INTEGRATED RISK AND ASSURANCE REPORT AS AT 31ST JAN 2018

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

Executive Summary

Context

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

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. Eight annual priorities, four of which are components of the Quality Commitment, have been assessed as off-track at month end, with six of these forecasted 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 159 risks recorded on the organisational risk (including 56 with a current rating of 15 and above). Five new risks scoring 15 and above have been entered on the risk register during the reporting period.
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 also to 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: [12.4.18 TB]

6. Executive Summaries should not exceed **2 pages**. [My paper does comply]

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **UHL TRUST BOARD**

DATE: **1ST MARCH 2018**

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

SUBJECT: **INTEGRATED RISK AND ASSURANCE REPORT (INCORPORATING UHL BOARD ASSURANCE FRAMEWORK & ORGANISATIONAL RISK REGISTER AS AT 31ST JANUARY 2018)**

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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.

2. BOARD ASSURANCE FRAMEWORK SUMMARY

2.1 The BAF remains a dynamic and developing document and has been kept under review during January 2018. Executive owners have updated the principal BAF risk ratings and progress with delivering against the annual priorities for 2017/18, with the Executive Boards having corporate oversight to scrutinise and endorse the final version, which is included at appendix one.

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*:* The percentage of patients discharged or admitted via Emergency Department within 4 hours in January was 75% compared to 71.5% in December, this is below trajectory level of 90%. With the inclusion of LLR performance reached 81.3%. The total number of attendances has remained relatively static over January, however we continue to see higher than planned ambulance attendances. The conversion rate has remained high over January indicating a high acuity of patients attending.
- **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

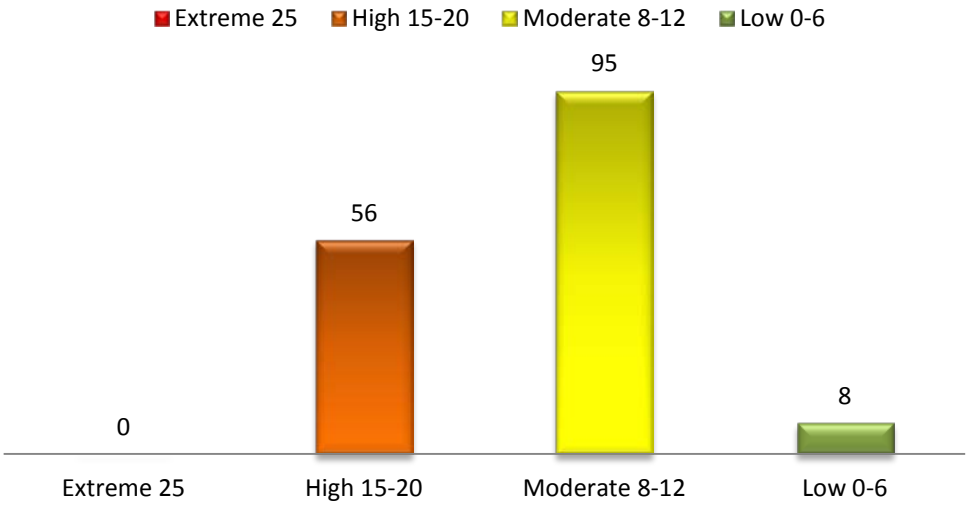
and maintain its financial plan, caused by ineffective solutions to the demand and capacity issue and ineffective strategies to meet CIP requirements, then it may result in widespread loss of public and stakeholder confidence with potential for regulatory action such as financial special measures.
Progress update: Month 10 (Jan 2018) has seen a significant financial impact following the national instruction to cancel elective inpatient activity. The Trust has not delivered its year to date financial plan but following discussions with NHSI is forecasting to deliver the planned financial plan for 2017/18.

2.3 Eight annual priorities have been assessed as off-track at month end, four of which are components of the Quality Commitment. In total six of the eight are 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 January 2018, there are 159 risks recorded on the organisational risk register. The graphic below illustrates the breakdown of the risks by their current rating. A dashboard of these risks is attached at appendix one. Figure 1, below, illustrates the breakdown of the risks by their current risk rating and further details are provided in a dashboard at appendix two.

Figure 1: UHL Risk Register profile



3.2 Five new risks scoring 15 and above has been entered on the risk register during the reporting period and are described below:

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score
3115	ITAPS	If there is an IT infrastructure failure or delay in accessing systems due to out of date and obsolete hardware and software in theatres and other clinical areas, then clinical teams will not be able to access essential patient information or imaging in a timely manner resulting in potential for patient harm.	20	4

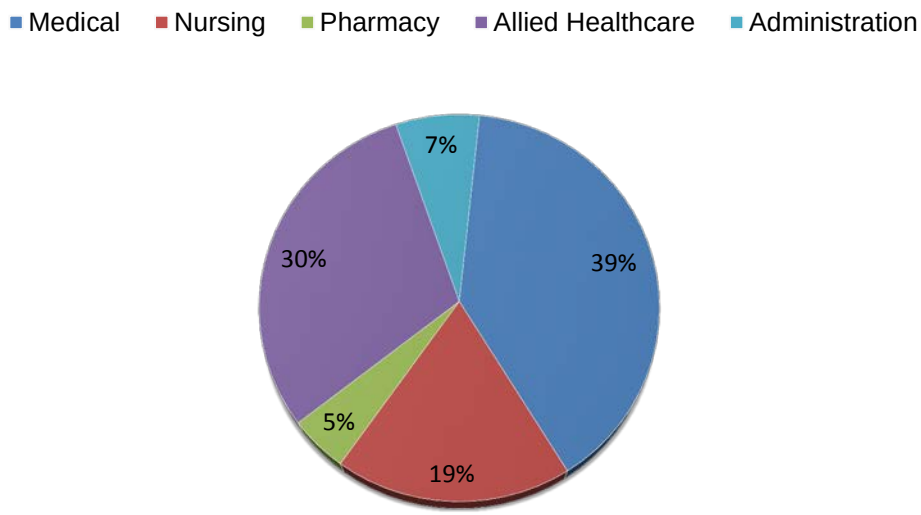
3122	ITAPS	If ITAPS CMG is unsuccessful in controlling expenditure, finding efficiency savings and maximising income, then it will be at risk of not achieving its set control total of £2,548k deficit and will under deliver further against the CIP.	20	6
3133	MSK & SS	If Trauma Orthopaedics is non-compliant with MHRA guidance on the follow up of metal-on-metal hip replacements, then patients may be placed at risk of harm due to a lack of timely detection and intervention.	16	8
3143	Estates & Facilities	If sufficient capital funding is not committed to reduce backlog maintenance across the estate, then there will be an increasing risk of key/critical failures in buildings, services and infrastructure, impacting on service provision and patient care.	16	6
3139	CHUGGS	If ageing decontamination equipment and poor general environment in Endoscopy, where some equipment is sited, is not improved, then the service may fail to meet national guidelines, resulting in a poor level of service for patients with the increased risk of harm to both patients and staff	15	3

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

- Workforce shortages;
- Imbalance between demand and capacity.

3.4 Figure 2 illustrates the results of the detailed analysis into the 42 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



3.5 During February the corporate risk team have worked closely with colleagues in IM&T to facilitate with a review of their risk register. This process has seen a number of new IM&T risks being escalated to the Executive Board for endorsement, including items relating to cyber-attack and fragility in the underlying IM&T infrastructure, and further details of these new entries will be reported in the risk paper to the Trust Board next month.

4 RECOMMENDATIONS

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

Appendix 1

UHL Board Assurance Dashboard: 2017/18							JANUARY 2018							
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 Trend Tracker	Year-end Forecast Tracker	Exec Owner	SRO	Executive Board Committee for Endorsement	Trust Board / Sub-Committee for Assurance
Primary Objective						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	1	↓	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
	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	↔	1.3	**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 Edwean / 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	1	↓	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	1	↓	1	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	1	↓	1	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 We will form new relationships with primary care in order to enhance our joint working and improve its sustainability	2	↔	2	DSC	J Currington / A Taylor	ESB	TB
Supporting Objectives		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
	KEY STRATEGIC ENABLERS: Progress our key strategic enablers	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	1	↓	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…	Jan-18											
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	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	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. 75% of July and August's deaths should have had completed SJRs and current performance is that 84% of July and 73% of August's cases referred for SJR have been completed. We are therefore below target for Q1. (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), performance continues to be below targe 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…	Jan-18											
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	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	2		

Controls assurance (planning)	Performance assurance (measuring)
Governance: Deteriorating Adult Patient Board - Jan 18 cancelled due to IMI.	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 ED WISE - 12/11/2017. Deployment of e-Obs in GPAU in Jan 2018.	

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	Audit Committee			
TB sub Committee	QOC	Jan-18	This priority is tied into the overall IT strategy that is planning to further develop NerveCentre.	
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…	Jan-18											
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**
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Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4	3	2	3	2	1	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	Jan-18	Since receiving the CQC's Warning Notice following their unannounced inspection in November 2017, we have reviewed our programme of work and will be focusing on "getting it right" in relation to timely and accurate administration of insulin. This includes: o Immediate and specific support and monitoring on the wards identified in the warning notice o A review of IT systems and functionality to support insulin management and reporting o Trust wide multi-professional education and training in insulin safety and the management of patients with diabetes o The development and implementation of improved "at a glance" guidance for staff for hyperglycaemia This work is being led by Deputy Chief Nurse and Deputy Medical Director and directly overseen by the Chief Nurse and Medical Director

Independent (Internal / External Auditors)

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

BAF 17/18: As of…	Jan-18											
Objective:	Safe, high quality, patient centered, efficient healthcare											
BAF Risk:	If the Trust is unable to achieve and maintain the required levels of clinical effectiveness, patient safety & patient experience, caused by inadequate clinical practice and ineffective information and technology systems, then it may result in widespread instances of avoidable patient harm, leading to regulatory intervention and adverse publicity that damage the Trust's reputation and could affect CQC registration.											
Annual Priority 1.2.2 (b) Warfarin	We will introduce safer use of high risk drugs (e.g. **warfarin)** in order to protect our patients from harm. **Trust QC Aim: Reduce incidents that result in severe / moderate harm by further 9%.**											
Objective Owner:	MD/CN	**SRO Warfarin:**		C Marshall		**Executive Board:**		EQB		**TB Sub Committee**		QOC
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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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	Jan-18	This month progress has been graded a red as, despite putting in place key project actions, two out of three of our metrics have deteriorated over the last two months. The anticoagulation group are formulating a plan to address this. It is thought that this down-turn is likely to be as a result of winter operational pressures, but more intelligence is needed to look at this in greater detail. However, it is reassuring that the rate of INR >6 has now reached the target trajectory.

BAF 17/18: As of…	Jan-18											
Objective:	Safe, high quality, patient centered, efficient healthcare											
BAF Risk:	If the Trust is unable to achieve and maintain the required levels of clinical effectiveness, patient safety & patient experience, caused by inadequate clinical practice and ineffective information and technology systems, then it may result in widespread instances of avoidable patient harm, leading to regulatory intervention and adverse publicity that damage the Trust's reputation and could affect CQC registration.											
Annual Priority 1.2.3	We will implement processes to improve diagnostics results management in order to ensure that results are promptly acted upon. **Trust QC Aim: Reduce incidents that result in severe / moderate harm by further 9%.**											
Objective Owner:	MD		**SRO:**	C Marshall		**Executive Board:**	EQB			**TB Sub Committee**		QOC
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4	3	2	2	2	2	2	1	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	Due Date	Owner
Prioritise IT resource to the project.	Review monthly	CM

Corporate Oversight (TB / Sub Committees)			
Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	QOC	Jan-18	Update given to QOC re: focus this year to be on driving behavioural change of acknowledging resutls using existing ICE system.

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.
External Audit	work plan TBA		

BAF 17/18: As of…	Jan-18											
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**
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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	4	4	2	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.
Audit methodology refined to enhance and validate the audit sample confidence level.	

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

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	Jan-18											
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	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 & Quarterly Executive Quality Board.	Patients waiting in excess of 12 months for a follow up (KPI trajectory: Q1-379; Q2-321; Q3-189; Q4 -0) - on track.
(GAP) Generate additional capacity and book patients in time order.	
Long term follow up report which allows us to track performance.	Outpatients Friends and Family Test - Red if <93%. (Dec 17 = 95.6%)
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 KPI's (baselines to be completed Feb 18); Programme plan (Complete), Q3 Initiate delivery (progress delayed 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 resulting in slow progress.

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 completed - support for resources not 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) . OP Transformation recommended as an annual priority in 2018/19.	Q4 17/18	JE

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	QOC	Jan-18	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 performance report & KPI's Feb 18.

Independent (Internal / External Auditors)

Source:-	Title:	Date:	Feedback:

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

BAF 17/18: Version	Jan-18											
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	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.
	High occupancy.
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 with CEO to ensure pace on actions in ED, medicine and RRCV.	

Actions planned to address gaps identified in sections above	Due Date	Owner
Bed cpacity and demand modelling for 18/19 and actions to bridge the deficit	Feb-18	SL
Winter funding spend to ensure maximum benefit	Mar-18	ED
AEDB system wide actions	on going	ED

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	Jan-18	The percentage of patients discharged or admitted via Emergency Department within 4 hours in January was 75% compared to 71.5% in December, this is below trajectory level of 90%. With the inclusion of LLR performance reached 81.3%. The total number of attendances has remained relatively static over January; however we continue to see higher than planned ambulance attendances. The conversion rate has remained high over January indicating a high acuity of patients attending. 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. The focus in January has been: • Safe care in ED and outlying wards • Ambulances are released as quickly as possible • Avoidance of 12 hour breaches • Decreasing the number of surgical cancellations and ensuring cancer and urgents proceed • Restarting elective procedures • Decreasing the number of outliers

BAF 17/18: As of…	Jan-18											
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.
	(GAP 6) Reduction in dependency of our non-contracted workforce - forecast to achieve NHSI target of £20.6m and to underspend against plan.
Apprenticeship workforce strategy.	
NHS WRES Technical Guidance refreshed - includes changes made to NHS Standard Contract (2017/18 to 2018/19) and definitions of terminology used in WRES indicators, and how affects organisations subject to WRES.	(GAP 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	Audit Committee		
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.

BAF 17/18: As of…	Jan-18											
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**
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Controls assurance (planning)	Performance assurance (measuring)
NHSI overall agency cap is £20.6m for 2017/18, specific target for medical agency reduction 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 month 10 Underspend of £622,604 (Plan £17.6m vs Actual of £16.9m). Year end forecast underspend of £760,737 (Plan £20.62m vs Forecast of £19.86m)
Nursing rostering prepared 8 weeks in advance.	
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.	
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	Audit Committee		
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…	Jan-18											
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	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	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 - awaiting Key Findings Report
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	Jan-18	HELM Recovery Action and progress against implementing workforce actions - complete.

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…	Jan-18											
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	1		
Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4	4	4	4	2	2	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~~ May 18.
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.
Leicester Medical School have been alerted to clinical pressures which are impacting on medical student placements.	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 is confirmed and 3 dates have been promoted for listening events (April).
	Job planning data for UG roles was presented at the January APRMs for each CMG.

Actions planned to address gaps identified in sections above	Due Date	Owner
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~~ April 18.	Apr-18	SS/JK

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

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee		Jan-18	Current clinical pressures and cancelled elective activity are impacting on medical student rotations and clinical experience - Impacts should be resolved by year-end. 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	To review the arrangements in place for consultant job planning and carry out testing of a sample of job plans to assess whether these meet good practice set out in 'A guide to Consultant Job Planning'.
External Audit	work plan TBA		

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

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 Junior Doctor LiA Sponsor Group met on Jan 24th 2018. The LiA process was agreed as well as a series of 'quick wins'. The Group will review progress on March 7th 2018.
On-going support work for Trust Grade doctors to minimise rota gaps and improved trainee experience at UHL.	The UHL Medical Education Survey will be re-launched in February 2018.
Cardio-Respiratory Improvement Steering group in place to respond to HEE triggered visit in Jul 17. Action plan in place and resources identified.	Job planning data and the postgraduate education quality dashboard were presented at the January APRM to each CMG.
The Junior Doctor Morale LiA was launched in January 2018. Key themes (from the UHL Morale Survey) were identified and an action plan will be reviewed at the next Sponsor Group meeting in March 2018.	HEE will re-visit Cardio-respiratory on May 4th 2018 to review progress against their action plan.
As part of the 'Attitudes and Behaviours to Improve Care' group work, Suzanne Khalid	Junior doctors are being encouraged to raise exception reports where clinical pressures are impacting on training (due to cross cover or cancelled activity).

is writing a business case to support new initiatives.	
The Director of Medical Education has written to the Postgraduate Dean about cross cover on medical wards due to clinical pressures.	
A meeting with Paediatric trainees will take place in February 2018. The Medical Director, Director of Medical Education and Clinical Director for W&C will chair the meeting.	

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

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

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
		Jan-18	Medical trainees cross-covering wards due to clinical pressures- impacts on morale, curricular requirements, retention; Current clinical pressures impacting on surgical and anaesthetic trainees due to cancelled elective activity - this impacts on their curricular requirements; Negative impact on all trainees, but especially Paediatric trainees, due to Dr Hadiza Bawa-Gaba case - Impacts on morale, recruitment and retention. Impacts described above may not be resolved by year end, affecting delivery of the annual 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	To review the arrangements in place for consultant job planning and carry out testing of a sample of job plans to assess whether these meet good practice set out in 'A guide to Consultant Job Planning'.
External Audit	work plan TBA		

BAF 17/18: As of…	Jan-18											
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	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	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…	Jan-18											
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	1		
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	1		

Controls assurance (planning)	Performance assurance (measuring)
UHL Frailty Oversight Group established and reporting to UHL Exec boards.	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).	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).	
Identification and management of interdependencies between STP work streams given most touch on frailty - work in progress.	
Commissioning and contracting model that supports deliver of frailty pathway - work in progress.	
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		Jan-18	Although there has been some good progress in introducing a focus on frailty in ED (80% CFS), reaching out to the rest of the organisation is in the planning stage rather than delivery phase. Delivery of this next stage will receive renewed focus though the 2018/19 Trust Priorities and the introduction of new programme governance arrangements.

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…	Jan-18											
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	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	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 March.
	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 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
Individual meetings with GPs - questionaire to agree training needs.	ongoing	AT

Corporate Oversight (TB / Sub Committees)			
Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee			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	Jan-18											
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	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	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 preferred option; work is progressing on this option at risk since it is dependant 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).	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 funding. Our 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	Jan-18											
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:**	Liz Simons		**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**	**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**	**2**		

Controls assurance (planning)	Performance assurance (measuring)
EPR Plan - Paperless Hospital 2020 (PH2020) scoped in Prog Def Doc.	(GAP) EPR Plan - key milestones to be developed for 18/19 - in progress.
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 and project closed.	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 - Prog plan & deliverables to be developed for 18/19 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. Plan to deploy 18/19.	2018/19	IM&T/UHL
Legacy Upgrades - HISS & ORMIS completed; ICE 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 Feb 18 - at advert stage.	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		IM&T report provided on request.
TB sub Committee	FIC	Jan-18	EPR plan – Best of Breed is progressing and alternative solutions are being reviewed. Work continues to implement NC Forms and Rules and Bed Management, the IM&T elements of these functions have been enabled and does now require support from the stakeholders to implement.
TB sub Committee	QOC		IM&T report provided on request.

Independent (Internal / External Auditors)

Source:-	Title:	Date:	Feedback:

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

BAF 17/18: Version	Jan-18											
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	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	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…	Jan-18											
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	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	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 was 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…	Jan-18											
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	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	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…	Jan-18											
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	1		
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	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 M10, 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.
	Contract income levels consistently being achieved and commissioner challenges resolved quarter by quarter.
A minimum of £18m of additional technical and other solutions to be transacted.	
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 end position and revised control totals.
Monitoring of CQUIN Targets.	
(GAP) Better retrieval of overdue debtors.	M10 has seen a significant financial impact following the national instruction to cancel elective inpatient activity. The Trust has not delivered it's year to date financial plan but following discussions with NHSI is forecasting to deliver the planned financial plan for 2017/18.
	The Trust is in receipt of additional funding for Winter (£2.2m full year) that will decrease the Trust's financial planned deficit for 2017/18 to £24.5m.

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	Feb-18	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 Jan 18

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Thematic Analysis of Risk Causation
2264	CHUGGS	If an effective solution for the nurse staffing shortages in CHUGGS at LGH and LRI is not found, then the safety and quality of care provided will be adversely impacted.	20	6	Workforce
2621	CHUGGS	If recruitment and retention to vacancies on Ward 22 at the LRI does not occur, then patients may be exposed to harm due to poor skill mix on the Ward.	20	6	Workforce
2354	RRCV	If the capacity of the Clinical Decisions Unit is not expanded to meet the increase in demand, then will continue to experience overcrowding resulting in potential harm to patients.	20	9	Demand & Capacity
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.	20	6	Workforce
2804	ESM	If the ongoing pressures in medical admissions continue, then ESM CMG medicine bed base will be insufficient thus resulting in jeopardised delivery of RTT targets.	20	12	Demand & Capacity
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.	20	6	Workforce
NEW 3115	ITAPS	If there is an IT infrastructure failure or delay in accessing systems due to out of date and obsolete hardware and software in theatres and other clinical areas, then clinical teams will not be able to access essential patient information or imaging in a timely manner resulting in potential for patient harm.	20	4	IT
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 timeframes and increased requirement for out of hours working this may result in: Delay in treatment to patients and Unmet performance targets.	20	12	Demand & Capacity
NEW 3122	ITAPS	If we are unsuccessful in controlling expenditure, finding efficiency savings and maximising income within ITAPS then the CMG is at risk of not achieving its set control total of £2,548k deficit and will under deliver further against the CIP	20	6	Finance

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Thematic Analysis of Risk Causation
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).	20	8	Estates
3119	ITAPS	If there is a deterioration in our theatre staff vacancies and we are unsuccessful in recruiting ODP's to agreed establishment; then we are at risk of not being able to deliver a safe and effective service.	20	6	Workforce
2940	W&C	Risk that paed cardiac surgery will cease to be commissioned in Leicester with consequences for intensive care & other services	20	8	Demand & Capacity
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.	20 ↑	4	Demand & Capacity
3054	HR	If the Trust's Statutory and Mandatory Training data can no longer be verified on the new Learning Management System, HELM, then it is not possible to confirm staff training compliance which could result in potential harm to patients, reputation impact, increased financial impact and non-compliance with agreed targets.	20	3	IT
3148	Corporate Nursing	If the Trust does not recruit the appropriate staff with the right skills in the right numbers then we may not be able to deliver safe, high quality, patient centred, efficient care and reduce our current nursing vacancy levels resulting in potential increased clinical risk to our patients and poor patient experience	20	12	Workforce
2404	Corporate Nursing	There is a risk that inadequate management of Vascular Access Devices could result in increased morbidity and mortality	20	16	Resource
2566	CHUGGS	If the range of Toshiba Aquilion CT scanners are not upgraded, Then patients will experience delays with their treatment planning process.	16	1	Resource
3040	RRCV	If there are insufficient medical trainees in Cardiology, then there may be an imbalance between service and education demands resulting in the inability to cover rotas and deliver safe, high quality patient care.	16	9	Workforce

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Thematic Analysis of Risk Causation
2820	RRCV	If a timely VTE risk assessments is not undertaken on admission to CDU, then we will be breach of NICE CCG92 guidelines resulting patients being placed at risk of harm.	16	3	Process & Procedures
3088	ESM	If non-compliant with national and local standards in Dermatology with relation to Safer Surgery checking processes, then patients may be exposed to an increased risk of potential harm.	16	6	Process & Procedures
3025	ESM	If there continues to be high levels of nursing vacancies and issue with nursing skill mix across Emergency Medicine, then quality and safety of patient care could be compromised.	16	4	Workforce
3044	ESM	If under achievement against key Infectious Disease CQUIN Triggers (Hepatitis C Virus), Then income will be affected.	16	8	Demand & Capacity
3121	ITAPS	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	16	9	Estates
2333	ITAPS	If we do not recruit into the Paediatric Cardiac Anaesthetic vacancies, then we will not be able to maintain a WTD compliant rota resulting in service disruption.	16	8	Workforce
2191	MSK & SS	Lack of capacity within the ophthalmology service is causing delays that could result in serious patient harm.	16	8	Demand & Capacity
NEW 3133	MSK & SS	If non compliant with MHRA guidance on the follow up of metal-on-metal (MoM) hip replacements, Then patients may be placed at risk of harm due to a lack of timely detection and intervention.	16	8	Process & Procedures
2989	MSK & SS	If we do not recruit into the Trauma Wards nursing vacancies, then patient safety and quality of care will be placed at risk	16	4	Workforce

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Thematic Analysis of Risk Causation
2955	CSI	If system faults attributed to EMRAD are not expediently resolved, then we will continue to expose patients to the risk of harm	16	4	IT
2673	CSI	If the bid for the National Genetics reconfiguration is not successful then there will be a financial risk to the Trust resulting in the loss of the Cytogenetics service	16	8	Demand & Capacity
2863	CSI	There is a risk of a reduced service and possible non-compliance with legislation due to a failure to recruit in RPS	16	4	Workforce
2378	CSI	If we do not recruit, up skill and retain staff into the Pharmacy workforce, then the service will not meet increasing demands resulting in reduced staff presence on wards or clinics.	16	8	Workforce
3118	CSI	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.	16	1	IT
2916	CSI	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.	16	6	IT
3008	W&C	If the paediatric retrieval and repatriation teams are delayed mobilising to critically ill children due to inadequately commissioned & funded provision of a dedicated ambulance service, then this will result in failure to meet NHS England standards, delayed care, potential harm and inability to free-up PICU capacity.	16	5	Demand & Capacity
2153	W&C	Shortfall in the number of all qualified nurses working in the Children's Hospital.	16	8	Workforce
2237	Corporate Medical	If a standardised process for requesting and reporting inpatient and outpatient diagnostic tests is not implemented, then the timely review of diagnostic tests will not occur.	16	8	Process & Procedures

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Thematic Analysis of Risk Causation
NEW 3143	Estates & Facilities	If sufficient capital funding is not committed to reduce backlog maintenance across the estate there will be an increasing risk of key/critical failures in buildings, building services and infrastructure impacting on service provision and patient care.	16	6	Finance
1693	Operations	If clinical coding is not accurate then income will be affected.	16	8	Workforce
NEW 3139	CHUGGS	Ageing decontamination equipment and poor environments where some of this equipment is cited is resulting in a poor level of service for patients and has the potential to cause harm to both patients and staff	15	3	Resource
3027	CHUGGS	If the UHL adult haemoglobinopathy service is not adequately resourced, then it will not function at its commissioned level	15	4	Workforce
3041	RRCV	If there are insufficient cardiac physiologists then it could result in increased waiting times for electrophysiology procedures and elective cardiology procedures	15	8	Workforce
3043	RRCV	If there is insufficient cardiac physiologists then it could result in reduced echo capacity resulting in diagnostics not being performed in a timely manner	15	6	Workforce
3047	RRCV	If the service provisions for vascular access at GH are not adequately resourced to meet demands, then patients will experience significant delays for a PICC resulting in potential harm.	15	6	Demand & Capacity
3077	ESM	If there are delays in the availability of in-patient beds, then the performance of the Emergency Department at Leicester Royal Infirmary could be adversely affected, resulting in overcrowding in the Emergency Department and an inability to accept new patients from ambulances.	15	10	Demand & Capacity
2837	ESM	If the migration to an automated results monitoring system is not introduced, Then follow-up actions for patients with multiple sclerosis maybe delayed resulting in potential harm.	15	2	IT

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Thematic Analysis of Risk Causation
2466	ESM	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.	15	1	Process & Procedures
2973	CSI	If the service delivery model for Adult Gastroenterology Medicine patients is not appropriately resourced, then the quality of care provided by nutrition and dietetic service will be suboptimal resulting in potential harm to patients.	15	6	Workforce
2787	CSI	If we do not implement the EDRM project across UHL which has caused wide scale recruitment and retention issues then medical records services will continue to provide a suboptimal service which will impact on the patients treatment pathway.	15	4	IT
2965	CSI	If we do not address Windsor pharmacy storage demands, then we may compromise clinical care and breach statutory duties	15	6	Estates
2601	W&C	There is a risk of delay in gynaecology patient correspondence due to a backlog in typing	15	6	Workforce
3023	W&C	There is a risk that the split site Maternity configuration leads to impaired quality of Maternity services at the LGH site	15	6	Workforce
3093	W&C	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	15	6	Workforce
3083	W&C	If gaps on the Junior Doctor rota are not filled then there may not ne enough junior doctors to staff the Neonatal Units at LRI	15	3	Workforce
3084	W&C	If there continues to be insufficient Neonatal Consultant cover to run 2 clinical sites, then it could impact on service provision resulting in potential for suboptimal care to the babies on the units at LRI & LGH.	15	5	Workforce
2394	Communications	If a service agreement to support the image storage software used for Clinical Photography is not in place, then we will not be able access clinical images in the event of a system failure.	15	3	IT
3079	Corporate Medical	If there is insufficient capacity with the administrative support for the Learning from Deaths Framework and the Specialty M&M Structured Judgment Review process is not addressed and substantive funding identified for an additional Bereavement Support Nurses, then this will lead to a delay with screening all deaths and undertaking Structured Judgment Reviews, resulting in failure to learn from deaths in a timely manner and non-compliance with the internal QC and external NHS England and Statutory Quality Account requirements	15	6	Workforce

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Thematic Analysis of Risk Causation
1149	CHUGGS	There is a risk to patient diagnosis and treatment due to a failure to deliver the cancer waiting time targets	12	6	Demand & Capacity
2771	CHUGGS	There is a risk to quality of patient care due to insufficient clinical oncologist PAs for radiotherapy treatments &Haem MDTs	12	8	Workforce
2976	CHUGGS	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.	12	4	Demand & Capacity
2977	CHUGGS	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.	12	4	Demand & Capacity
2978	CHUGGS	If DoH accreditation is lost, then radiotherapy SABR delivery model will be reduced.	12	4	Process & Procedures
3167	RRCV	If the -20 walk in freezer room were to malfunction/fail Then service delivery of the Transplant Lab could be compromised and non-compliance with UKAS	12	4	Resource
3109	RRCV	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.	12	8	Demand & Capacity
2917	RRCV	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.	12	2	Resource
2900	RRCV	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.	12	8	Process & Procedures
2886	RRCV	If we do not invest in the replacement of the Water Treatment Plant at LGH, then we may experience downtime from equipment failure impacting on clinical treatment offered.	12	8	Estates
2997	RRCV	If the technical malfunctions with the NxStage machines are not resolved, then our patients will be exposed to potential harm	12	4	Resource
3051	RRCV	If we do not effectively recruit to the Medical Staffing gaps for Respiratory Services, then there is a risk to deliver safe, high quality patient care, operational services and impacts on the wellbeing of all staff including medical staffing.	12	6	Workforce
2870	RRCV	Audit of DNACPR form have shown that the discussion with the patient or family is not consistently recorded	12	2	Process & Procedures
2905	RRCV	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.	12	6	Workforce
3110	ESM	Delay in Planned Elective Treatment in the Spastcicty Service	12	6	Demand & Capacity
2936	ESM	Failure to handover urgent medical jobs/information on transfer from AMU to a base ward	12	6	Process & Procedures
2937	ESM	Failure to arrange follow up, or act on results, following discharge from the Acute Medical Unit	12	6	Process & Procedures
2234	ESM	There is a medical staffing shortfall resulting in a risk of an understaffed Emergency Department impacting on patient care	12	6	Workforce
2388	ESM	There is risk of delivering a poor and potentially unsafe service to patients awaiting MH admission &/or fruther MH assessment.	12	6	Demand & Capacity
2838	ESM	NRU temporary ward environment does not fully meet the needs of the younger patients with disabilities	12	2	Estates

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Thematic Analysis of Risk Causation
3018	MSK & SS	There is a risk to the quality, standards and safety of ALL patients requiring Ambulance transportation	12	4	Demand & Capacity
3135	MSK & SS	If GP data is not received screening will not have up to date patient data. New Diabetic patients may be missed.	12	9	IT
3017	MSK & SS	Medinet - Use of an external provider to reduce RTT Backlog	12	4	Demand & Capacity
2759	MSK & SS	There is a risk that performance targets are not met due to a capacity gap within the ENT department	12	2	Demand & Capacity
3020	MSK & SS	Patients could suffer permanent damage to their eye sight due to lack of capacity within the Corneal Service	12	4	Demand & Capacity
3136	MSK & SS	Lack of planned IT hardware replacement/funding resulting in high levels of non-functioning/ non-repairable ePMA COWs within MSK	12	2	IT
3127	CSI	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.	12	3	Resource
2815	CSI	There is a risk of unescorted Inpatients, in the Imaging Department, becoming ill and of this not being noticed.	12	4	Workforce
2380	CSI	There is a risk of breach of Same Sex Accommodation Legislation in Imaging	12	3	Demand & Capacity
2575	CSI	Risk to patients due to a delay in Image reporting as there is a lack of reporting capacity in neuroradiology and head and neck.	12	4	Workforce
2890	CSI	Reduced delivery in the National Breast Screening Service due to a shortage of qualified mammographers	12	8	Workforce
2947	CSI	Risk to provide a robust Virology service with :Single-handed Consultant Virologist	12	2	Workforce
2983	CSI	There is a risk that high and low ambient temperatures in the Microbiology Laboratory will impact on service delivery and future	12	4	Estates
2615	CSI	Integrity and capacity of containment level 3 laboratory facility in Clinical Microbiology	12	2	Estates
1206	CSI	If the backlog of unreported Chest and Abdomen images on PAC'S are not cleared, then we will breach IRMER and Royal College of Radiologist guidelines.	12	6	IT
3117	CSI	If the ePMA Sofia system is not updated and configured as per UHL and IT 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.	12	4	IT
2364	W&C	Electronic Access to EMPath	12	3	IT
1367	W&C	Lack of Capacity in the Neonatal Service	12	8	Demand & Capacity
593	W&C	There is a risk of inadequate neonatal nursing staff /skill mix levels to meet clinical requirements	12	6	Workforce
2853	W&C	Quality improvement, governance and safety initiatives not being implemented/supported within Children's services	12	6	Process & Procedures

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Thematic Analysis of Risk Causation
2854	W&C	Poor environment on Ward 28 impacting on safety of patients, staff and visitors	12	6	Estates
2938	W&C	Inability to provide home INR testing for Leicester based adult congenital heart patients transferred from paediatric services.	12	1	Estates
2993	W&C	Paediatric Emergency Single Front Door	12	4	Demand & Capacity
3006	W&C	There is a risk to patient safety due to shortage of space in the Ward 27 day case and outpatient clinics.	12	2	Demand & Capacity
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.	12	4	Resource
2330	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.	12	6	Process & Procedures
2338	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.	12	9	Process & Procedures
2672	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.	12	4	Estates
2267	Corporate Nursing	Risk of reduced compliance with DoH requirements in relation to adherence to antimicrobial prescribing policy	12	3	Process & Procedures
2970	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.	12	4	Resource
2774	Operations	If there are delays with dispatching post consultation outpatient correspondences, then this may result in significant risk to patient safety.	12	6	Process & Procedures
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.	12	6	Process & Procedures
2878	Operations	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.	12	4	IT
2987	CHUGGS	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.	10	6	Resource
2999	RRCV	Lack of perfusion availability if theatre and ECMO case in progress at the same time out of hours	10	5	Workforce
2235	ESM	There is a risk of harm to patients during inter hospital transfers & transfers across to other UHL sites	10	8	Demand & Capacity
2409	W&C	There is an insufficient number or middle-grade doctors, both SpR's and SHO's to provide adequate service cover in Childrens	10	10	Workforce
3081	W&C	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.	10	5	Resource
2604	W&C	Lack of continuity in patient care due to Gynaecology Consultant cross site working	10	6	Workforce
3013	W&C	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/deco	10	3	Resource

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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.	9	6	Demand & Capacity
2894	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.	9	3	Workforce
2821	CHUGGS	There is a risk of breaching the single sex accommodation policy on Osbsorne Day Care Unit	9	4	Demand & Capacity
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.	9	6	Workforce
3152	CHUGGS	The triage room on Osborne Assessment Unit (OAU) is currently used as a side-room for inpatients, however, this room is too small and does not allow access around both sides of the bed.	9	1	Estates
3111	RRCV	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.	9	2	Process & Procedures
3112	RRCV	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.	9	3	Demand & Capacity
2926	RRCV	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	9	4	Demand & Capacity
2670	RRCV	If recruitment to the Clinical Immunology & Allergy Service Consultant vacancy does not occur, then patient backlog will continue to increase, resulting in delayed patient sequential procedures and patient management.	9	6	Workforce
2656	ESM	If Dermatology services is not adequately resourced, Then the level and quality of the service provided will be impacted.	9	6	Demand & Capacity
2504	MSK & SS	There is a risk that patients will wait for an unacceptable length of time for trauma surgery resulting in poor patient outcomes	9	6	Demand & Capacity
1196	CSI	If we do not increase the number of Consultant Radiologists, then we will not be able provide a comprehensive out of hours on call rota and PM cover for consultant Paediatric radiologists resulting in delays for patients requiring paediatric radiology investigations and suboptimal treatment pathway.	9	2	Workforce
2845	CSI	There is a risk to the delivery of a quality microbiology service due to lack of appropriate staffing.	9	1	Workforce
1157	CSI	Lack of planned maintenance for medical equipment maintained by Medical Physics	9	6	Workforce
3151	CSI	If the room temperature in treatment rooms is consistently high the stability & integrity of medicines may be affected .	9	6	Estates
2578	W&C	Scans undertaken in GAU & Gynaecology clinic cannot be archived (Screening)	9	2	IT
1042	W&C	Unavailability of USS and not meeting National Standards for USS in Maternity (Screening)	9	6	Process & Procedures
3094	W&C	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.	9	2	Resource
2327	Communications	If an effective collaborative relationship with stakeholders cannot be established and sustained, then the Trust may lose support from stakeholders.	9	4	Process & Procedures
2775	Finance & Procurement	If we do not have robust systems to manage supply of goods then it may impact on clinical service provision	9	9	Process & Procedures
3010	HR	There is a risk that the office space for Recruitment Services and Training are not fit for purpose	9	2	Demand & Capacity

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3123	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.	9	6	Process & Procedures
3125	Operations	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.	9	6	Process & Procedures
3033	RRCV	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	8	1	Demand & Capacity
2840	ESM	If the faulty windows affecting all ESM Wards in Windsor are not replaced, Then patient will continue to be exposed to challenging temperature levels.	8	4	Estates
3016	MSK & SS	There is a risk of cross-infection between patients with dental instruments	8	4	Process & Procedures
2876	MSK & SS	There is a risk that male and female patients will be cared for in the same area when wearing hospital gowns.	8	2	Demand & Capacity
510	CSI	There is a risk of staff shortages impacting on the Blood Transfusion Service at UHL	8	4	Workforce
2969	CSI	There is a risk of failure to deliver the TAT Standards of NHS Cervical and NHS Bowel Cancer Screening programmes	8	4	Workforce
2136	CSI	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.	8	4	Resource
3116	CSI	If the epma Medchart system is not updated and configured as per UHL and IT 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.	8	4	IT
2307	CSI	The Forensic Toxicology service will fail resulting in a substantial loss of income and prestige for the Department/empath	8	4	Workforce
2154	Communications	If Directorates and CMGs do not adequately engage with PPI processes, then we could breach our legal obligations.	8	6	Process & Procedures
3124	Operations	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.	8	4	Process & Procedures
3126	Operations	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.	8	4	Process & Procedures
2980	RRCV	If there is no mechanism set up to permit sharing and safe storage to the UHL shared renal drive of photographs of patients fistula, then this could lead to delay in review by nephrologists or surgeons	6	1	IT
3014	RRCV	If there is no fit for purpose Renal Proton Clinical System to collect all information required for reimbursement of dialysis, then this may result in poor patient experience, submission of data to the UK Renal Registry and tariffs	6	4	IT
3078	ESM	If the patient group directions used within the Emergency Department are not reviewed and updated there is a risk of harm to patients/Trust resulting from supply / administration of medicines to patients by non-medical professionals operating under patient group directions (PGDs) that have expired.	6	1	Process & Procedures
2988	MSK & SS	There is a risk of delays for appointments for the ARMD service that could result in loss of sight	6	3	Demand & Capacity

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3011	CSI	Risk to patient safety, business continuity and Department reputation when in hours generator tests are performed at GH.	6	1	Estates
2166	Communications	If fundraising plans are not aligned with CMG and Directorate plans, Then fundraising will be affected.	6	4	Demand & Capacity
2705	CHUGGS	If blood factor products and medicinal products are issued to patients without "dispensing" in conjunction with a prescription, then there will be a breach of Leicestershire medicines code for prescribing and supply of medications.	4	2	Process & Procedures
2867	CSI	If the Mortuary flooring is not repaired, then we will continue to breach Department of Health Building note 20 and the HSAC (Health Services Advisory Committee) advice by exposing staff to harm.	4	3	Estates