INTEGRATED RISK AND ASSURANCE REPORT AS AT 31ST OCT 2017

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

Executive Summary

Context

The purpose of this paper is to enable the UHL Trust Board to review the current position with progress of the risk management agenda, including the 2017/18 Board Assurance Framework (BAF) and the organisational risk register for items with a current rating of 15 and above.

Questions

1. What are the top rated (highest scoring) principal risks on the BAF?
2. What is the progress towards delivering the annual priorities for 2017/18?
3. What new risks, scoring 15 and above, have been entered on the organisational risk register since the previous version?
4. What are the key risk management themes evidenced on the organisational risk register?

Conclusion

1. The highest rated principal risks on the BAF relate to variation between capacity and demand, workforce capacity and capability and delivery of the financial plan. Thematic analysis of the annual priorities with delivering our quality commitment, continue to show there is reliance upon safe implementation of appropriate IM&T electronic observation systems and processes.
2. There are four annual priorities (all with regard to components of the Quality Commitment) which have been assessed as off-track at month end, two of which are forecast to be at risk of non-delivery in 2017/18. All other priorities are rated as on-track for month end and year end. Copies of the current tracker scores, along with more detailed narrative about the annual priorities, are included in the BAF report at appendix one of the paper.
3. There have been no new risks scoring 15 and above entered on the organisational risk register during the reporting period of October 2017. Details of risks scoring 15 and above are included in the risk register dashboard at appendix two of the paper.
4. Thematic analysis of the organisational risk register shows the common risk causation themes as workforce shortages and imbalance between demand and capacity (which correlates to the principal risks on the BAF). Analysis in relation to the typical impact, should the risks identified occur, displays the potential for harm.

Input Sought

The Board are invited to review the content of this report, note the updated position to items on the BAF and advise as to any further action required in relation to principal risks on the BAF and risks recorded on the organisational risk register.

For Reference

Edit as appropriate:

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

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

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

a. Organisational Risk Register [Yes]

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

b. Board Assurance Framework [Yes]

BAF entry	BAF Title	Current Rating
	See appendix one	

3. Related **Patient and Public Involvement** actions taken, or to be taken: [N/A]
4. Results of any **Equality Impact Assessment**, relating to this matter: [N/A]
5. Scheduled date for the **next paper** on this topic: [Monthly to TB meeting]
6. Executive Summaries should not exceed **2 pages**. [My paper does comply]
7. Papers should not exceed **7 pages.** [My paper does not comply]

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **UHL TRUST BOARD**

DATE: **7TH DECEMBER 2017**

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

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

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1 INTRODUCTION

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

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

2. BOARD ASSURANCE FRAMEWORK SUMMARY

2.1 The BAF remains a dynamic and developing document and has been kept under review during October 2017. Executive owners have updated the principal risk ratings and progress with delivering against the annual priorities for 2017/18 on the BAF, with the Executive Boards having corporate oversight to scrutinise and endorse the final version, which is included at appendix one.

2.2 The Board remains exposed to significant risk in the following areas:

- **Quality Commitment – Organisation of Care (Principal risk 2, current rating 20)**: If the Trust is unable to manage the level of emergency and elective demand, caused by an inability to provide appropriate staffing and fundamental process issues, then it may result in sustained failure to achieve constitutional standards in relation to ED; significantly reduced patient flow throughout the hospital; disruption to multiple services across CMGs; reduced quality of care for large numbers of patients; unmanageable staff workloads; and increased costs..
- **Our People - Right people with the right skills in the right numbers (Principal risk 3, current rating 20)**: If the Trust is unable to achieve and maintain staffing levels that meet service requirements, caused by an inability to recruit, retain and utilise a workforce with the necessary skills and experience, then it may result in reduced quality of care for large numbers of patients; extended unplanned service closures and disruption to services across CMGs.
- **We will deliver our Cost Improvement and Financial plans in order to make the Trust clinically and financially sustainable in the long term (Principal risk 11, current rating 20)**: If the Trust is unable to achieve and maintain its financial plan, caused by ineffective solutions to the demand and capacity issue and ineffective strategies to meet CIP requirements, then it may result in widespread loss of public and stakeholder confidence with potential for regulatory action such as financial special measures.

2.3 Other principal risks on the BAF scoring a high rating relate to education and research (concerning objectives in the new 5 year strategy with UoL, which will be discussed at the Trust Board Thinking Day in December 2017, to

agree a plan to deliver, when the current risk position will be reviewed and could revert to a moderate rating if all parties are in agreement), partnerships and integration, and reconfiguration and investment plans. Details of all principal risks on the BAF are included in the dashboard at appendix one.

2.4 Following the change to the annual priority tracker rating methodology in September, four annual priorities (all with reference to components of the Quality Commitment) have been assessed as off-track at month end, two of which are forecast to be at risk of non-delivery in 2017/18. Copies of the current tracker scores, along with more detailed narrative about the annual priorities, are included in the BAF report at appendix one.

3. UHL RISK REGISTER SUMMARY

3.1 For the reporting period ending 31st October 2017, there are 53 organisational risks open on the risk register scoring 15 and above. These organisational risks are described in a dashboard at appendix two.

3.2 There have been no new 'high or extreme' risks (rated 15 and above) entered on the organisational risk register during the reporting period.

3.3 Thematic analysis of the organisational risk register shows the common risk causation themes as workforce shortages and imbalance between demand and capacity. Analysis in relation to the typical impacts, should the risks occur, displays the potential for harm to patients, staff or others.

4 RECOMMENDATIONS

4.1 The TB are invited to review the content of this report, note the updated position to items on the BAF and advise as to any further action required in relation to principal risks on the BAF and items on the organisational risk register.

Appendix 1 - BAF Report

UHL Board Assurance Dashboard: 2017/18							OCT 2017 - FINAL - TRUST BOARD								
Objective	Principal Risk No.	Principal Risk Description	Current risk rating CxL	Target risk rating CxL	Monthly Risk Change	Annual Priority No.	Annual Priority	Current Tracker Rating	Monthly Tracker	Year-end Forecast Tracker	Exec Owner	SRO	Executive Board Committee for Endorsement	Trust Board / Sub-Committee for Assurance
Primary Objective														
QUALITY COMMITMENT: Safe, high quality, patient centered, efficient healthcare	1	If the Trust is unable to achieve and maintain the required levels of clinical effectiveness, patient safety & patient experience, caused by inadequate clinical practice and ineffective information and technology systems, then it may result in widespread instances of avoidable patient harm, leading to regulatory intervention and adverse publicity that damage the Trust's reputation and could affect CQC registration.	4 x 3 = 12	4 x 2 = 8	↔	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	2	↔	2	MD	J Jameson (R Broughton)	EQB	QOC
						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	1	↓	2	CN/MD	J Jameson (H Harrison)	EQB	QOC
						1.2.2 a	We will introduce safer use of high risk drugs **(e.g. insulin)** in order to protect our patients from harm	1	↓	1	MD/CN	E Meldrum / C Free	EQB	QOC
						1.2.2 b	We will introduce safer use of high risk drugs **(e.g. warfarin)** in order to protect our patients from harm	2	↔	2	MD/CN	C Marshall	EQB	QOC
						1.2.3	We will implement processes to improve diagnostics results management in order to ensure that results are promptly acted upon	1	↓	2	MD	C Marshall	EQB	QOC
						1.3	**Patient Experience - To use patient feedback to drive improvements to services and 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	2	↔	2	CN	S Hotson (C Ribbins) (H Harrison)	EQB	QOC
						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	2	↔	2	DCIE / COO	J Edyvean / D Mitchell	EQB	FIC
	2	If the Trust is unable to manage the level of emergency and elective demand, caused by an inability to provide safe staffing and fundamental process issues, then it may result in sustained failure to achieve constitutional standards in relation to ED; significantly reduced patient flow throughout the hospital; disruption to multiple services across CMGs; reduced quality of care for large numbers of patients; unmanageable staff workloads; and increased costs.	5 x 4 = 20	5 x 3 = 15	↔	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	1	↓	1	COO	S Barton	EPB	FIC
OUR PEOPLE: Right people with the right skills in the right numbers	3	If the Trust is unable to achieve and maintain staffing levels that meet service requirements, caused by an inability to recruit, retain and utilise a workforce with the necessary skills and experience, then it may result in extended unplanned service closures and disruption to services across CMGs.	4 x 5 = 20	4 x 3 = 12	↔	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	2	↔	2	DWOD	J Tyler-Fantom	EWB	FIC
						2.2	We will reduce our agency spend towards the required cap in order to achieve the best use of our pay budget	2	↔	2	DWOD	J Tyler-Fantom	EPB	FIC
						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'	2	↔	2	DWOD	B Kotecha	EWB	FIC
EDUCATION & RESEARCH: High quality, relevant, education and research	4	If the Trust does not have the right resources in place and an appropriate infrastructure to run clinical education and research, then we may not maximise our education and research potential which may adversely affect our ability to drive clinical quality, attract and retain medical students and deliver of our research strategy.	4 x 4 = 16	4 x 2 = 8	↑	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	2	↔	2	MD	S Carr	EWB	TB
						3.2	We will address specialty-specific shortcomings in postgraduate medical education and trainee experience in order to make our services a more attractive proposition for postgraduates	2	↔	2	MD	S Carr	EWB	TB
						3.3	We will develop a new 5-Year Research Strategy with the University of Leicester in order to maximise the effectiveness of our research partnership	2	↔	2	MD	N Brunskill	ESB	TB
PARTNERSHIPS & INTEGRATION: More integrated care in partnership with others	5	If the Trust does not work collaboratively with partners, then we may not be in a position to deliver safe, high quality care on a sustainable basis, patients might not be able to access the services that they require and we may not be in a position to meet our contractual obligations.	5 x 3 = 15	5 x 2 = 10	↔	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	2	↔	2	DCIE	J Currington	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	2	↔	2	DCIE	J Currington	ESB	TB
						4.3	We will form new relationships with primary care in order to enhance our joint working and improve its sustainability							
Supporting Objectives														
KEY STRATEGIC ENABLERS: Progress our key strategic enablers	6	If the Trust is unable to secure external capital funding to progress its reconfiguration programme then our reconfiguration strategy may not be delivered.	5 x 3 = 15	5 x 2 = 10	↔	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	2	↔	2	CFO	N Topham (A Fawcett)	ESB	TB
	7	If the Trust does not have the right resources in place and an appropriate infrastructure to progress towards a fully digital hospital (EPR), then we will not maximise our full digital strategy.	3 x 3 = 9	3 x 2 = 6	↔	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	2	↔	2	CIO	J Clarke	EIM&T	FIC
	8	If the Trust is unable to maximise its potential to empower its workforce and sustain change through an effective engagement strategy, then we may experience delays with delivering Year 2 of the UHL Way.	3 x 3 = 9	3 x 2 = 6	↔	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	2	↔	2	DWOD	B Kotecha	EWB	FIC
	9	If operational delivery is negatively impacted by additional financial cost pressures, then the delivery of the requirements of the Carter report will be adversely impacted resulting in an inefficient back-office support function.	3 x 3 = 9	3 x 2 = 6	↔	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	2	↔	2	DWOD/CFO	L Tibbert (J Lewin)	EWB	FIC
	10	If the Trust cannot allocate suitable resources to support delivery of its Commercial Strategy then we will not be able to fully exploit all available commercial opportunities.	4 x 3 = 12	4 x 2 = 8	↔	5.5	We will implement our Commercial Strategy, one agreed by the Board, in order to exploit commercial opportunities available to the Trust	2	↔	2	CFO	P Traynor	EPB	FIC
	11	If the Trust is unable to achieve and maintain its financial plan, caused by ineffective solution to the demand and capacity issue and ineffective strategies to meet CIP requirements, then it may result in widespread loss of public and stakeholder confidence with potential for regulatory action such as financial special measures or parliamentary intervention.	5 x 4 = 20	5 x 2 = 10	↔	5.6	We will deliver our Cost Improvement and Financial plans in order to make the Trust clinically and financially sustainable in the long term	2	↔	2	CFO/COO	P Traynor (B Shaw)	EPB	FIC

*Please be advised that the annual priority tracker rating criteria was adjusted in September following agreement by the Trust Board at a Thinking Day. All tracker ratings prior to September remain on the old rating criteria.

Board Assurance Framework (B A F) Scoring Guidance: For use when reviewing BAF items reported to UHL Committees.

How to assess BAF principal risk rating:

How to assess consequence:
If the described risk was to materialise…What would be the overall typical level of impact to the Trust?

How to assess likelihood:
Taking into account all mitigations that are in place…How likely is this risk to materialise?

The risk rating is calculated by multiplying the consequence score by the likelihood score.

	← Consequence →				
Likelihood	**1**	**2**	**3**	**4**	**5**
↓	**Rare**	**Minor**	**Moderate**	**Major**	**Extreme**
1 Rare	1	2	3	4	5
2 Unlikely	2	4	6	8	10
3 Possible	3	6	9	12	15
4 Likely	4	8	12	16	20
5 Almost certain	5	10	15	20	25

How to assess the BAF annual priority tracker rating:

How to assess current tracker position:
Is what needs to be happening actually happening in practice to aid delivery of the annual priority in 2017/18?

Current Position:

0: Not started
1: Off Track
2: On Track
3: Delivered

How to assess year-end forecast assurance position:
What is the year-end forecast for delivering the annual priority in 2017/18?

Year-end Forecast (from Sept onwards):

0: Not started
1: At risk of non-delivery
2: On Track
3: Delivered

BAF 17/18: As of…	Oct-17											
Objective:	Safe, high quality, patient centered, efficient healthcare											
BAF Risk:	If the Trust is unable to achieve and maintain the required levels of clinical effectiveness, patient safety & patient experience, caused by inadequate clinical practice and ineffective information and technology systems, then it may result in widespread instances of avoidable patient harm, leading to regulatory intervention and adverse publicity that damage the Trust's reputation and could affect CQC registration.											
Annual Priority 1.1.1	We will focus interventions in conditions with a higher than expected mortality rate in order to reduce our SHMI. **Trust QC Aim: SHMI < 99.**											
Objective Owner:	MD		**SRO:**	J Jameson		**Executive Board:**		EQB		**TB Sub Committee**		QOC
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4	4	4	4	2	2					
Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Sept**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4	4	4	4	2	2					

Controls assurance (planning)	Performance assurance (measuring)
Governance: Mortality Review Committee, chaired by Medical Director.	Published Summary Hospital-level Mortality Indictor (SHMI) - </= 99 - Latest published SHMI - 101 (period Apr 16 to March 17) within expected range. *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 (3057).*
Medical Examiner Mortality Screening of In-hospital Deaths.	% of deaths screened - target is 95% of all adult inpatient deaths. 96% of Adult Deaths were screened by the MEs in Q1 (includes Community and ED deaths) 90% of Q2 deaths have been screened to date.
Case Note Reviews using National Structured Judgement Review Tool (SJR) and thematic analysis.	% deaths referred for structured judgement reviews (SJR) have death classification - target is 75% of SJR cases have death classification within 4/12 and all within 6/12 of death. Process commenced 01/04/17. 112 adult cases referred for SJR in Q1 (April = 44; May = 34; June = 36). All of April's deaths should have been classified by end of October To date, details of SJR findings and death classifications have been identified for 30 of the 44 (68%). (GAP) Capacity constraints of both MEs and Admin Team leading to delays with screening of Q2 deaths and following up of Q1 and Q2 SJR outcomes. Bereavement Support Service are seeing an increase in activity.
UHL's Risk Adjusted Mortality Rates (SHMI) monitored using Dr Foster Intelligence and HED Clinical Benchmarking Tools.	UHL's latest rolling 'unpublished' 12 month SHMI July 16 to June 17 is 98.
Five top mortality governance priorities identified through the AQuA comparator report are now standing agenda items at the Mortality Review Committee.	Actions related to CUSUM alerts on track / completed (performance target is all actions on track / completed): April 2017 = Dr Foster CUSUM alert received (Coronary arterosclerosis disease) and actions on track response submitted to CQC on 26th July. July 17 - Dr Foster CUSUM alert received for Coronary Artery Bypass Graft 'Other' received. Response and action plan submitted to CQC on 29th September.
(GAP) ME / M&M administration support.	
UHL "Learning from the Deaths" Work Programme.	

Actions planned to address gaps identified in sections above	Due Date	Owner
Recruit additional Medical Examiners and ME / M&M administration support (risk entry 3079 - current rating = high). 5. Actions in place are recruitment to ME Assistant vacancy – new post-holder due to start 20th November and additional Medical Examiners – Induction Programme in place during November, 2 MEs due to start end of December 2017.	Dec-17	RB
90% of Quarter 2's deaths screened to date which is below the 95% target - Plans in place to address the backlog by end of Quarter 3. Number of completed SJRs for deaths in Quarter 1 still being collated.	Dec-17	RB

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

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

BAF 17/18: As of…	Oct-17											
Objective:	Safe, high quality, patient centered, efficient healthcare											
BAF Risk:	If the Trust is unable to achieve and maintain the required levels of clinical effectiveness, patient safety & patient experience, caused by inadequate clinical practice and ineffective information and technology systems, then it may result in widespread instances of avoidable patient harm, leading to regulatory intervention and adverse publicity that damage the Trust's reputation and could affect CQC registration.											
Annual Priority 1.2.1	We will further roll-out track and trigger tools (e.g. sepsis care), in order to improve our vigilance and management of deteriorating patients. **Trust QC Aim: Reduce incidents that result in severe / moderate harm by further 9%.**											
Objective Owner:	CN/MD		**SRO:**	J Jameson		**Executive Board:**		EQB		**TB Sub Committee**		QOC
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3	3	3	3	3	2	1					
Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4	4	4	4	2	2					

Controls assurance (planning)	Performance assurance (measuring)
Governance: Deteriorating Adult Patient Board - last meeting held 22nd August.	Audit EWS & Sepsis in all adult & paediatric wards in scope; day case, labour ward, CCU and ITU out of scope daily.
Electronic handover supported by NerveCentre.	
Sepsis and AKI awareness and training mandatory for clinical staff.	Review audit results of EWS & Sepsis fortnightly.
Team based training packages for recognition of a deteriorating patient.	Review of Datix reported incidents related to the recognition of the deteriorating patient quarterly - last report to DAPB July 2017.
7 days a week critical care outreach service - launched May 2017.	
Harm review of patients with red flag sepsis who did not receive Antibiotics within 3 hours - reviewed fortnightly by the EWS & Sepsis Review Group.	**Outcome KPIs:** ED KPI 90% of patients with red flag sepsis receive IV antibiotics within 1 hour. TRUST KPIs 95% of patients with an EWS of 3+ appropriately escalated & of those patients with an EWS 3+, 95% screened for sepsis & of those screened for sepsis and identified to have red flag sepsis, 90% receive IV antibiotics within 1 hour.
Roll out of e-obs to the modified National Early Warning Scoring System - with the exception of maternity & ward 27.	
Sepsis e-learning module on HELM - launched July 2017	
(GAP) Deteriorating patient e-learning module - due end of Dec 2017.	**Quality Commitment KPIs:** Q1 position: N/A Q2 position: • Clinical Rules for sepsis (NerveCentre) fully implemented - Complete • Alerts for sepsis (NerveCentre) fully implemented - outstanding: revised implementation date dependant upon outcome of sepsis assessment forms testing • Trust wide implementation of e-Obs (NerveCentre) - outstnading: revised implementaiton date end of Nov 2017 • Fully automated EWS reporting (NerveCentre) - Complete Q3 position: • Assessments for sepsis (NerveCentre) fully implemented • Fully automated Sepsis reporting (NerveCentre) Q4 position: N/A
EWS & Sepsis audit results reported to CQC monthly.	
Sepsis screening tool and care pathway - updated & relaunched July 2017	
Review of admissions to ITU with red flag sepsis at all 3 sites monthly.	
Monitoring of SUIs related to the deteriorating patient.	
(GAP) Latest version of NerveCentre mobile app to be deployed trust wide (6/11/2017) to enable alerts for sepsis to go live.	
(GAP) Sepsis assessment form to go into test environment (wc 6/11/2017) prior to trust wide deployment.	
(GAP) e-Obs (MEOWS) to undergo further testing (wc 6/11/2017) prior to trust wide deployment.	
GPAU to go live with NerveCentre EDWISE - 13/11/2017. Will enable deployment of e-Obs in GPAU in Dec 2017.	

Actions planned to address gaps identified in sections above	Due Date	Owner
Develop content for deteriorating patient e-learning module	31/12/2017	JJ

Deploy NerveCentre mobile app - to enable alerts for sepsis to go live		06/11/2017	JB
Trust Sepsis assessment form to go into test environment (w/c 6/11/2017) prior to trust wide deployment		06/11/2017	JB
Further testing of e-Obs (MEOWS) prior to trust wide deployment		06/11/2017	JB
Corporate Oversight (TB / Sub Committees)			
Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	QOC	Oct-17	This priority is tied into the overall IT strategy that is planning to further develop NerveCentre and this detail has yet to be agreed.
Independent (Internal / External Auditors)			
Source:-	Title:	Date:	Feedback:
Internal Audit	Internal Audit Report 2017/2018 CQC Follow up review	Oct-17	2 low risk findings identified - none relating specifically to the deteriorating patient actions.

BAF 17/18: As of…	Oct-17											
Objective:	Safe, high quality, patient centered, efficient healthcare											
BAF Risk:	If the Trust is unable to achieve and maintain the required levels of clinical effectiveness, patient safety & patient experience, caused by inadequate clinical practice and ineffective information and technology systems, then it may result in widespread instances of avoidable patient harm, leading to regulatory intervention and adverse publicity that damage the Trust's reputation and could affect CQC registration.											
Annual Priority 1.2.2 (a) Insulin	We will introduce safer use of high risk drugs (e.g. **insulin**) in order to protect our patients from harm. **Trust QC Aim: Reduce incidents that result in severe / moderate harm by further 9%.**											
Objective Owner:	MD/CN	**SRO Insulin:**		E Meldrum / C Free		**Executive Board:**		EQB		**TB Sub Committee**		QOC
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3	3	2	2	2	2	1					
Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4	3	2	3	2	1					

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

Actions planned to address gaps identified in sections above	Due Date	Owner
This project has an agreed action plan, to implement fit for purpose electronic systems, monitored through Quality Commitment oversight group and the Diabetes Inpatient Safety Committee.	Mar-18	EM
Reducing number of severe inpatient hypoglycaemia episodes by 20%. It has been agreed that this KPI will be difficult to achieve by year end. Baseline data for this is going to come from NerveCentre but is being manually inputted by nursing staff once they have taken the patients Capillary Blood Glucose (CBG). The data report for all CBG recorded on Nerve Centre (NC) <3.0 is now set up so reports can be run. However there is likely to be significant under-reporting as not all clinical areas are up to speed with manually entering all CBG on to NC.		EM
To have no in hospital Diabetic Ketoacidosis (DKA) "events" in quarter 4. To date there is approximately one inpatient DKA incidences per month reported across the Trust, but again there are concerns that these events are under-reported. The team have experienced delays in developing and implementing a Trust Comms publicity campaign in parallel with key educational messages delivered to all staff to eradicate DKA. However, a 'Pulse Check' and staff knowledge survey which includes questions on DKA has been circulated Trust wide in line with the original action plan. A more structured review process for any in-hospital DKA event (similar to pressure ulcers and falls) has been developed and will be ready for use in December 2017.		EM

Corporate Oversight (TB / Sub Committees)			
Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	QOC	Oct-17	Despite the KPIs being at significant risk of not being achieved by year end, there is a significant amount of work being undertaken by the diabetes team to provide assurance that pace with the above initiatives has increased and work is progressing to ensure staff have the knowledge and skills to effectively manage patients with diabetes. All hypoglycaemic episodes that are manually recorded on Nerve Centre are now being proactively reviewed by the diabetes team on a daily basis and this is proving to be invaluable in terms of pinpointing deficits in staff knowledge ward by ward and for individual practitioners. Clearly as reporting increases, continuing this face to face contact will be challenging but improvements in staff knowledge and actions to prevent hypoglycaemia are being seen with this approach. Progress with the numbers of staff completing the externally hosted Insulin Safety e-learning module is good with 1100 clinical staff completing the training since April 2017. A Trust wide theoretical assessment for registered nurses and HCAs to assess knowledge around insulin safety and blood glucose monitoring commenced in August 2017 led by the Advanced Practitioner for Diabetes and Nurse Education Leads focusing on the CHUGGs and RRCV CMGs and this will be evaluated at the end of November in terms of numbers and

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…	Oct-17											
Objective:	Safe, high quality, patient centered, efficient healthcare											
BAF Risk:	If the Trust is unable to achieve and maintain the required levels of clinical effectiveness, patient safety & patient experience, caused by inadequate clinical practice and ineffective information and technology systems, then it may result in widespread instances of avoidable patient harm, leading to regulatory intervention and adverse publicity that damage the Trust's reputation and could affect CQC registration.											
Annual Priority 1.2.2 (b) Warfarin	We will introduce safer use of high risk drugs (e.g. **warfarin)** in order to protect our patients from harm. **Trust QC Aim: Reduce incidents that result in severe / moderate harm by further 9%.**											
Objective Owner:	MD/CN	**SRO Warfarin:**		C Marshall		**Executive Board:**		EQB		**TB Sub Committee**		QOC
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4	3	3	3	2	2					

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

Actions planned to address gaps identified in sections above	Due Date	Owner
Content for e-learning module under development.	Nov-17	CM
On-going to review antidote availability and usage in the ED for patient with anticoagulant related haemorrhage.		CM

Corporate Oversight (TB / Sub Committees)			
Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	QOC	Oct-17	WARFARIN: The project is making good progress with KPIs all on trajectory to reach target level by project end date. Anticoagulation services have now moved into the community under primary care with the anticoagulation nurses now taking on in-reach roles within UHL to tackle difficult and complex cases on our wards. The anticoagulation discharge summary is now fully implemented. Remaining work-streams to be implemented are development of an e-learning tool for HELM; and more work needs to be done with antidote availability and usage in the ED for patient with anticoagulant related haemorrhage. These last two areas will be the focus of the QC oversight group's work going forwards.

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…	Oct-17											
Objective:	Safe, high quality, patient centered, efficient healthcare											
BAF Risk:	If the Trust is unable to achieve and maintain the required levels of clinical effectiveness, patient safety & patient experience, caused by inadequate clinical practice and ineffective information and technology systems, then it may result in widespread instances of avoidable patient harm, leading to regulatory intervention and adverse publicity that damage the Trust's reputation and could affect CQC registration.											
Annual Priority 1.2.3	We will implement processes to improve diagnostics results management in order to ensure that results are promptly acted upon. **Trust QC Aim: Reduce incidents that result in severe / moderate harm by further 9%.**											
Objective Owner:	MD		**SRO:**	C Marshall		**Executive Board:**		EQB		**TB Sub Committee**		QOC
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Controls assurance (planning)	Performance assurance (measuring)
Governance: Acting on Results programme board and task and finish groups to report to EQB quarterly.	(GAP) Development of metrics for monitoring performance against target. % of results acknowledged - target is 85% of results acknowledged by Q4 2017/18.
UHL diagnostic testing policy	
Acting on results detailed action plan monitored via EQB. This covers: developing a fit for purpose electronic system to acknowledge results; in depth work with each specialty to develop standard operating procedures; review of radiology and MDT processes; human factors review of our results reporting service; reviw of how urgent resutls are escalated with a view to putting them on NerveCentre; increasing patient involvement; and improved training in how to use ICE for results acknowledgment.	
(GAP) Conserus (alert email to clinician for unexpected imaging results) pilot in CDU (highest risk area) prior to Trust roll-out.	

Actions planned to address gaps identified in sections above	Due Date	Owner
Although IT resource has been allocated to the project – this has raised an issue which may critically affect the planned Mobile Ice pilot: a new technical design is required. Mobile ICE cannot be piloted until this is resolved. There is a further delay with Conserus deployment due to a Patient Safety Risk identified by the Supplier McKesson which they need to resolve. No time scales for full roll-out given to date. Once timescales are available from IT a more precise end of year delivery forecast will be available. Currently graded as green as the project will be able to deliver provided these issues are scheduled in the IT work-plan in a timely fashion. However, if this is not the case this may move to a red rating.	Review monthly	CM

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

TB sub Committee	QOC	Oct-17	Roll out of Conserus radiology solution for reporting unexpected findings to clinicians has been delayed due to technical issues. An electronic solution using Mobile ICE is due to be piloted pending allocation of IT resource to project. 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…	Oct-17											
Objective:	Safe, high quality, patient centered, efficient healthcare											
BAF Risk:	If the Trust is unable to achieve and maintain the required levels of clinical effectiveness, patient safety & patient experience, caused by inadequate clinical practice and ineffective information and technology systems, then it may result in widespread instances of avoidable patient harm, leading to regulatory intervention and adverse publicity that damage the Trust's reputation and could affect CQC registration.											
Annual Priority 1.3.1	We will provide individualised end of life care plans for patients in their last days of life (5 priorities of the Dying Person) in that our care reflects our patients' wishes. **Trust QC Aim: >75% of patients in the last days of life have individualised End of Life Care plans.**											
Objective Owner:	CN		**SRO:**	C Ribbins / S Hotson		**Executive Board:**		EQB		**TB Sub Committee**		QOC
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Controls assurance (planning)	Performance assurance (measuring)
Governance: Palliative & End of Life Care Committee meets bi-monthly.	**Quality Commitment KPIs**: (GAP) Patients in the last days of life will have an individual care plan in place as per the "One Chance to Get it Right" Guidance (2014): Care plan implemented in 75% of wards in new CMG and care plan sustained in 75% of CMG wards already implemented on.
Detailed project plan presented at the Palliative & End of Life Care Committee.	
End of life care plans which include specialist palliative care end of life care service.	
End of Life Care Facilitators rolling out implementation of taining and support in the use of End of Life care plans (reflected in the detailed project plan).	Review of Datix reported incidents related to the syringe drivers - last report to P&EoLCC July 2017.
"Guidance for care of patients in the last days of life" & "Individualised End of Life Care Plan" reviewed by the Palliateive & End of Life Care Committee - awaiting P&GC approval.	EoLC audits quarterly - Q1 results available, to be reported at the November 2017 P&EoLCC.
(GAP) Implementation of an electronic system - NerveCentre functionality enabled, further training & testing required.	EOLC facilitators attending board rounds (on implementaiton rollout wards) to ensure clinical teams are recognise dying patients.

Actions planned to address gaps identified in sections above	Due Date	Owner
Implementation of an electronic system - NerveCentre functionality to be tested and training deployed	tbc	RB

Corporate Oversight (TB / Sub Committees)

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

Independent (Internal / External Auditors)

Source:-	Title:	Date:	Feedback:
Internal Audit	Internal Audit Report 2017/2018 CQC Follow up review	Oct-17	2 low risk findings identified - none relating specifically to the EoLC actions

BAF 17/18: Version	Oct-17											
Objective:	Safe, high quality, patient centered, efficient healthcare											
BAF Risk:	If the Trust is unable to achieve and maintain the required levels of clinical effectiveness, patient safety & patient experience, caused by inadequate clinical practice and ineffective information and technology systems, then it may result in widespread instances of avoidable patient harm, leading to regulatory intervention and adverse publicity that damage the Trust's reputation and could affect CQC registration.											
Annual Priority 1.3.2	We will improve the patient experience in our current outpatients service and begin work to transform our outpatient models of care in order to make them more effective and sustainable in the longer term. Trust QC Aim: outpatients tba											
Objective owner:	DCIE		**SRO:**	J Edyvean / D Mitchell		**Executive Board:**		EQB		**TB Sub Committee**		IFPIC
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Controls assurance (planning)	Performance assurance (measuring)
Governance: Outpatient Performance Board & Executive Quality Board.	Patients waiting in excess of 12 months for a follow up (KPI trajectory: Q1-379 currently amber rating of 3;Q2-321; Q3-189; Q4 - 0 Year end position on track).
(GAP) Generate additional capacity and book patients in time order.	
Long term follow up report which allows us to track performance.	Outpatients Friends and Family Test - Red if <93%.
Agreed action plan in place and monitored through the Outpatient Quality report and this is monitored at CPM and in contracting meetings.	Clinical audit of additional schemes related to changes in the new to follow up ratio - Completed as planned.
(GAP) 50% of remaining outpatients opportunity to be added to the PMTT.	Q2 Finalise and Agree KPI's (GAP) and programme plan, Q3 Initiate delivery, Q4 speciality delivery (GAP scale of delivery).
Milestone plan agreed at Trust Board and Executive Performance Board	
Quarterly report to Quality and Outcomes Committee (First report February 2018)	(GAP) Delivery of CMG plans for ENT and Cardiology dependent on resources being released at speciality level to deliver changes.

Actions planned to address gaps identified in sections above	Due Date	Owner
Develop detailed service specific plans for ENT and cardiology, assess the level of resources/expertise required to deliver those plans and undertake a gap analysis.	Q3 17/18	JE
Issues identified at LiA events around the ability to deliver sustainable change. OD Team support in place. Cultural audit to be undertaken October 2017.	Q3 17/18	JE

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	QAC	Oct-17	Year end position deliverable with high risk associated due to resources and capacity to deliver the scale of ambition and the cultural change across the organisation to sustain transformation. Report to Quality and outcomes meeting due in February 2018.

Independent (Internal / External Auditors)

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

External Audit	work plan TBA		

BAF 17/18: Version	Oct-17											
Objective:	Safe, high quality, patient centered, efficient healthcare											
BAF Risk:	If the Trust is unable to manage the level of emergency and elective demand, caused by an inability to provide safe staffing and fundamental process issues, then it may result in sustained failure to achieve constitutional standards in relation to ED; significantly reduced patient flow throughout the hospital; disruption to multiple services across CMGs; reduced quality of care for large numbers of patients; unmanageable staff workloads; and increased costs.											
Annual Priorities 1.4.1	Organisation of Care - We will manage our demand and capacity to improve our Emergency flow (4 hour wait target): 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**		FIC / QOC
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Controls assurance (planning)	Performance assurance (measuring)
Submission of demand and capacity plan to NHSI – We are forecasting an overall peak bed shortfall of 105 beds. The major shortfalls are in medicine at the LRI and Glenfield.	ED 4 hour wait performance trajectory submitted to NHSI - Performance currently below national benchmark.
	Ambulance handover (delays over 60 mins) submitted to NHSI.
New ED building open to public from 26th April 2017.	RTT Incomplete waiting times trajectory submitted to NHSI.
Demand and Capacity Governance structure progressed.	2WW for urgent GP referral as per the NHSI submitted trajectories.
Programme Director appointed.	31 day wait for 1st treatment as per submitted NHSI trajectories.
Theatre trading model in place along with ACPL targets.	62 day wait for 1st treatment as per submitted NHSI trajectories.
Ward 7 moves to Ward 21 and becomes a medical ward in the recurrent baseline (+28 beds)	105 bed gap mitigated.
	Reduced cancelled operations due to no available bed.
(GAP) Staffing of additional 8 beds on the medicine emergency pathway at LRI on Ward 7 to meet continued demand in medicine.	Occupancy of 92% (as of June 2017).
	ACPL target achieved.
Plan for elective service changes at LGH involving MSS & CHUGGs.	The demand and capacity plan is not currently balanced for the year.
Re-launch of Red 2 Green & SAFER within Medicine at LRI.	
Launch of Red 2 Green & SAFER at Glenfield.	
A staffing plan from Paediatrics for Winter 17/18.	
Care model and a detailed plan for stepdown facility.	
Feasibility work commenced into physical capacity solutions for both LRI & GH. Decision on option for physical expansion at GH.	
(GAP) Out of hospital step-down solution at LRI for Winter 17/18.	
Population of additional evening and overnight senior medical shifts in ED.	

Daily Improvement meeting chaired by the Chief Executive with ED colleagues working with clinical teams in the component parts of the UEC system.	

Actions planned to address gaps identified in sections above	Due Date	Owner
Implementation of a new model of care for Acute medicine at LRI	Complete	LW
Implementation of a new model of command and infrastruture across the Trust	Dec-17	TL
Opening of 14 extra beds at GH from 5/12	Dec-17	SB
Implementation of electronic bed management system across UHL	Dec-17	JS
Additional weekend imaging to achieve 1 day turnaround for all inpatient imaging	Dec-17	SB
Opening of the new GP Ambulatory unit (GPAU)	Nov-17	TL

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

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…	Oct-17											
Objective:	Right people with the right skills in the right numbers											
BAF Risk:	If the Trust is unable to achieve and maintain staffing levels that meet service requirements, caused by an inability to recruit, retain and utilise a workforce with the necessary skills and experience, then it may result in extended unplanned service closures and disruption to services across CMGs.											
Annual Priority 2.1	We will develop a sustainable workforce plan, reflective of our local community which is consistent with the STP in order to support new, integrated models of care											
Objective Owner:	DWOD		**SRO:**	J Tyler-Fantom		**Executive Board:**		EWB		**TB Sub Committee**		FIC
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4	4	4	4	2	2					
Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3	3	3	3	3	2	2					

Controls assurance (planning)	Performance assurance (measuring)
Workforce plan relating to reduction in dependency on non contracted workforce, safe staffing, review of urgent and emergency care, impact of seven day services, shift of activity into community settings and increased specialised services where appropriate.	Apprenticeship levy - 430 predicted in 17/18 against 334 target. Currently falling short of TNA for range of reasons including lack of sign off of trailblazer programmes.
	BME Leadership - target 28%
People strategy and programme of work to address the leadership priorities, wellbeing of our workforce and ensure we focus on addressing actions to improve the diversity of our workforce - UHL Leadership programme.	Workforce sickness - target 3% - reporting for Estates and Facilities not adequate and when introduced will affect sickness levels.
	Safe Staffing targets: in accordance with Nursing requirements
Governance structure in place comprising internal and external groups, including Workforce OD Board and the Local Workforce Action Board and subgroups thereof who oversee delivery of the workforce and organisational development components of the Sustainable Transformation Plan.	Seven day services stats:
	Shift of activity in to community:
Apprenticeship workforce strategy.	(GAP 6) Reduction in dependency of our non-contracted workforce - forecast to achieve NHSI target of £20.6 m but run rate suggests a gap of 1.5m at end of year 17/18. £770K medical agency expenditure reduction.
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 7) Vacancy rates -target below 10% (equivalent to turnover to be proposed and agreed).
(GAP 1) STP refresh in progress – to provide a more accurate workforce prediction based on current capacity requirements - (revised deadline to be confirmed but likely to relate to revised consultation deadlines) - UHL revised their component following demand and capacity review - planning underway across Health Community.	
(GAP 2) insufficent resource to support system wide workforce planning and modelling approach - business case submitted to CSU. In place in some parts (Cardio Respiratory model of care) - complete - all other workstreams to develop a workforce plan.	

(GAP 3) Engagement of UHL planning leads in workforce approach to ensure triangulation with activity modelling - due June 2017 Will be required for new planning round for 18/19 and 19/20. Planning parameters to be agreed by Executive Team- early discussion taken place.	
(GAP 4) Predictive workforce modelling - Emergency and Urgent Care Vanguard commenced - revised deadline tbc.	
(GAP 5) ability to close nursing recruitment gaps particularly impacted by decline in supply of European nurses, higher turnover of EU nurses and slower entry of overseas nurses into workforce as a result of IELTs. Tommorows Ward Programme currently being set up to reduce demand for nursing.	

Actions planned to address gaps identified in controls and assurances sections above	Due Date	Owner
GAPS 1 and 3- Whole systems approach to STP workforce plan underway with greater engagement from clinical workstreams to understand the impact	Mar-18	LG
GAP 2 - Bid submitted to STP Programme Office for additional resource, in interim use of external partner to enable high level planning to be undertaken	Mar-18	LG
GAP 4 - Urgent and Emergency Care Workstream utilising Whole Systems Partnership to predict activity and impact on capacity	Dec-17	Urgent Care w-tream
GAP 5 - Undertaking Tomorrow's Ward planning to ensure better ward capacity- working with regulators to ensure safe and high quality care is provided	Mar-18	EM
GAP 6 - Focus on specific plans for reduction on high earner and long term agency bookings ensuring recruitment/ replacement plans are in place	Mar-18	CB

Corporate Oversight (TB / Sub Committees)

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

Independent (Internal / External Auditors)

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

BAF 17/18: As of…	Oct-17											
Objective:	Right people with the right skills in the right numbers											
BAF Risk:	If the Trust is unable to achieve and maintain staffing levels that meet service requirements, caused by an inability to recruit, retain and utilise a workforce with the necessary skills and experience, then it may result in extended unplanned service closures and disruption to services across CMGs.											
Annual Priority 2.2	We will reduce our agency spend towards the required cap in order to achieve the best use of our pay budget											
Objective Owner:	DWOD		**SRO:**	J Tyler-Fantom		**Executive Board:**		EPB		**TB Sub Committee**		FIC
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3	3	3	3	3	2	2					

Controls assurance (planning)	Performance assurance (measuring)
NHSI overall agency cap is £20.6m for 2017/18, specific target for medical agency reduction is £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. Forecast to achieve NHSI target of £20.6m but run rate suggests a gap of £0.6m at the end of year 17/18.
Monitoring of agency cap breaches to NHSI weekly.	Medical Agency Dashboard to Medical Oversight board.
Medical Oversight Broad established.	(GAP) Regional deliverables, including regional rate card, to be defined through regional working group in line with TOR - in development.
(GAP) Regional MOU and establishment of a regional working group for medical agency.	(GAP) No. of retrospective bank and agency bookings reported through to Premium Spend Group - target to be determined.
Monitoring of agency spend and tracker (including data analysis which shows reasons for request and rates of use by ward level) through Premium Spend Group with EWB, EPB, IFPIC oversight - There is a detailed agency action tracker in place, with monitored actions against agreed activities to reduce agency expenditure.	
Agreed escalation processes / break glass escalation control.	
Review of top 10 agency highest earners and long term through ERCB linking to vacancy positions and CMG recruitment plans.	
Process for signing off bank and agency staff at CMG level through Temporary staffing office following appropriate senior approval.	
Nursing rostering prepared 8 weeks in advance.	
Monthly premium spend meeting to monitor progress via agency tracker.	
No agency invoice is paid without booking number.	

Actions planned to address gaps identified in sections above	Due Date	Owner
Work on-going through regional MOU workstream - Trust /supplier engagement event on 20th Oct - actions confirmed.	31.12.17	LT/JTF

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

TB sub Committee	Audit Committee		
TB sub Committee	FIC	Oct-17	The agency ceiling target is £20.6m . At the current run rate agency spend will exceed the annual ceiling by £0.6m at year end. A significant number of controls and mechanisms are in place to monitor and reduce agency spend linked to recruitment activity, which are managed through the Premium Spend Group (PSG) with oversight from the WF and OD board, EPB and EWB. Monthly planned agency spend was adjusted upwards for the new plan in 17/18 to bring in line with current spend. The plan shows a trajectory downwards across the year in order to meet the Trust's agency ceiling /cap.

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

BAF 17/18: As of…	Oct-17											
Objective:	Right people with the right skills in the right numbers											
BAF Risk:	If the Trust is unable to achieve and maintain staffing levels that meet service requirements, caused by an inability to recruit, retain and utilise a workforce with the necessary skills and experience, then it may result in extended unplanned service closures and disruption to services across CMGs.											
Annual Priority 2.3	We will transform and deliver high quality and affordable HR, OH and OD services in order to make them 'Fit for the Future'											
Objective Owner:	DWOD		**SRO:**	B Kotecha		**Executive Board:**	EWB		**TB Sub Committee**	PPPC		
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	3	4	4	4	2	2					
Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3	3	4	4	4	2	2					

Controls assurance (planning)	Performance assurance (measuring)
Vision and programme plan in place (transforming HR Function) - HR Fit for the future programme roadmap.	Staff engagement staff survey score.
Maximising use of Technology (enabling processes).	(GAP) HR KPIs aligned to HR Roadmap (to be developed): Processes - Structure - People & Culture - Technology -
Listening Events held in July 2017 to work with stakeholders and customers to deliver service differently and to gain ownership.	
(GAP) Redefine and Up skill staff within the Service in order to be fit for the future: UHL Way Annual Priorities Map agreed: HR / OD Team have undergone development in UHL Way during June and will be supporting transformation aspects of UHL priority delivery.	(GAP) Reporting completion of statutory and mandatory training and essential to job training.
(GAP) Delivery structures not fit for purpose until target operating model has been developed - target operating model will be informed by feedback from listening events in July.	
(GAP) Full implementation of new Health Education Learning Management System - Additional implementation funds agreed by CMIC in September 2017.	

Actions planned to address gaps identified in sections above	Due Date	Owner
People Strategy currently being finalised	Dec-17	LT
HELM Action Plan agreed and weekly progress updates provided to Executive Team	Weekly	LT

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	PPP Committee	Oct-17	Update concerning HELM Recovery Action and contingency plans.

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…	Oct-17											
Objective:	High quality, relevant, education and research											
BAF Risk	If the Trust does not have the right resources in place and an appropriate infrastructure to run clinical education and research, then we may not maximise our education and research potential which may adversely affect our ability to drive clinical quality, attract and retain medical students and deliver of our research strategy.											
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**		
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Controls assurance (planning)	Performance assurance (measuring)
Medical Education Strategy to improve learning culture.	GMC/ HEE regional meeting scheduled for 21/09/17 to review progress against action plans for all Trusts visited.
Medical Education Quality Improvement Plan.	
(GAP) Transparent and accountable SIFT funding / expenditure in CMGs.	Leicester Medical School feedback (satisfaction / experience) - areas for improvement in 17/18 plan.
(GAP) UHL Multi-professional education facilities strategy to progress EXCEL@UHL.	
	UHL UG education quality dashboard (satisfaction / experience) - to be launched in Sept 17 - Draft to be submitted to EWB in Oct - outcomes available in Oct 17.
(GAP) CMG ownership of undergraduate education outcomes.	
(GAP) Overarching strategy with University of Leicester to integrate undergraduate and postgraduate training to improve outcomes and retention.	GMC National student survey (satisfaction / experience) - 2017 survey headlines show a decline in Overall Satisfaction for UoL.
MJPCC - either SC or DL to attend future meetings with details of individual's educational roles. This will be used to confirm and inform the job plan.	Currently <20% medical students complete the end of block feedback. The Medical School have agreed to address and improve this. We anticipate improvement by Dec 17.
UG representatives on the UHL Doctors in Training Committee.	
	(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'.

Actions planned to address gaps identified in sections above	Due Date	Owner
UG Quality dashboard will be shared with CMG Education Leads	Dec-17	SS/JK
Ongoing discussions between HEE and UoL to confirm Quality Management Visit process		HEE/UOL
SIFT funding and the facilities strategy was discussed at Trust Board on 05/09/17- please refer to actions from the meeting		SC/LT/PT
The UHL/UoL Strategic Group is developing the overarching strategy.	Mar-18	Strategic Group

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…	Oct-17											
Objective:	High quality, relevant, education and research											
BAF Risk	If the Trust does not have the right resources in place and an appropriate infrastructure to run clinical education and research, then we may not maximise our education and research potential which may adversely affect our ability to drive clinical quality, attract and retain medical students and deliver of our research strategy.											
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**		
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3	3	3	3	3	2	2					
Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4	4	4	4	2	2					

Controls assurance (planning)	Performance assurance (measuring)
Medical Education Strategy to address specialty-specific shortcomings.	GMC/ HEE regional meeting scheduled for 21/09/17 to review progress against action plans for all Trusts visited.
Medical Education Quality Improvement Plan for 2017/18.	
HEEM quality management visits for following specialties - Cardiology, Maxillo-Facial School of Surgery / Dentistry, Trauma & Orthopaedics School of Surgery and Respiratory Medicine.	(GAP) HEE Quality Management Process (satisfaction / experience) - new process still to be confirmed for 2017/18. It's likely that self assessment will increase and HEE will only visit areas with training challenges- 'triggered visits'.
(GAP) CMGs Quality Improvement Action Plans in response to GMC visit and survey results to address concerns in postgraduate education.	UHL Medical Education Survey - 415 junior doctors responded to the survey. 88% recommend UHL as a place to work, an improvement since March (83%).
Monthly Medical Education reports will now be included as part of the CMG Performance Review Meeting data packs.	UHL PG education quality dashboard (satisfaction / experience) - to be completedin Sept 17 outcomes available in Nov 17.
(GAP) Overarching strategy with University of Leicester to integrate undergraduate and postgraduate training to improve outcomes and retention.	UHL Trainer Survey completed in conjunction with the Clinical Senate - work is underway to re-launch the Grand Round within UHL.
GMC 'Approval and Recognition' of Clinical and Educational Supervisors - central database monitored and maintained.	(GAP) Data to show the number of postgraduate medical and trainees retained in the specialties with shortcomings. Data for Foundation trainees is available via the UKFPO. Specialty data is held by HEE.
GMC visit report - UHL action plan developed.	
A pilot audit of job plans for Cardiology shows a deficit in education time of 7 eSPAs. (GAP) Audit for other services to be commenced.	The Chief Resident is looking at junior doctor morale within UHL, to compare this against the recent HEE document and recommendations.
On-going support work for Trust Grade doctors to minimise rota gaps and improved trainee experience at UHL.	
Cardio-Respiratory Improvement Steering group in place to respond to HEE triggered visit in Jul 17. Action plan in place and resources identified.	
Attitudes and Behaviours to Improve Care' group has been established (chaired by Suzanne Khalid) - will support the GMC action on undermining in UHL.	

Actions planned to address gaps identified in sections above	Due Date	Owner
CMG Leads have been asked to submit their action plans in response to the GMC survey by the end of October 2017.	Nov-17	CMG Leads

The UHL/UoL Strategic Group is developing the overarching strategy.	Mar-18	Strategic Group
MJPCC- either SC or DL to attend future meetings with details of individual's educational roles. This will be used to confirm and inform the job plan.		SC/DL

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	FIC		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…	Oct-17											
Objective:	High quality, relevant, education and research											
BAF Risk	If the Trust does not have the right resources in place and an appropriate infrastructure to run clinical education and research, then we may not maximise our education and research potential which may adversely affect our ability to drive clinical quality, attract and retain medical students and deliver of our research strategy (3065).											
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**		
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4	4	4	4	2	2					
Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Sept**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Controls assurance (planning)	Performance assurance (measuring)
(GAP) UHL Research and Innovation Strategy in UHL - due Q2 2017/18.	Internal monitoring via metrics reported at joint strategic meetings including finance, communications, patient and public involvement.
(GAP) Dialogue with UoL to articulate (year 1 of the 5 year) research strategy which will consolidate our position in areas of existing strength such as BRU, Cancer, Respiratory and Cardiovascular and identify new areas for possible development such as Obstetrics and Childrens - due Q2 2017/18.	External monitoring via annual reports from NIHR re performance for funded research projects - report Q2 2017/18.
	(GAP) Sign-off (year 1 stage) of the 5 year research strategy.
Functioning organisational relationship in place with UoL which includes joint strategic meetings to discuss research performance and opportunities.	

Actions planned to address gaps identified in sections above	Due Date	Owner
UHL Research and Innovation Strategy presented to (i) ESB (Sept) and (ii) UoL College of Life Sciences Leadreship Team (Sept) (iii), UHL/UoL Strategic Partnership Committee (Sept) - to be ratified by UHL Trust Board in October 2017 and UHL TB TD in Nov 2017.	Nov-17	NB

Corporate Oversight (TB / Sub Committees)

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

Independent (Internal / External Auditors)

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

BAF 17/18: As of…	Oct-17											
Objective:	More integrated care in partnership with others											
BAF Risk	If the Trust does not work collaboratively with partners, then we may not be in a position to deliver safe, high quality care on a sustainable basis, patients might not be able to access the services that they require and we may not be in a position to meet our contractual obligations.											
Annual Priority 4.1	We will integrate the new model of care for frail older people with partners in other parts of health and social care in order to create an end to end pathway for frailty											
Objective Owner:	DCIE	**SRO:**	U Montgomery / J Currington			**Executive Board:**		ESB		**TB Sub Committee**		
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Controls assurance (planning)	Performance assurance (measuring)
UHL working group established and reporting to UHL Exec boards.	(GAP) Milestones and success criteria to monitor progress of bringing partners across LLR together to be defined in the Project Charter Documentation.
STP Governance arrangements (Work streams reporting to System Leadership Team and will report summary updates to individual organisational boards / governing bodies from Q2 2017/18 - subject to confirmation from the STP PMO).	(GAP) Performance data to be monitored at service level, once defined.
UHL clinical lead identified - Dr Ursula Montgomery.	Frailty Oversight Task and Finish Group meeting to bring together frailty streams across UHL.
CMG clinical lead identified - Dr Richard Wong.	
Strategic Development and Integration Manager appointed.	
UHL project plan - Better Change Project Charter, Benefits Realisation, Milestone Tracker and Stakeholder Analysis.	
System wide project plan / PID specific to frailty in place.	
System wide Tiger Team bringing clinicians together across LLR. Clinical Leadership Group and senior clinical leaders meet scheduled for 8th June 2017 to discuss draft report of the Tiger Team and agreeing next steps across the system.	
External senior representation on relevant STP Work stream Boards.	
STP Work stream Project Initiations Documents (which relate to frailty).	
(GAP) Identification and management of interdependencies between STP work streams given most touch on frailty - work in progress.	
(GAP) Commissioning and contracting model that supports deliver of frailty pathway.	
South Warwickshire visit to UHL planned to share their experience.	
Phase II and in-reach models added into the Delivery Plan along with capturing other frailty work underway.	

Actions planned to address gaps identified in sections above	Due Date	Owner

The Frailty Oversight Task and Finish Group is responsible for monitoring and mitigating the impact of the identified gaps.			Mar-18	DCIO
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	QOC		No scrutiny - The TB should consider where they are receiving assurance in relation to this priority.	
Independent (Internal / External Auditors)				
Source:-	Title:		Date:	Feedback:
Internal Audit	No involvement identified in 17/18 plan.			
External Audit	No involvement identified in 17/18 plan.			

BAF 17/18: As of…	Oct-17											
Objective:	More integrated care in partnership with others											
BAF Risk	If the Trust does not work collaboratively with partners, then we may not be in a position to deliver safe, high quality care on a sustainable basis, patients might not be able to access the services that they require and we may not be in a position to meet our contractual obligations.											
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											
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**		
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Controls assurance (planning)	Performance assurance (measuring)
Clinical Lead identified (Associate Medical Director – Primary Care Interface).	Performance assurance and reporting identified through UHL Project Charter to include number of new relationships with primary care.
UHL designated clinical lead and management lead report to UHL Exec boards.	
Clinical Lead member of STP Primary Care Resilience Group.	(GAP) Description of UHL offer or "Brochure" will be produced. Bid Support Manager started 31 July.
Project Plan / Project Charter in place. Better Change Project Charter, Benefits Realisation. Milestone Tracker and Stakeholder Analysis - Expert group implemented.	(GAP) A Baseline Mapping of existing integration initiatives which can be used as a measure the outputs of the project.
Primary Care Oversight Board (PCOB) in place.	GP Hotline core themes & volumes of activity report to be brought to November PCOB.
Tender opportunity search process reported through ESB monthly.	
(GAP) A Stakeholder Communication/Engagement Plan - Work in progress DRAFT to be presented at next PCOB.	Review to be carried out re. Consultant Connect impact on clinicians and PA's.
	Milestone plan to be completed for GP hotline and shared at next PCOB.
(GAP) A suite of Tender Response Documents ready for responding to any competitive tenders and to include a description of UHL's response team. Recruitment to Strategy and Bid Office Manager post completed - Work in progress.	(GAP) Research - what training and support do GPs want.
External Senior representation on relevant STP Work stream Boards, namely Integrated Teams Programme Board - high level proposal / scoping document approved in April 2017.	
Roll out of GP hotline to be signed off by the PCOB.	
PRISM - to be managed through the Planned Care Board, with updates to PCOB.	
(GAP) Education strategy.	
IPOA paper to ESB.	
(GAP) Lack of clarity (at this stage) about the availability of funding to support these	

'non-activity related' activities. Project Board will escalate this as appropriate.	
(GAP) Systematised approach to Education reacting to flags raised through: patient experience; incidents; risks; GP Hotline etc.	

Actions planned to address gaps identified in sections above	Due Date	Owner
Tender response documents being collated, will be presented to November PCOB.	Nov-17	JS
UHL offer or "Brochure" will be produced.	Q4 17/18	JS
Education strategy to be included in Comms strategy - to include systematised approach.	Dec-17	AT
Stakeholder Communciation/ Engagement plan in progress - to be agreed at Nov PCOB meeting.	Nov-17	AT
Availabilty of funding is being tracked and managed by PCOB.	ongoing	MW
Individual meetings with GPs - questionairre to agree training needs.	Jan-18	AT

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	QOC		No scrutiny - The TB should consider where they are receiving assurance in relation to this priority.

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

BAF 17/18: Version	Oct-17											
Objective:	Progress our key strategic enablers											
BAF Risk	If the Trust is unable to secure external capital funding to progress its reconfiguration programme then our reconfiguration strategy may not be delivered.											
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**		FIC
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**June**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Planning (controls)	Performance Management (assurance sources)
(GAP) Develop EMCHC full business case - subject to outcome of national review, final decision expected at the end of November 2017. If the outcome concludes that the EMCHC service is de-commissioned then this will impact our reconfiguration plans (risk ID 3072).	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 - external capital funding has been confirmed but receipt is subject to external approval of business cases. Confirmation now received that one OBC and one FBC to be completed within 2017/18 for the whole project of £30.8m.	Performance against updated Interim ICU project plan is on track - OBC approved by the UHL TB in November, and due for approval at the CCG Boards on 14th November; FBC to be completed by end Jan 2018.
Deliver Emergency Floor Phase 2 (to complete in 2017/18).	Performance against Emergency Floor Phase 2 project plan - on track.
(GAP) Deliver Vascular Outpatients move to GH subject to outcome of scoping exercise and decision at ESB (to complete in 2017/18).	Performance against Vascular Outpatients project plan - is dependent on project scoping – outcome delayed owing to complexity of solution.
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. Impact of using PF2 on overall affordablity has been assessed, and discussion has taken place with the DH Private Funding Unit to discuss impact of using PF2 as an alternative funding source if DH funding not forthcoming. Awaiting the outcome of the Autumn Budget on 22nd November.

Actions planned to address gaps identified in sections above	Due Date	Owner
EMCHC move to LRI - scope for project is being finalised while national consultation decision is pending.	Nov-17	MW
Interim ICU project - OBC is being drafted as first part of external approval process.	Oct-17	DM & JJ
Vascular OP move to GH - CMG to explore alternative options for space and model of care.	TBC	ST

Corporate Oversight (TB / Sub Committees)

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

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	Oct-17											
Objective:	Progress our key strategic enablers											
BAF Risk	If the Trust does not have the right resources in place and an appropriate infrastructure to progress towards a fully digital hospital (EPR), then we will not maximise our full digital strategy.											
Annual Priority 5.2	We will make progress towards a fully digital hospital (EPR) with user-friendly systems in order to support safe, efficient and high quality patient care											
Objective owner:	CIO		**SRO:**	Paula Dunnan		**Executive Board:**		EIM&T		**TB Sub Committee**		FIC / QOC
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4	4	4	**4**	**2**	**2**					
Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3	3	3	3	**3**	**2**	**2**					

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
Implemented NC bed management (Oct 2017).	
(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.	

Actions planned to address gaps identified in sections above	Due Date	Owner
Implemenation of NC forms and rules	TBC	IM&T/UHL
ICE in OP Pilot	Completed	IM&T/UHL
Strengthen the Project Management Support for the above implementations	TBC	IM&T/UHL
EPR Plan - work is progressing in finalising the EPR KPIs.	TBC	IM&T/UHL

Corporate Oversight (TB / Sub Committees)			
Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	Audit Committee		IM&T report provided on request.
TB sub Committee	FIC		Quarterly paper provided: EPR plan – Best of Breed is progressing and alternative solutions are being reviewed. Work continues to implement NC Forms and Rules and Bed Management, the IM&T elements of these functions have been enabled and does now require support from the stakeholders to implement.
TB sub Committee	QOC		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	Oct-17											
Objective:	Progress our key strategic enablers											
BAF Risk	If the Trust is unable to maximise its potential to empower its workforce and sustain change through an effective engagement strategy, then we may experience delays with delivering Year 2 of the UHL Way (3068).											
Annual Priority 5.3	We will deliver the year 2 implementation plan for the 'UHL Way' and engage in the development of the 'LLR Way' in order to support our staff on the journey to transform services											
Objective owner:	DWOD		**SRO:**	B Kotecha		**Executive Board:**		EWB		**TB Sub Committee**		PPP
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**August**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4	4	4	4	2	2					

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).	UHL Pulse check dashboard (Quarterly) - Q2 2017/18 results show an improvement against overall engement score however we note that several of the indicators have decreased - energy continues to be the lowest scoring indicator. (GAP) Must achieve a 30% response rate in the quarterly pulse check to ensure reliable and valid data.
Year 2 - Close liaison with all SROs for annual priorities in 17/18 to process map their journey to identify gaps against the 4 components of the UHL Way.	
UHL Way Year 2 implementation plan and tracker.	
LIA processes embedded.	(GAP) Metrics to measure number of UHL Way interventions utilised in supporting annual priorities - as a minimum Project Charter to be produced for all priorities.
	National staff survey (annually) - April 2017 = UHL joint 47th position.
	Metrics to measure number of staff through Way Master Class - 63 staff completed as at the end of Sept.
	Better Teams Aggregated Pulse Check Scores.
LLR Way	
LLR OD and Change Group (workforce enabling group).	(GAP) Metrics to measure no. of people through introduction.
LLR Governance structure with clinical and senior leadership from LLR services (including UHL, LPT, City & County Councils, EMAS) - Better care together improvement framework.	(GAP) Metrics to measure no. of interventions utilised.
	Funding secured to progress LLR Way Elements.
(GAP) LLR standardised improvement framework to approach change.	
(GAP) Framework to raise awareness of STP and LLR Way.	

Actions planned to address gaps identified in sections above	Due Date	Owner
Staff survey live - promoting to ensure good response rate	Nov-17	BK / LT
Final Review of LLR Way Introduction Programme including identifying metrics.	Nov-17	BK

Corporate Oversight (TB / Sub Committees)			
Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	Audit Committee		
TB sub Committee	PPP Committee	Oct-17	Agreement that Deep dive on H&WB and Sickness Absence at next meeting.

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…	Oct-17											
Objective:	Progress our key strategic enablers											
BAF Risk	If operational delivery is negatively impacted by additional financial cost pressures, then the delivery of the requirements of the Carter report will be adversely impacted resulting in an inefficient back-office support function - Risk ID 3056.											
Annual Priority 5.4	We will review our Corporate Services in order to ensure we have an effective and efficient support function focused on the key priorities											
Objective Owner:	DWOD		**SRO:**	DWOD (& J Lewin)		**Executive Board:**		EWB		**TB Sub Committee**		PPP
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3	3	3	3	3	2	2					
Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3	3	3	3	3	2	2					

Controls assurance (planning)	Performance assurance (measuring)
UHL's requirement for significant CIP savings and national imperatives such as delivery of Lord Carter's 2016 recommendations present UHL with the necessity and opportunity to redesign Corporate Services that are fit for the future. UHL will also need to deliver its contribution to the LLR STP review of back office savings.	(GAP) Milestones to be developed and agreed.
	(GAP) Performance KPIs in development.
	Additional UHL 2017/18 CIP target (service line targets agreed by July 2017 EQB).
	£577k STP savings target (service line targets agreed by July 2017 EQB).
All nine UHL Corporate Directorate plus Estates and Facilities are in scope.	Carter target for back office cost to be no more than 7% of turnover by March 2018.
PID ratified at IFPIC on 31/08/17.	
Project governance defined in PID.	Carter Target for back office cost to be no more than 6% of turnover by March 2020.
Project Board meeting monthly.	
(GAP) Diagnostic phase across all Corporate Services commencing in June 2017, progress to an options appraisal assigning in year delivery targets across service lines will be completed in November 2017.	
Project manager resource in place.	
(GAP) Service line strategy roadmaps outlining the direction of travel across the next 3 years alongside a thorough review of existing contracts (for goods and services both provided and bought in).	

Actions planned to address gaps identified in sections above	Due Date	Owner
Conclude Diagnostic Phase with Milestones and KPIs agreed.	Nov-17	DWOD
All service line leads are producing strategy roadmaps outlining the direction of travel across the next 3 years alongside a thorough review of existing contracts (for goods and services both provided and bought in).	Nov-17	DWOD

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	Audit Committee		
TB sub Committee	PPP	Oct-17	The PID for the Corporate Services review was ratified by IFPIC in August 2017. A Diagnostic Phase across all Corporate Services commenced in June 2017. This is progressing to an options appraisal assigning in year delivery targets across service lines which will be completed in November 2017.

Independent (Internal / External Auditors)

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

BAF 17/18: As of…	Oct-17											
Objective:	Progress our key strategic enablers											
BAF Risk	If the Trust cannot allocate suitable resources to support delivery of its Commercial Strategy then we will not be able to fully exploit all available commercial opportunities (3066).											
Annual Priority 5.5	We will implement our Commercial Strategy, one agreed by the Board, in order to exploit commercial opportunities available to the Trust											
Objective Owner:	CFO		**SRO:**	CFO		**Executive Board:**		EPB		**TB Sub Committee**		FIC
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4	4	4	4	2	2					
Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4	4	4	4	2	2					

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

Actions planned to address gaps identified in controls / assurances	Due Date	Owner
Strategy on track.		

Corporate Oversight (TB / Sub Committees)

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

Independent (Internal / External Auditors)

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

BAF 17/18: As of…	Oct-17											
Objective:	Progress our key strategic enablers											
BAF Risk	If the Trust is unable to achieve and maintain its financial plan, caused by ineffective solution to the demand and capacity issue and ineffective strategies to meet CIP requirements, then it may result in widespread loss of public and stakeholder confidence with potential for regulatory action such as financial special measures or parliamentary intervention (3070).											
Annual Priority 5.6	We will deliver our Cost Improvement and Financial plans in order to make the Trust clinically and financially sustainable in the long term											
Objective Owner:	CFO		**SRO:**	CFO		**Executive Board:**		EPB		**TB Sub Committee**		FIC
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4	4	4	4	2	2					
Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3	3	3	3	3	2	2					
Controls assurance (planning)						Performance assurance (measuring)						
Cost Improvement Plans												
CMGs and Corporate departments to fully deliver plans for 2017/18.						Monthly CIP report to EPB and FIC.						
100% of PIDS and QIAs signed off.						Monitoring of CIP tracker to measure completeness of programme for the remaining months.						
Production and delivery of the Closing the Gap plan.												
Procurement to deliver full £8m target against budgeted spend.						In M7, there remains an unidentified gap that is being worked through with CMGs in an escalation process where appropriate. Revised control totals have been set for all CMG and Corporate Directorates.						
Quarterly quality assurance reporting.												
Monthly CMG/Corporate meetings to include detailed review of CIP delivery and forecast - escalating to weekly where CMGs/Corporate departments are materially varying from plan.												
(GAP) Deliver more activity through a more productive capacity through beds, theatres & outpatients – improve efficiency indicators; Reduce the price we pay for goods/services; Remove waste and eliminate unnecessary variation.												
Financial Plans												
CIP (including supplementary) to achieve 100% delivery in 2017/18.						CIP measurement and reporting monthly.						
CMGs to achieve their control totals or better.						Monthly I&E submissions to NHSI, Trust Board, FIC and EPB.						
Cost pressures and service developments to be minimised and managed through RIC and CEO chaired 'Star Chamber'.						Expenditure run rates for pay, non-pay, capital charges and agency spend.						
A minimum of £18m of additional technical and other solutions to be transacted.						Contract income levels consistently being achieved and commissioner challenges resolved quarter by quarter.						
Agree an appropriate level of investment supporting the resolution of the demand/capacity issue.						Year on year reduction in agency spend in line with our 2 year trajectory.						
						I&E monitoring of progress against £18m technical challenge.						
Manage CCG and NHSE contracts to ensure accurate and full receipt of income noting changes to tariff (HRG4+) and new Emergency Floor currencies/flows.						Overall level of overdue debtors to reduce, BPPC performance to improve - monitored within cash paper to FIC.						
Implementation of first stages of UHL's Commercial Strategy and use of TGH Ltd.						Improvement in cash position as per the agreed plan.						
Reduction in agency spend moving towards the NHSI agency ceiling level.						Revised control totals have been set for all CMG and Corporate Directorates.						
New income streams realised and effective, financially beneficial use of TGH Ltd.						Additional corporate controls are being identified to assist in the delivery of the year						

Monitoring of CQUIN Targets.	end position and revised control totals.
(GAP) Better retrieval of overdue debtors.	

Actions planned to address gaps identified in controls / assurances	Due Date	Owner
Escalation process in place for retrieval of CCG overdue debtors	Ongoing	CFO
Detailed review of M6 year end forecasts	Complete	DoOF

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	Audit Committee	Monthly	Finance / CIP reports for assurance
TB sub Committee	FIC	Monthly	I&E information to FIC to include monitoring of progress against £18m technical challenge. The forecast financial position has recognised in full the current forecast CIP shortfall. However, whilst this is recognised, CMGs remain in an escalation process where appropriate. The additional investment to mitigate the demand and capacity bed requirements needs successful delivery of the supplementary CIP programme of £3.5m. The progress against this challenge has remained constant since the end of September at £1.7m. CMGs and Directorates have received revised control totals for delivery by year end. These have been developed from the detailed review of Month 6. The finance improvement and technical items of a minimum of £18m needs to be delivered. Further work is being undertaken to validate any further opportunities within this area.

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		

Appendix 2 Risk Register dashboard for risks rated 15+ as at 31 October 17

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Thematic Analysis of Risk Causation
2264	CHUGGS	If an effective solution for the nurse staffing shortages in CHUGGS at LGH and LRI is not found, then the safety and quality of care provided will be adversely impacted.	20	6	Workforce
2621	CHUGGS	If recruitment and retention to vacancies on Ward 22 at the LRI does not occur, then patients may be exposed to harm due to poor skill mix on the Ward.	20	6	Workforce
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	Resource
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	Demand & Capacity
2670	RRCV	If recruitment to the Clinical Immunology & Allergy Service Consultant vacancy does not occur, then patient backlog will continue to increase, resulting in delayed patient sequential procedures and patient management.	20	6	Workforce
2804	ESM	If the on going pressures in medical admissions continue, then ESM CMG medicine bed base will be insufficient thus resulting in jeopardised delivery of RTT targets.	20	12	Demand & Capacity
2149	ESM	If we do not recruit and retain into the current Nursing vacancies within SM, then patient safety and quality of care will be compromised resulting in potential financial penalties.	20	6	Workforce
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	Demand & Capacity
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.	20	4	Estates
2191	MSK	Lack of capacity within the ophthalmology service is causing delays that could result in serious patient harm.	20	8	Demand & Capacity
2940	W&C	Risk that paed cardiac surgery will cease to be commissioned in Leicester with consequences for intensive care & other services.	20	8	Demand & Capacity
3054	Human Resources	If the Trust's Statutory and Mandatory Training data can no longer be verified on the new Learning Management System, HELM, then it is not possible to confirm staff training compliance which could result in potential harm to patients, reputation impact, increased financial impact and non-compliance with agreed targets.	20	3	IM&T
2403	Corporate Nursing	There is a risk changes in the organisational structure will adversely affect water management arrangements in UHL.	20	4	Estates
2404	Corporate Nursing	There is a risk that inadequate management of Vascular Access Devices could result in increased morbidity and mortality.	20	16	Resource
3040	RRCV	If there are insufficient medical trainees in Cardiology, then there may be an imbalance between service and education demands resulting in the inability to cover rotas and deliver safe, high quality patient care.	16	9	Workforce
2820	RRCV	If a timely VTE risk assessments are not undertaken on admission to CDU, then we will be breach of NICE guidelines resulting patients being placed at risk of harm.	16	3	Processes and Procedures
3080	RRCV	If an alternative provider and procedure is not identified for wasp/bee venom desensitisation then patients will have an increased risk of anaphylaxis due to treatment & waiting list delays.	16	4	Estates
3051	RRCV	If we do not effectively recruit to the Medical Staffing gaps for Respiratory Services, then there is a risk to deliver safe, high quality patient care, operational services and impacts on the wellbeing of all staff including medical staffing.	16	6	Workforce
3031	RRCV	If the MDT activities for vasc surg are not resolved there is a risk of significant loss of income & activity from referring centres	16	1	CLOSED
3088	ESM	If non-compliant with national and local standards in Dermatology with relation to Safer Surgery checking processes, then patients may be exposed to an increased risk of potential harm.	16	6	Processes and Procedures
3025	ESM	If there continues to be high levels of nursing vacancies and issue with nursing skill mix across Emergency Medicine, then quality and safety of patient care could be compromised.	16	4	Workforce

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Thematic Analysis of Risk Causation
3044	ESM	If under achievement against key Infectious Disease CQUIN Triggers (Hepatitis C Virus), then income will be affected.	16	8	Demand & Capacity
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	Workforce
2989	MSK	If we do not recruit into the Trauma Wards nursing vacancies, then patient safety and quality of care will be placed at risk.	16	4	Workforce
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	IM&T
2673	CSI	If the bid for the National Genetics reconfiguration is not successful then there will be a financial risk to the Trust resulting in the loss of the Cytogenetics service.	16	8	Demand & Capacity
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	Workforce
2916	CSI	If blood samples are mislabelled, caused by problems with ICE printers and human error with not appropriately checking the correct label is attached to the correct sample, then we may expose patients to unnecessary harm.	16	6	IM&T
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	Demand & Capacity
3082	W&C	If funding from NHS England Specialised Commissioning for the CenTre Neonatal Transport call handling service is withdrawn, then calls regarding critically-ill & unstable patients will be delayed or mislaid resulting in the potential for serious harm to patients referred for critical care transfer.	16	5	Demand & Capacity
2153	W&C	Shortfall in the number of all qualified nurses working in the Children's Hospital.	16	8	Workforce
2237	Corporate Medical	If a standardised process for requesting and reporting inpatient and outpatient diagnostic tests is not implemented, then the timely review of diagnostic tests will not occur.	16	8	IM&T
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	Workforce
1693	Operations	If clinical coding is not accurate then income will be affected.	16	8	Workforce
3027	CHUGGS	If the UHL adult haemoglobinopathy service is not adequately resourced, then it will not function at its commissioned level.	15	4	Workforce
3047	RRCV	If the service provisions for vascular access at GH are not adequately resourced to meet demands, then patients will experience significant delays for a PICC resulting in potential harm.	15	6	Demand & Capacity
3041	RRCV	If there are insufficient cardiac physiologists then it could result in increased waiting times for electrophysiology procedures and elective cardiology procedures.	15	8	Workforce
3043	RRCV	If there is insufficient cardiac physiologists then it could result in reduced echo capacity resulting in diagnostics not being performed in a timely manner.	15	6	Workforce
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	Estates
3077	ESM	If there are delays in the availability of in-patient beds, then the performance of the Emergency Department at Leicester Royal Infirmary could be adversely affected, resulting in overcrowding in the Emergency Department and an inability to accept new patients from ambulances.	15	10	Demand & Capacity
2837	ESM	If the migration to an automated results monitoring system is not introduced, then follow-up actions for patients with multiple sclerosis maybe delayed resulting in potential harm.	15	2	IM&T
2466	ESM	Current lack of robust processes and systems in place for patients on DMARD and biologic therapies in Rheumatology.	15	1	Processes and Procedures

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Thematic Analysis of Risk Causation
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	Workforce
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	Workforce
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	Workforce
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	IM&T
2965	CSI	If we do not address Windsor pharmacy storage demands, then we may compromise clinical care and breach statutory duties.	15	6	Estates
2601	W&C	There is a risk of delay in gynaecology patient correspondence due to a backlog in typing.	15	6	Workforce
3023	W&C	There is a risk that the split site Maternity configuration leads to impaired quality of Maternity services at the LGH site.	15	6	Workforce
3083	W&C	If gaps on the Junior Doctor rota are not filled then there may not ne enough junior doctors to staff the Neonatal Units at LRI.	15	3	Workforce
3084	W&C	If there continues to be insufficient Neonatal Consultant cover to run 2 clinical sites, then it could impact on service provision resulting in potential for suboptimal care to the babies on the units at LRI & LGH.	15	5	Workforce
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	4	IM&T
3079	Corporate Medical	If the insufficient capacity with Medical Examiners is not addressed then this may lead to a delay with screening all deaths and undertaking Structured Judgement Reviews resulting in failure to learn from deaths in a timely manner and non-compliance with the internal QC and external NHS England duties.	15	6	Workforce
2985	Corporate Nursing	If 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	Workforce