INTEGRATED RISK REPORT AS AT 31ST DECEMBER 2016

Author: Risk and Assurance Manager **Sponsor: Medical Director** **Trust Board 2.2.17** **paper J**

Executive Summary

Context

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

Questions

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

Conclusion

1. Executive leads have identified principal risks affecting the achievement of our objectives. All risks have been reviewed and endorsed at the relevant Exec Board during the reporting period. Principal risk 16 - The Demand/Capacity gap if unresolved may cause a failure to achieve UHL deficit control total in 2016/17: The position has deteriorated at the end of Month 9 and the risk rating has been increased to 25 (extreme).
2. Many of our assurance sources are based on internal monitoring and some may benefit from external scrutiny (e.g. via internal audit) to provide additional assurance that controls are effective. Many of the risks are flagged with amber assurance ratings which suggest effective controls are believed to be in place but outcomes of assurances are uncertain / insufficient.
3. There are a small number of actions where the deadline for completion has been extended in recognition of delays being encountered. Narrative within the BAF 'action tracker' provides further detail.
4. There have been two new risks entered and two risks have reduced from high to moderate during the reporting period. The organisational risk register dashboard is included as an appendix to the paper.

Input Sought

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

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

For Reference

Edit as appropriate:

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

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

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

a. Organisational Risk Register [Yes]

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

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

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

b. Board Assurance Framework [Yes]

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

Principal Risk	Principal Risk Title	Current Rating	Target Rating
All BAF risks	See appendix one		

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

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

5. Scheduled date for the **next paper** on this topic: [02/03/17]

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **UHL TRUST BOARD**

DATE: **2ND FEBRUARY 2017**

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

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

---

1 INTRODUCTION

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

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

2. BAF SUMMARY

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

2.2 The TB is asked to note:

2.2.1 Principal risk 3 - Emergency attendance/ admissions increase without a corresponding improvement in process and / or capacity continues to be a concern: During January the four key actions being focussed on are:

- Embedding Red2Green within Emergency and Specialist Medicine CMG
- Ensure that we continue to drive down ambulance handover times by proactively cohorting up to 17 patients waiting for admission
- Improve the functioning of the ED assessment process
- Improve the pace of flow

2.2.2 Principal risk 4 - Failure to deliver the national access standards impacted by operational process and an imbalance in demand and capacity: A number of standards were failed during December including RTT Incomplete waiting times, Cancer Access - 31 day wait for 1st treatment, 62 day wait for 1st treatment.

2.2.3 Principal risk 16 - The Demand/Capacity gap if unresolved may cause a failure to achieve UHL deficit control total in 2016/17: The position has deteriorated at the end of Month 9 and the current risk rating has been increased to 25 (extreme) to reflect the impact on achievement of our planned deficit control. The Trust must take all necessary action to further minimise this variance and still have the ambition to deliver Plan.

3. UHL RISK REGISTER SUMMARY

3.1 At the end of the reporting period, there are 48 risks open on the operational risk register scoring 15 and above and these are displayed in the risk register dashboard in appendix two.

3.2 Two new 'high' risks have been entered on the risk register during December 2016 and are shown below. Full details are included in appendix three.

Datix ID	Risk Title	Risk Rating	CMG
2969	There is a risk of failure to deliver the TAT Standards of NHS Cervical and NHS Bowel Cancer Screening programmes	16	CSI
2965	If we do not address Windsor pharmacy storage demands, then we may compromise clinical care and breach statutory duties	15	CSI

3.3 Two risks have reduced from high to moderate ratings during December 2016:

Datix ID	Risk Title	Risk Rating	CMG
182	Inappropriate patient Management due to inaccurate diagnostic results from Point Of Care Testing equipment	12	CSI
2878	There is a risk of cancer patients not being discussed at MDTs due to inadequate video conferencing facilities	12	Operations

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

4 RECOMMENDATIONS

4.1 The TB is invited to:-

(a) receive and note this report;

(b) review this version of the 2016/17 BAF noting:

- any gaps in assurance about the effectiveness of the controls to manage the principal risks and consider the nature of, and timescale for, any further assurances to be obtained;
- the actions identified to address any gaps in either controls or assurances (or both).

Report prepared by UHL Corporate Risk Management Team
26th January 2017

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

Board Assurance Framework:	Updated version as at:	Dec-16											
Principal risk 1:	Lack of progress in implementing 2016/17 UHL Quality Commitment								**Risk owner:**	CN / MD			
Strategic objective:	Safe, high quality, patient centered healthcare								**Objective owner:**	CN			
Annual Priorities	To reduce avoidable deaths and avoidable re-admissions . To reduce harm caused by unwarranted clinical variation through introduction of 4 key 7 DS clinical standards in core services; implement UHL EWS and eObs processes; and safe use of insulin. To use patient feedback to drive Improvements to services and care by ensuring patients are informed and involved in their care; better end of life planning and improve the experience of outpatients.								**Risk Assurance Rating**	Exec Board RAG Rating = EQB 03/01/17			
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**	
	4x4=16	4x4=16	4x3=12	4x3=12	4x3=12	4x3=12	4x3=12	4x3=12	4x3=12				
Target risk rating (I x L):	4x2=8												

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Clinical Effectiveness **Directive controls** Screen all hospital deaths Sepsis screening tool and care pathway Implement daily PARR 30 report to direct specialised discharge planning and communication of risk with stakeholders **Detective controls** Hospital deaths screening tool findings % of deaths screened Case record review individual and thematic findings Dr Foster's Intelligence and HED data Audit of sepsis 6 interventions No. of SIs in relation to deteriorating patient/ sepsis Readmission rates and findings of PARR30 tool	**Clinical Effectiveness** SHMI scores reported to Mortality and Morbidity Committee and TB, QAC via Q&P report. Quarterly mortality report to ESB/QAC/TB 6 monthly TB report in relation to mortality parameters monthly review of mortality alerts reported to TB. UHL target SHMI <= 99 UHL SHMI Jun 15 - Jul 16: 101 Readmission rate to be < 8.5% Readmissions action plan progress reported monthly to Ward Programme Board Quarterly report to EQB Exception reports to EPB when rate over8.6% **Sepsis and deteriorating patient Audit**	Internal Audit mortality and morbidity review completed. Internal audit review in relation to outpatient patient experience due completed.	Currently not all deaths are screened. (1.1, 1.2 and 1.3) ~~Circa £3M funding gap to implement 7 day service standards. (1.4)~~ ~~Workforce shortage may inhibit implementation of 7 day service standards (1.4)~~ Data quality and volume due to manual data audit collection (1.6) Many avoidable readmissions caused due to factors in the community beyond influence of

Patient Safety **Directive controls** 7 Day service standards (including implementation of 14 hour consultant review, diagnostics, professional standards and daily consultant review) Tool for UHL EWS and e-obs Tool for insulin safety strategy **Detective control** Quarterly patient safety report highlighting number of severe/ moderate harms % of deaths screened 7 DS NHSE audit returns Insulin related incidents reported via Datix **Patient Experience** **Directive Control** End of life care plans Use of the 5 questions **Detective Controls** EoLC audits of use of care plan % uptake of EoLc training Outpatient group monitoring data	% of EWS 3+ appropriately escalated % of EWS 3+ screened for sepsis % of "red flag" sepsis patients receiving iv antibiotics within 1 hour (threshold 90% of antibiotics within 60mins) Harm reviews for patients >3 hours **7 Day Services** NHS E 7 DS quarterly self assessments **Patient experience** 6% improvement on patient involvement scores 10% improvement on care plan use and outpatient experience scores. Achieve 14 day correspondence standard.		UHL. ~~Develop a 6 month project plan to support the required improvements in sepsis and the deteriorating patient trust wide (1.7)~~ The current blood glucose monitoring is not networked or linked to e - obs (1.8)

Action tracker:	Due date	Owner	Progress update:	Status
Mortality database to be developed (1.1)	~~Nov 16~~ March 17	MD	Networked database proving slow and difficult to use. Plan is therefore for Medical Examiner module to be incorporated into the Bereavement Services Office	3
UHL Medical Examiners as Mortality Screeners (1.2)	~~July 16~~ ~~Nov 16~~ March 17	MD	Medical Examiners screening all adult deaths at LRI. Further changes to the process made following feedback from the Registrar and Coroner. Additinal cohort of Medical Examiners trained 12 Dec 16 with a view to roll-out to LGH in Feb2017. GGH to follow subject to being able to identify enough ME's.	3
Participate in National standardised mortality review process (1.3)	Apr-17	MD	UHL has registered as an early adopter and it is anticipated that this will start by April 2017. We have 6 clinicians undergoing training to be cascade trainers in Feb 17	4

Quantify workforce & financial gap to delivery of 4 clinical standards in the core services (1.4)	Complete	MD	Plan completed and UHL position re gap accepted by NHSE and NHS Imp	5
Implement EWS score to trigger sepsis care pathway and automate audit data collection for deteroriating patient (1.6)	~~Dec 16~~ March 17	MD	E-Obs now on all in-patient wards. Plan to introduce into ED in Feb 2017 and to launch sepsis track & trigger tool at end of March 2017. Further work being undertaken with Nervecentre to automate data collection and reporting of EWS/sepsis perfomance	3
Incorporate PARR30 scores into ICE and Nerve Centre (1.6)	~~Dec 16~~ March 17	MD	Delay in implementation related to IT resource being directed to implementation of ED Nervecentre solution. Now expected to be complete by end of Feb 17	3
Release wte discharge sister to prioritise high risk discharge planning (1.6)		MD	Action now superceded by changed organisational priorities. Resource diverted to support Red 2 Green work. It was therefore agreed that whole project to be assimilated into discharge element of Red to Green	N/A
Develop a 6 month project plan to support the required improvements in sepsis and the deteriorating patient trust wide (1.7)	Dec 16 Complete	CN/MD	Plan developed and being monitored through Deteriorating Patient Board	5
Develop a buisness case to support the implementation of networked blood glucose monitroing (1.8)	Mar-17	KH/JS	Case in development working with procurement and IT	4
In Q 3 commence face to face training on the safe use of insulin - targeted at areas with the highest no. of incidents (1.9)	Jan-17	KH	Plan to deliver to high incident areas in place	4

Board Assurance Framework:	Updated version as at:	Dec-16										
Principal risk 2:	Failure to provide an appropriate environment for staff/ patients								**Risk owner:**		DEF	
Strategic objective:	Safe, high quality, patient centred healthcare								**Objective owner:**		CN	
Annual priorities	Develop a high quality in-house Estates and Facilities service								**Risk Assurance Rating**		Exec Board RAG Rating = EQB 03/01/17	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4X3=12	4x2=8	4x3=12	4x3=12	4x3=12	4x4=16	4x4=16	4x4=16	4x4=16			
Target risk rating (I x L):	4x2=8											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Preventative Control Estates management infrastructure in place including committee structure (e.g. Fire Safety Committee (Reviewed & Transformed), Water Management Committee (Reviewed & Consulted), Waste Committee (Reviewed & Transformed), IP Committee). **Detective Control** IT systems to control processes and performance manage. Review of Estates and facilities related incident reports. Service user feedback (Staff). Weekly audits carried out by Management. EHO inspections. Compliance KPI data monitored. **Directive Control** Outline plan in place for developing Estates and Facilities Service: 0 - 3 months - Maintain safe services 0-9 months - Ensure compliance 0-18 months - Review, develop and optimise quality of services. Refresher training for food handlers Maintenance requests escalated. **Corrective Control** Escalation processes for deteriorating standards/ performance	Cleanliness audits PLANET SYSTEM providing data for Estates and 'soft' services SAFFRON system providing data for Patient feeding/ catering services. Internal Statutory Compliance Audit from PWC in December 2016, report due in January 2017. Annual ERIC return to benchmark efficiency against other organisations (due July 2016). Monthly performance reporting to EQB/ QAC and TB in relation to KPIs (September 2016). Triangulation of audit data with external audits and user feedback. Internal Workforce targets. Refresher training for food handlers. Maintenance requests escalated. Weekly audits carried out by Management. Increased Trust EHO inspections.	Annual 'PLACE' review (next due March 2017). Annual peer audit/ review (next due November 2016). Compliance with all appropriate regulatory bodies statutory requirements and audit (i.e. Environment Agency, Environmental Health, Food Standards, HSE, etc.). CQC Inspections. Local Authority Environmental Health Officer (EHO inspections). Increased Trust EHO inspections. Water Management Audit carried out in December 2016 by external specialists, report due by the end of January 2017.	(c) Lack of detailed plans to deliver outline plan (2.1) ~~(a) Some data not robust in relation to detailed KPIs (2.2)~~ (a) Poor quality of transition data related to staff details, work patterns, shifts, etc. (2.3) (c) Vacancy levels, management structure. Lack of training of inherited staff. (2.4) (c) Underfunding of the estates and facilities revenue budget (2.5). Inherited sub-optimal systems and inconsistent information retention records.

Action tracker:	Due date	Owner	Progress update:	Status
Develop detailed plans to cover 18 month review programme (2.1)	~~Dec 16~~ Feb 17	DEF	On-going. First draft being scoped.	3
Clean up ELI data and evaluate shift patterns, rotas, etc. (2.3)	~~Sep 16~~ ~~Dec 16~~ Feb 17	DEF	Major payroll/HR exercise undertaken. Minimal issues with pay - 3 clear months reviewed. All rotas evaluated - new proposals being prepared	3
KPI's to be developed for service delivery at 3 levels - National indicators; Trust indicators; Internal Divisional targets (2.2)	~~Oct 16~~ Feb 17	DEF	Currently being discussed with Service Users, external partners, etc. Continuing work on KPI's	3
Comprehensive "on-boarding" events to be organised and training needs evaluated and planned (2.4)	Review Jan 17	DEF	Staff Roadshows completed. Staff inductions c95% complete. LiA events scheduled for Sept 16. Training programme in development with dedicated OD support.	4
Review compliance of service (2.2)	Dec 16 Complete	DEF	New System - CASS - introduced. DoH Premises Assurance Model completed. Desktop exercise on major hard FM services underway. Completed but will be a continuous process of monitoring controls in place.	5
Recruit into vacancies, replace lost hours into cleaning/catering services, restructure management team. (2.4)	Review Jan 17	DEF	Recruitment campaign underway - dedicated events held. Staff offered hours back for cleaning/catering. Senior management team re-structure through MoC. Outline apprenticeship programme in development. Tiered management structures under development.	4
Identify investment required to address fundamental issues with layout of equipment and equipment replacement/additions (2.5)	~~Dec 16~~ Jan 17	DEF	Initial condition survey completed - further in-depth survey required to review insulation within walls. All minor works identified as requiring attention completed. New equipment now in place - i.e. refrigeration/oven. Final report on in depth survey to identify cause of condensation awaited. Revisit by local authority EHO on 13th December, 2016 5* rating achieved	3

Board Assurance Framework:	Updated version as at:	Dec-16										
Principal risk 3:	Emergency attendance/ admissions increase without a corresponding improvement in process and / or capacity								**Risk owner:**		Sam Leak, Director of Emergency Care and ESM	
Strategic objective:	An effective and integrated emergency care system								**Objective owner:**		COO	
Annual Priorities	Reduce ambulance handover delays in order to improve patient experience, care and safety. Fully utilise ambulatory care to reduce emergency admissions and reduce length of stay (including ICS). Develop a clear understanding of demand and capacity to support sustainable service delivery and to inform plans for addressing any gaps. Diagnose and reduce delays in the in-patient process to increase effective capacity								**Risk Assurance Rating**		Exec Board RAG Rating = EPB: 24/01/17	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	5x5=25	5x5=25	5x5=25	5x5=25	5x5=25	5x5=25	5x5=25	5x5=25	5x5=25			
Target risk rating (I x L):	3x2=6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive / Preventative Controls NHS '111' helpline GP referrals Local/ National communication campaigns Winter surge plan Triage by Lakeside Health (from 3/11/15) for all walk-in patients to ED. (reduced resource by 50% May 2016 and ceases November 16). Urgent Care Centre (UCC) now managed by UHL from 31/10/15 Admissions avoidance directory Reworking of LLR urgent care RAP- as detailed in COO report Bed capacity demand for 16/17 and 17/18 updated to show the bed gap by month. Red to Green (R2G) to eliminate delays in our processes.	ED 4 hour wait performance (threshold 95%) Poor performance continues to be primarily driven by increased ED attendances and emergency admissions but has also been contributed to by staffing issues (staff sickness and vacancies) Total attendances and admissions (compared to previous year) 1.% increase in emergency admissions 7% increase in total A&E attendances. Ambulance handover (threshold 0 delays over 30 mins) 29.0% over 30mins 12% over 60mins, 2.1% over 120 mins	National benchmarking of emergency care data New AE Delivery board chaired by CEO of UHL. RAP approved by NHSE and NHSI and being progressed by the new AE implementation group. ~~ECIP 3 day gap analysis in July and 2 days in August to review ward processes.~~ ~~1 Day ECIP review in October and new team expected to support delivery in November 2016.~~ New ECIP team started in November to support delivery over the next 12 months.	(c)Lack of effectiveness of attendance avoidance plan & winter surge capacity / Discharge plan (3.1) Lack of capacity to operate (3.2)

Detective Controls Q&P report monitoring ED 4-hour waits, ambulance handover >30 mins and >60 mins, total attendances / admissions. UCB RAP being revised to ensure priority on decreasing attendance and admissions Comparative ED performance summaries showing total attendances and admissions.	Difficulties continue in accessing beds from ED leading to congestion in ED and delayed ambulance handover.	In-depth ECIP review 12 & 13 January, including external ED consultant	

Action tracker:	Due date	Owner	Progress update:	Status
New LLR AE recovery plan to be progressed (as per the action dates on the plan) through the new AE recovery board. (3.1)	See plan	See plan	Plan has been produced New AE implementaion group started 12.10.16 Recovery plan updated fortnightly by SROs, and monitored via EQSG fortnightly. During January the four key actions we will be focusing on are: 1. Embedding Red2Green within Emergency and Specialist Medicine CMG 2. Ensure that we continue to drive down ambulance handover times by proactively cohorting up to 17 patients waiting for admission 3. Improve the functioning of the ED assessment process 4. Improve the pace of flow	4
Move to new build (3.2)	~~March 17~~ 24/04/17	LG / CF	Operational plan for moving the service to new build now in place. Ongoing discussions with workstream leads, including workforce and HR, to ensure pathways are updated and staff engaged in new processes prior to opening.	3
Escalation areas in ED to be used proactively (3.1)	~~Jan 17~~ Complete	LG	New pro-active co-horting policy now in place to support reduction in delayed ambulance handovers; up to 17 patients, both in and out of hours, can now be co-horted whilst awaiting admission.	5

Board Assurance Framework:	Updated version as at:	Dec-16										
Principal risk 4	Failure to deliver the national access standards impacted by operational process and an imbalance in demand and capacity.								**Risk owner:**		Will Monaghan, Director Of Performance And Information	
Strategic objective:	Services which consistently meet national access standards								**Objective owner:**		COO	
Annual Priorities	Maintain 18-week RTT and diagnostic access standard compliance Deliver all cancer access standards sustainably								**Risk Assurance Rating**		Exec Board RAG Rating = EPB: 24/01/17	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x5=20	4x5=20	4x5=20	4x5=20			
Target risk rating (I x L):	3 x 2 = 6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Detective Controls RTT incomplete waiting times, cancer access and diagnostic standards reported via Q&P report to TB **Corrective controls** Insourcing of external consultant staff to deliver additional sessions. Outsourcing of elective work to independent sector providers. Productivity improvements in-house. Additional premium expenditure work in house.	RTT Incomplete waiting times (threshold 92%). 91.2% (Dec 16) standard failed. Diagnostics (threshold 1%): 0.85% (Dec 16) position achieved. Cancer Access Standards (reported monthly). 2WW for urgent GP referral (Threshold 93%). 93.0% Achieved. 31 day wait for 1st treatment (threshold 96%). 85.0% Failed. 31 day wait for 2nd or subsequent treatments: (Drugs - threshold 98%). 98% Achieved. (Surgery - threshold 94%). 85% Failed. (Radiotherapy - threshold 94%). 98% Achieved. 62 day wait for 1st treatment (threshold 85%). 82% Failed. Cancer wait 104 days. 10	Cancer recovery action plan managed across the Trust, NHS Improvement and the CCG. Monthly performance call with NTDA. Internal audit review in relation to waiting times for elective care due in quarter 4 2015/16; initiated end January 2016. Elective IST have assured the action plans in Diagnostics and the Cancer plan. Demand management plan with CCG's	(c) Lack of progress on 62 day backlog reduction due to ITU/HDU capacity and gaps in clinical capacity in key specialties (4.1). (c) insufficient theatre staff to undertake additional sessions required to match growth (4.3). (c) Referral growth outmatching capacity growth. 12.1% YTD referal increase versus 2014/15 (4.4).

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

Sustained achievement of 85% 62 day standard (4.1)	Review ~~Nov 16~~ Jan 17	DPI	62 day backlog reduction currently off trajectory. Implementation of 'Next Steps' for cancer patients in key tumour sites to start end February 2016. Sustainable ability to meet the 62 day standard will not be achieved until the Trust has 2 consecutive months with no outliers. Actions below and mitigating steps outlined to support in achieving this. Continued medical outliers over winter in January, 62 day performance improved in December.	3
Development of ITU additional capacity plan including increased frequency of step downs. (4.1)	~~Sept 16~~ Jan 17	HofOps ITAPS	Cancellations per month for ITU/HDU across all sites continue to reduce: June=54, July=24, August = 13, September = 9, December = 7. Daily escalation of predicted surgical and medical step down at Gold Command to aid discharges. Plan to open additional physical beds pending nurse staffing recruitment. Continuing to actively pursue recruitment opportunities for both medical and nursing to get additional beds open at the LRI	3
Development of plan for closing the known theatre capacity Gap in 16/17 (4.3)	Review Jan 17	COO to allocate	Plans to develop to bridge internal capacity gaps and outsource/insource capacity to meet performance targets in progress. Outsourcing and Insourcing on-going recurrent action in ENT/Opthalmology/Gen Surg and Urology. Plans continue to include transfer of appropriate patients to IS and Alliance. Average cases per list actively monitored at Weekly Access Meeting and Theatre Program Board as mitigation in capacity gap.	4
Serving Activity query Notices to the commissioners (4.4)	Review ~~Nov 16~~ Apr 17	DPI	Reviewed at Monthly Cancer RTT board with commissioners. New Planned Care Delivery Group chaired by DPI to start from January 2017. Aim of demand management, Referral Management Hub – including the use of PRISM. Low Priority Treatments left shift – to maximise community facilities. Reduced referalls resulting from demand management will have a downstream impact unlikley to realised until start of 2017/18.	3

Board Assurance Framework:	Updated version as at:	Dec-16										
Principal risk 5:	There is a risk that UHL will lose existing, or fail to secure new, tertiary referrals flows from partner organisations which will risk our future status as a teaching hospital. Failure to support partner organisations to continue to provide sustainable local services, secondary referral flows will divert to UHL in an unplanned way which will compromise our ability to meet key performance measures.								**Risk owner:**		Director of Marketing and Comms (DoMC). Updates by John Currington	
Strategic objective:	Integrated care in partnership with others								**Objective owner:**		DoMC	
Annual priorities	Develop new and existing partnerships with a range of partners, including tertiary and local service providers to deliver a sustainable network of providers across the region. Progress the implementation of the EMPATH strategic outline case								**Risk Assurance Rating**		Exec Board RAG Rating = (Date: 10/01/17)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x3=12	4x3=12	4x3=12	4x3=12	4x3=12	4x3=12	4x3=12	4x3=12	4x3=12			
Target risk rating (I x L):	4x2=8											

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

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

Action tracker:	Due date	Owner	Progress update:	Status
(5.1) Apply criteria in Tertiary Partnership Strategy to prioritise service lines.	Feb-17	JC	The first priority strategy area is Cardiac Surgery with others to follow	4
(5.3) Statistical Process Control Reporting to be developed for other priority services.	~~Sep-16~~ ~~Nov-16~~ Feb 17	JC	To follow on from (5.1) Agreed to prioritise Lincolnshire Urology to be reported at the December Tertiary Partnership Board	3

Board Assurance Framework:	Updated version as at:	Dec-16										
Principal risk 6:	Failure to progress the Better Care Together programme at sufficient pace and scale impacting on the development of the LLR vision								**Risk owner:**		Director of Marketing and Comms (DoMC)	
Strategic objective:	Integrated care in partnership with others								**Objective owner:**		DoMC	
Annual priorities	Work with partners to deliver year 3 of the Better Care Together programme to ensure we continue to make progress towards the LLR vision (including formal consultation).								**Risk Assurance Rating**		Exec Board RAG Rating = (Date: 10/01/17)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16			
Target risk rating (I x L):	2x5=10											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls Draft STP Plan for 20/21, which builds on the BCT 5 Year Plan. New governance arrangements, including a new System Leadership Team (SLT) as a joint programme board with membership from the five NHS partner organisations and the three upper tier local authorities, a programme management office, and multi-agency boards (that include senior UHL representation) to progress each workstream of the STP (i.e. Integrated Teams Programme Board) A new System Stakeholder Forum (SSF) will be open to all members of Trust and CCG Boards, the Health and Wellbeing Boards for LLR, the Clinical Leadership Group, HealthWatch organisations within LLR, and PPI leads.	Monthly updates (including high level risks and mitigating actions) received and reviewed by a number of internal boards and committees, namely Trust Board, Executive Strategy Board, Reconfiguration Programme Board. Plans and assumptions for UHL bed base aligned to STP (in terms of demand and capacity, finance and capital, and worforce)	Healthwatch organisations across LLR and the PPI Group. Clinical Senate (external to the LLR Partnership). Externally commissioned Health checks (also known as Gateway Reviews). Pre-consultation business case (PCBC) considered and signed off by partner boards, including CCG Boards, provider boards, local authorities etc. Ultimate decision to go to consultation sits with NHS England - NHS England lead the national (external) assurance process. NHS Improvement when reviewing and approving Trust plans.	(a) Some early schemes may not be delivering the anticipated impact on demand, which is a significant risk for UHL. The STP currently lacks a programme dashboard (used to track progress) making it difficult to hold work stream leads to account (6.1). (c) Potential divergence from STP assumptions in the planning and contracting process (6.2) (c) Lack of visibility and engagement (of STP workstreams / programmes) across the wider CMG leadership teams (6.3) (c) Lack of funding in the STP for either transitional or

UHL governance arrangements include a Reconfiguration Programme Board and associated sub-committees / boards and work streams i.e. major capital business cases, estates, IM&T, Future Operating Model etc. **Detective Controls** Progress updates against pre-defined plans presented to both multi-agency boards and individual partner boards		New STP governance arrangements will strengthen controls - a more collaborative set of delivery and leadership arrangements have beenestablished across the LLR health andcare community.	either transitional or transformational costs (6.4) (a) Inability to deliver central control totals, making it more difficult to balance the LLR STP financially (6.5) (c) the LLR system is not in equilibrium, which is not fully reflected in the STP

Action tracker:	Due date	Owner	Progress update:	Status
(6.1) Finalise governance and reporting arrangements once STP work programmes are suitably developed - there is a need for a clear, detailed implementation plan, to operationalise the STP.	~~Sept 16~~ ~~Nov 16~~ ~~Dec 16~~ Apr 2017	MW	Broader arrangements for Assurance will form part of the new governance arrangements put in place for STP implementation, namely the STP Workstream updates that will be considered by the SLT each month.	3
(6.2) An internal STP Coordination Group has been established (chaired by John Adler) to oversee the process of bringing the STP and contracting assumptions together as much as possible	Jan-17	PT & MW	This group continues to meet fortnightly and has shaped the assumptions in our Operational Plans (and contracting strategy), which will be considered by the Trust Board at the end of January	4
(6.2) Consider how we better balance risk and control within the plan and contract to encourage the right behaviours / mutual incentives	Jan-17	PT	Contract negotiations are ongoing (at the time of writing) but the settlement is likely to include suitable provisions on matters such as risk.	4
(6.3) Ensure CMGs are well sighted to STP workstreams and assumptions, particularly where they are not directly engaged	Dec 16 Complete	MW	Summary of STP workstreams shared with CMGs as part of the planning process	5
(6.3) Undertake mapping exercise of governance arrangements (specifically the various meetings, internal and external, now in place) relating to STP Delivery in order to check we have the right representation and necessary alignment to emerging priorities i.e. integration	Feb-17	MW	Work has commenced	4

(6.4) Continue to lobby for the 'transformation' element of STF monies to be released as soon as possible given the requirement for investment	Mar-17	JA & PT	UHL (and commissioners) have continued to raise this centrally	4
(6.5) Submit a financial plan in line with the Trust's existing LTFM, which includes a £5m improvement in 17/18 and 18/19	~~Dec 16~~ Mar 17	PT	The financial plan (along with other parts of our Operational Plan) is being finalised for submission later in January, subject to Trust Board approval	3
(6.6) Work with partners to bolster existing plans as well as looking at new possibilities, particularly around the integration agenda	Apr-17	MW	Our approach and priorities for integration are currently being developed, aligned to the emerging work within STP programmes such as Integrated Teams	4

Board Assurance Framework:	Updated version as at:	RISK CLOSED SEPT 2016										
Principal risk 7:	Failure to achieve BRC status. The Trust was awarded BRC status 13/09/2016 therefore achieving this status is no longer a risk.								Risk owner:		Nigel Brunskill, DoR&D	
Strategic objective:	Enhanced delivery in research, innovation and clinical education								Objective owner:		MD	
Annual Priorities	Deliver a successful bid for a Biomedical Research Centre								Risk Assurance Rating		Exec Board RAG Rating = (ESB 11/10/16)	
Current risk rating (I x L):	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	3x2=6	Risk mitigated to target rating and this risk closed on BAF in Sept					
Target risk rating (I x L):	3x2=6											

Controls: (preventive, corrective, directive, detective)	Assurance on effectiveness of controls		Gaps in Control / Assurance
	Internal	External	
Directive Controls Each BRU has a strategy document **Preventive Controls** UHL R&I supportive role to BRUs by meeting with Universities (Joint Strategic Meeting) Good working relationships between UHL and University partners Good track record of attracting subjects into studies Contracting and innovation team. Work with Medipex to commercialise our projects/ ideas. **Detective Controls** Financial monitoring of BRUs via Annual Report **Corrective controls** UHL to provide funding from external sources for targeted posts if necessary	Financial performance and academic output reported to UHL Joint Strategic meetings for assurance. In addition financial performance reported to each BRU Executive Board. Financial performance currently on plan. Highest recruiting Trust in the East Midlands and 7th nationally	NIHR monitor BRU performance University analysis of data	

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

Board Assurance Framework:	Updated version as at:	Dec-16										
Principal risk 8:	Failure to deliver an effective learning culture and to provide consistently high standards of medical education								**Risk owner:**		Sue Carr, Medical Education /Louise Tibbert, Director of Workforce & OD	
Strategic objective:	Enhanced delivery in research, innovation and clinical education. A caring, professional and engaged workforce								**Objective owner:**		MD/DWOD	
Annual priorities	Improve the experience of our medical students to enhance their training and improve retention, and help to introduce the new University of Leicester Medical Curriculum. Develop training for New and Enhanced Roles i.e. Physician's Associates, Advanced Nurse Practitioners, Clinical Coders								**Risk Assurance Rating**		Exec Board RAG Rating = EQB 03/01/17	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3x4=12	3x4=12	3x4=12	3x4=12	3x4=12	3x4=12	3x4=12	3x4=12	3x4=12			
Target risk rating (I x L):	3x2=6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Delivery of Clinical, Non-Clinical and Medical Education **Directive Controls** Medical Education Strategy Non-Medical Education Strategy Apprenticeship Attraction Strategy Operational guidance TB, EWB & EPB scrutiny / challenge of Medical Education issues Medical Workforce Strategy Medical Education Committee Medical Workforce Policy. NED - Colonel (Retd) Iain Crowe has been appointed to support Clinical Education. Quality Improvement Plan for Undergraduate and Postgraduate Education and Training.	Medical Education Quality Dashboard. GMC Trainer recognition dashboard. Safe Learning Environment. Support and Development of Trainees. Trainer/Mentor Support. Funding Streams.	HEEM accreditation visits. GMC National trainee survey results - general improvement but some areas of concern raised. Leicester Medical School feedback (National Student Survey) - poor performance in National Student Survey 2016. GMC visit in Dec 2016 - formal report due early 2017. UK Foundation Programme - 19% of Leicester medical students chose LNR as their first choice for Foundation training and that of the 70% LNR Foundation year 2 doctors who progressed directly to speciality training – only 29% of those chose to stay in LNR.	~~(c) Poor engagement with Medical Students and Junior Doctors impacting on reputation and recruitment and retention (8.1) (c & a)~~ (c & a) UHL appraisal of GMC recognised trainer roles (8.2) (c) Poor quality training delivery (8.3) (feedback) (c) Lack of availability of Education/ training facilities (8.4)(c & a) (c) Reduction in education funding

Detective Controls Medical Education Quality Dashboard mapped to GMC Promoting Excellence Standards UHL trainee surveys. CMG Medical Education Leads meetings and reports University Dean's report. Department of Clinical Education risk register.			(SIFT) (8.4)

Action tracker:	Due date	Owner	Progress update:	Status
Better engagement with Medical Students and Junior Doctors (8.1) - Summary in the LiA Action Plan	Dec 16 Complete	DME/UoL	Project group established	5
UHL Appraisal of GMC recognised trainer roles (8.2)	Aug-17	DME/ Appraisal lead	Working with UHL Appraisal Lead Mary Mushambi - framework and education sessions developed already	4
Implementation of Listening into Action Quick Wins and Longer Term Actions across Education Specific LiA Pioneering Programmes - LiA Summary (8.3)	Mar-17	MD/ DWOD/ CN	Implementation monitored by Associated Sponsor Groups (including external partners such as the University of Leicester as appropriate) and progress reported to UHL LiA Sponsor Group	4
Develop & Implement Education Facilities Business Case (8.4)	Mar-17	MD/ DWOD/ CN	Project Group established, SRO and Project Manager appointed. Work commenced on developing Business Case	4
Implementation of Enabling Work Programme for Future Education of Health and Social Care Provision / Workforce Attraction and Recruitment (8.4)	Mar-17	DWOD	Implementation monitored by newly established LWAB and LWAG at monthly intervals	4

Board Assurance Framework:	Updated version as at:	Dec-16										
Principal risk 9:	Insufficient engagement of clinical services, investment and governance may cause failure to deliver the Genomic Medicine Centre project at UHL								Risk owner:		Nigel Brunskill, DoRaD	
Strategic objective:	Enhanced delivery in research, innovation and clinical education								Objective owner:		MD	
Annual priorities	Support the development of the Genomic Medical Centre and Precision Medicine Institute								Risk Assurance Rating		Exec Board RAG Rating = (Date: 10/01/17)	
Current risk rating (I x L):	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
	4x4=16	4x3=12	4x3=12	4x3=12	4x3=12	4x3=12	4x3=12	4x3=12	4x3=12			
Target risk rating (I x L):	3x2=6											

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

Action tracker:	Due date	Owner	Progress update:	Status
(9.1) Engagement of CMGs with process	~~June 16~~ ~~Sep - 16~~ ~~Dec 16~~ March 17	MD DRI	DRI and MD leading on engagement programme. Meetings to discuss future workforce plans contnue with Clinical Genetics and the W&C CMG Management.	3
(9.1) Recruitment against trajectories	~~June 16~~ ~~Sep - 16~~ ~~Dec 16~~ March 17	DRI	Recruitment for rare diseases continues above trajectory. Cancer arm has started and is moving toward trajectory. GMC Team staffing issues -both nurses now back from sick leave; new research assistant staring; NHS England Coordinator post - 4 candidates shortlisted for interview. Lung samples - as numbers increase chances of cabinet contamination with TB increase (equipment time out for decontamination) - new cabinet ordered. Remain on trajectory for rare diseases and cancer despite reduced activity over Christmas holiday. Pathology have increased hours of a BMS to work on the project.	3

Board Assurance Framework:	Updated version as at:		Dec-16									
Principal risk 10a:	Lack of supply and retention of the right staff, at the right time, in the right place and with the right skills that operates across traditional organisational boundaries								**Risk owner:**		DoWD	
Strategic objective:	A caring, professional and engaged workforce								**Objective owner:**		DoWD	
Annual Priorities	Develop an integrated workforce strategy to deliver a diverse and flexible multi-skilled workforce that operates across traditional organisational boundaries and enhances internal sustainability. Develop a more inclusive and diverse workforce to better represent the community we serve and to provide services that meet the needs of all patients								**Risk Assurance Rating**		Exec Board RAG Rating = EWB 17/01/17	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	New risk opened in July			4x4=16	4X4=16	4X4=16	4X4=16	4X4=16	4X4=16			
Target risk rating (I x L):	4x2=8											

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

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

Action tracker:	Due date	Owner	Progress update:	Status
10a.1 - Resourcing strategy to be developed	~~Dec 16~~ March 16	DWOD	Being developed through the Resourcing Board. LLR Recruitment and Attraction group established - Action plan agreed and in place. Developing overaching framework for LLR Strategy to ensure alignment at UHL.	3
10a. 2 - LWAG time out to clearly define workforce OD role on Clinical Workstreams	Feb-17	DWOD	Attended time out on 11 Jan 2017 and pack and role descripters being put together	4
10a.3 - Action unclear until informal negotiations have taken place once article 51 has been invoked.	TBC	DWOD	Awaiting national guidance - invoking of article 51 still to be invoked- FAQ's developed and shared to be clear on current status and position for individuals.	4
10a.4 Improve take up and response rate to exit interviews	Mar-17	DWOD	Promotion of take up being developed through CMG's and incorporated within Monthly IFPIC Report.	4

Board Assurance Framework:	Updated version as at:	Dec-16										
Principal risk 10b:	Lack of system wide consistency and sustainability in the way we manage change and improvement impacting on the way we deliver the capacity and capability shifts required for new models of care								**Risk owner:**	DoWD		
Strategic objective:	A caring, professional and engaged workforce								**Objective owner:**	DoWD		
Annual priorities	Deliver the Year 1 Implementation Plan for the UHL Way, ensuring an improved level of staff engagement and a consistent approach to change and development. Develop training for new and enhanced roles, i.e. Physician's Associates, Advanced Nurse Practitioners, Clinical Coders								**Risk Assurance Rating**	Exec Board RAG Rating = EWB 17/01/17		
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**		**March**
	4x4=16	4x4=16	4x4=16	4x4=16	4X4=16	4X4=16	4X4=16	4x4=16	4x4=16			
Target risk rating (I x L):	4x2=8											

Principal risk 10:	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Develop Integrated Workforce Strategy **Directive Controls** LWAB - Local Workforce Advisory Board LWAG - Local Workforce Advisory Group Workforce enabling group (strategic) Executive Workforce Board Local Education and Training Group New roles group Apprenticeship attraction strategy LLR Apprenticeship Attraction Strategy **Detective Controls** Workforce Enabling Plan	5 work streams to measure workforce strategy. 1.Strategic Workforce Planning - Develop a view of capacity and capability changes; 2.Workforce Attraction and Recruitment; 3. Staff Mobility – Developing the ability to move people around the system; 4.Future Education of Health & Social Care Provision; and 5.Organisational Development and Change.		(c) Ineffective training for new and enhanced roles (10b.1)
Deliver yr1 implementation 'The UHL Way' **Directive controls** Executive Workforce Board Internal Governance Structure established UHL Way Steering Group UHL 'LiA' Sponsor group **Detective Controls** Schedule of activities for each component of 'The UHL Way'	Measures against schedule of activities for the 4 components: 1. Better engagement 2. Better teams 3. Better change 4. Academy UHL Pulse Check National Staff Survey data	East Midlands Leadership Academy. Leicestershire Improvement Innovation Patient Safety Forum.	

Action tracker:	Due date	Owner	Progress update:	Status
10b.1 - Implementation of Enabling Works Programmes (across the system):- Strategic Workforce Planning - Develop a view of capacity and capability changes; Workforce Attraction and Recruitment; Staff Mobility – Developing the ability to move people around the system; Future Education of Health & Social Care Provision; and Organisational Development and Change.	Mar-17	DoWD	Progress monitored by LLR Local Workforce Advisory Board and Local Workforce Advisory Group. Work being undertaken on interdependancies between enabling and clinical workstreams as agreed at LLR event on 11 January 2017	4

Board Assurance Framework:	Updated version as at:	Dec-16										
Principal risk 11:	Ineffective structure to deliver the recommendations of the national 'freedom to speak up review'								**Risk owner:**	DoWD		
Strategic objective:	A caring, professional and engaged workforce								**Objective owner:**	DoWD		
Annual priorities	Deliver the recommendations of "Freedom to Speak Up" Review to further promote a more open and honest reporting culture								**Risk Assurance Rating**	Exec Board RAG Rating = EWB 17/01/17		
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x4=16	4x4=16	4x4=16	4x3=12	4X3=12	4X3=12	4X3=12	4x3=12	4x3=12			
Target risk rating (I x L):	4x2=8											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Freedom to speak up **Directive controls** UHL Whistle blowing policy Freedom to speak up internal policy Executive Quality Board Executive Workforce Board Quality Assurance Committee Resources agreed and business case to deliver the plan in place. Local Guardian appointed (Freedom to speak up). **Detective controls** No. of whistleblowing reported issues (via 3636 / gripe tool etc) Project plan with milestones for freedom to speak up Casework monitoring (investigations)	Detailed F2SU metrics: No. UHL Whistleblowing reported cases for reporting period: TBA		(c) No internal governance structure to comply with national recommendations (11.1).

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

Governance structure to be developed for Freedom to speak up. 11.1	~~Sep 16~~ ~~Oct 16~~ March 17	DoWD	Review of Whistle Blowing policy will take place once new guardian in role to fully determine goverance requirements.	3

Board Assurance Framework:	Updated version as at:	Dec-16										
Principal risk 12:	Insufficient estates infrastructure capacity may adversely affect major estate transformation programme								**Risk owner:**		DEF	
Strategic objective:	A clinically sustainable configuration of services, operating from excellent facilities								**Objective owner:**		CFO	
Annual priorities	Complete and open Phase 1 of the new Emergency Floor Deliver our reconfiguration business cases for vascular and level 3 ICU (and dependent services)								**Risk Assurance Rating**		Exec Board RAG Rating = (ESB 10/1/17)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16			
Target risk rating (I x L):	4X3=12											

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

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

Board Assurance Framework:	Updated version as at:	Dec-16										
Principal risk 13:	Limited capital envelope to deliver the reconfigured estate which is required to meet the Trust's revenue obligations								Risk owner:		CFO	
Strategic objective:	A clinically sustainable configuration of services, operating from excellent facilities								Objective owner:		CFO	
Annual priorities	Develop outline business cases for our integrated Children's Hospital, progress with the clinical scoping of other projects e.g. Women's Services and planned ambulatory care hub, theatres, beds and long term ICU								Risk Assurance Rating		Exec Board RAG Rating = (ESB 10/1/17)	
Current risk rating (I x L):	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
	4x5=20	4x4=16	4x3=12	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16			
Target risk rating (I x L):	4x2=8											

Controls: (preventive, corrective, directive, detective)	Assurance on effectiveness of controls		Gaps in Control / Assurance
	Internal	External	
Directive Controls/Preventive Controls Five year capital plan and individual capital business cases identified to support reconfiguration Business case development is overseen by the strategy directorate and business case project boards manage and monitor individual schemes. Capital plan and overarching programme for reconfiguration is regularly reviewed by the executive team. **Detective Controls** Capital Investment Monitoring Committee to monitor the programme of capital expenditure and early warning to issues. Monthly reports to ESB and IFPIC on progress of reconfiguration capital programme. Highlight reports produced for each project and submitted to the Reconfiguration Programme Board. **Corrective Control** Revised programme timescale approved by IFPIC on a monthly basis.	Capital expenditure and progress against reconfiguration programme monitored via Capital Investment committee ESB/ IFPIC/ TB. On track against revised schedule. Resource expenditure for development of business cases - on track/ monitored on a monthly basis Affordability of business cases (i.e. schemes within allocated budget envelope) - on track against revised programme. Capital expenditure against the agreed capital plan for reconfiguration is monitored via the monthly financial update to the Reconfiguration Board.	UHL's Annual Operating Plan, as submitted to NHS Improvement, includes capital requirements for 2016/17 strategic programme (awaiting feedback). Monthly meetings with NHSI ensures Trust's capital priorities are clearly identified and known. Formal communication with Regional Director at NHSE and NHSI regarding the strategic capital requirements linked to BCT. LLR BCT (and now STP) include the external capital values as part of the system wide case for change.	c) Limited capital funding within 2016/17 programme and future years (13.1 and 13.2). (c) ITU interim configuration has been delayed due to capital availability (13.3). (c) development of the DCP estates strategy in line with STP (13.4). (c) development of the SOC (13.5)

Action tracker:	Due date	Owner	Progress update:	Status

Consideration to be given to alternative sources of funding. (13.1)	~~June 16~~ ~~Aug 16~~ ~~Dec 16~~ Feb 17	CFO	STP submitted in October, assuming the use of PF2 for Women's and PACH projects. Exploratory discussions with expert PF2 advisors (Deloitte) regarding which capital schemes could potentially be suitable. Meeting with PFU in May 2016, options still being explored. A paper recommending PF2 use for the Women's and PACH projects was approved at the September 2016 Reconfiguration Board. ~~A meeting is now being organised for the Trust to meet with the PFU to ascertain their view.~~ Meeting held with the PFI & Transaction team and HMT - ongoing discussions around the suitability of PF2 for retained estate elements of projects. A follow up meeting will be held early in 2017. Paper to be presented to Trust Board Thinking Day in February.	3
Maintain dialogue with NHSI and NHSE regarding the pressing need for external capital to facilitate strategic change (13.2)	~~June 16~~ ~~Aug 16~~ ~~Dec 16~~ Feb 17	CEO/CFO	Alongside recent correspondence and discussion regarding BCT and its capital requirements, the LLR STP represents a further opportunity to formalise and emphasise the requirement. Meeting held with local NHSI representatives to discuss PF2 and the new national guidance for business cases (including SOCs).	3
Capital plan C has identified best way to prioritise / progress all reconfiguration projects within a reduced funding allocation (13.3)	~~July 16~~ ~~Aug 16~~ ~~Dec 16~~ Feb 17	CFO	Capital plan D has been developed which allows for the development of additional ward capacity at GH for HPB which is now necessary before the ICU interim move. Discussions with NHSI informed the need for an OBC and FBC - work on OBC has commenced. Development of ICU 2016/17. ICU construction will commence once capital funding becomes available. Interim measures have been put in place to manage risks in short-term in terms of capacity, these mitigations need to be reviewed if any further delays. Priorisation of projects for internal CRL in 2017/18 has commenced.	3

DCP Refresh - phase 2. The clinical design solution and capital plan for the two acute sites will be urgently reviewed in light of the approved STP bed numbers to understand impact (13.4)	~~Nov 16~~ ~~Dec 16~~ Feb 17	CFO	~~Delayed due to the addition of 200 beds into the STP bed numbers and the need to split the bed base by specialty to give a site location, and the need for a revised specialty split. Progress review meeting held 31st October with technical team and executive representatives. Clinical checkpoints to validate phase 2 (development of the DCP estates strategy in line with STP) planned for 7th November and will be planned for late November.~~ Detailed work on the DCP refresh has commenced and discussion is on-going to validate the revised capital costs. This has caused a delay to the DCP refresh programme.The delay to the DCP programme creates a risk to the delivery of the Strategic Outline Case; any delay to the SOC needs to be mitigated, so the DCP refresh and SOC programmes will be reviewed in light of recent discussions and agreed.	3
Reconfiguration Programme are currently developing a Strategic Outline Case (SOC); which will articulate how the programme is affordable overall, reflecting the STP and the DCP refresh. This will then form the basis for subsequent Outline Business Cases (OBC) and Full Business Cases (FBC) for individual projects (13.5).	Feb-17	CFO	~~The team are developing a detailed programme to demonstrate how the STP, DCP and SOC fit together; and the critical milestones where key decisions are needed to maintain Trust Board approval in February 2017.~~ As above, a recent delay to the DCP refresh has risked delivery of the SOC for approval at the February 2017 Turst Board. The team are currently reviewing the programme to ensure the SOC is delivered for approval at the Trust Board as soon as possible.	4

Board Assurance Framework:	Updated version as at:	Dec-16										
Principal risk 14:	Failure to deliver clinically sustainable configuration of services								Risk owner:		CFO	
Strategic objective:	A clinically sustainable configuration of services, operating from excellent facilities								Objective owner:		CFO	
Annual priorities	Develop new models of care that will support the development of our services and our reconfiguration plan								Risk Assurance Rating		Exec Board RAG Rating = (ESB 10/1/17)	
Current risk rating (I x L):	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
	4x5=20	4x5=20	4x5=20	4x5=20	4x5=20	4x5=20	4x5=20	4x5=20	4x5=20			
Target risk rating (I x L):	4x2=8											

Controls: (preventive, corrective, directive, detective)	Assurance on effectiveness of controls		Gaps in Control / Assurance
	Internal	External	
Directive Controls UHL reconfiguration programme governance structure aligned to new STP governance and interdependencies to be reported to ESB monthly identifying potential risks and issues affecting delivery. Strategic capital business case work streams aligned to new STP governance. A Reconfiguration Programme Strategic Outline Case (SOC) is in development, which will reflect the STP submission and the revised Development Control Plans. This SOC will demonstrate affordability of the programme as a whole; and therefore pave the way for approval of individual project Outline Business Cases (OBC). Monthly meetings with NHSI to identify new business cases coming up for approval. Detailed programme plan identifying key milestones for delivery of the capital plan. Project plans and resources identified against each project. A future operating model at speciality level	Progress of the reconfiguration programme is monitored via aggregated reporting to ESB/ IFPIC/ TB. Overall reconfiguration programme is RAG rated. Currently reported as 'amber 'due to complexity of programme and risks associated with delivery.	Regular meetings with - STP PMO and Leadership team - NHS Improvement - NHS England	(a) Detailed bed capacity model/assumptions have been included as part of the latest STP submission. Discussions are underway to agree the bed reduction plan over the 5 year period, to reflect the agreed 17/18 and 18/19 contract , to reflect the agreed end point of 1,697 beds in 2021 (14.1). (c) Indicative breakdown of beds, theatres and outpatients per speciality have been developed and will inform the revised Development Control Plans for UHL's reconfiguration programme. This will provide a detailed plan showing how UHL's sites will be reconfigured over the 5 year period, and will confirm the value of each project within the overall capital plan identified in

which supports a two acute site footprint. **Detective Controls** A monthly report outlining progress with the reconfiguration programme is submitted to the UHL Reconfiguration Programme Board. Monthly aggregate reporting to ESB, IFPIC and Trust Board. Monthly meetings with NHSI to discuss the programme of delivery. Monitoring of progress towards UHL two acute site model including interdependencies between projects. Monitoring of business case timescales for delivery. Requirements identified to deliver key projects overseen by PMO. Monitor spend against agreed budgets.			the STP. This plan will be reviewed and updated by the end of January in light of the annual plan. (14.2). (c) The need to produce an STP has delayed the ability of the PMO to gain approval of the pre-consultation business case. This has resulted in a delay to consultation, which is now anticipated to start in early 2017. There has been minimal impact on the development of the PACH and Women's business cases since capital funding is not available this financial year to progress design work. In the meanwhile, detailed models of care and patient pathways are being worked up (14.3).

Action tracker:	Due date	Owner	Progress update:	Status
The demand and capacity discussions concluded with the agreement that 200 beds would be added back into the UHL bed base within the STP; 2 new build wards at GH and the remainder at LRI within refurbished estate and the community. Impact on capital programme, Estates Strategy and DCPs is currently being worked up. Conclusions need to feed into NHSE led assurance process in advance of public consultation and reconfiguration. Internal work with estates, clinical, finance and workforce teams continues to support implementation when plans are agreed. (14.1, 14.2, 14.3)	~~June 16~~ ~~July 16~~ ~~Dec -16~~ Jan 17	COO / CFO	Phase 1 of the DCP refresh is complete to give a possible range of scenarios. Phase 2 of the DCP refresh is currently being undertaken utilising the final bed split by specialty, and will show moves by site location and programme. Discussion is on-going to validate the revised capital costs. This has caused a delay to the DCP refresh programme. This will inform the Reconfiguration Programme Strategic Outline Case. Estates strategy to be updated thereafter.	3

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

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls Governance arrangements established Overarching project plan for service reviews developed New structure / methodology agreed for capturing outputs in a consistent way, aligned to the IHI Triple Aim and UHL way New virtual team structure to support the intensive service reviews. Steering Group in place to monitor and provide assurance regarding the service review programme (all levels i.e. standard, enhance and intensive). **Detective Controls** SLM / Service Review Data Packs now to include a range of metrics, beyond finance Monthly updates required from services against pre-determined work programme. Measureable outcomes now embedded into the process via improved methodology - Where relevant, schemes with a financial benefit are added to the CIP Tracker	Regular update reports to ESB, EPB and IFPIC. Previous programme suspended. New programme being developed as agreed through ESB. Individual service reviews will report through to the Steering Group and the Steering Group will provide quarterly updates to ESB.	Internal Audit (PWC) October 2015 - Service Line Reporting	(c) BI capacity is (at times) limited which impacts on Data Pack production (15.1) (a) Assurance that resources are placed with the services who need them the most (15.4) (c) Roll out of the new service review process suspended pending internal restructure, to ensure arrangements align with new integrated improvement programme (15.5).

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

Revised Data Pack being scoped for discussion with BI leads. (15.1)	~~June 16~~ TBC	CFO	A sample data pack was circulated to the steering group on 11.5.16. Expert members to consider data for appropriateness. Steering Group suspended following instruction from ESB	3
Assurance that resources are placed with the services who need them the most (15.4)	~~June 16~~ TBC	CFO	The plan involves: Stratification of services to determine the level of input required (Intensive, Standard and Enhanced). ~~The priority order of services to be completed are dependant on their positioning in the Stratification matrix. This information will then be developed into a programme plan. The stratification matrix has been simplified by the Steering Group. Revised measures have been agreed and the data is being collected for the next steering group 22.6.16.~~ Roll out paused on instructions from ESB	3
Current Service review programme winding down (15.5)	Jan-17	CFO	Haematology coming to end of review ready for presenting to JA. Gynaecology has some on-going work to be transferred through the Theatre reconfiguration programme. Ophthalmology have pulled out of their service review due to current pressures.	4

Board Assurance Framework:	Updated version as at:	Dec-16										
Principal risk 16:	The Demand/Capacity gap if unresolved may cause a failure to achieve UHL deficit control total in 2016/17								**Risk owner:**		CFO	
Strategic objective:	A financially sustainable NHS organisation								**Objective owner:**		CFO	
Annual priorities	Reduce our deficit in line with our 5-Year Plan Reduce our agency spend to the national cash target								**Risk Assurance Rating**		Exec Board RAG Rating = EPB (Date: 24/01/17)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	5x3=15	5x3=15	5x3=15	5x3=15	5x3=15	5x4=20	5x4=20	5x4=20	5x5=25			
Target risk rating (I x L):	5x2=10											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls Agreed Financial Plan for 2016/17 (AOP) Standing Financial Instructions UHL Service and Financial strategy as per SOC and LTFM. **Preventative Controls** Sign-off and agreement of contracts with CCGs and NHS England CIP delivery plan for 2016/17 **Detective Controls** The detailed position will be reviewed by the Executive Performance Board monthly Integrated Finance, Performance & Investment Committee and Trust Board monthly. Monthly finance reporting in relation to	Contracts signed with both main commissioners. Robust internal process to set the financial plan for 2016/17 as agreed by IFPIC and TB. Adverse variance to plan of £6.5m at M9 with a year end forecast being adverse to I&E plan by £8.9m of a deficit of £40.9m (excluding STF). STF Funding of £11.4m recognised at M9 in line with STF rules at Q3. This is adverse to plan by £6.1m and becomes a cash pressure for the Trust in the remaining months of the	Regular review of financial plan by NHS Improvement. Quarterly submission to NHS Improvement of STF Performance.	(c) Significant deterioration in the financial performance within month 8. The additional organisational wide responses are defined and are required to ensure acheivement of the mitigated revised forecast year end deficit position (16.1). (c) STF cannot be recognised based on Q3 and Q4 financial forecast. A cash pressure exists that requires additional cash support. (16.2).

income and expenditure and CIP Monthly performance reporting in relation to STF performance trajectories. **Corrective Controls** Identification and mitigation of excess cost pressures Planned reduction in agency spend The CIP gap identified at the start of the year has been closed.	year. CIP within the year to date position has overdelivered against the plan of £25.3m by £0.1m. Run rates that deliver the £40.9m in each area (pay, non-pay, CIP and income) updated for month 9 and reported to Committees/Trust Board alongside the financial and performance position of STF funding.			

Reasonable assurance rating that risk is being managed:	Due date	Owner	Progress update:	Status
(16.1) Additional organisational wide responses are required to ensure acheivement of the planned deficit.	~~Sept 16~~ ~~Dec 16~~ Review monthly	CFO	Action plan developed and being reported at relevant Executive Team Meetings.	3
(16.2) as 16.1. Additional organisational wide responses are required to ensure acheivement of the planned deficit	Review Jan 2017	CFO	STF cannot be recognised for Q3 or Q4 based on current forecast deficit position. The cash impact is being discussed and followed up with NHSI (Local and Treasury Team)	4

Board Assurance Framework:	Updated version as at:	Dec-16										
Principal risk 17:	Failure to achieve a revised and approved 5 year financial strategy								**Risk owner:**	CFO		
Strategic objective:	A financially sustainable NHS organisation								**Objective owner:**	CFO		
Annual priorities	Reduce our deficit in line with our 5-Year Plan Reduce our agency spend to the national cash target								**Risk Assurance Rating**	Exec Board RAG Rating = EPB (Date: 24/01/17)		
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	5x3=15	5x3=15	5x3=15	5x3=15	5x3=15	5x3=15	5x3=15	5x3=15	5x3=15			
Target risk rating (I x L):	5x2=10											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls Overall strategic direction of travel defined through Better Care Together. Financial Strategy fully modelled and understood by all parties locally and nationally. UHL's working capital strategy in place. 2016/17 financial plan in place and monitored appropriately Sustainability and transformation plan (STP) LTFM & SOC approved. **Detective Controls** Monthly monitoring of performance against financial plan. IFPIC and TB receive half yearly updates in relation to financial strategy and LTFM **Corrective controls** Explore options for other (non-NHS) sources of capital funding	Monthly reporting against 2016/17 plan - As at M9 the Trust is £6.5m adverse to plan. Half yearly review of LTFM to ensure fitness for purpose i.e. checking consistency with UHL's strategy and ensuring we have a deliverable recovery plan over the medium term. Strong links to overall BCT 5 year strategy and the financial consequences (revenue and capital) of the transformational business cases	NHS England and NTDA review of: BCT SOC BCT PCBC Financial strategy LTFM System-wide five-year 'place-based' sustainability and transformation plan (STP) Individual business cases above a certain level	(c) Currently seeking authority to proceed with public consultation of STP (17.2) (c) The Trust is currently experiencing significant pressures within it's ability to achieve its obligations under the Better Payment Practice Code (BPPC). This pressure is being driven by a shortage of cash. (17.3 and 17.4)

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

(17.3) Assurnance over cash forecasting and working capital management completed by PWC.	~~Oct-16~~ ~~Nov-16~~ Jan-17	CE/CFO	Draft report received with further actions identified and being addressed within agreed timeframes and to be finalised by 30 November 2016. Revised date for completion of 22 December 2016.	3
(17.4) External cash injection required to resolved current working capital requirements.	~~Oct-16~~ ~~Dec-16~~ Jan-17	CE/CFO	Process for working capital loan application yet to be defined by NHSI Treasury team. Once defined the Trust will make an appropriate application. Cash is currently being accessed through the revolving working capital facility with the final drawdown being made to the Trust's approved limit in January 2017.	3

Board Assurance Framework:	Updated version as at:	Dec-16										
Principal risk 18:	Delay to the approvals for the EPR programme								**Risk owner:**		CIO	
Strategic objective:	Enabled by excellent IM&T								**Objective owner:**		CIO	
Annual priorities	Conclude the EPR business case and start implementation								**Risk Assurance Rating**		Exec Board: EPB 24/01/17	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4 x 4 = 16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	5x5 = 25	5x5 = 25			
Target risk rating (I x L):	3 x 2 = 6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls Regular communications with key contacts throughout the external approvals chain. IM&T Programme Board. EPR programme Board and the joint Governance Board. **Detective Controls** Weekly meeting to discuss progress and issues with IBM and separately with NHSI **Corrective Controls** Plan B to provide a paperlite solution for the new EF Build has been approved Works that support the EPR project but could be used for an alternative, have been completed	Internal and external meetings about the FBC are being undertaken. Until NHSI approval is given we can't engage with our key partners to implement the system, however we continue to work to mitigate the impact of the delay. Upgrades are now taking place on our major IT systems including Clinicom and ORMIS to ensure they can be supported for a longer period prior to replacement by EPR or alternative.	Internal audit review of implementation of gateway actions following review of EPR implementation in Q3 2015/16. HSCIC have completed a health check review on the EPR Project in March 2016. Rated as amber/green and action plan in place in response to recommendations	NHSI have confirmed that they are not in a position to support the proposal and their proposed cost envelope would mean that an integrated solution, UHLs prefered option, is no longer achievable (18.1). Option review of alternative solution (18.2) Propose SOC for paper lite EPR solution (18.3)

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
Progress work with NTDA/DoH to progress a firm timetable (18.1)		CIO	*** This action can not be supported by NHSI***	
Propose an alternative proposal for the delivery of a "best of breed" paper lite solution (18.2)	Jan-17	CIO	Initial work has been undertaken to review our options and produce a short term approach	4
Propose Strategic Outline Case for the development of a Paper Lite EPR solution (18.3)	Mar-17	CIO	First phase will be to revisit the work undertaken as part of the FBC for the Cerer EPR solution	4

Board Assurance Framework:	Updated version as at:	Dec-16										
Principal risk 19:	Lack of alignment of IM&T priorities to UHL priorities								**Risk owner:**	CIO		
Strategic objective:	Enabled by excellent IM&T								**Objective owner:**	CIO		
Annual priorities	Improve access to and integration of our IT systems								**Risk Assurance Rating**	Exec Board: EPB 24/01/17		
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3 x 4 = 12	3x4=12	3x4=12	3x4=12	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9			
Target risk rating (I x L):	3 x 2 = 6											

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

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
To look at re-introduction of the CMG account management role within a restructure of IM&T resources (19.1)	Mar-17	CIO	The development of a costed plan to re-introduce this role to IM&T	4
To review the deliverables in line with the EPR re-work to ensure the new programme accelerate the delivery of key items, such as desktop refresh.	Mar-17	CIO	The development of a costed plan to re-introduce this role to IM&T	4

Reasonable assurance rating:

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

Risk rating criteria:

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

Target Risk Rating: A reasonable estimate of the likely occurrence and likely consequence with the current control measures and future actions applied.
Risk target (also referred to as residual risk) is the amount of risk that is accepted or tolerated, or the level that has been decided to manage a risk down to in an ideal world.
As the BAF is focussed on the risks to achieving its most important annual objectives the risk target score should be achieved when all actions are applied taking into consideration that the objectives and principal risks will be refreshed on an annual basis (annual period 1st April to 31st March).

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

Action tracker status:

5	Complete
4	On-track
3	Some delay. Expected to be completed as planned
2	Significant delay. Unlikely to be completed as planned.
1	Not yet commenced.
0	Objective revised.

Appendix 2 **Risk Register Dashboard as at 31/12/16**

Risk ID	CMG	Risk Title	Current Risk Score	Target Risk Score	Risk Owner	Risk Movement	Elapsed risk deadline	Themes aligned with Trust Objectives
2236	ESM	There is a risk of overcrowding due to the design and size of the ED footprint & increased attendance to ED	25	16	Ian Lawrence	↔		Effective emergency care
2762	Corporate Nursing	Ability to provide safe, appropriate and timely care to all patients attending the Emergency Department at all times.	25	15	Julie Smith	↔		Effective emergency care
2566	CHUGGS	There is risk of delays to planning patient treatment due to the age of the Toshiba Aquilion CT scanner in the Radiotherapy Dept	20	1	Lorraine Williams	↔		Safe, high quality, patient centred healthcare
2354	RRCV	There is a risk of overcrowding in the Clinical Decisions Unit	20	9	Sue Mason	↔		Effective emergency care
2670	RRCV	There is a risk to the Immunology & Allergy Services due to a Consultant Vacancy	20	6	Karen Jones	↔		Workforce capacity and capability
2886	RRCV	LGH Water Treatment Plant risk of downtime, resulting from equipment failure of the water plant impacting on HD patients	20	8	Geraldine Ward	↔		Safe, high quality, patient centred healthcare
2931	RRCV	Increasing frequency of Cardiac Monitoring System on CCU failing to operate	20	4	Judy Gilmore	↔		Safe, high quality, patient centred healthcare
2804	ESM	Outlying Medical Patients into other CMG beds due to insufficient ESM inpatient bed capacity	20	12	Gill Staton	↔		Effective emergency care
2149	ESM	High nursing vacancies across the ESM CMG impacting on patient safety, quality of care and financial performance	20	6	Gill Staton	↔		Workforce capacity and capability
2333	ITAPS	Lack of Paediatric cardiac anesthetists to maintain a WTD compliant rota leading to interruptions in service provision	20	8	Rachel Patel	↔		Workforce capacity and capability
2763	ITAPS	Risk of patient deterioration due to the cancellation of elective surgery as a result of lack of ICU capacity	20	10	Heather Allen	↔		Workforce capacity and capability
2787	CSI	Failure of medical records service delivery due to delay in electronic document and records management (EDRM) implementation	20	4	Debbie Waters	↔		Workforce capacity and capability
2562	W&C	There is a risk that 2 vacant consultant paediatric neurology vacancies could impact sustainability of the service	20	4	J Visser	↔		Workforce capacity and capability
2940	W&C	Risk that paed cardiac surgery will cease to be commissioned in Leicester with consequences for intensive care & other services	20	8	Nicola Savage	↔		Safe, high quality, patient centred healthcare
2403	Corporate Nursing	There is a risk changes in the organisational structure will adversely affect water management arrangements in UHL	20	4	Elizabeth Collins	↔		Estates and Facilities services
2404	Corporate Nursing	There is a risk that inadequate management of Vascular Access Devices could result in increased morbidity and mortality	20	16	Elizabeth Collins	↔		Safe, high quality, patient centred healthcare

Risk ID	CMG	Risk Title	Current Risk Score	Target Risk Score	Risk Owner	Risk Movement	Elapsed risk deadline	Themes aligned with Trust Objectives
2471	CHUGGS	There is a risk of poor quality imaging due to age of equipment resulting in suboptimal radiotherapy treatment.	16	4	Lorraine Williams	↔		Workforce capacity and capability
2264	CHUGGS	Risk to the quality of care and safety of patients due to reduced staffing in GI medicine/Surgery and Urology at LGH and LRI	16	6	Georgina Kenney	↔		Safe, high quality, patient centred healthcare
2923	CHUGGS	There is a risk that nurse staffing vacancies in Oncology may result in suboptimal care to patients	16	6	Kerry Johnston	↔		Workforce capacity and capability
2905	RRCV	There is a risk of delays to patient diagnosis and treatment which will affect the delivery of the national 62 day cancer target	16	6	Karen Jones	↔		Workforce capacity and capability
2870	RRCV	Audit of DNACPR form have shown that the discussion with the patient or family is not consistently recorded	16	2	Elved Roberts	↔		Workforce capacity and capability
2819	RRCV	Risk of lack of ITU and HDU capacity will have a detrimental effect on Vascular surgery at LRI	16	12	Sarah Taylor	↔		Workforce capacity and capability
2820	RRCV	Risk that a timely VTE risk assessment is not performed on admission to CDU meaning that subsequent actions are not undertaken	16	3	Karen Jones	↔		Workforce capacity and capability
2193	ITAPS	There is a risk that the ageing theatre estate and ventilation systems could result in an unplanned loss of capacity at the LRI	16	4	Gaby Harris	↔		Safe, high quality, patient centred healthcare
2541	MSK & SS	There is a risk of reduced theatre & bed capacity at LRI due to increased spinal activity	16	8	Carolyn Stokes	↔		Workforce capacity and capability
2191	MSK & SS	Lack of capacity within the service is causing delays that could result in serious patient harm.	16	8	Clare Rose	↔		Workforce capacity and capability
2687	MSK & SS	Lack of appropriate medical cover will clinically compromise care or ability to respond in Trauma Orthopaedics	16	9	Carolyn Stokes	↔		Workforce capacity and capability
1206	CSI	There is a risk that a backlog of unreported images in plain film chest and abdomen could result in a clinical incident	16	6	ARI	↔		Workforce capacity and capability
182	CSI	POCT- Inappropriate patient Management due to inaccurate diagnostic results from Point Of Care Testing (POCT) equipment	12	2	Lianne Finnerty	↓		Workforce capacity and capability
2969	CSI	There is a risk of failure to deliver the TAT Standards of NHS Cervical and NHS Bowel Cancer Screening programmes	16	4	Mike Langford	**NEW**		Workforce capacity and capability
2378	CSI	There is a risk that Pharmacy workforce capacity could result in reduced staff presence on wards or clinics	16	8	Claire Ellwood	↔		Workforce capacity and capability
1926	CSI	There is a risk that insufficient staffing to manage ultrasound referrals could impact Trust operations and patient safety	16	6	Cathy Lea	↔		Workforce capacity and capability
2391	W&C	There is a risk of inadequate numbers of Junior Doctors to support the clinical services within Gynaecology & Obstetrics	16	8	Cornelia Wiesender	↔		Workforce capacity and capability

Risk ID	CMG	Risk Title	Current Risk Score	Target Risk Score	Risk Owner	Risk Movement	Elapsed risk deadline	Themes aligned with Trust Objectives
2153	W&C	Shortfall in the number of all qualified nurses working in the Children's Hospital.	16	8	HKI	↔		Workforce capacity and capability
2394	Communications	No IT support for the clinical photography database (IMAN)	16	1	Simon Andrews	↔		Workforce capacity and capability
2237	Corporate Medical	There is a risk of results of outpatient diagnostic tests not being reviewed or acted upon resulting in patient harm	16	8	Angie Doshani	↔		Workforce capacity and capability
2247	Corporate Nursing	There is a risk that a significant number of RN vacancies in UHL could affect patient safety	16	12	Maria McAuley	↔		Workforce capacity and capability
1693	Operations	There is a risk of inaccuracies in clinical coding resulting in loss of income	16	8	Shirley Priestnall	↔		IM&T services
2878	Operations	There is a risk of cancer patients not being discussed at MDTs due to inadequate video conferencing facilities	12	4	Charlie Carr	↓		Workforce capacity and capability
2872	RRCV	There is a risk of bedded bariatric patients being trapped compromising fire evacuation on ward 15 at GGH	15	6	Vicky Osborne	↔		Safe, high quality, patient centred healthcare
2837	ESM	There is a risk of delay in acting upon monitoring investigation results in patients with multiple sclerosis.	15	2	Ian Lawrence	↔		Workforce capacity and capability
2769	MSK & SS	There is a risk of cross infection of MRSA as a result of unscreened emergency patients being cared for in the same ward bays	15	5	Kate Ward	↔		Workforce capacity and capability
510	CSI	There is a risk of staff shortages impacting on the Blood Transfusion Service at UHL	15	5	AFE	↔		Safe, high quality, patient centred healthcare
2162	CSI	Cellular Pathology - Failure to meet TATs - Quality ; Patient Safety &HR risk	15	6	Mike Langford	↔		Safe, high quality, patient centred healthcare
2965	CSI	If we do not address Windsor pharmacy storage demands, then we may compromise clinical care and breach statutory duties	15	6	Claire Ellwood	**NEW**		Safe, high quality, patient centred healthcare
2601	W&C	There is a risk of delay in gynaecology patient correspondence due to a backlog in typing	15	6	DMAR	↔		Workforce capacity and capability
2330	Corporate Medical	Risk of increased mortality due to ineffective implementation of best practice for identification and treatment of sepsis	15	6	JPARK	↔		Safe, high quality, patient centred healthcare
2925	Estates & Facilities	Reduction in capital funding may lead to a failure to deliver the 2016/17 medical equipment capital replacement programme	15	10	Darryn Kerr	↔		Safe, high quality, patient centred healthcare
2402	Corporate Nursing	There is a risk that inappropriate decontamination practice may result in harm to patients and staff	15	3	Elizabeth Collins	↔		Safe, high quality, patient centred healthcare
2774	Operations	Delay in sending outpatient letters following consultations is resulting in a significant risk to patient safety & experience .	15	6	William Monaghan	↔		Workforce capacity and capability

Appendix 3 - New risks entered on risk register report as at 31/12/16

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
2969	CMG 6 - Clinical Support & Imaging (CSI)	Pathology - Cellular Pathology	There is a risk of failure to deliver the TAT Standards of NHS Cervical and NHS Bowel Cancer Screening programmes	19/12/2016	15/01/2017	Causes: 1.Gradual increase / growth in workload coming into the department that hasn't been matched with increases in capacity / resource - culminating in the service reaching a tipping point where specimens associated with specific screening programmes are affected. 2.Inadequate physical space to receive specimens and to adequate numbers of dissection tables (only 2) - workload has increased from 2 trays of biopsies a day up to approx. 10 trays a day (especially on a Monday) - this represents a considerable bottle neck for flow of workload, putting at risk the specific TATs associated with these programmes. 3.Difficulty in identifying bowel or cervical biopsies cases amongst the overall volumes of specimens delivered to the laboratory. 4.Insufficient operational processor capacity - aging equipment with high degree of downtime / breakdowns. 5.Waiting list initiatives in the trust for endoscopy - creates huge peak of workload on Monday from Saturday lists. 6.IT issues relating to out of date hardware and software making use of voice recognition (Dragon) unusable. 7.Increase in biopsy volumes ascribed to skill mix in colposcopy (nurse staff replacing Consultants) Consequences: 1.Gradual increase / growth in workload coming into the department that hasn't been matched with increases in capacity / resource - culminating in the service reaching a tipping point where specimens associated with specific screening programmes are affected.	Agreed Targets	- New replacement processors sourced via emergency capex route and via the UHL charity - Implemented prioritisation stickers red and blue, plus specific iLab codes - bowel only - Business case for short term locum staffing - Business case for longer term substantive staffing for all elements of the overall histology process - Business case for extension of the managed equipment service (MES) to UHL from NUH - route to sourcing equipment - Creation of an urgent laboratory stream of work to fast track these biopsy cases where identifiable	Major	Likely	16	1- Appoint and start in post of Office manager and replacement typing staff - revamp of reporting processes - Jan 2017; 2- Implementation of Consultant BMS role - Nov 2017; 3- Implementation of MES - March 2017.	4	Mike Langford

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2965	CMG 6 - Clinical Support & Imaging (CSI)	Pharmacy	If we do not address Windsor pharmacy storage demands, then we may compromise clinical care and breach statutory duties	30/01/2017 23/12/2016	Consequences: Increased likelihood of patients missing doses due to stock outs as inadequate quantities of some lines being kept. Delay or denial of new treatments due to insufficient suitable storage capacity. Inability to switch to preparations that are safer for patients e.g. ready made injectables due to requirement for increased storage space-this has contributed to an 'Never event'. Potential for statutory breaches resulting in improvement notices and critical reports from General Pharmaceutical Council. Increased wastage of drugs due to poor storage conditions/fridge failure. Economic impact with procuring more expensive drugs that have to be stored at room temperature. Inability to clean the walk-in cold store due to lack of decant facilities. Infection Prevention non-compliance due to rats regularly found within open sided area. Inability to switch to ready-made aseptic products to address current overcapacity of aseptic suite. Increased likelihood of staff sustaining manual handling injuries whilst operating in a crowded store area.	Patients (Clinical/Safety)	Reduction/removal of non-pharmaceutical products to other areas. Transfer of non-pharmaceutical consumables to external storage containers. Additional fridges purchased to maximum capacity. Direct delivery of IV fluids to ward areas where possible. Regular pest control visits with reports monitored.	Moderate	Almost certain	15	Complete Phase 2 of aseptic unit/pharmacy stores redevelopment as per existing business case and 17/18 capital plan - March 2018 Review fridge capacity and where necessary purchase additional fridges once space available through redevelopment (identified within 17/18 plans) - March 2018 Review stockholding-pilot of managed stockholding reduction - Feb 2017 Identify additional stockholding area external to pharmacy (SUP request submitted and response awaited) Identify items that can be stored out of dept and/or on an alternative site to release capacity - Jan 2017 Implement identified plans to maximise fridge capacity to temporarily mitigate -scope opportunities for further fridges within current space and temporarily use of fridges designated for clinical trials use - Jan 2017	6	Claire Ellwood