INTEGRATED RISK AND ASSURANCE REPORT AS AT 31ST MAY 2017

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

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 operational risk register. The BAF has been updated by its executive leads and considered at the relevant executive boards during May 2017. The risk register has been scrutinised by CMGs and at the Executive Performance Board in May.

Questions

1. Is the Board fully assured about the current progress with managing strategic risks that may threaten delivering our annual priorities?
2. How do we distinguish between the current assurance position and a year-end assurance forecast?
3. Does the Board have knowledge of new operational risks opened within the reporting period?

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 what do they show is actually happening) and risk assurance (what might threaten the achievement of the annual priority – in the form of a strategic risks escalated from the risk register). The strategic risks that threaten delivering the annual priorities are described in risk assurance section in the BAF and will be further worked-up and entered on the risk register. Key risk themes from the quality commitment components of the BAF identify the important role the safe implementation of electronic systems would contribute to delivering the Trust's overall objective of safe, high quality, patient centred, and efficient healthcare.
2. It is proposed that an additional column be introduced in the BAF dashboard to highlight the year-end assurance rating forecast for each annual priority, taking into consideration the owners view and judgement about risks that may threaten the likelihood of delivering the priority.
3. During the reporting period of May 2017, one new high risk has been entered on the risk register relating to mobilization of the Paediatric retrieval and repatriation teams to critically ill children due to inadequately commissioned & funded provision of a dedicated ambulance service.

Input Sought

We would welcome the Board's input to:

a) receive, note and approve this report;
b) endorse the pilot to report the HR, IM&T and Research/Education entries on the BAF on a quarterly basis.

For Reference

Edit as appropriate:

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

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

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

a. Organisational Risk Register [Yes]

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

b. Board Assurance Framework [Yes]

BAF entry	BAF Title	Current Rating
All BAF	See appendix one	

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

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

5. Scheduled date for the **next paper** on this topic: 3 August 2017

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **UHL TRUST BOARD**

DATE: **6TH JULY 2017**

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

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

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1 INTRODUCTION

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

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

2. BOARD ASSURANCE FRAMEWORK SUMMARY

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

2.2 Further to the feedback received from the Audit Committee in May and Trust Board in June, where it was acknowledged the new BAF format is designed to provide assurance in relation to delivering of our annual priorities for 2017/18, there was a view that in addition to the current assurance rating, for the month-end position, there should be consideration to a year-end forecast assurance rating.

2.3 To that end, it is proposed that an additional column be introduced in the BAF to highlight a forecast year-end assurance rating for each annual priority, taking into consideration the owners view and judgement about risks that may threaten the likelihood of delivering the priority. Please be advised the current assurance rating will continue to reflect the position for the reporting period in question (i.e. month-end position), taking take into account the effectiveness of controls in place and the outcome of performance indicators, as well as the identification and management of risks to delivering the annual priorities. The proposed forecast year-end assurance rating method is described, below:

Year-end forecast Assurance rating	Description:
0	Not started
1	Extreme risk associated - Predicted to fail
2	Major risk associated – unlikely to deliver in 2017/18
3	Moderate risk associated – expected to deliver in 2017/18
4	Minor risk associated - Expected to deliver in 2017/18
5	Delivered

2.4 Executive risk owners have updated their BAF entries to reflect the progress with achieving the annual priorities for 2017/18. Many of the current assurance ratings on the BAF are displayed as amber, however at the time of

this reporting all priorities are forecast to be delivered by year-end. A copy of the updated BAF is included at appendix one.

2.5 Thematic analysis of the risks on the BAF associated with delivering our quality commitment are as follows:

1. SHMI reduction – Dependent on the national measure for calculating data of hospital mortality.
2. Roll-out track and trigger tools – Trust-wide safe implementation of appropriate electronic observation systems and processes.
3. Introduce safer use of high risk drugs – Effective implementation of safety processes.
4. Improve diagnostics results management - Trust-wide safe implementation of appropriate electronic systems and processes.
5. Individualised end of life care plans for patients - co-ordination of care with community services utilising safe implementation of appropriate electronic systems and processes.
6. Improve patient experience in outpatient services - Trust-wide safe implementation of appropriate electronic systems and processes in outpatient services.
7. Management of demand and capacity - additional physical bed capacity cannot be opened due to an inability to provide safe staffing.

3. UHL RISK REGISTER SUMMARY

3.1 At the end of the reporting period, there are 41 operational (business as usual) risks open on the risk register scoring 15 and above. A report of these risks is attached in appendix two.

3.2 One new 'high' risk has been entered on the risk register during the reporting period:

Datix ID	Risk Description	Risk Rating	CMG
3008	If the Paediatric retrieval and repatriation teams are delayed mobilizing 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.	16	W&C

3.3 Thematic analysis of risks scoring 15 and above on the risk register continues to show the causal factor for the majority of risks relating to workforce capacity and capability with the likelihood to have an impact on harm and performance. A column to describe the thematic risk analysis, aligned to our Trust annual priorities, is included in the risk register report in appendix two.

4 RECOMMENDATIONS

4.1 The TB is invited to:

a) receive, note and approve this report;
b) endorse the new year-end assurance forecast rating method.

UHL Board Assurance Dashboard: 2017/18			MAY 2017								
	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	We will introduce safer use of high risk drugs (e.g. insulin and warfarin) in order to protect our patients from harm	MD/CN	E Meldrum & C Marshall	3	↓	4	EQB	QAC
		1.2.3	We will implement processes to improve diagnostics results management in order to ensure that results are promptly acted upon	MD	C Marshall	3	↔	4	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)	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	EPB	IFPIC
		1.4	**Organisation of Care - We will manage our demand and capacity:**							
		1.4.1	We will utilise our new Emergency Department efficiently and effectively 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	3	↔	4	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/EPB	IFPIC
		2.2	We will reduce our agency spend towards the required cap in order to achieve the best use of our pay budget	DWOD	J Tyler-Fantom	4	↔	3	EWB/EPB	IFPIC
		2.3	We will transform and deliver high quality and affordable HR, OH and OD services in order to make them 'Fit for the Future'	DWOD	B Kotecha	3	↓	3	EWB/EPB	IFPIC
	EDUCATION & RESEARCH: High quality, relevant, education and research	3.1	We will improve the experience of medical students at UHL through a targeted action plan in order to increase the numbers wanting stay with the Trust following their training and education	MD	S Carr	3	↓	4	EWB/EPB	TB
		3.2	We will address specialty-specific shortcomings in postgraduate medical education and trainee experience in order to make our services a more attractive proposition for postgraduates	MD	S Carr	3	↓	4	EWB/EPB	TB
		3.3	We will develop a new 5-Year Research Strategy with the University of Leicester in order to maximise the effectiveness of our research partnership	MD	N Brunskill	4	↔	5	ESB	TB
	PARTNERSHIPS & INTEGRATION: More integrated care in partnership with others	4.1	We will integrate the new model of care for frail older people with partners in other parts of health and social care in order to create an end to end pathway for frailty	DCIE	G Distefano	3	↔	3	ESB	TB
		4.2	We will increase the support, education and specialist advice we offer to partners to help manage more patients in the community (integrated teams) in order to prevent unwarranted demand on our hospitals	DCIE	G Distefano	3	↔	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	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/ EPB	IFPIC
		5.3	We will deliver the year 2 implementation plan for the 'UHL Way' and engage in the development of the 'LLR Way' in order to support our staff on the journey to transform services	DWOD	B Kotecha	3	↓	5	EWB/EPB	IFPIC
		5.4	We will review our Corporate Services in order to ensure we have an effective and efficient support function focused on the key priorities	DWOD/CFO	L Tibbert	3	↔	3	EWB/EPB	IFPIC
		5.5	We will implement our Commercial Strategy, one agreed by the Board, in order to exploit commercial opportunities available to the Trust	CFO	P Traynor	4	↔	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	↔	3	EPB	IFPIC

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

Controls assurance (planning)	Performance assurance (measuring)
Governance: Mortality Review Committee, chaired by Medical Director.	Summary Hospital-level Mortality Indictor (SHMI) (period June 2015 to June 2016 - <99 - within expected range.
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 - April 17 = 95%. May 17 = 87% 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. 57 cases referred for SJR in April (34) and May (23).
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 (Mar 16 - Feb 17) is 101.
	Actions related to CUSUM alerts on track / completed - target is All actions on track / completed - April 2017 = 1 alert received (Coronary arteriosclerosis disease) and actions on track.

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.	New

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	Audit Committee		
TB sub Committee	QAC	Jun-17	The recently received mortality alert regarding coronary atherosclerosis is on track to be completed and a report sent to be submitted to the Quality Assurance Committee in July.
TB sub Committee	QAC	Mar-17	UHL's SHMI has moved one point above the England average to 101. A recent in depth HED review of UHL mortality did not identify any additional areas of mortality by condition which needed action that we did not already have reviews or action plans in place for. The review identified that UHL's crude mortality has not increased but the expected number of deaths has decreased.

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

Controls assurance (planning)	Performance assurance (measuring)
Governance: Deteriorating Adult Patient Board.	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.
7 days a week critical care outreach service.	
Harm review of patients with red flag sepsis who did not receive Antibiotics within 3 hours.	ED KPI 90% of patients with red flag sepsis receive IV antibiotics within 1 hour.
Roll out of e-obs to the modified National Early Warning Scoring System - with the exception of maternity and paeds ED.	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.
(GAP) Sepsis e-learning module - due May 2017.	
(GAP) Deteriorating patient e-learning module - due Aug 2017.	
EWS & Sepsis audit results reported to CQC monthly.	
Sepsis screening tool and care pathway.	
Review of admissions to ITU with red flag sepsis at all 3 sites monthly.	
Monitoring of SUIs related to the deteriorating patient.	

Risk assurance (assessment)	Movement
If we fail to identify and act upon the results for the deteriorating patient, caused by lack of an appropriate observation (EWS) system, then this may result in preventable deaths or severe harm occurring.	New

Corporate Oversight (TB / Sub Committees)			
Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	Audit Committee		
TB sub Committee	QAC	01-Jun	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 from the inspection in 2016.

External Audit	work plan TBA		

BAF 17/18: As of…	May-17											
Objective:	Safe, high quality, patient centered, efficient healthcare											
Annual Priority 1.2.2	We will introduce safer use of high risk drugs (e.g. insulin and warfarin) in order to protect our patients from harm											
Objective Owner:	MD/CN	**SRO Insulin:**		E Meldrum		**Executive Board:**		EQB		**TB Sub Committee**		QAC
Objective Owner:	MD/CN	**SRO Warfarin:**		C Marshall		**Executive Board:**		EQB		**TB Sub Committee**		QAC
BAF Assurance Rating - 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)
Insulin	
Governance: Diabetes Inpatient Safety Committee.	Reduce number of severe inpatient hypoglycaemia episodes by 20%.
UHL insulin safety strategy tool.	(GAP) To have no DKA “never events” in the quarterly period.
(GAP) E-learning for Insulin Safety mandatory for staff who have responsibility for prescribing, preparing and administering insulin - to be uploaded onto HELM by June 30th 2017.	
(GAP) Develop a system/strategy to review and respond to episodes of severe hypoglycaemia.	
(GAP) Business case to implement a networked blood glucose meter system.	
(GAP) “Insulin safety Pulse Check”.	
Warfarin	
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.
(GAP) UHL Anticoagulation action plan.	
(GAP) E-learning warfarin safety programme mandatory for clinical staff.	
Anticoagulation in-reach nursing service.	
Discharge summary for patients on warfarin to improve communication with GPs.	
Improve time to octaplex delivery in bleeding patients.	
UHL Anticoagulation policy.	

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

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

TB sub Committee	QAC	Jun-17	Delay due to waiting for next anticoagulation board meeting in order to agree KPIs, work plan and to write project charter.

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…	May-17											
Objective:	Safe, high quality, patient centered, efficient healthcare											
Annual Priority 1.2.3	We will implement processes to improve diagnostics results management in order to ensure that results are promptly acted upon											
Objective Owner:	MD		**SRO:**	C Marshall		**Executive Board:**		EQB		**TB Sub Committee**		QAC
BAF Assurance Rating - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Controls assurance (planning)	Performance assurance (measuring)
Governance: Acting on Results programme board and task and finish groups to report to EQB quarterly.	(GAP) % of results acknowledged - target is 85% of results acknowledged by Q4 2017/18.
UHL diagnostic testing policy	
Acting on results detailed action plan monitored via EQB. This covers: developing a fit for purpose electronic system to acknowledge results; in depth work with each specilaty 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 prior to Trust roll-out - due end June 2017 in CDU which is the highest risk area.	
(GAP) Development of metrics for monitoring performance against target.	

Risk assurance (assessment)	Movement
If we don't develop a fit for purpose electronic system to monitor and ensure results are promptly acted upon then we may cause unnecessary harm to patients.	New

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	Audit Committee		
TB sub Committee	QAC	Jun-17	Making good progress. Roll out of Conserus radiology solution for reporting unexpected findings to clinicians is imminent. An electronic solution using Mobile ICE is due to be piloted next month. 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…	May-17											
Objective:	Safe, high quality, patient centered, efficient healthcare											
Annual Priority 1.3.1	We will provide individualised end of life care plans for patients in their last days of life (5 priorities of the Dying Person) in that our care reflects our patients' wishes											
Objective Owner:	CN		**SRO:**	C Ribbins / 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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	4	4										

Controls assurance (planning)	Performance assurance (measuring)
Governance: End of Life Care Board.	The number of patients with a care plan as a percentage of expected deaths - target is 75% of patients who are expected to die will have a care plan in place.
End of life care plans which include specialist palliative care end of life care service.	EoLC audits quarterly.
(GAP) Detailed education package for staff including ward education and study days.	
EoLC guidelines and policies / procedures.	
(GAP) Implementation of an electronic system.	

Risk assurance (assessment)	Movement
If we do not develop improved discharge arrangements and better co-ordination of care with a range of community services, whilst crucially for those who will remain in hospital ensuring they have a "good death", then we may not enable more people to die at the place of their choice	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	May-17											
Objective:	Safe, high quality, patient centered, efficient healthcare											
Annual Priority 1.3.2	We will improve the patient experience in our current outpatients service and begin work to transform our outpatient models of care in order to make them more effective and sustainable in the longer term.											
Objective owner:	DCIE		**SRO:**	J Edyvean / D Mitchell		**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**
	3	3										

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 (amber rating of 3);Q2-321; Q3-189; Q4 - 0 - Year end position deliverable).
(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.	(GAP) Clinical audit of additional schemes related to changes in the new to follow up ratio - This is now planned to be understood by the end of July.
(GAP) 50% of remaining outpatients opportunity to be added to the PMTT.	
Out patient transformation project initiated (Objectives and KPI's TBC).	

Risk assurance (assessment)	Movement
If a standardised process for reporting outpatient diagnostic tests is not implemented, caused by delayed outpatient correspondence, then the review of diagnostic tests will not occur in a timely manner.	New

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	Audit Committee		
TB sub Committee	QAC	01/05/2017	Year end position deliverable with moderate risk

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	May-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**
	3	3										
BAF Assurance Rating - Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4										

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

Risk identified to address Gaps in controls / performance	Movement
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.	
If the out of hospital step-down solution is not be operational for Winter 17/18 then it will lead to a continued demand and capacity imbalance at the LRI.	
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.	

Corporate Oversight (TB / Sub Committees)			
Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	QAC	May-17	Key risk is currently associated with the Elective bed increases required for CHUGGS at LGH, which given the staffing position for CHUGGS are unlikely to be able to be opened (4 beds). This gap will have to be mitigated by improved efficiency in this area.
TB sub Committee	QAC	Mar-17	The task for 2017/18 is to create additional effective capacity (through actual beds, demand mitigation or improved productivity) of 105 beds. The approach in 17/18 will be different to previous years in that it favours creating capacity sufficient to deal with peak demand and then reducing beds at time when demand is lower than the peak.
TB sub Committee	IFPIC		

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

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

Risk assurance (assessment)	Movement
If the Trust fails to engage effectively with staff through robust communication networks then this may affect the delivery of safe, high quality patient centered healthcare (See ID 2266 / 3009).	New
If we don't reduce the number of non-NHS standard contract employees then we will not deliver a sustainable workforce plan.	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: As of…	May-17											
Objective:	Right people with the right skills in the right numbers											
Annual Priority 2.2	We will reduce our agency spend towards the required cap in order to achieve the best use of our pay budget											
Objective Owner:	DWOD		**SRO:**	J Tyler-Fantom		**Executive Board:**		EWB / EPB		**TB Sub Committee**		IFPIC
BAF Assurance Rating	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4										

Controls assurance (planning)	Performance assurance (measuring)
NHSI overall agency cap is £20.6m for 2017/18, specific target for medical agency reduction £717,930 in 17/18 - incorporated into CMG financial planning.	£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.	(GAP) Medical Agency Dashboard to Medical Oversight board - in development.
Medical Oversight Broad established.	(GAP) Regional deliverables 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.	

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.	New

Corporate Oversight (TB / Sub Committees)

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

TB sub Committee	IFPIC	May-17	The agency ceiling target is £20.6m and at month 2 we are broadly on track, however at the current run rate agency spend will exceed the annual ceiling by £2.8m at year end. There are actions in place as above to robustly manage and monitor agency spend. Comparison of 15/16 premium spend shows agency has reduced from £33.4m to £25m . 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…	May-17											
Objective:	Right people with the right skills in the right numbers											
Annual Priority 2.3	We will transform and deliver high quality and affordable HR, OH and OD services in order to make them 'Fit for the Future'											
Objective Owner:	DWOD		**SRO:**	B Kotecha		**Executive Board:**	EWB / EPB			**TB Sub Committee**		IFPIC
BAF Assurance Rating	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	3										

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 -
(GAP) Working with stakeholders and customers to deliver service differently and to gain ownership - listening event planned to take place in July.	
(GAP) Redefine and Up skill staff within the Service in order to be fit for the future.	
(GAP) Delivery structures not fit for purpose until target operating model has been developed - target operating model will be informed by feedback from listening events in July.	Listening Events arranged for July 2017 (stakeholders invited).
	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 priorities delivery.

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 (See ID 2266 / 3009).	New

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	Audit Committee		
TB sub Committee	IFPIC		Next Workforce Report to be presented on 29 June 2017.

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…	May-17											
Objective:	High quality, relevant, education and research											
Annual Priority 3.1	We will improve the experience of medical students at UHL through a targeted action plan in order to increase the numbers wanting stay with the Trust following their training and education											
Objective Owner:	MD		**SRO:**	S Carr		**Executive Board:**		EWB		**TB Sub Committee**		
BAF Assurance Rating	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3	3										

Controls assurance (planning)	Performance assurance (measuring)
Medical Education Strategy to improve learning culture.	(GAP) GMC visit 2016 findings (satisfaction / experience) - to be published June 2017 - next visit due 2021.
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.
(GAP) Overarching strategy with University of Leicester to integrate undergraduate and postgraduate training to improve outcomes and retention.	GMC National student survey (satisfaction / experience) - annually - areas for improvement in 17/18 plan.
UG representatives on the UHL Doctors in Training Committee.	
(GAP) Audit time in Job plans for education and training roles - variable across CMGs.	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'.

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.	New
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.	New
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.	New

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

TB sub Committee	Audit Committee		No scrutiny - The TB should consider where they are receiving assurance in relation to this priority.
TB sub Committee	QAC		No scrutiny - The TB should consider where they are receiving assurance in relation to this priority.

Independent (Internal / External Auditors)			
Source:-	Title:	Date:	Feedback:
Internal Audit	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…	May-17											
Objective:	High quality, relevant, education and research											
Annual Priority 3.2	We will address specialty-specific shortcomings in postgraduate medical education and trainee experience in order to make our services a more attractive proposition for postgraduates											
Objective Owner:	MD		**SRO:**	S Carr		**Executive Board:**		EWB		**TB Sub Committee**		
BAF Assurance Rating	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3	3										

Controls assurance (planning)	Performance assurance (measuring)
Medical Education Strategy to address specialty-specific shortcomings.	(GAP) GMC visit 2016 findings - to be published June 2017 - next visit due 2021.
Medical Education Quality Improvement Plan for 2017/18.	GAP) HEE Quality Management Process (satisfaction / experience)- new process still to be confirmed 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	UHL Medical Education Survey (should see improvements if more attractive) - bi annual- next due in Sept 2017.
(GAP) CMGs Quality Improvement Action Plans in response to GMC visit and survey results to address concerns in postgraduate education.	UHL PG education quality dashboard (should see improvements if more attractive) - results variable across CMGs- next due in September 2017.
(GAP) Department of Clinical Education programme with CMGs to develop action plans to address poor performance and training challenges.	GMC national training survey (should see improvements if more attractive)
(GAP) Overarching strategy with University of Leicester to integrate undergraduate and postgraduate training to improve outcomes and retention.	(GAP) Data to show the number of postgraduate medical and trainees retained in the specialties with shortcomings.
GMC 'Approval and Recognition' of Clinical and Educational Supervisors - central database monitored and maintained.	
(GAP) GMC visit report - UHL action plan developed.	
A pilot audit of job plans for Cardiology is underway.	
On-going support work for Trust Grade doctors to minimise rota gaps and improved trainee experience at UHL.	

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.	New
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.	New
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.	New
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	New

Corporate Oversight (TB / Sub Committees)

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

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

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

Risk assurance (assessment)	Movement
If we don't have the right 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.	New

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

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

BAF 17/18: As of…	May-17											
Objective:	More integrated care in partnership with others											
Annual Priority 4.1	We will integrate the new model of care for frail older people with partners in other parts of health and social care in order to create an end to end pathway for frailty											
Objective Owner:	DCIE		**SRO:**	G Distefano		**Executive Board:**		ESB		**TB Sub Committee**		
BAF Assurance Rating	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3	3										

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	
(GAP) CMG clinical leads to be identified.	
(GAP) Designated managerial lead - Senior Project Manager being recruited (vacancy closes in June) as part of the Strategy Management of Change process.	
(GAP) UHL project plan - Better Change Project Charter, Benefits Realisation, Milestone Tracker and Stakeholder Analysis under development, linked to discussions of the Clinical Leadership Group (June 2017) re next steps as a system.	
(GAP) Resources / capacity available to the project (CMGs and corporate).	
(GAP) System wide project plan / PID specific to frailty.	
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.	
(GAP) Commissioning and contracting model that supports deliver of frailty pathway.	

Risk assurance (assessment)	Movement
If appropriate project resources are not allocated (caused by lack of project leads appointed, capital investment and ineffective STP governance 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	work plan TBA		

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

Controls assurance (planning)	Performance assurance (measuring)
UHL designated clinical lead and management lead report to UHL Exec boards.	(GAP) Milestones and success criteria to be defined in the Project Initiations Document
ESB approved high level scope in March 2017.	
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) Performance data will be monitored at service level, once defined.
(GAP) Working group / project team (virtual or otherwise) established.	
(GAP) Project plan - Better Change Project Charter, Benefits Realisation, Milestone Tracker and Stakeholder Analysis will be presented to ESB in July 2017.	
(GAP) Uncertainty around resources / capacity available to the project and/or in supporting / delivering the offer (CMGs namely).	
System wide Tiger Team bringing clinicians together across LLR.	
External Senior representation on relevant STP 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.	
(GAP) Lack of clarity (at this stage) about the availability of funding to support these 'non-activity related' activities.	
Draft - high level - educational programme established within UHL, which will need to now extend to wider stakeholders.	

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	work plan TBA		

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

Controls assurance (planning)	Performance assurance (measuring)
Clinical Lead identified (Associate Medical Director – Primary Care Interface)	(GAP) Performance assurance and reporting to be identified through 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.
(GAP) Project Plan / Project Charter - to be submitted to ESB in June 17. Better Change Project Charter, Benefits Realisation. Milestone Tracker and Stakeholder Analysis completed.	(GAP) A Baseline Mapping of existing integration initiatives which can be used as a measure the outputs of the project.
(GAP) Uncertainty regarding resources/capacity available to support the project (CMGs and corporate).	
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.	

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).	3x2=6 ↔

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	work plan TBA		

BAF 17/18: Version	May-17											
Objective:	Progress our key strategic enablers											
Annual Priority 5.1	We will progress our hospital reconfiguration and investment plans in order to deliver our overall strategy to concentrate emergency and specialist care and protect elective work											
Objective owner:	CFO		**SRO:**	N Topham		**Executive Board:**		ESB		**TB Sub Committee**		IFPIC
Current BAF rating	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3	3										

Planning (controls)	Performance Management (assurance sources)
(GAP) Develop EMCHC full business case - subject to outcome of consultation which is delayed due to period of 'purdah'; final decision expected December 2017	Performance against EMCHC project plan - is dependent on the outcome of the national consultation – scope for project is being finalised - on track.
(GAP) Deliver year 1 (of 3 year) Interim ICU project - subject to receipt of external capital funding following capital bid submitted to NHSI in April 2017	Performance against Interim ICU project plan - is dependent on 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 – actions on track.
(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 – actions on track.
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.

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

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	Audit Committee	26/05/2017	Approval received from Audit Committee to proceed with PWC post project review for Emergency Floor Phase 1 post project review.
		06/07/2017	Outcome of Emergency Floor Phase 1 post project review to be shared. Outcome of 2016 Reconfiguration Gateway Review (by external auditor) to be shared.
TB sub Committee	IFPIC		

Independent (Internal / External Auditors)

Source:-	Title:	Date:	Feedback:

Internal Audit	Emergency Floor Phase 1 - post project review	Q1 17/18	Will carry out post project evaluation of phase 1 to inform the phase 2 project. This will include a review of cost, time, governance and early quality benefits.
External Audit	work plan TBA		

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

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

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

Corporate Oversight (TB / Sub Committees)

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

Independent (Internal / External Auditors)

Source:-	Title:	Date:	Feedback:
Internal Audit	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	May-17											
Objective:	Progress our key strategic enablers											
Annual Priority 5.3	We will deliver the year 2 implementation plan for the 'UHL Way' and engage in the development of the 'LLR Way' in order to support our staff on the journey to transform services											
Objective owner:	DWOD		**SRO:**	B Kotecha		**Executive Board:**		EWB / EPB		**TB Sub Committee**		IFPIC
BAF Assurance Rating - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	3										

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.	UHL Pulse check dashboard (Quarterly) - Q1 2017/18 results to be reviewed by UHL Way Steering Group on 10 July.
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.	National staff survey (annually) - April 2017 = UHL joint 47th position.
LIA processes embedded.	(GAP) Fully populated project charters for each annual priority-development sessions provided and handbook produced and circulated.
LLR Way	
LLR OD and Change Group (workforce enabling group).	(GAP) Metrics to measure no. of people through introduction.
LLR Governance structure with clinical and senior leadership from LLR services (including UHL, LPT, City & County Councils, EMAS).	(GAP) Metrics to measure no. of interventions utilised.
(GAP) LLR standardised improvement framework to approach change.	LLR Making Things Happen Event on 13 July to launch Introduction Package and further work up Implementation of LLR Improvement Framework.
(GAP) Framework to raise awareness of STP and LLR Way.	

Risk assurance (assessment)	Movement
To be identified.	

Corporate Oversight (TB / Sub Committees)			
Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	Audit Committee		
TB sub Committee	IFPIC	Apr-17	UHL Way Priorities Map submitted to provide assurance about plan.

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…	May-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 / EPB		**TB Sub Committee**		IFPIC
BAF Assurance Rating	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3	3										

Controls assurance (planning)	Performance assurance (measuring)
UHL's requirement for significant CIP savings and national imperatives such as the 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.
	(GAP) £1.5m additional UHL 2017/18 CIP target (service line targets tbc).
	(GAP) £577k projected STP savings target (service line targets tbc).
All nine UHL Corporate Directorate plus Estates and Facilities are in scope.	Carter target for back office cost to be no more than 8% of turnover by March 2018.
(GAP) PID drafted - to be agreed in June 2017.	
(GAP) Project governance defined in PID and to be signed off by EPB/EWB - July 17.	Carter Target for back office cost to be no more than 6% of turnover by March 2020.
Project Board meeting scheduled for 04/07/17; meeting monthly thereafter.	
(GAP) Diagnostic phase across all Corporate Services commencing in June 2017.	
Project manager resource in place.	

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).	New

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	Audit Committee		
TB sub Committee	IFPIC	27/07/2017	Progress update paper to propose initial 2017/18 plan.

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

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

Risk assurance (assessment)	Movement
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.	

Corporate Oversight (TB / Sub Committees)

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

Independent (Internal / External Auditors)

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

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

Controls assurance (planning)	Performance assurance (measuring)
Cost Improvement Plans	
CMGs and Corporate departments to fully identify (complete) plans for 2017/18.	Monthly CIP report to EPB and IFPIC.
100% of PIDS and QIAs signed off.	Monitoring of CIP tracker to measure completeness of programme for the remaining months.
Production and delivery of the Closing the Gap plan.	
Procurement to deliver full £8m target against budgeted spend.	
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 to achieve 100% delivery in 2017/18.	CIP measurement and reporting monthly.
CMGs to achieve their control totals or better.	Monthly I&E submissions to NHSI, Trust Board, IFPIC and EPB.
Cost pressures and service developments to be minimised and managed through RIC and CEO chaired 'Star Chamber'.	Expenditure run rates for pay, non-pay, capital charges and agency spend.
A minimum of £18m of additional technical and other solutions to be transacted.	Contract income levels consistently being achieved and commissioner challenges resolved quarter by quarter.
Agree an appropriate level of investment supporting the resolution of the demand/capacity issue.	Year on year reduction in agency spend in line with our 2 year trajectory.
	I&E monitoring of progress against £18m technical challenge.
Manage CCG and NHSE contracts to ensure accurate and full receipt of income noting changes to tariff (HRG4+) and new Emergency Floor currencies/flows.	Overall level of overdue debtors to reduce, BPPC performance to improve - monitored within cash paper to IFPIC.
Implementation of 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.	

Risk assurance (assessment)	Movement

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

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

Independent (Internal / External Auditors)			
Source:-	Title:	Date:	Feedback:
Internal Audit	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 Ratings

Current Assurance Rating: Month-end

0	Not started
1	Extreme risk associated - Predicted to fail
2	Major risk associated – unlikely to deliver in 2017/18
3	Moderate risk associated – expected to deliver in 2017/18
4	Minor risk associated - Expected to deliver in 2017/18
5	Will deliver

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 appropriately managed.

3	Moderate risk associated – expected to deliver in 2017/18
4	Minor risk associated - Expected to deliver in 2017/18
Follow up question - By when will the priority be delivered?	

or

2	Major risk associated – unlikely to deliver in 2017/18
Follow up questions - What further actions have been identified to get the annual priority back on track and when is it expected to deliver?	

or

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

or

0	Not yet started

Year-end Forecast Assurance Rating: Year-end

0	Not started
1	Extreme risk associated - Predicted to fail
2	Major risk associated – unlikely to deliver in 2017/18
3	Moderate risk associated – expected to deliver in 2017/18
4	Minor risk associated - Expected to deliver in 2017/18
5	Will deliver

Key questions to BAF owners each month:

What is the year-end forecast for delivering the annual priority in 2017/18?
Consider are controls effective, are performance outcomes positive and have risks been identified and are appropriately managed.

3	Moderate risk associated – expected to deliver in 2017/18
4	Minor risk associated - Expected to deliver in 2017/18

or

2	Major risk associated – unlikely to deliver in 2017/18
Follow up questions - What further actions have been identified to get the annual priority back on track and when is it expected to deliver?	

or

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

or

0	Not yet started

Appendix 2 Risk Register Dashboard as at 31 May 17

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Risk Owner	Risk Movement	Elapsed Risk Review	Themes aligned with Trust Objectives
2236	ESM	There is a risk of overcrowding due to the design and size of the ED footprint & increased attendance to ED	25	16	Dr Ian Lawrence	↔		Quality Commitment
2566	CHUGGS	If the range of Toshiba Aquilion CT scanners are not upgraded, Then patients will experience delays with their treatment planning process.	20	1	Lorraine Williams	↔		Quality Commitment
2354	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.	20	9	Sue Mason	↔		Quality Commitment
2670	RRCV	If we do not recruit into the Clinical Immunology & Allergy Service Consultant vacancy, Then the patient backlog will continue to increase, thus resulting in delays with patient sequential procedures.	20	6	Karen Jones	↔		Our People
2886	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.	20	8	Geraldine Ward	↔		Quality Commitment
2931	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.	20	4	Judy Gilmore	↔		Quality Commitment
2804	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.	20	12	Susan Burton	↔		Quality Commitment
2149	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 thus resulting in potential financial penalties.	20	6	Susan Burton	↔		Our People
2763	ITAPS	Risk of patient deterioration due to the cancellation of elective surgery as a result of lack of ICU capacity at LRI	20	10	Chris Allsager	↔		Our People
2990	MSK & SS	There is a risk of delayed outpatient correspondence to referrer/patient following clinic attendance.	20	3	Clare Rose	↔		Quality Commitment
2191	MSK & SS	Lack of capacity within the ophthalmology service is causing delays that could result in serious patient harm.	20	8	Clare Rose	↔		Our People
2867	CSI	If the Mortuary flooring is not repaired, then we will continue to breach Department of Health Building note 20 and the HSAC (Health Services Advisory Committee) advice by exposing staff to harm.	20	3	Mike Langford	↔		Our People
2940	W&C	Risk that paed cardiac surgery will cease to be commissioned in Leicester with consequences for intensive care & other services	20	8	Nicola Savage	↔		Quality Commitment
2403	Corporate Nursing	There is a risk changes in the organisational structure will adversely affect water management arrangements in UHL	20	4	Elizabeth Collins	↔		Key Strategic Enablers
2404	Corporate Nursing	There is a risk that inadequate management of Vascular Access Devices could result in increased morbidity and mortality	20	16	Elizabeth Collins	↔		Quality Commitment

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Risk Owner	Risk Movement	Elapsed Risk Review	Themes aligned with Trust Objectives
2471	CHUGGS	If the Trust does not invest in upgrading our aged imaging equipment, then we will continue to breach national guidance and Radiotherapy Services specification of 10 years replacement recommendations.	16	4	Lorraine Williams	↔		Our People
2264	CHUGGS	If an effective solution for the 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.	16	6	Georgina Kenney	↔		Quality Commitment
2819	RRCV	If we do not address the shortages of ITU and HDU beds capacity available to Vascular surgery, then we will be more prone to delaying complex and high-risk surgeries at LRI	16	12	**CLOSED**			Our People
2820	RRCV	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.	16	3	Karen Jones	↔		Our People
2333	ITAPS	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.	16	8	Chris Allsager	↔		Our People
2193	ITAPS	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.	16	4	Gaby Harris	↔		Quality Commitment
2955	CSI	If system faults attributed to EMRAD are not expediently resolved, Then we will continue to expose patient to the risk of harm	16	4	Cathy Lea	↔		Quality Commitment
1206	CSI	If the backlog of unreported Chest and Abdomen images on PAC'S are not cleared, then we will breach IRMER and Royal College of Radiologist guidelines.	16	6	ARI	↔		Our People
2378	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.	16	8	Claire Ellwood	↔		Our People
2391	W&C	There is a risk of inadequate numbers of Junior Doctors to support the clinical services within Gynaecology & Obstetrics	16	8	Ms Cornelia Wiesender	↔		Our People
2153	W&C	If we do not recruit into the current Children's Nurses vacancies and effectively manage the return of long term sick staff, then the standard of care provided in the Children's Hospital will be compromised.	16	8	Hilliary Killer	↔		Our People
3008	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.	16	5	Andrew Leslie	**NEW**		Quality Commitment
2237	Corporate Medical	If a standardise process for requesting and reporting outpatient diagnostic tests is not implemented, then the timely review of diagnostic tests will not occur.	16	8	Colette Marshall	↔		Our People
2247	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.	16	12	Maria McAuley	↔		Our People
1693	Operations	If clinical coding is not accurate, then income will be affected.	16	8	Shirley Priestnall	↔		Key Strategic Enablers

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Risk Owner	Risk Movement	Elapsed Risk Review	Themes aligned with Trust Objectives
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.	15 ↓	1	Simon Andrews	↓		Our People
2872	RRCV	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.	15	6	Vicky Osborne	↔		Quality Commitment
3005	RRCV	If we do not recruit and retain into the current Thoracic Surgery Ward RN vacancies, then Ward functionality will be compromise resulting in increased likelihood of incidences leading to patient harm.	15	6	Sue Mason	↔		Our People
2837	ESM	If we do not migrate to a automated results monitoring system, Then follow-up actions for patients with multiple sclerosis maybe delayed	15	2	Dr Ian Lawrence	↔		Our People
2989	MSK & SS	If we do not recruit into the Trauma Wards nursing vacancies, then patient safety and quality of care will be placed at risk	15	4	Nicola Grant	↔		Our People
1196	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.	15	2	Rona Gidlow	↔		Our People
2946	CSI	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.	15	2	Cathy Steele	↔		Our People
2973	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.	15	6	Cathy Steele	↔		Our People
2787	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.	15	4	Debbie Waters	↔		Our People
2965	CSI	If we do not address Windsor pharmacy storage demands, then we may compromise clinical care and breach statutory duties	15	6	Claire Ellwood	↔		Quality Commitment
2601	W&C	There is a risk of delay in gynaecology patient correspondence due to a backlog in typing	15	6	DMAR	↔		Our People
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.	15	4	Cathy Steele	↑		Harm (Patient/Non-patient)
2402	Corporate Nursing	There is a risk that inappropriate decontamination practice may result in harm to patients and staff	15	3	Elizabeth Collins	↔		Quality Commitment

Appendix 3 **UHL Risk Register Report as at 31 May 2017**

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
2236	CMG 3 - Emergency & Specialist Medicine (ESM)	Emergency Department	There is a risk of overcrowding due to the design and size of the ED footprint & increased attendance to ED	04/Oct/13	31/05/2017	Design and size of footprint in resus causes delay in definitive treatment, delay in obtaining critical care, risk of serious incidents, increased crowding in majors, risk to four hour target. Poorer quality care. Risk of rule 43. Lack of privacy and dignity. Increased staff stress. Design and size of majors causes delay in definitive treatment and medical care. Poor quality care. Lack of privacy and dignity. High number of patient complaints. Risk of deterioration. Difficulty in responding to unwell patient in majors. Risk of adverse media interest. Staff stress. Risk of serious incident. Inability to meet four hour target resulting in patient safety and financial consequences. High number of incidents. Increased staff stress. Infection control risk. Risk of rule 43. Design and size of footprint in paediatrics causes delay in being seen by clinician. Risk of deterioration. Risk of four hour target and local CQUINS. Lack of patient confidentiality. Increased violence and aggression. Design and size of assessment bay causes delay in time to assessment. Paramedics unable to reach turnaround targets. Inability to meet CQUIN targets. Risk of patient deterioration. Delay in diagnosis and treatment. Increased staff stress. Patient complaints. Increased risk of patients being in the corridor on trolleys. Lack of dignity and privacy. Serious incident risk.	Harm (Patient/Non-patient)	The Emergency Care Action Team, was established in spring 2013 with aims to improve emergency flow and therefore reduce the ED crowding. This has now been changed to Emergency Quality Steering Group(EQSG) meetings. The Emergency department is actively engaging in plans to increase the ED footprint via the emergency floor initiative, but in the shorter term to increase the capacity of assessment bay and resus. The Resus Bed area has been created. Increase in Clinical Education staff, to assist with upskilling of Nursing Staff. Majors Floor has been marked out and numbered to prevent to many trolleys from blocking Majors and assessment Bay. Improving quality of care in the ED sessions open to staff, led by ED Consultant. Direct referrals from assessment bay and UCC to ambulatory clinic/GPAU. CAD system went live highlighting number of ambulance patients on route to ED. SOP's completed, including SOP's for managing assessment bay at full capacity & for supporting an escalation area when the main ED is full. Actions in place from EQSG Emergency Floor New ED floor working stream.	Extreme	Almost certain	25	Launch and implementation of additional patient on ward process (SAFER placement) Red to Green in process through trust, ongoing review 30/09/17	16	Dr Ian Lawrence	Operational Risk

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
2566	CMG 1 - Cancer, Haematology, Urology, Gastroenterology & Surgery (CHUGGS)	Oncology	If we do not upgrade our range of Toshiba Aquilion CT scanners, Then patients will experience delays with their treatment planning process.	26/06/2015	30/06/2017	The current Toshiba scanner is 9 years old with an expected 10 year life cycle. It is the only scanner in the department, scanning provision would need to be provided at either another Radiotherapy department or possibly in radiology in the event of a prolonged or permanent period of downtime. The likelihood of such an event significantly increases towards the end of its life cycle. Consequences would be: - Patients wouldn't be able to have their treatment planned having an impact on the cancer waiting time targets and outcomes of the patients treatment; - There is a risk to patients being planned for treatment in a timely manner due to availability of alternative scanning capacity; Consequences of using radiology (or another radiotherapy dept) scanner - Slice position numbering may differ between scanner and planning computer which could cause positioning errors; - Inconvenience to patients having to go to different dept for scan, possibly on a separate date to other apts in radiotherapy; radiotherapy staff would need to be allocated sessions working in radiology/another radiotherapy dept to scan radiotherapy patients; - A specific couch top is required for planning radiotherapy treatment, the existing couch top doesn't fit the diagnostic scanner in the radiology dept. The cost of a new couch top is approx £28k and would also require a modification to the table top. The modification to table top would take approx a day	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 Aug 17 Agreement for monthly 1/2 day physics QA sessions on radiology scanner during periods of Toshiba breakdown to ensure continued compability between scanner and planning system - 31 Aug 17 Purchase of compatible couch top for use with CT scanners - 31 Aug 17 Service level agreement with radiology for scanner capacity for radiotherpay patients in the case of long term breakdown of scanner - 31 Aug 17 Contingency plan for instances of breakdown of the Toshiba scanner using radiology scanner - 31 Aug 17 Awaiting formal business case for the propsoed replacemnent - 31 Dec 17	1	Lorraine Williams	Operational Risk

Risk ID	CMG	Specialty	Risk Title	Review Date	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
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.	31/Jul/17	28/05/2014	Causes of the risk (hazard) 1.CDU originally designed to take in a 24 hour period 25-30 patients, on average it is now taking 60-70 patients/24 hr period. Despite the extension of the triage area the foot print of the unit still remains inadequate to cope with this increase number of patients. There is not the physical space to see/examine/review the number of patients that are currently presenting to CDU, particularly in the afternoon and evening. 2.The workforce on CDU (medical, nursing, therapy, admin/clerical) has increased since 2014 in accordance with the increase in the number of patients that require processing in the department, however at times the processing capacity of the staff available does not match demand. 3.Increasing risk to the compliance of CDU Quality Performance Indicators; patients being triaged within 15 minutes from arrival to CDU and seen by a Doctor within 60 minutes. 4.Due to the pressures within the Emergency Department at the LRI the level 1 diverts are enacted on occasions, compounding the overall processing power within CDU and impacting on bed capacity. 5.The out of hour's provision from support services such as pharmacy, radiology and pathology does not match the requirements of an increasing emergency take at the GH.	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	Maior	Almost certain	20	Task group to be set up to review space and decide next steps - 31.5.17 Identify physical space changes to increase capacity - 31.8.17 Develop & monitor action plans from ESIP review - 1.9.17 Review inpatient x-rays being undertaken on CDU - 31.7.17	9	Sue Mason	Operational Risk

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
2670	CMG 2 - Renal, Respiratory, Cardiac & Vascular (RRCV)		If we do not recruit into the Clinical Immunology & Allergy Service Consultant vacancy, Then the patient backlog will continue to increase, thus resulting in delays with patient sequential procedures.	05/Oct/15	31/09/2017	Consequences of the risk: Recruitment delay of the Consultant post is impacting on the timely review of the Immunology and Allergy patients and in turn will increase the risk of not complying with Referral to Treatment (RTT) targets. This risk is further increased from the 2nd consultants resignation. The vacant post and backlog impacts on the appointment capacity for patients, facilities available and nursing support introducing additional delays to patient waiting lists Immunology Specialist Nurse vacancy from May 2016 will impact on Allergy & Immunology Services whilst recruitment is completed – delay to patients due to less support at clinic The speciality service requirements will increase the difficulty of replacing with a 'like for like' replacement. The previous post holder had clinical experience in Immunology and Allergy and covered clinic responsibilities for both of these specialist areas. The advertisement for temporary, short-term locum cover has been unsuccessful due to the speciality service requirements There will be a financial impact on the service to recruit to a medium term locum to cover the service and to assist with completing the patient backlog. In addition the service will potentially require two posts one to maintain the Immunology service and one for the Allergy Risk to the patients who has an allergy condition which is are high priority condition	Harm (Patient/Non-patient)	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	Maior	Almost certain	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	6	Karen Jones	Operational Risk

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
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.	03/Jun/17 29/06/2016	Causes (hazard) 1.The existing Water Treatment Plant that currently provides the LGH Haemodialysis Unit adjacent to the Haemodialysis Unit LGH site. with all of its treated water requirements for dialysis, has now exceeded its expected service life, (some parts dating back 42years) with the most recent addition dating back 20years. 2.Failure of the exiting ring main RO systems 3.Out-dated design without intergural disinfection capabilities RISK TO PATIENTS •There is a risk that downtime resulting from equipment failure of the water plant impacts directly on the clinical treatment offered to all haemodialysis patients receiving dialysis therapy at the LGH Renal Unit. This may result in patients having to travel to other units. •Risk from both long and short term complication to patients due to unacceptable bacterial contamination of water that supplies the Haemodialysis unit. •Emergency business continuity plans would need to be activated this would have an associated impact on other support services transport, community services etc). •Risk of a rise in clinical incident, complaints, litigation (staff stress, patient injury and clinical negligence)	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.	Extreme	Likely	20	Replacement options paper to be compiled for submission to the Renal and CMG board before submitting to capital and investment committee - Capital Purchase - Initial £165K Capital purchase and annual maintenance costs of approximately £10K per annum. To replace the ring main and complete water treatment system. Business Case to be presented at the Capital & Investment Committee Meeting on 14.10.16 for decision. Decision made by the Capital Investment Committee to replace Water Treatment Plant. Funding to come from 17/18 capital expenditure. Weekly water sampling will continue. Scoping exercised commenced in January 17 and contract to be awared in April 17. Work should then commence on the installation of a new water treatment plant. Tender process underway. Preferred supplier not know yet. Review date 3rd June 17.	8	Geraldine Ward	Operational Risk

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
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.	31/07/2017	05/Sep/16	Causes (hazard) Cardiac Monitoring system failure due to age, obsolescence, replacement parts not available, no GE service contract/support. System includes bedside, central, telemetry. Vital signs inc O2 sats, Bp, Pacemaker checks. 12 lead ECG's. Event history ie. Arrhythmia review Consequence (harm / loss event) 19 bedded, direct admitting CCU would not be able to safely admit critically unwell, unstable people through EMAS with, STEMI, nSTEMI, OoHCA, Arrhythmias etc. Critically ill patients could not be safely transferred internally post Cardiac Arrest, TAVI, IABP insertion post procedure, ITU transfers, transfers from other sites, E/D, other trusts LLNR would not have functioning CCU available to population of over 1 million Cardiac arrests not detected, life threatening arrhythmia not seen/treated Delayed delivery of care Out of Hospital Cardiac Arrests, could not be safely admitted to the GH site Entire GH site affected operationally inc. ITU blocking LRI E/D detrimentally affected due to increased activity/delays in transferring Reduces operational capacity of the unit to safely admit monitored patients Potential risk to wider population and the reputation of UHL as impacts on emergency bed base Cancelled procedures/surgery eg. PCI/TAVI Increased expenditure as staffing levels would need to be increased	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.	Extreme	Likely	20	Replace obsolete monitoring system in its entirety including service contract - implementation plan being developed to install by July 17	4	Judy Gilmore	Operational Risk

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
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.	06/May/16	31/10/2017	There is a risk that if ongoing pressures in medical admissions continue that the Emergency and Specialist Medicine CMG medicine bed base will be insufficient resulting in the need to out lie into other speciality/CMG beds jeopardizing delivery of the RTT targets and affecting quality and safety of patient care. There is a requirement to outlie medical patients because of: o8% increase in medical admissions and current insufficient medical bed capacity oDischarge processes not as efficient as they should be internally impacting patient flow and patients waiting in ED for admission oContinued delayed transfers of care oOn-going risks and potential harm to patients as a consequence of overcrowding in ED oOOH teams have to make decisions to use all available capacity to cope with pressures in ED The ability to open extra beds within the CMG is compounded by: o>100 Nursing vacancies oHigh patient acuity oHigh inflow of patients being admitted oNo available bed capacity on the LRI site	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.	Maior	Almost certain	20	Daily Red to green process in place with meetings	12	Susan Burton	Operational Risk

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
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 thus resulting in potential financial penalties.	31/08/2017	21/02/2013	Many clinical areas are currently experiencing low levels of staffing to manage effectively the current numbers of patients. Often the nurse to bed ratio falls below that identified as the funded establishment, and therefore the required level of staffing to appropriately meet patient need. In addition within most of the clinical areas there is high bank and agency use further increasing the risk to the quality of care delivered. In addition we are required to staff the old TIA clinic and look after ambulance patients in ED corridors and provide support to outlying patients which further depletes numbers and nursing skills. Causes - "Large Number Vacant Nursing posts, "Lack of appropriately trained nursing staff to manage specialised patients, "Poor Agency and bank fill rates, " High level of maternity leave/sick leave, " Outlying of patients, " TIA Clinic, " Ambulance cohorting in the corridor protocol. Consequences - "Delays with Patient care, "Patient medications not being completed in a timely manner, "Patient buzzers not being answered in a timely manner, "Patient safety compromised, "Increased risk of patient pressure ulcer formation, "Increased risk of patient falls, "Increased risk of incidents due to lack of familiarity with treatment regimes, "Inability to deliver quality care to different patient groups, "Decreased patient satisfaction/ quality of care, "Delays in treatment and appropriate referral, "Increase in complaints, "Increase in incident reporting,	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.	Maior	Almost certain	20	Enhanced rate of pay now in place for 3 months period and due for ongoing regular reviews. New staff to be appointed from Philippines and India. Advanced booking of staff bank levy in place.	6	Susan Burton	Operational Risk

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
2763	CMG 4 - Intensive Care, Theatres, Anaesthesia, Pain	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	31/10/2017	Causes: Lack of capacity (beds) within ICU cross-site. Lack of base ward bed for ICU patients to be discharged. Lack of nursing staff to manage ICU patients. Delays with discharging ICU patients to Wards. Consequences: Deterioration in condition with the potential for patients to become too unwell to have surgery when re-booked or worse case scenario patient dies waiting for surgery. Impacts to quality of service through failure to meet treatment targets. Also, potential for increase in complaints from patients/family. Breach in contract. Reputation amongst other CMGs as an inability to provide a service. Potential to attract media interest. Potential for financial penalties due to inability to meet national targets.	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.	Extreme	Likely	20	1. Recruitment still ongoing - middle grade rota remains with gaps. Recruitment plan in place & interview schedules June & July. Revised review date to reflect interveiw outcomes of 30/08/17 2. 6 additonal ITU beds at LRI to be flexibly opened as staffing and demand indicate but requires Trust Board sign off. review 30/08/17. 3. PACU staff to support 6 bed HÅkanson but to review as poer above. 30/08/17	10	Chris Allsager	Operational Risk

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
2990	CMG 5 - Musculoskeletal & Specialist Surgery (MSK & SS)		There is a risk of delayed outpatient correspondence to referrer/patient following clinic attendance.	02/Mar/17	31/07/2017	Causes: Issues with Dict8 invoices not being paid by Trust Accounts resulting in the suspension of out sourcing services from November 2016 creating a large backlog Due to suspension of outsourcing current staff establishment not able to deliver typing demand. Delay in replacing Dict8 with Dictate IT due to IM&T capacity to support roll out. Planned and unplanned leave for current workforce adding to pressure on service. Extra capacity created to deliver clinical demand on service without uplift of admin team. Consequences: Delayed letter to GP/Patient regarding changes in medication and care plans following clinic attendance resulting in incorrect strength medication being dispensed, length of treatment being extended and DNA/missed appointment not communicated. Delay in referring on to other Departments/Clinical Teams regarding further management required. Increased stress on admin team due to concern over increasing backlog now at approximately 8000 letters with longest letter December 2016. Increased staff sickness	Harm (Patient/Non-patient)	Admin Team have 3 hours a day minimum protected typing time. Bank staff and overtime provided by team weekly Dictate IT - commenced on 20.02.17 plan is for all letters generated from 20.02.17 to be outsourced while admin team catch up with backlog approx. recovery will take 6 weeks to clear back log. After backlog clear percentage of typing will remain outsourced to ensure backlog is not created again.	Maior	Almost certain	20	Overtime and Bank staff to assist typing letter backlog ongoing Admin team to type 8,000 letter backlog until clear - approx. 6 weeks to deliver	3	Clare Rose	Operational Risk

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
2191	CMG 5 - Musculoskeletal & Specialist Surgery (MSK & SS)	Ophthalmology	Lack of capacity within the ophthalmology service is causing delays that could result in serious patient harm.	30/06/2017 12/Jun/13	Causes: Nationally Ophthalmology services have severe capacity constraints. Lack of capacity within our services due to: Lack of Consultant work force Junior Doctor decision makers resulting in increased follow-ups. The current infrastructure is not fit for purpose Follow-ups not protocol led. Consultant annual leave booking adhoc Clinic cancellation process unclear, inadequate communication and escalation. Overbooking of Clinics that are not deliverable as per the template and medical availability Consequences: Backlog of outpatients to be seen, which continues to grow. Risk of high risk patients not being seen/delayed. Poor patient outcomes. Increased complaints and potential for litigation, including SUI's that evidence harm. Reputation damaged PPI compromised Low morale of the whole work force Increased scrutiny from the CQC and CCG's	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.	Maior	Almost certain	20	Post Code Analysis for LTFU adn RTT Incompletes for transfer to Alliance	8	Clare Rose	Operational Risk

Risk ID	CMG	Specialty	Risk Title	Review Date	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
2867	CMG 6 - Clinical Support & Imaging (CSI)	Pathology - Cellular Pathology	If the Mortuary flooring is not repaired, then we will continue to breach Department of Health Building note 20 and the HSAC (Health Services Advisory Committee) advice by exposing staff to harm.	16/06/2016	15/06/2017	Synopsis of Cause: Approximately ten years ago LRI Mortuary received a major refurbishment, this included renewal of floor surfaces in the Post-mortem and Fridge Room. The non-slip, non-porous, chemical and biological resistant floors had a life span estimated to be ten years. Over the past ten years micro-cracks have formed across floor surfaces. Both the Fridge and PM room floors have pronounced gradients to open gullies to assist drainage. Imperfections in the floors from non-critical structural settlement of the building have left areas where fluid has pooled and is unable to drain; these areas have the increased occurrence of cracks that have progressively expanded and led to lifting of the floor. These can be more than a centimetre in width and five to ten centimetres in length and now permanently harbour fluid and other debris. The condition of LRI Post-mortem room floor has, and continues to deteriorate at a significant rate. External contractors have assessed the floor and have confirmed that no external factors have caused the deterioration that is in keeping with a floor that has surpassed its life expectancy.Chemical, Biological and Radiological Hazards: "The progressive deterioration of the Floor surface means it can no longer be effectively cleaned and disinfected. The faults in the floor are providing pockets for fluids containing biological and chemical hazards even after attempts at removal. The predominant hazards are biological pathogens derived from bodily fluids, human tissue and waste. Floors can also be exposed to fixatives, reagents, therapeutically administered radioisotopes and other chemical hazards. Department of Health Building note 20 and the HSAC (Health Services Advisory Committee) clearly state that floors and gullies must be easily cleanable and constructed of non-porous material that does not harbour infection, at present the floor presents a potential source of infection to staff and others which could result in staff absence through illness causing a compromised service and litigation and	Harm (Patient/Non-patient)	"Staff aware of potential hazards, shared at huddles. "The Post-mortem room floor has the larger cracks, areas of lifting and contamination is clearly marked as a high risk area, Mortuary staff are trained in the prevention and control of infection and supervisor visitors within that area. Cracks in the PM room are predominantly above former gullies on the periphery of the room and around drainage areas which have benching preventing access by hoists and foot fall of individuals, thus preventing slips, trips and falls. Those entering the post-mortem room where the greatest risk of infection occurs, wear full PPE and are supervised / trained in the control of biological and chemical hazards. MR has sought advice on temporary solutions from Dave Finch, Facilities LRI and he has confirmed there are no suitable short to medium term solutions. Update Nov 2016: Plans of Mortuary interior arranged by Facilities with options for flooring.	Maior	Almost certain	20	Investigate UHL funding options;Creation and approval of business case: 15/06/2017 Review contingency plan for service whilst work is performed; Completion of replacement floor 15/09/2017. 15.05.2017: C.Whiteley: Project group established; Chaired by C.W, membership includes AMcG, CSI,Estates and IPC. No formal start date identified for commencement of works.Estates completing business case with Cell Path input.The tendering process will follow, planning for an August refit of new floor, inc site survey of GH for business continuity. A monthly update report to sent to HTA.	3	Mike Langford	Operational Risk

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
2940	CMG 7 - Women's and Children's (W&C)	Paediatrics	Risk that paed cardiac surgery will cease to be commissioned in Leicester with consequences for intensive care & other services	08/Jun/17 30/09/2016	Causes of the risk : Outcome of NHS England assessment of Congenital Heart Disease Services against the new standards and their intentions to cease commissioning children's heart surgery in the East Midlands (EMCHC). Consequences of the risk (harm / loss event): Many Children and families within the East Midlands will have to travel further to their nearest paediatric cardiac surgical centre during the most stressful episode of their care. This is particularly difficult when mothers have just given birth and the baby's condition is complex. 12 Paediatric Intensive Care Unit (PICU) beds at Glenfield Hospital will be lost. The loss of a specialist PICU will mean that the children's intensive care will cease to be as attractive a place for our clinical teams to work; we are at risk of losing existing staff and find it harder to attract new staff. The above scenario poses the risk of not being able to sustain a children's intensive care service in Leicester with a subsequent domino effect on other specialist paediatric services including children's general surgery, ear nose and throat surgery, metabolic medicine, fetal and respiratory medicine (for long term ventilated children), children's cancer and the neonatal units. Neighbouring hospitals currently supported by the specialist teams in Leicester are at risk of no longer be able to look for support for their more complex patients from within the East Midlands. These include hospitals in Burton, Coventry, Kettering, Northampton and Peterborough.	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	Extreme	Likely	20	Support session established to aid stakeholders and staff complete consultation questions due 17/07/2017 MP strategy - provision of key information and updates to East Midlands MPs to aid support and for them to complete consultation responses due 30/06/2017 Full and robust response from UHL Trust to consultation questions - to be approved through Trust Governance process from May onwards , with final approval at Trust Board on 2nd June due 23/06/2017 Support for Locum surgical consultant to submit and meet GMC specialist registration due 30/06/2017 Ensure project to relocate EMCHC to Children's Hospital stays within capital budget allocation due 30/04/2019	8	Nicola Savage	Operational Risk

Risk ID	CMG	Specialty	Risk Title	Review Date Opened		Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
2403	Corporate Nursing	Infection prevention	There is a risk changes in the organisational structure will adversely affect water management arrangements in UHL	19/08/2014	30/06/2017	Causes National guidance from the Health and Safety Executive advise that water management should fall under the auspices of hospital infection Prevention (IP) teams. Lack of clarity in UHL water management policy/plan since the award of the Facilities Management contract to Interserve and the previous assurance structure for water management has been removed had meant that a suitable replacement has not yet been implemented. As of May 2016 Interserve no longer provide Facilities Management Services for UHL. The systems and process for water management are being reviewed. This review is expected to be complete by February 2017 Consequences Resources not identified at local (i.e. ward/ CMG) or corporate (e.g. Interserve /IPC) level to perform flushing of water outlets leading to infection risks, including legionella pneumophila and pseudomonas aeruginosa to patients, staff and visitors from contaminated water. Non-compliance with national standards and breeches in statutory duty including financial penalty and/or prosecution of the Chief Executive by the HSE Adverse publicity and damage to reputation of the Trust and loss of public confidence Loss/interruption to service due to water contamination Potential for increase in complaints and litigation cases	Service disruption	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.	Maior	Almost certain	20	Revised Water Management Policy and Water Safety Plan approved by the Trust Infection Prevention Committee. Implementation programme to be confirmed by Facilities colleagues - 30/06/17 It is anticipated that the further mitigation (implementation of a plan) will enable the risk to be reduced by the end of Q1 2017/18 - Liz Collins.	4	Elizabeth Collins	Operational Risk

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
2404	Corporate Nursing	Infection prevention	There is a risk that inadequate management of Vascular Access Devices could result in increased morbidity and mortality	19/08/2014	30/06/2017	Causes: There is currently no process for identifying patients with a centrally placed vascular access (CVAD) device within the trust. Lack of compliance with evidence based care bundles identified in areas where staff are not experienced in the management of CVAD's. There are no processes in place to assess staff competency during insertion and ongoing care of vascular access devices. Inconsistent compliance with existing policies. Consequences: Increased morbidity, mortality, length of stay, cost of additional treatment non-compliance with epic-3 guidelines 2014, non-compliance with criteria 1, 6 and 9 of the Health and Social Care Act 2010 and non-compliance with UHL policy B13/2010 revised Sept 2013, and UHL Guideline B33/2010 2010, non-compliance with MRSA action plan report on outcomes of root cause analyses submitted to commissioners twice yearly	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	Maior	Almost certain	20	Development of an education programme relating to on-going care of CVAD's - 30/06/17. Targeted surveillance in areas where low compliance identified via trust CVC audit - Yet to be established due to lack of staff required. For further review by the Vascular Access Committee - 30/06/17. 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 - 30/06/17.	16	Elizabeth Collins	Operational Risk

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
2471	CMG 1 - Cancer, Haematology, Urology, Gastroenterology & Surgery (CHUGGS)		If the Trust does not invest in upgrading our aged imaging equipment, then we will continue to breach national guidance and Radiotherapy Services specification of 10 years replacement recommendations.	05/Dec/14	30/06/2017	Consequences: In the event of a major breakdown patients would need to be transferred to another radiotherapy centre resulting in inconvenience to the patient with the nearest centre over 30 miles away, and loss of income in the region of £1 million per annum to the trust. Loss of reputation with patients and commissioners using equipment over 10 years old Increased risk of CQC reportable incident due to poor imaging capabilities of the machine. Arrangement to be made with other radiotherapy centres to transfer patients Inability to develop new techniques which have the potential to bring in extra income Dependent upon dose and fractionation this could result in a significant amount of the intended dose being delivered to the wrong area with significant damage to the patient resulting in a reportable incident. Repeated high dose imaging due to deteriorating MV imaging panel increases the risk of exceeding current dose limits. If kV or cone beam imaging is required, patients will need transferring from Bosworth to Varian machines. This transfer process will entail patients missing treatment days to give staff time to produce back-up plans that are labour intensive. There is a risk of increasing waiting times leading to potential breaches in cancer waiting time targets since all complex treatments requiring advanced imaging cannot be performed on Bosworth. Restricted participation in National Clinical Trials, due to lack of current imaging technologies such as cone beam CT.	Harm (Patient/Non-patient)	Increase in imaging dose (up to 10 MU) to produce a usable image. This however restricts the number of times an image may be repeated (due to dose limits). N.B imaging dose of 1MU is used on the Varian treatment machines. Pre-selection of patients with a reduced imaging requirement are booked on Bosworth. However this list is getting fewer and fewer due to best practice and national guidelines. We have introduced long day working on Varian machines to absorb patients that cannot be treated on Bosworth due to imaging limitations Clear Set-Up instructions plus photographs are provided to treatment staff to aid set-up. These do not fully eliminate the risk due to variable patient stability and condition hence the need for on-treatment imaging. Regular update meetings to check on progress of building works	Major	Likely	16	Replacement of Linac - 30/4/17; Building works underway prior to installation of the new Linac all on schedule. Linac due to be delivered at the end of January 2017, completed 04/04/2017. Linac due to be clinical from end of April 2017 following commissioning. Completed 04/04/2017 NHS England's chief executive Simon Stevens, announced on 6th Dec 2016 that Leicester's Hospitals will receive a new linear accelerator (LINAC) as well as the chance to access a share of £200m of NHS England funding over two years to improve local cancer services. Leicester's Hospitals are part of the first wave of 15 NHS Trusts to benefit from a major national investment in NHS radiotherapy machines. Update May 2017 New Linac clinical 15th May 2017. Old Elekta Linac still being used during Varian Linac upgrades in order to maintain capacity. Once upgrades completed on June 30th 2017 the Linac will be taken out of clinical use, and the risk can be closed.	4	Lorraine Williams	Operational Risk

Risk ID	CMG	Specialty	Risk Title	Review Date Opened		Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
2264	CMG 1 - Cancer, Haematology, Urology, Gastroenterology & Surgery (CHUGGS)		If an effective solution for the 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.	31/Jul/17	03/Dec/13	Consequences Difficult to release sister or deputies for non clinical duties due to pt care being priority. Despite existing controls, some shifts manned with one RN from area and 1 borrowed from other wards or agency, leading to acute care being prioritised and other jobs being left. Best Shot and repositioning not completed in timely fashion. All documentation not being completed. IV's being given late. Patients waiting in triage and poor communication regarding progress with beds. . Appraisal rate low, Over due Datix forms Need to close triage due to difficulty in staffing area leading to lack of capacity for emergencies. Triage being regularly opened due to lack of beds which puts extra workload on already minimal staffing levels. Staff moved daily from other areas, resulting in all areas running on or below minimum numbers and struggling to deliver high standards of care. Risk of increase in hospital acquired pressure ulcers, poor standards of documentation, increase in complaints and poor family and friends results. Staff working all shift without a break. Patients waiting in triage for long periods of time and not being monitored appropriately.	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	Likely	16	Corporate HCA recruitment to be a priority for CHUGGS - 31 July 17 Matrons to work adhoc clinical shifts to support wards with high vacancies - 30 Sep 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 July 17 First and second tier agencies to be offered long lines of work for two months in advance, including educational opportunities. 31 July 2017 Explore opportunities for recruiting to non-nursing roles that will support the nursing workforce, such as Ward Clerks and Pharmacy Technicians. 31 Aug 2017. Explore other opportunities for support from other CMG's. 30 June 2017.	6	Georgina Kenney	Operational Risk

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
2819	CMG 2 - Renal, Respiratory, Cardiac & Vascular (RRCV)		If we do not address the shortages of ITU and HDU beds capacity available to Vascular surgery, then we will be more prone to delaying complex and high-risk surgeries at LRI	25/04/2016	01/Jun/17	Causes Lack of beds in ITU and HDU available to Vascular Surgery causing delays to complex, high-risk surgery at LRI. Consequences Mental, emotional and physical impact on patients of having their surgery cancelled at very short notice. Clinical risk associated with rupture of the AAA. Negative impact on RTT performance. Loss of income if patient is transferred to another hospital. Negative effect on the reputation/morale of the Department. Risk of incurring financial penalties resulting from potential 28-day breaches following same-day cancellation. Potential to hinder strategic move to secure complex, Level 1 activity from other Trusts in East Midlands (discussions with some Trusts are underway). Waste of Consultant and Theatre Team resource.	Harm (Patient/Non-patient)	Highlighting of ITU bed requirement day before to Gold Meeting attendee by text via Operational Manager Book ITU bed requirement as soon as the need is identified and await confirmation No business continuity plan - patients would need to be sent to another hospital	Maior	Likely	16	Daily monitoring and escalation from Vascular Surgeons to GOLD if no ITU bed available - 31.5.17 Monthly monitoring of ITU cancellations via Operational Planning Group - 31.5.17 Monthly reporting of ITU cancellations to CMG quality and safety performance meetings (with Exec) - 31.5.17	12	Sarah Taylor	Operational Risk

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
2820	CMG 2 - Renal, Respiratory, Cardiac & Vascular (RRCV)	Clinical Decisions Unit	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	31/Aug/17	Causes of the risk: VTE risk assessment form not completed Lack of understanding or awareness of process to ensure VTE risk assessment form completed to the requirements of National Guidelines (http://guidance. nice.org.uk/CG92) Insufficient communication and reminders of process to relevant staff CDU Medical Clerking Proforma layout results in the VTE risk assessment being missed or delayed completion Consequences of the risk: Potential risk of patient developing VTE, resulting in prolonged length of stay and risk to health Financial loss to the CDU unit and UHL due to VTE risk assessment form not being recorded on patient centre and any Impact on delivery of monthly VTE target of 95% for UHL Impact on quality indicators and maintaining external standards and reputation	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	Maior	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 - 31.8.17	3	Karen Jones	Operational Risk

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
2333	CMG 4 - Intensive Care, Theatres, Anaesthesia, Pain Management & Sleep	Anaesthesia	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	30/06/2017	Causes: Retirement of previous consultants Ill health of consultant Lack of applicants to replace substantively Following NHS England announcement that Paeds Cardiac will close one consultant has resigned leaving the sustainability of the service until closure in April 17 in doubt. Consequences: Need for remaining paeds anaesthetists to work a 1:2 rota on-call Lack of resilience puts cardiac workload at risk May adversely affect the national reputation of GGH as a centre of excellence Current rota non complaint Working Time Directive (WTD) Patients requiring urgent paeds surgery may be at risk of having to be transferred to other centres Income stream relating to paeds cardiac surgery may be subsequently affected Risk of suboptimal patient treatment resulting in harm.	Harm (Patient/Non-patient)	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.	Major	Likely	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/?serviceclosure	8	Chris Allsager	Operational Risk

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
2193	CMG 4 - Intensive Care, Theatres, Anaesthesia, Pain Management & Sleep (ITAPS)	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.	30/06/2017 28/06/2013	Causes: The Theatre and Recovery estate and supporting plant(s) are old, unsupported from a maintenance perspective and not fit for purpose. There is recent history of unplanned loss of surgical functionality at the LRI site due to plant failure, problems with sluice plumbing and ventilation. In addition, the poor quality of the floors, walls, doors, fittings and ceilings mean an unfit working environment from a working life, infection prevention and patient experience perspectives. There is insufficient electricity and medical gas outlets per bed. Aged electrical sockets resulting in actual and potential electrical faults - fire in theatres at LRI (Theatre 4) in July 2013. There have been occasions where the cooling system has failed. There are issues with leaking roofs in the theatre estate. Consequences: Periodic failure of the theatre estate (ventilation etc) so elective operating has to cease. Risk of complete failure of the theatre estate so elective and emergency operating has to stop. Increase risk of patient infections. Poor staff morale working in an aged and difficult working environment. Difficulty in recruiting and retaining specialised staff (theatre and anaesthetic) due to poor working environment.	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.	Major	Likely	16	Ventilation audit actions to be undertaken as per Trust wide working party - Staged approach - short, medium and long term actions to be monitored monthly. Some remedial works completed in LRI Theatres and some floors and doors repaired and replaced. Higher risk areas have had remedial actions to improve ventilation flow and await results. Higher risk anaesthetic room (TH 16) has been tested for nitrous oxide and volatile gases and results demonstrated no risk to patients or staff. On going works and funding to be finalised. Review progress of refurbishment of LRI theatres - 31/03/17 Further update 08/02/17 - Provisional plan once capital agreed to use Theatre 7 and place back into service Theatre 18 to enable rolling programme of maintenance for theatre ventilation works and required upgrades.	4	Gaby Harris	Operational Risk

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
2955	CMG 6 - Clinical Support & Imaging (CSI)		If system faults attributed to EMRAD are not expediently resolved, Then we will continue to expose patient to the risk of harm	17/01/2017	30/06/2017	Causes: Slow and unresponsive radiology reporting system. Unavailability of reports associated with old films / scans. Inability to hold and compare multiple images or use integral work lists. Breast Care Services lost 50% of previous images due to integration failure between breast system (IDI) and GE PACS. Increased system navigation steps has reduced productivity by 50% in some modalities. Inability to use imaging sharing function across consortium. Consequences: Delays to the delivery of clinical diagnosis, treatment and ultimately discharged arrangements due to slow image retrieval system. Unavailability of previous images to be viewed concurrently with recent images enhances the likelihood misdiagnosis on a daily basis. Unable to meet PHE 5 day reporting targets (currently at 12 days) which could result in PHE ceasing UHL screening programme.	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.	Major	Likely	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) - 18th Jun 17. 3. GE to upgrade eRC to version 6.05 to rectify performance issues and crashes (to resolve issues with reporting examinations) - Currently due March (GE currently updating timescales as this was originally scheduled for December) - 31 Jun 17 4. GE to resolve pulling of prior images and integration of IDI with UVWEB for loading mammography images - Ongoing and GE have not provided resolution timeframe. - Awaiting confirmation of dates 5. Review and resolution of system reference data processes and management of central reference data that impacts on patient care - Due to discuss with IT 18th Mar 17, no resolution date agreed. - 18 Jun 17	4	Cathy Lea	Operational Risk

Risk ID	CMG	Specialty	Risk Title	Review Date	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
1206	CMG 6 - Clinical Support & Imaging (CSI)	Cross Sectional Imaging (CT/MRI)	If the backlog of unreported Chest and Abdomen images on PAC'S are not cleared, then we will breach IRMER and Royal College of Radiologist guidelines.	28/07/2009	30/06/2017	Causes Backlog of unreported images on PAC'S (Plain Film, CT, MRI) which could lead to a major clinical risk incident and a potential for litigation and adverse media publicity. Royal College Radiologists guidelines state that all images should be reported IRMER require all images involving ionising radiation to be clinically evaluated Consequences Risk of suboptimal treatment Potential for patient dissatisfaction / complaint Potential for litigation	Harm (Patient/Non-patient)	Ongoing reporting by radiologists and reporting radiographers Allocation of CT/MRI examinations to a intended radiologist or specialty group House keeping done by clerical and superintendents to ensure images are visible on PACS. Outsourcing overdue reporting to medica.	Major	Likely	16	Housekeeping of unreported work by Superintendents - 30/Jun/2017 Use external company for plain xray - 30/Jun/2017	6	ARI	Operational Risk
2378	CMG 6 - Clinical Support & Imaging (CSI)	Pharmacy	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	31/Jul/17	Causes: High levels of vacancies and sickness High levels of activity Training requirements for newly recruited staff Consequences: There is a risk that arises because of pharmacy workforce capacity across multiple teams which will result in reduced staff presence on wards or clinics, as well as capacity for core functions. This will result in reduced prescription screening capacity and the ability to intervene to prevent prescribing errors and other medicines governance issues in a number of areas including some high risk.	Harm (Patient/Non-patient)	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 - 31/07/2017 Recruitment of band 5 and band 7 to vacancies - 31/7/2017	8	Claire Ellwood	Operational Risk

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
2916	CMG 6 - Clinical Support & Imaging (CSI)	Phlebotomy	There is a risk that patient blood samples can be mislabelled impacting on patient safety	11/Aug/16	31/08/2017	Causes 1)problems with ICE printers with occasionally printing out previous patients labels 2) Human error - staff print labels from ICE and manually stick to bag and blood bottles - there is a risk of error if staff do not fully check that the correct label is stuck on the correct sample Consequences (1)That sample has wrong label on and wrong result is processed (2)Time delay for patient if need re bleeding (3)Serious Clinical risk to patient and/or their treatment if error not picked up by lab or checking clinician (4)Psychological harm to staff due to fear and worry that they could cause patients serious harm (5)Potential for compensation claims if harm is caused to a patient (6)Adverse publicity if issue becomes public knowledge	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	6	Debbie Waters	Operational Risk
2391	CMG 7 - Women's and Children's (W&C)		There is a risk of inadequate numbers of Junior Doctors to support the clinical services within Gynaecology & Obstetrics	24/06/2014	30/06/2017	Causes: Currently there are not enough Junior Doctors on the rota to provide adequate clinical cover and service commitments within the specialties of Gynaecology & Obstetrics. Consequences: Impact on key objectives and delivery of service. Potential to lose Junior Drs training within the CMG. Reduced training opportunities and inconsistencies in placements. On call rota gaps/ Increased requirement for locums to fill gaps. Possibility for LETB to remove training accreditation within obstetrics and gynaecology. This will lead to the removal of training posts. Potential for mismanagement / delay in patients treatment/pathway.	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 Trust Grade Post Due 30/06/2017	8	Ms Cornelia Wiesender	

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2153	CMG 7 - Women's and Children's (W&C)	Paediatrics	If we do not recruit into the current Children's Nurses vacancies and effectively manage the return of long term sick staff, then the standard of care provided in the Children's Hospital will be compromised.	05/Mar/13	31/08/2017	Causes The Children's Hospital is currently experiencing a shortfall in the number of Children's registered nurses. This is due to high numbers of vacancies and staff on maternity leave and long term sickness. Consequences There is a short fall in the number of appropriately qualified children's nurses in the Children's Hospital which could impact on the quality of patient care.	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 qualified nurses. Specialise Nurses are helping to cover ward clinical shifts. Cardiac Liaison Team cover Outpatient clinics Overtime, bank & agency staff requested Head of Nursing, Lead Nurse, Matron and ECMO Co-ordinator cover clinical shifts Adult ICU staff cover shifts where possible Recruitment and retention premium in place to reduce turn-off of staff Part time staff being paid overtime Program in place for international nurses in the HDU and Intensive Care Environment Second Registration for Adult nurses in place	Major	Likely	16	Continue to recruit to remaining vacancies - due 31/08/17 Second Registration cohort to complete course - due Sep 2017	8	Hilliary Killer	Operational Risk

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
3008	CMG 7 - Women's and Children's (W&C)	Paediatrics East Midlands Transport Team	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.	07/Jun/17 18/05/2017	The new paediatric critical care transport service will provide a 24/7 acute team and 12-hour repatriation team. The service will launch with a daytime service from mid-March 2017, with a plan for 24-hour operation from later in 2017. NHSE are funding clinicians and equipment to undertake transport. No new funding has been allocated for provision of ambulance vehicles to convey the teams. The expectation that East Midlands Ambulance Service (EMAS) would provide vehicles from within existing resources has proved incorrect. For acute transfers the team will contact EMAS using the 999 system. EMAS will allocate a vehicle based on their service-wide demand for emergency response, including public 999 calls. At times of high demand there may be significant delay (several hours) in a vehicle being deployed. Critically-ill children in non-specialist centres are at significant risk of harm until expert paediatric intensive care is provided. The NHSE service specification says that specialist teams should mobilise within 30 minutes of the decision to transfer, in order to minimise these delays. This requires on-site dedicated vehicles.	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.	Maior	Likely	16	EMPTS working with EMAS and NHSE to develop a solution due 30/09/2017	5	Andrew Leslie	Operational Risk

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2237	Corporate Medical		If a standardise process for requesting and reporting outpatient diagnostic tests is not implemented, then the timely review of diagnostic tests will not occur.	07/Oct/13	30/Sep/17	Consequences Potential for mismanagement of patients to include: Severe harm or death to patient. Suboptimal treatment. Delayed diagnosis. Increased potential for incidents, complaints, inquests and claims. Risk of adverse publicity to UHL leading to loss of good reputation. Financial consequences to include: Potential increase in NHSLA contributions. Potential increased LOS.	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.	Major	Likely	16	Awaiting ICE upgrade and implementation in outpatients - Update, Delivery date for ICE pilot roll out in TBC in near future Dr Steve Jackson and Ann Hall Project Manager will keep corporate risk management team aware - 30/04/17 -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	Angie Doshani	Operational Risk

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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	30/06/2017	Consequences: Potential increased clinical risk in areas. Increase in occurrence of pressure damage and patient falls. Increase in patient complaints. Reduced morale of staff, affecting retention of new starters. Risk to Trust reputation. Impact on Trust financial position due to premium rate staffing being utilised to maintain safety. Increased vacancies across UHL. Increased pay bill in terms of cover for establishment rotas prior to permanent appointments. HRSS capacity has not increased to coincide and support the increase in vacancies across the Trust. Delays in processing of pre employment checks due to increased recruitment activity. Delayed start dates for business critical posts. Benefits of bulk and other recruitment campaigns not being realised as effectively as anticipated and expected. Service areas outside of nursing being impacted upon due to emphasis on nursing roles.	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.	Maior	Likely	16	International recruitment Over recruitment of HCAs in the short term Introduction of new roles across key ward areas Focused recruitment activity Review 30/06/17	12	Maria McAuley	Operational Risk

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
1693	Operations		If clinical coding is not accurate, then income will be affected.	02/Aug/11	30/06/2017	Causes: Casenote availability and casenote documentation. High workload (coding per person above national average). Unable to recruit enough staff to trained coder posts (band 4/5) Inaccuracies / omissions in source documentation (e.g. case notes and discharge summaries may not include co-morbidities, high cost drugs may not be listed). Coding proformas/ tick lists designed (LiA scheme and previously) but not widely used. Electronic coding (Medicode Encoder) implemented February 2012 but has no support model with IM&T. Consequences: Loss of income (PbR) £2-3 million potential (as at 31st May 2016). Non- optimisation of HRG. Loss of Trust reputation.	Financial loss (Annual)	As at May 2017 - 5 Trainee Coders have completed their 21 Day Standards course. All of the trainees who commenced in 2015 have moved into trained Coder role (band 4). We have an Apprentice Coding Trainer and a Qualified Coding Trainer in post. These posts are responsible for increasing clinical engagement with Coding as well as dedicated support to the new Trainees. Additional accommodation at LGH has been found and refurbished for use as a Trainig Room ready for the next 4 trainees who will start in Jun/Jul 2017. Additional accommodation at GH is urgently needed. Additional accommodation at LRI has been found (office swap with Medicine CMG) An audit cycle is established. Coding backlog is being currently at approximately <7 days (7000 cases uncoded). Reduced backlog minimises inefficiencies of multiple casenote transfers. Medicode (the Encoder interfaced to PAS) has been upgraded to the current version. An apprentice Coding runner has been employed to help with transfer of casenotes to the Coders for specific wards. Agency Coders are being used to backfill some of our vacant posts. An enhanced sessional weekend rate for our own trained Coders encourages additional weekend working.	Maior	Likely	16	Work with CMGs / ward clerks to maximise transfer of casenotes to Clinical Coding - 30/06/17 Additional accommodation required at GH site - 31/03/18 Discontinue use of Agency Coders - 31/07/17	8	Shirley Priestnall	Operational Risk

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
2872	CMG 2 - Renal, Respiratory, Cardiac & Vascular (RRCV)		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.	31/Jul/17 27/06/2016	Causes The two final exit doors to fresh air do not have sufficient exit width in order to facilitate the movement of bedded bariatric patients. Also there is a gradient on both escape routes. There must not be excessive gradients on escape routes which would prevent the free and controlled movement of the bariatric patients on beds/trolleys/wheelchairs. The gradients on the two escape routes from the final exits to fresh air will be difficult to overcome as Ward 15 is located at lower ground floor level. If bedded bariatric patients cannot use the two final exit doors they will need to be evacuated via the lift provided which is located in the means of escape outside the Ward; however this lift does not meet the appropriate standard to be used as an evacuation or fire fighting lift. Consequences Bedded bariatric patients not being evacuated to a place of safety in a fire situation. Injury to staff during attempted evacuation – smoke inhalation, manual handling. Gross failure of patient / staff safety if findings not acted on. Critical report from Fire Service (main inspecting body) and other inspectorate bodies. Non-compliance with statutory requirements in the RR Fire Safety Order. Adverse publicity and media coverage.	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.	Extreme	Possible	15	Estates to provide quote to upgrade lift to a suitable dedicated evacuation lift to move bedded bariatric patients from the area - report initially needs to be discussed with the Fire Safety meeting scheduled for 31.7.17 Estates to provide quote to install a new fire escape in bay 2 - 31.12.16 - Update 18 Jan 2017 - Risk Owner has sent an email to estates and facilities requesting a progress update on the two remaining actions. Update 13.2.17. - We have received the Compliance Analyses Report from our consultants and there many areas highlighted that indicate unsuitability for hosting Bariatric Patients on this ward. The report highlights not just fire risk/evacuation concerns but also health and safety issues for staff/patients and patients. There also clinical operational issues that indicate the area unsuitable for these patients at this time according to the relevant compliance documentation. Taking guidance from this report, to bring the Ward into a condition fit for this category of patient will require a considerable capital outlay and an exdended period of works both in and around the ward area.	6	Vicky Osborne	Operational Risk

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
3005	CMG 2 - Renal, Respiratory, Cardiac & Vascular (RRCV)		If we do not recruit and retain into the current Thoracic Surgery Ward RN vacancies, then Ward functionality will be compromise resulting in increased likelihood of incidences leading to patient harm.	27/03/2017	27/06/2017	If we do not recruit and retain into the current Thoracic Surgery Ward RN vacancies, then Ward functionality will be compromise resulting in increased likelihood of incidences leading to patient harm. Causes (hazard) 1.Current RN vacancy level is 6.19 wte , this equates to 25 % of the RN establishment. In addition there is 1.84 wte maternity leave and 0.92 WTE long term sickness = 37% 2.In experienced RN workforce in relation to thoracic speciality, 7.76 wte - 32% have less than 12 months specialty experience 3.Lack of HDU trained RNs: 58% HDU competent Consequence (harm / loss event) 1.Delay in nursing interventions resulting in poor quality nursing care. 2.Increased potential in the incidence of patient harms. 3.Delay in recognising and escalation of the deteriorating patient post -operatively. 4.Delay in the delivery of treatment resulting in a negative/poor patient experience. 5.ITU delay transfers.	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	Moderate	Almost certain	15	Interview date/appt - 30.4.17 Matron working - 27.6.17 Review after closure of ward 23 relocation of staff - 27.6.17	6	Sue Mason	Operational Risk

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
2837	CMG 3 - Emergency & Specialist Medicine (ESM)		If we do not migrate to a automated results monitoring system, Then follow-up actions for patients with multiple sclerosis maybe delayed	09/May/16	30/06/2017	Causes All results are sent as a paper copy to the named consultant's in-tray. There is duplication of workload as results are sent to the same consultant more than once in the space of 2 months even if a result has been noted, acted upon, a letter dictated and filed. The number of patients with multiple sclerosis on disease modifying therapies (DMT) requiring monitoring has significantly increased year on year to now around 500 patients. The number of disease modifying therapies available has increased by 4 in the past year to 12 different options. Each of these disease modifying therapies have varying frequency of blood test and other monitoring investigations. The resulting complexity of monitoring requirements and number of tests sent in the internal post as paper results to be checked by the MS team (2 consultant neurologists and 1.6 WTE MS nurses) increases the risk of results being mislaid or an unacceptable delay in reviewing and acting upon results.	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 30/06/2017. Business Case in development to review 31 Aug 2017	2	Dr Ian Lawrence	Operational Risk

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
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	30/06/2017	Currently Trauma orthopedics has a high number of unfilled qualified posts (experienced band 5 staff nurse) due to a large number of staff having left the unit, moving elsewhere within UHL & maternity leave. Whilst the CMG has been actively trying to recruit to the area with some success and waiting for start dates for Philipino and other internationally recruited nurses the shortfall we are now experiencing whilst waiting for recruits to arrive,is now reaching a point where all the Trauma msk ward areas are finding it extremely difficult to safely cover shifts within the off duty. Ward 32: Has an substantive band 6 Nurse on maternity leave with a band 5 acting up to cover that post. The ward is budgeted for 18.3 WTE band 5s with 12.38 in post. 4 WTE band 5s are waiting to start. One being a clearing house student nurse and will require a 6 month preceptorship. Two are from the Philipino co-hort and will require significant support and a programme of education and training. One has been recruited from another NHS hospital, being the only nurse arriving with an active NMC PIN number 1 band 5 SN is on maternity leave until the Summer. In real terms ward 32 is functioning on 6.26 WTE SN vacancies with 24 funded beds.	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	All band 5 and Band 2 vacancies to be placed on job swap monthly Band 5 and Band 2 vacancies to be declared for the monthly Trust recruitment (international/ national / clearing house) Further Trauma bespoke advert if required Matron / senior nurse on site to review staffing and beds on a daily basis, if unable to achieve minimum staffing levels to escalation to head of nursing for consideration of further bed closures to reflect the staffing available	4	Nicola Grant	Operational Risk

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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.	30/06/2017	29/06/2009	Causes: There are Consultant Radiologists on call however there are not sufficient numbers to provide an on call service. Registrars are available but they have variable experience. Lack of cover for PM work Consequences: Delays for patients requiring Paediatric radiological investigations. Sub-optimal treatment. Paediatric patients may have to be sent outside Leicester for treatment. Potential for patient dissatisfaction / complaints. Consultants are called in when they are not officially on call and they take lieu time back for this, resulting in loss of expertise during the normal working day. Delays in reports for Pathology and Coroner	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/Aug/2017	2	Rona Gidlow	

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
2946	CMG 6 - Clinical Support & Imaging (CSI)	Dietetics	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	30/06/2017	Causes : An increased head and neck cancer caseload over the last 10 years.Head and Neck Cancer MDT historically reviewed 100-120 patients it is now reviewing 140 to 160 patients per annum representing an approx increase of 60% caseload per annum. This increase has been significant for the last 2 to 3 years The current head and neck cancer dietetic service resource consists of 0.6wte band 7 senior specialist Dietitian and 0.5 wte band 6 senior Dietitian.This falls below national dietetic averages for other Trusts / Centres eg some London Trusts have x 3 fold dietetic resource for the same number of patients. The service delivery model has changed in the Head and Neck CNS team (nb now x 2 wte increased from 1 wte in the last year) to all patients being seen by CNS at pre diagnosis and at treatment planning highlighting the need for dietetic input without the dietetic resource in place to meet this need. An additional Consultant in ENT post approved by the Trust without dietetic resourcing built in to meet increased needs; however additional increase in dietetic time was never discussed with dietetic service with this appointment and therefore no additional funding was provided to support the additional consultants work load.	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) Discuss resourcing with MSS CMG Exec team - (No due date assigned) Matter now escalted to CSI HOOPS Matter now escalated to H of S Mr Hayter	2	Cathy Steele	Operational Risk

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
2973	CMG 6 - Clinical Support & Imaging (CSI)	Dietetics	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	30/06/2017	Inadequate Nutrition and Dietetic Service to Adult Gastroenterology Medicine inpatients, outpatients and those attending structure education groups e.g. newly diagnosed coeliac disease patients. due to increases patient activity and number of Consultant Clinicians. 50% increase in referrals to dietetics.	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 qualified 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.	Moderate	Almost certain	15	Need to review dietetic resourcing levels for adult gastro medicine with CHUGGS CMG Exec team - Withdraw FODMAP dietary management for IBS until resourced with adequate dietetic time - To instigate a separate managed dietetic outpatient service with referrals only from Consultant Gastroenterologists and not other members of the MDT as not resourced - Develop virtual telephone outpatient clinics to safely manage outpatient caseload - Implement the Nutrition Liver Care Pathway at ward level for inpatients - Develop a first line ward procedure for consideration of prescribable oral nutritional supplements for acutely admitted IBD inpatients -	6	Cathy Steele	Operational Risk

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2787	CMG 6 - Clinical Support & Imaging (CSI)	Medical Records	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.	31/08/2017 17/02/2016	Causes: Insufficient staffing to manage current levels of activity. Since 2013 all vacancies have been filled with fixed term contracts due to EDRM project. Paediatric EDRM rollout with failure of UHL staff to follow correct new business change processes - has not resulted in the expected reduction in activity. subsequent pause in paediatric EDRM and further delay in Adult EDRM rollout. Consequences: large-scale cancellation of requests, late availability of case notes and subsequent impact to patients including cancellation of procedures and appointments. Insufficient staffing leading to non-compliance with health & safety requirements due to overcrowded library storage areas. Also this increases the potential for increased staff long-term sickness due to musculoskeletal injuries as a result of working environment. increase in complaints about the service.	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.	Moderate	Almost certain	15	- Exec team approved additional staffing to support pause in paediatric EDRM - 3 wte recruited in Feb 2017, 2 more to recruit to, interview taking place in May 2017. Due to length of pause these staff are expected to stay in place until the relaunch has happened - awaiting timeline from IBM - Weekly monitoring of patients TCI cancelled due to notes availability undertaken by med recs management, reported and discussed with each CMG to aid learning with monthly report to CSI exec as part of assurance process - ongoing action no end date EDRM for paeditrics given go ahead Feb 2017 - awaiting update and timeline from IM&T - DW to chase - relaunch group meeting end April 2017, awaiting timeline for relaunch from IM&T expected by June 2017	4	Debbie Waters	Operational Risk

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
2965	CMG 6 - Clinical Support & Imaging (CSI)	Pharmacy	If we do not address Windsor pharmacy storage demands, then we may compromise clinical care and breach statutory duties	31/Jul/17 23/12/2016	Causes: Insufficient floor space within Windsor pharmacy - unable to adequately provide secure storage to meet pharmaceutical demands for the LRI site. There are acute issues with accommodating new treatments or changes to medications that require an increase in storage demands. Insufficient cold storage for pharmaceuticals - Fridges over capacity. Year on year increase in requirements for storage/fridge/freezer space due to changing product lines- this is not a new issue, but significant increase in scale and frequency of issue within Q3 and rapidly worsening position. Consequences: Increased likelihood of patients missing doses due to stock outs as inadequate quantities of some lines being kept. Delay or denial of new treatments due to insufficient suitable storage capacity. Inability to switch to preparations that are safer for patients e.g. ready made injectables due to requirement for increased storage space-this has contributed to an 'Never event'. Potential for statutory breaches resulting in improvement notices and critical reports from General Pharmaceutical Council. Increased wastage of drugs due to poor storage conditions/fridge failure. Economic impact with procuring more expensive drugs that have to be stored at room temperature. Inability to clean the walk-in cold store due to lack of decant facilities.	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.	Moderate	Almost certain	15	Complete Phase 2 of aseptic unit/pharmacy stores redevelopment as per existing business case and 17/18 capital plan - March 2018 Review fridge capacity and where necessary purchase additional fridges once space available through redevelopment (identified within 17/18 plans) - March 2018 Review stockholding-pilot of managed stockholding reduction - complete Identify additional stockholding area external to pharmacy (SUP request submitted and response awaited) Identify items that can be stored out of dept and/or on an alternative site to release capacity - May2017 Implement identified plans to maximise fridge capacity to temporarily mitigate -scope opportunities for further fridges within current space and temporarily use of fridges designated for clinical trials use - May 2017	6	Claire Ellwood	Operational Risk

Risk ID	CMG	Specialty	Risk Title	Review Date Opened		Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
2601	CMG 7 - Women's and Children's (W&C)	Gynaecology	There is a risk of delay in gynaecology patient correspondence due to a backlog in typing	24/08/2015	13/07/2017	Causes: An increase in the number of referrals to gynaecology services. 1.0 wte vacancy of an audio typist. Bank and Agency staff being used to reduce typing backlog are not consistent especially during holiday periods. In addition delays can occur due to Consultants working cross-site and not accessing results promptly in order for the letters to be completed. Consequences: Delay in timely appointment letters to patients Delay in patients receiving results Delay in patients receiving follow up appointments Breach in the Trust standard for typing and sending out of patients letters (48 hours maximum time from date of dictation) As at 21/08/15 - there is a delay in gynaecology correspondence to the patient of: - 8 weeks following a general gynaecology appointment at LRI - 8 weeks for 1st appointment letters for Colposcopy at LRI - 1 week and 5 days for colposcopy result letters at LRI - 10 days for communication to GP with regards to the patient.	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.	Moderate	Almost certain	15	Clearance of backlog of letters - due 13/07/2017	6	DMAR	Operational 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/Jun/17	Cause: IMAN stores the clinical photographs taken by the clinical photographers on behalf of clinical staff requesting them and form part of the patient's medical record. It contains >60,000 images of >9,000 patients since 2009. The hardware is supported by IM&T but is now out of warranty. The application software is no longer supported by its creator SEARCH Technologies (since April 2014). Consequence: If a fault were to occur with the database we cannot fix it. Clinicians would not be able to view the photographs of their patients. Patient safety will be jeopardised.	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.	Moderate	Almost certain	15	Tender document issued July 2016. IM&T support agreed Oct 2016. Preferred supplier chosen Dec 2016. Final costs being agreed Jan-Mar 2017. Funding sought from RIC Apr-May 2017.Funding decision awaited June 2017.	1	Simon Andrews	Operational Risk

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
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/Jul/17	Cause: Risk to inpatients related to parenteral nutrition caused by problems with delays in supply and delivery and delays in administration at ward level. Consequences: such as incidents, catheter related sepsis, reduced patency of central venous catheter, reduced clinical review and monitoring and increased hours of working in pharmacy	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	Operational Risk

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Risk Type
2402	Corporate Nursing	Infection prevention	There is a risk that inappropriate decontamination practice may result in harm to patients and staff	19/08/2014	30/06/2017	Causes: Endoscope Washer Disinfector (EWD) reprocessing is undertaken in multiple locations within UHL other than the Endoscopy Units. These areas do not meet current guidelines with regard to a.Environment b.Managerial oversight c.Education and Training of staff There is decontamination of Trans Vaginal probes being undertaken within the Women's CMG and Imaging CMG according to historical practice, that is no longer considered adequate. Bench top sterilisers within Theatres continue to be used. The use of these sterilisers is monitored by an AED. Purchase of Equipment is not always discussed with the Decontamination Committee. Consequences: Lack of oversight of Decontamination practice across the Trust Equipment purchased may not be capable of adequate decontamination if not approved by Infection Prevention Current Endoscope Washer Disinfectors (EWD) re-processing locations (other than endoscopy units) are unsatisfactory. All of the above having the potential for inadequately decontaminated equipment to be used Patient harm due to increased risk of infection Risk to staff health either by infection or chemical exposure Reputational damage to the organisation Financial penalty Additional cost to the organisation when further equipment must be purchased	Harm (Patient/Non-patient)	Surgical instrument decontamination outsourced to third party provider. Joint management board and operational group oversee this contract. The endoscopy units undergo Joint Advisory Group on GI endoscopy (JAG) accreditation. This is an external review that includes compliance with decontamination standards. Current policy in place for decontamination of equipment at ward level. Equipment cleanliness at ward level is audited as part of monthly environmental audits and an annual Trust wide audit is carried out. Benchtop sterilisers are serviced by a third party Endoscope washer disinfectors are serviced as part of a maintenance contract Lead for Decontamination and Infection prevention team are auditing current decontamination practice within UHL. The responsibility for Decontamination within UHL is shared by the ITAPS Head of Operations and the Director of Infection Prevention (Chief Nurse) A Lead for Decontamination has been appointed a who will report to the CMG Head of Operations/DIPAC and be supported in this role by the Lead for Infection Prevention and the Infection Prevention Team.	Moderate	Almost certain	15	Review all education and training for staff involved in reprocessing reusable medical equipment - 30/06/17 Develop a decontamination plan for the Trust, endorsed via the appropriate Trust forum - 30/06/17 It is anticipated that the further mitigation identified above will enable the risk to be reduced by the end of Q1 2017/18 - Liz Collins.	3	Elizabeth Collins	Operational Risk