan agreed with individual annual programmes developed each year	Capital Investment Monitoring Committee will monitor the overall programme of capital expenditure and early warning to issues	(c) Lack of Contingency funding	Discussions between D. Kerr and P. Traynor to identify funding (12.2)	Sep 2015 DEF

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 13	Lack of robust assurance in relation to statutory compliance of the estate	**Overall level of risk to the achievement of the objective**	**Current score 4x3=12**	**Target score 4x2=8**
Executive Risk Lead(s)	Director of Facilities			
Link to strategic objectives	A clinically sustainable configuration of services, operating from excellent facilities			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Outsourced facilities management contract performance managed by the Estates and Facilities Management Collaborative Defined KPI's which Interserve FM are measured against.	LLR FMC Board Monthly Contact Management Panel, and Service Review Meeting	(a) A lack of electronic evidence by IFM on compliance (a) Limited contractual KPI's on compliance	Additional assurance to be identified through spot checks and deep dive analysis (13.1) Develop improved software dashboard reporting (CASS) (13.2)	July 2015 DEF Sep 2015 DEF

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 14	**Failure to deliver clinically sustainable configuration of services**	**Overall level of risk to the achievement of the objective**	**Current score 4x3=12**	**Target score 4x2=8**
Executive Risk Lead(s)	Director of Strategy			
Link to strategic objectives	Clinically sustainable configuration of services, operating from excellent facilities			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Agreed capital programme with NTDA identified what resources the NTDA need to commence their approval processes	Monthly meetings with the NTDA to discuss the programme of delivery and identify new cases coming up for approval A monthly highlight report is submitted to the BCT-UHL Programme Delivery Board.	(c) Lack of capacity within the NTDA to resource each of the business cases	NTDA to look at providing a management and financial lead for each business case (14.1)	Sep 2015 DS
UHL structure and resources identified for delivery of the key projects • ITU • Vascular • Emergency Floor • Planned Treatment Centre • Maternity • Children's Hospital • Theatres • Beds • multi-storey car park Business Case Project resources identified against each project	A report is submitted to the BCT-UHL Programme Delivery Board on a monthly basis that tracks progress to date, including financial assurance, risks with mitigations	(a) Further work required looking at the remaining acute services at the LGH to determine the gap in the current capital plan	Work stream to be established to identify gaps (14.2)	Sep 2015 DS
Consultation- • BCT Consultation programme established • Each of the appropriate BC have a consultation and engagement plans in place and work closely through the UHL communication and engagement lead to ensure continuity with the BCT Plan	The communication lead for the business cases for women's sits on the wider BCT consultation work stream. This is led by UHL Director of Communications and Marketing. A monthly report is submitted to the BCT-UHL Programme Delivery Board from the communication and engagement work stream.			

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 15	Failure to deliver the 2015/16 programme of services reviews, a key component of service-line management (SLM)	**Overall level of risk to the achievement of the objective**	**Current score 3x3= 9**	**Target score 3x2=6**
Executive Risk Lead(s)	Director of Finance			
Link to strategic objectives	A financially sustainable NHS Organisation			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Overarching project plan for service reviews developed	Service Review Update and Roll Out Plan considered by ESB.	(c) Alignment with CIP and future operating model.	Discuss with the Director of CIP the Future Operating Model and that through this we will cement delivery (15.1)	Jul 2015 DS
Governance arrangements established which includes: - Monthly highlight reporting process embedded (includes progress, risks, issues, and mitigation) - Monthly updates / assurance reported to Integrated Finance, Performance and Investment Committee (IFPIC) and EPB as part of the Cost Improvement Programme paper.	Monthly reporting to IFPIC and EPB as part of CIP report.	(a) Monthly updates to ESB	High level updates to be included in the Director of Strategy's monthly report for ESB. (15.2)	Jul 2015 DS
Capacity bolstered through the appointment of: - Programme Support Officer appointed to coordinate the programme of service reviews, provide support to service leads, and to engage key stakeholders in the process e.g. heads of service, transformation managers, operational managers etc. - Transformation managers within CMGs who will support the facilitation of service reviews	N/A	(c) Capacity and level of clinical engagement determines when service reviews can happen and how many can run at any given time	Approach and scheduling of service reviews to be reviewed to ensure process remains viable and/or to identify resource requirement. (15.3)	July 2015 DS
Service reviews to be considered as part of the Clinical Strategy work stream which reports into the BCT UHL Delivery Board (and PMO) to ensure alignment with wider provision of data and intelligence designed to inform new models of care / ways of working	Monthly reporting to BCT UHL Delivery Board (PMO)	N/A	N/A	N/A

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 16	Failure to deliver UHL's deficit control total in 2015/16	**Overall level of risk to the achievement of the objective**	**Current score 5x3=15**	**Target score 5x2=10**
Executive Risk Lead(s)	Director of Finance			
Link to strategic objectives	A financially sustainable NHS organisation			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Completion and delegation of final, detailed income and expenditure control totals each CMG and Department within UHL	Final agreed financial plan including detailed budget book to IFPIC (draft in April 2015) in early May 2015 Full devolution of budgets to CMGs and Departments, clarity achieved by robust integrated planning process in advance of April 2015 Monthly reporting via Exec Performance Board, IFPIC and Trust Board			
Sign off and agreement of contracts with CCGs and NHSE including activity plans for all areas and the terms and conditions attached to the contracts in 2015/16	Detail of the agreed contracts to IFPIC (draft in April 2015) in early May 2015 Full devolution of activity and performance plans to CMGs and Departments, clarity achieved by robust integrated planning process in advance of April 2015 Monthly reporting via Exec Performance Board, IFPIC and Trust Board			
Finance and CIP delivery by CMGs at UHL	Weekly reviews between DoF/COO and all CMGs, covering key areas of performance including finance and CIPs Monthly reporting via Exec Performance Board, IFPIC and Trust Board	(c) CIP plans for 2015/16 do not total £43m (100%) as yet but are due for completion by end of July 2015	Full population of CIP plans by end July 2015 (16.2)	July 2015 COO/DoF
UHL service and financial strategy (as per SOC and LTFM)	Updates and reporting to the BCT UHL Monthly			

	Delivery Group (chaired by DS or DoF), reporting into Executive Strategy Board, IFPIC and Trust Board			
Identification and mitigation of excess cost pressures	Robust process involving the CEO to identify and fund where necessary any unavoidable cost pressures in advance of the start of 2015/16 Monthly reporting via Exec Performance Board, IFPIC and Trust Board			

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 17	Failure to achieve a revised and approved 5 year financial strategy	**Overall level of risk to the achievement of the objective**	**Current score 5x3=15**	**Target score 5x2=10**
Executive Risk Lead(s)	Director of Finance			
Link to strategic objectives	A financially sustainable NHS organisation			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Overall strategic direction of travel defined through Better Care Together	The pending approval of the Better Care Together Strategic Outline Case (SOC) by TDA and NHSE	(c) SOC not yet approved	Approval currently being sought (17.1)	CEO Date TBA
Financial Strategy fully modelled and agreed by all parties locally and nationally	2015/16 financial plan (as per existing LTFM) approved by both Trust Board and TDA LTFM being revised for review by Trust Board in mid-May Approval of the LTFM by the TDA will be sought late May into June depending on TDA governance process	(c)LTFM not yet approved	Liaise with TDA to agree process for LTFM submission and sign-off (17.3)	Jul 2015 DoF
Cash required for capital and existing deficit support	Trust Board have approved UHL's working capital strategy (in April 2015) In principle, TDA are supportive of the 5 year strategy and the cash/loan support that is required This will be formalised through TDA approval of BCT SOC and the revised LTFM	(c)SOC not yet approved (c)LTFM not yet approved	As above	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 18	Delay to the approvals for the EPR programme	**Overall level of risk to the achievement of the objective**	**Current score 4x4 =16**	**Target score 2x3=6**
Executive Risk Lead(s)	Chief Information Officer			
Link to strategic objectives	Enabled by excellent IM&T			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Communications with key contacts throughout the external approvals chain	Weekly meeting to discuss progress and issues. Updates on the IM&T transformation Board, EPR programme Board and the joint Governance Board.	(c) Local TDA approval has been given and the project now sits with the Department of Health who are unable to give us a clear timetable	Further work with NTDA/DoH to progress a firm timetable to the ATP (18.1)	Aug 2015 CIO
Communications with key contacts throughout the Internal approvals chain	Weekly meeting to discuss progress and issues. Updates on the IM&T transformation Board, EPR programme Board and the joint Governance Board.	(c) Lack of confirmed planning, hindered by the external ATP steps, could lead to delays in the internal processing of the final FBC	Further work to expose the executive and the Trust board to the likely shape of the FBC and the required internal steps. (18.2)	Aug 2015 CIO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 19	Perception of IM&T delivery by IBM leads to a lack of confidence in the service	**Overall level of risk to the achievement of the objective**	**Current score 4x4=16**	**Target score 3x2=6**
Executive Risk Lead(s)	Chief Information Officer			
Link to strategic objectives	Enabled by excellent IM&T			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Review of contractual deliverable and quality of service	External reviews, PWC and ISO 27001 Audit in 2014 Monthly service delivery board, covering all aspects of service delivery	(a) VfM review	Engage third party, as per contract, to asses and review VfM (19.1)	Aug 2015 CIO
Communication to end users of the performance of IBM and IM&T in service delivery	Monthly service delivery board, covering all aspects of service delivery Performance reports are available on InSite Project performance is reported quarterly through the trust executive	(c) Communication about successes is not sufficiently robust	Production of a quarterly newsletter available to all staff (19.3)	Aug 2015 CIO
End user's service meets their requirements	Liaison with the CMGs to ensure we are meeting their requirements Monitoring of complaints around the service and it's delivery	(c) No formal process, post the contract award, to test the delivery principles	Following LiA Event in June, plans are being created to address the gaps found in the user expectations of the service (19.5)	Aug 2015 CIO

Appendix two

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
ACTION TRACKER FOR THE 2015/16 BOARD ASSURANCE FRAMEWORK (BAF)

Monitoring body (Internal and/or External):	UHL Executive Team
Reason for action plan:	Board Assurance Framework
Date of this review	**June 2015**
Frequency of review:	Monthly
Date of last review:	May 2015

REF	ACTION	BOARD LEVEL LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
1	**Lack of progress in implementing UHL Quality Commitment (QC).**					
1.1	Nurse and medical workforce recruitment strategies	MD/CN		Review July 2015	Recruitment and redesign are two pillars of the Medical Workforce Strategy and are being taken forward through the Medical Redesign and Recruitment Group. International Medical Recruitment has a dedicated resource. Focus on nursing international recruitment continues, sharing of best practice amongst the disciplines to occur.	4
1.2	Roll-out plan to be developed to move to 100% screening of deaths	MD	HOE	September 2015	Process drafted and incorporated into policy. Being launched at M&M Lead's forum on 18th May.	4
1.3	Audit support to be provided.	MD	HOE	July 2015	Funding approved. M&M Clerks and analyst recruitment process commenced.	4
1.4	Monitor uptake of screening.	MD/CN	HOE	Review July 2015	Mortality death report revised to facilitate monitoring. HOE and Bank M&M Clerk meeting with M&M leads to agree monitoring process.	4
1.5	Mortality database to be developed.	MD/CN	HOE	Review July 2015	Database scoping exercise being undertaken. Awaiting feedback from potential providers. Excel spread sheet database being used in the meantime.	4

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

2	**Demographic growth plus ineffective admission avoidance schemes may counteract any internal improvements in emergency pathway**					
2.1	Continue to implement and monitor progress of LLR action plan	COO		Review September 2015		4
2.2	UHL is working with LLR colleagues to identify a more effective work of reducing attendances and admissions. Plan to achieve this to be presented to UCB in July	COO		~~June 2015~~ July 2015	Updated plan to UCB in July. Timescale for completion amended to reflect this.	3
3	**Failure to transfer elective activity to the community , develop referral pathways, and key changes to the cancer providers in the local health economy may adversely affect our ability to consistently meet national access standards**					
3.3	Theatre productivity improvements driven through the cross-cutting work stream.	COO		July 2015	Theatre CCT is concentrating on reducing out of hours sessions at present	4
3.4	Recovery of cancer standards	COO	W Monaghan / C Carr	September 2015	Revised tumour site plans and trajectory. Appointment of 3 band 7's to support key tumour sites underway.	4
3.5	Recovery of diagnostic 6 week standard	COO	W Monaghan / C Carr	September 2015	Main issue within endoscopy, Medinet IS provider starting additional capacity 1st week in July	4
4	**Existing and new tertiary flows of patients not secured compromising UHL's future more specialised status.**					
4.1	Consider options/benefits/risks of establishing UHL Partnership Board.	DS		July 2015	Discussions continue	4
4.2	Memorandum of Understanding (MoU) to be reviewed by both organisations.	DS		July 2015	Positive discussions have started at Chief Executive level between UHL and NUH looking at ways of working and taking a more strategic leadership position across the East Midlands. Priorities include cancer services, children's services, spinal services and engagement with United Lincolnshire Hospitals Trust	4
4.3	Future minutes of Partnership Board for Specialised Services to be included DS report to ESB.	DS		July 2015	A process has been put in place to ensure the minutes come to ESB under the strategy update	4

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

5	**Failure to deliver RTT improvement plan. Failure to deliver integrated care in partnership with others including failure to: Deliver the Better Care Together year 2 programme of work; Participate in BCT formal public consultation with risk of challenge and judicial review; Develop and formalise partnerships with a range of providers; Explore and pioneer new models of care. Failure to deliver integrated care.**					
5.2	BCT PMO establishing a master plan for regular LLR wide performance monitoring.	DS		June 2015	**Complete** - The BCT-PMO has established a master plan for performance monitoring	5
5.3	LLR wide business intelligence group established. UHL dashboard in draft to be used to inform LLR wide dashboard.	DS		~~May 2015~~ ~~July 2015~~ August 2015	UHL dashboard has been agreed and shared with the LLR BCT PMO team. Following June TB, a BCT Programme Dashboard is to be established and agreed with the BCT PMO. The dashboard is to be aligned and consolidated to the UHL Reconfiguration Dashboard highlighting progress/risks against the eight BCT work streams. The BCT dashboard to be presented to the August TB meeting.	3
5.4	BCT PMO to facilitate triangulation process for plans at an organisational and system level	DS		~~May 2015~~ July 2015	In progress – series of presentations going to the BCT delivery board in May June and July. Deadline extended to reflect the sequencing of presentations	3
5.8	Plan for consultation including a full governance roadmap to be completed.	DMC		July 2015		4
5.9	Project plan to be developed Integrated Frail Older Person Service Project plan to be developed	DS		~~May 2015~~ July 2015	The second workshop is to be held in June with the final report expected at the end of July. The report is to then go to the August ESB for approval. Work is on track to deliver the final report to the August ESB	3
6	**Failure to retain BRU status.**					
6.1	BRUs to re-consider theme structures for renewal, identifying potential new theme leads.	MD	Nigel Brunskill	~~June 2015~~ Dec 2015	Ongoing – Target date updated to align with schedule from NIHR	3

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

6.2	BRUs to identify potential recruits and work with UoL/ LU to structure recruitment packages.	MD	Nigel Brunskill	~~June 2015~~ Dec 2015	Ongoing – Target date updated to align with schedule from NIHR	3
6.3	UHL to use Research Capability Funding to pump prime appointments if possible and LU planning new academic appointments to support lifestyle BRU.	MD		June 2015	Complete - RCF allocated to BRUs; RCF used to support appointment package; LU have appointed a new academic	5
6.4	University of Leicester (UoL) and Leicester University to ensure successful applications for Silver Swan status.	MD		March 2016	VC and President has re-constituted group leading Medical School Bid with appointment of new project manager.	4
7	**Clinical service pressures and too few trainers meeting GMC criteria may mean we fail to provide consistently high standards of medical education.**					
7.2	Continue to improve facilities i.e. to re-provide LRI Jarvis education centre in 1771 building, provide UHL Simulation facility and consider feasibility of Glenfield as an expanding training site	MD		~~Sept 2015~~ November 2015	Meetings planned with facilities with Darryn Kerr, Gareth Faulkner and Stuart Turner and a draft strategy for medical education facilities development. However, it is necessary to develop an inter-professional strategy and work with other academic partners to develop facilities for the longer term. Deadline for strategy extended due to seasonal commitments.	3
7.3	Engagement with CMGs in ensuring education expenditure matches income	MD		August 2015	Meetings held with all CMGs, updates given about education and training issues and funding and supporting documentation to advice re calculation for expenditure. Follow up meetings will be held over next few months	4

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

7.4	Medical education quality dashboard, SPA time in job plans for training, support for CMG Medical Education leads and local faculty groups (College Tutors etc) to be developed	MD		August 2015	Quality dashboard is now being completed quarterly by education quality manager and education leads. Will be demonstrated as example of best practice on UK NACT website Local faculty group to be piloted with CMG education lead in O&G, DCE involved in College Tutor appointments but roles need to be funded and visible in job plans	4
8	**Insufficient engagement of clinical services, investment and governance may cause failure to deliver the Genomic Medicine Centre project at UHL**					
8.1	Develop appropriate training for clinical and non-clinical staff		Nigel Brunskill	March 2016	New action	4
8.2	Support CMGs with transformation of GMC project into clinical services		Nigel Brunskill	March 2016	New action	4
8.3	Coordinate public engagement activity aimed at (i) raising expectation of participating in the GMC project and (ii) benefits to patients of genomic medicine		Nigel Brunskill	June 2016	New action	4
9	**Changes in senior management/ leaders in partner organisations may adversely affect relationships / partnerships with universities.**					
9.2	Develop regular meeting with Universities	MD	Nigel Brunskill	March 2016	Develop new 4 way strategy meeting with UHL, UoL, LU and DMU	4
10	**Gaps in inclusive and effective leadership capacity and capability , lack of support for workforce well-being, and lack of effective team working across local teams may lead to deteriorating staff engagement and difficulties in recruiting and retaining medical and non-medical staff**					
10.1	Scrutinise at CMG level the organisational health dashboard at quarterly EWB.	DHR	J Tyler-Fantom	September 2015	Work is being undertaken in ensuring all fields/data are up to date in the Organisational Health Dashboard.	4
10.2	Continue with the spread of LiA to enable staff to make contributions to changes and improvements at work	DHR	B Kotecha	March 2016	Progress on track against LiA Year 3 Plan	4

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

10.3	CMGs to produce a trajectory of premium spend linked to recruitment to be monitored through the CMG performance and Cross Cutting Workforce Meeting.	DHR	B Kotecha	March 2016	Plans in place to reduce Premium Spend – implementation monitored by existing performance meetings (CIP/Workforce). Work is underway in populating the Workforce Modelling Tool with recruitment and workforce plans. Workforce tool is now being populated on a monthly basis and now plans are in place to monitor actions to reduce premium expenditure based on the DH toolkit	4
10.4	Improvements in local leadership and the management of well led teams including holding to account for the basics	DHR	B Kotecha	March 2016	Progress on track against Trust Wide Action Plan	4
10.5	NED apprenticeship scheme to be implemented	DMC	D Baker	March 2016	Proposal drafted - to be discussed at the June NED meeting.	4
10.6	Targeted interventions for BME band 5 and 6 to be developed and implemented	DMC	D Baker	March 2016	Graduate traineeship scheme under development focussed around recruitment at operational manager level. Communication Plan being developed in promoting leadership development opportunities to band 5 and 6 BME staff	4
10.7	Await national guidance in relation to the post of 'Freedom to Speak' Guardian	MD	DSR	September 2015		4
10.8	Undertake actions from 'Freedom to Speak' gap analysis	MD	DSR	September 2015		4
10.9	CMGs to nominate appropriate managers to receive staff concerns	MD	DSR	September 2015		4
10.11	Training for clinicians on role redesign and functional mapping	MD	AMD	December 2015	Resource identified through Better Care Together Team. Pilot work being undertaken in RRC re 'How to Staff a Ward Differently'.	4
10.12	Work with HEEM to influence posts to be redistributed	MD	AMD	March 2016	Good clinical and education team engagement in discussions relating to redistribution.	4

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10.13	Need to identify the resources required to implement the national nursing revalidation guidance and submit business cases for funding	CN		March 2016		4
11	**Insufficient estates infrastructure capacity and the lack of capacity of the Estates team may adversely affect major estate transformation programme**					
11.2	Develop a programme of works for infrastructure improvements	DEF	Nigel Bond	September 2015	Work in progress	4
11.3	Develop an operational risk register for the projects	DEF	Mike Webster	August 2015	Work in progress	4
11.4	Identification of investment required and allocation of capital funding	DEF	Nigel Bond/ Richard Kinnersley	September 2015	Work in progress	4
11.5	Define resource and skills gaps and agree an enhanced team structure to support the significant reconfiguration programme	DEF		September 2015	Work in progress	4
11.6	Plans being developed and liaison between Estates and Strategy team programmed to ensure effective governance and oversight and scrutiny of investment programme demands	DEF/DS		August 2015		4
11.7	Assessment of current capacity of Estates infrastructure being established	DEF		September 2015		4
12	**Limited capital envelope to deliver the reconfigured estate which is required to meet the Trust's revenue obligations**					
12.2	Discussions between D. Kerr and P. Traynor to identify contingency funding	DEF	Darryn Kerr	September 2015	Work in progress	4
12.3	PMO holding estates workshop and followed by a joint estates and strategy workshop to develop a 'road map' of deliverability and programme of change	DEF/DS		August 2015		4

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13	**Lack of robust assurance in relation to statutory compliance of the estate**					
13.1	Additional assurance to be identified through spot checks and deep dive analysis	DEF	Mike Webster	July 2015	Currently underway and reported in compliance monthly report	4
13.2	Develop improved software dashboard reporting (CASS)	DEF	Mike Webster	September 2015	Supplier identified, quotation accepted and plans to commence work in July	4
14	**Failure to deliver clinically sustainable configuration of services**					
14.1	NTDA to look at providing a management and financial lead for each of the business cases	DS		September 2015	Initial meeting was held on the 12.05.15 with the NTDA where they recognised the need for NTDA resource	4
14.2	Work stream to be established to identify gaps in the current capital plan	DS		September 2015	Work has started- the LTFM has been updated and a revised project programme has been put in place	4
15	**Failure to deliver the 2015/16 programme of services reviews, a key component of service-line management (SLM)**					
15.1	Discuss with the Director of CIP the Future Operating Model and that through this we will cement delivery	DS		July 2015	Discussions are on-going. A paper is to go to the EPB on the 28 June for approval	4
15.2	High level updates to be included in the Director of Strategy's monthly report for ESB.	DS		~~May 2015~~ July 2015	A paper went to the July ESB meeting on the evaluation of the service review process.	3
15.3	Approach and scheduling of service reviews to be reviewed to ensure process remains viable and/or to identify resource requirement.	DS		July 2015	Discussions have started	4
16	**Failure to deliver UHL's deficit control total in 2015/16**					
16.2	Full population of 2015/16 CIP plans to achieve £43million	DoF/COO	DCIPFOM	~~May 2015~~ ~~June 2015~~ July 2015	As of 2/7/15 there is an actual forecast of £41.4m. Agreement that actual forecast will be £43m by 28/7/15. Timescale for completion extended to reflect this.	3
17	**Failure to achieve a revised and approved 5 year financial strategy**					

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17.1	Approval to be sought for SOC	CEO		TBA (Awaiting information from BCT programme Board for approx. date)		
17.2	Production of revised LTFM and submission for approval to Trust Board and TDA	DoF		June 2015	**Complete**	5
17.3	Liaise with TDA to agree process for LTFM submission and sign-off	DoF		July 2015		4
18	**Delay to the approvals for the EPR programme**					
18.1	Further work with NTDA to progress a firm timetable to the ATP	CIO	E. Simons	~~May 2015~~ ~~June 2015~~ August 2015	Further reviews have happened with the NTDA. The recommendation has gone to, and been approved by, the local NTDA Capital investment Group in June 2015 The plan is now sitting with the DoH for their approval. No formal timetable for this has been given.	3
18.2	Further work to expose the executive and the Trust board to the likely shape of the FBC and the required internal steps.	CIO	E. Simons	~~July 2015~~ August 2015	Plan is currently being finalised for this action above	3
19	**Perception of IM&T delivery by IBM leads to a lack of confidence in the service**					
19.1	Engage third party, as per contract, to asses and review VfM	CIO	T. Hind	August 2015	Gartner have been approached to facilitate this work on behalf of the Trust and IBM	4
19.3	Production of a quarterly newsletter available to all staff	CIO	T. Webb	August 2015	Plans are in place	4
19.4	LiA event to surface any issues with the service delivery and the delivery model	CIO	M. Cloney/ J. Spiers	June 2015	22nd of June 2015. Complete	5
19.5	The creation of a credible delivery plan to address the key concerns highlighted through the LIA process.	CIO	IM&T/J. Spiers	August 2015	Work is underway with a Target of the August CEO briefings	4

Status key:											
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Key

CEO	Chief Executive
DF	Director of Finance
MD	Medical Director
DoF	Director of Finance
DEF	Director of Estates and Facilities
DP&I	Director of Performance and Improvement
COO	Chief Operating Officer
DHR	Director of Human Resources
DS	Director of Strategy
DMC	Director of Marketing and Communications
CIO	Chief Information Officer
CN	Chief Nurse
AMD (CE)	Associate Medical Director (Clinical Education)
HOE	Head of Outcomes and Effectiveness
DSR	Director of Safety and Risk
AMD	Associate Medical Director

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Risk ID	CMG	Risk Title	Current Risk Score	Target Risk Score	Risk Movement
2467	Emergency and Specialist Medicine	Outlying Extra Capacity - Winter months	25	9	↔
2236	Emergency and Specialist Medicine	There is a risk of overcrowding due to the design and size of the ED footprint	25	16	↔
2445	Emergency and Specialist Medicine	SpR gaps on the ESM CMG Medical Rota	20	9	↔
2234	Emergency and Specialist Medicine	There is a medical staffing shortfall resulting in a risk of an understaffed Emergency Department impacting on patient care	20	6	↔
2488	ITAPS	Risk of vacancies on resident on call rotas being unfilled resulting in increased use of locums and Consultant acting down	20	12	↔
2557	ITAPS	There is a risk that consultant and jnr dr staffing levels in Glenfield ITU could impact on patient care	20	5	NEW
2530	ITAPS	Vacant Consultant post in pain management resulting in backlog of new and follow up patients	20	9	↔
2529	ITAPS	Risk of vacancies on junior doctor on-call rota resulting in greater use of agency staff	20	8	↔
2333	ITAPS	Lack of paediatric cardiac anaesthetists to maintain a WTD compliant rota leading to interuptions in service provision	20	8	↔
2415	ITAPS	There is a risk of loss of ITU facilities at the LGH resulting in a lack of Consultant cover for the Service	20	2	↔
510	Clinical Support and Imaging	There is a risk of staff shortages impacting on the Blood Transfusion Service at UHL	20	15	↔
2564	Clinical Support and Imaging	System issues with displaying past and present breast images could result in patient harm.	20	8	NEW
2391	Women's and Children's	There is a risk of inadequate numbers of Junior Doctors to support the clinical services within Gynaecology & Obstetrics	20	8	↔
2553	Women's and Children's	There is a risk of spread of infection due to inadequate levels of cleaning on the Neonatal Unit (NNU) at LRI.	20	6	NEW
2562	Women's and Children's	There is a risk that 2 vacant consultant paediatric neurology vacancies could impact sustainability of the service	20	4	NEW
2403	Corporate Nursing	There is a risk changes in the organisational structure will adversely affect water management arrangements in UHL	20	4	↔
2404	Corporate Nursing	There is a risk that inadequate management of Vascular Access Devices could result in increased morbidity and mortality	20	8	↔
2471	CHUGS	There is a risk of Radiotherapy Tx on the Linac (Bosworth) being compromised due to poor Imaging capability of the machine.	16	4	↔

Risk ID	CMG	Risk Title	Current Risk Score	Target Risk Score	Risk Movement
2518	CHUGS	There is a risk of harm to the patients, staff and visitors due to the design, layout & general environment of Ward 29/30 LRI	16	9	↔
2422	CHUGS	There is a risk nurse staffing levels on SAU LRI could adverserly impact the quality of patient care delivered	16	4	↔
2057	RRC	There is a risk that Insufficient Echo provision cross-site could impact on planned referrals	16	1	↔
2388	Emergency and Specialist Medicine	There is risk of delivering a poor and potentially unsafe service to patients presenting in ED with mental health conditions	16	6	↔
2466	Emergency and Specialist Medicine	Risk of Patient Harm due to delays in timely review of results and Monitoring in Rheumatolgy	16	1	↔
2541	Musculoskeletal and Specialist Surgery	There is a risk of reduced theatre & bed capacity at LRI due to increased spinal activity	16	8	↔
2504	Musculoskeletal and Specialist Surgery	There is a risk that patients will wait for an unacceptable length of time for trauma surgery resulting in poor patient outcomes	16	8	↔
607	Clinical Support and Imaging	Failure of UHL BT to fully comply with BCSH guidance and BSQR in relation to traceability and positive patient identification	16	4	↔
2487	Clinical Support and Imaging	Maintaining the quality of the Nuclear Medicine service for PET, Cardiac MPI and general diagnostics	16	6	↔
2378	Clinical Support and Imaging	Pharmacy workforce capacity	16	8	↔
1926	Clinical Support and Imaging	There is a risk that insufficient staffing to manage ultrasound referrals could impact Trust operations and patient safety	16	6	↔
2384	Women's and Children's	There is an increased risk in the incidence of babies being born with HIE (moderate & severe) within UHL	16	8	↔
2153	Women's and Children's	Shortfall in the number of all qualified nurses working in the Children's Hospital.	16	8	↔
2237	Medical Directorate	There is a risk of results of outpatient diagnostic tests not being reviewed or acted upon resulting in patient harm	16	8	↔
2338	Medical Directorate	There is a risk of patients not receiving medication and patients receiving the incorrect medication due to an unstable homecare	16	9	↔
2093	Medical Directorate	Athena Swan - potential Biomedical Research Unit funding issues.	16	4	↔
2318	Estates & Facilities	There is a risk of blocked drains causing leaks and localized flooding of sewage impacting on service provision	16	2	↔
2325	Corporate Nursing	There is a risk that security staff not assisting with restraint could impact on patient/staff safety	16	6	↔

Risk ID	CMG	Risk Title	Current Risk Score	Target Risk Score	Risk Movement
2247	Corporate Nursing	There is a risk that a significant number of RN vacancies in UHL could affect patient safety	16	12	↔
1693	Operations	There is a risk of inaccuracies in clinical coding resulting in loss of income	16	8	↔
2316	Operations	There is a risk of flooding from fluvial and pluvial sources resulting in interuption to Services	16	12	↔
2456	Musculoskeletal and Specialist Surgery	There is a risk of transmission of blood borne and other infections between patients due to inadequately cleaned nasoendoscopes	15	5	↔
2496	Clinical Support and Imaging	Risks associated with implementation of an Electronic Blood Tracking and Traceability Management System within MHRA timescales	15	4	↔
2426	Clinical Support and Imaging	Compromised safety for patients with complex nutritional requirements	15	3	↔
2501	Clinical Support and Imaging	The Proposal to relocate the Womens Health Physiotherapy Service to the LGH and to review the ward cover on LRI/LGH sites	15	2	↔
2278	Women's and Children's	There is a risk that the Leicester Fertility Centre could have its licence for the provision of treatment and services withdrawn	15	6	↔
2402	Corporate Nursing	There is a risk that inappropriate decontamination practise may result in harm to patients and staff	15	3	↔
1456	Corporate Nursing	Exceeding agreed numbers of pre-registration nursing and midwifery students allocated to placements	15	12	↔
1551	Corporate Nursing	Failure to manage Category C documents on UHL Document Management system (Insite)	15	9	↔

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
2557	ITAPS		There is a risk that consultant and jnr dr staffing levels in Glenfield ITU could impact on patient care	15/06/2015	31/07/2015	Causes: There are currently 2.5 vacancies in the ITU consultant workforce and a 1 vacancy in Adult ECMO at the Glenfield site. This has resulted in rota gaps of 62 AICU consultant shifts (24 hour and morning day shifts) and 24 ECMO consultant shifts (8am-6pm). Consequences: A shift with no consultant on the night shift, the lack of senior assessment and decision making would put any patient currently on ICU or deteriorating patients in the hospital requiring admission at risk of serious harm, up to and including death. A daytime shift with no, or reduced senior cover (there would normally be 2 consultants on duty during the day) would increase risk of dealing with life threatening emergencies and potentially result in cancellations of elective surgery as post-operative care could not be guaranteed. A trainee working without consultant supervision would leave the trainee vulnerable to working under stressful circumstances.	HR	Communications (emails, telephone calls) to existing workforce to find cover. Jobs are currently advertised externally on NHS jobs. Locum bookers for trainee gaps. Active attempts to cover trainee gaps by local trainees. Move consultant cover from Theatre to ITU - Resulting in cancellation of a theatre list.	Extreme	Likely	20	Use Locum bookers to fill trainee gaps - 31/7/15 Appoint to vacancy in ITU consultants x 2.5 - 30/9/15 Appoint to vacancy in Adult ECMO x 1 - 30/9/15	5	WBE

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
2564	Clinical Support and Imaging	Breast	System issues with displaying past and present breast images could result in patient harm.	25/06/2015	31/07/2015	Causes: Retrieval of prior imaging was updated for all of imaging in December 2014. Issues had been resolved for all but Breast Images. What should happen is that when the patient's details are barcode read on the PACS workstations the current images should appear on the top part of the screens, and the priors immediately below. What actually happens is that the current images appear and the priors do not or take excessive time to upload. The film readers are having to manually retrieve prior screening images from PACS, this is causing an unnecessary time and poses the risk of error. On many occasions no priors are available. Consequences: Potential harm to patients includes calling patients to return for additional appointment when actually not required causing anxiety to patients. Also additional ionisation radiation and intervention risks. Without access to this imaging early cancer changes could be missed. This failure of process will not be evident until a patients presents symptomatically with cancer between her screening rounds (3 year window). Impacts on service as significantly more time is required to Cases of repetitive strain experienced by staff (film readers)	Quality	All film readers aware of issues Extra caution being taken when retrieving and reviewing prior films escalation policy in place for film reading Additional paid film reading sessions are in place	Extreme	Likely	20	Systems being interrogated by ACCENTURE. IBM aware - escalated to Business Manager. Fully resolved and working PAC system due 31/08/15.	8	AGO
2553	Women's and Children's	Neonatology	There is a risk of spread of infection due to inadequate levels of cleaning on the Neonatal Unit (NNU) at LRI.	09/06/2015	31/07/2015	Causes Reduction in the number of domestic (cleaning) hours by 4 hours PER DAY provided for the NNU, a very high risk area. Consequences 1.Unable to maintain an acceptable standard of cleanliness on NNU affeciting quality and safety of babies care. 2.Breach of national specifications for cleanliness in the NHS. 3.Risk of infection outbreak on NNU resulting in increased mortality and morbidity of babies. 4.Risk of damage to NNU and Trust reputation and possible litigation.	Patients	Daily meetings with Interserve from May 18th to review standards of cleanliness. Weekly ServiceTrack audits to be undertaken with Facilities and Infection prevention team.	Major	Almost certain	20	Reinstate cleaning hours to level to meet National Cleaning Standards - 31/07/2015 Meet with Interserve daily from implementation date - 18.5.15 - to monitor cleaning standards - complete Undertake frequent ServiceTrack audits with facilities and IP team to monitor cleaning standards - due 31/7/15	6	JFO

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
2562	Women's and Children's	Paediatrics	There is a risk that 2 vacant consultant paediatric neurology vacancies could impact sustainability of the service	18/06/2015	31/07/2015	Causes: National shortage of suitable candidates to fill vacant posts Substantive Consultant Staffing levels inadequate for continuity of service Consequences: Delayed access to Consultant Paediatric Neurologist for inpatient & outpatient consultations. Loss of continuity for patients, families and Consultants as a result of changing workforce. Potential for a negative reputation of the service.	Quality	We have 1 substantive appointment, 1 locum for 6 months and 1 Consultant General Paediatrician with an interest in Neurology on a 12 month NHS contract covered by Locum Agency and NHS fixed term contracts.	Major	Almost certain	20	Actively recruit to vacant posts - Due 30/09/2015 Transfer patients not in need of tertiary neurology follow up to GP, general Paediatrics or Community Consultants in a staged way so that other services are not overwhelmed - Due 30/09/2015 Continue established weekly referral meeting to grade patients and referral to appropriate services - Due 31/07/2015 Guideline being written for General Paediatricians to ensure appropriate in-patient & out-patient referrals - Due 31/07/2015 To work with NUH on a regional solution to service delivery - Due 30/09/2015 Work with LPT to further enhance vertical integration of care for patients with complex neurological problems requiring acute admission - Due 30/09/2015	4	TCL