Author: Risk and Assurance Manager Sponsor: Medical Director

INTEGRATED RISK AND ASSURANCE REPORT AS AT 31 DECEMBER 2017

Executive Summary

Trust Board paper G

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.

Questions

1. What are the top rated (highest scoring) principal risks on the BAF?
2. What is the progress (month-end and year-end forecast) 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. All are currently rated 20 (high).
2. Three annual priorities (all components of the Quality Commitment) have been assessed as off-track at month end, with four priorities 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.
3. There are 167 risks recorded on the organisational risk (including 51 with a current rating of 15 and above – high). One new risk scoring 15 has been entered on the risk register during the reporting period concerning Midwifery establishment.
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 and national trends).

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 **1 page**. [My paper does comply]

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **UHL TRUST BOARD**

DATE: **1ST FEBRUARY 2018**

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

SUBJECT: **INTEGRATED RISK AND ASSURANCE REPORT (INCORPORATING UHL BOARD ASSURANCE FRAMEWORK & ORGANISATIONAL RISK REGISTER AS AT 31ST DECEMBER 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 December 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.
  Progress update: December has been a challenging month where the focus has been on ensuring safe care in an at times overcrowded ED and to patients on outlying wards. Our focus for January is to continue to deal with intense pressure (notably driven by very high respiratory demand which has impacted on the LRI as well as Glenfield).
- **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

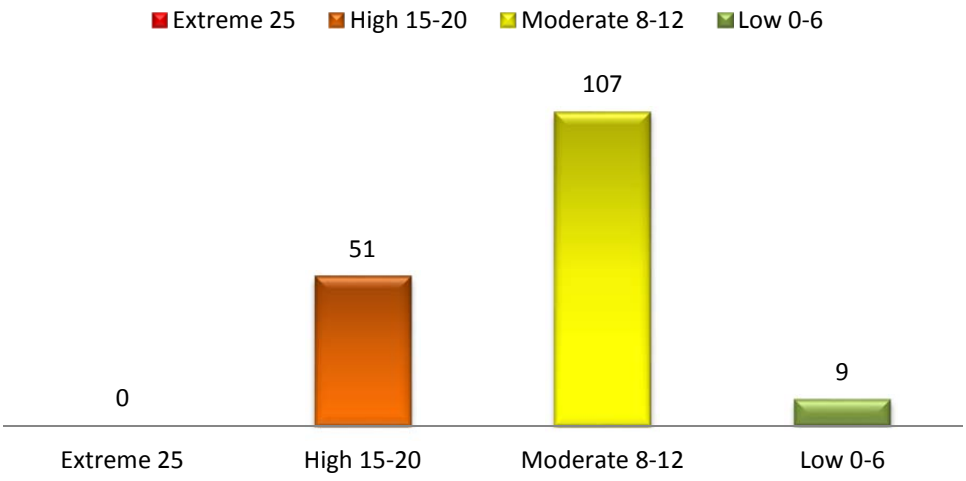
requirements, then it may result in widespread loss of public and stakeholder confidence with potential for regulatory action such as financial special measures.
Progress update: In Month 9, there remains an unidentified gap that is being worked through with CMGs in an escalation process where appropriate. Revised control totals have been set for all CMG and Corporate Directorates.

2.3 Three annual priorities (all components of the Quality Commitment) have been assessed as off-track at month end, with four (again all related to the QC) forecasted to be at risk of non-delivery in 2017/18. Copies of the current tracker scores for all the annual priorities are included in the BAF report at appendix one.

3. UHL ORGANISATIONAL RISK REGISTER SUMMARY

3.1 For the reporting period ending 31st December 2017, there are 167 risks recorded on the organisational risk register. One new risk scoring 15 and above has been entered on the risk register during the reporting period concerning Midwifery establishment, rated 15. Figure 1, below, illustrates the breakdown of the risks by their current risk rating and further description is provided in a dashboard at appendix two.

Fig 1 - UHL Risk Profile - Current Ratings

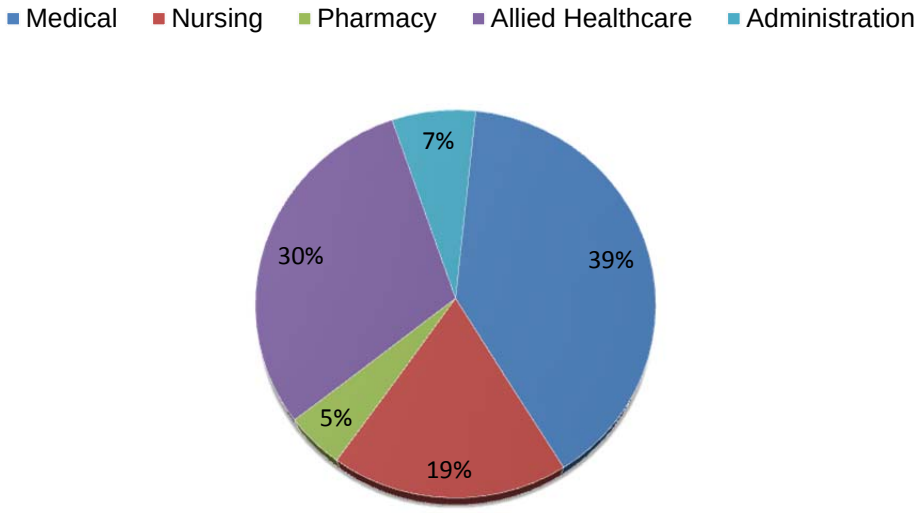


3.2 Thematic analysis of the organisational risk register shows the common risk causation themes as:

- Workforce shortages;
- Imbalance between demand and capacity.

3.3 Figure 2 illustrates the results of the detailed analysis into the 43 workforce associated risks recorded on the CMGs risk registers in order to ascertain level of impact to the employment groups.

Fig 2 - Workforce Associated CMG Risks



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.

UHL Board Assurance Dashboard: 2017/18							DECEMBER 2017								
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	2	↑	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	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	2	↔	1	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	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	1	↓	1	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 Leak	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	3	↑	3	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	DSC	J Currington / A Taylor	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	DSC	J Currington / A Taylor	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 / Justin Hammond)	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…	Dec-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	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	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 - 100 (period July 16 to June 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).*
Recruit additional Medical Examiners - 2 new MEs started since Dec and 3rd due to start April 18.	
Medical Examiner Mortality Screening of In-hospital and Emergency Dept Adult Deaths.	% of deaths screened - target is 95% of all adult inpatient deaths. 97% of Adult Deaths were screened by the Medical Examiners in Qs 1&2 (includes Community and ED deaths).
Case Note Reviews using National Structured Judgement Review Tool (SJR) and thematic analysis.	
UHL's Risk Adjusted Mortality Rates (SHMI) monitored using Dr Foster Intelligence and HED Clinical Benchmarking Tools.	
Five top mortality governance priorities identified through the AQuA comparator report are now standing agenda items at the Mortality Review Committee.	% 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. 254 cases referred for SJR in Qs1&2 (to date) . All of Q1's deaths should have been classified by end of December To date, details of SJR findings and death classifications have been identified for 102 of the 152 cases referred for SJR (67%). (GAP) Capacity constraints of the Corporate Admin Team has led to delays with following up of SJR outcomes. Bereavement Support Service are seeing an increase in activity and additional capacity being provided through the Nursing Bank.
ME / M&M administration support and ME assistant now in place.	
UHL "Learning from the Deaths" Work Programme - includes Medical Examiner Screening, Specialty M&M Process and Bereavement Support Services.	
	UHL's latest rolling 'unpublished' 12 month SHMI July 16 to June 17 is 98.
	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

	received. Response and action plan submitted to CQC on 29th September.
	Gap in capacity for analysis and theming of ME screening and Specialty M&M SJR findings.

Actions planned to address gaps identified in sections above	Due Date	Owner
Aadditional Medical Examiners and ME Assistant now in place. M&M administration support (risk entry 3079 - current rating = high). Business case for increase in Administrative and Analytical resource plus additional Bereavement Support Nurse post being submitted to January Revenue Investment Committee.	Jan-18	RB

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	QOC	Dec-17	Newly identified gap in control in respect of capacity constraints for the Corporate M&M Administrative team, Mortality data analysis and theming and Bereavement Support Service. Whilst the overarching objective of reducing our SHMI would appear to be on track (latest published SHMI is 100), there has been a further drop in performance in respect of meeting completion of Structured Judgment Reviews and collating of data for external reporting and publication. Business case being submitted to the January meeting of the Revenue Investment Committee.

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…	Dec-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	1	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	2	2			

Controls assurance (planning)	Performance assurance (measuring)
Governance: Deteriorating Adult Patient Board - last meeting held 21st Nov 2017.	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) - Complete. • Trust wide implementation of e-Obs (MEOWS) - outstanding: revised implementation date end of Feb 2018. • Fully automated EWS reporting (NerveCentre) - Complete. Q3 position: • Assessments for sepsis (NerveCentre) fully implemented - Complete • Fully automated Sepsis reporting (NerveCentre) - outstanding: revised implementation date (phased implementation during) Jan - Mar 2018 Q4 position: N/A.
Sepsis screening tool and care pathway - updated & relaunched July 2017	
Review of admissions to ITU with red flag sepsis at all 3 sites monthly - LRI, LGH, GGH.	
Monitoring of SUIs related to the deteriorating patient.	
Latest version of NerveCentre mobile app deployed trust wide (w/c 20/11/2017) to enable alerts for sepsis to go live.	
Testing of sepsis assessment form complete and deployed to live environment (w/c 1/1/2018).	
Testing of e-Obs (MEOWS) complete. Awaiting deployment to the live environment - revised implementation date end of Feb 2018.	
GPAU gone live with NerveCentre EDWISE - 12/11/2017. Deployment of e-Obs in GPAU delayed from Dec 2017 to Feb 2018 subject to configuration of mobile devices.	

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

Develop content for deteriorating patient e-learning module - requirement for this e-learning module to be reviewed and proposal presented to EQB	Feb EQB	JJ
Trust wide deployment of Obs (MEOWS)	End of Feb	JB

Corporate Oversight (TB / Sub Committees)			
Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	QOC	Dec-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…	Dec-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 / M Chauhan		**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	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	1	1			

Controls assurance (planning)	Performance assurance (measuring)
Insulin	
Insulin Safety Action Plan developed in response to the CQC unannounced inspection of Wards 42, 43, 37, (LRI) and 27 & 33 (GH).	**Outcome KPIs:**
	Reduce number of severe inpatient hypoglycaemia episodes by 20%.
Governance: Diabetes Inpatient Safety Committee - meets monthly chaired by the Clinical Lead for Inpatient Diabetes Care. Further governance arrangements (weekly task & finish group & Insulin Safety Board) to be established.	To have no in hospital Diabetic Ketoacidosis (DKA) "events" in quarter 4.
Diabetes decision support (for Hyperglycaemia and PRN insulin dose guidance) developed and distributed to all wards and departments.	
Implementation plan developed for the recording, reporting blood glucose through e-Obs / NerveCentre - all actions to be completed by End of Feb 2018. Diabetes Rules ready for test end of Jan 2018, for deployment by the end of Feb 2018.	
Undertaking a review of exisiting diabetes & insulin education packages - to be completed by the end of Jan 2018.	
Undertake a review of the diabetes workforce and future recruitment strategy for Diabetes Specialst nurses and support workers - to be completed by end of Feb 2018.	
Establishing a Consultant Outreach rota to support timely interventions for complex patients, preventing deterioration or complications of diabetes.	
(GAP) Implement a networked blood glucose meter system to record and monitor episodes of severe hypoglycaemia.	
RCA analysis of all in hospital DKAs - first review of case in Oct 2017.	
An all staff newsletter has been circulated via Comms in relation to DKA.	

A structured review process for any in-hospital DKA event (similar to pressure ulcers and falls) has been developed and is up and is up and running.	

Actions planned to address gaps identified in sections above	Due Date	Owner
POCT to determine solution for networked blood glucose meter sysyem.	Mar-18	EM

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	QOC	Nov-17	Despite the KPIs being at significant risk of not being achieved by year end, a significant amount of work has been 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. **Training Assurance:** Numbers of staff who have completed mandatory training are increasing each month. There remain on-going issues with accessing the e-learning and ability to indicate training completed on HELM. We noted very few doctors had completed the e-learning and so to address this have put on essential to role training sessions at end of working day for doctors and if attended then signed off as recieved training. Evaluation of these sessions has been good

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.

BAF 17/18: As of…	Dec-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**
	3	3	3	3	3	2	2	2	2			
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	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.		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	Nov-17	WARFARIN: The project continues to make good progress against its objectives with KPIs on track to deliver by year-end.

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.

BAF 17/18: As of…	Dec-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**
	3	3	3	2	2	2	1	2	2			
Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4	3	2	2	2	2	2	1			

Controls assurance (planning)	Performance assurance (measuring)
Governance: Acting on Results programme board and task and finish groups to report to EQB quarterly.	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	Current metrics show that compliance with % of results acknowledged is <1%. (Gap)
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.	
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	Review:	Owner
Prioritise IT resource to the project.	Monthly	CM

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	QOC	Dec-17	In December there has been lots of progress on the project with both Conserus and Mobile ICE going into pilot with clinicians. Baseline metrics are now available which show that acknowledgment of results using the "File" functionality in ICE is used only very rarely by clinicians. Due to critical delays in progress with this project the year-end objective of achieving acknowledgment of results in 85% of cases is unlikely to be achieved. This project is being rolled over into the Quality Commitment for 18/19 in order to give more time to achieve this. Roll out of Mobile ICE will be critical to reaching this target and this is unlikely to be able to be rolled out before the end of the financial year as the necessary ICE upgrade that supports this is scheduled for March 2018. In the interim, as mitigation for this delay, a communications campaign, supported by training with specialties will aim to get clinicians using the file functionality currently available in desktop ICE.

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

BAF 17/18: As of…	Dec-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		**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	2	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	2	2			

Controls assurance (planning)	Performance assurance (measuring)
Governance: Palliative & End of Life Care Committee meets bi-monthly.	**Quality Commitment KPIs**: Patients in the last days of life will have an individual care plan in place as per the "One Chance to Get it Right" Guidance (2014): Care plan implemented in 75% of wards in new CMG and care plan sustained in 75% of CMG wards already implemented on.
Detailed project plan presented at the Palliative & End of Life Care Committee.	
End of life care plans which include specialist palliative care end of life care service.	
End of Life Care Facilitators rolling out implementation of taining and support in the use of End of Life care plans (reflected in the detailed project plan).	EoLC audits quarterly - Q1 results reported at the November 2017 P&EoLCC. Audit methodology to be refined to enhance and validate the audit sample confidence level.
"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 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
Audit methodology to be refined to enhance and validate the audit sample confidence level.	TBA	

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	Dec-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	**Trust QC Aim:** We will improve the patient experience in our current outpatients service and begin work to transform our outpatient models of care in order to make them more effective and sustainable in the longer term.											
Objective owner:	DCIE		**SRO:**	J Edyvean / D Mitchell		**Executive Board:**		EQB		**TB Sub Committee**		PPP/QOC
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3	3	3	3	3	2	2	2	1			
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 Programme 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 -).
(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.
Milestone plan agreed at Trust Board and Executive Performance Board - monitored via OP Programme Board.	Q2 Finalise and Agree KPI's (delay) and programme plan (Complete), Q3 Initiate delivery (delay in some areas), Q4 speciality delivery (GAP scale of delivery, competing operational pressures and resource requirements).
Quarterly report to Quality and Outcomes Committee (First report February 18). PPPC to receive update on KPI's Jan 18.	(GAP) Delivery of CMG plans for ENT and Cardiology dependent on resources being released at speciality level to deliver changes - competing operational pressures and scale of change.

Actions planned to address gaps identified in sections above	Due Date	Owner
Service specific plans for ENT and cardiology developed. Assessment of the level of resources/expertise required to deliver those plans to be confirmed.	Q3 17/18	JE
Issues identified at LiA events around the ability to deliver sustainable change. OD Team support in place. Cultural audit completed in October 2017. OD Interventions and area for targetted support being identified. Opportunities to participate in Virtual Academy of Large Scale Change Masterclasses being explored.	Q3 17/18	JE
Develop milestone plan beyond March 2017 (partially complete).	Q4 17/18	JE

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	QAC	Dec-17	Year end position is rated as a high risk 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. PPPC to receive draft KPI's Jan 18 (On track).

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.

BAF 17/18: Version	Dec-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 Leak		**Executive Board:**		EPB	**TB Sub Committee**		FIC / QOC / PPPC	
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	4	3	2	1	1	1	1			

Controls assurance (planning)	Performance assurance (measuring)
Submission of demand and capacity plan to NHSI – The major shortfalls are in medicine at the LRI and Glenfield. Deficit of 32 against a plan of 39 This progress has not delivered the material drop in occupancy required due to medicine seeing 1116 admissions above the (downside) plan (9%) - additional demand is using what would have been vacant capacity.	ED 4 hour wait performance trajectory submitted to NHSI - Performance currently below national benchmark.
	Ambulance handover (delays over 60 mins) submitted to NHSI.
	RTT Incomplete waiting times trajectory submitted to NHSI.
	2WW for urgent GP referral as per the NHSI submitted trajectories.
New ED building open to public from 26th April 2017.	31 day wait for 1st treatment as per submitted NHSI trajectories.
Demand and Capacity plans being progressed for 2018 / 19.	62 day wait for 1st treatment as per submitted NHSI trajectories.
Programme Director appointed.	105 bed gap mitigated.
Theatre trading model in place along with ACPL targets. Fours eyes consultancy supporting deliverability.	Reduced cancelled operations due to no available bed.
	Occupancy of 92% (as of June 2017).
Ward 7 moves to Ward 21 and becomes a medical ward in the recurrent baseline (+28 beds)	ACPL target achieved.
	The demand and capacity plan is not currently balanced for the year.
Staffing of additional 8 beds on the medicine emergency pathway at LRI on Ward 7 to meet continued demand in medicine.	There remain significant vacancies in ED (156) and Specialist Medicine (203).
Plan for elective service changes at LGH involving MSS & CHUGGs.	
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.	
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.	
New model of command and infrastruture across the Trust.	
Electronic bed management system introduced across UHL.	
Additional weekend imaging to achieve 1 day turnaround for all inpatient imaging	
Daily SCRUM in place ensuring rapid action and change programme.	

Actions planned to address gaps identified in sections above	Due Date	Owner
New Head of Operations for ED	Jan-18	ED
New Interim COO	Jan-18	ED
Winter funding spend to ensure maximum benefit	Mar-18	ED
Review of actions over the last 6 months to identify which require further input to embed	Jan-18	SL

Strategic Risk assurance (assessment)	Movement
If the additional physical bed capacity cannot be opened at the LRI, caused by an inability to provide safe staffing, then it will lead to a continued demand and capacity imbalance resulting in delays in patients gaining access to beds and cancelled operations. Risk register 3074.	
If the physical capacity options at Glenfield are not affordable from a capital and revenue perspective, then it will lead to a demand and capacity imbalance at GH in the winter of 2017/18. Risk register 3076.	

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	PPPC	Dec-17	The percentage of patients discharged or admitted via Emergency Department within 4 hours in December was 71.5% (LLR 79.6%); this is below trajectory level of 90%. The total number of attendances has remained relatively static over December; however we continue to see higher than planned ambulance attendances. Daily improvement meetings continue to take place, chaired by the Chief Executive, including the Chief Nurse, Chief Operating Officer, and Medical Director working with the clinical teams in the component parts of the Trusts Emergency care system to make improvements. Actions over the coming weeks will continue to focus on fast turnaround actions through the scrums and also ensure that previous actions are embedded (particularly those derived from L&D recommendations).

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.

BAF 17/18: As of…	Dec-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/ PPPC
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)
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 £20.6m and to underspend against plan.
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). Scrutinised as part of CMG performance review meetings.
(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 review how wards might be staffed differently and safely.	

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 - additional resource appointed and commenced - priority work area urgent and emergency care workstream	Mar-18	LG
GAP 4 - Urgent and Emergency Care Workstream utilising Whole Systems Partnership to predict activity and impact on capacity	Mar-18	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/MM

Corporate Oversight (TB / Sub Committees)			
Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	FIC	Mar-18	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.		

BAF 17/18: As of…	Dec-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/PPPC
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	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 with an underspend at the end of year 17/18. (YTD underspend at month 9 is £0.8m, forecast £1.2m year end).
Monitoring of agency cap breaches to NHSI weekly.	
Medical Oversight Broad established.	Medical Agency Dashboard to Medical Oversight board.
Monthly premium spend meeting to monitor progress via agency tracker.	(GAP) Regional deliverables, including regional rate card, to be defined through regional working group in line with TOR - in development.
(GAP) Regional MOU and establishment of a regional working group for medical agency.	(GAP) No. of retrospective bank and agency bookings reported through to Premium Spend Group - target to be determined.
Monitoring of agency spend and tracker (including data analysis which shows reasons for request and rates of use by ward level) through Premium Spend Group with EWB, EPB, IFPIC oversight - There is a detailed agency action tracker in place, with monitored actions against agreed activities to reduce agency expenditure.	
Agreed escalation processes / break glass escalation control.	
Review of top 10 agency highest earners and long term through ERCB linking to vacancy positions and CMG recruitment plans.	
Process for signing off bank and agency staff at CMG level through Temporary staffing office following appropriate senior approval.	
Nursing rostering prepared 8 weeks in advance.	
No agency invoice is paid without booking number.	

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.	Mar-18	LT/JTF

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

TB sub Committee	FIC	Dec-17	The agency ceiling target is £20.6m. Forecast to achieve NHSI target of £20.6m with an underspend at year end 17/18. 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.

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…	Dec-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	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	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).	Workforce Report Outcomes and Measures agreed and reviewed at monthly CMG Performance Assurance Meetings.
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) Delivery structures not fit for purpose until target operating model has been developed - target operating model 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.	
HELM progress updates provided to Executive Team weekly.	

Actions planned to address gaps identified in sections above	Due Date	Owner
People Strategy currently being finalised	Feb-18	LT

Corporate Oversight (TB / Sub Committees)			
Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	PPP Committee	Dec-17	Update concerning HELM Recovery Action and progress against implementing workforce actions.

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…	Dec-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**
	3	3	3	3	3	2	2	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	2	2			

Controls assurance (planning)	Performance assurance (measuring)
Medical Education Strategy to improve learning culture.	GMC/ HEE regional meeting took place on 21/09/17 to review progress against action plans for all Trusts visited. UHL's action plan submitted to HEE & the GMC.
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) - launched in Sept 17 - Draft to be submitted to EWB in Oct - outcomes available in Jan 18.
(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.	
Undergraduate Education has now been included in the monthly CMGs APRM.	(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'.
	A 'Medical Educator' LiA for UG Medical Education will be launched in Jan 18.
	The monthly Medical Education Report for CMGs APRM includes job planning data for educational roles (i.e. roles vs time in job plans).

Actions planned to address gaps identified in sections above	Due Date	Owner
UG Quality dashboard will be shared with CMG Education Leads	Jan-18	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
A 'Medical Educator' LiA for UG Medical Education will be launched in January 18	Jan-18	SS/JK

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'.

BAF 17/18: As of…	Dec-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	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	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 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.	The monthly Medical Education report for CMGs APRM includes job planning data (i.e. roles vs time in job plans).
Cardio-Respiratory Improvement Steering group in place to respond to HEE triggered visit in Jul 17. Action plan in place and resources identified.	HEE will re-visit Cardio-respiratory on May 4th 2018 to review progress against their action plan.
An LiA will commence early in 2018 to act on the Junior Dr Morale survey results. John Adler and Andrew Furlong are the Executive Sponsors.	
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
The UHL/UoL Strategic Group is developing the overarching strategy.	Mar-18	Strategic Group
HEE will re-visit Cardio-respiratory on May 4th 2018 to review progress against their action plan	May-18	SC
An LiA will commence early in 2018 to act on the Junior Dr morale survey results. John Adler and Andrew Furlong are the Executive Sponsors for the LiA event.	Mar-18	SC
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'.

BAF 17/18: As of…	Dec-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	2	3			
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	2	3			

Controls assurance (planning)	Performance assurance (measuring)
UHL Research and Innovation Strategy in UHL - delivered Q4 2017/18.	Internal monitoring via metrics reported at joint strategic meetings including finance, communications, patient and public involvement.
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.
	Sign-off (year 1 stage) of the 5 year research strategy - complete Jan 2018.
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). Discussed and ratified at the Trust Board Thinking Day (14th December 2017)	complete	NB

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

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…	Dec-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:	DSC	**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**
	3	3	3	3	3	2	2	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	2	2			

Controls assurance (planning)	Performance assurance (measuring)
UHL Frailty Oversight 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. To be supported by an operational group which is being set up.
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 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…	Dec-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:	DSC		**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**
	3	3	3	3	3	2	2	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	2	2			

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.	Review to be carried out re. Consultant Connect impact on clinicians and PA's.
Tender opportunity search process reported through ESB monthly.	(GAP) Research - what training and support do GPs want.
(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.	GP Hotline quarterly report to PCOB.
	CQUIN 6 A&G reports to come to PCOB.
	Consultants and clinicians "top gripes" survey scheduled for December.
	GP Hotline - feedback re. effectiveness gathered from Transferring Care Group.
External Senior representation on relevant STP Work stream Boards, namely Integrated Teams Programme Board - high level proposal / scoping document approved in April 2017.	
PRISM - to be managed through the Planned Care Board, with updates to PCOB.	
(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.	
(GAP) GP Hotline SOP.	

(GAP) GP Hotline to be reported at CQRG.	
(GAP) GP Hotline info to be shared with Mortality and Morbidity meetings.	

Actions planned to address gaps identified in sections above	Due Date	Owner
Tender response documents being collated, timeline to be presented to Jan PCOB and DRAFT suite of documents to the February board.	~~Feb 18~~ Mar- 18	JS
UHL offer or "Brochure" will be produced.	Q4 17/18	JS
Stakeholder Communciation/ Engagement plan in progress - to be agreed at Nov PCOB meeting. DRAFT presented - will be signed off at March PCOB. As needs to include new annual priorities.	~~Jan 18~~ Mar - 18	AT
Availabilty of funding is being tracked and managed by PCOB.	ongoing	MW
GP Hotline SOP to be completed and presented to March PCOB.	Mar-18	CH
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	Dec-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**		AC / FIC
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3	3	3	3	3	2	2	2	2			
Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**June**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3	3	3	3	3	2	2	2	2			

Planning (controls)	Performance Management (assurance sources)
Develop EMCHC full business case - the outcome that UHL will keep the EMCHC servcie was announced as the outcome of the national review on the 30th November 2017. Work will now proceed at pace to move the EMCHC service on to the LRI.	Performance against EMCHC project plan - detailed plan being developed to confirm timelines. Preferred options for the relocation of the service to be confirmed. Two options exist: Balmoral and kensington. Kensington is the preferredoption; work is progressing on this option at risk since it is depenmdant on the funding of the whole programmme.
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 one month delayed owing to NHSI requesting an additional month to approve the OBC. OBC approved by the UHL TB in November, and the CCG Boards on 14th November; FBC to be completed by end Feb 2018. NHSI have advised that the OBC is scheduled to be presented to the February 12th National Resouece meeting.
Deliver Emergency Floor Phase 2 (to complete in 2017/18).	Performance against Emergency Floor Phase 2 project plan - on track.
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. This was discussed at the November Reconfiguration Programme Board and agreed that delivery should be the responsibility of the CMG with support from estates.
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).	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 prioritisation process following the Autumn Budget on 22nd November. Performance against Reconfiguration Programme project plan - will be delayed as we await confirmation of funing. out ability to mitigate delay will be clear when we develop the design

Actions planned to address gaps identified in sections above	Due Date	Owner
EMCHC move to LRI - scope for project is being finalised, detailed delivery plan to progress the Kensington option.	Feb-18	MW
Interim ICU project - FBC is being drafted as first part of external approval process.	Mar-18	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 / 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	Dec-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**	**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**	**2**	**2**			

Controls assurance (planning)	Performance assurance (measuring)
EPR Plan - Paperless Hospital 2020 (PH2020) scoped in Prog Def Doc (draft)	(GAP) EPR Plan - key milestones to be developed.
Wards - Implement NC forms and rules to support clinical practice.	IM&T Project Dashboard - Milestones reported are on track
Wards - NC bed management Roll-out completed Jan18	Paperless Hospital 2020 Board - monthly programme governance mtg
Outpatient - Specification for NC agreed. ICE OCS pilot completed	
Upgrade legacy systems - part of prioritisation plan	
(GAP) Desktop replacement programme	
IM&T Project Dashboard reported to EIM&T Board.	
(GAP) IM&T Project Management Support.	

Actions planned to address gaps identified in sections above	Due Date	Owner
Demand for projects exceeds capacity - project prioritisation till Mar18 agreed	Mar-18	IM&T/UHL
EPR Plan - Draft Prog Def Document to be approved; prog plan & deliverables to be developed and agree the EPR KPIs.	Feb-18	IM&T/UHL
ICE in Outpatients - waiting for ICE hardware and Software upgrades (legacy upgrade) as pre-requisites. In pipeline	TBC	IM&T/UHL
Legacy Upgrades - HISS; ORMIS; ICE all in progress. Desktop computing - proposal submitted	Mar-18	IM&T/UHL
Strengthen the Project Management Support - Recruitment in progress - PSO started Jan 18, PAM leaving Feb18	May-18	IM&T/UHL
Vacancies for IM&T architect, analysts and funding for NC developers - recruitment in progress	ongoing	IM&T/UHL

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	Audit Committee/QOC		IM&T report provided on request.
TB sub Committee	FIC	Dec-17	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.

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	Dec-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**
	4	3	4	4	4	2	2	2	2			
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	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 Annual Survey 2017/18 raw data results show an improvement against some elements of the overall engement score, however we note that several of the measures have decreased - Awaiting results by key finding areas in order to conduct detailed analysis.
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.	Metrics to measure number of UHL Way interventions utilised in supporting annual priorities - as a minimum Project Charter to be produced for all priorities.
LIA processes embedded.	
	Metrics to measure number of staff through UHL Way Master Class - 70 staff completed as at the end of Dec.
	Better Teams Aggregated Pulse Check Scores.
LLR Way	
LLR OD and Change Group (workforce enabling group).	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.	Metrics to measure no. of interventions utilised.
	Funding secured to progress LLR Way Elements.
LLR standardised improvement framework to approach change implemented.	
Framework to raise awareness of STP and LLR Way.	

Actions planned to address gaps identified in sections above	Due Date	Owner
Awaiting UHL Annual survey results by key finding areas in order to conduct detailed analysis.	Feb-18	BK

Corporate Oversight (TB / Sub Committees)			
Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	PPP Committee	Dec-17	Workforce Update Report - deep dive on WRES / Equality and Diversity Data

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…	Dec-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	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	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 has been achieved.
PID ratified at IFPIC on 31/08/17.	
Project governance defined in PID.	(GAP) 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 and future delivery targets across service lines will be completed in February 2018.	
Limited 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.	Feb-18	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).	Feb-18	DWOD

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	PPP	Jan-18	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 delivery targets across service lines which will be completed in February 2018. A progress update and presentation will be tabled at PPP in January 2018

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…	Dec-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	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	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…	Dec-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	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	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 M9, 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
Revised Control Totals to be signed-off by CMG Boards	Dec-17	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.

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 UHL Risk Register Report as at 31 Dec 17

Risk ID	Specialty	Risk Description	Risk Subtype	Controls in place	Likelihood	Impact	Current Risk	Action summary	Target Risk	Risk Type
2284	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.	Harm (Patient/Non-patient)	Staffing levels checked on daily basis and staff movement from other areas decided by Matron on site/bleep holder. Head of Nursing and Deputy Head of Nursing available at weekends to advise about staffing moves. All shifts required out to bank and agency contract due to lack of fill from Staff bank for some areas, other wards adhoc. Over time offered to all staff in advance. Reassurance and support from Matron where possible to pick up non clinical duties and sickness management, bank requests etc.	Almost certain	Major	20	CHUGGS Participation in all international recruitment during 2016; Deputy Head of Nursing to meet with HR Shared Services on a monthly basis; Active recruitment to Assistant Practitioner posts - due 31/01/17; Closed 26/Jan/2017. Participate in recruitment from Philippines and India; Pilot increased bank rates of pay on all GI, Medicine and Surgery and Urology wards at LRI and LGH Corporate HCA recruitment to be a priority for CHUGGS - 31/10/17. Completed 02/01/2018 Shifts for ward 22 at LRI/LGH, 27 LGH and SAU's on both sites going to break glass two weeks in advance- 31/01/18 First and second tier agencies to be offered long lines of work for two months in advance, including educational opportunities - 31/01/2018 Explore opportunities for recruiting to non-nursing roles that will support the nursing workforce, such as Ward Clerks and Pharmacy Technicians. 31/01/2018. Explore other opportunities for support from other CMG's. 31/01/18 Matrons to work one clinical shift per week. Head of Nursing and Deputy Head of Nursing to work clinical shift every two weeks. - 31/01/18 Head of Nursing meeting with ITAPS and MSS CMG to explore joint working opportunities. - 31/10/17. Head of Nursing had meeting with ITAPS. GSSU set up and opened 31/07/17 to remain open for 6 months. Review date 31/03/2018.	6	CMG Risk
2282	Clinical Support & Surgery	If recruitment and retention to vacancies on Ward 22 at the LRI does not occur, then patients may be exposed to harm due to poor skill mix on the Ward.	Harm (Patient/Non-patient)	Shifts escalated to bank and agency at an early stage; Increased the numbers of band 6's to provide leadership support. Agency contract in place for one nurse on day shift and night shift to increase nursing numbers. Staffing is reviewed on a day by day basis and staff are moved across the CMG to support the ward as required. Matron to work clinically on the ward for 2 days a week to provide support and increase nursing numbers. Matron to ensure daily matron ward rounds for leadership/ increased monitoring of care standards/accessibility to patients/relatives to discuss any concerns.	Almost certain	Major	20	Ongoing recruitment of trained and untrained nurses as per CHUGGS nursing action plan - 28/02/18; Training needs analysis of all registered nurses and action plan developed - 28/02/18. Restructuring of team to provide more senior support on a day by day basis - 28/02/18 Action plan being developed to be discussed with the Chief Nurse - 31/01/18 GSSU opened and being staffed by ITAPS for 6 months - 31/03/2018 Educational support and supervision requested for all new starters to the ward - 28/02/18 Plans to be developed to open beds that are currently in GSSU back to Ward 22 - 31/03/2018	6	CMG Risk
2284	Respiratory Medicine	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.	Harm (Patient/Non-patient)	Respiratory Consultant on CDU 5 days/week 0800-20 00 hrs Respiratory Consultant on CDU at weekends and bank holidays 0800-1200 hrs and on call thereafter Cardiology Consultant assigned on CDU 5 days a week (shared rota) Cardio Respiratory Streaming flow, including referral criteria and acceptance Short stay ward adjacent to CDU Discharge Lounge utilised GH duty Manager present 24/7 Bed co-ordinator and Flow co-ordinator, providing 7 day cover CDU dash board – performance indicators UHL bed state and triage times includes CDU data Daily nurse staffing review with plan to ensure safe staffing levels on CDU EDIS operational on CDU Daily patient discharge conference calls for all wards Matron of the day - rota covers 7 day working Daily board rounds across all wards Primary Care Co-ordinators and increased community support Escalation plans Implementation of triage audit CDU Operations Meeting Monitoring of patient triage times and other quality performance indicators at monthly CDU ops meeting with appropriate representation from all staff groups Gowns are provided to completely cover patients to protect their dignity. Increase staff awareness of privacy and dignity issues associated with the x-ray room. Commence introduction of cardiac and respiratory ANP's programme - reviewed - a VAU to be established on ward 23 GH, instead of using CDU . ANP's commenced in post. - complete Space utilisation review of CDU and Ward 20 to include the x-ray room - in progress at present, estates are working through potential solutions - 15.1.17 Review of extension of pharmacy working hours - complete Appoint Respiratory Consultant - Locum Respiratory Consultant appointed until June 2017, whilst substantive funding to be identified.	Almost certain	Major	20	Additional Imaging at weekends - complete Restructure pharmacy provision at weekends - complete To revise Matron of the Day and Manager of the Day responsibilities - 31.1.18 To open additional 14 beds for winter capacity - complete Additional Respiratory Consultant resource for weekend discharges - 31.1.18 Develop business case for Respiratory & Cardiology medical cover and gain RIC approval - 31.1.18 Winter plan to cancel OPD clinics between Christmas & New Year - complete	9	CMG Risk
2149	ESM	If we do not recruit and retain into the current Nursing vacancies within SM, then patient safety and quality of care may be compromised resulting in potential delayed care.	Harm (Patient/Non-patient)	*Staffing Escalation policy *Staffing Bleep Holder / Matron support ,Site Manager and Duty Manager *Incident reporting *Complaints monitoring *Daily Staffing Meetings *Monitor staffing levels *Monitoring recruitment and retention *Monitoring sickness levels *Provision of nursing support from other base wards *Support from the Outreach Team *Support from Education & Development Team *Support from Deputy/ Head of Nursing. *Moving staff between clinical areas as a means to balance risk. *Agency and bank as a means to increase nursing numbers. *Clinical matron/senior nurse available daily to ensure clinical risk is mitigated and managed. * Silver Nursing structure in place to review safe staffing 3 times a day linked in with safe care *Bed management meeting at 9.00, 11.00 16.00, 18.00 and 20.00 to review bed demands and staffing issues across the Trust. *Matron visibility on wards Monday to Friday 8 - 8pm and 8 - 4pm at weekends to ensure Trust Safe Staffing Monitor sheet. *Agreed staffing levels and establishment reviews completed bi-annually. *Workforce meeting for CMG. *Dashboards in place for clinical issues to monitor quality. *Engaging in Trust recruitment strategy. *Monthly staffing engagement forum. *Block book contracts with agency to improve fill rate *Workstreams established which will help support the effective management of improved simple & complex discharge to support nursing staff in minimizing patient say reducing LOS & supporting potential closure of beds reducing demands on nurse staffing. *Undertake regular stress assessments and manage according to outcome. *Ensure staff have regular appraisals as a means to valuing staff and supporting them in stressful times. * Undertake Exit interviews taking place.	Almost certain	Major	20	New staff from Philippines and India are awaiting IELT's and Visa's. Discussion with Eleanor Meldrum and Maria McAuley on how to attract agency staff to Long Lines. Ongoing work with the "Team around the patient and Tomorrow's Ward"	8	CMG Risk
2804	ESM	If the ongoing pressures in medical admissions continue, then ESM CMG medicine bed base will be insufficient thus resulting in jeopardised delivery of RTT targets.	Harm (Patient/Non-patient)	Review of capacity requirements throughout the day 4 X daily. Issues escalated at Gold command meetings and outlying plans executed as necessary taking into account impact on elective activity. Opportunities to use community capacity (beds and community services) promoted at site meetings. Daily board rounds and conference calls to confirm and challenge requirements for patients who have met criteria for discharge and where there are delays ICS/ICRS in reach in place. PCC roles fully embedded. Discharges before 11am and 1pm monitored weekly supported by review of weekly ward based metrics. Ward based discharge group working to implement new ways of delivering safe and early discharge. Explicit criteria for outlying in place supported. Review of complaints and incidents data. Safety rota developed to ensure there is an identified consultant to review outliers on non-medical wards. Access to community resources to enable patients to be discharged in a timely manner. CMG to access and act on additional corporate support to focus on discharge processes. Matron for discharge appointed to provide consistent care for patients needing to be outlied. Continue to review outlying daily at conference call and flow team dedicated matron. Ongoing implementation of Base ward discharge plans at weekly meeting. New Red to Green initiative rolled out December to reduce delays. On-going implementation of EQSG action plan for improving emergency flow- support from other Specialities as in their funded beds, i.e workforce.	Almost certain	Major	20	E-Beds being rolled out live on 20 November - ongoing monitoring and action planning.	12	CMG Risk

Risk ID	Specialty	Risk Description	Risk Subtype	Controls in place	Impact	Likelihood	Current Risk	Action summary	Target Risk	Risk Type
3114	ITAPS	If we are unsuccessful in recruiting ITU medical and nursing staff to agreed establishment, then we are at risk of not being able to deliver a safe and effective service, resulting in delay in treatment to patients and deterioration in performance.	Harm (Patient/Non-patient)	Preventive: *Early identification of risks around staffing gaps *Daily discussion to gain overview of staffing cross site *Targeted recruitment approach with a rolling recruitment programme *Retention-CMG run development programme for career progression *Support Nurses to undertake the critical care course at DMU *CMG dash board discussed weekly in the CMG business meeting. Activity, adherence to targets and income included. *Medical and non medical recruitment leads in post *Medical and non medical workforce meetings to discuss way forward and potential efficiencies as well as the risks. *Electronic roster for nursing staff *CLW for medical staff allowing transparence *Cross site communication daily through gold command and movement of staff when possible cross site and early escalation to corporate colleagues via gold command *Avoid OTDC through early detection of staffing gaps resulting in CMG unable to admit elective patients post op *Review of emergency activity and potential admissions to ITU Detective: *Daily communication within CMG regarding risks to performance, efficiency and cancellations *Non medical and medical recruitment lead working closely with HR and CMG management tracking the recruitment and reporting any deviation to recruitment targets *Timely review and action of Datix reported incidents *Review of pay budgets Corrective: *Review of staffing establishment *Recruitment and retention programme *Exploration of new ways of working *Future service reconfiguration - 2 site model and transfer team	4 Major	20 Almost certain	LiA event with ITU staff to develop and enact R&R strategy Focus on safe staffing numbers in ITU Agree a recruitment target with HR recruitment services Ongoing focused recruitment and retention Monitor premium and acting down spend v. FIY	6	OMG Risk
3120	ITAPS	If there is a continued mismatch between capacity and demand for access to emergency theatres we are at risk of cat 2 and 3 patients not receiving surgery within the NCEPOD timeframe's and increased requirement for out of hours working with cases that should have been completed during day-time hours, and a knock on effect for the consultants on call and their next day working	Service disruption	Preventive: *Prioritisation of access to emergency theatres on the basis of clinical priority *Adherence to safer surgery Detective: *Continuous monitoring of NCEPOD compliance and OTDC *CMG dashboard discussed weekly in the CMG business meeting. Activity and adherence to targets included. *Timely review and action of Datix reported incidents *Tracking of demand and capacity Corrective: *In-hours emergency demands can / will replace elective activity *Recruitment and retention plans in place *SOP developed for extreme circumstances to tackle peaks in activity including movement of staff / patients cross site.	5 Extreme	20 Likely	To disseminate to all affected CMGs	12	OMG Risk
3113	ITAPS	If the infrastructure in our ITU's is not updated and expanded to meet current standards and demand, then clinical teams will not be able to provide safe care to all patients requiring level 2 or 3 care resulting in deterioration in clinical outcomes benchmarked against other centres (ICNARC).	Harm (Patient/Non-patient)	Preventive: *Ensure patients are prioritised and activity discussed across all 3 units *IP audits and ward rounds *Cross CMG discussions regarding reconfiguration plans *Staff movement between sites to create beds and staffing matched to clinical need *Non clinical patient transfer between units *Out of area non clinical transfers Detective: *Patient safety incident reporting *RCA's for all preventable infections with action plans *Recruitment and retention targets monitored Corrective: *Investment in infrastructure and reconfiguration - 2 site model	4 Major	20 Almost certain	Trust Board support and investment for unit rebuild CA/GH - 31 Mar 18 CMG commitment to remedial works where feasible eg IT hardware, IP actions, superficial decoration for patient/staff experience GH/JH- 31 Mar 18 Impact of reconfiguration on priorities, site and size CA/GH Oct 2017 March 2018 - 31 Mar 18	8	OMG Risk
2940	Medicine	Risk that paed cardiac surgery will cease to be commissioned in Leicester with consequences for intensive care & other services	Financial loss (Annual)	Weekly staff communications briefings. Regular staff 'open' meetings to provide opportunity for concerns to be raised. Dedicated EMCHC project manager recruited. Dedicated project campaign resourced. Data manager employed to monitor EMCHC KPIs and performance. Legal advice instructed (Sharing the same legal team with Brompton Hospital). Opening additional ward capacity to meet the commissioning cardiac standards. UHL performance recognised by the Care Quality Commission who, in their initial feedback letter following their inspection in June 2016, reported: "We noted the excellent clinical outcomes for children following cardiac surgery at Glenfield Hospital. EMCHC website developed High priority activity strategy to meet the standard of 375 cases per year Trust Board led challenge to reject the NHSE decision by way of a signed letter by the CEO (05/07/16). NHS England visit to Leicester QC to brief the legal options to the TB in Oct 2016 Expansion of Ward 30 to open an extra 7 beds Liaising with East Midlands MP's	5 Extreme	20 Likely	Ensure project to relocate EMCHC to Children's Hospital stays within capital budget allocation due 30/04/2019	8	OMG Risk
2403	Medicine	There is a risk changes in the organisational structure will adversely affect water management arrangements in UHL	Harm (Patient/Non-patient)	Instruction re: the flushing of infrequently used outlets is incorporated into the Mandatory Infection Prevention training package for all clinical staff. Senior Infection Prevention Nurse works as an integral part of the estates and facilities team and undertakes the infection prevention review of water results. Part of this role is the coordination, communication and management of any affected outlets in conjunction with E&F colleagues. Flushing of infrequently used outlets is part of the Interserve contract with UHL and this should be immediately reviewed to ensure this is being delivered by Interserve All Heads of Nursing have been advised through the Nursing Executive Team and via the widely communicated National Trust Development Action Plan (following their IP inspection visit in Dec 2013) that they must ensure that their wards and depts are keeping records of all flushing undertaken and this must be widely communicated Monitoring of flushing records has been incorporated into the CMG Infection Prevention Toolkit (reviewed monthly) and the Ward Review Tool (reviewed quarterly). Senior Infection Prevention Nurse working with Facilities.	4 Major	20 Almost certain	To review and agree Water Safety Plan-Revised Water Management Policy and Water Safety Plan approved by the Trust Infection Prevention Committee. Implementation programme to be confirmed by Facilities colleagues - 31/01/18	4	Corporate Risk
3054	HR, Training & 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.	Service disruption	Preventive: eUHL has been turned back on for those staff whose accounts could not be created or data integrity is in question Social media communication has been sent to all bank staff with clear guidelines and actions in relation to using HELM or eUHL Core Training Team working with bank team and supporting where required Core Training Team monitoring daily Detective: Currently over 9000 staff have access to the new HELM system, the core Training Team with OCB Media and JOLT monitor this on a daily basis. There should be an increase in staff having access to HELM and all data is correct. The plan agreed for governance and assurance is that all staff will have an account and data correct by 31 July 17. Corrective: Weekly telephone conference arranged with the Chief Information Officer for assurance plus weekly telephone meetings with the developers (OCB Media and JOLT) to hold to account on deadlines. Removal of requirement to provide evidence of statutory and mandatory completion at time of appraisal.	5 Extreme	20 Likely	HELM development priority - data accuracy - completion of adjustments required Implementation of HELMX2 - Jan 2018 Maintain and correct issues raised through HELM support desk (interrvals as per attached Actiion Plan) - 30 Jan 18 Correct misaligned accounts on HELM (at intervals as per attached Action Plan) - 30 Jan 18 Correct misaligned accounts on HELM (at intervals as per attached Action Plan) - 30 Jan 18 Creation of compliance reporting - 30 Jan 18 HELM development priority - centralised reporting - 30 Jan 18 HELM development priority - data accuracy / integrity - 30 Jan 18 Implementation of eGreen Book - 31 Mar 18 Implementation of HELMX2 - 31 Mar 18 Testing of compliance reports - 31 Jan 18	3	Corporate Risk

Risk ID	Specialty	Risk Description	Risk Subtype	Controls in place	Impact	Likelihood	Current Risk	Action summary	Target Risk	Risk Type
2404	Clinical Support Services	There is a risk that inadequate management of Vascular Access Devices could result in increased morbidity and mortality	Harm (Patient/Non-patient)	UHL Policies are in place to minimise the risk to patients that staff are required to adhere too. A revised data report is being produced for the January 2017 Trust Infection Prevention Assurance Committee that will provide greater transparency with regard to audit results and allow Clinical Management Group boards and Senior staff the insight into areas that require actions to address poor performance	Moderate	Almost certain	20	Targeted surveillance in areas where low compliance identified via trust CVC audit - Yet to be established due to lack of staff required. For further review by the Vascular Access Committee - 31 Jan 18. Develop the recommendations of the Vascular Access Committee action plans to increase the Vascular Access Team within the Trust in line with other organisations. Business Case to be submitted within the organisation by the CSI CMG with support from the Assistant Medical Director appointed by the Medical Director to oversee this objective - 31 Jan 18. Support the recommendations of the Vascular Access Group action plans to reduce the risk of harm to patients and improve compliance with legislation and UHL policies - 31 Jan 18.	16	Corporate Risk
2568	Clinical Support Services	If the range of Toshiba Aquilion CT scanners are not upgraded, Then patients will experience delays with their treatment planning process.	Harm (Patient/Non-	Limited arrangements for planning palliative patients only (unable to treat radical patients) Comprehensive Service Contract with Toshiba for scanner up until May 2016.	Major	Likely	16	Update 18.10.17 Alternative contingency plans explored but not progressed due to technical difficulties. Business case approved and CT scanner to be purchased by MES provisional installation date of March 2018 Installation of new CT scanner - 31 Mar 18	1	CMG Risk
3040	Clinical Support Services	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.	Harm (Patient/Non-patient)	Preventive: •Medical workforce Manager and JDA team monitor the current rotas to identify significant gaps and complete the necessary actions and planning to ensure cover or reduce the number of medical gaps •Planning of rotations during the 2017/18 with the support of Medical HR to identify gaps and complete the necessary actions to ensure cover or reduce the number of medical gaps •Efficient recruitment processes – rolling adverts •Maximising current resources to cover the gaps where possible •Effective communication with medical group and escalation procedures •Increased educational sessions in Trust Grade job plan to develop skills and career progression •Provide a more supportive network to Trust Grades within cardiology Detective: •RRCV CMG performance meetings where medical cover is discussed •Respiratory and Cardiology Board meetings with attendance from Education representatives to escalate concerns •Junior Dr and other Dr forums and 'gripe' system to identify themes of issues •LRI support •Review of different working models and RRCV investment to explore alternative options including the use of Advanced Care Practitioners (ACPs) and Physician Associate (PA) •Benchmarking from other Trusts and Organisations for different ways of working Corrective: •Recruitment to gaps •Action plan for HEE-EM •Scheduling of RRCV meetings with relevant personnel to review gaps and solutions - e.g time out	Major	Likely	16	Medical Workforce Manager and JDA team to continue to monitor rotation gaps and take the necessary steps to make base wards and CDU safe ensuring escalation is completed when required - Adequate number of SpR's and Trust grades for service provision for continual monitoring - 31.3.18 Effective and timely recruitment completed with the support of the medical HR team to fill medical staffing gaps and reduce risk as much as possible - HR workforce meetings in place to offer support with current vacancies - completed Frequent scheduled meetings to ensure the monitoring of the HEE-EM action plan and reassurance of actions being completed. - completed RRCV CMG winter and operational plans and escalation of issues to appropriate Executive Trust Board(s) - 1.2.18 Recruitment of ANP and PA posts to RRCV to support the medical gaps which are unable to be filled to improve staffing numbers on base wards and CDU - complete	9	CMG Risk
2820	Clinical Support Services	If a timely VTE risk assessments is not undertaken on admission to CDU, then we will be breach of NICE CCG92 guidelines resulting patients being placed at risk of harm.	Harm (Patient/Non-patient)	Interim solution to highlight the VTE risk assessment form on the CDU Medical Clerking proforma with a bold red/white sticker. Raise awareness at Junior Doctor Local Induction training. Close monitoring of the monthly VTE target with support from VTE nurse specialist. Complete 'spot check' audit at least once a month - complete	Major	Likely	16	Implementation of Nerve Centre in CDU which will support the recording of VTE status - 31 Mar 18	3	CMG Risk
3088	Clinical Support Services	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.	Harm (Patient/Non-patient)	"Safer surgery checklist Capacity and demand review undertaken to identify size of the problem and resources required this has been completed and no knowledge of gaps identified but Admin staff did feel overwhelmed with current demands. LOCSIPS/NATSIPS pertaining to dermatology procedures robust team briefings will take place before all outpatient procedure lists start in dermatology to include medics and outpatient staff immediately. spot audits of checking & consent processes and procedures for dermatology procedure lists for the next 2 weeks Immediately. All staff have received and read new SOP, Service Manager has met with all admin staff to ensure training needs are met. No training needs identified. GM from ophthalmology to provide external review of Dermatology admin processes taken place. Admin & clerical vacancies with HR service agreed a plan to recruit and retain admin & clerical staff. Current gap x2 wte, put out to bank and pulling from other areas where possible, posts now filled with permanent and bank until March 2018	Major	Likely	16	Demand and capacity work undertaken review of vacancy gap completed by Jodie Bale, this has highlighted a gap in current capacity in clinics and Jodie is looking at options to close gap due for review and update by 31.12.2017 Agreement to be reached regarding plan to resource service (as required) in the longer term after capacity and demand review. Current gap os 2 x WTE, where possible we are pulling from other teams across ESM to help we have also put out bank shifts. 1 post recruited to and 1 out to advert 31/12/2017 Process mapping of admin processes to be undertaken regarding key patient pathways to identify inefficiencies in service delivery due 31.12.2017 Jodie Bale & Katrina Toland to review tasks undertaken by nurse specialists to ensure maximum efficiency in the short term overdue 31.12.2017. Review tasks undertaken by medical staff to ensure maximum efficiency in the short term, job planning meeting taken place and agreed to extend PA to 4 hour sessions. Jodie Bale to review demand and capacity to see if there is any additional capacity ongoing and due 31.12.2017 Jodie Bale and Katrina Toland to communicate Safer Surgery checklist process to all medical and nursing staff in dermatology for clarity due 31.12.2017 Dr Lawrence to Review Risk ID 2590 in conjunction with this risk to ensure that all key actions are taking place/planned due 31.12.2017	16	CMG Risk
3025	Clinical Support Services	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.	Harm (Patient/Non-patient)	1.Shifts escalated to bank and agency at an early stage. 2.Increased the numbers of Band 6's to provide leadership support on the floor. 3.Agency shifts escalated to break glass agencies one week in advance. 4.Amvale paramedic in assessment bay to support timely ambulance handover. 5. Incentive scheme payments for HCA's and RN's working additional shifts in ED on the bank. 6.VAC Nurse in place to observe the waiting areas for patients at all times to ensure patient safety whilst awaiting assessment. 7. Lead role for recruitment within the Matron team and dedicated time spent on recruitment. 8.Rolling advert for recruitment to band 5 and band 2 roles. Continue actively recruiting to all grades of nursing staff. 9.International recruitment undertaken - awaiting start dates of staff 10.Review of staffing levels across all areas on a daily basis and staff moved around to support areas most in need. 11.Active Management of staff absence to maximise staff availability to work. 12.Agency staff working regular shifts for continuity of care.	Major	Likely	16	Advertise to recruit to GPAU and CSSU as individual areas to work 31/01/2018 Recruit to nursing associate roles31/01/2018 Further recruitment to vacant ECP / ACP Roles 31/01/2018 Offer rotational posts across dept/wards 31/01/2018 Offer rotational posts into Childrens ED 31/01/2018	4	CMG Risk
3044	Clinical Support Services	If under achievement against key Infectious Disease CQUIN Triggers (Hepatitis C Virus), Then income will be affected.	Financial loss (Annual)	Monthly business meetings to monitor progress. Monitoring run rate on a monthly basis. Regular updates with Northampton and Kettering around low cost acquisition drugs. ODN meeting to take place in June 21st at Northampton.	Major	Likely	16	Letter to ODN network leads from UHL senior finance manager Jon Currington currently on hold. Secure honorary contract for Prof Wiselka to work at Northampton ongoing. Set up formal ODN network business meeting. Set up monthly clinics in Northampton. Monthly updates to ESM Board by Richard Philips. 29 Dec 17 Set up monthly clinics in Northampton - 29 Dec 17 Set up formal ODN network business meetings - 29 Dec 17 Secure honorary contract for Prof Wiselka to work at Northampton - 29 Dec 17 Monthly updates to ESM Board - 29 Dec 17	8	CMG Risk

Risk ID	Specialty	Risk Description	Risk Subtype	Controls in place	Impact	Likelihood	Current Risk	Action summary	Target Risk	Risk Type
3121	T&O/PC	If operating theatres' ventilation systems fail due to lack of maintenance, then the affected theatres cannot be used to provide patient care resulting in reduced theatre capacity and pressure on other theatres to meet demand and may lead to patient cancellations	Service disruption	Preventive: *Refurbishment programme- as estate is old there is a need to improve / validate the ventilation system in theatre to the HTM03-01 guidelines *All ventilation systems have been checked and guidance has been produced Detective: *Clinical incident recording *Closure of theatres Corrective: *Recommission th18 at LRI for use as a decant theatre, with staff and cases moved accordingly	Minor	Likely	16	Refurbishment programme- as estate is old there is a need to improve / validate the ventilation system in theatre to the HTM03-01 guidelines	9	CMG Risk
2383	Anaesthesia	If we do not recruit into the Paediatric Cardiac Anaesthetic vacancies, then we will not be able to maintain a WTD compliant rota resulting in service disruption.	Harm (Patient/Non-patient)	1:4 rota covered by 3 colleagues Fellow appointed in July 2016 who has now undergone appointments process and started as consultant on 1st of May 2017.	Major	Likely	16	The service still has a consultant vacancy which is proving difficult to recruit to due to the uncertainty of future commissioning/?service closure 9. Updated 03/07/17 - 1 consultant appointed. The second vacant post to be converted to a fellowship post as currently unable to recruit. The revised JD is being reviewed. Due to this change the review date has been moved to 30/12/17.	8	CMG Risk
2988	T&O/Trauma & Orthopaedics	If we do not recruit into the Trauma Wards nursing vacancies, then patient safety and quality of care will be placed at risk	Harm (Patient/Non-patient)	The wards are on electronic staff rostering and off duties is produced 6 weeks in advance; requests for temporary staffing are made 6 weeks in advance when possible. All shifts required are escalated to bank and agency and over time is offered to all staff in advance. Staffing levels are checked on a daily basis by the bed co-ordinator and matron. Staff are moved between the areas to try & maintain safety & service. Staff are moved from other areas if / when possible when escalated to Matron / head (or assistant head) of nursing / duty manager. New staff to the area attend the relevant study days in order to gain the relevant skills to look after the patients. Exploring the possibility of staff moving from other areas within the CMG (on a daily basis) where possible & potentially needing to close more beds.	Major	Likely	16	On-going nurse recruitment programmes	4	CMG Risk
2395	CSI	If system faults attributed to EMRAD are not expediently resolved, Then we will continue to expose patient to the risk of harm	Harm (Patient/Non-patient)	Use of out sourcing in order to make up for reduced service efficiency Conference calls with GE to ensure system faults are expediently brought to their attention for a swift resolution in order to minimise service impact. Continued meetings with GE and IMT to obtain solutions and deadline dates to restore service efficiency. Log of system faults recorded and monitored to ensure developers are finding resolutions in a timely manner. Negotiation to terminate use of ERAD cockpit and revert to local CRIS system under way. UHL will leave the EMRAD consortium once this negotiation is complete.	Major	Likely	16	2. GE to provide breakdown of reported issues with the EMRAD system and feedback on their resolution (with timescales - although GE have stated some items they will not be able to provide timescale) - 31st Jan 2018. 3. GE to upgrade eRC to version 6.05 to rectify performance issues and crashes (to resolve issues with reporting examinations) - Currently due March (GE currently updating timescales as this was originally scheduled for December) - 31st Jan 2018. 5. Review and resolution of system reference data processes and management of central reference data that impacts on patient care - Due to discuss with IT 18th Mar 17, no resolution date agreed. -- 31st Jan 2018. Negotiate withdrawal from EMRAD consortium and use of ERAD cockpit.	4	CMG Risk
2873	CSI/Pathology - Cytogenetics	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	Financial loss (Annual)	Empath procurement specification utilising exiting services within UHL and NUH pathology services. This includes Molecular genetics at NUH and Empath molecular diagnostics to ensure that all elements of the procurement be addressed. Public consultation period clarifying the scope and service specification requirements in autumn 2014. Plans to form a single genetic laboratory service for the east midlands under Empath which would be able to cover the expected requirement s of the service specification There is a verbal agreement to submit a joint response to the tender between UHL and NUH incorporating Empath services and genetics at NUH.(Update Dec 2016:Time line now Spring 2017 with advice to bidders Autumn 2017)	Major	Likely	16	Empath response to procurement (with NUH). To submit a successful bid to provide the Genetics lab service for E.Midlands- 28 Feb 2018 L.Cresswell updated 12/12/17: The submission of tender in extended to end of Feb 2018.Staffing information has been shared with NHSE, a further bilateral meeting has been held with NHSE. Progress is being made on the operational model for the hub and subcontractors. The contractual model for the three trusts is to be confirmed however Uhl most likely will be as a subcontractor. The draft test directory has been published and commented on but a lot of information e.g. eligibility criteria are not available. There are some concerns particularly around the cancer directory. Teleconferences and meetings continue between the UHL, NUH and CUH working on operational and organisation form. A paper relating to this procurement and other challenges around genomics was presented at ESB on 12/12/17. A task and finish group chaired by Nigel Brunskill is being set up.	8	CMG Risk
2983	CSI/Radiation Safety	There is a risk of a reduced service and possible non-compliance with legislation due to a failure to recruit in RPS	Harm (Patient/Non-patient)	The previous Head of Radiation Protection has returned on a temporary 2 day a week basis. The Head of Medical Physics will be acting as the interim RPA, RWA and MPE. They are devoting 1 day per week to supporting this service. KPIs are in place which should detect any slippage early. There are other members of staff who are competent to carry out some aspects of the QA. Recruit band 5 and ATO posts - completed Recruit band 5 post - completed Train ATO to cover QA work - completed Finish cross training of other members of staff currently working in the area - completed Write a briefing paper to CSI Exec Team about required staffing levels - completed	Major	Likely	16	Recruit band 8b - 31/12/18 Agree staffing levels with CSI Exec Team - 1/4/18	4	CMG Risk
2378	CSI/Pharmacy	If we do not recruit, up skill and retain staff into the Pharmacy workforce, then the service will not meet increasing demands resulting in reduced staff presence on wards or clinics.	Harm (Patient/Non-patient)	extra hours being worked by part time staff, payment for weekend commitment / toil and reduction in extra commitments where possible team leaders involved in increased 'hands' on delivery staff time focused on patient care delivery (project time, meeting attendance reduced) Prioritisation of specific delivery issues e.g. high risk areas and discharge prescriptions, chemo suite . Reduced presence at non direct patient focused activities e.g. CMG board/ Q&S and delay projects / training where possible. Revised rotas in place to provide staff/ service based on risk Recruit 8A pharmacists to replace those promoted to 8B Release band 3 staff to support onc/haem satellite	Major	Likely	16	review technician deployment and impact of band 5 technician losses at GH - 31/03/2018	9	CMG Risk
3118	CSI/Pharmacy	If there is a lack of planned IT hardware replacement then this will result in high levels of non-functioning/ non-repairable ePMA COWs Resulting in Nursing staff being non-compliant with requirements of both NMC and Leicestershire Medicines Code because the Computers on Wheels (COWS) will be unable to be taken to the bedside of the patient for drug administration.	Harm (Patient/Non-patient)	Preventive: Care of your COW guidance was circulated and attached to all drug COWs in mid-2015 ePMA guidance was reviewed and incorporates instructions on reporting failure of equipment Detective A paper on failing COWs was presented and discussed at EQB in February 2017 and it was agreed to consider the current issues with IM&T equipment with senior managers within IM&T. Corrective: CMGs agreed mass purchase of laptop batteries in 2015, which allowed the ePMA team to carry out battery replacement programme with laptops, to raise level of functioning equipment, but this is not possible with the RDP COWs. An RDP (manufacturer of the ePMA COWs) engineer has to undertake replacement of batteries. Functioning RDP COWs from other sites purchased to support the Trust wide rollout of Medchart have been relocated to live Medchart wards to maximise level of functioning equipment 15 iPads were distributed to live Medchart ePMA areas in April 2017 to help nursing staff administer medications on ward. In particular 6 iPads were taken to Ward 38, who are now a flagship iPad ward and utilise a traditional drug trolley and an iPad to conduct their drug rounds. Ward 37 purchased three new Infinity Parity carts and Ward 34 has recently purchased one new Medstore laptop Parity carts as they had significant problems with broken equipment. The new equipment has been well received on these wards.	Major	Likely	16	IT policy to be reviewed to ensure that response times/ repair target times match urgent equipment repair needs. Managed equipment service to be in place to facilitate better management of broken equipment - 31/03/2018	1	CMG Risk

Risk ID	Speciality	Risk Description	Risk Subtype	Controls in place	Impact	Likelihood	Current Risk	Action summary	Target Risk	Risk Type
2816	Urology	If blood samples are mislabeled, 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.	Harm (Patient/Non-patient)	1 - Training guide in place - Staff must check the label before putting it on sample bottle and make sure the correct information is put on, if any problems with the ICE printer they must Log it X8000 and report it to Management . 2 - Daily audit by each member of staff for each ward on all 3 sites listing numbers of issues with reprinting and printing of incorrect patient details. 3 - Reported to IM&T daily and CSI management as an additional monitoring process 4 - Policy reviewed and all phlebotomy staff have received refresher training and advice on monitoring and reporting 5 - Weekly spot check audits by Phlebotomy management to ensure staff are following processes	Minor	Likely	16	IT now updating weekly however still no resolution to the issue - DW to chase weekly - ongoing chasing and feedback received but no resolution to the issue as yet - DW to continue escalating and chasing IM&T IM&T confirmed that they now have this risk on their risk register as well A working group was set up to review the implementation of the Blood trac system as being a possible solution to the risk of patient samples being mixed up. Review 31/12/17 IT have found a solution to the printer delay/reprint issue and LRI has been error free for 2 months, GH were updated Dec 17 and LGH due for completion end January - will continue to monitor until end of March and if no further issues then risk will be closed - 31/3/2018	6	CMG Risk
3008	Urology	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.	Harm (Patient/Non-patient)	From March 2017 the transport team will continue to dial for an ambulance when required. An escalation procedure through Trust & EMAS management has been developed for when vehicles are not available as needed. Datix forms will be submitted for delayed response. The EMPTS core team will continue to discuss with EMAS and NHSE to develop a solution. Enquiries will be made to other ambulance providers, regarding specification of vehicles, accessibility and cost. All material will be shared with the Trusts' Implementation group who meet on a monthly basis to update and discuss.	Major	Likely	16	EMPTS working with EMAS and NHSE to develop a solution due 20/01/2018	15	CMG Risk
2153	Urology	Shortfall in the number of all qualified nurses working in the Children's Hospital.	Harm (Patient/Non-patient)	Where possible the bed base is flexed on a daily bases to ensure we are maintaining our nurse to bed ratios There is an active campaign to recruit nurses locally, national and internationally Additional health care assistance have been employed to support the shortfall of qualified nurses. Specialise Nurses are helping to cover ward clinical shifts. Cardiac Liaison Team cover Outpatient clinics Overtime, bank & agency staff requested Head of Nursing, Lead Nurse, Matron and ECMO Co-ordinator cover clinical shifts Adult ICU staff cover shifts where possible Recruitment and retention premium in place to reduce turn-off of staff Part time staff being paid overtime Program in place for international nurses in the HDU and Intensive Care Environment Second Registration for Adult nurses in place	Major	Likely	16	Continue to recruit to remaining Band 5 vacancies in PICU & Ward 30 GH - due 31/12/18 Brochure to be sent out to all Universities, visiting universities to inform students of the opportunities in Leicester due 30/04/2018 Attend Job fairs throughout the year 31/07/2018	8	CMG Risk
2267	Urology	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.	Harm (Patient/Non-patient)	Abnormal pathology results escalation process Suspicious imaging findings escalated to MDTs Trust plan to replace iCM (to include mandatory fields requiring clinicians to acknowledge results). Diagnostic testing policy approved.	Major	Likely	16	Conserus is currently being piloted before more widespread roll-out. IT have just allocated project resource to project which will allow aspirations to develop ICE to be taken forward - this be contingent on upgrade of hardware and software which is unlikely to take place before Jan 2018. In the interim, small scale piloting of the Mobile ICE app will be able to take place with a group of 20 clinicians - 31 Jan 18	8	Corporate Risk
2808	Urology	If there are insufficient Management controls in place to meet Regulation 4 of the Control of Asbestos Regulations (CAR) then there is a increased risk of enforcement action by the HSE resulting in prosecution, and/or significant financial impact and reputational damage.	Reputation	Interim Asbestos register created in Excel by Head of QSHE. All pre-existing remedial actions from latest re-inspection surveys sent to Capital to generate 3 Capital Schemes across the 3 locations. Removal project tendered for - awaiting contract award. Asbestos Working Group established Re-Survey Scope to be generated and sent for Tender. Update Floorplans on MICAD to allow ACM details to be uploaded and managed.	Major	Likely	16	Current Status: - Interim Asbestos Register created, UHL is currently operating on a part manual and par automatic register. Perform Asbestos survey - 31 Dec 18	4	Corporate Risk
2247	Urology	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.	Harm (Patient/Non-patient)	HRSS structure review. A temporary Band 5 HRSS Team Leader appointed. A Nursing lead identified. Recruitment plan developed with fortnightly meetings to review progress. Vacancy monitoring. Bank/agency utilisation. Shift moves of staff. Ward Manager/Matron return to wards full time.	Major	Likely	16	Recruitment continues with monthly rolling adverts, under the umbrella of the national shortage of Registered Nurses. International recruitment continues with 38 non EU commenced in 2017. Second cohort of trainee Nursing Associates will hopefully be recruited in January 2018 (50 places for LLR, minimum of 20 places for UHL). Review 5/3/18	12	Corporate Risk
1693	Urology	If clinical coding is not accurate then income will be affected.	Financial loss (Annual)	As at December 2017, We have commenced an LiA scheme to improve quality of documentation and casenote flow to the coding offices. In July 4 Trainee Coders commenced and have completed their 21 Day Standards course in-house with our 2 Trainers. They are already contributing to the Coding workload under close supervision and will go out into the Coding offices from January 2018. We will shortly be out to advert for the next 4 trainees. Additional accommodation at GH is urgently needed. We have ceased all use of agency staff because there are now sufficient substantive staff to manage the workload. We still need to appoint to remaining vacancies to ensure the team is working to recommended coding volume (7500 episodes/year). The workload remains too high to ensure good quality Coding. An audit cycle and plan and a training plan are established. Coding backlog is being maintained at approximately <7 days (<7000 cases uncoded). Reduced backlog minimises inefficiencies of multiple casenote transfers. Medicode (the Encoder interfaced to PAS) has been upgraded to the current version. An apprentice Coding runner has been employed to help with transfer of casenotes to the Coders for specific wards. An enhanced sessional weekend rate for our own trained Coders encourages additional weekend working. 3 year refresher training for all Coders is in place and funded recurrently Coding manager/trainers present overview for Junior doctor induction. Consultants have also been involved in useful specialty /procedure presentations to the Coders. A Coding Strategy has been developed for the next 4 years. Funding for this was approved at RIC (Jul16) but in the current financial year the required improvements depend on the funding being available. Coded activity is available on request to all consultants to validate their own activity.	Major	Likely	16	Additional accommodation required at GH site - 31/03/18 Discontinue use of Agency Coders - 31/03/18 LiA to be established to work with CMGs / ward clerks to maximise transfer of casenotes to Clinical Coding - 31 Aug 18	8	Corporate Risk
3062	Urology	If the UHL adult haemoglobinopathy service is not adequately resourced, then it will not function at its commissioned level	Harm (Patient/Non-patient)	Preventive Control: Dr Hunter is taking on the Lead for the service. NUH lead to cover annual reviews at NGH for ta period of 12 months. Interim consultant cover from Haematology Malignancy Team to provide annual reviews for UHL patients. Policy for emergency management of ED patients in place, education sessions planned.	Moderate	Almost certain	15	Case of Need for an additional consultant in Haemoglobinopathy for comprehensive care link. AH - Due date 30/06/2017(completed and submitted to CMG management for further action) All patients within the service need to be checked to ensure they have had a yearly review - 31/01/2018 Discussions taking place between UHL and the Commissioners as to what is the right way forward for this service - 31/01/2018 Business case for a Heamaglobinopathy Consultant post to be completed and submitted to the Revenue & Investment Committee - 28/02/2018	4	CMG Risk
3047	Urology	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.	Harm (Patient/Non-patient)	Preventive: Optimise PiCC line insertion on days it is available Cannula insertions kept to minimum Robust I.P plans constantly being reviewed – cannulae care pathway completion Detective: Ward reporting delays on Datix Matron utilising Red to Green to identify patients who are awaiting for service and take actions to iradicate the causation of the delay in accordance with Red to Green protocols. IP performance indicators	Moderate	Almost certain	15	Action plan under review	6	CMG Risk

CMG Risk ID	Specialty	Risk Description	Risk Subtype	Controls in place	Impact	Likelihood	Current Risk	Action summary	Target Risk	Risk Type
2941	Cardiology	If there are insufficient cardiac physiologists then it could result in increased waiting times for electrophysiology procedures and elective cardiology procedures	Harm (Patient/Non-patient)	Preventive: Additional sessions being undertaken by UHL staff Patients referred back to GP for Non Attendance. Communication to referrers to ensure all referrals are essential/appropriate to manage demand WLI initiative for Saturday EP procedures Overtime offered to current band 7 to complete EP training on Saturdays/Days off Detective: On-going to source locum support On-going to actively advertise Corrective: On going recruitment of staff into vacant posts	5 Extreme	3 Possible	15	Recruit 3.0 WTE staff - Recruited for two and out to 1 more and that we have resourced two agency locums within the department - Two agency staff are in post to cover maternity, recruited to 1 band 7 - awaiting interview date for remaining vacancy - 3.1.18 Explore Support from equipment manufacturers- continue to use to support for complex cases, but not as stand alone option - 05/12/17 - this is still a viable alternative when staffing is short - 1.2.18 Demand management - EP specialty meeting to be held 18.8.17 - discussed RTT and demand management plan, market share analysis to be completed review of current capacity - 1.12.17 - still awaiting for market share analysis from Mei Mei - ep referals have dropped, majority of patients remain on the back log - 3.1.18	8	CMG Risk
2943	Cardiology	If there is insufficient cardiac physiologists then it could result in reduced echo capacity resulting in diagnostics not being performed in a timely manner	Harm (Patient/Non-patient)	Controls: List what is currently in place and having a positive effect to control the risk Preventive: •Additional sessions being undertaken by UHL staff •Communication to referrers to ensure all referrals are essential/appropriate to manage demand •Strict adherence to auditing of referrals with clinical input/support when required Detective: •Continue to source locum support •Establish if external providers are able to provide support/capacity Corrective: •Recruitment of staff into vacant posts	3 Moderate	5 Almost certain	15	Recruit 2.0 WTE staff , recruited 1 wte internal - review 31.10.17 - ongoing 31.1.18 - further recruitment of one substantive will mitgate against further echo breaches - complete	5	CMG Risk
3067	Rheumatology	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.	Harm (Patient/Non-patient)	All ambulance staff perform a clinical assessment prior to arrival at the Emergency Department. Patients who are identified as requiring immediate assessment in the Emergency Room are pre-alerted by means of a dedicated phone line to give staff advance notification of the patient's arrival. Patients have a "Dynamic Priority Score" (DPS) calculated which is reported at the time of registration. This score is used to triage and prioritise the sickest patients for entry into the Emergency Department for assessment and treatment. A senior Emergency Department clinician (ST3 or above, Consultant, or Advanced Nurse Practitioner) re-assesses each patient who is waiting in an ambulance for entry into the Emergency Department, to confirm their DPS and to identify any patient who needs prioritisation for entry into the Emergency Department. There is an expectation that this assessment will occur within 15 minutes of the patient's arrival, and that patients will be re-assessed hourly while they are still waiting on the ambulance for entry into the Emergency Department. This ensures that those who are most ill are allocated space in the Emergency Department as a priority. Patients who have spent more than 2 hours in an ambulance waiting to enter the Emergency Department are considered for an increase in their DPS to expedite their entry into the Emergency Department. Such reviews of DPS are undertaken by senior clinicians working in the Assessment Zone, in liaison with the Nurse in Charge, Doctor in Charge, and site management team as necessary.	5 Extreme	3 Possible	15	An effective in-reach escalation plan is required for when in-patient speciality assessment beds are not available - 31 Oct 17 Initiatives to discharge suitable patients from medical wards earlier in the day, for example by increased use of Discharge Lounge - 31 Oct 17 A review of the feasibility of direct admission of medical patients to Short Stay Unit rather than to the Acute Medical Unit (AMU) - 30 Nov 17	10	CMG Risk
2887	Rheumatology	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.	Harm (Patient/Non-patient)	Paper results for blood, urine tests and MRI scans are sent to consultant. Face-to-face outpatient clinic reviews by doctors or MS nurses.	5 Extreme	3 Possible	15	Dawn on hold until additional; MSSN Business Case has been approved by RIC. Plan to review DAWN progress due 31 Jan 18. Business Case in development to review 31 Jan 2018	12	CMG Risk
2466	Rheumatology	Current lack of robust processes and systems in place for patients on DMARD and biologic therapies in Rheumatology resulting in a risk of patient harm due to delays in timely review of results and blood monitoring.	Harm (Patient/Non-patient)	The Rheumatology Department follows the 'BSR/BHPR guideline for disease-modifying anti-rheumatic drug (DMARD) therapy in consultation with the British Association of Rheumatologists (2). This stipulates the type and frequency of blood test monitoring, as well as recommendations for actions if results are found to be abnormal. *Action plan in place to identify and act on further risks, process review; supported by LiA programme. *General Manager appointed for 6 months to support service review and implementation. *Matron appointed to establish current specialist nursing establishment job plans and skill mix.*Pharmacy support lead identified for service (due to start August 2017). *Database administration team fully established. Long standing spread sheet system remains in place - Nurse Prescribers currently validating to move towards full DAWN implementation. *Process mapping is on-going of prescriptions which will involve senior engagement completed and agreed 13 October 2017. *Prescribing pharmacist to work in the service with CMG back filling on the wards for initial 6 months. Pharmacy Staff member identified to support service from August 2017. *MBP Project Manager allocated to DAWN project and meeting arranged to review MER forms and to clarify scope and timeframes for on-going IT support, Dawn upgrade is now complete. *IM&T and 4S to ensure updates and adequate licenses are in place. Options appraisal and costing to increase IT support (all brought in house, or increase externally or from within the CMG) completed. *Specialist Nurse clinics have been reduced until w/c 14/08/2017 to validate all patient level detail. *SOP upgrade target completed 24/11/2017.	3 Moderate	5 Almost certain	15	Full Service review including workforce in progress completion due 31 December 2017	3	CMG Risk
2473	Gastroenterology	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.	Harm (Patient/Non-patient)	There is an Enteral Feeding Guideline in place which means that any patient on enteral feeding can start on a protocol, with risk of refeeding identified. This then has a 3 day build up, after which a Dietitian will need to give a full assessment. Agreement from the Divisional Head of Nursing that all qualified nurses in CHUGGS CMG are to complete Malnutrition Universal Screening Tool (MUST) e-learning module. Dietetic education of medical and nursing staff on a case by case basis by dieticians for catering queries and first line nutritional care plan. Helen Ord (Dietetic Practice Learning Lead) to train all four new housekeepers on nutritional care. Dietetics and CHUGGS CMG to plan for increased dietetic investment.	3 Moderate	5 Almost certain	15	Withdraw FODMAP dietary management for IBS until resourced with adequate dietetic time - 30 Dec 17 Develop virtual telephone outpatient clinics to safely manage outpatient caseload - 30 Dec 17 Implement the Nutrition Liver Care Pathway at ward level for inpatients - 30 Dec 17 Develop a first line ward procedure for consideration of prescribable oral nutritional supplements for acutely admitted IBD inpatients - 30 Dec 17	8	CMG Risk
2787	Medical Records	If we do not implement the EDRM project across UHL which has caused wide scale recruitment and retention issues then medical records services will continue to provide a suboptimal service which will impact on the patients treatment pathway.	Harm (Patient/Non-patient)	Use of A&C bank staff where possible, though very limited in supply. Use of overtime from remaining substantive staff (though dwindling due to duration of the EDRM project and subsequent delays); staff are tired and under pressure. Cancellation of non-clinical requests for case notes daily (e.g. audit) to minimise disruption to front line clinical need (though with clear consequent impact on other areas of service delivery). On going urgent recruitment to existing vacancies. A waiting list of suitable applicants is created to minimise the risk of the current staffing levels reoccurring in the future. Medical records management supporting HRSS by chasing references and other checks. Daily review of staffing levels and management of requests with concentration of staffing in areas of greatest demand and clinical priority.	3 Moderate	5 Almost certain	15	EDRm paediatric pause as of 18/7/16 - relaunch agreed April 2017 - awaiting time line for go live - relaunch now cancelled - IT working on new strategy so action closed 10-1-18 Review of staffing and activity levels and subsequent business case for increased staffing to RIC - paper to EWB in October 2017 - additional 5wte staff at cost pressure from Feb 2018 - action closed	5	CMG Risk
2985	Pharmacy	If we do not address Windsor pharmacy storage demands, then we may compromise clinical care and breach statutory duties	Harm (Patient/Non-patient)	Reduction/removal of non-pharmaceutical products to other areas. Transfer of non-pharmaceutical consumables to external storage containers. Additional fridges purchased to maximum capacity. Direct delivery of IV fluids to ward areas where possible. Regular pest control visits with reports monitored.	3 Moderate	5 Almost certain	15	Extension to pharmacy stores, capital project - 30 Jun 18	6	CMG Risk
2801	Gynaecology	There is a risk of delay in gynaecology patient correspondence due to a backlog in typing	Harm (Patient/Non-patient)	2 week wait clinics or any letters highlighted on Windscribe in red are typed as urgent. Weekly admin management meeting standing agenda item: typing backlog by site also by Colposcopy and general gynaecology. Using Bank & Agency Staff. Protected typing for a limited number of staff.	3 Moderate	5 Almost certain	15	Clearance of backlog of letters - due 04/03/2018	5	CMG Risk

Risk ID	Specialty	Risk Description	Risk Subtype	Controls in place	Impact	Likelihood	Current Risk	Action summary	Target Risk	Risk Type
3023	Maternity	There is a risk that the split site Maternity configuration leads to impaired quality of Maternity services at the LGH site	Harm (Patient/Non-patient)	Consultant Obstetrician presence until 20.00 Delay of elective LSCS if emergency LSCS are required Use of second theatre if emergency LSCS required while EI LSCS in progress Post natal pathway of care for elective LSCS cases for staff to follow Delivery Suite Consultant & SpR can be contacted for any emergencies Consultants undertaking additional sessions to cover rota gaps (unpaid) and visit wards prior to clinics etc Locum Consultants are employed to provide cover if no other alternative Senior Specialist Trainee's only allocated to cover out of hours Formation of working party to implement recommended changes in working practices	Moderate	Almost certain	15	Implementation of Trust reconfiguration strategy: LGH to LRI site Due 31/01/2018 Review into expanding elective capacity at LRI Due 31/01/2018 Review of provision of maternity services (efficiency and different ways of working) Due 30/04/2018 Formulation of Business case for extra Gynaecology Consultant due 31/01/2018	6	CMG Risk
3093	Maternity	If there is insufficient Midwifery establishment to achieve the recommended Midwife to Birth ratio, in view of increased clinical acuity, then patient care may be delayed resulting in potential increase in maternal and fetal morbidity and mortality rates	Service disruption	Preventive: When shortfall in shift identified staff asked to work overtime and Bank shifts Rolling Recruitment drive On call manager to provide support Daily review of staffing, awaiting safe care live in maternity Detective: Identified through acuity Daily Real Time Staffing Red flags Incident / near miss monitoring Corrective: Staff redeployed from other areas (including midwives from community and home birth team, out of hours) Managers and education team working clinically Transfer admissions cross site SOS text to staff to work extra hours Prioritisation of workload Manage redeployment of staff on shift by shift basis	Moderate	Almost certain	15	Continue to recruit to achieve current establishment - due 31/03/2018	6	CMG Risk
3083	Neonatology	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	Harm (Patient/Non-patient)	Range of options to recruit middle grade staff from UK and overseas being urgently pursued Flexible use of ANNP workforce Additional clinical fellow posts approved and currently in recruitment process Explore options of acquiring high cost agency locums from their agency Implementation of the escalation Standard Operating Procedure for addressing neonatal rota gaps (appended).	Moderate	Almost certain	15	To continue to try and recruit to unfilled gaps - Due 10/08/2018 To provide the service on a single site would dramatically reduce the number of Drs required to maintain the service - Due 31/12/2022	3	CMG Risk
3084	Neonatology	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.	Harm (Patient/Non-patient)	*A business case to incrementally recruit to a 6 person resident consultant rota has been produced. There is current resident consultant cover 1/3 of the time at LRI. *There is 24 hour registrar cover at LGH with 2.5 gaps in tier 2 rota from August 2017. *Obstetrician and midwives on delivery suite trained in neonatal resuscitation *Criteria developed for in-utero transfer of babies considered at high risk of neonatal complications for delivery at LRI *Activation of escalation SOP for Neonatal Staffing (appended) when necessary, ultimately leading to transfer of new obstetric admissions to the LRI site until adequate staffing restored. *Community midwives to advise women with pre term labour (less than 32 weeks gestation) to attend the LRI	Extreme	Possible	15	To have a single site service - Due 31/12/2022 Explore options for clinical fellows and non training grade doctors - Due 28/02/2018 Continue to electively move all high risk obstetric work to LRI site to decrease the risk of simultaneous emergencies - Due 31/01/2018	5	CMG Risk
2994	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.	Harm (Patient/Non-patient) Reputation	IM&T hardware support; IM&T Integration & Development team best endeavours to support the application software; separate backup of images on Apple server in Medical Illustration. Project brief published Nov 2014 for new database. IM&T Functional Spec complete Dec 2015. Tender prepared Feb 2016. Supplier demos held Nov 2016. Supplier chosen Dec 2016. Funding agreed by RIC August 2017.	Moderate	Almost certain	15	Waiting for project engagement from GE Healthcare. Likely to be March 2018. IM&T to commit resource to deliver project at same time. Review 31 Jan 18	3	Corporate Risk
3079	Corporate Medical	If the insufficient capacity with Medical Examiners is not addressed then this may lead to a delay with screening all deaths and undertaking Structured Judgement Reviews resulting in failure to learn from deaths in a timely manner and non-compliance with the internal QC and external NHS England duties		Preventive: Currently we have the equivalent of 13 PAs a week of ME time. Whilst there are delays in the screening process, they have been managing to screen the majority of cases (93% for Quarter 1) but this is during the quietest time of year from a mortality point of view. We have 1 WTE ME Assistant and 0.8 WTE M&M Assistant supported by 1 WTE M&M Clerk to support both the ME process and SJR Process (corporately). We have a Lead Bereavement Support Nurse in post (continued from CQUIN scheme) and supported by a Bank Nurse (with Chaplaincy experience). Bank staff (Medical Students) currently supporting M&M Admin team with maintaining the ME Process but further backlog with collating outcomes of SJRs and details of Death Classifications. Detective: The UHL Mortality database includes details of all in-hospital, ED and community deaths (brought to UHL's mortuary) and where deaths are screened by the ME, this information is inputted into the database by either the ME Assistant or M&M Admin Team. The Database is also used to input information about SJR completion and outcome. Reports on both of the above are submitted to the UHL Mortality Review Committee on a monthly basis. Corrective: Specialty M&M Leads would be advised which deaths had not been screened. ME Assistants and M&M Team have been supported by Bank staff (Medical Students) to try and keep on track with data collection and inputting, reporting.	Moderate	Almost certain	15	Recruit ME/M&M Admin Support - Review March 2018. Submit Business Case for additional ME PAs and Admin support - Jan 2018. Submit Business Case for substantive funding of Bereavement Support Nurse - Jan 2018. Bereavement Services Database modification to include ME and Bereavement Support Nurse data - Review March 2018.	6	Corporate Risk
760	Facilities	If the integrity of compartmentation is compromised then during a real event the rate of fire and/or smoke spread will accelerate resulting in a greater impact to the building occupiers. The ability to utilise horizontal and/or vertical evacuation will be limited and the potential exists for a greater loss of areas / beds until the fire and resultant damage is contained.	Harm (Patient/Non-patient)	Fire Plans to be generated / amended as required to reflect the above position and to act as a baseline. Fire Risk assessment programme continues to identify potential compartmentation breaches across the 3 sites Fire Door Maintenance across the 3 sites. Fire Door replacement schemes as part of Capital Backlog Fire Stopping protocol / specification to be developed. Fire risk assessment monitored on a regular basis. Early warning fire detection and alarm systems. Staff statutory fire safety training. Fire Advisors and Capital Teams aware of issues.	Extreme	Possible	15	Fire door seals repaired/replaced in ward areas as identified in the Fire Risk Assessments - 30 Mar 18	2	Corporate Risk
1149	CHUSCS	There is a risk to patient diagnosis and treatment due to a failure to deliver the cancer waiting time targets	Harm (Patient/Non-patient)	Attendance at the weekly Cancer Action Board meeting by tumour site representatives to review PTL and review cross speciality and department barriers to delivering the patient pathways. Attendance of the CMG at the monthly CMG Cancer Action Board to review and refine the cancer action plans for the tumour sites and review performance. Local PTL meetings within the individual tumour sites with Cancer tracking staff and General Managers/Service Managers to ensure that at an individual patient level, they are receiving care and treatment in line with the Cancer pathway timelines Review overall performance at the CMG Board Meeting and review local action plans; Attendance of Clinicians and Managers at the monthly Cancer Board to review patient pathways. Attendance at Weekly Access Meeting (WAM) to manage RTT admitted and non admitted performance. To escalate to CMG Head of Operations any issues -UHL Cancer Board. Outside MDT decision making in place with MDT leads; Next-steps for all cancer places has been rolled out.	Moderate	Likely	12	Specialities to review and follow-up actions that are part of the over arching action plan for the trust - 31/01/18	6	CMG Risk
2771	Haematology	There is a risk to quality of patient care due to insufficient clinical oncologist PAs for radiotherapy treatments &Haem MDTs	Harm	Review of Clinical Oncologist job plans to maximise resource.	Major	Possible	12	Allocate additional PAs through the job planning process for radiotherapy planning - 31/01/18.	8	CMG Risk

Risk ID	Speciality	Risk Description	Risk Subtype	Controls in place	Impact	Likelihood	Current Risk	Action summary	Target Risk	Risk Type
2976	Oncology	If capacity is not increased to accommodate the growing new patient oncology referrals and change in complex treatment offered, Then delivery of cancer access targets will be compromised resulting in a breach of 7 days CQUIN target.	Harm (Patient/Non-patient)	Pooling of new patient referrals for each tumour site where clinically appropriate; Weekly validation of new patient referrals to ensure patients are dated as soon as possible; Standardising consultant out-patient clinic slots to maximise capacity; Ad ho additional clinics where appropriate	Moderate	Likely	12	Waiting list initiative work being undertaken while recruitment takes place	4	CMG Risk
2977	Oncology	If capacity is not increased to accommodate new patient referrals and changes in complex radiotherapy planning - SABR, Then patients will experience delays to their treatment due to an increased waiting time for radiotherapy planning.	Harm (Patient/Non-patient)	Pooling of new patient referrals for each tumour site where clinically appropriate; Weekly validation of radiotherapy referrals to ensure patients are dated as soon as possible; Standardising consultant radiotherapy planning clinic slots to maximise capacity.	Moderate	Likely	12	Waiting list initiative work being undertaken while recruitment takes place	4	CMG Risk
2978	Oncology	If DoH accreditation is lost, then radiotherapy SABR delivery model will be reduced.	Harm	Pooling of new patient referrals for each tumour site where clinically appropriate; weekly validation of radiotherapy referrals to ensure patients are dated as soon as possible; Standardising consultant radiotherapy planning clinic slots to maximise capacity.	Moderate	Likely	12	Waiting list initiative work being undertaken while recruitment takes place	4	CMG Risk
3109	R&DV	If additional capacity, resource and support is not provided for the Respiratory Consultant Pharmacist then there is a risk of patient harm as they will be unable to deliver current commitments, service requirements or meet the future demands of the CMG due to the significant gaps in resource versus demand in this highly specialised role.	Harm (Patient/Non-patient)	Preventive: Consultant Pharmacist claim for additional hours up to 1WTE (off set against RRCV CMG Lead Pharmacist Vacancy). Individual still working considerably more hours to meet demands of role. Consultant Pharmacist time has been released from dispensary duties to support ward based teaching to help increased skills and knowledge of pharmacy, nursing and medical teams. Detective: Deputy Chief Pharmacist meeting regularly with Consultant Pharmacist to review workload, priorities and provide support. Deputy Chief Pharmacist met with Respiratory General Manager to highlight risks and raise concerns with CMG and identify next steps to support individual and progress plan for business continuity. Corrective: Awareness of Consultant Pharmacist specialist role raised with CMG and knowledge that due to specialist nature of role unable to be covered this from existing pharmacy skills.	Major	Possible	12	Agree plan with CMG for a Specialist Pharmacist Post to work with the Respiratory Consultant Pharmacist in "Registrar model" (utilising combined funding from within the Severe Asthma and ILD business cases) - 31.12.17 Scope elements of the service to be withdrawn due to limitations on capacity OR identify substantive funding to increase Consultant Pharmacist hours to 1WTE - 1.3.18 Consultant Pharmacist to complete log of time and work done to assess critical jobs to continue, identify work to be stopped and/or handed over to other colleagues in the CMG - 1.3.18 Develop business continuity plans for post - 1.3.18 Review increase in clinic activity against previous baselines to identify growth and opportunities or investment linked to income Implement clinic activity monitoring and agree thresholds for future increases and investments - 31.12.17 Introduce support mechanisms for Consultant Pharmacist (Clinical Mentor and Resilience training) - 31.12.17	8	CMG Risk
2917	Cardiology	If the Ambulatory ECG Analysis equipment nearing obsolete are not replaced and appropriately supported with a suitable data management system, then patients may experience delays with analysing & processing of results.	Harm (Patient/Non-patient)	Maintenance contract in place for analysers MEE Bid 2017-18 for 5 new analysers IM&T Bid for Sentinel – IT data management system Analysers have comprehensive maintenance cover which includes 1 annual PPM visit. Rapid reporting of faults to Spacelabs to ensure downtime kept at a minimum. Regular back up of data from hard drive to DVD	Moderate	Likely	12	Approval at MEE panel - 24/08/16 - 31.3.18 Following approval of above replace existing systems - 30.6.18 - no funding available, charity funds bid to be submitted - 30.11.17 Implementation and training plans to be rolled out - 30.6.18	12	CMG Risk
2900	R&DV	If patients cannot be isolated as per UHL Isolation Policy due to the lack of side room provision in CDU, then likelihood of cross infection would be increased.	Harm (Patient/Non-patient)	Controls: List what is currently in place to control the risk •CDU NiC reviews current side room occupancy to prioritise infections •Notification of isolation to IPT via ICE •Expert advice & support from IPT to appropriately risk assess patients re isolation requirements •Infection Prevention Policies •Trained and competent staff •Yellow isolation risk assessment IP sticker in notes •Communication between CDU NiC, Bed Co-ordinator, Manager of the Day and Duty Manager to locate ward side room •Completion of incident form if appropriate isolation not available •Escalation of situation at capacity meetings/conference call	Major	Possible	12	Space utilisation review across CDU & ward 20 - in progress at present, estates are working through potential solutions - update - We have submitted a proposal for a feasability study for CDU expansion to be included in the capital programme - 1.4.18	8	CMG Risk
2886	R&DV	If we do not invest in the replacement of the Water Treatment Plant at LGH, then we may experience downtime from equipment failure impacting on clinical treatment offered.	Service disruption	Discussion to be reached on the future model for LGH Haemodialysis Unit 1. Capital Purchase). Initial £200K Capital purchase and annual maintenance costs of approximately £10K per annum. To replace the ring main and complete water treatment system. LGH technical team will potentially organise internally to undertake weekly chemical disinfections – UHL Infection informed. Discontinue HDF therapy Samples for Endotoxin testing will continue on a weekly bases. Non-payment of invoices in January 17 has resulted in no chemical disinfect being undertaken by Veola in February 17. This will have an affect on the type of treatment provided to some patients. Contingency Plan in place following Capital Investment Committee Meeting. This will be ongoing and reviewed on a monthly basis until the new WTP is fully replaced. This falls in line with the UHL Business Continuity Plan relating to the WTP.	Moderate	Likely	12	Work commenced on replacement plant 9.10.17. Temporary water treatment plant on site. New water connections and ring main installed upon return of pre-start water samples. Complete handover and commissioning of the new plant will take place w/c 11 December 17. New plant will be fully operational Q4	8	CMG Risk
2987	R&DV	If the technical malfunctions with the NxStage machines are not resolved, then our patients will be exposed to potential harm	Harm (Patient/Non-patient)	Suspend further training and installation of all NxStage dialysis machines. - Internal meeting held on 15 December 16. Matt Walker contacted (NxStage Matthew Walker Business Development Manager - UK). Matt Walker confirmed he has today notified Pete Newcombe (Head of UK/Europe) and Pete has escalated the issue to their QA Director. - The home therapy community leads have confirmed that they have spoken with each patient today. Patients have been advised to contact the team if they notice any issues (they should also log/report any with the NxStage help desk. - The patient with a weight discrepancy up to 2kg is to have dialysis in centre. - There are 15 patients across the Network on NxStage high flow with 3 recent reported issues - post meeting note - Marcus Gunby has confirmed that there have been 4 previous and 2 new calls relating to weight loss/gain since the software upgrade. - Matron has emailed colleagues in Derby and Coventry to see if they are experiencing any issues (NxStage confirm that this is not an issue at any other unit). - Deputy HON emailed the community team to ensure that patients are monitored. - HOS to re-draft patient letter covering the issue and action to be taken if there is a discrepancy in fluid balance following dialysis.	Major	Possible	12	Regular meeting to be held with NxStage until the problem has been resolved. Any changes in weight gain/loss to be escalated by patients immediately to community nurses. Last meeting - no progress. Investigation continues by NxStage. They need to respond to MHRA . The investigation is ongoing for High Flow dialysis treatment and the Company are working through this to find a solution. The Department have taken a decision to restart those patients who wish to use the low flow dialysis treatment - Review Dec 2017. No new patients to be commenced on NxStage until this issue is resolved.	4	CMG Risk

Risk ID	Specialty	Risk Description	Risk Subtype	Controls in place	Impact	Likelihood	Current Risk	Action summary	Target Risk	Risk Type
3051	Respiratory Medicine	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.	Harm (Patient/Non-patient)	Preventative: Medical Workforce Manager and JDA team monitor the current rotas to identify significant gaps and complete the necessary actions and planning to esnure cover or reduce the number of medical gaps Planning of rotations during 2017/18 with the support of Medical HR to identify gaps and complete the necessary actions to ensure cover or reduce the number of medical gaps Efficient recruitment processes - rolling adverts Maximising current resources to cover the gaps where possible Effective communication with medical groups and escalation procedures Scheduled training and meetings at all medical levels to provide an opportunity for discussion and feedback and Continual Professional Development (CPD) / competence signoff Trust policies and procedures for medical staffing including recruitment, appraisals and local inductions Detective: RC CMG - Respiratory performance meetings where medical staffing is discussed Respiratory Board meetings with attendance from Education representatives to escalate concerns and discuss Junior Dr and Dr forums and 'gripe' system to identify theme of issues LRI support for medical gaps Review of different working models and RRCV investment to explore alternative options including the use of Advanced Nurse/Clinical Practitioners (ANP/ACP) and Physician Associate (PA) Benchmarking from other Trusts and Organisations for different ways of working Corrective: Recruitment to gaps in a timely manner Action plan for HEE-EM Scheduling of RRCV meetings with relevant personnel to review gaps and solutions e.g. time outs Escalation procedure to relevant meeting groups; Respiratory Board, RRCV CMG Board Business Continuity policy and Emergency planning	Major	Possible	12	Effective and timely recruitment completed with the support of the Medical HR team to fill medical staffing gaps and reduce risk of vacancies as much as possible - 30 Jan 18 Medical Workforce Manager and JDA team to continue to monitor rotation gaps and take the necessary actions to ensure base wards ad CDU staffing is safe ensuring escalation procedures are carried out in a timely manner - 30 Dec 17 Recruitment of ANP/ACP and PA posts to RRCV to support the medical gaps which are unable to be filled to improve staffing numbers on base wards and CDU - 30 Dec 17 Frequent meetings scheduled to ensure the monitoring of the HEE-EM action plan and the reassurance of actions being completed - 30 Dec 17 RRCV CMG winter and operational plans and escalation of issues to appropriate Executive Trust Board(s) - 30 Mar 18	6	CMG Risk
2870	Respiratory Medicine	Audit of DNACPR form have shown that the discussion with the patient or family is not consistently recorded	Harm (Patient/Non-patient)	1. UHL DNACPR POLICY 2. Audit of policy Schedule repeat audit - complete Implementation of monthly spot audit - complete	Major	Possible	12	Further audit to be undertaken by Trust Grade doctor -There has been a repeat audit which shows improvement but some continued problems along the same lines as previously identified. The frequency of variance from guidance is 10% according to the repeat audit, so the likelihood drops to 3 in relevant domains and is reflected in the slightly improved scores. A repeat audit is due by the end of March. - There has been a repeat audit. Drs Tawil and Lordanidis have completed it and are compiling their findings. The updated version will be available soon - 30.10.17 - Audit repeated in May 2017 - compared to the previous February audit, there appears to have been a deterioration, there is a strong possibility of "initiative fatigue". - complete	2	CMG Risk
2905	Respiratory Medicine	If the gaps in workforce are not addressed, then the delivery of the 62 day cancer target will be affected resulting in delays to patient diagnosis and treatment.	Harm (Patient/Non-patient)	Cancer Service Manager in post to manage the lung cancer pathway Weekly Cancer Action Board attended by Cancer Service Manager/General Manager Cancer Service Manager reviews Patient Tracking List (PTL) daily MDT Meetings Weekly PTL meetings with Clinical Lead and Thoracic Head of Service Cancer Service Manager to attend RAL and Thoracic clinics for real-time outcomes Cancer Recovery Action Plan (RAP) Cancer Service Manager meets weekly with Lung Cancer Specialist Nurses Establishment of adhoc clinics Cancer Lead consultant provides support to Service Manager and Cancer Centre Cancer Centre Team support of Lung Tumour site including navigators, management & clinical support Improved communication between Lung Tumour site/Cancer Centre and tertiary sites Cancer Nurse Specialist (CNS) to telephone patients post MDT meeting Implement next steps co-ordinator - complete - completion date extended due to recruiment complications, an internal member of staff has been appointed to the role on 6 Dec 16 and there is an expectation the successful candidate will be in post in January 17. - complete	Major	Likely	12	Request to implement '7 day' target for first appointment for Lung Cancer Patients (provided with a deadline of 6 weeks) - 11/12/17 Lung Cancer Team to complete Business Case to support local 'optimal lung pathway based on 'Manchester model' - 1.1.18	6	CMG Risk
3110	ESM	Delay in Planned Elective Treatment in the Spastcicty Service	Harm (Patient/Non-patient)	Preventive: "Weekend Clnics planned Detective: "Waiting times will not reduce Corrective: "Overbook clinic lists where clinical	Major	Likely	12	Business case presented to RIC 08/12/2017 Business case presented to ESM Board 30/11/2017	6	CMG Risk
2386	Medical & Frailty Assessment	Failure to handover urgent medical jobs/information on transfer from AMU to a base ward	Harm (Patient/Non-patient)	Existing policy of no patient being moved from the Acute Medical Unit without a previous senior review. Establish regular AMU audit of compliance with new policy and completion of handover proforma , audit completed. Ensure new policy is documented in Junior Doctor Handbook completed. Nurse to Nurse handover via the Nerve centre system completed. New agreed policy of no patient being transferred from AMU without the Medical Proforma updated highlighting any pending urgent medical jobs on handover. New clinical handover system introduced for daytime and night-time medical on-call teams.	Major	Likely	12	Repeat audit to monitor compliance with procedures	6	CMG Risk
2387	Medical & Frailty	Failure to arrange follow up, or act on results, following discharge from the Acute Medical Unit	Harm (Patient/Non-	An Acting on Results SOP Dedicated administration time for consultants in Acute Medicine Departmental handbook for Junior Doctors to explain current pathways Simplified "Referral Pro Forma" on the AMU. Review existing acting on results policy completed. It has been agreed that we will replace this. Established regular AMU audits in place.	Major	Likely	12	Review acting on results policy	6	CMG Risk
2234	Emergency Department	There is a medical staffing shortfall resulting in a risk of an understaffed Emergency Department impacting on patient care	Harm (Patient/Non-patient)	The chief executive and medical director have met with senior trainees in Leicester ED to invite them to apply for consultant positions. The East Midlands Local Education and training board has recognised middle grade shortages as a workforce issues and has set up several projects aiming to attract and retain emergency medicine trainees and consultants. Advanced care practitioners and non-training CT1 grades have been employed in order to backfill the shortage of SHO grade junior doctors. Locums have been opened up to ACP's already working in the department. All locum EM doctors are all long term, no ad hoc agency used. There has been shared teaching sessions in which non ED consultants and ED consultants have shared skills, (i.e. ED consultants learning about collapse in the elderly and elderly medicine consultants doing ALS). The non ED consultants have been set up on a specific mailing list so that new developments and departmental 'mini-teaches' (= learning cases from incidents) can be shared. ED internal locums and external pre approved locums are used, and their CVs are checked for suitability prior to appointing them. A regular pool of non EM Consultants who can see specific patient groups has been set up, eg - cardiology, acute medical consultants. Locums receive a brief shop floor induction on arrival and also must sign the green locum induction book, which introduces trust policies such as hand hygiene. Locums work only in a supervised environment (either by an ED consultant or a substantive middle grade). Locum doctors are only placed in paeds ED in exceptional circumstances, where thay already have specific paeds training Consultants have been allocated specific time in paediatric's on the consultant rota. The grid paediatric trainees shift pattern has changed in the evening, allowing better matching of clinical experience to peak demand. Employment of emergency nurse practitioners and advanced nurse practitioners that see children with minor injuries and illnesses allows the senior clinicians to better prioritise unwell children and provide training to juniors. ED consultants have extended their shop-floor hours from 23:00 - 01:00, 7 days per week. ED employs locum medical consultants to improve senior decision making during times of peak flow. i.e. evening and weekends. ED has employed oversees doctors at specialty and trust grade level on short fixed term contracts (6 to 12 months) Deanery report actions, completed. Guidelines created governing minimum standards of locum doctor approval. An internal induction document has been produced for locum grade doctors. Review of shift vs rota and the required number of juniors per shift, has been completed. Doctor In Induction' badges are now available to distinguish staff who cannot yet make decisions. New rota for August 2014 juniors with higher number of doctors at CT3 level. Although there are still gaps at the Senior Registrar levels ST4 and above. R & R Package relaunched.	Major	Likely	12	This risk has been reviewed by the ED Medical staff and sent for approval by IL (ESM CD) and for discussion at Q & S Board.	6	CMG Risk

Risk ID	Specialty	Risk Description	Risk Subtype	Controls in place	Impact	Likelihood	Current Risk	Action summary	Target Risk	Risk Type
2388	Emergency Department	There is risk of delivering a poor and potentially unsafe service to patients awaiting MH admission &/or fruther MH assessment.	Harm (Patient/Non-patient)	Security staff allocated to ED via SLA agreement (can intervene if staff become at risk), including NISE security as required. Violence & Aggression policy. Staff in ED undergo training with regard to mental health. Staff attend personal awareness/disengagement/restraint training. Mental health pathway and assessment process in place in ED. Mental health triage nurse based in MH assessment room in ED. EDU & ward areas are covered by a separate MH Nurse. ED Mental Health Nurse Practitioner employed in ED. Medical lead for mental health identified in ED from Consultant body. Timely initial assessment by Mental Health Team. Effective working between ED/EDU staff & MH team. Extensive cooperative working between UHL & LPT relevant partners in last 12 months has led to service improvements & this is ongoing. Extra funding for security staff on EDU whilst in the interim area. Mh better care together group, which is implementing the system transformation partnership. Conflict resolution training now available via E learning Mental Health Study Day for ED staff Nursing staff attend Mental Health First Aid 2 day course. The All Age Place of safety Unit is now open at the Bradgate Unit. Joint UHL & LPT SOP in place, covering all MH patients. CAHMS crisis resolution team now in place. Development of protocol for management & escalation of adults patients awaiting MH admission in UHL, in draft form awaiting formatting. Business case for the provison of care, 24 liason psychiatry was submitted in Jan 17, unfortunately unsuccessful & will re submit to phase 2 bidding.(2018) Regular meetings bewteen LPT & LPT with regard to MH in ED. Issues relating to datix incidents, compaints etc are discussd at MH board. Continuing links with UHL, LPT and other relevant partners in LLR through better care together board, feeding into transformational and SDIP's New Mental Health Nursing Assessment booklet has been introduced (comms to staff via team read, MH practitioner providing advice, including at front door)	Moderate	Likely	12	Prioritisation of EDU staff to attend restraint / personal awareness training (relocation of EDU) 01/12/17. Awaiting update from ED Education team. Requested data for number of staff that have already received training. Meetings to be arranged with CAHMS and ED to resolve long wait issues 31/03/2018	6	CMG Risk
2838	Neurology	NRU temporary ward environment does not fully meet the needs of the younger patients with disabilities	Harm (Patient/Non-patient)	*One bay has been transformed to a gym/activities room. *Patients have been advised to use most suitable bathroom/shower facilities. *Storage facilities have been used as efficiently as possible. *A scoping exercise has taken place with estates to outline the work required to render this facility acceptable for use. This exercise has resulted in a requirements document which is currently being costed by the finance department.	Moderate	Likely	12	Awaiting update from Strategy re future planning Q4	2	CMG Risk
3018	MSK & SS	There is a risk to the quality, standards and safety of ALL patients requiring Ambulance transportation	Harm	Staff are forced to stay beyond their shift finish time in order to maintain patient safety. Vulnerable patients are required to occupy an in-patient bed, if deemed to be at risk of harm	Moderate	Likely	12	Continue to escalate delays to DM/Gold Ensure all patients are 'made ready' to avoid internal delays	4	CMG Risk
3135	MSK & SS	If GP data is not received screening will not have up to date patient data. New Diabetic patients may be missed.	Harm (Patient/Non-patient)	Preventive: (What is currently in place to prevent something going wrong) •The DESP currently has no alternative to receiving GP patient data via GEM CSU. The programme has never undertaken this function. Detective: (How will you know if your risk is off trajectory) •The DESP Failsafe & Quality team, monitors and tracks patients through the DESP pathway. However, without updated data we will have no knowledge of the missing patients or those with updated demographics. The longer this goes on the more likely patients will be missed. Corrective: (What contingencies are in place if the risk was to materialise) •The DESP currently has no workable alternative to receiving GP patient data via GEM CSU. The programme would continue to screen known patients.	Moderate	Likely	12	DESP Management in liaison with UHL contracts team to discuss with NHS England/commissioners a strategy for replacing GEM CSU to obtain data DESP admin team will write to GP's who become due for screening to send list of newly registered patients.	12	CMG Risk
3017	MSK & SS	Medinet - Use of an external provider to reduce RTT Backlog	Harm (Patient/Non-patient)	Cancer and clinically urgent patients booked onto UHL Consultants Lists Consultant led vetting of referral letter to Medinet clinics Medinet operate on their own patients Agreed list of procedures in place for Medinet to undertake which has been agreed by UHL Consultants Handover of clinical care outcome form in place including identified potential cancer patients Written & provided an ENT Induction Booklet with the department pathways and processes Regular meetings with external provider Clear admin processes in place Dedicated Medinet secretary Medinet respond to all complaints and concerns related to their patients via UHL PILS Team & ENT Management Medinet monitor any adverse events Medinet Consultants CV's are reviewed prior to working within UHL	Moderate	Likely	12	Ensure complaints are followed up in a timely manner and monitor responses - ongoing Continue to Vett referrals to prevent inappropriate patients being seen by the Medinet Team - Ongoing Dedicated Secretarial & WL Team to support Medinet - Ongoing	4	CMG Risk
2769	MSK & SS	There is a risk that performance targets are not met due to a capacity gap within the ENT department	Harm (Patient/Non-patient)	WLI for both IP and OPD work Use of independent sector Insourcing clinics	Moderate	Likely	12	Action plan under review	2	CMG Risk
3020	MSK & SS	Patients could suffer permanent damage to their eye sight due to lack of capacity within the Corneal Service	Harm (Patient/Non-patient)	Extra Waiting list Capacity being created weekly and at weekends where possible Transfer of care of Non -Urgent patients between Consultants to create 'Short Notice Urgent Follow Up' Capacity for Immunosuppressant patients Transfer of CXL Patient Treatment to weekly Nurse Lead CXL service Locum (SpR/Fellow) backfill planned until full recruitment completed of Fellow vacancy from Mid March Locum Consultant requested as part of Establishment uplift paper for RIC approval/discussion on 03.03.17 Secretarial support arranged in department to allow transfer/hand over to occur prior to Senior Secretary leaves post	Major	Possible	12	Corneal Fellow recruitment early 2018	4	CMG Risk
2191	MSK & SS	Lack of capacity within the ophthalmology service is causing delays that could result in serious patient harm.	Harm (Patient/Non-patient)	Outpatient efficiency work ongoing. Further education and information to admin team regarding booking outpatient booking process No further overbooking of clinics all patients to be added to the outpatient waiting listened reviwed weekly by the GM and HOOP. Full recovery plan for improvements to Ophthalmology service are in place . EED Breaches monitored daily via text.	Major	Possible	12	Get start dates for all 5 new Consultants -30 Dec 2017 Idenify start date for 3 session day working - 30 Dec 17	8	CMG Risk

Risk ID	Specialty	Risk Description	Risk Subtype	Controls in place	Impact	Likelihood	Current Risk	Action summary	Target Risk	Risk Type
3136	CSU Human & Biomolecular Sciences	Lack of planned IT hardware replacement/funding resulting in high levels of non-functioning/ non-repairable ePMA COWs within MSK	Harm (Patient/Non-patient)	Care of your COW guidance was circulated and attached to all drug COWs in mid-2015 ePMA guidance was reviewed and incorporates instructions on reporting failure of equipment CMG mskss agreed mass purchase of laptop batteries in 2015, which allowed the ePMA team to carry out battery replacement programme with laptops, to raise level of functioning equipment, but this is not possible with the RDP COWs. An RDP (manufacturer of the ePMA COWs) engineer has to undertake replacement of batteries. Functioning RDP COWs from other sites purchased to support the Trust wide rollout of Medchart have been relocated to live Medchart wards to maximise level of functioning equipment 15 iPads were distributed to live Medchart ePMA medical areas areas in April 2017 to help nursing staff administer medications on ward. In particular 6 iPads were taken to Ward 38, who are now a flagship iPad ward and utilise a traditional drug trolley and an iPad to conduct their drug rounds. Ward 17 have one of the empa teams laptops to try and reduce the problem, this is used daily. Ward 37 purchased three new Infinity Parity carts and Ward 34 has recently purchased one new Medstore laptop Parity carts as they had significant problems with broken equipment. The new equipment has been well received on these wards. A Trust paper on failing COWs was presented and discussed at EQB in February 2017 and it was agreed to consider the current issues with IM&T equipment with senior managers within IM&T.	Major	Possible	12	IT policy to be reviewed to ensure that response times/ repair target times match urgent equipment repair needs. Managed equipment service to be in place to facilitate better management of broken equipment IT to conduct procurement exercise to review suitable IT equipment to purchase for example laptops. IT to purchase appropriate IT equipment for dissemination to wards. Wards to purchase appropriate drug trollies to be used in conjunction with recommended IT equipment. No money for this. A laminated poster to be displayed on each COW detailing how to look after your COW	12	CMG Risk
31127	CSU	If the contractual dispute with AES Medical regarding Haemosys reporting system is not satisfactorily resolved, then there will be a cost pressure with liability of costs of £171k plus legal fees and /or loss of the system resulting in lack of compliance with Cancer Peer review requirements, delays or inaccurate diagnosis of haematological malignancies and possible patient harm associated with this.	Service disruption	Preventive: Ongoing discussions with AES and reviewing options for alternative systems. 23/11/17Attempting to go to forma mediation Detective: (How will you know if your risk is off trajectory) On-going review of risk at monthly quality meeting Corrective: (What contingencies are in place if the risk was to materialise) Can return to manual processes if needed but with significant risk both patient safety and quality assurance. These include delays in diagnosis, inappropriate tests being performed, increase in staff and cost and ultimately incorrect diagnosis with patients receiving the wrong treatment. Preventive: Ongoing discussions with AES and reviewing options for alternative systems. 23/11/17Attempting to go to forma mediation Detective: (How will you know if your risk is off trajectory) On-going review of risk at monthly quality meeting Corrective: (What contingencies are in place if the risk was to materialise) Can return to manual processes if needed but with significant risk both patient safety and quality assurance. These include delays in diagnosis, inappropriate tests being performed, increase in staff and cost and ultimately incorrect diagnosis with patients receiving the wrong treatment.	Moderate	Likely	12	Mediation being organised through BJ 15 Feb 2018; Termination (with negotiation) from contract July 2018 Update Dr Barton:14th Jan 18: Review of alternative suppliers: HILIS would not be as good a proposition as DXC LIMS as hosted in Leeds and reports would not be available in a UHL reporting system with risk associated with this. DXC LIMS business case to be presented 25th Jan 18. Termination options: discussed and agreed. Will need to negotiate an appropriate period of time to ensure UHL is not at risk of litigation from AES. It is anticipated 6-9 months would be a good compromise between our needs (assuming iLAB upgrade agreed) and the legal advice that we need to allow AES time to replace the business lost from terminating our contract. Mediation: meeting date arranged 2/2/18.	3	CMG Risk
2980	CSU	There is a risk of breach of Same Sex Accommodation Legislation in Imaging	Harm (Patient/Non-patient)	Imaging staff can provide patients with wrap-around gowns (or two gowns, one worn backwards) to reduce exposure, but this practice is inconsistent. Patients can be offered the opportunity to wait in the cubicles (where available) if preferred, but again this practice is inconsistent. Portable screens are available in CT waiting area for use when inpatients overflow into this area. (LRI)	Moderate	Likely	12	LGH Action Plan:- . Where feasible, implement appropriate changes, based on business case, costings approval and planning. Options to consider include: * Increasing numbers of cubicles * Provision of solid doors on cubicles instead of curtains * Investigate possibility of single sex sessions, i.e. males in the morning, females in the afternoon, for both inpatients and outpatients * Creating single sex recovery areas * Area D: utilise chair area for dressed patients only. Undressed patients could wait in the cubicles. Trolley area could have cubicles and chairs removed so that curtained area can be created to accommodate 1 trolley patient, allowing maximum of 2 patients in this area at a time. If opposite sex, one could be curtained behind the screened area.	3	CMG Risk
2975	CSU	Risk to patients due to a delay in Image reporting as there is a lack of reporting capacity in neuroradiology and head and neck.	Harm (Patient/Non-patient)	Insourcing with premium payment Prioritisation of work based on relative clinical risk Use of external reporting company on temporary basis	Major	Possible	12	1. Review the introduction of reporting radiographers for CT heads - 4. Substantive post recruitment - 30/Dec/2017 5. Locum head and neck post adverised. 30/Dec/17	4	CMG Risk
2978	CSU	There is a risk due to lack of qualified & experienced radiographers to the quality of the service provided to patients	Harm (Patient/Non-patient)	Core staff used as appropriate Lists cancelled if levels are deemed unsafe e-rostering allowing staffing levels to be identified Monitoring of annual leave and sickness Continue to use Assistant Practitioners Cross site cover	Major	Possible	12	International recruitment campagin	4	CMG Risk
2815	CSU	There is a risk of unescorted Inpatients, in the Imaging Department, becoming ill and of this not being noticed.	Harm (Patient/Non-patient)	In accordance with the Adult Patient Transfer and Escort Policy and Guidelines (2011), Nursing staff on the wards make decisions on whether or not patients require escorts and what level of escort is required. CT, however, always insist on always having escorts outside of normal office hours. The same does not apply for other areas of the department, and despite CT's insistence on having escorts, these do not always arrive. Also, wards will sometimes send relatives down with patients as 'escorts'. Some of the waiting areas are staffed with receptionists for at least some of the time (Balmoral X-Ray reception is staffed continuously between 08.30AM and 4AM). Other areas are less well covered. CCTV exists around Balmoral X-Ray and CT. These monitors are located in the viewing areas and they are useful, but there is not always someone looking at them. In accordance with the Adult Patient Transfer and Escort Policy and Guidelines (2011), Nursing staff on the wards make decisions on whether or not patients require escorts and what level of escort is required. CT, however, always insist on always having escorts outside of normal office hours. The same does not apply for other areas of the department, and despite CT's insistence on having escorts, these do not always arrive. Also, wards will sometimes send relatives down with patients as 'escorts'. Some of the waiting areas are staffed with receptionists for at least some of the time (Balmoral X-Ray reception is staffed continuously between 08.30AM and 4AM). Other areas are less well covered. CCTV exists around Balmoral X-Ray and CT. These monitors are located in the viewing areas and they are useful, but there is not always someone looking at them.	Major	Possible	12	2. Consider presenting a case for UHL to employ escort nurses. 3.Consider insisting on escorts for Inpatients attending radiology outside of normal working hours (as some other trusts do e.g. The Luton & Dunstable). This might require a change in the UHL Adult Patient Transfer and Escort Policy and Guidelines (2011). Employ escort for LRI site.	4	CMG Risk
2890	CSU	Reduced delivery in the National Breast Screening Service due to a shortage of qualified mammographers	Harm (Patient/Non-patient)	Staff rota's are carefully written to ensure they are safe Monitor performance of the National Programme and acting on findings Escalation policy is place for delay in PHE targets Additional sessions are in place either OT/Time owing	Major	Possible	12	4. Employment of qualified mammographers following agreed tariff and contract review 30/Sep/17 International Recruitment - 31 Dec 17 Review training opportunities for post graduates - 31 Jan 18	8	CMG Risk

Risk ID	Status	Risk Description	Risk Subtype	Controls in place	Impact	Likelihood	Current Risk	Action summary	Target Risk	Risk Type
2947	Path\Open\ - Clinical Microbiology	Risk to provide a robust Virology service with :Single-handed Consultant Virologist	Harm (Patient/Non-patient)	Short term controls only in place for ongoing patients 1.Clinical cover provided by Microbiology SpRs (with only 3-6 months experience in Virology only) 2.Clinical cover from part-time Clinical Consultant Microbiologist with an interest in Virology only 3.Aware of alternative Virology services in the region which could support Long-term controls 4.Contingency plans in place around workforce development of new Consultant Virologists and possible regional service in collaboration with other pathology services 5.Closure of the service and transfer to another clinical virology service within the region or beyond	Moderate	Likely	12	Appoint additional Consultant Virologist - 15 Jan 2018. Update by S.Hardy ,C.Bradley on behalf of Dr Modha -13.10.2017: The substantive Virologist post was not appointed to in August and will be re-advertised, to extend action 3 months. Currently a locum (lower grade) is supporting Dr Tang in Virology and there is also a rotating ST assisting. Dr Modha will review the risk rating on her return.	12	CMG Risk
2983	Path\Open\ - Clinical Microbiology	There is a risk that high and low ambient temperatures in the Microbiology Laboratory will impact on service delivery and future	Harm (Patient/Non-patient)	Use of fans and ice to help cooling around analysers Hire of portable AC units in the summer, portable ACUs are installed with the predicted onset of high seasonal temperatures. These create noise and space issues, require daily maintenance and necessitate top windows being left open to accommodate the exhaust hose venting hot air out from the laboratory. Use of portable radiators in the winter Staff are advised to wear light clothing, take short breaks, keep hydrated - standard heat wave guidance Daily temperature monitoring using the ICESPY system in bacteriology Some areas of the laboratory have blinds to provide shading in the summer; Although a number of blinds are broken and as a consequence unable to provide shade during the summer however these are in the process of being repaired / replaced	Major	Possible	12	Progress with DTM's [design team meetings] and support from UHL Trust Capital Projects team through to implementation:Jan 2018 S.Hardy updated 02.10.2017:Faulty blinds have now been replaced and fitted during September(Action closed).Air con units have been used during the summer months at a cost of £4500 - £5000.Despite the A/C units which help but are not totally effective, there has been one incident of assay failure due to high ambient temperature affecting 45 patient samples having delay in reporting of test results.The capital project continues to remain outside of our control . score to remain the same as we have had incidents even with portable AC units to attempt to maintain adequate ambient temperature.	4	CMG Risk
2615	Path\Open\ - Clinical Microbiology	Integrity and capacity of containment level 3 laboratory facility in Clinical Microbiology	Harm (Patient/Non-patient)	Annual inspection of the facility is carried out by Crowthorne. Emergency fumigation subcontracted with Crowthorne Repairs identified in Crowthorne report carried out by Interserve or Crowthorne Interserve aware of water leakages from their plant room I roof; Suspended ceiling regularly monitored through visual checks Restricted number of staff allowed to work in this facility at any given time Facility internally audited twice a year Update Dec 2016: The feasibility for the CL3 has been completed and preferred option is being costed up.	Major	Possible	12	Prep of full business case for capital investment to consider construction of new facility 2018/19 . "Risk 2615 reviewed by Simon Hewson 05/12/2017: There is no change to CL3 risk magnitude. PMO have need disbanded. The Operational Manager will resume control of the project.	12	CMG Risk
1506	Open\ - Cross Specialty Imaging	If the backlog of unreported Chest and Abdomen images on PAC'S are not cleared, then we will breach IRMER and Royal College of Radiologist guidelines.	Harm (Patient/Non-patient)	Ongoing reporting by radiologists and reporting radiographers Allocation of CT/MRI examinations to a intended radiologist or specialty group House keeping done by clerical and superintendents to ensure images are visible on PACS. Outsourcing overdue reporting to medica.	Major	Possible	12	Housekeeping of unreported work by Superintendents - Use external company for plain xray - 31/Jan/2018	6	CMG Risk
3117	Path\Open\ - Pathology	If the ePMA Sofia system is not updated and configured as per UHL and IM&T requirements then our staff may not be using a system which provides high quality care Resulting in potential harm to our patients through dropping off drugs, missed doses, lack of adequate training and other key configuration components.	Harm (Patient/Non-patient)	Preventive: When individual requests are received for new drugs they are been built into the system - currently reliant on one individual. There is one pharmacist in post who can prioritise acute problems. Paper charts are available for emergency situations including drug prescribing. Pharmacists do a regular check of 'red triangles' (warning that drug may 'drop off the system') on Fridays to try and stop issues happening especially over a weekend. There is significant work currently undergoing by the UHL ePMA team with the supplier to work on configurations to enable UHL to update the system to meet our minimum requirements. This includes a fix to the current 'dropping off' of drugs issue. Detective: No incidents related drugs dropping off after 30 days An overall reduction in the number of Datix incidents related to Sofia Corrective: Engagement with healthcare professionals using Sofia to understand outstanding issues Continued support from UHL ePMA team for the renal nursing, medical and pharmacy teams, including discussion at Electronic Medicines Management Group regarding outstanding issues	Major	Possible	12	test and implement into live latest DM&D updates - 31/01/2018 liaise with company to determine and implement a solution for drugs dropping off after 30 days - 31/01/2018 liaise with company to determine and implement a solution for prescribing methotrexate weekly to prevent a never event happening - 31/1/2018 written governance processes to be in place for all aspects of Sofia - to be similar to medchart - 31/01/2018 Trustwide comms to be circulated to remind all staff to log themselves off after they have finished using computers -31/12/2017 IM&T to switch off the auto-save functionality on Google chrome -31/01/2018	4	CMG Risk
2464	Open\ - Maternity	Electronic Access to EMPath	Harm (Patient/Non-patient)	Paper results to booking hospital and requestor Abnormal results telephoned and faxed by the Lab to the relevant department in the booking Hospital Education to clinical staff that unscreened/unbooked women in labour must be offered a rapid HIV test and urgent screening for blood group, antibodies, HIV, HepB, Syphilis and rubella immunity via UHL Lab. Database of rejected samples issued monthly to ensure all samples are repeated and a result is available.	Major	Possible	12	Blood test results to be managed through UHL and a project group is being set up with Pathology Due 27/03/2018	3	CMG Risk
1593	Open\ - Neonatal	There is a risk of inadequate neonatal nursing staff /skill mix levels to meet clinical requirements	Harm (Patient/Non-patient)	Establishment numbers, duty rotas LGH neonatal unit running as level 1 Nursing staff have moved sites to match skills to patient dependency nursing off duty controlled by senior management team Escalation policy and cross site transfer policy Training package to increase competency of Band 4 nursery nurses Update 15 March 2012 Nurse study leave has been managed to minimise impact on clinical area Neonatal transfer Team now manage transfers out of the units Escalation policy and cross site transfer policy Training package to increase competency of Band 4 nursery nurses Update 18/2/16 High fidelity simulation training for all NNU clinical staff Senior staff undertaking extra shifts to assess HDU/ITU competencies are completed 0.8wte Practice Development Nurse commenced	Major	Possible	12	Continue to recruit to vacancies Due 05/03/2018	6	CMG Risk
1367	Open\ - Neonatal	Lack of Capacity in the Neonatal Service	Harm (Patient/Non-patient)	Existing capacity NNU is part of CNN so following resuscitation and stabilisation babies can be transferred out to other units In-utero transfer of women to other maternity units if neonatal service is unable to accept admissions	Moderate	Likely	12	Increase cot capacity due 30/04/2018	8	CMG Risk
2993	Open\ - Paediatrics	Paediatric Emergency Single Front Door	Harm (Patient/Non-patient)	PED and CAU presently run independently PED and CAU staff working together to ensure effective flow of patients when possible SOP/Escalation policy in place for PED and CAU Reviewed throughout the day through Board rounds and Gold Command	Major	Possible	12	Developing protocols for PED processes due 30/Apr/18 Childrens Hospital Escalation policy to be developed to clearly out line actions required when children's hospital is at capacity due 30/Apr/18 Reviewing and agreeing transitional plan for staff to CAU from PED due 30/Apr/18 Reviewing discharge process and developing SOP due 30/Apr/18 Implementing Red to Green in March 2017 due 30/Apr/18 Developing admissions SOP due 30/Apr/18 Action plan to be developed to address the issues which are preventing a move at this time due 30/04/2018 Roles & responsibilities of Paed Consultants due 30/04/2018 Staffing & funding of 5 additional beds on ward 11 due 30/04/2018	4	CMG Risk

Risk ID	Specialty	Risk Description	Risk Subtype	Controls in place	Impact	Likelihood	Current Risk	Action summary	Target Risk	Risk Type
3006	Paediatrics	There is a risk to patient safety due to shortage of space in the Ward 27 day case and outpatient clinics.	Harm (Patient/Non-patient)	Staffing has been increased on days where clinic run. Reception space altered to provide better confidentiality and allow more space. TYA patients no longer able to have treatment in the quiet room unless accompanied by another person. Meeting planned in February with clinicians and management to work out a solution that works best for all involved. There is a need to reorganise the clinics in order to improve patient flow. Review of day care nurse establishment	Moderate	Likely	12	Identify larger/ extra space for treating paediatric/ TYA patients Due 03/09/2018 Allocate space for play team cupboard to create space for ward Due 28/04/2018 Reorganise or relocate the clinics in order to improve patient flow Due 27/03/2018 Look into possibility of moving off treatment patients to another area Due 27/03/2018 Improve patient waiting times by reviewing processes and patient pathways. With pharmacy, blood bank and day care Due 27/03/2018 Look at staffing ratio. ? Separate day case staffing from ward establishment Due 18/04/2018 Development and job description for Pilot liaison role to improve coordination of care Due 27/03/2018	12	CMG Risk
2388	Paediatrics	Inability to provide home INR testing for Leicester based adult congenital heart patients transferred from paediatric services.	Harm (Patient/Non-patient)	Referral to existing anticoagulation services within the network but not Leicester Referral to GP Review patient need for warfarin (if not valve patient) and consider alternative therapies such as aspirin and NOAC Continue to allow adult patients to use the paediatric anticoagulation service (time/resource limited)	Moderate	Likely	12	Review the need and cost implications of developing a dedicated adult congenital heart anticoagulation service, including prescribing warfarin due 06/02/2018 Formal discussion with Clinical Support Services (CMG 6) regarding the referral criteria for existing and new patients who home INR test due 06/02/2018 Review with General Manager/ Head of Service potential alternatives to resolve the current situation due 06/02/2018	12	CMG Risk
2383	Paediatrics	Quality improvement, governance and safety initiatives not being implemented/supported within Children's services	Harm (Patient/Non-patient)	Staff members are volunteering to cover the gaps on a temporary basis Appointment of a Quality, Safety & Governance lead to identify gaps and build the quality agenda/structure Short term mitigation through the appointment of a Quality & Safety Nurse (0.8wte - 1 year fixed term) to assist with coordination of guidelines & audit within Children's services	Moderate	Likely	12	Structure set out to ensure guidance published by NICE, colleges & societies is responded to appropriately and incorporated into the relevant local guidance Due 03/01/2018 Quality Improvement Nurse (with 25% of time dedicated to masters level quality improvement learning) and spread of learning throughout Children's services an integral part of the role Due 03/01/2018 Children's Data analyst - band 7 equivalent. To coordinate, analyse and support interpretation of the quality initiatives and agenda Due 03/01/2018 Children's Information Scientist - band 3 equivalent. To collect quality improvement and audit data Due 03/01/2018	6	CMG Risk
2854	Medicine	Poor environment on Ward 28 impacting on safety of patients, staff and visitors	Harm (Patient/Non-patient)	Directive: Infection Prevention Policy, Fire Safety Policy Preventive: Annual fire safety training & education. Annual Fire Safety ward reviews. Monthly environmental audits (infection prevention) Monthly cleanliness audits Detective: Patient experience (FFT), review of complaints Corrective: Concerns raised with IP Lead Nurse, Estates Management (no plan to repair deficits in the environment), Fire Safety Officer	Major	Possible	12	Install protective cladding to prevent future damage Due 31/03/18 Repair all damaged window fasteners 31/03/18 Install opaque glass or opaque film between cubicles Due 31/01/18 Remove sink from sluice Due 31/01/18 Install additional toilets for staff and patients Due 31/03/18 Refurbish drug preparation area Due 31/03/18 Upgrade lighting Due 31/03/18	6	CMG Risk
3015	Corporate Medical	If ISO compliant non-luer devices are not implemented when available from the manufactures then patients may be placed at harm during the administration of medicines.	Patient Safety Harm (Patient/Non-patient)	Preventive Controls: Protocols in place to prevent wrong route administration (e.g. syringe labeling, double checking of prior to administrations, etc). Staff awareness training to include dangers - e-learning package Planned transition to new products with removal of mismatching items from clinical areas Detective Controls: Regular progress report to EQB. Monthly Local Neuraxial Group Meeting.	Major	Possible	12	Implement ISO compliant non-luer devices across relevant areas once full range becomes available - 30 Apr 2018. Current position: We remain on track for Mid-December 2017 deployment. Evaluate off-label usage with relevant clinicians and clinical areas - December 2017 Launch UHL Communications Strategy to make staff aware about the new process - December 2017 Launch training programme (including e-learning) targeted at specific clinical staff groups - November 2017 Develop Procurement contingency plan - October 2017. Review implementation plan as per NHS Improvement Patient Safety Resources Alert NHS/PSA/RE/2017/004 - 11th Dec 2017.	4	Corporate Risk
2438	Corporate Medical	If the Homecare market remains unstable, caused by a major company leaving the market, then existing providers of homecare services will experience difficulties achieving satisfactory levels of deliveries resulting in patients not receiving medication and patients receiving the incorrect medication.	Patient Safety Harm (Patient/Non-patient)	UHL Homecare team liaising with homecare companies to try and resolve issues of which they are made aware. H@H high risk patients currently being repatriated to UHL. UHL procurement pharmacist in discussion with NHS England (statement due out soon - timeframe unsure), and with the CMU. Patient groups and peer group discussions also been had to support patient education and support during this uncertain period. Reviewing which medicines can be done through UHL out-patient provider or through UHL Discussions with Medical Director and CMG (CSI) and clinical speciality teams to ensure that any necessary clinical pathway changes are supported Repatriation of urgent drugs back to UHL out-patient provider Self - assessment against Hackett criteria against all homecare schemes. Hold all new potential Homecare schemes unless essential to implement NICE guidance. Utilise clinical pharmacist teams to support Homecare technician. 8A Homecare pharmacist in post as part of a 6 month internal secondment.	Major	Possible	12	Review processes within rheumatology - 31/12/17 Recruit and induct additional posts - 31/12/17 Implement pharmacist checking for high risk homecare - 31/12/17	9	Corporate Risk
2430	Corporate Medical	If clinical staff do not consistently recognise and act on early indicators of sepsis, then patients will be placed at risk of increased mortality due to ineffective implementation of best practice identification and treatment of sepsis.	Patient Safety Harm (Patient/Non-patient)	Appointed sepsis lead, sepsis nurse and sepsis working party. Regular reports to Adult Critical and Augmented Care Board and on to Executive Quality Board as required. Network of sepsis champions across UHL, delivering face to face training to >2000 staff. Simulation based training in sepsis to all FY 1&2 staff. Ad hoc training to specialist areas. A brief introduction to Sepsis is provided on Trust induction days. Standardised sepsis pathway for adults and children across whole of UHL. Standardised early warning system. Deployment of sepsis boxes with standard antibiotic regimen across whole trust. Continuous audits of adherence to pathway and screening via UHL Quality Commitment and National CQUIN on sepsis. Weekly Sepsis performance reporting to CQC requirements (since Dec 2015). Appointment of 6 nurses, externally funded from the NHSLA to support management of the deteriorating patient/sepsis care in ED & assessment areas. Sepsis education is completed via the deteriorating patient scenario training via CMG education team. UHL have introduced a mandatory E-Learning package via HELM for all staff members to complete. Face to face training continues to be available via HELM.	Major	Possible	12	Setup automated prompts for sepsis as NEWS and e-obs introduced into UHL - Update - This work has been delayed and we are working with Nerve centre - review date for Dec 2017	8	Corporate Risk
1592	Estates & Facilities	If a replacement program for the ageing electrical infrastructure at the GH is not adequately resourced and implemented, Then the Trust is at an increased likelihood of experiencing a sudden loss of electrical supply.	Reputation	Monitoring condition (PPM) Capital development and backlog maintenance bids	Major	Possible	12	Current Status: - Progress delayed due to lack of Capital funding Replace existing equipment - technical report received by NBO in Nov 2016 - 31 Mar 18	8	Corporate Risk
1612	Estates & Facilities	Foul Drain Blockages	Reputation	Matter brought to attention of clinical colleagues/IP&C to highlight the problems caused by flushing inappropriate materials. Estates Reactive/PPM's in place. Identifying mian problem areas with a view to replacement with stainless steel with a particular focus to ward 25/26/27 which are impacting on University space below.	Major	Possible	12	Current Status: - Progress delayed due to lack of Capital funding	12	Corporate Risk

Risk ID	Specialty	Risk Description	Risk Subtype	Controls in place	Impact	Likelihood	Current Risk	Action summary	Target Risk	Risk Type
1179	DD Estates Management & Maintenance Services - Estates & Facilities	If a replacement program for the ageing electrical infrastructure at the LRI is not adequately resourced and implemented, then the Trust is at an increased likelihood of experiencing a sudden loss of electrical supply.	Service disruption	Monitoring of controls & PPM Capital bids for priorities Steady state being maintained, however, increasing risk of electrical failure resulting in a loss of pelectrical supply. The Trust Capital Works programme has a specific infrastructure workstream. Currently overlayoing the Trust's 5 year plan onto the current infrastructure priorities to develop an investment strategy. Load monitoring.	Major	Possible	12	Current Status: - Progress delayed due to lack of Capital funding	6	Corporate Risk
1180	DD Estates Management & Maintenance Services - Estates & Facilities	If a replacement program for the ageing electrical infrastructure at the LGH is not adequately resourced and implemented, Then the Trust is at an increased likelihood of experiencing a sudden loss of electrical supply.	Reputation	Monitor, audit and review by site Electrical Authorised Person and external validation from Independent High Voltage Authorising Engineer. Priorities have been identified and a Capital programme of upgrading and maintenance is in place. Additional generator connection points added to sub-stations inthe first quarter of 2016 to enhance resilliance and safety.	Major	Possible	12	Current Status: - Progress delayed due to lack of Capital funding Replace existing equipment - New 500 kVA Generator required for Radiolagy, as existing generator identified as under capacity for current essential electrical load - 31 Mar 18	6	Corporate Risk
3012	DD Estates Management & Maintenance Services - Estates & Facilities	If a planned down time program for maintaining and cleaning the Theatres facilities across all UHL sites cannot be agreed, then staff and patients will be exposed to increased likelihood of airborne microbiological contamination.	Service disruption	Annual validation reports provided to Theatre management/Infection Pevention to assist with planning/approving theatre procedures suitable for the enviromental conditions of the theatre. Multi-disciplinary Theatre ventilation Task and Finish group set up in 2016 to review the engineering/patient/staff impacts of not being given 'down time' to carry out annual maintenance and cleaning and to lobby for a minimum of three weeks per theatre protected time for programmed works each year.	Major	Possible	12	Current Status: - Annual Programme for Theatre Maintenance & Cleaning has been agreed for 17/18. Some refurbishment work have been completed for the LRI. Develop Capital programme to gain access to theatres and critical areas - 30 Mar 18	1	Corporate Risk
2944	DD Estates Management & Maintenance Services - Estates & Facilities	If the integrity of external footpaths, road surfaces, car park surfaces across all UHL sites are not restored, Then the Trust may be susceptible to personal injury and property damage claims.	Harm (Patient/Non-patient)	Reintroduction of road and footpath inspections by Estates. Capital investment - part funded, awaiting confirmation for more funding.	Moderate	Likely	12	Current Status: - Progress delayed due to lack of Capital funding Estates to reintroduce road & footpath inspection - 31/Aug/18 Phase 2 & 3 Priority repairs LGH & GH subject to Trust approving plan D of the 2017/18 Capital Plan - 31/12/17	3	Corporate Risk
2942	DD Estates Management & Maintenance Services - Estates & Facilities	If the technical fault with main fire alarm system at GH is not resolved, Then the timely and safe evacuation of the premises may be jeopardised.	Harm (Patient/Non-patient)	Fire Officers aware of the status of the system and manual fire alert arrangements are reported as the back-up arrangements. Referred to Capital Works Team to work with Estates to design-in or install a fire alarm system with greater back-up resilliance.	Major	Possible	12	Incorporate local fire alert training for the event of a loss of fire alarm signal into fire training - 30 Dec 17 Produce condition & resilliance report - 28 Dec 17	4	Corporate Risk
2672	DD Estates Management & Maintenance Services - Estates & Facilities	If restrictors on windows above ground level are not installed, Then staff, patients, visitors and contractors may utilise unrestricted windows to expose themselves to harm.	Harm (Patient/Non-patient)	Both falls from height incidents were initially attributed to Patient reactions to anaesthetic/medication (Delirium). Trust produced a Delirium Assessment tool for Clinical staff to follow in January 2016. New window surveys reported as completed by specialist contractor in 2015/16. Clinical assessment, move to safe environment and 1:1 or increased supervision. All glazing subject to window planned preventative maintenance inspection by Estates.	Major	Possible	12	Current Status: - Overhaul underway and due for completion in Dec 17. Overhaul existing equipment reconfigured to be completed over 2yrs by the Capital Team - Actions from survey - 31 Dec 17	4	Corporate Risk
2276	DD Estates Management & Maintenance Services - Estates & Facilities	If the current Fire alarm system (panels and devices) fail or need to be replaced then due to the age and lack of available replacement parts a new system would need to be installed at considerable cost to ensure fire detection and alarm provision is consistent and reliable throughout the hospital.	Harm (Patient/Non-patient)	Planned Preventative Maintenance, reactive maintenance, highlighted to Capital Team for investment consideration. Trust Fire safety professionals and Estates Regional Manager aware of issues and contingency options.	Major	Possible	12	Current Status: - Awaiting for confirmed funding and commencement date for pending actions. Plan to address on-gong issues with faults on the system - 31 Dec 17	1	Corporate Risk
2881	DD Estates Management & Maintenance Services - Estates & Facilities	If the aging medical gases pendent hoses are not replaced to the manufactures recommendations, Then patients and staff may be placed at risk of harm.	Harm (Patient/Non-patient)	Estates made aware and asked for a programme of replacement. Enhanced inspection regime recommended until hoses over five years old are replaced. Management actions monitored through Medicines Optimisation Committee	Major	Possible	12	Current Status: - Progress delayed due to lack of Capital funding Escalated to Medicine Optimisation committee Regional Estates Managers & Capital to Overhaul existing equipment - 30 Dec 17	3	Corporate Risk
2262	Corporate Nursing	Risk of reduced compliance with DoH requirements in relation to adherence to antimicrobial prescribing policy	Infection Prevention	Education and training of prescribers (including educating prescribers to record duration for antimicrobials). Monitoring of progress (including weekly telecommunications) in relation to including an antimicrobial sections within EPMA and exception reports to TIPAC if there is a failure to progress.	Moderate	Likely	12	Create separate antimicrobial tab within EPMA - on CSC development request list, not in development stages yet, and hence no expected date known for delivery of this aspect - 31/12/17	6	Corporate Risk
2370	Corporate Nursing	If ENFit ISO Standard for enteral feeding is not implemented, Then the Trust will be non-compliant resulting increased potential of never events and harm.	Harm (Patient/Non-patient)	Project plan with comms, briefing, training, new equipment via MAT MAN and links to nhssupplychain	Major	Possible	12	Procurement manager to develop new ordering code set - 31/03/2018 Dietetic staff to target wards and get them to order in new ENFit equipment if off MAT MAN - 31/03/2018 MAT MAN to order in new ENFit equipment - 31/03/2018 Weekly meetings between Procurement and Dietetics - 31/03/2018 Action plan developed for risk related to Ryles tubes - escalated to ITAPS Quality and Safety Lead and Adult Critical Care Core Group - 31/03/2018 To be reported on at next Trust Nutrition and Hydration Assurance Committee on the - 31/03/2018 Trust wide audit of ENFit implementation to date across Trust at ward/unit and patient level planned for Oct 17 - Audit registered with CASE awaiting registration number - 31/03/2018	4	Corporate Risk

Risk ID	Specialty	Risk Description	Risk Subtype	Controls in place	Current Risk Impact	Current Risk Likelihood	Current Risk	Action summary	Risk Type Target Risk	Risk Type
2774	Operations	If there are delays with dispatching post consultation outpatient correspondences, then this may result in significant risk to patient safety.	Harm (Patient/Non-patient)	Third party electronic systems i.e. Dictate IT, Winscribe. Upgrading electronic system versions i.e. Dictate IT in order to help support improved outcomes. Differing performance monitoring mechanisms by managers and administrative teams within each CMG. Routine monitoring report now in place Controls are monitored via Outpatient programme board. On average, 81% of the Trust's outpatient letters are sent within 14 days. Q1 81% achieved, Q2 86% achieved and Q3 84% achieved against a target of 40%. Q4 77% achieved against a target of 51%.	Moderate	Likely	12	Following review of the current systems for generating outpatient letters within the Trust it was identified there was an opportunity to implement a coordinated approach to systems within CMGs to improve turnaround times and reduce backlogs. At the July EPB it was agreed the trust would move away from multiple dictation systems to a maximum of three. 1 for outsourced typing 1 for insourced typing and 1 for voice recognition. In the short term each CMG has put together an action plan to meet the 14 day turnaround standard. These are monitored at the outpatient programme board and are currently on track. We are also monitoring this through the quality commitment. Pre-engagement events were held with suppliers in April 17, and the tender document has now been submitted by procurement. Deadline for responses is May 17 with a date for evaluating and scoring thereafter.	6	Corporate Risk
2850	Operations	If patients follow up or cancelled appointments are not rebooked within the appropriate clinical timescale, then patients may experience harm as a result of the delays between appointments.	Harm (Patient/Non-patient)	The Trust issued guidance on the administration of the follow up process (2014), this has since been re issued in May 2016. February 2017 a series of additional data quality reports are now in place to ensure that these patients are visible to the organisation. These reports are reviewed monthly at the Outpatients programme board , chaired by the Director of Performance Patient level detail reports are sent weekly by the Deputy Head of Performance to specialties. Total number of patients across all DQ reports reduced from circa 45,000 to 33,000	Moderate	Likely	12	with additional data quality reports in place the risks to patients is reduced as we are confident that thye are all visible. A wide ranging review of other waiting list 'unknowns' has been undertaken in Jan / Feb,a detailed action plan will be taken to the Executive team for sign off dutring March. Update - Action plan amended following EPB in April. Ammended plan to go to June's QAC. Update- Patient level details for LTFU's continue to be sent weekly to services and monitored at the monthly outpatient program board. Longest waiting patients continue to be reviewed within service.	6	Corporate Risk
2878	Diagnostics	If the technical faults attributed to the video conferencing facilities for cancer MDTs in the Osborne seminar room and Glenfield Radiology rooms are not resolved, Then discussion of cancer patients will continue to be interrupted resulting in increased likelihood of clinical errors.	Harm (Patient/Non-patient)	MDT clinicians make a case by case judgement on the day about whether cases can be discussed via the video conferencing system. Use of telephone conferencing as a back up facility Lock down procedure of Osborne LRI and GH seminar room new kit to stop alterations happening.	Major	Possible	12	February 2017: Inspite of SLA being in place, there are ongoing issues with intermittent performance which have resulted in detlays in MDTs. A critical IT / technical meeting is taking place with the suppliers and UHL IT in March to aim to finally resolve this.	4	Corporate Risk
2887	CHUGCS	If the lack of availability of safe and appropriate ambulatory infusion devices for subcutaneous infusions is not resolved, then patients may be exposed to harm.	Harm (Patient/Non-patient)	*Drug checking policy in place for monitoring of infusions *Regular checks on equipment settings whilst in use *Syringe Driver Amnesty in an attempt to reclaim missing equipment from ward areas. *Training video available on patient safety portal * Ward link nurses attend supportive and palliative care study days that includes infusion device training.	Minor	Almost certain	10	Syringe Driver Multi-disciplinary work group set to oversee implementation of safe and appropriate ambulatory SC syringe driver use. - Rosie Bronnert, Gayle Hemstock & Carl Bond , on-going by 30/11/2017. Spot audits across UHL and within SPCT to better determine the number of subcutaneous infusions in place across UHL to guide procurement process - Rosie Bronnert by 30/11/2017. Establish clear responsibility for procurement of T34 pumps, question asked to EQB January 2017 - awaiting feedback - Rosie Bronnert by 30/11/2017. Establish clear responsibility for funding of returns process of T34 pumps and accountability - question asked at EQB Jan 2017, awaiting feedback - Rosie Bronnert by 30/11/2017 Process to be developed to address storage and retrieval of equipment from wards and after use on a patient discharged into the community - Rosie Bronnert & Carl Bond by 30/11/2017 Develop policies and SOP's to provide guidance to staff in the selection and use of appropriate equipment (excluding for the administration of insulin) and returns procedure. - Rosie Bronnert & Gayle Hemstock by 30/11/2017 Procure appropriate number of devices once audit and returns procedure & accountability for returns is confirmed - Rosie Bronnert by 30/11/2017 Education and training program to be developed for use of infusion pumps/syringe drivers for subcutaneous infusion - medical devices education personnel & Gayle Hemstock by 31/12/2017 Training database to be developed to maintain list of staff who are competent to use the equipment - Mecial Physics (Carl Bond) by 30/11/2017 Develop a process for audit/review of syringe issues on a regular basis to avoid recurrence - Carl Bond by 30/11/2017	8	CMG Risk
2989	Cardiology	Lack of perfusion availability if theatre and ECMO case in progress at the same time out of hours	Harm (Patient/Non-patient)	Controls: List what is currently in place to control the risk •Currently there is a voluntary control in place to support a three tier system of on-call when transport ECMO's take place. This system is described earlier in this document. This voluntary support cannot be relied on in the future and therefore has the potential to leave the Trust at risk at times of an ECMO transport.	Extreme	Unlikely	10	Develop workforce plan to meet current and future requirements Including paediatric surgery transfer to LRI - Developed a workforce plan for the Paediatric move to the LRI, which would give 12 perfusionists working on two sites. At the moment 10 and one in training, two more to be recuited. This will enable us to have three on call; one for paediatrics at the LRI, one for Adults at GGH and one for mobil ECMO. Funding to be sourced - Awaiting EMCHC decision - 31.12.17 Develop business case to support work force plan and if required expand perfusion team (including potential paediatric development) - At present awaiting the result of a grievance entered by the Perfusion staff, risk will remain until we have an answer on the grievance. 31.12.17	5	CMG Risk
2235	Emergency Department	There is a risk of harm to patients during inter hospital transfers & transfers across to other UHL sites	Harm (Patient/Non-patient)	Internal policy of which patients should have a nurse transfer to CT (now co located in dept) Transfer information form used to provide inpatient teams with patient overview. EMT suspended until further notice. Policy is that all EDU pathways should be signed by both the doctor and and discussed with the EDU Coordinator. Back page of ED nursing notes has pre-transfer safety check list (Recent reaudit of usage, will be presented at Ed Q and S) ED uses transfer envelopes for patient notes.(External transfers) Ongoing education delivered regarding the pre transfer safety checklist located in the nursing assessment booklets.(Named nurses identified) Original Notes are transferred with the patient and scanned copy of the notes remain in the department. (Notes are scanned as patient leaves the department) Process in place for ED GP letters to be sent via ICE. This is currently being audited to ensure it is effective. Non ICE GP surgeries continue to receive paper copied of patient letters.	Extreme	Likely	10	Nerve Centre to be rolled out to all assessment units during 2017, to aid sharing of patient records. 31/12/2017 Awaiting update Transfer SOP to be developed 31/12/2017 Transfer documentation audit to be presented at ED Q and S Meeting 10/01/18 (Medical Student to present awaiting confirmation) Amendments to Adult Patient Transfer & Escort Policy (6.4 ED & 6.5 update of new service for non emergency transfers) 30/12/17 Transfer & Escorting patients training to be incorporated into ED training days 31/01/18	8	CMG Risk
2469	Medicine for Older Peoples	There is an insufficient number or middle-grade doctors, both SpR's and SHO's to provide adequate service cover in Childrens	Harm (Patient/Non	Consultant cover in place. However, the workload is increasing and there is an inadequate number of consultants to provide ward level cover as required.	Minor	Almost certain	10	Reviewing out of hours medical cover to ward 30 - GH due 27/07/2018	10	CMG Risk

Risk ID	Speciality	Risk Description	Risk Subtype	Controls in place	Impact	Likelihood	Current Risk	Action summary	Target Risk	Risk Type
3081	Maternity Neonatal Transport Service	If essential neonatal equipment (including patient administration and monitoring systems, ventilator and syringe pumps) is not replaced in a timely manner then there might be loss of service capacity, resulting in potential hazards for patients and staff.	Harm (Patient/Non-patient)	Preventive: Trolley base: Regular inspection & servicing by medical engineering. Daily check by clinical team Incubator: Regular inspection & servicing by medical engineering. Daily check by clinical team. Patient monitor: Third-party batteries (not approved by manufacturer) may be available. Daily check by clinical team. Patient ventilator: Guideline has been produced to guide effective use. Regular training & updates for the team with assessment of competencies. Transcutaneous blood gas monitors x 2 being purchased by charitable funds to improve monitoring capabilities and avert carbon dioxide problems. Installation in 2017-18. Nitric oxide system: Regular training & updates for the team with assessment of competencies. Daily check by clinical team. Syringe pumps are regularly inspected & serviced by medical engineering. Daily check by clinical team. Detective: (How will you know if your risk is off trajectory) Trolley base: Regular inspection & servicing by medical engineering. Incubator: Regular inspection & servicing by medical engineering. Corrective: Each potential event will be dealt with by CenTre Neonatal Transport leadership team depending on the nature and severity of the event.	5 Extreme	1 Unlikely	5	Replace all trolleys and associated equipment due 01/04/2019	5	CMG Risk
2804	Maternity	Lack of continuity in patient care due to Gynaecology Consultant cross site working	Harm (Patient/Non-patient)	Daily Specialist Trainee ward rounds (Mon - Friday) Individualised management plans Detailed post surgery plans Consultant rounds during weekends and bank holidays Named Consultant contacted if complications arise Multi disciplinary working - nursing staff will escalate concerns to named consultant Ad hoc Consultant rounds wherever possible	4 Major	5 Almost certain	20	Approval awaited for 2nd Consultant post from Trust Board - due Q4	8	CMG Risk
3013	Maternity	There is a risk to the safety of patients, staff and visitors at St Mary's Birth Centre due to the condtion of the building	Harm (Patient/Non-patient)	Patient call system: Use of temporary call system. Call sets can be moved around to where they are needed however, there are insufficient call sets for all areas and the call will only sound in the staff office. Staff working on the ward will not hear the call. The temporary call system is on short term loan only. Security system: The front door to the Maternity building is locked between the hours of 1700 to 0800 'Room in use' signs are placed on Birth room and Quiet room doors when in use. Staff knock before entering room. Babies are not left unattended in the unlocked rooms Midwife in charge carries the central unlocking key at all times in case of system failure and need to unlock doors Staff would call 999 to request police attendance if intruders present	4 Major	5 Almost certain	20	Complete all estates work required due 08/05/2018	3	CMG Risk
2565	CHUGGS	If capacity is not increased to meet demand, then delivery of national targets in General Surgery, Gastro and Urology will be compromised resulting in delays in patient treatment pathways.	Harm (Patient/Non-	Regular monitoring of the PTLs and activity levels by the speciality management teams. Review of position on a weekly basis within the services as well as at a corporate level. All services are putting on extra sessions as well as utilising independent sector partners to ensure patients are treated as soon as possible. While General Surgery continues to have a high backlog of patients waiting for surgery, their non-admitted performance is improving and is now at 40% of the level it was at the end of October.	3 Moderate	4 Possible	12	Ensure validation is on-going and completed timely - due 31/01/18.	6	CMG Risk
2821	CHUGGS	There is a risk of breaching the single sex accommodation policy on Osbsorne Day Care Unit	Harm (Patient/Non-patient)	Use of CNS and ward staff for specific treatments which has an impact on their roles? Use of inpatient beds to treat isolated patients. For injections having to curtain off a bed space, thus reducing capacity further on Day Ward; Booked at cohorting female and male patients to separate areas (either side of Day Ward) but causes further reduction in capacity.	3 Moderate	4 Possible	12	Capacity and demand review of chemo suite with a view to moving haematology chemo activity - 31/12/17; Restrictions to be applied to day care booking system - 31/12/2017	4	CMG Risk
2823	CHUGGS	If recruitment to admin workforce gaps does not occur, then potential for errors with patient medical review and chemotherapy appointments will increased resulting in potential harm.	Harm (Patient/Non-patient)	Staff working over time to cover unfilled shifts on chemotherapy suite; Book bank staff to fill gaps in service; Staff rotated into chemotherapy suite from administrative office to provide cover whenever possible; On a daily basis staff are being moved to chemotherapy suite if the ward workload allows; Recruitment actively taking place; At last resort, roster nurses / HCA's / clinical aides to fill the gaps and to fulfil role; Support from systems manager - to implement new scheduler; Manage staff sickness to support a sustained return to work;	3 Moderate	4 Possible	12	Review of the organisation of oncology administrative services and action as appropriate - Review due 30/11/17.	6	CMG Risk
2824	CHUGGS	If the insufficient staffing levels in Radiotherapy Physics is not resolved, then the likelihood of breaching waiting time targets and possibility of serious radiotherapy treatment error will be increased.	Harm (Patient/Non-patient)	Vacancy out to advert to replace an experienced senior clinical scientist; 1 month summer holiday research student appointment to assist with a project; 2 month summer holiday research student appointment to assist with clinical trial data submission; staff working flexibly to maximise resource; staff trialling 2 late working nights per week to access linacs to perform patient QA required to verify unusual/complex treatments - required before treatment can commence; 1 staff member trialling 9 day fortnight working late very Friday to access linacs to keep up with machine QA; Paid overtime being offered to encourage extra hours from existing staff to cover summer period - currently take up equivalent to 0.8 wte; Staff undergoing training to become competent to cover more services; Department trains Clinical Scientists and Technologists; Visit to Hull planned for 13th July to look at paper-lite working which should increase efficiency; Visit will also be an opportunity to inform planning service redesign eg role expansion of Dosimetrists/Scientists to improve efficiency and release time of higher grade staff including Clinicians, changes to skill mix to ensure most efficient model going forward; 2 and 5 year workforce plan in work up to address staffing shortage in the longer term.	3 Moderate	4 Possible	12	Produce 2 and 5 year workforce plan - 31/01/2018. Complete; submit business case to address staffing - 31/01/18.	3	CMG Risk
2826	CHUGGS	If there is a shortage of capacity to meet the current demand for patients awaiting intervention Cardiac Angio Procedures then this may result in patients treatment being delayed	Harm (Patient/Non-patient)	Controls: •Ice system being reviewed to find a way to remove patients that have had procedure or have been discharged •Patient list being reviewed daily to ensure data accuracy •Patients that have been referred, date of referral put onto Nerve centre handover so all nursing and medical staff have that information •Utilise the NEWS observation to identify the deteriorating patient to enable escalation •Prioritisation of patients according to clinical acuity/chronological order •Patients highlighting concerns are being communicated with regularly regarding there plans and updated with changes •Patients reviewed at the daily board round and escalated and ensured that all patients have been referred •Daily review of numbers waiting at the discharge conference call	3 Moderate	4 Possible	12	Short term •Develop and escalation process for demand/capacity and agree the process to be followed as a result of high demand and lack of capacity. - Local escalation activated by Senior Lab Co-ordinator to cardiology management team, currently long waiters are managed in week with additional weekend list. Formal escalation plan to be written end of April. •Review with the IPC team the position regarding urgent non swab patients in the lab. - Position remains steadfast on IPC position of urgent non swabbed patients. We will need to review 72 hours NSTEMI guidelines - awaiting feedback from C.Gray on near patients testing for MRSA	4	CMG Risk
3111	Cardiology	If notes are missing or lost caused by misfiling or removal of notes, then there is a risk that pacing notes will not be available resulting inappropriate actions being taken with the implantable cardiac device.	Harm (Patient/Non-	We now scan current/new paperwork on to the CRIS system Retain paper copies as not all have access to CRIS in all areas Linked to risk no. (TBC) – notes storage	3 Moderate	4 Possible	12	Installation of Fysicon system - Integrated solution for all devices implanted at UHL and surrounding Trusts (Northampton and Derby) - 31.12.17	2	CMG Risk

Risk ID	Specialty	Risk Description	Risk Subtype	Controls in place	Impact	Likelihood	Current Risk	Action summary	Target Risk	Risk Type
3112	Cardiology	If shelves/storage are overloaded caused by insufficient storage space then there is a risk of the shelving in the pacing clinic falling from the wall leading to injury to staff and loss of patients records.	Harm (Patient/Non-patient)	Notes evenly spread Pacing paperwork scanned on to the CRIS system Paper records retained due to availability of CRIS in all areas Additional care by all staff when accessing information inc. manual handling advise Linked to risk no. (TBC) – lost patient records in pacing clinic	Moderate	Possible	12	nstallation of Fysicon system - Integrated solution for all devices implanted at UHL and surrounding Trusts (Northampton and Derby) - 31.12.17	3	OMG Risk
2820	Clinical Immunology & Allergy	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.	Harm (Patient/Non-patient)	Weekly Access Meeting (WAM) attendance for support and completion of actions. Review of patient referrals to identify the high risk patients and complete a trajectory plan. Advice and actions being agreed with the Head of Performance and Operations to ensure all patients waiting for sequential procedures have been identified and are allocated to the appropriate patient waiting list. Continued monitoring of these patient waiting list at Respiratory RTT meetings and escalation of concerns. To standardise referral and waiting list procedure to ensure all patients are recorded on the correct patient waiting list. Completion of Business Case and Risk Assessment to recruit an Allergy Consultant for the service. Respiratory Physicians to help maintain current and future Allergy Service. Route to Recruit and advert to be authorised ASAP to cover allergy gap(s). Further discussions of future model of Allergy and Immunology and identifying possible support from Consultant Dietitian. Clinical Immunology/Allergy Consultant commenced 9.10.16 - Consultant will support an additional allergy clinic due to allergy consultant has been appointed started on the 3.10.16 - complete Regular meetings with Senior Management, Head of Performance and Allergy Team to continue to monitor patient backlog and work through solutions. complete Respiratory Physicians with allergy expertise to temporarily change job plans to support the allergy service and enable patient appointments to be booked for a 6 month period - complete Trust Grade appointed 23.9.16 to support allergy service due to loss of Spr trainee - complete Sustainability of service meeting to be hel on week of 14th November - Completed	Moderate	Possible	12	Agree job plan and recruit to Consultant Immunology post (retirement) - Review Jan 2018.	6	OMG Risk
3006	Thoracic Surgery	If recruitment and retention to the current Thoracic Surgery Ward RN vacancies does not occur, then Ward functionality will be compromise, resulting in an increased likelihood of incidences leading to patient harm.	Harm (Patient/Non-patient)	Controls in place: List what processes are already in place to control the risk (Copy & paste to add rows where necessary) On-going external advertising and recruitment for band 5 vacancies, including clearing house, international recruitment and job swap. Internal rostering of existing staff to do additional hours/overtime All unfilled shifts are routinely sent to staff bank office when health roster is approved Experienced bank staff encouraged to book shifts on ward Matron undertaking skill mix revisions ie converting RN to HCA bank requests All non-essential study leave cancelled Matrons all aware of vacancy level and taking appropriate action in daily staff management Matron/Ward Sister/Nurse in charge to review off duty daily Continue to up skill current staff who have 6 months experience on the ward Consultant surgeons to pre-book an ITU bed daily in order to operate on 3 level 2 cases per list DHON working clinically to support ward team. Matron job plan is to currently work clinically on ward	Moderate	Possible	12	Robust control and management of sickness absence and authorisation of annual leave - 1.1.18	6	OMG Risk
3131	ESM	If we do not increase the casenotes storage capacity within the Dermatology admin dept on Oliver ward, the dept will be unable to retain notes in order to ensure last letters are filed by the medical secretaries. This means that last letters need to be printed off and filed by the clinic co-ordinator/s who prep the clinics (when notes are requested back to the department), which is an additional burden on this staff group and could increase the likely of mistakes being made when prepping clinics.	Harm (Patient/Non-patient)	Preventive: Clinic/Notes Prepping - Standard Operating Procedure Detective: Audit of prepped notes Increased complaints Corrective: Clinical huddle before the start of each clinic whereby patient list is reviewed and safety checks performed (stop the line). Additional storage room identified and used from September 2017	Moderate	Possible	12	Additional storage room shelving quotation 31/01/2018	6	OMG Risk
2656	ESM	If Dermatology services is not adequately resourced, Then the level and quality of the service provided will be impacted.	Harm (Patient/Non-patient)	Regular review of RTT performance and attendance at weekly access meeting. Consultant post advertised (interviews planned for early October). Extra capacity being created with waiting list initiative clinics. Regular review of PTL with Cancer Tracking Team and attendance at weekly Cancer Action Board Meeting. Medical staffing capacity gaps regularly reviewed at fortnightly medical workforce meetings. Exploring Specialist nurse led roles to fill capacity gap. Weekly Cancer Waiting Times Reviewed. RTT performance review and capacity planning through WLI daily/weekly. Ongoing work with cancer pathway. 2 CNS due to start post May 2016. I Cesr post filled with permanent & 1 Locum at full capacity. January 2017 Review * Redesign Dermatology service to establish super 2 week waiting clinics and Dermatology Specialties. * Dermatology Specialist Nurse appointed, nurse currently undergoing additional training to become an independent practitioner. * Admin Staff recruited to. * Exploring different diagnostic views. Dermoscopy pilot now up and running with an additional clinic per week of 10 patients.	Moderate	Possible	12	Determine funding for additional CNS post 31/12/2017 Link with Cancer Centre 31/12/2017	8	OMG Risk
2604	Trauma & Orthopaedics	There is a risk that patients will wait for an unacceptable length of time for trauma surgery resulting in poor patient outcomes	Harm (Patient/Non-patient)	Monitoring of performance against BPT criteria Monitoring of morbidity at M&M meetings Action plan in place and monitored monthly Increased Orthogeriatrician Input Mandatory reporting to CQRG Trauma unit meeting chaired by CD. Explore options for transferring patients to LGH	Moderate	Possible	12	Employment and training of further TNPs to bolster junior doctor gaps and facilitate more stable CT training - 30 Nov 18 Employment of further staff to support the service across 7 days as per the recent business case - 30 Nov 18	15	OMG Risk
1196	CSU	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.	Harm (Patient/Non-patient)	To provide as much cover as possible within the working time directive. Registrars cover within the capability of their training period. Other Radiologists assist where practical however have limited experience and are unable to give interventional support. Locums are used when available.	Moderate	Possible	12	All action complete - risk under review.	12	OMG Risk

Risk ID	Specialty	Risk Description	Risk Subtype	Controls in place	Impact	Likelihood	Current Risk	Action summary	Target Risk	Risk Type
2496	Pathology - Blood Transfusion	Risks associated with implementation of an Electronic Blood Tracking (Phase 2)	Harm (Patient/Non-patient)	1.Blood Transfusion Electronic Tracking Group Members and meeting - held fortnightly and consisting of multi team specialists to address all aspects of procurement and implementation of the system 2.Business case for the Electronic Tracking System completed. Capital and Revenue Funds (PQQ) allocated for the purchase of the system - completed June 2014 3.Timeline and action plan for implementation of the Electronic Tracking System - active 4.Procurement process for the 'expressions of interest' for the Electronic system actioned and review of the expressions of interest presently being reviewed by Group Members 5.Defined specification of required Electronic system completed in preparation for the procurement process 6.Completion of scoring mechanism for system functionality and 'fit for purpose' being completed by Group members 7.IT specification for the non-functionality of the Electronic system requirements - members of the group collating system interfacing with UHL IT systems, data storage, training and equipment needs 8.Appointment of a project manager to support the implementation and dissemination of the Electronic Tracking system to service areas/users within UHL 9.Oct - Nov 2015: Project support post in place. LIMS and blood track courier in stalled. 10. July 2016 - Further team member in post. 11. Oct 2016 -2nd phase training roll out nearly complete LRI, estimated completion Feb 2017	Moderate	Possible	12	To monitor Implementation performance for 3 months to Jan 2018. The training of BloodTrack TX to the wards was completed mid-September 17 when the LGH was completed.The "Orange card" paper receipting now been replaced by the electronic BloodTrack system for all blood components when it was withdrawn at the LGH as the final site. (Note paper receipting remains in place for bottled batched products due to inadequacies in the TX App but recording the final fate of bottled products is not yet law.)The TX implementation project was formally closed on Tuesday an now enters the delivery stage however a further action is added to monitor the implementation for 3 months to make sure everything is in place and no transgressions of system, overall compliance for September was 97% . The risk will stay the same for this period. Further risk assessments with reference to delivery stage may be required and is to be discussed with Operational Head.	4	CMG Risk
2845	Pathology - Clinical Microbiology	There is a risk to the delivery of a quality microbiology service due to lack of appropriate staffing.	Harm (Patient/Non-patient)	*Have a fixed term contract (12 months) for a retired BMS to help support training delivery *Empath executive have been made aware of the need for supernumerary training posts due to the unavailability of experienced staff wishing to relocate to locality. *Locum staff employed *Bank BMA and BMS staff used to support core hours *Band 6 secondment to a band 7 post	Moderate	Possible	12	Supernumerary staff to either provide training provision, or release staff so they have time to provide dedicated training and supervision - 15 Mar 2018 Increase substantive BMS posts - 15 Mar 2018 Increase substantive BMA (2/4) posts -15Mar 2018 Make trainee BMS staff supernumerary to provide future home grown experienced BMS staff - 15 Mar 2018 Update by Daxa Patel 05/12/2017:Since the last update (13.09.17) the department has continued to experience a high turnover of staff.This continues to put training pressure on the department. The work started with the empath organisational and development team has been suspended due to changes within that team. Have not managed to secure any further support from the UHL OD team.No change to risk , 3 month extension required	1	CMG Risk
1157	Radiation Safety	Lack of planned maintenance for medical equipment maintained by Medical Physics	Harm (Patient/Non-patient)	Some critical equipment is being maintained under service agreements set up with supplier. Medical Physics team are targeting "High" risk equipment as a first priority. Trust wide project team has been assembled to categorise the risk rating of equipment categories for both Maintenance and training needs - work from this team will eventually lead to many of the recommended actions being possible Identified all critical equipment and maintenance needs through the risk assessment process Reviewed the Medical Devices policy Site wide audit of medical devices Standardise medical equipment wherever possible Trust wide communication about future of medical device management issued. Develop robust mechanism to ensure the revenue consequences of maintenance for medical equipment purchases are identified - 30/9/13 - completed Develop process to allow appropriate funding for Medical Physics to ensure programmed maintenance can be performed - completed 2/12/13 Quantify the shortfall in maintenance provision from existing resources and identify to the Trust (to enable Trust decision on corrective to be made) - 31/5/14 Establish infusion pump libraries at LGH and LRI - completed 4/7/16 Secure funding to increase current staff base for Medical Physics technical staff or outsource maintenance contracts - completed 4/8/16	Moderate	Possible	12	Monitor PPM rates over next 12 months - 31/7/18 Trust to deliver year 2 investment in MEMS budget - 1/4/18	16	CMG Risk
2578	Maternity	Scans undertaken in GAU & Gynaecology clinic cannot be archived (Screening)	Harm (Patient/Non-patient)	Results of scans are written in full when patients are discharged Meetings with IMT to look at options for archiving and linking scan machines Paper scan images are filed in the patients notes	Moderate	Possible	12	The business case for the upgrade of the VIEWPOINT maternity system is being discussed at the Capital Investment Committee on 13th October. This includes the storage of scans and connectivity of stand alone machines due 27/02/2018	2	CMG Risk
1042	Maternity	Unavailability of USS and not meeting National Standards for USS in Maternity (Screening)	Harm (Patient/Non-patient)	Detailed scan pro-forma US performed by suitable trained staff Self audit Use of regular pre-booked agency sonographers Daily review of outstanding requests to monitor the situation Access to consultants for second opinion if suspicious re possible abnormality All ultrasound machines now of suitable specification and replaced 5 yearly Incident report forms Update 18.10.12 Continued use of Agency Sonographers; Continued 'extra' lists by Fetal Med Consultants; Additional u/s machine in place but next step is need for additional scan room - this is built in to the interim solution for Maternity (phase 1) and should be converted by April 2013. R/v of the implementation of the GROW package	Moderate	Possible	12	Review the requirement of MW Sonographers Due 27/02/2018	6	CMG Risk
3094	Maternity	If the existing call system (Aidcall) is not replaced (current system is now obsolete and compatible spares cannot be obtained) then not all areas of the Birth Centre will have a working system (there are only 5 of the 22 original units working) ad response times may be delayed resulting in deterioration of the situation and a worse outcome for the patient such as delay in resuscitation.	Harm (Patient/Non-patient)	Preventive: The estates department have provided the Centre with a temporary call system. The call sets can be moved around to where they are needed however, there are insufficient call sets for all areas and the call will only sound in the staff office. Staff working on the ward will not hear the call. The call system is on short term loan only. Detective: Daily checking of the call sets is carried out but problems have been found to be intermittent and difficult to predict. As incidents are reported or complaints received.	Moderate	Possible	12	Quotation to upgrade the existing patient call system due 31/08/2018	2	CMG Risk
2387	Communications	If an effective collaborative relationship with stakeholders cannot be established and sustained, then the Trust may lose support from stakeholder.	Reputation	Stakeholder relations assessment; Patient advisor group meetings; Members engagement forum; Quarterly CE/Healthwatch meetings; Ongoing contact with Healthwatch board and officers; Communications and Engagement strategy; Promotion of public board meetings; AGM; Regular communication with members; Partnership working with Age UK. ePartner scheme. Quarterly Community Conversation events supported by Board members.	Moderate	Possible	12	Regular communication with Membership via quarterly magazine and email communications. Board paper with Community Engagement Proposal approved by February 2017 Board.	4	Corporate Risk
2777	Communications	If fundraising targets for the new Childrens's Hospital are greater than the amount held, then the charity will not be able to underwrite the required expenditures.	Financial loss (Annual)	The Children's Hospital Board are aware. The Charitable Funds Committee are to be made aware. Both groups will monitor progress against plan.	Moderate	Possible	12	The Charity and Children's Hospital Board are monitoring progress against plan. There is a delay in securing larger lead gifts but this will happen in due course.	4	Corporate Risk

Risk ID	Specialty	Risk Description	Risk Subtype	Controls in place	Impact	Likelihood	Current Risk	Action summary	Target Risk	Risk Type
2775	Emergency Planning & Business Continuity Procurement & Facilities	If we do not have robust systems to manage supply of goods then it may impact on clinical service provision	Harm (Patient/Non-patient)	Suppliers business continuity plans UHL materials management service to manage stock levels - assurance via annual audit of ward store rooms Mat manning of goods by supplies team (to high volume areas only - not set up to all wards - to meet predetermined stock levels - assurance via 1 / 2 times weekly visits to high volume areas Product sharing and movement of goods within the CMGS / Wards / department to meet service requirements Internal resilience plans which include use of alternative suppliers and products with direct ordering via courier service where required Training to UHL staff (requistioners) Procurement helpdesk in place Table top review of critical supplies carried out Attendance and involvement at corporate business continuity meetings.	Moderate	Possible	12	*All actions assigned to risk entry have been completed - all actions that can be taken have been taken and risk has been re-assessed and remains a moderate risk to the service - Review quarterly*	12	Corporate Risk
3010	Accommodation Human Resources	There is a risk that the office space for Recruitment Services and Training are not fit for purpose	Financial loss (Annual)	Multi-professional Education Training Facilities Project Group Established as part of the UHL Reconfiguration Programme Procurement of Apprenticeship Levy Management Partnership in progress Development of an action plan Organisational Health Dashboard Well-lead domain part of Chief Executive's Briefing Executive Workforce Board UHL Way Sponsor Group Workforce and OD Operational Group	Moderate	Possible	12	Source new office space to accommodate Payroll, ESR Admin, Recruitment Services Source new training space to accommodate the Training and Development team. Detailed action plan will be agreed with and monitored by Mulit-professional Education Training Facilities Group at monthly intervals. Project lead assigned (John Lewin)	12	Corporate Risk
3125	Communications Emergency Planning & Business Continuity	If the Trust was to experience the loss of IT and Telecommunications infrastructure caused by a planned / unplanned outage, Then delivery of safe, effective, high quality, patient centred care may be compromised resulting in potential patient harm and service disruptions.	Service disruption	Preventive: Regular security updates of the Trust IT systems Restriction placed on the use of none quarantined hardware and software Detective: Advance warning of scheduled outages to the infrastructure Warning of potential malicious attack on government IT systems Corrective: Report to IM&T for further investigations Implement local Service/Depart Business Continuity plan LRF Resilient telecommunications plan Trust procedure to utilise radio handsets for crash teams and other critical users within the Trust	Moderate	Possible	12	Develop a procedure sheet for the loss of Data for inclusion in the Business Continuity Plan (Critical Incident Plan) - 31 Dec 17	6	Corporate Risk
3123	Emergency Planning & Business Continuity Operations	If the Trust was to experience the lack of staff availability caused by Industrial action, adverse weather conditions, disruptions to local or national transport infrastructure or mass resignation. Then delivery of safe, effective, quality, patient centred care may be compromised resulting in potential patient harm and service disruptions.	Service disruption	Preventive: Advance notifications of potential industrial actions and potential adverse weather conditions Contractual agreement with employment agencies to provide Bank staff in place Contractual obligation in place to ensure key staff group members provide resignation notice Detective: Mass resignations from key staff groups Corrective: Implement local Service/Depart Business Continuity plan Utilise local employment agencies to acquire staff Bank Staff program	Moderate	Possible	12	Assurance programme in place to test local BCP - review in Feb 2018	6	Corporate Risk
3093	Clinical Services Behavioural Sciences	If Vascular inpatients and theatre is moved to Glenfield Hospital, leaving Outpatients at the LRI, then this may result in a fragmented and less efficient vascular surgery department	Harm (Patient/Non-patient)	Currently on LRI site still so no risk until after 8th May 2017 Trust are now actively looking to relocate Vascular Outpatients to Glenfield but the timeline for this is 6 months from initiation, which is likely to be in April 17	Major	Unlikely	12	MW/SM to work on the agreed plan to instigate the move of outpatients from LRI to GH - 31.1.18 MW has draft plan to facilitate move, to speak to MSK&MS HoOps to discuss utilising space - 31.1.18 MW to seek CMIC approval for plan - 31.1.18	1	CMG Risk
2840	ESM Ophthalmology	If the faulty windows affecting all ESM Wards in Windsor are not replaced, Then patient will continue to be exposed to challenging temperature levels.	Harm (Patient/Non-patient)	There is a window replacement programme being rolled out across the Trust. Extra blankets are required/extra clothing for patients. Taping of windows by estates team with 'galfer' tape. Cards to be given to patients/relatives to explain	Minor	Likely	12	Window replacement program on going, Capital programme been to review all outstanding windows that haven't been replaced and will report back in the New Year 31/01/2018.	4	CMG Risk
3016	Orthodontics & Restorative Dentistry Oral & MaxFac SS	There is a risk of cross-infection between patients with dental instruments	Harm (Patient/Non-patient)	In the six dental surgery rooms there is available the following for the decontamination of reusable instruments, one dedicated sink for the cleaning and rinsing of instruments and dental impressions, an ultrasonic cleaner and a steam steriliser (Little Sister 2). The current process staff manually clean and rinse the dirty instruments in the surgery sink, place in ultrasonic cleanser and then steam steriliser.	Major	Unlikely	12	Develop and submit business case for a dedicated decontamination room and associated equipment.- 01 Jan 18	4	CMG Risk
2876	Oral & MaxFac SS Ophthalmology	There is a risk that male and female patients will be cared for in the same area when wearing hospital gowns.	Harm (Patien/Non-	· Patients are mainly in their own clothes, but when they are not, staff encourage patients to dress as soon as possible. · When patients of different sexes are nursed on trolleys, curtains are closed. · Patients are made aware of the accomodation prior to admission.	Minor	Likely	8	All actions under review to avoid breaches	2	CMG Risk

Risk ID	Specialty	Risk Description	Risk Subtype	Controls in place	Impact	Likelihood	Current Risk	Action summary	Target Risk	Risk Type
510	Pathology - Blood Transfusion	There is a risk of staff shortages impacting on the Blood Transfusion Service at UHL	Harm (Patient/Non-patient)	Full 24/7 rota implemented. Voluntary rota for spare sessions - sickness leave etc. Full rota has created additional sessions as satellite laboratories to comply with 24/7 working. Associate practitioners included in early and late roster sessions Associate practitioners to cover entire night at LRI Phased extended contractual hours 8 to 8 B.S & B.Transfusion Phased extended day B Transfusion to 23:00 Employed Bank/Locum BMS staff to cover short term deficiencies in rota Investigate additional lean working options to reduce pressure on laboratory staff. Introduced a forced rota Multi discipline staff to assist cover overnight B.S(24/7) at LRI Retrained Lab Manager One-off training Risk assessed the process of a "Plan B" 24/7 Rotas with voluntary sessions in place from May 2012 2 new BMS band 5 staff recruited 24/09/2012 - to complete local competecy training Feb 2013 Introduction of cross cover form NUH to support UHL BT Roster - limited cover at present (Oct 2013) Numerous meetings taken place with empath management team to raise acute risk of service failure (August 2013 to Jan 2014 & ongoing). Approval in principle agreed to replace vacancies and also create 12 month secondment role to band 8a for additional managerial support. Also to consolidate 3 x band 5 bank staff into fixed term contracts. From January 2016: Business cases and approvals for Associate Practitioners x 4 , to support out of hours working. From June 2016: Locums in place to ensure service continuity. Further business case and approval for extra BMS staff required, including dedicated trainers.	Major	Unlikely	12	Recruitment of additional/replacement staff to maintain Service 15/03/2018. To review and re-asses capacity within depts, to move staff for multi disciplinary training - 15/06/18 Risk reviewed by A.Ghattaoraya 15/12/2017:The risk score is still the same as we currently may have extra personnel in the department but they are trainees that need HCPC registration. Although staff turnover has stabilised considerably in the department, there are a high number of band 5 trainees in the department (5 x trainee band 5) that require completion of their registration portfolio. As requested, the update:Outstanding vacancies: 2 x Band 6, 1 x Band 7, 3 x Band 3, 2 x band 4, 1 x band 5.Multi discipline training still to be considered in future but after consolidation of recruitment.	4	CMG Risk
2989	Pathology - Cellular Pathology	There is a risk of failure to deliver the TAT Standards of NHS Cervical and NHS Bowel Cancer Screening programmes	Harm (Patient/Non-patient)	· New replacement processors sourced via emergency capex route and via the UHL charity · Implemented prioritisation stickers red and blue, plus specific iLab codes - bowel only · Business case for short term locum staffing · Business case for longer term substantive staffing for all elements of the overall histology process · Business case for extension of the managed equipment service (MES) to UHL from NUH - route to sourcing equipment · Creation of an urgent laboratory stream of work to fast track these biopsy cases where identifiable	Major	Unlikely	12	Implementation of MES - Jan 2018. Update by Diana Cullen 09.10.2017:The building works to accommodate the new equipment are due to be completed by the end of this week (13th October). Delivery of the new equipment will be taking place through the last 2 weeks of October and early November. We will then be validating and carrying out some process redesign to streamline the way we work which will run into the New Year. At this stage the score needs to remain the same until the next review	4	CMG Risk
2136	Radiation Safety	If the aging asset base of infusion pumps is not addressed then this could result in infusion pump obsolescence which may result in patients being exposed to harm.	Harm (Patient/Non-patient)	Historically pumps have been purchased by CBU's when required. The cost of infusion pumps falls under the category of revenue expenditure and therefore falls outside the remit of the annual capital medical equipment replacement process. In normal circumstances CBU's would therefore be expected to replace pumps when beyond repair; the scale of this situation may make this practice unaffordable. Increase spares stock for P6000 pumps - 3/4/13 - task completed Swop out ED P6000 pumps for Braun Infusomats; retain P6000 to support ITU areas - 5/5/13 - task completed Standardise on infusion pump model - completed 1/12/17 Tender for replacement pumps - completed 1/12/17	Major	Unlikely	12	Replace obsolete stock - 31/12/18 Write business case and submit to Trust committees - 31/3/18	4	CMG Risk
3116	Pharmacy	If the epma Medchart system is not updated and configured as per UHL and IM&T requirements then staff may not be using a system which provides high quality care resulting in potential harm to patients through out of date training, web browser issues, drug dictionary not up to date.	Harm (Patient/Non-patient)	Preventive: When individual requests are received for new local configurations including drugs, quicklists, protocols, rules they are been built into the system. Paper charts are available for emergency situations including drug prescribing. Pharmacists have been informed not to use the workaround functionality for ordering medications to help reduce patients from missing doses. The ePMA Team are maintaining the Medchart system with minimal resource and log new requests with the supplier for developments to the system The ePMA Team provide continued support to all healthcare professionals for any queries related to Medchart Detective: An overall reduction in the number of Datix incidents related to Medchart system issues Corrective: Engagement with healthcare professionals using Medchart to understand outstanding issues Continued support from ePMA team for the nursing, medical and pharmacy teams, including discussion at Electronic Medicines Management Group regarding outstanding issues	Major	Unlikely	12	written governance processes to be in place for all aspects of Medchart - to be similar to Sofia - 31/01/2018 IM&T to centrally switch off auto-complete functionality on Internet explorer 11 - 31/01/2018	4	CMG Risk
2907	Pathology - Specialist Biochemistry	The Forensic Toxicology service will fail resulting in a substantial loss of income and prestige for the Department/empath	Harm (Patient/Non-patient)	Staff are working extra sessions and overtime at weekends but this is not sustainable in the long term. This doesn't address the lack of analytical time available on the current equipment.	Major	Unlikely	12	Installation;validation , go live LIMS - Jan 2018 - Update by F.Hollingworth 12.10.2017:Following a cloud update the software can no longer be used by PCs running Windows Vista or XP. This is the majority of the PCs in the lab. The PCs are too out-dated to be upgraded. A request for additional PCs is unlikely to be progressed so we are at a standstill. Once access to Starlims is restored the previous 3 months to complete testing is still valid(extend action 3 months). The contract for Starlims expires next year. A revised risk score to be confirmed by Operational Head would be a high risk to service disruption.	4	CMG Risk
2454	Communications	If Directorates and CMGs do not adequately engage with PPI processes, then we could breach our legal obligations.	Regulation	PPI strategy Bi-monthly magazine to UHL membership E- communications to membership Membership strategy PPI and Membership Manager Liaising with patient/community groups and membership. PPI leads Director of Communications and External Relations Communication Team managing stakeholder communications Patient Advisors attached to CMGs Regular meetings with Healthwatch Quarterly Community Conversation event supported by Board members. PIPEEAC assurance committee established and receiving quarterly CMG reports Band 5 PPI Officer appointed May 2016. There are now 21 Patient Partners distributed across all CMG's.	Major	Unlikely	12	On-going enagagement campaign	5	Corporate Risk
3124	Emergency Planning & Business Continuity	If the Trust was to experience the loss of a key premises or Services (Power, Water, Gasses) caused by fire, flood, an act of nature, explosion or an act of terrorism. Then delivery of safe, effective, quality, patient centred care may be compromised resulting in potential patient harm and service disruptions.	Service disruption	Preventive: Mandatory servicing and maintenance program of premises is carried by Estates and Facilities Annual fire inspections conducted Prevent training for key staff groups UHL Bomb threat policy in place Detective: Advance warning of potential adverse weather conditions which could lead to flooding. Corrective: Inform Estates and Facilities Helpdesk for further assistance Implement local Service/Depart Business Continuity plan	Major	Unlikely	12	Review of local BCP - Review Feb 2018	4	Corporate Risk

Risk ID	Corporate Risk	Speciality	Risk Description	Risk Subtype	Controls in place	Impact	Likelihood	Current Risk	Action summary	Target Risk	Risk Type
3126	Corporate Risk	Clinical Supply Chain & Business Continuity	If the Trust was to experience a loss of a key supply chain partner impacting on the Trust's ability to acquire pharmaceutical goods, medical devices, catering produces and housekeeping products, Then delivery of safe, effective, high quality, patient centred care may be compromised resulting in potential patient harm and service disruptions.	Service disruption	Preventive: Suppliers have a business continuity plans Training and education to UHL reacquisition staff Detective: Regular management meetings with suppliers to ascertain assurance of their ability to meet contractual agreement. Corrective: Procurement helpdesk to assist with the coordination of capacity and demands from clinical areas Implement local Service/Depart Business Continuity plan Product sharing and movement of goods within CMG's and Wards to meet service requirements UHL materials management service to monitor and manage stock (including MAT management) Direct purchasing via courier service where required	Minor	Unlikely	2	Develop a procedure sheet for inclusion in the Business Continuity Plan (Critical Incident Plan) - Review Feb 2018	2	Corporate Risk