# INTEGRATED RISK AND ASSURANCE REPORT AS AT 28TH APRIL 2017

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

# Executive Summary

## Context

This paper informs the UHL Trust Board of the current position with progress of the refresh of the 2017/18 Board Assurance Framework (BAF). The new BAF was discussed at the Trust Board Thinking Day in March 2017, to consider what might threaten achievement of the annual priorities and outcomes from that meeting have been incorporated in to the new document. The BAF has been worked-up via the Executive Team during May and the aim is that the new BAF will act as a more effective tool to provide assurance to the Board about plans to deliver the Trust's annual priorities for 2017/18.

## Questions

1. Is the Board assured about the current progress with managing strategic risks that may threaten the achievement of our annual priorities?
2. How will the new BAF be reported in the Trust?
3. Does the Board have knowledge of new operational risks opened within the reporting period?

## Conclusion

1. The revised BAF format includes greater focus on controls assurance (what needs to happen to achieve the annual priority), performance assurance (what performance measures are being used to track progress and what do they show is actually happening) and risk assurance (what might threaten the achievement of the annual priority – in the form of a strategic risks escalated from the risk register). Executive leads have updated their new BAF entries during May and the assurance ratings in the dashboard should reflect the current position in terms of effective controls and performance to provide a level of confidence about the achievement of the annual priorities. Where the assurance ratings are amber this reflects that there are gaps in developing the control and performance assurances. The strategic risks that threaten achievement of the annual priorities are described in the BAF entries and will be further worked-up and entered on the risk register.
2. The BAF will be disaggregated with each Executive Owner responsible for reporting their item to the appropriate executive board from June 2017. The role of the executive board will be to review, challenge and endorse the BAF entry. The BAF will be reported to the Trust Board for approval as a standing agenda item on a monthly basis and will be reported to Audit Committee to continually review the relevance and rigour of the BAF and the arrangements surrounding it.
3. During the reporting period of April 2017, two new high scoring operational risks have been entered on the risk register relating to potential for suboptimal Nutrition and Dietetic Service provision to adult gastroenterology medicine patients and to head and neck cancer patients.

# Input Sought

We would welcome the Board's input to receive, note and approve this report:

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]

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

b. Board Assurance Framework [Yes]

| BAF entry | BAF Title | Current Rating |
|---|---|---|
| All BAF | 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: [6 July 2017]

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:** **1ST JUNE 2017**

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

**SUBJECT:** **INTEGRATED RISK AND ASSURANCE REPORT (INCORPORATING UHL BOARD ASSURANCE FRAMEWORK & RISK REGISTER)**

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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 copy of the 2017/18 BAF, based on the revised annual priorities.
b. A summary of risks on the risk register with a score of 15 and above.

## 2. BOARD ASSURANCE FRAMEWORK SUMMARY

2.1 The BAF arrangements are an embedded tool of the Trust's existing risk management process, therefore ensuring that risk, control and performance assurance identification and monitoring processes are considered as one and not disparate activities.

2.2 The refresh of the 2017/18 BAF was discussed at the Trust Board Thinking Day in March 2017, to consider what might threaten achievement of the annual priorities, and outcomes from that meeting have been incorporated in the new BAF. The Trust Board should note that a number of risks in the new BAF will include elements carried forward from the previous year.

2.3 The revised format includes greater focus on controls assurance (what needs to happen to achieve the annual priority), performance assurance (what measures are being used to track progress and what do they show is actually happening) and risk assurance (what might threaten the achievement of the annual priority – in the form of strategic risks that the Trust Board remain exposed to that have been escalated from the risk register).

2.4 The BAF assurance rating method has been reviewed and a new simplified standard developed to define the current position to achieve the annual priorities. The assurance indicator should take into account whether the controls in place are effective, the performance reported is positive and that the risks identified are being managed appropriately. The new current assurance rating system is described, below:

| Current Assurance Rating | Description: |
|---|---|
| 0 | Not yet started |
| 1 | Fail |
| 2 | Significant Delay – unlikely to be completed in 2017/18 |
| 3 | Some Delay – expected to be completed in 2017/18 |
| 4 | On Track |
| 5 | Complete |

2.5 Executive risk owners have updated their BAF entries to reflect the progress with achieving the annual priorities for 2017/18. A copy of the new BAF is attached at appendix one.

2.6 The Trust Board should note for the quality commitment components of the new BAF that a number of the assurance measures are still under development and this is reflected in the reported assurance ratings.

## 3. UHL RISK REGISTER SUMMARY

3.1 At the end of the reporting period, there are 42 operational (business as usual) risks open on the risk register scoring 15 and above. A report of these risks is attached in appendix two.

3.2 Two new 'high' risks have been entered on the risk register during the reporting period:

| Datix ID | Risk Title | Risk Rating | CMG |
|---|---|---|---|
| 2973 | Risk of suboptimal and unsafe Nutrition and dietetic Service provision to Adult Gastroenterology Medicine patients | 15 | CSI |
| 2946 | Risk of suboptimal provision of nutrition and dietetic service to head and neck cancer patients | 15 | CSI |

3.3 Thematic analysis of risks scoring 15 and above on the risk register continues to show the majority of risks comprise causal factors relating 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 Trust annual priorities, is included in the risk register report in appendix two.

## 4 RECOMMENDATIONS

4.1 The TB is invited to receive, note and approve this report.

Report prepared by UHL Risk & Assurance Manager
25th May 2017

Appendix 1 - 2017/18 BAF

| UHL Board Assurance Dashboard: 2017/18 | | | APRIL 2017 | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Objective | | Annual Priority No. | Annual Priority | Exec Owner | SRO | Assurance Rating | Monthly Change | Executive Board Committee for Endorsement | Trust Board / Sub-Committee for Assurance |
| Primary Objective | **QUALITY COMMITMENT:** Safe, high quality, patient centered, efficient healthcare | 1.1 | **Clinical Effectiveness - To reduce avoidable deaths:** | | | | | | |
| | | 1.1.1 | We will focus interventions in conditions with a higher than expected mortality rate in order to reduce our SHMI | MD | J Jameson (R Broughton) | 4 | | EQB | QAC |
| | | 1.2 | **Patient Safety - To reduce harm caused by unwarranted clinical variation:** | | | | | | |
| | | 1.2.1 | We will further roll-out track and trigger tools (e.g. sepsis care), in order to improve our vigilance and management of deteriorating patients | CN/MD | J Jameson (H Harrison) | 4 | | EQB | QAC |
| | | 1.2.2 | We will introduce safer use of high risk drugs (e.g. insulin and warfarin) in order to protect our patients from harm | MD/CN | E Meldrum & C Free / C Marshall | 4 | | EQB | QAC |
| | | 1.2.3 | We will implement processes to improve diagnostics results management in order to ensure that results are promptly acted upon | MD | C Marshall & J Ball | 3 | | EQB | QAC |
| | | 1.3 | **Patient Experience - To use patient feedback to drive improvements to services an care:** | | | | | | |
| | | 1.3.1 | We will provide individualised end of life care plans for patients in their last days of life (5 priorities of the Dying Person) in that our care reflects our patients' wishes | CN | C Ribbins & M Metcalf | 3 | | EQB | QAC |
| | | 1.3.2 | We will improve the patient experience in our current outpatients service and begin work to transform our outpatient models of care in order to make them more effective and sustainable in the longer term | DCIE/COO | H Leatham & C Free | 3 | | EPB | IFPIC |
| | | 1.4 | **Organisation of Care - We will manage our demand and capacity:** | | | | | | |
| | | 1.4.1 | We will utilise our new Emergency Department efficiently and effectively<br>We will use our bed capacity efficiently and effectively (including Red2Green, SAFER, expanding bed capacity)<br>We will implement new step down capacity and a new front door frailty pathway<br>We will use our theatres efficiently and effectively | COO | S Barton | 3 | | EPB | IFPIC |
| Supporting Objectives | **OUR PEOPLE:** Right people with the right skills in the right numbers | 2.1 | We will develop a sustainable workforce plan, reflective of our local community which is consistent with the STP in order to support new, integrated models of care | DWOD | J Tyler-Fantom | 4 | | EWB/EPB | IFPIC |
| | | 2.2 | We will reduce our agency spend towards the required cap in order to achieve the best use of our pay budget | DWOD | J Tyler-Fantom | 4 | | EWB/EPB | IFPIC |
| | | 2.3 | We will transform and deliver high quality and affordable HR, OH and OD services in order to make them 'Fit for the Future' | DWOD | B Kotecha | 4 | | EWB/EPB | IFPIC |
| | **EDUCATION & RESEARCH:** High quality, relevant, education and research | 3.1 | We will improve the experience of medical students at UHL through a targeted action plan in order to increase the numbers wanting stay with the Trust following their training and education | MD | S Carr | 4 | | EWB/EPB | TB |
| | | 3.2 | We will address specialty-specific shortcomings in postgraduate medical education and trainee experience in order to make our services a more attractive proposition for postgraduates | MD | S Carr | 4 | | EWB/EPB | TB |
| | | 3.3 | We will develop a new 5-Year Research Strategy with the University of Leicester in order to maximise the effectiveness of our research partnership | MD | N Brunskill | 4 | | ESB | TB |
| | **PARTNERSHIPS & INTEGRATION:** More integrated care in partnership with others | 4.1 | We will integrate the new model of care for frail older people with partners in other parts of health and social care in order to create an end to end pathway for frailty | DCIE | G Distefano | 3 | | ESB | TB |
| | | 4.2 | We will increase the support, education and specialist advice we offer to partners to help manage more patients in the community (integrated teams) in order to prevent unwarranted demand on our hospitals | DCIE | G Distefano | 3 | | ESB | TB |
| | | 4.3 | We will form new relationships with primary care in order to enhance our joint working and improve its sustainability | DCIE | J Currington ( U Montgomery) | 3 | | ESB | TB |
| | **KEY STRATEGIC ENABLERS:** Progress our key strategic enablers | 5.1 | We will progress our hospital reconfiguration and investment plans in order to deliver our overall strategy to concentrate emergency and specialist care and protect elective work | CFO | N Topham | 4 | | ESB | TB |
| | | 5.2 | We will make progress towards a fully digital hospital (EPR) with user-friendly systems in order to support safe, efficient and high quality patient care | CIO | J Clarke | 4 | | EIM&T/ EPB | IFPIC |
| | | 5.3 | We will deliver the year 2 implementation plan for the 'UHL Way' and engage in the development of the 'LLR Way' in order to support our staff on the journey to transform services | DWOD | B Kotecha | 4 | | EWB/EPB | IFPIC |
| | | 5.4 | We will review our Corporate Services in order to ensure we have an effective and efficient support function focused on the key priorities | DWOD/CFO | L Tibbert | 3 | | EWB/EPB | IFPIC |
| | | 5.5 | We will implement our Commercial Strategy, one agreed by the Board, in order to exploit commercial opportunities available to the Trust | CFO | P Traynor | 4 | | EPB | IFPIC |
| | | 5.6 | We will deliver our Cost Improvement and Financial plans in order to make the Trust clinically and financially sustainable in the long term | CFO/COO | P Traynor | 4 | | EPB | IFPIC |

| BAF 17/18: As of… | Apr-17 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Objective:** | Safe, high quality, patient centered, efficient healthcare | | | | | | | | | | | |
| **Annual Priority 1.1.1** | We will focus interventions in conditions with a higher than expected mortality rate in order to reduce our SHMI | | | | | | | | | | | |
| **Objective Owner:** | MD | | **SRO:** | J Jameson | | **Executive Board:** | | EQB | | **TB Sub Committee** | | QAC |
| **BAF Assurance Rating** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 4 | | | | | | | | | | | |

| Controls assurance (planning) | Performance assurance (measuring) |
|---|---|
| (GAP) Hospital deaths screening tool - currently not all deaths screened. | Summary Hospital-level Mortality Indictor (SHMI) (period June 2015 to June 2016 - <99 - within expected range |
| Case record review individual and thematic findings. | |
| Dr Foster's Intelligence and HED data. | % of deaths screened - target is 95% of all adult deaths - April 2017 = 90% of LRI adult deaths screened |
| Mortality and morbidity review committee. | |
| | % deaths referred for structured judgement reviews (SJR) have death classification within 3 months - target is 85% of SJR cases have death classification within 3/12 of death - April 2017 = process commenced 1/4/17 |
| | |
| | |
| | Actions related to CUSUM alerts on track / completed - target is All actions on track / completed - April 2017 = 1 alert received (Coronary arterosclerosis disease) and actions on track |
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| Risk assurance (assessment) | Movement |
|---|---|
| If the Trust is unable to sustain performance against key metrics (caused by some factors beyond the influence of UHL) then it may fail to reduce avoidable harm and to reduce the reported mortality rate to the expected level. | New |
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**Corporate Oversight (TB / Sub Committees)**

| Source:- | Title: | Date: | Assurance Feedback: |
|---|---|---|---|
| TB sub Committee | Audit Committee | | |
| TB sub Committee | QAC | 30/03/2017 | UHL's SHMI has moved one point above the England average to 101. A recent in depth HED review of UHL mortality did not identify any additional areas of mortality by condition which needed action that we did not already have reviews or action plans in place for. |

**Independent (Internal / External Auditors)**

| Source:- | Title: | Date: | Feedback: |
|---|---|---|---|
| Internal Audit | work plan TBA | | |
| External Audit | work plan TBA | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: As of…** | Apr-17 | | | | | | | | | | | |
| **Objective:** | Safe, high quality, patient centered, efficient healthcare | | | | | | | | | | | |
| **Annual Priority 1.2.1** | We will further roll-out track and trigger tools (e.g. sepsis care), in order to improve our vigilance and management of deteriorating patients | | | | | | | | | | | |
| **Objective Owner:** | CN/MD | | **SRO:** | J Jameson | | **Executive Board:** | | EQB | | **TB Sub Committee** | | QAC |
| **BAF Assurance Rating** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 4 | | | | | | | | | | | |

| Controls assurance (planning) | Performance assurance (measuring) |
|---|---|
| Electronic handover supported by NerveCentre. | EWS & Sepsis audit in all adult & paediatric wards in scope; day case, labour ward, CCU and ITU out of scope daily. |
| Sepsis and AKI awareness and training mandatory for clinical staff. | |
| Team based training packages for recognition of a deteriorating patient. | Review of EWS & Sepsis audit results fortnightly. |
| 7 days a week critical care outreach service. | Review of Datix reported incidents related to the recognition of the deteriorating patient quarterly. |
| Harm review of patients with red flag sepsis who did not receive Antibiotics within 3 hours. | Review of admissions to ITU with red flag sepsis at all 3 sites monthly. |
| Roll out of e-obs to the modified National Early Warning Scoring System - with the exception of maternity and paeds ED. | Monitoring of SUIs related to the deteriorating patient. |
| (GAP) Sepsis e-learning module - due May 2017. | |
| (GAP) Deteriorating patient e-learning module - due Aug 2017. | |
| EWS & Sepsis audit results reported to CQC monthly. | |
| Sepsis screening tool and care pathway. | |
| | |

| Risk assurance (assessment) | Movement |
|---|---|
| If we fail to identify and act upon the results for the deteriorating patient then this may result in preventable deaths or severe harm occurring. | New |
| | |

**Corporate Oversight (TB / Sub Committees)**

| Source:- | Title: | Date: | Assurance Feedback: |
|---|---|---|---|
| TB sub Committee | Audit Committee | | |
| TB sub Committee | QAC | 30/03/2017 | Following the sepsis team appointment, improvements had been made with the IV antibiotics indicator within an hour which is seen in the improved performance in the April 2017. |

**Independent (Internal / External Auditors)**

| Source:- | Title: | Date: | Feedback: |
|---|---|---|---|
| Internal Audit | work plan TBA | | |
| External Audit | work plan TBA | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: As of…** | Apr-17 | | | | | | | | | | | |
| **Objective:** | Safe, high quality, patient centered, efficient healthcare | | | | | | | | | | | |
| **Annual Priority 1.2.2** | We will introduce safer use of high risk drugs (e.g. insulin and warfarin) in order to protect our patients from harm | | | | | | | | | | | |
| **Objective Owner:** | MD/CN | **SRO Insulin:** | | E Meldrum | | **Executive Board:** | | EQB | | **TB Sub Committee** | | QAC |
| **Objective Owner:** | MD/CN | **SRO Warfarin:** | | C Marshall | | **Executive Board:** | | EQB | | **TB Sub Committee** | | QAC |
| **BAF Assurance Rating** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
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| Controls assurance (planning) | Performance assurance (measuring) |
|---|---|
| **Insulin** | |
| UHL insulin safety strategy tool. | Reduce number of severe inpatient hypoglycaemia episodes by 20%. |
| (GAP) E-learning for Insulin Safety mandatory for staff who have responsibility for prescribing, preparing and administering insulin - to be uploaded onto HELM by June 30th 2017. | (GAP) To have no DKA “never events” in the quarterly period. |
| (GAP) Develop a system/strategy to review and respond to episodes of severe hypoglycaemia. | |
| (GAP) Business case to implement a networked blood glucose meter system. | |
| (GAP) “Insulin safety Pulse Check”. | |
| **Warfarin** | |
| UHL Anticoagulation taskforce group reporting to EQB quarterly. | Monitoring of anticoagulant related harm with key performance indicators: |
| (GAP) UHL Anticoagulation action plan. | Number of missed doses of warfarin. |
| (GAP) E-learning warfarin safety programme mandatory for clinical staff. | number of INRs>6. |
| Anticoagulation in-reach nursing service. | Safety thermometer triggers to zero. |
| Discharge summary for patients on warfarin to improve communication with GPs. | |
| Improve time to octaplex delivery in bleeding patients. | |
| UHL Anticoagulation policy. | |

| Risk assurance (assessment) | Movement |
|---|---|
| If appropriate project support is unavailable to lead the introduction of safer use of high risk drugs then the project may not deliver and patients safety impacted. | New |

| **Corporate Oversight (TB / Sub Committees)** | | | |
|---|---|---|---|
| Source:- | Title: | Date: | Assurance Feedback: |
| TB sub Committee | Audit Committee | | |
| TB sub Committee | QAC | | |

| **Independent (Internal / External Auditors)** | | | |
|---|---|---|---|
| Source:- | Title: | Date: | Feedback: |
| Internal Audit | work plan TBA | | |
| External Audit | work plan TBA | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: As of…** | Apr-17 | | | | | | | | | | | |
| **Objective:** | Safe, high quality, patient centered, efficient healthcare | | | | | | | | | | | |
| **Annual Priority 1.2.3** | We will implement processes to improve diagnostics results management in order to ensure that results are promptly acted upon | | | | | | | | | | | |
| **Objective Owner:** | MD | | **SRO:** | C Marshall | | **Executive Board:** | | EQB | | **TB Sub Committee** | | QAC |
| **BAF Assurance Rating** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 3 | | | | | | | | | | | |

| Controls assurance (planning) | Performance assurance (measuring) |
|---|---|
| (GAP) Acting on Results programme board and task and finish groups to report to EQB quarterly. | (GAP) % of results acknowledged - target is 85% of results acknowledged by Q4 2017/18. |
| UHL diagnostic testing policy | |
| Acting on results detailed action plan monitored via EQB. | |
| (GAP) Concerns (alert email to clinician for unexpected imaging results) pilot prior to Trust roll-out - due end May 2017. | |
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| Risk assurance (assessment) | Movement |
|---|---|
| If we don't develop a fit for purpose electronic system to monitor and ensure results are promptly acted upon then we may cause unnecessary harm to patients. | New |
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| **Corporate Oversight (TB / Sub Committees)** | | | |
|---|---|---|---|
| Source:- | Title: | Date: | Assurance Feedback: |
| TB sub Committee | Audit Committee | | |
| TB sub Committee | QAC | | |

| **Independent (Internal / External Auditors)** | | | |
|---|---|---|---|
| Source:- | Title: | Date: | Feedback: |
| Internal Audit | work plan TBA | | |
| External Audit | work plan TBA | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: As of…** | Apr-17 | | | | | | | | | | | |
| **Objective:** | Safe, high quality, patient centered, efficient healthcare | | | | | | | | | | | |
| **Annual Priority 1.3.1** | We will provide individualised end of life care plans for patients in their last days of life (5 priorities of the Dying Person) in that our care reflects our patients' wishes | | | | | | | | | | | |
| **Objective Owner:** | CN | | **SRO:** | C Ribbins | | **Executive Board:** | | EQB | | **TB Sub Committee** | | QAC |
| **BAF Assurance Rating** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 3 | | | | | | | | | | | |

| Controls assurance (planning) | Performance assurance (measuring) |
|---|---|
| UHL End of life care plans which include the EoLCP 5 questions. | The number of patients with a care plan as a percentage of expected deaths - target is 75% of patients who are expected to die will have a care plan in plan |
| The End of Life Care Board. | |
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| Risk assurance (assessment) | Movement |
|---|---|
| If we do not improve communication with our patients then this may lead to poor patient experience. | New |
| | |

| **Corporate Oversight (TB / Sub Committees)** | | | |
|---|---|---|---|
| Source:- | Title: | Date: | Assurance Feedback: |
| TB sub Committee | Audit Committee | | |
| TB sub Committee | QAC | | |

| **Independent (Internal / External Auditors)** | | | |
|---|---|---|---|
| Source:- | Title: | Date: | Feedback: |
| Internal Audit | work plan TBA | | |
| External Audit | work plan TBA | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: Version** | Apr-17 | | | | | | | | | | | |
| **Objective:** | Safe, high quality, patient centered, efficient healthcare | | | | | | | | | | | |
| **Annual Priority 1.3.2** | We will improve the patient experience in our current outpatients service and begin work to transform our outpatient models of care in order to make them more effective and sustainable in the longer term. | | | | | | | | | | | |
| **Objective owner:** | COO | | **SRO:** | Heather Leatham | | **Executive Board:** | | EPB | | **TB Sub Committee** | | IFPIC |
| **Current BAF rating** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 3 | | | | | | | | | | | |

| Controls assurance (planning) | Performance assurance (measuring) |
|---|---|
| (GAP) Generate additional capacity and book patients in time order. | Patients waiting in excess of 12 months for a follow up (KPI trajectory: Q1-379; Q2-321; Q3-189; Q4 - 0. |
| Performance monitored monthly at outpatients correspondence. | |
| Long term follow up report which allows us to track performance. | |
| Agreed action plan in place and monitored through the Outpatient Quality report and this is monitored at CPM and in contracting meetings. | |
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| | |

| Risk assurance (assessment) | Movement |
|---|---|
| If we do not improve communication with our patients then this may lead to poor patient experience and suboptimal outpatient models of care. | New |
| | |

| **Corporate Oversight (TB / Sub Committees)** | | | |
|---|---|---|---|
| Source:- | Title: | Date: | Assurance Feedback: |
| TB sub Committee | Audit Committee | | |
| TB sub Committee | QAC | | |

| **Independent (Internal / External Auditors)** | | | |
|---|---|---|---|
| Source:- | Title: | Date: | Feedback: |
| Internal Audit | work plan TBA | | |
| External Audit | work plan TBA | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: Version** | Apr-17 | | | | | | | | | | | |
| **Objective:** | Safe, high quality, patient centered, efficient healthcare | | | | | | | | | | | |
| **Annual Priorities 1.4.1** | Organisation of Care - We will manage our demand and capacity:<br>We will utilise our new Emergency Department efficiently and effectively.<br>We will use our bed capacity efficiently and effectively (including Red2Green, SAFER, expanding bed capacity).<br>We will implement new step down capacity and a new front door frailty pathway.<br>We will use our theatres efficiently and effectively. | | | | | | | | | | | |
| **Objective owner:** | COO | | **SRO:** | S Barton | | **Executive Board:** | | EPB | | **TB Sub Committee** | | IFPIC/QAC |
| **Current BAF rating** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 3 | | | | | | | | | | | |

| Controls assurance (planning) | Performance assurance (measuring) |
|---|---|
| Submission of demand and capacity plan to NHSI – We are forecasting an overall peak bed shortfall of 105 beds. The major shortfalls are in medicine at the LRI and Glenfield. | ED 4 hour wait performance trajectory submitted to NHSI. |
| | Ambulance handover (delays over 60 mins). |
| | RTT Incomplete waiting times trajectory submitted to NHSI. |
| New ED building open to public from 26th April 2017. | 2WW for urgent GP referral as per the NHSI submitted trajectories. |
| (GAP) Demand and Capacity Governance structure being progressed. | 31 day wait for 1st treatment as per submitted NHSI trajectories. |
| (GAP) Programme Director to be appointed. | 62 day wait for 1st treatment as per submitted NHSI trajectories. |
| Ward 7 moves to Ward 21 and becomes a medical ward in the recurrent baseline (+28 beds) | |
| | |
| Staffing of additional 8 beds on the medicine emergency pathway at LRI on Ward 7. | |
| Plan for elective service changes at LGH involving MSS & CHUGGs. | |
| Relaunch of Red 2 Green & SAFER within Medicine at LRI. | |
| A staffing plan from Paediatrics for Winter 17/18. | |
| Care model and a detailed plan for reablement facility. | |
| Feasibility work commenced into physical capacity solutions for both LRI & GH. Decision on option for physical expansion at GH. | |
| | |
| | |

| Risk identified to address Gaps in controls / performance | Movement |
|---|---|
| There is a risk that additional physical bed capacity will not be able to be opened due to an inability to provide staffing for it leading to a continued demand and capacity imbalance at LRI | |
| There is a risk that the out of hospital reablement solution will not be operational for Winter 17/18 | |
| There is a risk that physical capacity options at Glenfield will not be affordable from a capital and revenue perspective leading to a demand and capacity imbalance at GH this winter | |
| | |

| **Corporate Oversight (TB / Sub Committees)** | | | |
|---|---|---|---|
| Source:- | Title: | Date: | Assurance Feedback: |

| | | | |
|---|---|---|---|
| TB sub Committee | QAC | Mar-17 | The task for 2017/18 is to create additional effective capacity (through actual beds, demand mitigation or improved productivity) of 105 beds. The approach in 17/18 will be different to previous years in that it favours creating capacity sufficient to deal with peak demand and then reducing beds at time when demand is lower than the peak. |
| TB sub Committee | IFPIC | | |

| **Independent (Internal / External Auditors)** | | | |
|---|---|---|---|
| Source:- | Title: | Date: | Feedback: |
| Internal Audit | work plan TBA | | |
| External Audit | work plan TBA | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: As of…** | Apr-17 | | | | | | | | | | | |
| **Objective:** | Right people with the right skills in the right numbers | | | | | | | | | | | |
| **Annual Priority 2.1** | We will develop a sustainable workforce plan, reflective of our local community which is consistent with the STP in order to support new, integrated models of care | | | | | | | | | | | |
| **Objective Owner:** | DWOD | | **SRO:** | J Tyler-Fantom | | **Executive Board:** | | EWB / EPB | | **TB Sub Committee** | | IFPIC |
| **BAF Assurance Rating** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 4 | | | | | | | | | | | |

| Controls assurance (planning) | Performance assurance (measuring) |
|---|---|
| Workforce plan relating to reduction in dependency on non contracted workforce, safe staffing, review of urgent and emergency care, impact of seven day services, shift of activity into community settings and increased specialised services where appropriate. | Apprenticeship levy - 345 predicted in 17/18 against 334 target. |
| | BME Leadership - target 28% |
| | Workforce sickness - target 3% |
| | Statutory and mandatory training - target 95% |
| People strategy and programme of work to address the leadership and team working priorities, wellbeing of our workforce and ensure we focus on addressing actions to improve the diversity of our workforce. | |
| | |
| | |
| Governance structure in place comprising internal and external groups, including Workforce OD Board and the Local Workforce Action Board and subgroups thereof who oversee delivery of the workforce and organisational development components of the Sustainable Transformation Plan. | |
| | |
| | |
| | |
| Apprenticeship workforce strategy. | |
| NHS WRES Technical Guidance refreshed - includes changes made to NHS Standard Contract (2017/18 to 2018/19) and definitions of terminology used in WRES indicators, and how affects organisations subject to WRES. | |
| | |
| | |
| (GAP) STP refresh in progress – to provide a more accurate workforce prediction based on current capacity requirements - due June 2017. | |
| | |
| (GAP) System wide workforce planning and modelling approach in place (Cardio Respiratory model of care) - due June 2017. | |
| | |
| (GAP) Engagement of UHL planning leads in workforce approach to ensure triangulation with activity modelling - due June 2017 | |
| | |
| (GAP) Predictive workforce modelling - Emergency and Urgent Care Vanguard commenced - due June 2017. | |
| | |
| | |

| Risk assurance (assessment) | Movement |
|---|---|
| If the Trust fails to engage effectively with staff through robust communication networks then this may affect the delivery of safe, high quality patient centered healthcare. | New |
| | |

**Corporate Oversight (TB / Sub Committees)**

| Source:- | Title: | Date: | Assurance Feedback: |
|---|---|---|---|
| TB sub Committee | Audit Committee | | |
| TB sub Committee | IFPIC | | |

| **Independent (Internal / External Auditors)** | | | |
|---|---|---|---|
| Source:- | Title: | Date: | Feedback: |
| Internal Audit | work plan TBA | | |
| External Audit | work plan TBA | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: As of…** | Apr-17 | | | | | | | | | | | |
| **Objective:** | Right people with the right skills in the right numbers | | | | | | | | | | | |
| **Annual Priority 2.2** | We will reduce our agency spend towards the required cap in order to achieve the best use of our pay budget | | | | | | | | | | | |
| **Objective Owner:** | DWOD | | **SRO:** | J Tyler-Fantom | | **Executive Board:** | | EWB / EPB | | **TB Sub Committee** | | IFPIC |
| **BAF Assurance Rating** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 4 | | | | | | | | | | | |

| Controls assurance (planning) | Performance assurance (measuring) |
|---|---|
| NHSI overall agency cap is £20.6m for 2017/18, specific target for medical agency reduction £717,930 in 17/18 - incorporated into CMG financial planning. | Monitoring of agency cap breaches to NHSI weekly. |
| | Medical agency spend monthly |
| (GAP) Agency programme board | Nursing vacancy rate |
| (GAP) Regional MOU and establishment of a regional working group for medical agency. | Agency as a % of employee expenditure. |
| | Bank as a % of employee expenditure. |
| Monitoring of agency tracker through Premium spend gap with EWB, EPB oversight. | Total vacancy rate (% established posts within staff members in place). |
| Agreed escalation processes / break glass escalation control. | Staff turnover (total as a %). |
| Review of top 10 agency highest earners and long term through ERCB linking to vacancy positions and CMG recruitment plans. | Year on year reduction in agency spend in line with our 2 year trajectory. |
| | |
| Process for signing off bank and agency staff at CMG level through vacancy control panel. | |
| | |
| | |

| Risk assurance (assessment) | Movement |
|---|---|
| If the Trust is unable to control expenditure on agency staff caused by an inability to recruit and retain sufficiently skilled and capable staff, then we may exceed the pay budget and this may result in suboptimal care delivered to patients. | New |
| | |

| **Corporate Oversight (TB / Sub Committees)** | | | |
|---|---|---|---|
| Source:- | Title: | Date: | Assurance Feedback: |
| TB sub Committee | Audit Committee | | |
| TB sub Committee | IFPIC | Monthly | Monitoring of agency tracker through Premium spend gap. |

| **Independent (Internal / External Auditors)** | | | |
|---|---|---|---|
| Source:- | Title: | Date: | Feedback: |
| Internal Audit | work plan TBA | | |
| External Audit | work plan TBA | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: As of…** | Apr-17 | | | | | | | | | | | |
| **Objective:** | Right people with the right skills in the right numbers | | | | | | | | | | | |
| **Annual Priority 2.3** | We will transform and deliver high quality and affordable HR, OH and OD services in order to make them 'Fit for the Future' | | | | | | | | | | | |
| **Objective Owner:** | DWOD | | **SRO:** | B Kotecha | | **Executive Board:** | | EWB / EPB | | **TB Sub Committee** | | IFPIC |
| **BAF Assurance Rating** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 4 | | | | | | | | | | | |

| Controls assurance (planning) | Performance assurance (measuring) |
|---|---|
| Vision and programme plan in place (transforming HR Function). | Staff engagement score from staff survey. |
| Maximising use of Technology (enabling processes). | Response rate for staff survey. |
| (GAP) Working with stakeholders and customers to deliver service differently and to gain ownership. | |
| (GAP) Redefine and Up skill staff within the Service in order to be fit for the future. | |
| (GAP) Delivery structures not fit for purpose until target operating model has been developed. | |
| | |

| Risk assurance (assessment) | Movement |
|---|---|
| If the Trust fails to engage effectively with staff and act on staff experience survey feedback and results, then this may affect the delivery of safe, high quality patient centered healthcare. | |
| | |

| **Corporate Oversight (TB / Sub Committees)** | | | |
|---|---|---|---|
| Source:- | Title: | Date: | Assurance Feedback: |
| TB sub Committee | Audit Committee | | |
| TB sub Committee | IFPIC | | |
| TB sub Committee | QAC | | |

| **Independent (Internal / External Auditors)** | | | |
|---|---|---|---|
| Source:- | Title: | Date: | Feedback: |
| Internal Audit | work plan TBA | | |
| External Audit | work plan TBA | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: As of…** | Apr-17 | | | | | | | | | | | |
| **Objective:** | High quality, relevant, education and research | | | | | | | | | | | |
| **Annual Priority 3.1** | We will improve the experience of medical students at UHL through a targeted action plan in order to increase the numbers wanting stay with the Trust following their training and education | | | | | | | | | | | |
| **Objective Owner:** | MD | | **SRO:** | S Carr | | **Executive Board:** | | EWB | | **TB Sub Committee** | | |
| **BAF Assurance Rating** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 4 | | | | | | | | | | | |

| Controls assurance (planning) | Performance assurance (measuring) |
|---|---|
| Medical Education Strategy to improve learning culture. | (GAP) GMC visit 2016 findings - to be published June 2017 - next visit due 2021. |
| Medical Education Quality Improvement Plan. | Leicester Medical School feedback - areas for improvement in 17/18 plan. |
| (GAP) Transparent and accountable SIFT funding / expenditure in CMGs. | HEE Quality Management Process- new process still to be confirmed. |
| UHL Multi-professional education facilities strategy to progress EXCEL@UHL. | GMC National Trainee survey - annually - areas for improvement in 17/18 plan. |
| (GAP) CMG ownership of undergraduate education outcomes. | Data to show no. of Graduates retained - negative assurance |
| (GAP) Overarching strategy with University of Leicester to integrate undergraduate and postgraduate training to improve outcomes and retention. | End of Block feedback- quarterly - areas for improvement in 17/18 plan. |
| | UHL UG education quality dashboard- to be launched in Sept 17 |
| UG representatives on the UHL Doctors in Training Committee. | Audit time in Job plans for education and training roles - variable across CMGs. |
| | Trainee Exit Survey - areas for improvement in 17/18 plan. |
| | |

| Risk assurance (assessment) | Movement |
|---|---|
| If we don't create time in Consultants job planning for undergraduate education and training then we may not achieve the annual priority. | New |
| If SIFT funding allocated to CMGs is not used for education and training and linked to undergraduate education quality outcomes then this may impact achievement of the annual priority. | New |
| If we do not improve the learning culture raised by the GMC in their visit in 2016 and in students and trainees surveys then this may impact achievement of the annual priority | New |
| If we do not secure sufficient capital funding to progress EXCEL@UHL then this may impact achievement of the annual priority. | New |
| | |

**Corporate Oversight (TB / Sub Committees)**

| Source:- | Title: | Date: | Assurance Feedback: |
|---|---|---|---|
| TB sub Committee | Audit Committee | | No scrutiny - The TB should consider where they are receiving assurance in relation to this priority. |
| TB sub Committee | QAC | | No scrutiny - The TB should consider where they are receiving assurance in relation to this priority. |

**Independent (Internal / External Auditors)**

| Source:- | Title: | Date: | Feedback: |
|---|---|---|---|
| Internal Audit | work plan TBA | | |
| External Audit | work plan TBA | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: As of…** | Apr-17 | | | | | | | | | | | |
| **Objective:** | High quality, relevant, education and research | | | | | | | | | | | |
| **Annual Priority 3.2** | We will address specialty-specific shortcomings in postgraduate medical education and trainee experience in order to make our services a more attractive proposition for postgraduates | | | | | | | | | | | |
| **Objective Owner:** | MD | | **SRO:** | S Carr | | **Executive Board:** | | EWB | | **TB Sub Committee** | | |
| **BAF Assurance Rating** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 4 | | | | | | | | | | | |

| Controls assurance (planning) | Performance assurance (measuring) |
|---|---|
| Medical Education Strategy to improve learning culture | Medical Education Quality Improvement Plan for 2017/18. |
| HEEM quality management visits for following specialties - Cardiology, Maxillo-Facial School of Surgery / Dentistry, Trauma & Orthopaedics School of Surgery and Respiratory Medicine | (GAP) GMC visit 2016 findings - to be published June 2017 - next visit due 2021. |
| | (GAP) HEE accreditation process- revised process to be confirmed by HEE |
| | UHL Survey - bi annual- next due in Sept 2017 |
| (GAP) CMGs Quality Improvement Action Plans in response to GMC visit and survey results to address concerns in postgraduate education. | UHL PG education quality dashboard - results variable across CMGs- next due in September 2017. |
| (GAP) Department of Clinical Education programme with CMGs to develop action plans to address poor performance and training challenges. | Action plans for services with training challenges reviewed monthly - some issues resolved but rota/staffing/supervision issues remain unresolved. |
| (GAP) Overarching strategy with University of Leicester to integrate undergraduate and postgraduate training to improve outcomes and retention. | GMC Regional visit action plan - on track. |
| GMC 'Approval and Recognition' of Clinical and Educational Supervisors - central database monitored and maintained. | |
| | |
| (GAP) GMC visit report - UHL action plan developed. | |
| (GAP) Audit time in Job plans for education and training roles. | |
| | |

| Risk assurance (assessment) | Movement |
|---|---|
| If MADEL funding allocated to CMGs is not used for education and training and linked to education quality outcomes then this may impact achievement of the annual priority | New |
| If we do not address recommendations by the GMC following their visit in 2016, including improve the learning culture, address IT improvements, and improving facilities, as well as address feedback in students and trainees surveys then we may not provide an attractive proposition for postgraduate students. | New |
| If we do not ensure that mandatory training requirements for Specialty curricula are met we will lose posts ( eg T&O and CMT) | New |
| If we don't ensure that those with Postgraduate medical education roles ( including Educational Supervisors) have identified time in their job plans then we may not achieve the annual priority | New |
| | |

| **Corporate Oversight (TB / Sub Committees)** | | | |
|---|---|---|---|
| Source:- | Title: | Date: | Assurance Feedback: |
| TB sub Committee | Audit Committee | | No scrutiny - The TB should consider where they are receiving assurance in relation to this priority. |
| TB sub Committee | IFPIC | | No scrutiny - The TB should consider where they are receiving assurance in relation to this priority. |

| Independent (Internal / External Auditors) | | | |
|---|---|---|---|
| Source:- | Title: | Date: | Feedback: |
| Internal Audit | work plan TBA | | |
| External Audit | work plan TBA | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: As of…** | Apr-17 | | | | | | | | | | | |
| **Objective:** | High quality, relevant, education and research | | | | | | | | | | | |
| **Annual Priority 3.3** | We will develop a new 5-Year Research Strategy with the University of Leicester in order to maximise the effectiveness of our research partnership | | | | | | | | | | | |
| **Objective Owner:** | MD | | **SRO:** | N Brunskill | | **Executive Board:** | | ESB | | **TB Sub Committee** | | |
| **BAF Assurance Rating** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 4 | | | | | | | | | | | |

| Controls assurance (planning) | Performance assurance (measuring) |
|---|---|
| (GAP) UHL Research and Innovation Strategy in UHL - due Q2 2017/18. | Internal monitoring via metrics reported at joint strategic meetings including finance, communications, patient and public involvement. |
| (GAP) Dialogue with UoL to articulate (year 1 of the 5 year) research strategy which will consolidate our position in areas of existing strength such as BRU, Cancer, Respiratory and Cardiovascular and identify new areas for possible development such as Obstetrics and Childrens - due Q2 2017/18. | External monitoring via annual reports from NIHR re performance for funded research projects - next report due Q2 2017/18. |
| | |
| Functioning organisational relationship in place with UoL which includes joint strategic meetings to discuss research performance and opportunities. . | |
| | |
| | |

| Risk assurance (assessment) | Movement |
|---|---|
| If we don't have the right personnel in place and an appropriate infrastructure to run clinical research then we may not maximise our research potential which may adversely affect our ability to drive clinical quality. | New |
| If we are not successful with our bids for external funding then we may not be able to support delivery of our research strategy. | New |
| | |

**Corporate Oversight (TB / Sub Committees)**

| Source:- | Title: | Date: | Assurance Feedback: |
|---|---|---|---|
| TB sub Committee | Audit Committee | | No scrutiny - The TB should consider where they are receiving assurance in relation to this priority. |
| TB sub Committee | IFPIC | | No scrutiny - The TB should consider where they are receiving assurance in relation to this priority. |

**Independent (Internal / External Auditors)**

| Source:- | Title: | Date: | Feedback: |
|---|---|---|---|
| Internal Audit | work plan TBA | | |
| External Audit | work plan TBA | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: As of…** | Apr-17 | | | | | | | | | | | |
| **Objective:** | More integrated care in partnership with others | | | | | | | | | | | |
| **Annual Priority 4.1** | We will integrate the new model of care for frail older people with partners in other parts of health and social care in order to create an end to end pathway for frailty | | | | | | | | | | | |
| **Objective Owner:** | DCIE | | **SRO:** | G Distefano | | **Executive Board:** | | ESB | | **TB Sub Committee** | | |
| **BAF Assurance Rating** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
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| Controls assurance (planning) | Performance assurance (measuring) |
|---|---|
| UHL working group established and reporting to UHL Exec boards. | (GAP) Milestones and success criteria to be defined in the Project Initiations Document |
| (GAP) Designated clinical lead. | |
| (GAP) Designated managerial lead. | (GAP) Performance data will be monitored at service level, once defined. |
| (GAP) UHL project plan. | STP Governance arrangements (Workstreams reporting to System Leadership Team and will report summary updates to individual organisational boards / governing bodies from Q2 2017/18 - subject to confirmation from the STP PMO). |
| (GAP) Resources / capacity available to the project (CMGs and corporate). | |
| System wide Tiger Team bringing clinicians together across LLR. | |
| External senior representation on relevant STP Workstream Boards. | |
| STP Workstream Project Initiations Documents. | |
| (GAP) Identification and management of interdependencies between STP workstreams given most touch on frailty. | |
| | |
| (GAP) Commissioning and contracting model that supports deliver of frailty pathway. | |
| | |
| | |

| Risk assurance (assessment) | Movement |
|---|---|
| If appropriate project resources are not allocated (caused by lack of project leads appointed, capital investment and ineffective STP governance workstreams) then we may not deliver an effective end to end pathway for frailty. | New |
| | |

**Corporate Oversight (TB / Sub Committees)**

| Source:- | Title: | Date: | Assurance Feedback: |
|---|---|---|---|
| TB sub Committee | Audit Committee | | |
| TB sub Committee | IFPIC | | |
| TB sub Committee | QAC | | |

**Independent (Internal / External Auditors)**

| Source:- | Title: | Date: | Feedback: |
|---|---|---|---|
| Internal Audit | work plan TBA | | |
| External Audit | work plan TBA | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: As of…** | Apr-17 | | | | | | | | | | | |
| **Objective:** | More integrated care in partnership with others | | | | | | | | | | | |
| **Annual Priority 4.2** | We will increase the support, education and specialist advice we offer to partners to help manage more patients in the community (integrated teams) in order to prevent unwarranted demand on our hospitals | | | | | | | | | | | |
| **Objective Owner:** | DCIE | | **SRO:** | G Distefano | | **Executive Board:** | | ESB | | **TB Sub Committee** | | |
| **BAF Assurance Rating** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 3 | | | | | | | | | | | |

| Controls assurance (planning) | Performance assurance (measuring) |
|---|---|
| UHL Designated clinical lead and management lead report to UHL Exec boards. | (GAP) Milestones and success criteria to be defined in the Project Initiations Document |
| ESB approved high level scope in March 2017. | |
| (GAP) Working group / project team (virtual or otherwise) established. | (GAP) Performance data will be monitored at service level, once defined. |
| (GAP) Project plan agreed. | STP Governance arrangements (Workstreams reporting to System Leadership Team and will report summary updates to individual organisational boards / governing bodies from Q2 - subject to confirmation from the STP PMO) |
| (GAP) Uncertainty around resources / capacity available to the project and/or in supporting / delivering the offer (CMGs namely). | |
| System wide Tiger Team bringing clinicians together across LLR. | |
| External Senior representation on relevant STP Workstream Boards, namely Integrated Teams Programme Board. | |
| | |
| Integrated Teams Programme Board approved a high level proposal / scoping document in April 2017. | |
| | |
| STP Workstream Project Initiations Documents. | |
| (GAP) Identification and management of interdependencies between STP workstreams given most touch on frailty. | |
| | |
| (GAP) Lack of clarity (at this stage) about the availability of funding to support these 'non-activity related' activities. | |
| | |

| Risk assurance (assessment) | Movement |
|---|---|
| If appropriate project resources are not allocated (caused by lack of project leads appointed, capital investment and ineffective STP governance workstreams) then we may not deliver an effective end to end pathway for frailty. | |

| **Corporate Oversight (TB / Sub Committees)** | | | |
|---|---|---|---|
| Source:- | Title: | Date: | Assurance Feedback: |
| TB sub Committee | Audit Committee | | |
| TB sub Committee | IFPIC | | |
| TB sub Committee | QAC | | |

| **Independent (Internal / External Auditors)** | | | |
|---|---|---|---|
| Source:- | Title: | Date: | Feedback: |
| Internal Audit | work plan TBA | | |
| External Audit | work plan TBA | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: As of…** | Apr-17 | | | | | | | | | | | |
| **Objective:** | More integrated care in partnership with others | | | | | | | | | | | |
| **Annual Priority 4.3** | We will form new relationships with primary care in order to enhance our joint working and improve its sustainability | | | | | | | | | | | |
| **Objective Owner:** | DCIE | | **SRO:** | J Currington | | **Executive Board:** | | ESB | | **TB Sub Committee** | | |
| **BAF Assurance Rating** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 3 | | | | | | | | | | | |

| Controls assurance (planning) | Performance assurance (measuring) |
|---|---|
| Clinical Lead identified (Associate Medical Director – Primary Care Interface) | (GAP) Performance assurance and reporting to be identified through PID. |
| Managerial Lead identified (Head of Partnerships and Business Development). | (GAP) Description of UHL offer or "Brochure" will be produced. |
| Clinical Lead member of STP Primary Care Resilience Group. | |
| (GAP) Project Plan / PID - to be submitted to ESB in June 17. | |
| (GAP) Uncertainty regarding resources/capacity available to support the project (CMGs and corporate). | |
| Tender opportunity search process are reported through ESB monthly.. | |
| | |

| Risk assurance (assessment) | Movement |
|---|---|
| If appropriate project resources are not allocated (caused by uncertainty regarding resources) then we may not develop effective relationships with primary care providers. | |
| | |

**Corporate Oversight (TB / Sub Committees)**

| Source:- | Title: | Date: | Assurance Feedback: |
|---|---|---|---|
| TB sub Committee | Audit Committee | | |
| TB sub Committee | IFPIC | | |
| TB sub Committee | QAC | | |

**Independent (Internal / External Auditors)**

| Source:- | Title: | Date: | Feedback: |
|---|---|---|---|
| Internal Audit | work plan TBA | | |
| External Audit | work plan TBA | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: Version** | Apr-17 | | | | | | | | | | | |
| **Objective:** | Progress our key strategic enablers | | | | | | | | | | | |
| **Annual Priority 5.1** | We will progress our hospital reconfiguration and investment plans in order to deliver our overall strategy to concentrate emergency and specialist care and protect elective work | | | | | | | | | | | |
| **Objective owner:** | CFO | | **SRO:** | N Topham | | **Executive Board:** | | ESB | | **TB Sub Committee** | | IFPIC |
| **Current BAF rating** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 4 | | | | | | | | | | | |

| Planning (controls) | Performance Management (assurance sources) |
|---|---|
| (GAP) Develop EMCHC full business case - subject to outcome of consultation which is delayed due to period of 'purdah'; final decision expected December 2017 | Performance against EMCHC project plan - positive assurance |
| (GAP) Deliver year 1 (of 3 year) Interim ICU project - subject to receipt of external capital funding following capital bid submitted to NHSI in April 2017 | Performance against Interim ICU project plan - positive assurance |
| Deliver Emergency Floor Phase 2 (to complete in 2017/18) | Performance against Emergency Floor Phase 2 project plan - positive assurance |
| (GAP) Deliver Vascular Outpatients move to GH subject to outcome of scoping exercise | Performance against Vascular Outpatients project plan - positive assurance |
| (GAP) Deliver Infill beds at LRI and GGH subject to approval of Business case (to complete in 2017/18) | Performance against Infill beds at LRI and GGH project plan - positive assurance |
| Full review of affordability of Reconfiguration Programme, including use of PF2 to reduce reliance on external funding from the Department of Health, and re-assess capital priorities in line with the Trust's Strategic Objectives and Annual Priorities. Submission of capital bid for external funding (to complete in 2017/18). | Performance against Reconfiguration Programme project plan - positive assurance |
| | |

| Risk identified to address Gaps in controls / assurance | Movement |
|---|---|
| If the national review into congenital heart services concludes that the EMCHC service is de-commissioned then this will impact our reconfiguration plans | ↔ |
| If external capital funding is not available when it is required to maintain the reconfiguration programme to initially progress the interim ICU project then this may impact our reconfiguration plans. | ↔ |
| | |

**Corporate Oversight (TB / Sub Committees)**

| Source:- | Title: | Date: | Assurance Feedback: |
|---|---|---|---|
| TB sub Committee | Audit Committee | 26/05/2017 | Approval to be sought on methodology for Emergency Floor Phase 1 post project review (from internal or external auditors). |
| | | 06/07/2017 | Outcome of Emergency Floor Phase 1 post project review to be shared.<br>Outcome of 2016 Reconfiguration Gateway Review (by external auditor) to be shared. |
| TB sub Committee | IFPIC | 25/05/2017 | Capital Bid submitted to NHSI for Reconfiguration Programme external funding to be shared. |

**Independent (Internal / External Auditors)**

| Source:- | Title: | Date: | Feedback: |
|---|---|---|---|
| Internal Audit | work plan TBA | | |
| External Audit | work plan TBA | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: Version** | Apr-17 | | | | | | | | | | | |
| **Objective:** | Progress our key strategic enablers | | | | | | | | | | | |
| **Annual Priority 5.2** | We will make progress towards a fully digital hospital (EPR) with user-friendly systems in order to support safe, efficient and high quality patient care | | | | | | | | | | | |
| **Objective owner:** | CIO | | **SRO:** | Paula Dunnan | | **Executive Board:** | | EIM&T / EPB | | **TB Sub Committee** | | IFPIC/QAC |
| **Current BAF rating** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 4 | | | | | | | | | | | |

| Controls assurance (planning) | Performance assurance (measuring) |
|---|---|
| EPR Plan - Best of breed (new systems & building on our Nervecentre solution). | (GAP) EPR Plan - key milestones to be developed. |
| (GAP) Implement NC forms and rules to support clinical practice. | IM&T Project Dashboard - Milestones reported are on track |
| (GAP) Implement NC bed management. | |
| (GAP) Create outpatient NC/ICE functionality | |
| IM&T Project Dashboard reported to EIM&T Board. | |
| IM&T Governance structure and specialty sub-groups in place. | |
| (GAP) IM&T Project Management Support. | |
| | |

| Risk assurance (assessment) | Movement |
|---|---|
| If we don't have appropriate project management support to develop the Trust's specified IT programmes then this may impact our ability to achieve the priority within the cost envelope. | New |
| If a continuous hardware and software replacement programme is not effectively implemented then our systems will become dated resulting in suboptimal end user interface. | New |
| | |

**Corporate Oversight (TB / Sub Committees)**

| Source:- | Title: | Date: | Assurance Feedback: |
|---|---|---|---|
| TB sub Committee | Audit Committee | | IM&T report provided on request. |
| TB sub Committee | IFPIC | | Quarterly paper provided |
| TB sub Committee | QAC | | IM&T report provided on request. |

**Independent (Internal / External Auditors)**

| Source:- | Title: | Date: | Feedback: |
|---|---|---|---|
| Internal Audit | work plan TBA | | |
| External Audit | work plan TBA | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: Version** | Apr-17 | | | | | | | | | | | |
| **Objective:** | Progress our key strategic enablers | | | | | | | | | | | |
| **Annual Priority 5.3** | We will deliver the year 2 implementation plan for the 'UHL Way' and engage in the development of the 'LLR Way' in order to support our staff on the journey to transform services | | | | | | | | | | | |
| **Objective owner:** | DWOD | | **SRO:** | B Kotecha | | **Executive Board:** | | EWB / EPB | | **TB Sub Committee** | | IFPIC |
| **Current BAF rating** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 4 | | | | | | | | | | | |

| Controls assurance (planning) | Performance assurance (measuring) |
|---|---|
| **UHL Way** | |
| UHL Way governance structure (with programme leads for the 4 components of Better - engagement, teams, change and Academy). | (GAP) Fully populated UHL Way implantation plan - metrics to be developed |
| | UHL Pulse check dashboard (Quarterly) - Q4 2016/17 = TBA |
| UHL Way Year 2 implementation plan and tracker. | National staff survey (annually) - April 2017 = UHL joint 47th position. |
| Year 2 - Close liaison with all SROs for annual priorities in 17/18 to process map their journey to identify gaps against the 4 components of the UHL Way. | LIA Wave 8 will be presenting to the trust their LiA journey on 16 May 2017. |
| | |
| | |
| **LLR Way** | |
| LLR OD and Change Group (workforce enabling group). | (GAP) Metrics to measure no. of people through introduction. |
| LLR Governance structure with clinical and senior leadership from LLR services (including UHL, LPT, City & County Councils, EMAS). | (GAP) Metrics to measure no. of interventions utilised. |
| | |
| (GAP) LLR standardised improvement framework to approach change. | |
| (GAP) Framework to raise awareness of STP and LLR Way. | |
| | |

| Risk assurance (assessment) | Movement |
|---|---|
| To be identified. | |
| | |

**Corporate Oversight (TB / Sub Committees)**

| Source:- | Title: | Date: | Assurance Feedback: |
|---|---|---|---|
| TB sub Committee | Audit Committee | | |
| TB sub Committee | IFPIC | Apr-17 | UHL Way implementation tracker submitted to provide assurance about plan. |

**Independent (Internal / External Auditors)**

| Source:- | Title: | Date: | Feedback: |
|---|---|---|---|
| Internal Audit | work plan TBA | | |
| External Audit | work plan TBA | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: As of…** | Apr-17 | | | | | | | | | | | |
| **Objective:** | Progress our key strategic enablers | | | | | | | | | | | |
| **Annual Priority 5.4** | We will review our Corporate Services in order to ensure we have an effective and efficient support function focused on the key priorities | | | | | | | | | | | |
| **Objective Owner:** | DWOD | | **SRO:** | DWOD | | **Executive Board:** | | EWB / EPB | | **TB Sub Committee** | | IFPIC |
| **BAF Assurance Rating** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 3 | | | | | | | | | | | |

| Controls assurance (planning) | Performance assurance (measuring) |
|---|---|
| The Carter review identified that the Trust has £1.5 Mil to come out from corporate services by March 2018). The work streams within the CIP programme are actively addressing the areas identified in the Carter Review. | (GAP) Milestone to be developed and agreed. |
| | £1.5m CIP target agreed for UHL (service line targets being confirmed by finance). |
| | (GAP) £2m STP savings target (UHL % not yet confirmed). |
| (GAP) PID drafted - to be agreed in June 2017. | Carter target for back office cost to be no more than 8% of turnover by March 2018. |
| Project delivery group in place - first meeting 8 May 2017. | |
| (GAP) Project governance defined in PID and to be signed off by Exec team then EPB/EWB. | Carter Target for back office cost to be no more than 6% of turnover by March 2020. |
| All Corp services are in scope. | Performance KPIs in place and being met for all service lines. |
| Project manager resource in place. | |
| | |

| Risk assurance (assessment) | Movement |
|---|---|
| To be identified. | |
| | |

| **Corporate Oversight (TB / Sub Committees)** | | | |
|---|---|---|---|
| Source:- | Title: | Date: | Assurance Feedback: |
| TB sub Committee | Audit Committee | | |
| TB sub Committee | IFPIC | | |

| **Independent (Internal / External Auditors)** | | | |
|---|---|---|---|
| Source:- | Title: | Date: | Feedback: |
| Internal Audit | work plan TBA | | |
| External Audit | work plan TBA | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: As of…** | Apr-17 | | | | | | | | | | | |
| **Objective:** | Progress our key strategic enablers | | | | | | | | | | | |
| **Annual Priority 5.5** | We will implement our Commercial Strategy, one agreed by the Board, in order to exploit commercial opportunities available to the Trust | | | | | | | | | | | |
| **Objective Owner:** | CFO | | **SRO:** | CFO | | **Executive Board:** | | EPB | | **TB Sub Committee** | | IFPIC |
| **BAF Assurance Rating** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 4 | | | | | | | | | | | |

| Controls assurance (planning) | Performance assurance (measuring) |
|---|---|
| (GAP) Implement overall Commercial Strategy. | (GAP) Monitoring of specific programme/work streams (once agreed) |
| (GAP) Identify work streams which can be implemented in 2017/18. | (GAP) Income streams measured monthly against target (once agreed) |
| (GAP) Identify resources to support the strategy this year. | |
| (GAP) Link programme to subsidiary company TGH and agree priorities. | |
| Deliver new income or cost saving schemes in line with agreed target | |
| Publicise the Commercial Strategy across UHL and engage key stakeholders | |
| | |

| Risk assurance (assessment) | Movement |
|---|---|
| Lack of resources to implement Commercial Strategy properly | |
| Negative impact of reduced focus on core business as a result of implementing this strategy | |
| | |

**Corporate Oversight (TB / Sub Committees)**

| Source:- | Title: | Date: | Assurance Feedback: |
|---|---|---|---|
| TB sub Committee | Audit Committee | | Twice yearly review of progress to Trust Board. |
| TB sub Committee | IFPIC | | Bi monthly update |

**Independent (Internal / External Auditors)**

| Source:- | Title: | Date: | Feedback: |
|---|---|---|---|
| Internal Audit | work plan TBA | | |
| External Audit | work plan TBA | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: As of…** | Apr-17 | | | | | | | | | | | |
| **Objective:** | Progress our key strategic enablers | | | | | | | | | | | |
| **Annual Priority 5.6** | We will deliver our Cost Improvement and Financial plans in order to make the Trust clinically and financially sustainable in the long term | | | | | | | | | | | |
| **Objective Owner:** | CFO | | **SRO:** | CFO | | **Executive Board:** | | EPB | | **TB Sub Committee** | | IFPIC |
| **BAF Assurance Rating** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 4 | | | | | | | | | | | |

| Controls assurance (planning) | Performance assurance (measuring) |
|---|---|
| **Cost Improvement Plans** | |
| CMGs and Corporate departments to fully identify (complete) plans for 2017/18. | Monthly CIP report to EPB and IFPIC. |
| 100% of PIDS and QIAs signed off. | Monitoring of CIP tracker to measure completeness of programme for the remaining months. |
| Production and delivery of the Closing the Gap plan. | |
| Procurement to deliver full £8m target against budgeted spend. | Monthly performance meetings with individual CMGs to include detailed review of CIP delivery and forecast. |
| Quarterly quality assurance reporting. | |
| Monthly CMG/Corporate position reviews - escalating to weekly where CMGs/Corporate departments are materially varying from plan. | |
| | |
| | |
| **Financial Plans** | |
| CIP to achieve 100% delivery in 2017/18. | CIP measurement and reporting monthly. |
| CMGs to achieve their control totals or better. | Monthly I&E submissions to NHSI, Trust Board, IFPIC and EPB. |
| Cost pressures and service developments to be minimised and managed through RIC and CEO chaired 'Star Chamber'. | Expenditure run rates for pay, non-pay, capital charges and agency spend. |
| A minimum of £18m of additional technical and other solutions to be transacted. | Contract income levels consistently being achieved and commissioner challenges resolved quarter by quarter. |
| Agree an appropriate level of investment supporting the resolution of the demand/capacity issue. | Year on year reduction in agency spend in line with our 2 year trajectory. |
| | I&E monitoring of progress against £18m technical challenge. |
| Manage CCG and NHSE contracts to ensure accurate and full receipt of income noting changes to tariff (HRG4+) and new Emergency Floor currencies/flows. | Overall level of overdue debtors to reduce, BPPC performance to improve - monitored within cash paper to IFPIC. |
| Implementation of the first stages of UHL's Commercial Strategy and use of TGH Ltd. | Improvement in cash position as per the agreed plan. |
| | |
| Reduction in agency spend moving towards the NHSI agency ceiling level. | |
| New income streams realised and effective, financially beneficial use of TGH Ltd. | |
| | |

| Risk assurance (assessment) | Movement |
|---|---|
| If the CIP plan is not successfully delivered, caused by cost pressures and ineffective strategies in CMGs, then the Trust's CIP may not successfully be delivered against the target. | |
| If the financial plan is not successfully delivered, caused by ineffective solution to the demand and capacity issue, then the Trust's financial control total may not successfully be delivered against the target. | |
| | |

| Corporate Oversight (TB / Sub Committees) | | | |
|---|---|---|---|
| Source:- | Title: | Date: | Assurance Feedback: |
| TB sub Committee | Audit Committee | Monthly | Finance / CIP reports |
| TB sub Committee | IFPIC | Monthly | I&E information to IFPIC to include monitoring of progress against £18m technical challenge |

| Independent (Internal / External Auditors) | | | |
|---|---|---|---|
| Source:- | Title: | Date: | Feedback: |
| Internal Audit | CIP function and process | Q1 17/18 | |
| External Audit | work plan TBA | | |

# BAF scoring

## BAF Assurance Rating:

| | |
|---|---|
| 0 | Not yet started |
| 1 | Fail |
| 2 | Significant Delay – unlikely to be completed in 2017/18 |
| 3 | Some Delay – expected to be completed in 2017/18 |
| 4 | On Track |
| 5 | Complete |

**Key questions to BAF owners each month:**

Is progress to achieve the annual priority in 2017/18 on track?

| | |
|---|---|
| 3 | Some Delay - on track for 2017/18 |
| 4 | On Track |
| *Follow up question* - By when will the priority be achieved? | |

or

| | |
|---|---|
| 2 | Significant Delay – unlikely to be completed in 2017/18 |
| *Follow up questions* - What further actions have been identified to get the objective / annual priority back on track and when is it expected to be achieved? | |

or

| | |
|---|---|
| 1 | Failed |
| *Follow up question* - why have we failed to deliver the annual priority? | |

or

| | |
|---|---|
| 0 | Not yet started |
| | |

**Appendix 2 Risk Register Dashboard as at 28 Apr 17**

| Risk ID | CMG | Risk Title | Current Risk Score | Target Risk Score | Risk Movement | 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 | ↔ | Quality Commitment |
| 2762 | Corporate Nursing | Ability to provide safe, appropriate and timely care to all patients attending the Emergency Department at all times. | 25 | 15 | ↔ | Quality Commitment |
| 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 | ↔ | Quality Commitment |
| 2354 | RRCV | There is a risk of overcrowding in the Clinical Decisions Unit | 20 | 9 | ↔ | Quality Commitment |
| 2670 | RRCV | There is a risk to the Immunology & Allergy Services due to a Consultant Vacancy | 20 | 6 | ↔ | Our People |
| 2886 | RRCV | LGH Water Treatment Plant risk of downtime, resulting from equipment failure of the water plant impacting on HD patients | 20 | 8 | ↔ | Quality Commitment |
| 2931 | RRCV | Increasing frequency of Cardiac Monitoring System on CCU failing to operate | 20 | 4 | ↔ | Quality Commitment |
| 2804 | ESM | Outlying Medical Patients into other CMG beds due to insufficient ESM inpatient bed capacity | 20 | 12 | ↔ | Quality Commitment |
| 2149 | ESM | High nursing vacancies across the ESM CMG impacting on patient safety, quality of care and financial performance | 20 | 6 | ↔ | Our People |
| 2763 | ITAPS | Risk of patient deterioration due to the cancellation of elective surgery as a result of lack of ICU capacity at LRI | 20 | 10 | ↔ | Our People |
| 2990 | MSK & SS | There is a risk of delayed outpatient corrospondance to referer/patient following clinic attendance. | 20 | 3 | ↔ | Quality Commitment |
| 2191 | MSK & SS | Lack of capacity within the ophthalmology service is causing delays that could result in serious patient harm. | 20 | 8 | ↔ | Our People |
| 2867 | CSI | A risk to staff health and not meeting regulatory requirements due to cracks in LRI Mortuary Floor | 20 | 3 | ↔ | Our People |

| Risk ID | CMG | Risk Title | Current Risk Score | Target Risk Score | Risk Movement | Themes aligned with Trust Objectives |
|---|---|---|---|---|---|---|
| 2940 | W&C | Risk that paed cardiac surgery will cease to be commissioned in Leicester with consequences for intensive care & other services | 20 | 8 | ↔ | Quality Commitment |
| 2403 | Corporate Nursing | There is a risk changes in the organisational structure will adversely affect water management arrangements in UHL | 20 | 4 | ↔ | Key Strategic Enablers |
| 2404 | Corporate Nursing | There is a risk that inadequate management of Vascular Access Devices could result in increased morbidity and mortality | 20 | 16 | ↔ | Quality Commitment |
| 2471 | CHUGGS | There is a risk of poor quality imaging due to age of equipment resulting in suboptimal radiotherapy treatment. | 16 | 4 | ↔ | Our People |
| 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 | ↔ | Quality Commitment |
| 2819 | RRCV | Risk of lack of ITU and HDU capacity will have a detrimental effect on Vascular surgery at LRI | 16 | 12 | ↔ | Our People |
| 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 | ↔ | Our People |
| 2333 | ITAPS | Lack of Paediatric cardiac anesthetists to maintain a WTD compliant rota leading to interruptions in service provision | 16 ↓ | 8 ↓ | ↓ | Our People |
| 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 | ↔ | Quality Commitment |
| 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 | ↔ | Quality Commitment |
| 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 | ↔ | Our People |
| 2378 | CSI | There is a risk that Pharmacy workforce capacity could result in reduced staff presence on wards or clinics | 16 | 8 | ↔ | Our People |
| 2391 | W&C | There is a risk of inadequate numbers of Junior Doctors to support the clinical services within Gynaecology & Obstetrics | 16 | 8 | ↔ | Our People |
| 2153 | W&C | Shortfall in the number of all qualified nurses working in the Children's Hospital. | 16 | 8 | ↔ | Our People |

| Risk ID | CMG | Risk Title | Current Risk Score | Target Risk Score | Risk Movement | Themes aligned with Trust Objectives |
|---|---|---|---|---|---|---|
| 2394 | Communications | No IT support for the clinical photography database (IMAN) | 16 | 1 | ↔ | Our People |
| 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 | ↔ | Our People |
| 2247 | Corporate Nursing | There is a risk that a significant number of RN vacancies in UHL could affect patient safety | 16 | 12 | ↔ | Our People |
| 1693 | Operations | There is a risk of inaccuracies in clinical coding resulting in loss of income | 16 | 8 | ↔ | Key Strategic Enablers |
| 2872 | RRCV | There is a risk of bedded bariatric patients being trapped compromising fire evacuation on ward 15 at GGH | 15 | 6 | ↔ | Quality Commitment |
| 3005 | RRCV | The current level of RN vacancies and inability to format an appropriate roster may compromise the ward to fully function | 15 | 6 | ↔ | Our People |
| 2837 | ESM | There is a risk of delay in acting upon monitoring investigation results in patients with multiple sclerosis. | 15 | 2 | ↔ | Our People |
| 2989 | MSK & SS | If we do not recruit into the Trauma Wards nursing vacancies, then patient safety and quality of care will be placed at risk | 15 | 4 | ↔ | Our People |
| 1196 | CSI | No comprehensive out of hours on call rota and PM cover for consultant Paediatric radiologists | 15 | 2 | ↔ | Our People |
| 2973 | CSI | Risk of suboptimal and unsafe Nutrition and dietetic Service provision to Adult Gastrenterology Medicine patients | 15 | 6 | **NEW** | Our People |
| 2946 | CSI | Risk of suboptimal provision of nutrition and dietetic service to head and neck cancer patients | 15 | 2 | **NEW** | Our People |
| 2787 | CSI | Failure of medical records service delivery due to delay in electronic document and records management (EDRM) implementation | 15 | 4 | ↔ | Our People |
| 2965 | CSI | If we do not address Windsor pharmacy storage demands, then we may compromise clinical care and breach statutory duties | 15 | 6 | ↔ | Quality Commitment |
| 2601 | W&C | There is a risk of delay in gynaecology patient correspondence due to a backlog in typing | 15 | 6 | ↔ | Our People |

| Risk ID | CMG | Risk Title | Current Risk Score | Target Risk Score | Risk Movement | Themes aligned with Trust Objectives |
|---|---|---|---|---|---|---|
| 2925 | Estates & Facilities | Reduction in capital funding may lead to a failure to deliver the 2016/17 medical equipment capital replacement programme - NOTE - this risk is to be replaced with a new risk for 2017/18 | 15 | 10 | | Quality Commitment |
| 2402 | Corporate Nursing | There is a risk that inappropriate decontamination practice may result in harm to patients and staff | 15 | 3 | ↔ | Quality Commitment |