INTEGRATED RISK AND ASSURANCE REPORT AS AT 31ST AUGUST 2017

Author: Richard Manton Sponsor: Andrew Furlong **Trust Board paper G**

Executive Summary

Context

This paper informs the UHL Trust Board of the current position with progress of the risk management agenda, including the 2017/18 Board Assurance Framework (BAF) and the organisational risk register for items with a current rating of 15 and above. Entries on the BAF have been updated by their executive owners and considered at the relevant Executive Boards and items on the organisational risk register have been scrutinised by CMGs and at the Executive Performance Board during the reporting period.

Questions

1. Is the Board assured about the current progress with managing BAF risks that may threaten delivering our annual priorities?
2. Does the Board have knowledge of new organisational risks opened within the reporting period and the key themes recorded on the risk register?

Conclusion

1. The BAF format provides focus on controls assurance (what needs to happen to achieve the annual priority), performance assurance (what performance measures are being used to track progress and do they show what is actually happening) and risk assurance (what gaps have been identified). The BAF risks that threaten delivering the annual priorities are described in the risk assurance section in the report and principal themes relate to management of finances, workforce, IM&T systems and demand & capacity capability. A mid-year review of the BAF has been undertaken and improvements to the current structure will be worked up with the Executive Team during October and a revised version will be presented to the Trust Board in November.
2. During the reporting period of August 2017, three high risks (two new and one increased from moderate) have been entered on the organisational risk register. Thematic analyses of risks scoring 15 and above on the risk register shows the principal causal factor is related to workforce capacity and capability with the typical impact relating to harm.

Input Sought

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

For Reference

Edit as appropriate:

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

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

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

a. Organisational Risk Register [Yes]

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

b. Board Assurance Framework [Yes]

BAF entry	BAF Title	Current Rating
	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: [2 November 2017 TB]

6. Executive Summaries should not exceed 2 **pages**. [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: **5TH OCTOBER 2017**

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

SUBJECT: **INTEGRATED RISK AND ASSURANCE REPORT (INCORPORATING UHL BOARD ASSURANCE FRAMEWORK & ORGANISATIONAL RISK REGISTER AS AT 31ST AUGUST 2017)**

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1 INTRODUCTION

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

a. A copy of the 2017/18 Board Assurance Framework (BAF).
b. A summary of risks on the organisational risk register with a current rating of 15 and above.

2. BOARD ASSURANCE FRAMEWORK SUMMARY

2.1 The BAF remains a dynamic and developing document and has been kept under review during August 2017. Executive owners have updated the BAF to take account of progress with delivering against the annual priorities for 2017/18, with the Executive Boards having corporate oversight to scrutinise and endorse the final version, which is included at appendix one. The Trust Board should note the deteriorating position for entry 1.4.1 - we will manage our demand and capacity and the revised forecast position for entry 5.6 - we will deliver our Cost Improvement and Financial plans in order to make the Trust clinically and financially sustainable in the long term.

2.2 Findings from a mid-year review of the current arrangements for managing the BAF in the UHL, which included feedback received from Audit Committee, Trust Board and informal advice from our internal auditors have identified some areas where the process could be strengthened; including a clear description of the principal risks to the strategic objectives, identifying actions to address gaps in controls and assurances, and a simplified 'tracker' rating to show whether the related annual priority is on track or at risk of non-delivery. These improvements have been endorsed by EPB in September and will be worked up with the executive team during October and a revised version will be presented to the Trust Board in November.

2.3 Thematic analysis from the operational risk register for items scoring 15 and above, along with details included in our current BAF, and a review of items on previous TB agendas, have identified the following as the top risks in the Trust:

1. If the Trust is unable to achieve and maintain staffing levels that meet service requirements, caused by an inability to recruit, retain and utilise a workforce with the necessary skills and experience, then it may result in extended unplanned service closures and disruption to services across CMGs, leading to poor clinical outcomes & experience for large numbers of patients; failure to achieve constitutional standards; unmanageable staff workloads; and increased costs. (This will be for the Workforce objective).

2. If the Trust is unable to achieve and maintain the required levels of clinical effectiveness, patient safety & patient experience, caused by inadequate clinical practice and ineffective information and technology systems, then it may result in widespread instances of avoidable patient harm, leading to regulatory intervention and adverse publicity that damage the Trust's reputation and could affect CQC registration. (This will be for the Quality Commitment annual priorities, with the exception of OoC component).
3. If the Trust is unable to manage the level of emergency and elective demand, caused by an inability to provide safe staffing and fundamental process issues, then it may result in sustained failure to achieve constitutional standards in relation to ED; significantly reduced patient flow throughout the hospital; disruption to multiple services across CMGs; reduced quality of care for large numbers of patients; unmanageable staff workloads; and increased costs. (This will be for the QC OoC annual priority).
4. If the Trust is unable to achieve and maintain its financial plan, caused by ineffective solution to the demand and capacity issue and ineffective strategies to meet CIP requirements, then it may result in widespread loss of public and stakeholder confidence with potential for regulatory action such as financial special measures or parliamentary intervention. (This will be for the financial annual priority – key enabler).

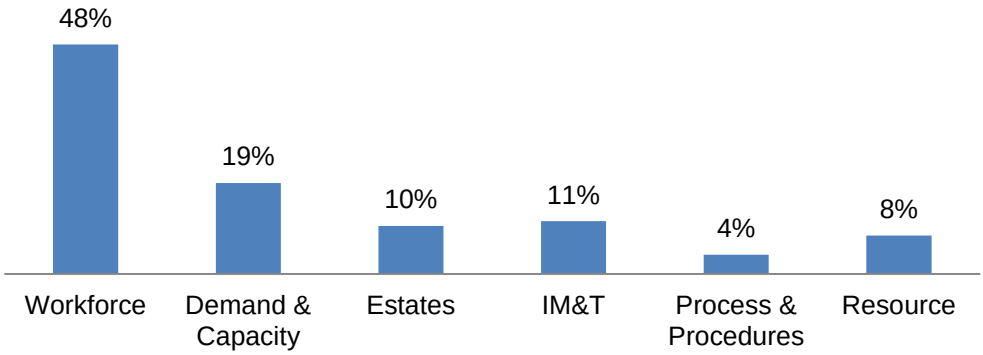
3. UHL RISK REGISTER SUMMARY

3.1 For the reporting period ending 31st August 2017, there are 52 organisational (business as usual) risks open on the risk register scoring 15 and above. A report of these risks is attached in appendix two.

3.2 During the reporting period, three 'high' risks have been entered on the risk register, including two newly identified and one increased from a moderate rating:

Datix ID	Risk Description	Risk Rating	CMG
3077	If there are delays in the availability of in-patient beds, then the performance of the Emergency Department could be adversely affected, resulting in overcrowding in the Emergency Department and an inability to accept new patients from ambulances.	NEW 15	ESM
3079	If the insufficient capacity with Medical Examiners is not addressed then this may lead to a delay with screening all deaths and undertaking Structured Judgement Reviews, resulting in failure to learn from deaths in a timely manner and non-compliance with the internal QC and external NHS England duties.	NEW 15	Corp Medical
2673	If the bid for the National Genetics reconfiguration is not successful then there will be a financial risk to the Trust, resulting in the loss of the Cytogenetics service.	16 ↑	CSI

3.3 Thematic analysis to determine the main causativeness for the risk entries rated as high is illustrated in the graphic below.



3.4 Further analysis in relation to the typical impacts, should the risk occur, displays the potential for harm to patients, staff or others.

4 RECOMMENDATIONS

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

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

BAF 17/18: As of…	Aug-17											
Objective:	Safe, high quality, patient centered, efficient healthcare											
Annual Priority 1.1.1	We will focus interventions in conditions with a higher than expected mortality rate in order to reduce our SHMI. **Trust QC Aim: SHMI < 99.**											
Objective Owner:	MD		**SRO:**	J Jameson		**Executive Board:**		EQB		**TB Sub Committee**		QAC
BAF Assurance Rating - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4	4	4	4							
BAF Assurance Rating - Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4	4	4	4							

Controls assurance (planning)	Performance assurance (measuring)
Governance: Mortality Review Committee, chaired by Medical Director.	Published Summary Hospital-level Mortality Indictor (SHMI) - </= 99 - Latest published SHMI - 101 (period Jan to December 2016) within expected range. Next published SHMI is due end of September 17 (period 16/17).
Medical Examiner Mortality Screening of In-hospital Deaths.	
Case Note Reviews using National Structured Judgement Review Tool (SJR) and thematic analysis.	% of deaths screened - target is 95% of all adult inpatient deaths. 96% of Adult Deaths were screened by the MEs in Q1 (includes Community and ED deaths) 88% of July's deaths have been screened to date.
UHL's Risk Adjusted Mortality Rates (SHMI) monitored using Dr Foster Intelligence and HED Clinical Benchmarking Tools.	% deaths referred for structured judgement reviews (SJR) have death classification within 3 months - target is 85% of SJR cases have death classification within 3/12 of death. Process commenced 01/04/17. 112 adult cases referred for SJR in Q1 (April = 41; May = 34; June = 36). April's deaths should have been classified by end of July. To date, 28 of the 41 (68%) have been classified. (GAP) Capacity constraints of both MEs and Admin Team leading to build up of August's cases to be screened and SJRs to be followed up. Bereavement Support Service seeing an increase in activity - see Risk Assurance below.
Five top mortality governance priorities identified through the AQuA comparator report are now standing agenda items at the Mortality Review Committee.	
	UHL's latest rolling 'unpublished' 12 month SHMI (May 16 - April 17) is 100.
	Actions related to CUSUM alerts on track / completed (performance target is all actions on track / completed): April 2017 = Dr Foster CUSUM alert received (Coronary arterosclerosis disease) and actions on track response submitted to CQC on 26th July. July 17 - New Dr Foster CUSUM alert received for Coronary Artery Bypass Graft 'Other' received. Currently being investigated and response drafted for review by MRC prior to submission to the CQC at end of September.

Strategic Risk assurance (assessment)	Movement
If the national measure for calculating data of hospital mortality, for 'in-house deaths' and 'deaths occurring within 30 days of discharge from hospital', is reduced due to improvements made by other English Acute Trusts, then in-hospital improvement work may not reflect the national adjusted SHMI target. Risk register 3057	

If the insufficient capacity with Medical Examiners is not addressed then this may lead to a delay with screening all deaths and undertaking Structured Judgement Reviews resulting in failure to learn from deaths in a timely manner and non-compliance with the internal QC and external NHS England duties. Risk register 3079. Bereavement Support Nurse workload increasing and would not be able to deliver service without almost full time support from Bank Nurse (with bereavement support experience). Additional MEs and replacement ME Assistant being recruited. Further admin support to be recruited and Bereavement Support Nurse post to be formalised. Risk Score = 15. Target Score = 6	

Corporate Oversight (TB / Sub Committees)			
Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	Audit Committee		
TB sub Committee	QAC	Aug-17	Quarterly report to be submitted to the Quality Assurance Committee in August to include outcomes of Structured Judgement Reviews and details of Death Classifications prior to national reporting and publication via the Trust Board in September.

Independent (Internal / External Auditors)			
Source:-	Title:	Date:	Feedback:
Internal Audit	Review of Mortality and Morbidity	2015/16	Actions Completed - End Jun 17
External Audit	LLR Quality Clinical Audit	2017/18	Audit population = SHM Deaths over 4 week period in Jun/July 17. Due to be published Feb 18.

BAF 17/18: As of…	Aug-17											
Objective:	Safe, high quality, patient centered, efficient healthcare											
Annual Priority 1.2.1	We will further roll-out track and trigger tools (e.g. sepsis care), in order to improve our vigilance and management of deteriorating patients. **Trust QC Aim: Reduce incidents that result in severe / moderate harm by further 9%.**											
Objective Owner:	CN/MD		**SRO:**	J Jameson		**Executive Board:**		EQB		**TB Sub Committee**		QAC
BAF Assurance Rating - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3	3	3	3	3							
BAF Assurance Rating - Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4	4	4	4							

Controls assurance (planning)	Performance assurance (measuring)
Governance: Deteriorating Adult Patient Board - last meeting held 22nd August.	Audit EWS & Sepsis in all adult & paediatric wards in scope; day case, labour ward, CCU and ITU out of scope daily.
Electronic handover supported by NerveCentre.	
Sepsis and AKI awareness and training mandatory for clinical staff.	Review audit results of EWS & Sepsis fortnightly.
Team based training packages for recognition of a deteriorating patient.	Review of Datix reported incidents related to the recognition of the deteriorating patient quarterly - last report to DAPB July 2017.
7 days a week critical care outreach service - launched May 2017.	
Harm review of patients with red flag sepsis who did not receive Antibiotics within 3 hours - reviewed fortnightly by the EWS & Sepsis Review Group.	**Outcome KPIs:** ED KPI 90% of patients with red flag sepsis receive IV antibiotics within 1 hour. TRUST KPIs 95% of patients with an EWS of 3+ appropriately escalated & of those patients with an EWS 3+, 95% screened for sepsis & of those screened for sepsis and identified to have red flag sepsis, 90% receive IV antibiotics within 1 hour.
Roll out of e-obs to the modified National Early Warning Scoring System - with the exception of maternity & ward 27.	
Sepsis e-learning module on HELM - launched July 2017	
(GAP) Deteriorating patient e-learning module - due Aug 2017.	**Quality Commitment KPIs:** Q1 position: N/A Q2 position: • Clinical Rules for sepsis (NerveCentre) fully implemented • Alerts for sepsis (NerveCentre) fully implemented • Trust wide implementation of e-Obs (NerveCentre) • Fully automated EWS reporting (NerveCentre) Q3position: • Assessments for sepsis (NerveCentre) fully implemented • Fully automated Sepsis reporting (NerveCentre) Q4 position: N/A
EWS & Sepsis audit results reported to CQC monthly.	
Sepsis screening tool and care pathway - updated & relaunched July 2017	
Review of admissions to ITU with red flag sepsis at all 3 sites monthly.	
Monitoring of SUIs related to the deteriorating patient.	

Strategic Risk assurance (assessment)	Movement
If appropriate observation (EWS) systems are not developed and implemented to identify and act upon the results for the deteriorating patient then this may result in preventable deaths or severe harm occurring. Risk register 3007.	New

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

TB sub Committee	QAC	Jun-17	This priority is tied into the overall IT strategy that is planning to further develop NerveCentre and this detail has yet to be agreed.

Independent (Internal / External Auditors)			
Source:-	Title:	Date:	Feedback:
Internal Audit	Follow up from CQC inspection (June 2016)	Q2 17/18	Will validate and assess how the Trust is addressing the findings, in relation to the quality commitment, from the inspection in 2016.
External Audit	work plan TBA		

BAF 17/18: As of…	Aug-17											
Objective:	Safe, high quality, patient centered, efficient healthcare											
Annual Priority 1.2.2 (a) Insulin	We will introduce safer use of high risk drugs (e.g. **insulin** and warfarin) in order to protect our patients from harm. **Trust QC Aim: Reduce incidents that result in severe / moderate harm by further 9%.**											
Objective Owner:	MD/CN	**SRO Insulin:**		E Meldrum / C Free		**Executive Board:**		EQB		**TB Sub Committee**		QAC
BAF Assurance Rating - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3	3	2	2	2							
BAF Assurance Rating - Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4	3	2	3							

Controls assurance (planning)	Performance assurance (measuring)
Insulin	
Governance: Diabetes Inpatient Safety Committee.	**Outcome KPIs:**
E-learning for Insulin Safety mandatory for staff who have responsibility for prescribing, preparing and administering insulin.	Reduce number of severe inpatient hypoglycaemia episodes by 20%.
	To have no in hospital DKA “events” in quarter 4.
(GAP) Nursing staff anually enter BM into NerveCentre.	
(GAP) Implement a networked blood glucose meter system to record and monitor episodes of severe hypoglycaemia.	
(GAP) RCA analysis of all in hospital DKAs.	
Insulin safety Pulse Check in Q2 & Q4.	
(GAP) UHL guidelines for the management of hypoglycaemia.	
(GAP) spot check audits of recording of BM on NerveCentre.	

Strategic Risk assurance (assessment)	Category
INSULIN RISK - If fit for purpose electronic systems and processes are not developed linking with nerve centre to monitor safer use of high risk drugs then we are unable to effectively assess patients and monitor insulin safety improvements. Risk register 3060.	

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	Audit Committee		
TB sub Committee	QAC	Jul-17	In light of current challenges around the delays in implementing the controls assurance for Insulin Safety, including the reporting issues linked e-learning on HELM, we will be implementing a Trust wide theoretical assessment for registered nurses and HCAs to assess knowledge around insulin safety and blood glucose monitoring. This will be led by the Advanced Practitioner for Diabetes and Nurse Education Leads w/c 8th August commencing in CHUGGs LRI and RRCV. this process will be similar to the one used to test knowledge of staff in the care of the deteriorating patient. The assessments will provide assurance around staff ability to manage patients with Type 2 Diabetes but additional education and training will be given post assessment to ensure that there is a consistent level of knowledge across all inpatient wards.

Independent (Internal / External Auditors)			
Source:-	Title:	Date:	Feedback:
Internal Audit	Follow up from CQC inspection (June 2016)	Q2 17/18	Will validate and assess how the Trust is addressing the findings from the inspection in 2016.
External Audit	work plan TBA		

BAF 17/18: As of…	Aug-17											
Objective:	Safe, high quality, patient centered, efficient healthcare											
Annual Priority 1.2.2 (b) Warfarin	We will introduce safer use of high risk drugs (e.g. insulin and **warfarin)** in order to protect our patients from harm. **Trust QC Aim: Reduce incidents that result in severe / moderate harm by further 9%.**											
Objective Owner:	MD/CN	**SRO Warfarin:**		C Marshall		**Executive Board:**		EQB		**TB Sub Committee**		QAC
BAF Assurance Rating - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3	3	3	3	3							
BAF Assurance Rating - Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4	3	3	3							

Controls assurance (planning)	Performance assurance (measuring)
Warfarin	
Governance: UHL Anticoagulation taskforce group reporting to EQB quarterly / Medicines Optimisation Committee.	Monitoring of anticoagulant related harm with key performance indicators: - Number of missed doses of warfarin. - Number of INRs>6. - Safety thermometer triggers to zero.
UHL Anticoagulation action plan.	
(GAP) E-learning warfarin safety programme mandatory for clinical staff.	
Anticoagulation in-reach nursing service - delay with implementation.	
Discharge summary for patients on warfarin to improve communication with GPs.	
Improve time to octaplex delivery in bleeding patients in ED.	
UHL Anticoagulation policy.	

Strategic Risk assurance (assessment)	Category
WARFARIN RISK - If fit for purpose electronic systems and processes are not developed linking with nerve centre to monitor safer use of high risk drugs then we are unable to effectively assess patients and monitor insulin safety improvements. Risk register 3060.	

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	Audit Committee		
TB sub Committee	QAC	Aug-17	WARFARIN: Delay due due to contract negotiations with City Clinical Commissioning Group around start dates for the new anticoagulation service which has been delayed from an original start date of April 2017 to October 2017. This delay affects the ability to deliver the proposed in-reach service which is a key element in the implementation of quality improvements in anticoagulation. Project management support for the project needs to be identified to help support the clinicians who are delivering the actions. August 17 : support from MD to develop 'non compulsory' e-learning package for anticoagulation. Agreement reached with ED & Haematology to ensure Octaplex is available in ED, currently with pharmacy colleagues to finalise paperwork needed. UHL Anticoagulation policy now finalised, all CCGs using the same policy. Anticoagulation discharge template in place, on ICE.

Independent (Internal / External Auditors)

Source:-	Title:	Date:	Feedback:
Internal Audit	Follow up from CQC inspection (June 2016)	Q2 17/18	Will validate and assess how the Trust is addressing the findings from the inspection in 2016.
External Audit	work plan TBA		

BAF 17/18: As of…	Aug-17											
Objective:	Safe, high quality, patient centered, efficient healthcare											
Annual Priority 1.2.3	We will implement processes to improve diagnostics results management in order to ensure that results are promptly acted upon. **Trust QC Aim: Reduce incidents that result in severe / moderate harm by further 9%.**											
Objective Owner:	MD		**SRO:**	C Marshall		**Executive Board:**		EQB		**TB Sub Committee**		QAC
BAF Assurance Rating - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3	3	3	2	2							
BAF Assurance Rating - Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4	3	2	2							

Controls assurance (planning)	Performance assurance (measuring)
Governance: Acting on Results programme board and task and finish groups to report to EQB quarterly.	% of results acknowledged - target is 85% of results acknowledged by Q4 2017/18.
UHL diagnostic testing policy	
Acting on results detailed action plan monitored via EQB. This covers: developing a fit for purpose electronic system to acknowledge results; in depth work with each specialty to develop standard operating procedures; review of radiology and MDT processes; human factors review of our results reporting service; reviw of how urgent resutls are escalated with a view to putting them on NerveCentre; increasing patient involvement; and improved training in how to use ICE for results acknowledgment.	
(GAP) Conserus (alert email to clinician for unexpected imaging results) pilot in CDU (highest risk area) prior to Trust roll-out - slipped to September 2017.	
(GAP) Development of metrics for monitoring performance against target.	

Strategic Risk assurance (assessment)	Movement
If fit for purpose electronic systems are not developed and implemented to monitor and ensure results are promptly acted upon then this may cause unnecessary harm to patients. Risk register 3061.	New

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	Audit Committee		
TB sub Committee	QAC	Aug-17	Roll out of Conserus radiology solution for reporting unexpected findings to clinicians has been delayed. An electronic solution using Mobile ICE is due to be piloted in August 2017. This will be rolled out trust-wide if successful. Development of reporting metrics is happening in tandem.

Independent (Internal / External Auditors)

Source:-	Title:	Date:	Feedback:
Internal Audit	Follow up from CQC inspection (June 2016)	Q2 17/18	Will validate and assess how the Trust is addressing the findings from the inspection in 2016.

External Audit	work plan TBA		

BAF 17/18: As of…	Aug-17											
Objective:	Safe, high quality, patient centered, efficient healthcare											
Annual Priority 1.3.1	We will provide individualised end of life care plans for patients in their last days of life (5 priorities of the Dying Person) in that our care reflects our patients' wishes. **Trust QC Aim: >75% of patients in the last days of life have individualised End of Life Care plans.**											
Objective Owner:	CN		**SRO:**	C Ribbins / S Hotson		**Executive Board:**		EQB		**TB Sub Committee**		QAC
BAF Assurance Rating - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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BAF Assurance Rating - Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Controls assurance (planning)	Performance assurance (measuring)
Governance: Palliative & End of Life Care Committee meets bi-monthly.	**Quality Commitment KPIs**: Patients in the last days of life will have an individual care plan in place as per the "One Chance to Get it Right" Guidance (2014): Care plan implemented in 75% of wards in new CMG and care plan sustained in 75% of CMG wards already implemented on.
Detailed project plan presented at the Palliative & End of Life Care Committee.	
End of life care plans which include specialist palliative care end of life care service.	
End of Life Care Facilitors rolling out implementation of taining and support in the use of End of Life care plans (reflected in the detailed project plan).	Review of Datix reported incidents related to the syringe drivers - last report to P&EoLCC July 2017.
"Guidance for care of patients in the last days of life" & "Individualised End of Life Care Plan" reviewed by the Palliateive & End of Life Care Committee - awaiting P&GC approval.	EoLC audits quarterly.
(GAP) Implementation of an electronic system.	

Strategic Risk assurance (assessment)	Movement
If discharge arrangements and better co-ordination of care with community services via effective electronic systems is not implemented, whilst crucially for those who will remain in hospital ensuring they have a "good death", then this may not enable more people to die at the place of their choice. Risk register 3058.	New

Corporate Oversight (TB / Sub Committees)

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

Independent (Internal / External Auditors)

Source:-	Title:	Date:	Feedback:
Internal Audit	Follow up from CQC inspection (June 2016)	Q2 17/18	Will validate and assess how the Trust is addressing the findings from the inspection in 2016.
External Audit	work plan TBA		

BAF 17/18: Version	Aug-17											
Objective:	Safe, high quality, patient centered, efficient healthcare											
Annual Priority 1.3.2	We will improve the patient experience in our current outpatients service and begin work to transform our outpatient models of care in order to make them more effective and sustainable in the longer term. Trust QC Aim: outpatients tba											
Objective owner:	DCIE		**SRO:**	J Edyvean / D Mitchell		**Executive Board:**		EQB		**TB Sub Committee**		IFPIC
BAF Assurance Rating - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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BAF Assurance Rating - Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Controls assurance (planning)	Performance assurance (measuring)
Governance: Outpatient Performance Board & Executive Quality Board.	Patients waiting in excess of 12 months for a follow up (KPI trajectory: Q1-379 currently amber rating of 3;Q2-321; Q3-189; Q4 - 0 Year end position on track).
(GAP) Generate additional capacity and book patients in time order.	
Long term follow up report which allows us to track performance.	Outpatients Friends and Family Test - Red if <93%.
Agreed action plan in place and monitored through the Outpatient Quality report and this is monitored at CPM and in contracting meetings.	Clinical audit of additional schemes related to changes in the new to follow up ratio - Completed as planned.
(GAP) 50% of remaining outpatients opportunity to be added to the PMTT.	(GAP) Q1 Scoping, Q2 Agree KPI's and programme plan, Q3 Initiate delivery, Q4 speciality delivery (TBC).
(GAP) Out patient transformation project initiated (Objectives and KPI's TBC).	
	(GAP) Delivery of CMG plans for ENT and Cardiology dependent on resources being released at speciality level to deliver changes.

Strategic Risk assurance (assessment)	Movement
If resources are not allocated to support change and standardised process, and fit for purpose electronic systems, are not developed and implemented to monitor and ensure outpatient diagnostic results are promptly acted upon, then it may cause unnecessary harm to patients. Risk register 3059.	New

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	QAC	Aug-17	Year end position deliverable with moderate risk associated. The scale of cultural change across the organisation and the associated behavioural changes to sustain transformation is a significant challenge for the organisation is achieving the required outcomes

Independent (Internal / External Auditors)

Source:-	Title:	Date:	Feedback:
Internal Audit	Follow up from CQC inspection (June 2016)	Q2 17/18	Will validate and assess how the Trust is addressing the findings from the inspection in 2016. OP Transformation plan to include CQC requirements.
External Audit	work plan TBA		

BAF 17/18: Version	Aug-17											
Objective:	Safe, high quality, patient centered, efficient healthcare											
Annual Priorities 1.4.1	Organisation of Care - We will manage our demand and capacity: We will utilise our new Emergency Department efficiently and effectively. We will use our bed capacity efficiently and effectively (including Red2Green, SAFER, expanding bed capacity). We will implement new step down capacity and a new front door frailty pathway. We will use our theatres efficiently and effectively.											
Objective owner:	COO		**SRO:**	S Barton		**Executive Board:**		EPB		**TB Sub Committee**		IFPIC/QAC
BAF Assurance Rating - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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BAF Assurance Rating - Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Controls assurance (planning)	Performance assurance (measuring)
Submission of demand and capacity plan to NHSI – We are forecasting an overall peak bed shortfall of 105 beds. The major shortfalls are in medicine at the LRI and Glenfield.	ED 4 hour wait performance trajectory submitted to NHSI - Performance currently below national benchmark.
	Ambulance handover (delays over 60 mins) submitted to NHSI.
New ED building open to public from 26th April 2017.	RTT Incomplete waiting times trajectory submitted to NHSI.
(GAP) Demand and Capacity Governance structure being progressed.	2WW for urgent GP referral as per the NHSI submitted trajectories.
Programme Director appointed.	31 day wait for 1st treatment as per submitted NHSI trajectories.
Theatre trading model in place along with ACPL targets.	62 day wait for 1st treatment as per submitted NHSI trajectories.
Ward 7 moves to Ward 21 and becomes a medical ward in the recurrent baseline (+28 beds)	105 bed gap mitigated.
	Reduced cancelled operations due to no available bed.
Staffing of additional 8 beds on the medicine emergency pathway at LRI on Ward 7.	Occupancy of 92% (as of June 2017).
Plan for elective service changes at LGH involving MSS & CHUGGs.	ACPL target achieved.
Re-launch of Red 2 Green & SAFER within Medicine at LRI.	The demand and capacity plan is not currently balanced for the year.
Launch of Red 2 Green & SAFER at Glenfield.	
A staffing plan from Paediatrics for Winter 17/18.	
Care model and a detailed plan for stepdown facility.	
Feasibility work commenced into physical capacity solutions for both LRI & GH.	
Decision on option for physical expansion at GH.	

Strategic Risk assurance (assessment)	Movement
If the additional physical bed capacity cannot be opened, caused by an inability to provide safe staffing, then it will lead to a continued demand and capacity imbalance at the LRI resulting in delays in patients gaining access to beds and cancelled operations. Risk register 3074.	
If the out of hospital step-down solution is not operational for Winter 17/18 then it will lead to a continued demand and capacity imbalance at the LRI. Risk register 3075.	

If the physical capacity options at Glenfield are not affordable from a capital and revenue perspective, then it will lead to a demand and capacity imbalance at GH in the winter of 2017/18. Risk register 3076.	
If demand continues to grow above plan for medicine this may lead to a widening of the bed demand and capacity imbalance at LRI.	

Corporate Oversight (TB / Sub Committees)			
Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	QAC	Aug-17	Whilst there is progress ahead of plan within the bed demand and capacity at this stage, some beds have not opened due to staffing in CHUGGS and Medicine. Demand and capacity within ED is not aligned, particularly overnight. Demand for medicine emergency admissions is above plan year to date. The demand and capacity gap for beds remain unbalanced for the year and the medical step down project is not at this stage forecast to deliver additional capacity. Whilst a short-term plan as part of the September surge was implemented to better align medical demand and capacity by hour, this still needs a sustainable plan in place.
TB sub Committee	IFPIC		

Independent (Internal / External Auditors)			
Source:-	Title:	Date:	Feedback:
Internal Audit	ED - Dynamic Priority Score	Q2 17/18	Will review the process for assessing patients on arrival at ED through the DPS process.
External Audit	work plan TBA		

BAF 17/18: As of…	Aug-17											
Objective:	Right people with the right skills in the right numbers											
Annual Priority 2.1	We will develop a sustainable workforce plan, reflective of our local community which is consistent with the STP in order to support new, integrated models of care											
Objective Owner:	DWOD		**SRO:**	J Tyler-Fantom		**Executive Board:**		EWB		**TB Sub Committee**		IFPIC
BAF Assurance Rating - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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BAF Assurance Rating - Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Controls assurance (planning)	Performance assurance (measuring)
Workforce plan relating to reduction in dependency on non contracted workforce, safe staffing, review of urgent and emergency care, impact of seven day services, shift of activity into community settings and increased specialised services where appropriate.	Apprenticeship levy - 430 predicted in 17/18 against 334 target. Currently falling short of TNA for range of reasons including lack of sign off of trailblazer programmes.
	BME Leadership - target 28%
People strategy and programme of work to address the leadership priorities, wellbeing of our workforce and ensure we focus on addressing actions to improve the diversity of our workforce - UHL Leadership programme.	Workforce sickness - target 3% - reporting for Estates and Facilities not adequate and when introduced will affect sickness levels.
	Safe Staffing targets: in accordance with Nursing requirements
Governance structure in place comprising internal and external groups, including Workforce OD Board and the Local Workforce Action Board and subgroups thereof who oversee delivery of the workforce and organisational development components of the Sustainable Transformation Plan.	Seven day services stats:
	Shift of activity in to community:
	(GAP) Reduction in dependency of our non-contracted workforce - on track to achieve NHSI target of £20.6 m and £770K medical agency expenditure reduction.
Apprenticeship workforce strategy.	(GAP) Vacancy rates -target below 10% (equivalent to turnover to be proposed and agreed).
NHS WRES Technical Guidance refreshed - includes changes made to NHS Standard Contract (2017/18 to 2018/19) and definitions of terminology used in WRES indicators, and how affects organisations subject to WRES.	
(GAP) STP refresh in progress – to provide a more accurate workforce prediction based on current capacity requirements - ~~due June 2017~~ (revised deadline to be confirmed but likely to relate to revised consultation deadlines) - UHL revised their component following demand and capacity review - planning underway across Health Community.	
(GAP) insufficent resource to support system wide workforce planning and modelling approach - business case submitted to CSU. In place in some parts (Cardio Respiratory model of care) - complete - all other workstreams to develop a workforce plan.	
(GAP) Engagement of UHL planning leads in workforce approach to ensure triangulation with activity modelling - due June 2017 Will be required for new planning round for 18/19 and 19/20. Planning parameters to be agreed by Executive Team-	

early discussion taken place.	
(GAP) Predictive workforce modelling - Emergency and Urgent Care Vanguard commenced - due June 2017 (revised deadline tbc).	
(GAP) ability to close nursing recruitment gaps particularly impacted by decline in supply of European nurses, higher turnover of EU nurses and slower entry of overseas nurses into workforce as a result of IELTs. Tommorows Ward Programme currently being set up to reduce demand for nursing.	

Strategic Risk assurance (assessment)	Movement
If the Trust fails to engage effectively with staff through robust communication networks and reduce the non-contracted workforce then this may affect the delivery of a sustainable workforce plan resulting in sub-optimal patient centered healthcare. Risk register 3009.	
If we don't reduce the number of non-NHS standard contract employees then we will not deliver a sustainable workforce plan. Risk register 3064.	

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	Audit Committee		
TB sub Committee	IFPIC	Jun-17	The gaps in supply of future workforce cannot be readily met therefore a revised Workforce Plan is being developed which will have a greater emphasis on new teams around the patient.

Independent (Internal / External Auditors)

Source:-	Title:	Date:	Feedback:
Internal Audit	No involvement identified in 17/18 plan.		
External Audit	work plan TBA		

BAF 17/18: As of…	Aug-17											
Objective:	Right people with the right skills in the right numbers											
Annual Priority 2.2	We will reduce our agency spend towards the required cap in order to achieve the best use of our pay budget											
Objective Owner:	DWOD		**SRO:**	J Tyler-Fantom		**Executive Board:**		EPB		**TB Sub Committee**		IFPIC
BAF Assurance Rating - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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BAF Assurance Rating - Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Controls assurance (planning)	Performance assurance (measuring)
NHSI overall agency cap is £20.6m for 2017/18, specific target for medical agency reduction £717,930 in 17/18 - incorporated into CMG financial planning.	£20.6 ceiling target and agency spend - monthly monitoring through financial trajectories in place to measure variance to plan.
Monitoring of agency cap breaches to NHSI weekly.	Medical Agency Dashboard to Medical Oversight board.
Medical Oversight Broad established.	(GAP) Regional deliverables, including regional rate card, to be defined through regional working group in line with TOR - in development.
(GAP) Regional MOU and establishment of a regional working group for medical agency.	(GAP) No. of retrospective bank and agency bookings reported through to Premium Spend Group - target to be determined.
Monitoring of agency spend and tracker (including data analysis which shows reasons for request and rates of use by ward level) through Premium Spend Group with EWB, EPB, IFPIC oversight - There is a detailed agency action tracker in place, with monitored actions against agreed activities to reduce agency expenditure.	
Agreed escalation processes / break glass escalation control.	
Review of top 10 agency highest earners and long term through ERCB linking to vacancy positions and CMG recruitment plans.	
Process for signing off bank and agency staff at CMG level through Temporary staffing office following appropriate senior approval.	
Nursing rostering prepared 8 weeks in advance.	
No agency invoice is paid without booking number.	

Strategic Risk assurance (assessment)	Movement
If the Trust is unable to control expenditure on agency staff, caused by an inability to recruit and retain sufficiently skilled and capable staff, then we may exceed the pay budget and this may result in sub optimal patient care. Risk register 3063.	New

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

TB sub Committee	IFPIC	Aug-17	The agency ceiling target is £20.6m . At the current run rate agency spend will exceed the annual ceiling by £1.54m at year end. A significant number of controls and mechanisms are in place to monitor and reduce agency spend linked to recruitment activity, which are managed through the Premium Spend Group (PSG) with oversight from the WF and OD board, EPB and EWB. Monthly planned agency spend was adjusted upwards for the new plan in 17/18 to bring in line with current spend. The plan shows a trajectory downwards across the year in order to meet the Trust's agency ceiling /cap.

Independent (Internal / External Auditors)			
Source:-	Title:	Date:	Feedback:
Internal Audit	No involvement identified in 17/18 plan.		
External Audit	work plan TBA		

BAF 17/18: As of…	Aug-17											
Objective:	Right people with the right skills in the right numbers											
Annual Priority 2.3	We will transform and deliver high quality and affordable HR, OH and OD services in order to make them 'Fit for the Future'											
Objective Owner:	DWOD		**SRO:**	B Kotecha		**Executive Board:**		EWB		**TB Sub Committee**		IFPIC
BAF Assurance Rating - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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BAF Assurance Rating - Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Controls assurance (planning)	Performance assurance (measuring)
Vision and programme plan in place (transforming HR Function) - HR Fit for the future programme roadmap.	Staff engagement staff survey score.
Maximising use of Technology (enabling processes).	(GAP) HR KPIs aligned to HR Roadmap (to be developed): Processes - Structure - People & Culture - Technology -
Listening Events held in July 2017 to work with stakeholders and customers to deliver service differently and to gain ownership.	
(GAP) Redefine and Up skill staff within the Service in order to be fit for the future: UHL Way Annual Priorities Map agreed: HR / OD Team have undergone development in UHL Way during June and will be supporting transformation aspects of UHL priority delivery.	(GAP) Reporting completion of statutory and mandatory training and essential to job training.
(GAP) Delivery structures not fit for purpose until target operating model has been developed - target operating model will be informed by feedback from listening events in July.	
(GAP) Full implementation of new Health Education Learning Management System - Additional implementation funds agreed by CMIC in September 2017.	

Strategic Risk assurance (assessment)	Movement
If the Trust fails to engage effectively with staff and act on staff experience survey feedback and results, then this may affect the delivery of safe, high quality patient centered healthcare. Risk register 3062.	⟷

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	Audit Committee		
TB sub Committee	PPP Committee	Sep-17	Update to be provided to new People Process and Performance Committee - Forms part of new work programme.

Independent (Internal / External Auditors)

Source:-	Title:	Date:	Feedback:

Internal Audit	Induction of temporary staff	Q2 17/18	Will review the adequacy of the policy for induction of temporary staff and consider whether this is being effectively implemented.
Internal Audit	Review of Payroll Contract	Q3 17/18	Will review the robustness of the contract management arrangements for new payroll provide who will be in place from 01/08/17.
External Audit	work plan TBA		

BAF 17/18: As of…	Aug-17											
Objective:	High quality, relevant, education and research											
Annual Priority 3.1	We will improve the experience of medical students at UHL through a targeted action plan in order to increase the numbers wanting stay with the Trust following their training and education											
Objective Owner:	MD		**SRO:**	S Carr		**Executive Board:**		EWB		**TB Sub Committee**		
BAF Assurance Rating - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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BAF Assurance Rating - Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Controls assurance (planning)	Performance assurance (measuring)
Medical Education Strategy to improve learning culture.	GMC/ HEE regional meeting scheduled for 21/09/17 to review progress against action plans for all Trusts visited.
Medical Education Quality Improvement Plan.	
(GAP) Transparent and accountable SIFT funding / expenditure in CMGs.	Leicester Medical School feedback (satisfaction / experience) - areas for improvement in 17/18 plan.
UHL Multi-professional education facilities strategy to progress EXCEL@UHL.	
(GAP) CMG ownership of undergraduate education outcomes.	UHL UG education quality dashboard (satisfaction / experience) - to be launched in Sept 17 - Draft to be submitted to EWB in Sept - outcomes available in Oct 17.
(GAP) Overarching strategy with University of Leicester to integrate undergraduate and postgraduate training to improve outcomes and retention.	GMC National student survey (satisfaction / experience) - 2017 survey headlines show a decline in Overall Satisfaction for UoL.
UG representatives on the UHL Doctors in Training Committee.	
MJPCC - either SC or DL to attend future meetings with details of individual's educational roles. This will be used to confirm and inform the job plan.	Currently <20% medical students complete the end of block feedback. The Medical School have agreed to address and improve this. We anticipate improvement by Dec 17.
	(GAP) HEE Quality Management Process (satisfaction / experience)- new process still to be confirmed for 2017/18.
	Student Exit Survey - areas for improvement included in 17/18 QI plan.
	UKFPO shows that whilst 2017 figures for the % of LMS students who 'preferenced' LNR Foundation School has increased slightly to 25% (19 % in 2016), Leicester is still ranked 23rd out of 31 for 'Local Applications by Medical School'.

Strategic Risk assurance (assessment)	Movement
If CMGs don't ensure that those with Undergraduate and Postgraduate medical education roles (including Educational Supervisors) have identified time in their job plans then this may impact the quality of medical education. Risk register 3035.	⟺
If SIFT and MADEL funding allocated to CMGs is not used for education and training and linked to education quality outcomes then this may be withdrawn by HEE impacting the Trust position as a teaching hospital. Risk register 3037.	⟺
If the requirements imposed by the GMC in their 2016 report, including improvements to learning culture, IT infrastructure and facilities, are not met then this may impact the Trust position as a teaching hospital and our ability to effectively recruit and retain medical students and trainees. Risk register 3036.	⟺

Corporate Oversight (TB / Sub Committees)				
Source:-	Title:	Date:	Assurance Feedback:	
TB sub Committee	Audit Committee		No scrutiny - The TB should consider where they are receiving assurance in relation to this priority.	
TB sub Committee	QAC		No scrutiny - The TB should consider where they are receiving assurance in relation to this priority.	
Independent (Internal / External Auditors)				
Source:-	Title:		Date:	Feedback:
Internal Audit	Consultant Job Planning		Q1 17/18	Will review the arrangements in place for consultant job planning and carry out testing of a sample of job plans to assess whether these meet good practice set out in 'A guide to Consultant Job Planning'.
External Audit	work plan TBA			

BAF 17/18: As of…	Aug-17											
Objective:	High quality, relevant, education and research											
Annual Priority 3.2	We will address specialty-specific shortcomings in postgraduate medical education and trainee experience in order to make our services a more attractive proposition for postgraduates											
Objective Owner:	MD		**SRO:**	S Carr		**Executive Board:**		EWB		**TB Sub Committee**		
BAF Assurance Rating - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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BAF Assurance Rating - Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Controls assurance (planning)	Performance assurance (measuring)
Medical Education Strategy to address specialty-specific shortcomings.	GMC/ HEE regional meeting scheduled for 21/09/17 to review progress against action plans for all Trusts visited.
Medical Education Quality Improvement Plan for 2017/18.	
HEEM quality management visits for following specialties - Cardiology, Maxillo-Facial School of Surgery / Dentistry, Trauma & Orthopaedics School of Surgery and Respiratory Medicine.	(GAP) HEE Quality Management Process (satisfaction / experience) - new process still to be confirmed for 2017/18. It's likely that self assessment will increase and HEE will only visit areas with training challenges- 'triggered visits'.
(GAP) CMGs Quality Improvement Action Plans in response to GMC visit and survey results to address concerns in postgraduate education.	UHL Medical Education Survey (should see improvements if more attractive) - bi annual- next due in Sept 2017 - results available in Oct 17.
(GAP) Department of Clinical Education programme with CMGs to develop action plans to address poor performance and training challenges.	UHL UG education quality dashboard (satisfaction / experience) - to be launched in Sept 17 - Draft to be submitted to EWB in Sept - outcomes available in Oct 17.
(GAP) Overarching strategy with University of Leicester to integrate undergraduate and postgraduate training to improve outcomes and retention.	2017 GMC national training survey - outcomes show improvements for some specialties (Anaesthetics, Paediatric Surgery) but deterioration in others (ENT, Cardiology, Resp Medicine). Improvements shown in 'Reporting Systems and Study Leave' but deterioration for 'Clinical Supervision and Feedback'. Detailed finding have been circulated and CMG Education Leads to present QI action plans on 29/09
GMC 'Approval and Recognition' of Clinical and Educational Supervisors - central database monitored and maintained.	
GMC visit report - UHL action plan developed.	
A pilot audit of job plans for Cardiology shows a deficit in education time of 7 eSPAs. (GAP) Audit for other services to be commenced.	(GAP) Data to show the number of postgraduate medical and trainees retained in the specialties with shortcomings.
MJPCC- either SC or DL to attend future meetings with details of individual's educational roles. This will be used to confirm and inform the job plan.	UHL Trainer Survey completed in conjunction with the Clinical Senate- issues with workload and time for training were highlighted. Outcomes to be discussed on Sept 15th at Clinical Senate meeting.
On-going support work for Trust Grade doctors to minimise rota gaps and improved trainee experience at UHL.	
Cardio-Respiratory Improvement Steering group in place to respond to HEE triggered visit in Jul 17. Action plan in place and resources identified.	
Attitudes and Behaviours to Improve Care' group has been established (chaired by Suzanne Khalid) - will support the GMC action on undermining in UHL.	

Strategic Risk assurance (assessment)	Movement

If SIFT and MADEL funding allocated to CMGs is not used for education and training and linked to education quality outcomes then this may be withdrawn by HEE impacting the Trust position as a teaching hospital. Risk register 3037.	⟺
If the requirements imposed by the GMC in their 2016 report, including improvements to learning culture, IT infrastructure and facilities, are not met then this may impact the Trust position as a teaching hospital and our ability to effectively recruit and retain medical students and trainees. Risk register 3036.	⟺
If the mandatory training curricula are not adhered, caused by rota gaps and service pressures, then we may lose posts (e.g. T&O and CMT) impacting the Trust position as a teaching hospital. Risk register 3034.	⟺
If CMGs don't ensure that those with Undergraduate and Postgraduate medical education roles (including Educational Supervisors) have identified time in their job plans then this may impact the quality of medical education. Risk register 3035.	⟺

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

Independent (Internal / External Auditors)			
Source:-	Title:	Date:	Feedback:
Internal Audit	Consultant Job Planning	Q1 17/18	Will review the arrangements in place for consultant job planning and carry out testing of a sample of job plans to assess whether these meet good practice set out in 'A guide to Consultant Job Planning'.
External Audit	work plan TBA		

BAF 17/18: As of…	Aug-17											
Objective:	High quality, relevant, education and research											
Annual Priority 3.3	We will develop a new 5-Year Research Strategy with the University of Leicester in order to maximise the effectiveness of our research partnership											
Objective Owner:	MD		**SRO:**	N Brunskill		**Executive Board:**		ESB		**TB Sub Committee**		
BAF Assurance Rating - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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BAF Assurance Rating - Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Controls assurance (planning)	Performance assurance (measuring)
(GAP) UHL Research and Innovation Strategy in UHL - due Q2 2017/18.	Internal monitoring via metrics reported at joint strategic meetings including finance, communications, patient and public involvement.
(GAP) Dialogue with UoL to articulate (year 1 of the 5 year) research strategy which will consolidate our position in areas of existing strength such as BRU, Cancer, Respiratory and Cardiovascular and identify new areas for possible development such as Obstetrics and Childrens - due Q2 2017/18.	(GAP) External monitoring via annual reports from NIHR re performance for funded research projects - next report due Q2 2017/18.
	(GAP) Sign-off (year 1 stage) of the 5 year research strategy.
Functioning organisational relationship in place with UoL which includes joint strategic meetings to discuss research performance and opportunities.	

Strategic Risk assurance (assessment)	Movement
If we don't have the right resources in place (including personnel and external funding) and an appropriate infrastructure to run clinical research, then we may not maximise our research potential which may adversely affect our ability to drive clinical quality and delivery of our research strategy. Risk register 3065.	

Corporate Oversight (TB / Sub Committees)			
Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	ESB	Jul-17	DRI (N Brunskill) to provide a draft Research and Innovation Strategy for the Sept 2017 ESB meeting.
TB sub Committee	Audit Committee		No scrutiny - The TB should consider where they are receiving assurance in relation to this priority.
TB sub Committee	IFPIC		No scrutiny - The TB should consider where they are receiving assurance in relation to this priority.

Independent (Internal / External Auditors)			
Source:-	Title:	Date:	Feedback:
Internal Audit	No involvement with research in 17/18 plan.		
External Audit	work plan TBA		

BAF 17/18: As of…	Aug-17											
Objective:	More integrated care in partnership with others											
Annual Priority 4.1	We will integrate the new model of care for frail older people with partners in other parts of health and social care in order to create an end to end pathway for frailty											
Objective Owner:	DCIE	**SRO:**	U Montgomery / J Currington			**Executive Board:**		ESB		**TB Sub Committee**		
BAF Assurance Rating - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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BAF Assurance Rating - Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Controls assurance (planning)	Performance assurance (measuring)
UHL working group established and reporting to UHL Exec boards.	(GAP) Milestones and success criteria to monitor progress of bringing partners across LLR together to be defined in the Project Charter Documentation.
STP Governance arrangements (Work streams reporting to System Leadership Team and will report summary updates to individual organisational boards / governing bodies from Q2 2017/18 - subject to confirmation from the STP PMO).	(GAP) Performance data will be monitored at service level, once defined.
UHL clinical lead identified - Dr Ursula Montgomery.	Frailty Oversight Group meeting to bring together frailty streams across UHL - scheduled for 10/10/17.
CMG clinical lead identified - Dr Richard Wong.	A PDSA cycle from the previous weekend with in-reach into assessment bay resulted in 40% of the cohort being discharged home.
Strategic Development and Integration Manager appointed.	
UHL project plan - Better Change Project Charter, Benefits Realisation, Milestone Tracker and Stakeholder Analysis.	
System wide project plan / PID specific to frailty in place.	
System wide Tiger Team bringing clinicians together across LLR. Clinical Leadership Group and senior clinical leaders meet scheduled for 8th June 2017 to discuss draft report of the Tiger Team and agreeing next steps across the system.	
External senior representation on relevant STP Work stream Boards.	
STP Work stream Project Initiations Documents (which relate to frailty).	
(GAP) Identification and management of interdependencies between STP work streams given most touch on frailty - work in progress.	
(GAP) Commissioning and contracting model that supports deliver of frailty pathway.	
(GAP) Links to other work-streams and any required support are to be identified and supported by executive membership.	
South Warwickshire visit to UHL planned to share their experience.	
Phase II and in-reach models are being added into the Delivery Plan along with capturing other frailty work underway - First draft plan due by 12th September.	
(GAP) There is a need to look at therapy input/pharmacy and possibly alternative	

workforce models - Needs to be incorporated into the delivery plan.	

Strategic Risk assurance (assessment)	Movement
If appropriate project resources are not allocated (caused by lack of project leads appointed, capital investment and ineffective STP governance work streams) then we may not deliver an effective end to end pathway for frailty (Risk ID 3028).	

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

Independent (Internal / External Auditors)			
Source:-	Title:	Date:	Feedback:
Internal Audit	No involvement identified in 17/18 plan.		
External Audit	No involvement identified in 17/18 plan.		

BAF 17/18: As of…	Aug-17											
Objective:	More integrated care in partnership with others											
Annual Priority 4.2	We will increase the support, education and specialist advice we offer to partners to help manage more patients in the community (integrated teams) in order to prevent unwarranted demand on our hospitals											
Objective Owner:	DCIE	**SRO:**	U Montgomery / J Currington			**Executive Board:**		ESB		**TB Sub Committee**		
BAF Assurance Rating - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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BAF Assurance Rating - Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Controls assurance (planning)	Performance assurance (measuring)
UHL designated clinical lead and management lead report to UHL Exec boards.	Milestones and success criteria defined in the Project Initiations Document.
ESB approved high level scope in March 2017.	(GAP) Performance data will be monitored at service level, once defined - Awaiting Project Board.
STP Governance arrangements (Work streams reporting to System Leadership Team and will report summary updates to individual organisational boards / governing bodies from Q2 - subject to confirmation from the STP PMO).	(GAP) Feedback from current Podcasts – need to ensure schedule is suitable for the target audience - evening sessions etc.
Primary Care Oversight Board.	
Project plan - Better Change Project Charter, Benefits Realisation, Milestone Tracker and Stakeholder Analysis.	
System wide Tiger Team bringing clinicians together across LLR.	
External Senior representation on relevant STP Work stream Boards, namely Integrated Teams Programme Board.	
Integrated Teams Programme Board approved a high level proposal / scoping document in April 2017.	
STP Work stream Project Initiations Documents although these are not specific to this project / objective but align in a number of ways.	
(GAP) Identification and management of interdependencies between STP work streams given most touch on frailty - this project will work most closely with the Integrated Teams work stream but will need to establish links with others. Project Board will bring together leads from existing workstreams to ensure interdependencies are managed - Work in progress.	
(GAP) Lack of clarity (at this stage) about the availability of funding to support these 'non-activity related' activities. Project Board will escalate this as appropriate.	
(GAP) Systematised approach to Education reacting to flags raised through: patient experience; incidents; risks; GP Hotline etc.	
Draft - high level - educational programme established within UHL, which will need to	

now extend to wider stakeholders.	

Strategic Risk assurance (assessment)	Movement
If appropriate project resources are not allocated (caused by lack of project leads appointed, capital investment and ineffective STP governance work streams) then we may not deliver an effective end to end pathway for frailty (Risk ID 3028).	

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

Independent (Internal / External Auditors)			
Source:-	Title:	Date:	Feedback:
Internal Audit	No involvement identified in 17/18 plan.		
External Audit	No involvement identified in 17/18 plan.		

BAF 17/18: As of…	Aug-17											
Objective:	More integrated care in partnership with others											
Annual Priority 4.3	We will form new relationships with primary care in order to enhance our joint working and improve its sustainability											
Objective Owner:	DCIE		**SRO:**	J Currington		**Executive Board:**		ESB		**TB Sub Committee**		
BAF Assurance Rating - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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BAF Assurance Rating - Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Controls assurance (planning)	Performance assurance (measuring)
Clinical Lead identified (Associate Medical Director – Primary Care Interface)	Performance assurance and reporting identified through UHL Project Charter to include number of new relationships with primary care.
Managerial Lead identified (Head of Partnerships and Business Development).	
Clinical Lead member of STP Primary Care Resilience Group.	(GAP) Description of UHL offer or "Brochure" will be produced. Bid Support Manager started 31 July.
Project Plan / Project Charter in place. Better Change Project Charter, Benefits Realisation. Milestone Tracker and Stakeholder Analysis completed - Expert group identified.	(GAP) A Baseline Mapping of existing integration initiatives which can be used as a measure the outputs of the project.
Primary Care Oversight Board (PCOB) in place.	GP hotline pilot in place 01/09 - 30/11. Consultant Connect report due to next PCOB. PRISM currently at 64% coverage of elective referrals / core pathways.
Tender opportunity search process are reported through ESB monthly.	
(GAP) A Stakeholder Communication/Engagement Plan.	
(GAP) A suite of Tender Response Documents ready for responding to any competitive tenders and to include a description of UHL's response team. Recruitment to Strategy and Bid Office Manager post completed - Work in progress.	

Strategic Risk assurance (assessment)	Movement
If appropriate project resources are not allocated (caused by uncertainty regarding resources) then we may not develop effective relationships with primary care providers (Risk ID 1888).	

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

Independent (Internal / External Auditors)			
Source:-	Title:	Date:	Feedback:
Internal Audit	No involvement identified in 17/18 plan.		
External Audit	No involvement identified in 17/18 plan.		

BAF 17/18: Version	Aug-17											
Objective:	Progress our key strategic enablers											
Annual Priority 5.1	We will progress our hospital reconfiguration and investment plans in order to deliver our overall strategy to concentrate emergency and specialist care and protect elective work											
Objective owner:	CFO		**SRO:**	N Topham		**Executive Board:**		ESB		**TB Sub Committee**		IFPIC
BAF Assurance Rating - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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BAF Assurance Rating - Year end Forecast @	**April**	**May**	**June**	**June**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Planning (controls)	Performance Management (assurance sources)
(GAP) Develop EMCHC full business case - subject to outcome of consultation, delayed due to period of 'purdah'; final decision expected at the end of November 2017.	Performance against EMCHC project plan - is dependent on the outcome of the national consultation – scope for project is being finalised - on track.
Deliver year 1 (of 3 year) Interim ICU project - external capital funding has been confirmed but receipt is subject to external approval of business cases. Confirmation now received that one OBC and one FBC to be completed within 2017/18 for the whole proejct of £30.8m.	Performance against updated Interim ICU project plan that delivers OBC by end Oct and FBC by end Jan 2018 - is dependent on external approval of business cases to secure external funding – design solutions for project are being revalidated - on track.
Deliver Emergency Floor Phase 2 (to complete in 2017/18).	Performance against Emergency Floor Phase 2 project plan - on track.
(GAP) Deliver Vascular Outpatients move to GH subject to outcome of scoping exercise and decision at ESB (to complete in 2017/18).	Performance against Vascular Outpatients project plan - is dependent on project scoping – outcome delayed owing to complexity of solution.
(GAP) Deliver Infill beds at LRI and GGH subject to approval of Business case (to complete in 2017/18).	Performance against Infill beds at LRI and GGH project plan - is dependent on business case approval – updated action is that LRI infill beds have been postponed owing to staffing levels, and GH only will have additional beds in 2017/18: solution for this is still under review.
Full review of affordability of Reconfiguration Programme, including use of PF2 to reduce reliance on external funding from the Department of Health, and re-assess capital priorities in line with the Trust's Strategic Objectives and Annual Priorities. Submission of capital bid for external funding (to complete in 2017/18).	Performance against Reconfiguration Programme project plan - on track.

Strategic Risk assurance (assessment)	Movement
If the national review into congenital heart services concludes that the EMCHC service is de-commissioned then this will impact our reconfiguration plans. Risk register 3072.	↔
If external capital funding is not available when it is required to maintain the reconfiguration programme to initially progress the interim ICU project then this may impact our reconfiguration plans. Risk register 3073.	↔

Due to lack of availability of external funding over recent years, the delivery date for the Reconfiguration Programme has been extended by 2 years; now completing in 2022/23 instead of 2020/21. There is a risk that this extension will have a negative impact on clinical sustainability and clinical risk for services currently located on the LGH site.	NEW

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

Independent (Internal / External Auditors)			
Source:-	Title:	Date:	Feedback:
Internal Audit	No involvement identified in 17/18 plan.		
External Audit	work plan TBA		

BAF 17/18: Version	Aug-17											
Objective:	Progress our key strategic enablers											
Annual Priority 5.2	We will make progress towards a fully digital hospital (EPR) with user-friendly systems in order to support safe, efficient and high quality patient care											
Objective owner:	CIO		**SRO:**	Paula Dunnan		**Executive Board:**		EIM&T		**TB Sub Committee**		IFPIC/QAC
BAF Assurance Rating - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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BAF Assurance Rating - Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Controls assurance (planning)	Performance assurance (measuring)
EPR Plan - Best of breed (new systems & building on our Nervecentre solution).	(GAP) EPR Plan - key milestones to be developed.
(GAP) Implement NC forms and rules to support clinical practice.	IM&T Project Dashboard - Milestones reported are on track
(GAP) Implement NC bed management.	
(GAP) Create outpatient NC/ICE functionality	
IM&T Project Dashboard reported to EIM&T Board.	
IM&T Governance structure and specialty sub-groups in place.	
(GAP) IM&T Project Management Support.	

Strategic Risk assurance (assessment)	Movement
If we don't have appropriate project management support and implementation specialist to develop the Trust's specified IT programmes then this may impact our ability to achieve the priority within the cost envelope. Risk register 3022.	↔
If a continuous hardware and software replacement programme is not effectively implemented then our systems will become dated resulting in suboptimal end user interface. Risk register 3067.	↔

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	Audit Committee		IM&T report provided on request.
TB sub Committee	IFPIC		Quarterly paper provided: EPR plan – Best of Breed is progressing and alternative solutions are being reviewed. Work continues to implement NC Forms and Rules and Bed Management, the IM&T elements of these functions have been enabled and does now require support from the stakeholders to implement.
TB sub Committee	QAC		IM&T report provided on request.

Independent (Internal / External Auditors)

Source:-	Title:	Date:	Feedback:
Internal Audit	Electronic Patient Record Plan 'B'	Planned Q2 17/18	Will review the alternative solution and consider the processes and controls that the Trust will put in place to deliver the solution.
External Audit	work plan TBA		

BAF 17/18: Version	Aug-17											
Objective:	Progress our key strategic enablers											
Annual Priority 5.3	We will deliver the year 2 implementation plan for the 'UHL Way' and engage in the development of the 'LLR Way' in order to support our staff on the journey to transform services											
Objective owner:	DWOD		**SRO:**	B Kotecha		**Executive Board:**		EWB		**TB Sub Committee**		IFPIC
BAF Assurance Rating - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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BAF Assurance Rating - Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Controls assurance (planning)	Performance assurance (measuring)
UHL Way	
UHL Way governance structure (with programme leads for the 4 components of Better - engagement, teams, change and Academy).	(GAP) Fully populated UHL Way Annual Priorities Map - metrics to be developed.
UHL Way Year 2 implementation plan and tracker. Year 2 - Close liaison with all SROs for annual priorities in 17/18 to process map their journey to identify gaps against the 4 components of the UHL Way.	UHL Pulse check dashboard (Quarterly) - Q1 2017/18 results show an improvement against overall engement score (from 3.8 to 3.91 out of 5) and increased response rate (by 2.32%).
	National staff survey (annually) - April 2017 = UHL joint 47th position.
LIA processes embedded.	(GAP) Metrics to measure number of UHL Way interventions utilised in supporting annual priorities - as a minimum Project Charter to be produced for all priorities.
	Metrics to measure number of staff through Way Master Class - 59 staff completed as at the end of July.
	Better Teams Aggregated Pulse Check Scores.
LLR Way	
LLR OD and Change Group (workforce enabling group).	(GAP) Metrics to measure no. of people through introduction.
LLR Governance structure with clinical and senior leadership from LLR services (including UHL, LPT, City & County Councils, EMAS) - Better care together improvement framework.	(GAP) Metrics to measure no. of interventions utilised.
	Funding secured to progress LLR Way Elements.
(GAP) LLR standardised improvement framework to approach change.	
(GAP) Framework to raise awareness of STP and LLR Way.	
LLR Making Things Happen Event on 13 July to launch Introduction Package - Timeline agreed for Improvement Package.	

Strategic Risk assurance (assessment)	Movement
If we don't adopt the UHL Way approach then we may not maximise our potential to empower staff and sustain change which may adversely affect our ability to achieve our Annual Priorities. Risk register 3068.	⟷

If we are not able to achieve a minimum 30% response rate in the UHL Quarterly Pulse Check then the data may not be reliable and valid. Risk register 3069.	

Corporate Oversight (TB / Sub Committees)			
Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	Audit Committee		
TB sub Committee	PPP Committee	Sep-17	Update to be provided to new People Process and Performance Committee - Forms part of new work programme.
TB sub Committee	IFPIC	Jul-17	Improvements in key measures including the Quarterly Pulse Check and full engagement by Annual Priority Senior Responsible Officers in implementing priorities the UHL Way. Progress with LLR Way to be shared at LLR Clinical Leadership Group Event (140 clinicians to attend this event from across the system) and agreement reached on 'LLR Way' implementation actions in the first year (2017/18). Key implementation activity to be agreed at LLR Board to Board Meeting in July 2017.

Independent (Internal / External Auditors)			
Source:-	Title:	Date:	Feedback:
Internal Audit	No involvement identified in 17/18 plan.		
External Audit	work plan TBA		

BAF 17/18: As of…	Aug-17											
Objective:	Progress our key strategic enablers											
Annual Priority 5.4	We will review our Corporate Services in order to ensure we have an effective and efficient support function focused on the key priorities											
Objective Owner:	DWOD		**SRO:**	DWOD (& J Lewin)		**Executive Board:**		EWB		**TB Sub Committee**		IFPIC
BAF Assurance Rating - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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BAF Assurance Rating - Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Controls assurance (planning)	Performance assurance (measuring)
UHL's requirement for significant CIP savings and national imperatives such as delivery of Lord Carter's 2016 recommendations present UHL with the necessity and opportunity to redesign Corporate Services that are fit for the future. UHL will also need to deliver its contribution to the LLR STP review of back office savings.	(GAP) Milestones to be developed and agreed.
	(GAP) Performance KPIs in development.
	Additional UHL 2017/18 CIP target (service line targets agreed by July 2017 EQB).
	£577k STP savings target (service line targets agreed by July 2017 EQB).
All nine UHL Corporate Directorate plus Estates and Facilities are in scope.	Carter target for back office cost to be no more than 7% of turnover by March 2018.
PID ratified at IFPIC on 31/08/17.	
Project governance defined in PID.	Carter Target for back office cost to be no more than 6% of turnover by March 2020.
Project Board meeting monthly.	
(GAP) Diagnostic phase across all Corporate Services commencing in June 2017, progress to an options appraisal assigning in year delivery targets across service lines will be completed in October 2017.	
Project manager resource in place.	

Strategic Risk assurance (assessment)	Movement
If operational delivery (across 2017/18) is negatively impacted by CIP (i.e. targets may reduce the ability of Corporate Services to "invest to save" limiting potential service transformation and agile working - particularly with regard to IT enablement) and other cost pressures, then this will affect delivery of the requirements within the Carter report to manage back-office costs (diagnostic phase and subsequent options appraisal will provide mitigation) - Risk ID 3056	New

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	Audit Committee		
TB sub Committee	IFPIC	Aug-17	The PID for the Corporate Services review was ratified by IFPIC in August 2017. An options appraisal assigning in year delivery targets across service lines will be completed in October 2017 following an extensive diagnostic exercise. This work will be informed by the Supplementary CIP Programme - Pay Bill / Workforce Reductions 2017/18 action plans.

Independent (Internal / External Auditors)

Source:-	Title:	Date:	Feedback:

Internal Audit	No involvement identified in 17/18 plan.		
External Audit	work plan TBA		

BAF 17/18: As of…	Aug-17											
Objective:	Progress our key strategic enablers											
Annual Priority 5.5	We will implement our Commercial Strategy, one agreed by the Board, in order to exploit commercial opportunities available to the Trust											
Objective Owner:	CFO		**SRO:**	CFO		**Executive Board:**		EPB		**TB Sub Committee**		FIC
BAF Assurance Rating - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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BAF Assurance Rating - Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Controls assurance (planning)	Performance assurance (measuring)
Implement overall Commercial Strategy.	(GAP) Monitoring of specific programme/work streams (once agreed).
Identify work streams which can be implemented in 2017/18.	(GAP) Income streams measured monthly against target (once agreed).
Identify resources to support the strategy this year.	
Link programme to subsidiary company TGH and agree priorities.	
Deliver new income or cost saving schemes in line with agreed target.	
Publicise the Commercial Strategy across UHL and engage key stakeholders.	

Strategic Risk assurance (assessment)	Movement
If suitable resources cannot be allocated to support delivery of our Commercial Strategy properly then we will not be able to exploit commercial opportunities available to the Trust and there may be a negative impact of reduced focus on core business. Risk register 3066.	

Corporate Oversight (TB / Sub Committees)			
Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	Audit Committee		Twice yearly review of progress to Trust Board.
TB sub Committee	FIC		Bi monthly update

Independent (Internal / External Auditors)			
Source:-	Title:	Date:	Feedback:
Internal Audit	No involvement identified in 17/18 plan.		
External Audit	work plan TBA		

BAF 17/18: As of…	Aug-17											
Objective:	Progress our key strategic enablers											
Annual Priority 5.6	We will deliver our Cost Improvement and Financial plans in order to make the Trust clinically and financially sustainable in the long term											
Objective Owner:	CFO		**SRO:**	CFO		**Executive Board:**		EPB		**TB Sub Committee**		FIC
BAF Assurance Rating - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4	4	4	4							
BAF Assurance Rating - Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3	3	3	3	2							

Controls assurance (planning)	Performance assurance (measuring)
Cost Improvement Plans	
CMGs and Corporate departments to fully deliver plans for 2017/18.	Monthly CIP report to EPB and FIC.
100% of PIDS and QIAs signed off.	Monitoring of CIP tracker to measure completeness of programme for the remaining months.
Production and delivery of the Closing the Gap plan.	
Procurement to deliver full £8m target against budgeted spend.	In M5, there remains an unidentified gap that is being worked through with CMGs in an escalation process where appropriate.
Quarterly quality assurance reporting.	
Monthly CMG/Corporate meetings to include detailed review of CIP delivery and forecast - escalating to weekly where CMGs/Corporate departments are materially varying from plan.	
(GAP) Deliver more activity through a more productive capacity through beds, theatres & outpatients – improve efficiency indicators; Reduce the price we pay for goods/services; Remove waste and eliminate unnecessary variation.	
Financial Plans	
CIP (including supplementary) to achieve 100% delivery in 2017/18.	CIP measurement and reporting monthly.
CMGs to achieve their control totals or better.	Monthly I&E submissions to NHSI, Trust Board, FIC and EPB.
Cost pressures and service developments to be minimised and managed through RIC and CEO chaired 'Star Chamber'.	Expenditure run rates for pay, non-pay, capital charges and agency spend.
A minimum of £18m of additional technical and other solutions to be transacted.	Contract income levels consistently being achieved and commissioner challenges resolved quarter by quarter.
Agree an appropriate level of investment supporting the resolution of the demand/capacity issue.	Year on year reduction in agency spend in line with our 2 year trajectory.
	I&E monitoring of progress against £18m technical challenge.
Manage CCG and NHSE contracts to ensure accurate and full receipt of income noting changes to tariff (HRG4+) and new Emergency Floor currencies/flows.	Overall level of overdue debtors to reduce, BPPC performance to improve - monitored within cash paper to FIC.
Implementation of first stages of UHL's Commercial Strategy and use of TGH Ltd.	Improvement in cash position as per the agreed plan.
Reduction in agency spend moving towards the NHSI agency ceiling level.	
New income streams realised and effective, financially beneficial use of TGH Ltd.	
Monitoring of CQUIN Targets.	

(GAP) Better retrieval of overdue debtors.	

Strategic Risk assurance (assessment)	Movement
If the CIP plan is not successfully delivered, caused by cost pressures and ineffective strategies in CMGs and inability to meet supplementary CIP, then the Trust's CIP may not successfully be delivered against the target. Risk register 3070.	
If the financial plan is not successfully delivered, caused by ineffective solution to the demand and capacity issue, then the Trust's financial control total may not successfully be delivered against the target. Risk register 3071.	

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

Independent (Internal / External Auditors)			
Source:-	Title:	Date:	Feedback:
Internal Audit	Cash Management	Q3 17/18	Will review the adequacy of Trust's arrangements for cash flow forecasting and processes for managing working capital.
Internal Audit	Financial Systems	Q3 17/18	Will meet the requirements of external audit and will also include data analysis.
Internal Audit	CIP function and process	Q1 17/18	Will review the adequacy of arrangements for delivery of CIP and the robustness of planning for future years. This will include a review of arrangements against the NHS Efficiency Map.
External Audit	work plan TBA		

BAF Assurance Ratings

Current Assurance Rating: Month-end

0	Not started
1	Extreme challenge
2	Significant challenge
3	Some challenge
4	On Track
5	Delivered

Key questions to BAF owners each month:

Is what needs to be happening actually happening in practice to aid delivery of the annual priority in 2017/18?
Consider are controls effective, are performance outcomes positive and have risks been identified and are being appropriately managed.

Follow up question - By when will the priority be delivered?
Follow up questions - What further actions have been identified to get the annual priority back on track and when is it expected to deliver?

Year-end Forecast Assurance Rating: Year-end

0	Not started
1	Extreme risk associated - Predicted to fail
2	Major risk associated - Significant challenge but expected to deliver in 2017/18
3	Moderate risk associated - Some challenge but expected to deliver in 2017/18
4	Minor risk associated - Predicted to deliver in 2017/18
5	Delivered

Key questions to BAF owners:

What is the year-end forecast for delivering the annual priority in 2017/18?

Follow up question - If unlikely to deliver:
What further actions have been identified to get the annual priority back on track and when is it expected to deliver?

Appendix 2 **Risk Register Report (15+) - As at 31/08/17**

Risk ID	CMG	Specialty	Risk Description	Opened	Review Date	Risk Subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
2264	CMG 1 - Cancer, Haematology, Urology, Gastroenterology & Surgery (CHUGGS)		If an effective solution for the nurse staffing shortages in GI Medicine Surgery and Urology at LGH and LRI is not found, then the safety and quality of care provided will be adversely impacted.	03/Dec/13	31/10/2017	Harm (Patient/Non-patient)	Staffing levels checked on daily basis and staff movement from other areas decided by Matron on site/bleep holder. Head of Nursing and Deputy Head of Nursing available at weekends to advise about staffing moves. All shIfts required out to bank and agency contract due to lack of fill from Staff bank for some areas, other wards adhoc. Over time offered to all staff in advance. Reassurance and support from Matron where possible to pick up non clinical duties and sickness management, bank requests etc.	Major	Almost certain	20	CHUGGS Participation in all international recruitment during 2016; Deputy Head of Nursing to meet with HR Shared Services on a monthly basis; Active recruitment to Assistant Practitioner posts - due 31/01/17; Closed 26/Jan/2017. Participate in recruitment from Philippines and India; Pilot increased bank rates of pay on all GI, Medicine and Surgery and Urology wards at LRI and LGH Corporate HCA recruitment to be a priority for CHUGGS - 31/10/17 ShIfts for ward 22 at LRI/LGH, 27 LGH and SAU's on both sites going to break glass two weeks in advance- 31/10/17 First and second tier agencies to be offered long lines of work for two months in advance, including educational opportunities - 31/10/2017 Explore opportunities for recruiting to non-nursing roles that will support the nursing workforce, such as Ward Clerks and Pharmacy Technicians. 31/10/2017. Explore other opportunities for support from other CMG's. 31/10/17 Matrons to work one clinical shIft per week. Head of Nursing and Deputy Head of Nursing to work clinical shIft every two weeks. - 30/10/17	6	Georgina Kenney	CMG Risk
2621	CMG 1 - Cancer, Haematology, Urology, Gastroenterology & Surgery	General Surgery	If recruitment and retention to vacancies on Ward 22 at the LRI does not occur, then patients may be exposed to harm due to poor skill mix on the Ward.	20/10/2015	31/01/2018	Harm (Patient/Non-patient)	ShIfts escalated to bank and agency at an early stage; Increased the numbers of band 6's to provide leadership support. Agency contract in place for one nurse on day shIft and night shIft to increase nursing numbers. Staffing is reviewed on a day by day basis and staff are moved across the CMG to support the ward as required. Matron to work clinically on the ward for 2 days a week to provide support and increase nursing numbers. Matron to ensure daily matron ward rounds for leadership/ increased monitoring of care standards/accessibility to patients/relatives to discuss any concerns.	Major	Almost certain	20	Ongoing recruitment of trained and untrained nurses as per CHUGGS nursing action plan - 30/09/17; Training needs analysis of all registered nurses and action plan developed - 31/09/17. Restructuring of team to provide more senior support on a day by day basis - 31/09/17 Action plan being developed to be discussed with the Chief Nurse - 31/09/17 GSSU opened and being staffed by ITAPS for 6 months - 31/01/2018	6	Kerry Johnston	CMG Risk
2566	CMG 1 - Cancer, Haematology, Urology, Gastroenterology & Surgery	Oncology	If the range of Toshiba Aquilion CT scanners are not upgraded, then patients will experience delays with their treatment planning process.	26/06/2015	30/09/2017	Harm (Patient/Non-patient)	Limited arrangements for planning palliative patients only (unable to treat radical patients) Comprehensive Service Contract with Toshiba for scanner up until May 2016.	Extreme	Likely	20	Contingency plan for instances of breakdown of the Toshiba scanner using another radiotherapy departments scanner - 31/10/17. Agreement for monthly 1/2 day physics QA sessions on radiology scanner during periods of Toshiba breakdown to ensure continued compability between scanner and planning system - 30/09/17. Purchase of compatible couch top for use with CT scanners - 30/09/17. Service level agreement with radiology for scanner capacity for radiotherapy patients in the case of long term breakdown of scanner - 30/09/17. Contingency plan for instances of breakdown of the Toshiba scanner using radiology scanner - 30/09/17. Awaiting formal business case for the proposed replacement - 31 Dec 17. Completed 01/06/2017.	1	Lorraine Williams	CMG Risk

2354	CMG 2 - Renal, Respiratory, Cardiac & Vascular (RRCV)	If the capacity of the Clinical Decisions Unit is not expanded to meet the increase in demand, then will continue to experience overcrowding resulting in potential harm to patients.	28/05/2014	30/09/2017	Harm (Patient/Non-patient)	Respiratory Consultant on CDU 5 days/week 0800-20 00 hrs Respiratory Consultant on CDU at weekends and bank holidays 0800-1200 hrs and on call thereafter Cardiology Consultant assigned on CDU 5 days a week (shared rota) Cardio Respiratory Streaming flow, including referral criteria and acceptance Short stay ward adjacent to CDU Discharge Lounge utilised GH duty Manager present 24/7 Bed co-ordinator and Flow co-ordinator, providing 7 day cover CDU dash board – performance indicators UHL bed state and triage times includes CDU data Daily nurse staffing review with plan to ensure safe staffing levels on CDU EDIS operational on CDU Daily patient discharge conference calls for all wards Matron of the day - rota covers 7 day working Daily board rounds across all wards Primary Care Co-ordinators and increased community support Escalation plans Implementation of triage audit CDU Operations Meeting Monitoring of patient triage times and other quality performance indicators at monthly CDU ops meeting with appropriate representation from all staff groups	Almost certain	Major	20	Develop & monitor action plans from ECIP review - 30.9.17 Implentation of September reset: Focus on improving red to green metrics - 30.9.17	9	Sue Mason	CMG Risk
2670	CMG 2 - Renal, Respiratory, Cardiac & Vascular (RRCV)	If recruitment to the Clinical Immunology & Allergy Service Consultant vacancy does not occur, then patient backlog will continue to increase, resulting in delayed patient sequential procedures and patient management.	05/Oct/15	30/09/2017	Service disruption	Weekly Access Meeting (WAM) attendance for support and completion of actions. Review of patient referrals to identIfy the high risk patients and complete a trajectory plan. Advice and actions being agreed with the Head of Performance and Operations to ensure all patients waiting for sequential procedures have been identIfied and are allocated to the appropriate patient waiting list. Continued monitoring of these patient waiting list at Respiratory RTT meetings and escalation of concerns. To standardise referral and waiting list procedure to ensure all patients are recorded on the correct patient waiting list. Completion of Business Case and Risk Assessment to recruit an Allergy Consultant for the service. Respiratory Physicians to help maintain current and future Allergy Service. Route to Recruit and advert to be authorised ASAP to cover allergy gap(s). Further discussions of future model of Allergy and Immunology and identIfying possible support from Consultant Dietitian. Clinical Immunology/Allergy Consultant commenced 9.10.16 - Consultant will support an additional allergy clinic due to allergy consultant has been appointed started on the 3.10.16 - complete	Almost certain	Major	20	Monitoring of patient backlog at Respiratory RTT meetings - sustainability meetings planned for September 17. WLI will continue to support backlog and respiratory consultants will continue to back fill until to be reviewed in September at the sustainability meeting - Sep 17 Agree job plan and recruit to Consultant Immunology post - retirement September 2017	6	Karen Jones	CMG Risk
2886	CMG 2 - Renal, Respiratory, Cardiac & Vascular (RRCV)	If we do not invest in the replacement of the Water Treatment Plant at LGH, then we may experience downtime from equipment failure impacting on clinical treatment offered.	29/06/2016	31/Oct/17	Service disruption	Discussion to be reached on the future model for LGH Haemodialysis Unit 1. Capital Purchase). Initial £200K Capital purchase and annual maintenance costs of approximately £10K per annum. To replace the ring main and complete water treatment system. LGH technical team will potentially organise internally to undertake weekly chemical disinfections – UHL Infection informed. Discontinue HDF therapy Samples for Endotoxin testing will continue on a weekly bases. Non-payment of invoices in January 17 has resulted in no chemical disinfect being undertaken by Veola in February 17. This will have an affect on the type of treatment provided to some patients.	Likely	Extreme	20	New plant to commence week commencing 14.9.17. There will be a piggyback system in place so that the existing plant and new plant run side by side until the new plant is up and running. The new plant should be installed w/c 4 December 2017 and project closed down w/c 11 December 2017.	8	Geraldine Ward	CMG Risk

2931	CMG 2 - Renal, Respiratory, Cardiac & Vascular (RRCV)	If the failing Cardiac Monitoring Systems in CCU are not replaced, then we will not be able safely admit critically unwell, unstable persons through EMAS with, STEMI,NSTEMI, OoHCA and Errhythmais.	31/10/2017 05/Sep/16	Harm (Patient/Non-patient)	Medical physics called for assistance and make contact with GE Matron, bleep holder and manager on call informed Nursing Rounds Escalated Nurses to be based at bedside/bay Escalation policy via duty manager to senior team Doctors based on CCU to review all patients Ensure capacity is available on the other clinical areas which have functioning central monitoring If bedside monitors available then parameter alarms set to max audible Patient review by cardiologist Datix completed by NiC Patients prioritised and moved to available ward beds or more visible beds Bleep holder/Matron/Senior team to assess numbers of staff across RRCV and acuity, monitored patients and potentially reallocate staff IdentIfy through senior team/shIft co's/Medical team/med physics and reallocate stand-alone bedside systems to most appropriate patients Escalated to Director/Gold command Business case submitted to Medical Equipment replacement board and to capital investment committee in September 2016.	Likely	Extreme	20	Replace obsolete monitoring system in its entirety including service contract - implementation plan being developed to install by July 17. Project plan development dates confirmed - 30.9.17 Funding approved - Implementation plan being developed and start date to be confirmed - complete Develop specIfic business continuity plan - in progress to be completed as planned - complete	4	Judy Gilmore	CMG Risk
2804	CMG 3 - Emergency & Specialist Medicine (ESM)	If the ongoing pressures in medical admissions continue, then ESM CMG medicine bed base will be insufficient thus resulting in jeopardised delivery of RTT targets.	31/10/2017 06/May/16	Harm (Patient/Non-patient)	Review of capacity requirements throughout the day 4 X daily. Issues escalated at Gold command meetings and outlying plans executed as necessary taking into account impact on elective activity. Opportunities to use community capacity (beds and community services) promoted at site meetings. Daily board rounds and conference calls to confirm and challenge requirements for patients who have met criteria for discharge and where there are delays ICS/ICRS in reach in place. PCC roles fully embedded. Discharges before 11am and 1pm monitored weekly supported by review of weekly ward based metrics. Ward based discharge group working to implement new ways of delivering safe and early discharge. Explicit criteria for outlying in place supported. Review of complaints and incidents data. Safety rota developed to ensure there is an identIfied consultant to review outliers on non-medical wards. Access to community resources to enable patients to be discharged in a timely manner. CMG to access and act on additional corporate support to focus on discharge processes. Matron for discharge appointed to provide consistent care for patients needing to be outlied.	Almost certain	Major	20	Daily Red to green process in place with meetings	12	Susan Burton	CMG Risk
2149	CMG 3 - Emergency & Specialist Medicine (ESM)	If we do not recruit and retain into the current Nursing vacancies within ESM, then patient safety and quality of care will be compromised resulting in potential financial penalties.	31/08/2017 21/02/2013	Harm (Patient/Non-patient)	"Staffing Escalation policy "Staffing Bleep Holder / Matron support ,Site Manager and Duty Manager "Incident reporting "Complaints monitoring "Daily Staffing Meetings "TIA rota "Monitor staffing levels "Monitoring recruitment and retention "Monitoring sickness levels "Provision of nursing support from other base wards, "Support from the Outreach Team "Support from Education & Development Team "Support from Matrons and Deputy/ Head of Nursing, Moving staff between clinical areas as a means to balance risk. Agency and bank as a means to increase nursing numbers- agreed contracts to block book allowing temporary staff to get use to environment and standards within the workplace to each of the clinical areas for agency/bank staff -(green book compliance). Clinical matron/senior nurse available daily to ensure clinical risk is mitigated and managed. Bed management meeting at 8.00, 12.00 16.00 and 18.00 to review bed demands and staffing issues across the Trust. Forum agrees the strategic plan for the 24/7 with on-call director and Senior on a daily basis. Active recruitment strategies to reduce vacancies. Matron visibility on wards Monday to Friday 8 - 8pm and 8 - 4pm at weekends.	Almost certain	Major	20	Enhanced rate of pay now in place for 3 months period and due for ongoing regular reviews. New staff to be appointed from Philippines and India. Advanced booking of staff bank levy in place.	6	Susan Burton	CMG Risk

2763	Critical Care	Risk of patient deterioration due to the cancellation of elective surgery as a result of lack of ICU capacity at LRI	22/01/2016	30/09/2017	Harm (Patient/Non-patient)	IdentIfy patients ready for discharge from ICU in previous 24 hours Highlight potential cancellations to consultant on call Electronic bed booking system to identIfy potential issues with electives Highlight to General Managers potential cancellations Regular discussions cross-site with Consultants to balance the elective lists. Moving staff from between sites to maximise ITU capacity on all. Reviewing booking into ICU daily and for the week ahead to identIfy any risks or special requirements. Monitoring of cancellation rates on a monthly/ weekly basis including cancer cases. IdentIfication of discharges for next day the night before to allow ring-fencing of beds on wards where possible.	Likely	Extreme	20	1. Recruitment still ongoing - middle grade rota remains with gaps. Recruitment plan in place & interview schedules June & July. Revised review date to reflect interview outcomes of 30/08/17 Updated 03/07/17 - 3 gaps remain on middle grade rota. Interviews were scheduled for 06/07/17 but all applicants withdrawn. Aim to go out to advert again as monthly ongoing rolling advert. 30 Sep 17 2. 6 additional ITU beds at LRI to be flexibly opened as staffing and demand indicate but requires Trust Board sign off. review 31 Sep 17. 3. 3.Working group exploring dIfferent ways of working to support capacity expansion PACU staff to support 6 bed HÅkanson but to review as per above. 30 Sep 17 Increase additional capacity (6 beds at LRI). Not agreed by board.	10	Chris Allsager	CMG Risk
2193	Theatres	If an effective maintenance schedule for Theatres and Recovery plants is not put in place, then we are prone to unplanned loss of capacity at the LRI.	28/06/2013	30/08/2017	Service disruption	Regular contact with plant manufacturers to ensure any possible maintenance is carried out. Use of limited charitable funds available to purchase improvements such as new staff room chairs and anaesthetic stools - improve staff morale. TAA building work completed. Recovery area rebuild completed. Compliance with all IP&C recommendations where estate allows. Purchase of new disposable curtains for recovery area, reducing infection risk and improving look of environment. A minor refurbishment programme has taken place which included replacement of doors and seals and repair or replacement of balancing flaps - this has had a minor beneficial effect on the performance of the systems. Low air change rates in some Theatres and Anaesthetic rooms - assurance to address safety concerns to patients and staff from issues such as potential dangerous anaesthetic gases, an independent survey was conducted on a worst case basis (Theatre 16) during 2016. The report stated the following: The exposures measured in this study are not so high as to cause signIficant concern in relation to the Workplace Exposure Limit for nitrous oxide. On the basis of these results, it is reasonable to assert that staff exposure to nitrous oxide and the anaesthetic agents in the areas in which monitoring took place was compliant with the COSHH Regulations 2002.	Almost certain	Major	20	Ventilation audit actions to be undertaken as per Trust wide working party - Staged approach - short, medium and long term actions to be monitored monthly. Some remedial works completed in LRI Theatres and some floors and doors repaired and replaced. Higher risk areas have had remedial actions to improve ventilation flow and await results. Higher risk anaesthetic room (TH 16) has been tested for nitrous oxide and volatile gases and results demonstrated no risk to patients or staff. On going works and funding to be finalised. Review progress of refurbishment of LRI theatres - 31/03/17 Further update 08/02/17 - Provisional plan once capital agreed to use Theatre 7 and place back into service Theatre 18 to enable rolling programmer of maintenance for theatre ventilation works and required upgrades. 7. Updated 03/07/17 - Rolling refurbishment for ventilation and maintenance work has now commenced 08.05.17. Theatre 7 ongoing with some works partially completed. Theatre 18 has partially commenced but not completed. There is currently no end date provided by estates for completion of works in theatres 7 and 18 and no confirmation of continuing works programmer as was agreed in March 2017 by the Executive Team. We will review monthly. The risks may now need to be increased.	4	Gaby Harris	CMG Risk
2191	Ophthalmology	Lack of capacity within the ophthalmology service is causing delays that could result in serious patient harm.	12/Jun/13	30/11/2017	Harm (Patient/Non-patient)	Outpatient efficiency work ongoing. Further education and information to admin team regarding booking outpatient booking process No further overbooking of clinics all patients to be added to the outpatient waiting listened reviwed weekly by the GM and HOOP. Full recovery plan for improvements to Ophthalmology service are in place . EED Breaches monitored daily via text.	Almost certain	Major	20	All actions complete	8	Clare Rose	CMG Risk

CMG 4 - Intensive Care, Theatres, Anaesthesia, Pain Management & Sleep

CMG 4 - Intensive Care, Theatres, Anaesthesia, Pain Management & Sleep (ITAPS)

CMG 5 - Musculoskeletal & Specialist Surgery (MSK &

2940	Paediatrics CMG 7 - Women's and Children's (W&C)	Risk that paed cardiac surgery will cease to be commissioned in Leicester with consequences for intensive care & other services	26/09/2016 30/09/2017	Financial loss (Annual)	Weekly staff communications briefings. Regular staff 'open' meetings to provide opportunity for concerns to be raised. Dedicated EMCHC project manager recruited. Dedicated project campaign resourced. Data manager employed to monitor EMCHC KPIs and performance. Legal advice instructed (Sharing the same legal team with Brompton Hospital). Opening additional ward capacity to meet the commissioning cardiac standards. UHL performance recognised by the Care Quality Commission who, in their initial feedback letter following their inspection in June 2016, reported: "We noted the excellent clinical outcomes for children following cardiac surgery at Glenfield Hospital. EMCHC website developed High priority activity strategy to meet the standard of 375 cases per year Trust Board led challenge to reject the NHSE decision by way of a signed letter by the CEO (05/07/16). NHS England visit to Leicester QC to brief the legal options to the TB in Oct 2016 Expansion of Ward 30 to open an extra 7 beds Liaising with East Midlands MP's	Likely	Extreme	20	Support for Locum surgical consultant to submit and meet GMC specialist registration due 31/12/2017 Ensure project to relocate EMCHC to Children's Hospital stays within capital budget allocation due 30/04/2019	8	Nicola Savage	CMG Risk
2403	Infection prevention Corporate Nursing	There is a risk changes in the organisational structure will adversely affect water management arrangements in UHL	19/08/2014 30/09/2017	Harm (Patient/Non-patient)	Instruction re: the flushing of infrequently used outlets is incorporated into the Mandatory Infection Prevention training package for all clinical staff. Infection Prevention inbox receives all positive water microbiological test results and an IPN daily reviews this inbox and informs affected areas. This is to communicate/enable affected wards/depts to ensure Interserve is taking necessary corrective actions. Flushing of infrequently used outlets is part of the Interserve contract with UHL and this should be immediately reviewed to ensure this is being delivered by Interserve All Heads of Nursing have been advised through the Nursing Executive Team and via the widely communicated National Trust Development Action Plan (following their IP inspection visit in Dec 2013) that they must ensure that their wards and depts are keeping records of all flushing undertaken and this must be widely communicated Monitoring of flushing records has been incorporated into the CMG Infection Prevention Toolkit (reviewed monthly) and the Ward Review Tool (reviewed quarterly). Senior Infection Prevention Nurse working with Facilities.	Almost certain	Major	20	To review and agree Water Safety Plan-Revised Water Management Policy and Water Safety Plan approved by the Trust Infection Prevention Committee. Implementation programme to be confirmed by Facilities colleagues - 30/09/17	4	Elizabeth Collins	Corporate Risk
2404	Infection prevention Corporate Nursing	There is a risk that inadequate management of Vascular Access Devices could result in increased morbidity and mortality	19/08/2014 30/09/2017	Harm (Patient/Non-patient)	UHL Policies are in place to minimise the risk to patients that staff are required to adhere too. A revised data report is being produced for the January 2017 Trust Infection Prevention Assurance Committee that will provide greater transparency with regard to audit results and allow Clinical Management Group boards and Senior staff the insight into areas that require actions to address poor performance	Almost certain	Major	20	Targeted surveillance in areas where low compliance identIfied via trust CVC audit - Yet to be established due to lack of staff required. For further review by the Vascular Access Committee - 30 Sept 17. Develop the recommendations of the Vascular Access Committee action plans to increase the Vascular Access Team within the Trust in line with other organisations. Business Case to be submitted within the organisation by the CSI CMG with support from the Assistant Medical Director appointed by the Medical Director to oversee this objective - 30 Sept 17. Support the recommendations of the Vascular Access Group action plans to reduce the risk of harm to patients and improve compliance with legislation and UHL policies - 30 Sept 17.	16	Elizabeth Collins	Corporate Risk
3040	Cardiology CMG 2 - Renal, Respiratory, Cardiac & Vascular (RRCV)	If there are insufficient medical trainees in Cardiology, then there may be an imbalance between service and education demands resulting in the inability to cover rotas and deliver safe, high quality patient care.	27/06/2017 31/Dec/17	Service disruption	Preventive: •Medical workforce Manager and JDA team monitor the current rotas to identIfy signIficant gaps and complete the necessary actions and planning to ensure cover or reduce the number of medical gaps •Planning of rotations during the 2017/18 with the support of Medical HR to identIfy gaps and complete the necessary actions to ensure cover or reduce the number of medical gaps •Efficient recruitment processes – rolling adverts •Maximising current resources to cover the gaps where possible •Effective communication with medical group and escalation procedures •Increased educational sessions in Trust Grade job plan to develop skills and career progression •Provide a more supportive network to Trust Grades within cardiology	Likely	Major	16	Medical Workforce Manager and JDA team to continue to monitor rotation gaps and take the necessary steps to make base wards and CDU safe ensuring escalation is completed when required - 30.12.17 Effective and timely recruitment completed with the support of the medical HR team to fill medical staffing gaps and reduce risk as much as possible - 30.12.17 Recruitment of ANP and PA posts to RRCV to support the medical gaps which are unable to be filled to improve staffing numbers on base wards and CDU, wards assigned still in progress - 1.10.17 Frequent scheduled meetings to ensure the monitoring of the HEE-EM action plan and reassurance of actions being completed. - 30.12.17 RRCV CMG winter and operational plans and escalation of issues to appropriate Executive Trust Board(s) - 30.12.17	9	Darren Turner	CMG Risk

2820	Clinical Decisions Unit	CMG 2 - Renal, Respiratory, Cardiac & Vascular	If a timely VTE risk assessments is not undertaken on admission to CDU, then we will be breach of NICE CCG92 guidelines resulting patients being placed at risk of harm.	01/Jun/16	30/09/2017	Harm (Patient/Non-patient)	Interim solution to highlight the VTE risk assessment form on the CDU Medical Clerking proforma with a bold red/white sticker. Raise awareness at Junior Doctor Local Induction training. Close monitoring of the monthly VTE target with support from VTE nurse specialist. Complete 'spot check' audit at least once a month - complete	Major	Likely	16	Review current CDU Medical Clerking proforma and agree changes through correct Trust procedures to ensure the VTE risk assessment form is prominent (12 months of old stock) - 1.10.16. - emailed Caroline Baxter for a response - 18.11.16 - An SpR has been identIfied to review the CDU medical clerking proforma - alternative solution identIfied and VTE assessments to be potentially recorded on NERVE centre - 30.12.17 Review of Nerve Centre System to identIfy opportunity to use system to record VTE assessment	4	Karen Jones	CMG Risk
3051	Respiratory Medicine	CMG 2 - Renal, Respiratory, Cardiac & Vascular (RRCV)	If we do not effectively recruit to the Medical Staffing gaps for Respiratory Services, then there is a risk to deliver safe, high quality patient care, operational services and impacts on the wellbeing of all staff including medical staffing.	13/07/2017	30/09/2017	Service disruption	Preventative: Medical Workforce Manager and JDA team monitor the current rotas to identIfy signIficant gaps and complete the necessary actions and planning to esnure cover or reduce the number of medical gaps Planning of rotations during 2017/18 with the support of Medical HR to identIfy gaps and complete the necessary actions to ensure cover or reduce the number of medical gaps Efficient recruitment processes - rolling adverts Maximising current resources to cover the gaps where possible Effective communication with medical groups and escalation procedures Scheduled training and meetings at all medical levels to provide an opportunity for discussion and feedback and Continual Professional Development (CPD) / competence signoff Trust policies and procedures for medical staffing including recruitment, appraisals and local inductions Detective: RC CMG - Respiratory performance meetings where medical staffing is discussed Respiratory Board meetings with attendance from Education representatives to escalate concerns and discuss Junior Dr and Dr forums and 'gripe' system to identIfy theme of issues	Major	Likely	16	Effective and timely recruitment completed with the support of the Medical HR team to fill medical staffing gaps and reduce risk of vacancies as much as possible - 30 Jan 18 Medical Workforce Manager and JDA team to continue to monitor rotation gaps and take the necessary actions to ensure base wards ad CDU staffing is safe ensuring escalation procedures are carried out in a timely manner - 30 Dec 17 Recruitment of ANP/ACP and PA posts to RRCV to support the medical gaps which are unable to be filled to improve staffing numbers on base wards and CDU - 30 Dec 17 Frequent meetings scheduled to ensure the monitoring of the HEE-EM action plan and the reassurance of actions being completed - 30 Dec 17 RRCV CMG winter and operational plans and escalation of issues to appropriate Executive Trust Board(s) - 30 Mar 18	6	Karen Jones	CMG Risk
3031	Vascular Services	CMG 2 - Renal, Respiratory, Cardiac & Vascular	If the MDT activities for vasc surg are not resolved there is a risk of signIf loss of income & activity from referring centres	16/06/2017	30/10/2017	Service disruption	Controls: (List current controls in place under each of the relevant sub headings) General Manager actively trying to facilitate appropriate MDT space in existing facilities on Glenfield site Team travelling to LRI on Friday to use facilities	Major	Likely	16	A case to fund installing new MDT facilities for vascular surgery - 30.10.17 IdentIfy funding sources and execute - 30.10.17	1	Martin Watts	CMG Risk

3025	Emergency Department CMG 3 - Emergency & Specialist Medicine (ESM)	If there continues to be high levels of nursing vacancies and issue with nursing skill mix across Emergency Medicine, then quality and safety of patient care could be compromised.	30/05/2017	30/Sep/17	Quality	1.Shlfts escalated to bank and agency at an early stage. 2.Increased the numbers of Band 6's to provide leadership support on the floor. 3.Agency shlfts escalated to break glass agencies one week in advance. 4.Amvale paramedic in assessment bay to support timely ambulance handover. 5. Incentive scheme payments for HCA's and RN's working additional shlfts in ED on the bank. 6.VAC Nurse in place to observe the waiting areas for patients at all times to ensure patient safety whilst awaiting assessment. 7. Lead role for recruitment within the Matron team and dedicated time spent on recruitment. 8.Rolling advert for recruitment to band 5 and band 2 roles. 9.International recruitment undertaken - awaiting start dates of staff 10.Review of staffing levels across all areas on a daily basis and staff moved around to support areas most in need. 11.Active Management of staff absence to maximise staff availability to work. 12.Agency staff working regular shlfts for continuity of care. 13. Staff risk assessment focus groups have been undertaken to gain further insight into staff stresses. 14.Training needs analysis completed to ensure staff skills are priortised & fast tracked to increase flexibility of the workforce. 15. Monitor pressures within CSSU regarding nurse staffing and	Likely	Major	16	Continue actively recruiting to all grades of nursing staff. - 30/09/17 Offer ACP/ECP roles additional hours at band to fill essential nursing roles at grade. - 30/09/17 Review the possibility of rotational shifts for staff across other areas to increase attractiveness to staff and reduce burnout of working within one area. -30 Sept 17 Develop recruitment and retention group focusing on staff engagement and training and development of staff. - 30 Sept 17 Continue to review enhanced rates of pay schemes to ensure that these are managed effectively - 30/09/17 Recruit to Band 6 Childrens ED educator role for more focused training around paediatric emergency care. - 30/09/17	4	Kerry Johnston	CMG Risk
3044	Infectious Diseases CMG 3 - Emergency & Specialist Medicine	If under achievement against key Infectious Disease CQUIN Triggers (Hepatitis C Virus), then income will be affected.	13/07/2017	30/09/2017	Financial loss (Annual)	Monthly business meetings to monitor progress. Monitoring run rate on a monthly basis. Regular updates with Northampton and Kettering around low cost acquisition drugs. ODN meeting to take place in June 21st at Northampton.	Likely	Major	16	Letter to ODN network leads from UHL senior finance manager Jon Currington, Secure honorary contract for Prof Wiselka to work at Northampton, Set up formal ODN network business meetings, Set up monthly clinics in Northampton Elaine Graves and Monthly updates to ESM Board by Richard Philips. 31 Oct 2017 Set up monthly clinics in Northampton - 30 Sep 17 Set up formal ODN network business meetings - 30 Sep 17 Secure honorary contract for Prof Wiselka to work at Northampton - 30 Sep 17 Monthly updates to ESM Board - 30 Sep 17	12	Elaine Graves	CMG Risk
2333	Anaesthesia CMG 4 - Intensive Care, Theatres, Anaesthesia, Pain Management & Sleep	If we do not recruit into the Paediatric Cardiac Anaesthetic vacancies, then we will not be able to maintain a WTD compliant rota resulting in service disruption.	17/04/2014	30/09/2017	Service disruption	1:4 rota covered by 3 colleagues Fellow appointed in July 2016 who has now undergone appointments process and started as consultant on 1st of May 2017.	Likely	Major	16	**Although all actions are completed ITAPS wish this risk to remain open. One consultant has joined the new Vascular anaesthetic group having requested to leave service over a year ago. The new appointment has replaced him. The service still has a consultant vacancy which is proving dIfficult to recruit to due to the uncertainty of future commissioning/?service closure 9. Updated 03/07/17 - 1 consultant appointed. The second vacant post to be converted to a fellowship post as currently unable to recruit. The revised JD is being reviewed. Due to this change the review date has been moved to 30/09/17.	8	Chris Alsager	CMG Risk
2953	CMG 6 - Clinical Support & Imaging (CSI)	If system faults attributed to EMRAD are not expediently resolved, then we will continue to expose patient to the risk of harm	17/01/2017	30/09/2017	Harm (Patient/Non-patient)	Use of out sourcing in order to make up for reduced service efficiency Conference calls with GE to ensure system faults are expediently brought to their attention for a swIft resolution in order to minimise service impact. Continued meetings with GE and IMT to obtain solutions and deadline dates to restore service efficiency. Log of system faults recorded and monitored to ensure developers are finding resolutions in a timely manner.	Likely	Major	16	2. GE to provide breakdown of reported issues with the EMRAD system and feedback on their resolution (with timescales - although GE have stated some items they will not be able to provide timescale) - 30th Sep 17. 3. GE to upgrade eRC to version 6.05 to rectIfy performance issues and crashes (to resolve issues with reporting examinations) - Currently due March (GE currently updating timescales as this was originally scheduled for December) - 30th Sep 17 5. Review and resolution of system reference data processes and management of central reference data that impacts on patient care - Due to discuss with IT 18th Mar 17, no resolution date agreed. - 30th Sep 17	4	Cathy Lea	CMG Risk

2673	Pathology - Cytogenetics	CMG 6 - Clinical Support & Imaging (CSI)	If the bid for the National Genetics reconfiguration is not successful then there will be a financial risk to the Trust resulting in the loss of the Cytogenetics service	14/10/2015	15/09/2017	Financial loss (Annual)	Empath procurement specIfication utilising exiting services within UHL and NUH pathology services. This includes Molecular genetics at NUH and Empath molecular diagnostics to ensure that all elements of the procurement be addressed. Public consultation period clarIfying the scope and service specIfication requirements in autumn 2014. Plans to form a single genetic laboratory service for the east midlands under Empath which would be able to cover the expected requirement s of the service specIfication There is a verbal agreement to submit a joint response to the tender between UHL and NUH incorporating Empath services and genetics at NUH.(Update Dec 2016:Time line now Spring 2017 with advice to bidders Autumn 2017)	Major	Likely	16	Empath response to procurement (with NUH). To submit a successful bid to provide the Genetics lab service for E.Midlands- Nov 2017; Attend an appointment for bilateral discussion with NHSE CSO with NUH and CUH - Sept 2017.	8	Lara Cresswell	CMG Risk
2378	Pharmacy	CMG 6 - Clinical Support & Imaging (CSI)	If we do not recruit, up skill and retain staff into the Pharmacy workforce, then the service will not meet increasing demands resulting in reduced staff presence on wards or clinics.	19/06/2014	30/09/2017	Service disruption	extra hours being worked by part time staff, payment for weekend commitment / toil and reduction in extra commitments where possible team leaders involved in increased 'hands' on delivery staff time focused on patient care delivery (project time, meeting attendance reduced) Prioritisation of specIfic delivery issues e.g. high risk areas and discharge prescriptions, chemo suite . Reduced presence at non direct patient focused activities e.g. CMG board/ Q&S and delay projects / training where possible. Revised rotas in place to provide staff/ service based on risk Recruit 8A pharmacists to replace those promoted to 8B Release band 3 staff to support onc/haem satellite	Major	Likely	16	Review methotrexate from LRI and move onto chemocare - 31/10/2017 Develop methodology to report pharmacy service level by ward and triangulate with medical/nursing to agree risk-based approach to staff deployment - 31/10/17 Recruit to bank and fixed term contract to address critical staffing gaps - 30/09/17	8	Claire Elwood	CMG Risk
2916	Phlebotomy	CMG 6 - Clinical Support & Imaging (CSI)	There is a risk that patient blood samples can be mislabelled impacting on patient safety	11/Aug/16	31/10/2017	Harm (Patient/Non-patient)	1 - Training guide in place - Staff must check the label before putting it on sample bottle and make sure the correct information is put on, If any problems with the ICE printer they must Log it X8000 and report it to Management . 2 - Daily audit by each member of staff for each ward on all 3 sites listing numbers of issues with reprinting and printing of incorrect patient details. 3 - Reported to IM&T daily and CSI management as an additional monitoring process 4 - Policy reviewed and all phlebotomy staff have received refresher training and advice on monitoring and reporting 5 - Weekly spot check audits by Phlebotomy management to ensure staff are following processes	Major	Likely	16	IT working on locating the issue and providing a solution - 31/8/16, no update from IT chased again 14-9-16, numerous chases during November and December, now escalating via senior CSi exec team - 31/12/16 Paper to be prepared for the Exec Quality Board EQB to highlight the issues as being Trust wide and not just local to central phlebotomy - 31/8/16 completed IT now updating weekly however still no resolution to the issue - DW to chase every week - ongoing chasing and feedback received but no resolution to the issue as yet - DW to continue escalating and chasing IM&T IM&T confirmed that they now have this risk on their risk register as well A working group was set up to review the implementation of the Blood trac system as being a possible solution to the risk of patient samples being mixed up. A trial will take place during September - 30/9/17 Although Blood trac will mean patients are identIfied by wristbands and separate bottle labels will print, a printed request label froM ICE is still required so concerns raised with the workign group by DW as the implementation of Bllod trac may not resolve the issue - DW 30/9/17	6	Debbie Waters	CMG Risk
2391		CMG 7 - Women's and Children's (W&C)	Inadequate numbers of Junior Doctors to support the clinical services within Gynaecology & Obstetrics	24/06/2014	04/Sept/17	Harm (Patient/Non-patient)	Locums used where available. Specialist Nurses being used to cover the services where possible and appropriate. Update 17/2/16 All antenatal clinics have a Consultant Lead present Rota accomodated to address specIfic training needs of juniors Rota reviewed and monitored on a daily basis by Dr representative Consultants act down If required X2 wte MTI to be recruited from overseas via RCOG	Major	Likely	16	Appoint to Senior Reg post Due 04/09/2017	8	Ms Cornelia Wiesender	CMG Risk
2153	Paediatrics	CMG 7 - Women's and Children's (W&C)	Shortfall in the number of all quallfied nurses working in the Children's Hospital.	03/Mar/13	26/Oct/17	Harm (Patient/Non-patient)	Where possible the bed base is flexed on a daily bases to ensure we are maintaining our nurse to bed ratios There is an active campaign to recruit nurses locally, national and internationally Additional health care assistance have been employed to support the shortfall of quallfied nurses. Specialise Nurses are helping to cover ward clinical shIfts. Cardiac Liaison Team cover Outpatient clinics Overtime, bank & agency staff requested Head of Nursing, Lead Nurse, Matron and ECMO Co-ordinator cover clinical shIfts Adult ICU staff cover shIfts where possible Recruitment and retention premium in place to reduce turn-off of staff Part time staff being paid overtime Program in place for international nurses in the HDU and Intensive Care Environment Second Registration for Adult nurses in place	Major	Likely	16	Continue to recruit to remaining vacancies in PICU & Ward 30 GH - due 31/12/17	8	Ms Hillary Killer	CMG Risk

3008	Paediatrics East Midlands Transport Team	CMG 7 - Women's and Children's (W&C)	If the paediatric retrieval and repatriation teams are delayed mobilising to critically ill children due to inadequately commissioned & funded provision of a dedicated ambulance service, then this will result in failure to meet NHS England standards, delayed care, potential harm and inability to free-up PICU capacity.	18/05/2017	30/09/2017	Harm (Patient/Non-patient)	From March 2017 the transport team will continue to dial for an ambulance when required. An escalation procedure through Trust & EMAS management has been developed for when vehicles are not available as needed. Datix forms will be submitted for delayed response. The EMPTS core team will continue to discuss with EMAS and NHSE to develop a solution. Enquiries will be made to other ambulance providers, regarding specIfication of vehicles, accessibility and cost. All material will be shared with the Trusts' Implementation group who meet on a monthly basis to update and discuss.	Likely	Major	16	EMPTS working with EMAS and NHSE to develop a solution due 30/09/2017	5	Andrew Leslie	CMG Risk
2237	Corporate Medical	Corporate Medical	If a standardised process for requesting and reporting inpatient and outpatient diagnostic tests is not implemented, then the timely review of diagnostic tests will not occur.	07/Oct/13	30/09/2017	Harm (Patient/Non-patient)	Abnormal pathology results escalation process Suspicious imaging findings escalated to MDTs Trust plan to replace iCM (to include mandatory fields requiring clinicians to acknowledge results). Diagnostic testing policy approved.	Likely	Major	16	Awaiting ICE upgrade and implementation in outpatients - Update, Delivery date for ICE pilot roll out in TBC in near future Dr Steve Jackson and Ann Hall Project Manager will keep corporate risk management team aware - 30/04/17 -Update: 16th June 2017 Standardised requesting electronically using ICE will be rolled out in outpatient settings by October 2017 - this project is underway. The 2017 Quality Commitment contains a work-stream which addresses Acting on Results. The majority of risk in this area is related to imaging reports in the Clinical Decisions Unit area. This risk will be mitigated by piloting of "Conserus" at the end of June 2017 - this software allows radiologists to directly inform the requesting clinician via e-mail about unexpected findings. Mobile ICE software is also available for piloting in this area with this occurring from July onwards - this will provide a better software package for clinicians to acknowledge their results. Full trust roll out will follow If the pilot is successful but will require business case approval. 30 Sep 17	8	Colette Marshall	Corporate Risk
2247	Corporate Nursing	Corporate Nursing	If we do not recruit and retain Registered Nurses, then we may not be able to deliver safe, high quality, patient centred and effective care.	30/10/2013	30/Sep/17	Harm (Patient/Non-patient)	HRSS structure review. A temporary Band 5 HRSS Team Leader appointed. A Nursing lead identIfied. Recruitment plan developed with fortnightly meetings to review progress. Vacancy monitoring. Bank/agency utilisation. ShIft moves of staff. Ward Manager/Matron return to wards full time.	Likely	Major	16	International recruitment continues, although the arrival of the nurses is taking longer than originally predicted, due to achievement of IELTS. We do however have a small number of nurses in the Trust, (10) undergoing intense training. Review Sept 2017 Over recruitment of HCA s has been very successful, and vacancies for HCAs across the Trust is currently less than 60wte. The bulk recruitment programme will continue to support over recruitment into these roles. Review Sept 2017 Good progress continues to be to be made with LLR trainee Nursing Associates and the trainees Nursing Associate programme across key clinical areas. There is a new process in place for bulk housekeeper recruitment to support ward teams Review October 2017	12	Maria McAuley	Corporate Risk
1893	Operations	Operations	If clinical coding is not accurate then income will be affected.	02/Aug/11	30/09/2017	Financial loss (Annual)	As at August 2017, 3 of our 5 Trainee Coders who commenced in Jun16 have now passed their assessment/audit and become band 4 trained coders. In July a further 4 Trainee Coders commenced and are completing modules of their 21 Day Standards course in-house with our 2 Trainers. They are already contributing to the Coding workload under close supervision. The training room at LGH (refurbished old Porters Lodge) is now in full use. Additional accommodation at GH is urgently needed. Due to 2 trained Coder appointments, we will cease all use of agency staff from end August. From September there will be sufficient substantive staff to manage the workload. We still need to appoint to remaining vacancies to ensure the team is working to recommended coding volume (7500 episodes/year). The workload remains too high to ensure good quality Coding. An thematic LiA for Coding will commence in September focusing on the quality and availability of documentation (casenotes) available to the Coders.	Likely	Major	16	Additional accommodation required at GH site - 31/03/18 Discontinue use of Agency Coders - 31/03/18 LiA to be established to work with CMGs / ward clerks to maximise transfer of casenotes to Clinical Coding - 31 Aug 18	8	Shirley Priestnall	Corporate Risk
3027	Haematology	CMG 1 - Cancer, Haematology, Urology, Gastroenterology & Surgery	If the UHL adult haemoglobinopathy service is not adequately resourced, then it will not function at its commissioned level	13/07/2017	30/09/2017	Harm (Patient/Non-patient)	Preventive Control: Dr Hunter is taking on the Lead for the service. NUH lead to cover annual reviews at NGH for ta period of 12 months. Interim consultant cover from Haematology Malignancy Team to provide annual reviews for UHL patients. Policy for emergency management of ED patients in place, education sessions planned.	Almost certain	Moderate	15	Case of Need for an additional consultant in Haemoglobinopathy for comprehensive care link. AH - Due date 30/06/2017(completed and submitted to CMG management for further action) Re-appoint x2 CNS vacant posts - 1 CNS started on 05/06/2017, second CNS Starting 8th August @ NUH. Completed 31/08/17. Appoint a locum consultant for 1 year into Haematology. AH/MT - Due date 30/09/2017. All patients within the service need to be checked to ensure they have had a yearly review - 31/10/2017 Review the data submitted to the national data base to ensure accuracy - Completed 31/08/17 Ensure data manager is being supervised and supported in terms of data submission - Completed 31/08/17.	4	Ann Hunter	CMG Risk

3047	Cardiology	If the service provisions for vascular access at GH are not adequately resourced to meet demands, then patients will experience signIficant delays for a PICC resulting in potential harm.	13/07/2017	30/09/2017	Harm (Patient/Non-patient)	Preventive: Optimise PiCC line insertion on days it is available Cannula insertions kept to minimum Robust I.P plans constantly being reviewed – cannulae care pathway completion Detective: Ward reporting delays on Datix Matron utilising Red to Green to identIfy patients who are awaiting for service and take actions to iradicate the causation of the delay in accordance with Red to Green protocols. IP performance indicators	Almost certain	Moderate	15	RRCV transfer of funding to support the vascular service provision at GH - complete Recruitment to vascular access service - 1.10.17 To identIfy the level of service that is going to be provided at GH following recruitment - 1.10.17	6	Sue Mason	CMG Risk	CMG 2 - Renal, Respiratory, Cardiac & Vascular
3041	Cardiology	If there are insufficient cardiac physiologists then it could result in increased waiting times for electrophysiology procedures and elective cardiology procedures	27/06/2017	30/Sept/17	Harm (Patient/Non-patient)	Preventive: Additional sessions being undertaken by UHL staff Patients referred back to GP for Non Attendance. Communication to referrers to ensure all referrals are essential/appropriate to manage demand WLI initiative for Saturday EP procedures Overtime offered to current band 7 to complete EP training on Saturdays/Days off Detective: On-going to source locum support On-going to actively advertise Corrective: On going recruitment of staff into vacant posts	Possible	Extreme	15	Recruit 3.0 WTE staff - 1.9.17 Explore market for locum staff - National shortage but will continue to explore this as an option, two locums physiologists have been sort to support cath lab and pacing clinic for initially two months, query longer due to winter pressures - review end of November Explore Support from equipment manufacturers- continue to use to support for complex cases, but not as stand alone option - 30.9.17 Explore outsourcing of EP activity - Market share analysis to be completed - 8.9.17 Demand management - EP specialty meeting to be held 18.8.17 - discussed RTT and demand management plan, market share analysis to be completed review of current capacity - 31.10.17	8	Darren Turner	CMG Risk	CMG 2 - Renal, Respiratory, Cardiac & Vascular (RRCV)
3043	Cardiology	If there is insufficient cardiac physiologists then it could result in reduced echo capacity resulting in diagnostics not being performed in a timely manner	27/06/2017	31/Oct/17	Harm (Patient/Non-patient)	Controls: List what is currently in place and having a positive effect to control the risk Preventive: •Additional sessions being undertaken by UHL staff •Communication to referrers to ensure all referrals are essential/appropriate to manage demand •Strict adherence to auditing of referrals with clinical input/support when required Detective: •Continue to source locum support •Establish If external providers are able to provide support/capacity Corrective: •Recruitment of staff into vacant posts	Almost certain	Moderate	15	Recruit 2.0 WTE staff , recruited 1 wte internal - review 31.10.17 Explore if any non-Echo team staff can support - WLI initiative being undertaken by SpR that can provide echo support - WLI initiative being undertaken for review 31.10.17 Explore outsourcing of echo activity - In health have limited capacity for review - in health can provide some adhoc cover to be confirmed - 9.10.17 Demand management - Continued validation of echo referrals - 6th November 17	6	Darren Turner	CMG Risk	CMG 2 - Renal, Respiratory, Cardiac & Vascular (RRCV)
2872	Respiratory Medicine	If a suitable fire evacuation route for bariatric patients on Ward 15 at GGH is not found, then we will be in breach of Section 14.2b of The Regulatory Reform (Fire Order) 2005.	27/06/2016	30/09/2017	Harm (Patient/Non-patient)	Early warning fire detection system fitted (L1). The Ward is designed as a one hour fire compartment divided into four 30 minute sub-compartments; allowing a progressive horizontal phase evacuation within the Ward area. Staff awareness of the risk and staff attend annual fire safety training Fire evacuation plans in place for the Ward to include transfer of bedded bariatric patients to chairs where possible. Personal Emergency Evacuation Plans for patients considered to be at risk (in conjunction with the UHL Fire safety officer). LFRS Western Fire Brigade aware and have this included in their action cards when attending Glenfield site.	Possible	Extreme	15	A compliance analyses report from a consultant indicated unsuitability for hosting Bariatric Patients on this ward. The report highlights not just fire risk/evacuation concerns but also health and safety issues for staff/patients and patients. There also clinical operational issues that indicate the area unsuitable for these patients at this time according to the relevant compliance documentation. Risk has been considered by the Exec team at EPB in July 2017. Taking guidance from this report, to bring the Ward into a condition fit for this category of patient will require a considerable capital outlay and an extended period of works both in and around the ward area. Review of Respiratory Wards to identIfy alternative location for Ward 15 and strategic options for 2017/18 and 2018/19. Project team to be set up to develop and discuss the opportunity for ward relocation - to provide initial feedback in Sept 2017.	6	Vicky Osborne	CMG Risk	CMG 2 - Renal, Respiratory, Cardiac & Vascular (RRCV)

3005	Thoracic Surgery	If recruitment and retention to the current Thoracic Surgery Ward RN vacancies does not occur, then Ward functionality will be compromise, resulting in an increased likelihood of incidences leading to patient harm.	27/03/2017	30/09/2017	Harm (Patient/Non-patient)	Controls in place: List what processes are already in place to control the risk (Copy & paste to add rows where necessary) On-going external advertising and recruitment for band 5 vacancies, including clearing house, international recruitment and job swap. Internal rostering of existing staff to do additional hours/overtime All unfilled shIfts are routinely sent to staff bank office when health roster is approved Experienced bank staff encouraged to book shIfts on ward Matron undertaking skill mix revisions ie converting RN to HCA bank requests All non-essential study leave cancelled Matrons all aware of vacancy level and taking appropriate action in daily staff management Matron/Ward Sister/Nurse in charge to review off duty daily Continue to up skill current staff who have 6 months experience on the ward Consultant surgeons to pre-book an ITU bed daily in order to operate on 3 level 2 cases per list DHON working clinically to support ward team. Matron job plan is to currently work clinically on ward	Moderate	Almost certain	15	Interview date/appt - 30.9.17 Matron working -complete Review after closure of ward 23 relocation of staff - complete DHON working clinically to support ward team - complete Robust control and management of sickness absence and authorisation of annual leave - 1.12.17	6	Sue Mason	CMG Risk
3077	Emergency Department	If there are delays in the availability of in-patient beds, then the performance of the Emergency Department at Leicester Royal Infirmary could be adversely affected, resulting in overcrowding in the Emergency Department and an inability to accept new patients from ambulances.	04/Aug/17	30/09/2017	Harm (Patient/Non-patient)	All ambulance staff perform a clinical assessment prior to arrival at the Emergency Department. Patients who are identIfied as requiring immediate assessment in the Emergency Room are pre-alerted by means of a dedicated phone line to give staff advance notIfication of the patient's arrival. Patients have a "Dynamic Priority Score" (DPS) calculated which is reported at the time of registration. This score is used to triage and prioritise the sickest patients for entry into the Emergency Department for assessment and treatment. A senior Emergency Department clinician (ST3 or above, Consultant, or Advanced Nurse Practitioner) re-assesses each patient who is waiting in an ambulance for entry into the Emergency Department, to confirm their DPS and to identIfy any patient who needs prioritisation for entry into the Emergency Department. There is an expectation that this assessment will occur within 15 minutes of the patient's arrival, and that patients will be re-assessed hourly while they are still waiting on the ambulance for entry into the Emergency Department. This ensures that those who are most ill are allocated space in the Emergency Department as a priority.	Extreme	Possible	15	As part of the Trust's 2017/18 Quality Commitment, there is an Organisation of Care Programme which will oversee four work streams. One of the work streams will be 'Efficient & Effective Emergency Department' overseen by an Emergency Department Group to improve emergency flow. - 31 Oct 17 An effective in-reach escalation plan is required for when in-patient speciality assessment beds are not available. - 31 Oct 17 Implementation and roll-out of the "Red2Green" initiative on medical Wards to reduce length of stay, particularly for patients with length of stay over seven days. - 31 Oct 17 Initiatives to discharge suitable patients from medical wards earlier in the day, for example by increased us of Discharge Lounge - 31 Oct 17 Enhanced provision of ambulatory care services with the opening of a new and enlarged medical ambulatory assessment unit (GPAU) in phase 2 of the Emergency Floor at the LRI site. - 30 Nov 17 A review of the feasibility of direct admission od medical patients to Short Stay Unit rather than to the Acute Medical Unit (AMU) - 30 Nov 17 Medical bed capacity will be increased with the openning of an additional 28 beds on Ward 21, Emergency Decisions Unit (EDU) - 30 Sep 17	10	Dr Ian Lawrence	CMG Risk
2837	Neurology	If the migration to an automated results monitoring system is not introduced, then follow-up actions for patients with multiple sclerosis maybe delayed resulting in potential harm.	09/May/16	31/08/2017	Harm (Patient/Non-patient)	Paper results for blood, urine tests and MRI scans are sent to consultant. Face-to-face outpatient clinic reviews by doctors or MS nurses.	Extreme	Possible	15	Dawn on hold until additional; MSSN Business Case has been approved by RIC. Plan to review DAWN progress due 31Aug 17. Business Case in development to review 31 Aug 2017	2	Dr Ian Lawrence	CMG Risk

CMG 2 - Renal, Respiratory, Cardiac & Vascular (RRCV)	
CMG 3 - Emergency & Specialist Medicine (ESM)	
CMG 3 - Emergency & Specialist Medicine	

2466	Rheumatology CMG 3 - Emergency & Specialist Medicine (ESM)	Current lack of robust processes and systems in place for patients on DMARD and biologic therapies in Rheumatology resulting >	03/Dec/14	29/09/2017	Harm (Patient/Non-patient)	The Rheumatology Department follows the 'BSR/BHPR guideline for disease-modIfying anti-rheumatic drug (DMARD) therapy in consultation with the British Association of Rheumatologists (2). This stipulates the type and frequency of blood test monitoring, as well as recommendations for actions If results are found to be abnormal. Action plan in place to identIfy and act on further risks, process review; supported by LiA programme. General Manager appointed for 6 months to support service review and implementation. Matron appointed to establish current specialist nursing establishment job plans and skill mix. Pharmacy support lead identIfied for service (due to start August 2017). Database administration team fully established. Long standing spread sheet system remains in place - Nurse Prescribers currently validating to move towards full DAWN implementation. Action summary Process mapping is on-going of prescriptions which will involve senior engagement. Meeting dates currently being arranged with team. Prescribing pharmacist to work in the service with CMG back filling on the wards for initial 6 months. Pharmacy Staff member identIfied to support service from August 2017. MBP Project Manager allocated to DAWN project and meeting arranged to review MER forms and to clarIfy scope and timeframes for on-going IT support.	Moderate	Almost certain	15	Undertake DAWN process mapping exercise and review - 30 Sep 17	1	Dr Alison Kinder	CMG Risk
2989	CMG 5 - Musculoskeletal & Specialist Surgery (MSK & SS)	If we do not recruit into the Trauma Wards nursing vacancies, then patient safety and quality of care will be placed at risk	02/Mar/17	30/12/2017	Harm (Patient/Non-patient)	The wards are on electronic staff rostering and off duties is produced 6 weeks in advance; requests for temporary staffing are made 4 weeks in advance when possible. All shIfts required are escalated to bank and agency and over time is offered to all staff in advance. We have put out agency long line requests. Staffing levels are checked on a daily basis by the bed co-ordinator and matron. staff are moved between the areas to try & maintainsafety & service. Staff are moved from other areas If / when possible when escalated to Matron / head (or assistant head) of nursing / duty manager. New staff to the area attend the relevant study days in order to gain the relevant skills to look after the patients. Matron spends time on wards & with the acting band 7 & 6 to develop their skills and knowledge. Exploring the possibility of staff moving from other areas within the CMG (on a daily basis) where possible & potentially needing to close more beds.	Extreme	Possible	15	Review Ward 18's decrease in bed base to 24 beds If unable to safely staff. - 30.09.17	4	Nicola Grant	CMG Risk
1196	CMG 6 - Clinical Support & Imaging (CSI)	If we do not increase the number of Consultant Radiologists, then we will not be able provide a comprehensive out of hours on call rota and PM cover for consultant Paediatric radiologists resulting in delays for patients requiring paediatric radiology investigations and suboptimal treatment pathway.	29/06/2009	30/09/2017	Harm (Patient/Non-patient)	To provide as much cover as possible within the working time directive. Registrars cover within the capability of their training period. Other Radiologists assist where practical however have limited experience and are unable to give interventional support. Locums are used when available.	Moderate	Almost certain	15	Issues around Locum Payments 30/Sep/2017	2	Miss Rona Gidlow	CMG Risk
2948	Dietetics CMG 6 - Clinical Support &	If the service delivery model for Head and Neck Cancer patients is not appropriately resourced, then the Trust will be non-compliant with Cancer peer review standards resulting in poor pre and post-surgery malnutrition.	31/10/2016	30/09/2017	Harm (Patient/Non-patient)	Currently overbooking pre-assessment clinics and follow up clinics Relying on CNS colleagues to cover all dietetic aspects when dietitians absent Defined job plans for the 2 sessional dietetic post holders in place	Moderate	Almost certain	15	UplIft dietetic resource to head and neck cancer patients (discuss resourcing with MSS CMG senior team) - 30 Sep 17 Discuss resourcing with MSS CMG Exec team - 30 Sep 17	2	Cathy Steele	CMG Risk

2973	Dietetics	CMG 6 - Clinical Support & Imaging (CSI)	If the service delivery model for Adult Gastroenterology Medicine patients is not appropriately resourced, then the quality of care provided by nutrition and dietetic service will be suboptimal resulting in potential harm to patients.	20/01/2017	30/09/2017	Harm (Patient/Non-patient)	There is an Enteral Feeding Guideline in place which means that any patient on enteral feeding can start on a protocol, with risk of refeeding identIfied. This then has a 3 day build up, after which a Dietitian will need to give a full assessment. Agreement from the Divisional Head of Nursing that all quallfied nurses in CHUGGS CMG are to complete Malnutrition Universal Screening Tool (MUST) e-learning module. Dietetic education of medical and nursing staff on a case by case basis by dieticians for catering queries and first line nutritional care plan. Helen Ord (Dietetic Practice Learning Lead) to train all four new housekeepers on nutritional care. Dietetics and CHUGGS CMG to plan for increased dietetic investment.	Almost certain	Moderate	15	Withdraw FODMAP dietary management for IBS until resourced with adequate dietetic time - 30 Sep 17 Develop virtual telephone outpatient clinics to safely manage outpatient caseload - 30 Sep 17 Implement the Nutrition Liver Care Pathway at ward level for inpatients - 30 Sep 17 Develop a first line ward procedure for consideration of prescribable oral nutritional supplements for acutely admitted IBD inpatients - 30 Sep 17	6	Cathy Steele	CMG Risk
2787	Medical Records	CMG 6 - Clinical Support & Imaging (CSI)	If we do not implement the EDRM project across UHL which has caused wide scale recruitment and retention issues then medical records services will continue to provide a suboptimal service which will impact on the patients treatment pathway.	17/02/2016	31/12/2017	Harm (Patient/Non-patient)	Use of A&C bank staff where possible, though very limited in supply. Use of overtime from remaining substantive staff (though dwindling due to duration of the EDRM project and subsequent delays); staff are tired and under pressure. Cancellation of non-clinical requests for case notes daily (e.g. audit) to minimise disruption to front line clinical need (though with clear consequent impact on other areas of service delivery). On going urgent recruitment to existing vacancies. A waiting list of suitable applicants is created to minimise the risk of the current staffing levels reoccurring in the future. Medical records management supporting HRSS by chasing references and other checks. Daily review of staffing levels and management of requests with concentration of staffing in areas of greatest demand and clinical priority.	Almost certain	Moderate	15	EDRm paediatric pause as of 18/7/16 - relaunch agreed April 2017 - awaiting time line for go live - 31 Dec 17 Review of staffing and activity levels and subsequent business case for increased staffing to RIC - 31 Dec 17	4	Debbie Waters	CMG Risk
2365	Pharmacy	CMG 6 - Clinical Support &	If we do not address Windsor pharmacy storage demands, then we may compromise clinical care and breach statutory duties	23/12/2016	30/09/2017	Harm (Patient/Non-patient)	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.	Almost certain	Moderate	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. Identify additional options to increase fridge capacity - 31/10/17.	6	Claire Elwood	CMG Risk
3023		CMG 7 - Women's and Children's (W&C)	There is a risk that the split site Maternity configuration leads to impaired quality of Maternity services at the LGH site	18/09/2017	01/Sep/17	Harm (Patient/Non-patient)	Consultant Obstetrician presence until 20.00 Delay of elective LSCS If emergency LSCS are required Use of second theatre If emergency LSCS required while El LSCS in progress Post natal pathway of care for elective LSCS cases for staff to follow Delivery Suite Consultant & SpR can be contacted for any emergencies Consultants undertaking additional sessions to cover rota gaps (unpaid) and visit wards prior to clinics etc Locum Consultants are employed to provide cover If no other alternative Senior Specialist Trainee's only allocated to cover out of hours Formation of working party to implement recommended changes in working practices	Almost certain	Moderate	15	Formulation of Business case for extra Obstetric Consultant Due 31/12/2017 Implementation of Trust reconfiguration strategy: LGH to LRI site Due 31/12/2017 Review into expanding elective capacity at LRI Due 31/12/2017 Review of provision of maternity services (efficiency and dIfferent ways of working) Due 31/12/2017 Formulation of Business case for extra Gynaecology Consultant due 31/12/2017	6	Ms Cornelia Wiesender	CMG Risk
2601	Gynaecology	CMG 7 - Women's and Children's (W&C)	There is a risk of delay in gynaecology patient correspondence due to a backlog in typing	24/08/2015	17/10/2017	Harm (Patient/Non-patient)	2 week wait clinics or any letters highlighted on Windscribe in red are typed as urgent. Weekly admin management meeting standing agenda item: typing backlog by site also by Colposcopy and general gynaecology. Using Bank & Agency Staff. Protected typing for a limited number of staff.	Almost certain	Moderate	15	Clearance of backlog of letters - due 17/10/2017	6	Donna Marshall	CMG Risk
2394	Communications		If a service agreement to support the image storage software used for Clinical Photography is not in place, then we will not be able access clinical images in the event of a system failure.	04/Jul/14	30/Sep/17	Harm (Patient/Non-patient)	IM&T hardware support; IM&T Integration & Development team best endeavours to support the application software; separate backup of images on Apple server in Medical Illustration. Project brief published Nov 2014 for new database. Funding from IM&T agreed April 2015. Functional Specification for new system published Sep 2015. IM&T project support Oct 2015. IM&T project manager appointed Nov 2015. IM&T Functional Spec complete Dec 2015. Tender prepared Feb 2016. Supplier demos held Nov 2016. Supplier chosen Dec 2016.	Almost certain	Moderate	15	IM&T to commit resource to deliver project - 30 Sep 17 Supplier to develop project plan for implementation - 30 Sep 17	1	Simon Andrews	Corporate Risk

3079	Corporate Medical		If the insufficient capacity with Medical Examiners is not addressed then this may lead to a delay with screening all deaths and undertaking Structured Judgement Reviews resulting in failure to learn from deaths in a timely manner and non-compliance with the internal QC and external NHS England duties	16/08/2017	30/09/2017	Reputation	Preventive: Currently we have the equivalent of 13 PAs a week of ME time. Whilst there are delays in the screening process, they have been managing to screen the majority of cases (93% for Quarter 1) but this is during the quietest time of year from a mortality point of view. We have 1 WTE ME Assistant and 0.8 WTE M&M Assistant supported by 1 WTE M&M Clerk to support both the ME process and SJR Process (corporately). We have a Lead Bereavement Support Nurse in post (continued from CQUIN scheme) and supported by a Bank Nurse (with Chaplaincy experience). Detective: The UHL Mortality database includes details of all in-hospital, ED and community deaths (brought to UHL's mortuary) and where deaths are screened by the ME, this information is inputted into the database by either the ME Assistant or M&M Admin Team. The Database is also used to input information about SJR completion and outcome. Reports on both of the above are submitted to the UHL Mortality Review Committee on a monthly basis.	Moderate	Almost certain	15	Recruit additional MEs - review 30/09/17 Recruit ME/M&M Admin Support - review 30/09/17 Bereavement Services Database modIfication to include ME and Bereavement Support Nurse data - 30/09/17	6	Rebecca Broughton	Corporate Risk
2985	Corporate Nursing		If the delays with supplying, delivering and administrating parental nutrition at ward level are not resolved, then we will deliver a suboptimal and unsafe provision of adult inpatient parental nutrition resulting in the Trust HISNET Status.	09/Mar/17	31/07/2017	Harm (Patient/Non-patient)	1. Review of inpatient PN supplier via East Midlands Procurement process (Jane Page, Kate Dawson with LIfFT representation) July 2016 to see If an alternative suppler can meet UHL needs. 2. Fixed Term Secondment for Clinical Project Manager recruited to and commenced in post end of October 2016. The Clincal Project manager will review MDT processes and plan future PN service, with business case.	Moderate	Almost certain	15	Report lack of nurses PN trained in the Trust to the Trust Nutrition and Hydration Assuarance Committee - 30 Aug 17 Pharmacy to log when the PN bags are delivered to the wards - 30 Jun 17 Pharmacy to audit receipt of PN bag delivery to each site - 30 Jun 17 Implementation of stocked batch ordered PN by Pharmacy - 31 Jul 17 Review contract for inpatient PN supply - 31 Jul 17	4	Cathy Steele	Corporate Risk