INTEGRATED RISK AND ASSURANCE REPORT AS AT 31ST MARCH 2018

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

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 Board Assurance Framework (BAF) and the organisational risk register.

Questions

1. What are the top rated principal risks on the 2017/18 BAF?
2. What is the year-end position with delivering the annual priorities for 2017/18?
3. What are the proposed new strategic risks for entry on the 2018/19 BAF?
4. What new risks, scoring 15 and above, have been entered on the organisational risk register since the previous version?
5. 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. Eleven of the (22) 2017/18 annual priorities have been graded as not delivered at year-end.
3. The seven strategic risks identified by the executive team for inclusion on the 18/19 BAF relate to: quality standards of safety and care, workforce gaps, emergency care pathway, financial planning, fit for the future IM&T infrastructure, sustainability and transformation partnerships, and estates compliance. These will be worked up with executive directors during May 2018.
4. There are 185 risks recorded on the organisational risk register (including 71 with a current rating of 15 and above). Three new risks scoring 15 and above have been entered on the risk register during the reporting period.
5. 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). Managing financial pressures, relating to external funding and internal control arrangements, is also recognised on the risk register as an enabler to support the delivery of the Trust’s objectives.

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 risks recorded on the BAF and on the organisational risk register.

For Reference

Edit as appropriate:

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

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

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

a. Organisational Risk Register [Yes]

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

b. Board Assurance Framework [Yes]

BAF entry	BAF Title	Current Rating
	See appendix one	

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

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

5. Scheduled date for the **next paper** on this topic: [Monthly to TB meeting]

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: UHL TRUST BOARD

DATE: 3RD MAY 2018

REPORT BY: ANDREW FURLONG – MEDICAL DIRECTOR

SUBJECT: INTEGRATED RISK AND ASSURANCE REPORT (INCORPORATING UHL BOARD ASSURANCE FRAMEWORK & ORGANISATIONAL RISK REGISTER AS AT 31ST MARCH 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 document and has been kept under review during March 2018. Executive owners have prepared their 2017/18 BAF close-down reports, including overall 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 attached 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.
  March update*: Emergency care performance remains below NHSI trajectory and acceptable levels. This is resulting in a poor experience for patients and the failure to achieve key national performance standards.*
- **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.
  March update*: Recognising the continuing gap between supply and demand of workforce, particularly in nursing, the Trust has not delivered a sustainable workforce plan in 17/18, which is consistent with the challenging national position on workforce and unprecedented demand relating to emergency care activity. This was in part mitigated by a number of initiatives to introduce new roles, overseas recruitment and more innovative work practices.*

- **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.
  March update*: The Trust has an unidentified gap of £4.9m re CIP and has not delivered its year to date financial plan but following discussions with NHSI has delivered the forecast deficit of £34.4m, which represents £9.9m under-performance driven by operational winter pressures.*

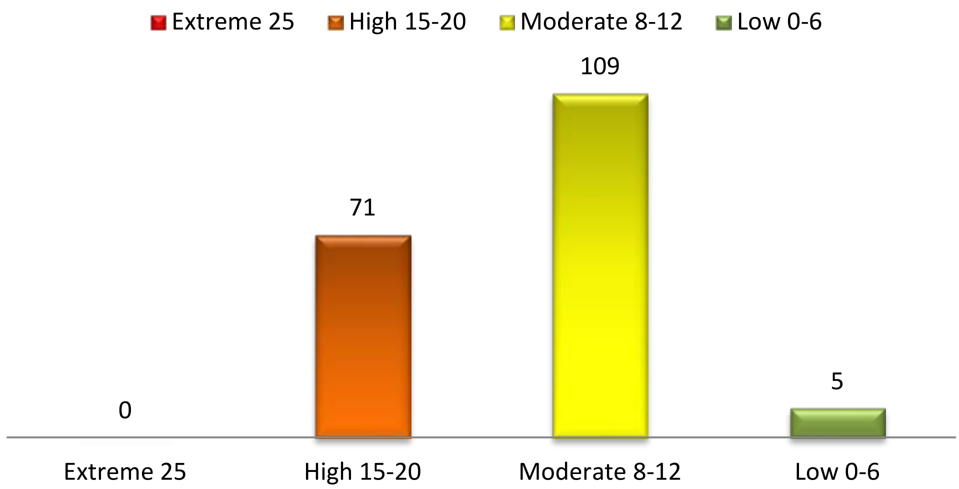
2.3 Eleven of the (22) 2017/18 annual priorities have been graded as not delivered at year-end. A column is included in the BAF dashboard, to report details about non-delivery of these priorities, attached at appendix one.

2.4 The Trust's strategic objectives and annual priorities have been refreshed as part of an integrated business planning cycle for 2018/19 and were agreed by the Board during Quarter 4 of 2017/18. Consequently, management arrangements for the delivery of the annual priority programme & BAF requirements in 2018/19 have been considered by the executive team and a decision agreed to move away from using the BAF as a tracker to monitor month-end and year-end ratings for delivery of our annual priorities. Also, acting on feedback from the recent CQC visit that commented the BAF has become an unwieldy at over 50 pages, the new BAF will focus attention on the effectiveness of the key systems and controls, as well as identifying and monitoring progress of treatment plans to mitigate gaps, in managing our strategic risks. The seven strategic risks identified by the executive team for inclusion on the 18/19 BAF are described in appendix two and will be worked up with executive directors, endorsed by the executive boards during May and presented to the Trust Board in June 2018 (reporting April 2018 data).

3. UHL ORGANISATIONAL RISK REGISTER SUMMARY

3.1 For the reporting period ending 31st March 2018, there are 185 risks recorded on the organisational risk register. A dashboard of the risks rated 15 and above is attached at appendix three. Figure 1, below, illustrates the Trust's risk profile by current risk rating.

Figure 1: UHL Risk Register profile



3.2 Three new risks, scoring 15 and above, have been entered on the risk register during the reporting period and their descriptions are included below:

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score
3186	RRCV	If RRCV CMG fails to achieve the allocated financial control total, then this will result in deterioration in the Trust overall financial deficit.	20	10
3191	IM&T	If the Trust is unable to demonstrate 95% compliance with IG training, then we may lose level 2 IG accreditation, resulting in potential loss of research status and difficulties with forging future collaborative working arrangements with prospective partners.	20	15
3192	IM&T	If GDPR is not effectively implemented in UHL, then the Trust will be unable to demonstrate regulatory compliance, resulting in potential enforcement action from the ICO and reputational damage.	16	12

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

- Workforce shortages;
- Imbalance between demand and capacity.

3.3.1 Managing financial pressures, relating to external funding and internal control arrangements, is also well recognised on the risk register as an enabler to support the delivery of the Trust's priorities and objectives.

4 RECOMMENDATIONS

4.1 The TB are invited to review the content of this report, note the updated position to items on the 17/18 BAF and advise as to any further action required in relation to principal risks on the 18/19 BAF and items on the organisational risk register.

Appendix 1 - 17/18 BAF

MARCH 2018 - YEAR-END DASHBOARD WITH JUSTIFICATIONS

UHL Board Assurance Dashboard: 2017/18

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	Justification for year-end position
Primary Objective **QUALITY COMMITMENT:** Safe, high quality, patient centered, efficient healthcare	1	If the Trust is unable to achieve and maintain the required levels of clinical effectiveness, patient safety & patient experience, caused by inadequate clinical practice and ineffective information and technology systems, then it may result in widespread instances of avoidable patient harm, leading to regulatory intervention and adverse publicity that damage the Trust's reputation and could affect CQC registration.	4 x 3 = 12	4 x 2 = 8	↔	1.1	**Clinical Effectiveness - To reduce avoidable deaths:**					
						1.1.1	We will focus interventions in conditions with a higher than expected mortality rate in order to reduce our SHMI	3	↑	3	MD	Delivered
						1.2	**Patient Safety - To reduce harm caused by unwarranted clinical variation:**					
						1.2.1	We will further roll-out track and trigger tools (e.g. sepsis care), in order to improve our vigilance and management of deteriorating patients	1	↔	1	CN/MD	This priority is tied into the overall IT strategy that is planning to further develop NerveCentre. Further testing of sepsis assessment form required in Haematology & Oncology prior to trust wide rollout. Changes to Obstetric EWS (MEOWS) have delayed implementation - now planned for April 2018.
						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	CQC Warning Notice following their unannounced inspection in November 2017 - New focus on "getting it right" in relation to timely and accurate administration of insulin. Included in 18/19 QC.
						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	↓	1	MD/CN	Despite processes being put in place, the three key performance metrics have not consistently delivered the expected benefits. As such the year end delivery is graded as "non-delivered" despite the numerous process improvements.
						1.2.3	We will implement processes to improve diagnostics results management in order to ensure that results are promptly acted upon	1	↔	1	MD	The requirement of input from IT to Upgrade ICE before further development can take place has delayed the project considerably. The development of ICE in ALL areas (not just Acting on Results) will become part of one larger Programme to ensure consistency of approach and oversight of developing the IT system cohesively.
						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	3	↑	3	CN	Delivered
						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	Year end position is rated red due to resources and capacity to deliver the scale of ambition and the cultural change across the organisation to sustain transformation. Emergency pressures impacting on progress.
	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	UHL is ranked 8th worst A&E for seeing 95% of patients in four hours. The winter pressures means the NHS has recorded its worst-ever annual performance - at 88.4% - since records began in 2004, NHS England data showed.
Supporting Objectives **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	1	↓	1	DWOD	Recognising the continuing gap between supply and demand of workforce, particularly in nursing, we have not delivered a sustainable workforce plan in 17/18, which is consistent with the challenging national position on workforce and unprecedented demand relating to emergency care activity. This was in part mitigated by a number of initiatives to introduce new roles, overseas recruitment and more innovative work practices. Further work is still required to address a widening gap which will form part of the 5 year workforce plan to be formulated by the end of quarter 1 18/19.
						2.2	We will reduce our agency spend towards the required cap in order to achieve the best use of our pay budget	3	↑	3	DWOD	Delivered
						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'	3	↑	3	DWOD	Delivered
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	3	↑	3	MD	Delivered
						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	Whilst there are on-going actions, within UHL, to address shortcomings and improve trainee experience, the media coverage and winter pressures have had an adverse effect on UHL's reputation.
						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	Delivered
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	Although there has been some 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 Priorities
						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	1	↓	1	DSC	Due to delays with GP strategy and the Offer brochure the delivery of this (combined), this priority has slipped - both are being progressed accordingly now we have the annual priorities to include in the documents / literature.
KEY STRATEGIC ENABLERS: Progress our key strategic enablers	6	If the Trust is unable to secure external capital funding to progress its reconfiguration programme then our reconfiguration strategy may not be delivered.	5 x 3 = 15	5 x 2 = 10	↔	5.1	We will progress our hospital reconfiguration and investment plans in order to deliver our overall strategy to concentrate emergency and specialist care and protect elective work	3	↑	3	CFO	Delivered
	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	3	↑	3	CIO	Delivered
	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	3	↑	3	DWOD	Delivered
	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	3	↑	3	DWOD/CFO	Delivered
	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	3	↑	3	CFO	Delivered
	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	↓	1	CFO/COO	Unidentified gap of £4.9m re CIP and the Trust has not delivered its year to date financial plan but following discussions with NHSI has delivered the forecast deficit of £34.4m which represents £9.9m under-performance driven by operational winter pressures.

*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...	Mar-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	2	3
Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Sept**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4	4	4	4	2	2	2	2	2	2	3

Controls assurance (planning)
Governance: Mortality Review Committee, chaired by Medical Director.
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.
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.
ME / M&M administration support and ME assistant now in place.
Five top mortality governance priorities identified through the AQuA comparator report are now standing agenda items at the Mortality Review Committee.
UHL “Learning from the Deaths” Work Programme - includes Medical Examiner Screening, Specialty M&M Process and Bereavement Support Services.

Performance assurance (measuring)
Published Summary Hospital-level Mortality Indictor (SHMI) - </= 99 - Latest published SHMI - 98 (period Oct 16 to Sept 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).*
% 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). 88% of Q3 adult deaths screened to date although additional MEs in December this coincided with increased number of deaths.
% 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.
UHL's latest rolling 'unpublished' 12 month SHMI Dec 16 to Nov 17 is 93
Actions related to CUSUM alerts on track / completed (performance target is all actions on track / completed).
Backlog of cases for screening due to lack of capacity of Mes and delays with analysis and theming of ME screening and Specialty M&M SJR findings due to lack of

	admin/analyst capacity.

Actions planned to address gaps identified in sections above	Due Date	Owner
Aadditional Medical Examiners started Dec 17. 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 submitted to February Revenue Investment Committee. Funding approved for additional Administrative and Analytical resource - recruitment process in progress.		RB

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	QOC	Mar-18	Learning from completed reviews and actions being taken where problems in care more than likely contributed to patients' death noted.

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…	Mar-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

	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Annual Priority Tracker - Current position @	3	3	3	3	3	2	1	1	2	2	1	1
Annual Priority Tracker Year end Forecast @	4	4	4	4	4	2	2	2	2	2	2	1

Controls assurance (planning)

- Governance: Deteriorating Adult Patient Board - March 18 meeting cancelled.
- Electronic handover supported by NerveCentre.
- Sepsis and AKI awareness and training mandatory for clinical staff.
- Team based training packages for recognition of a deteriorating patient.
- 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.
- Roll out of e-obs to the modified National Early Warning Scoring System - with the exception of maternity. Ward 27 went live in March 2018.
- Sepsis e-learning module on HELM - launched July 2017
- (GAP) Deteriorating patient e-learning module - due end of April 2018.
- 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 in Haematology & Oncology for further testing prior to trust wide rollout. Trust wide deployment is dependent upon the availibility of electronic sepsis reporting through the DataWarehouse. These reports are ungoing QA prior to deployment. Trust wide deployment is anticipated to commence in April 2018.
- To accommodate recent changes in MEOWS, changes to the Obstetric EWS (MEOWS) scope are under development, this has delayed implementation which is now planned for March 2018 - further changes requested by the W&C CMG are in development by NerveCentre, with a revised implementation date of the end April 2018.

Performance assurance (measuring)

- Audit EWS & Sepsis in all adult & paediatric wards in scope; day case, labour ward, CCU and ITU out of scope daily.
- Review audit results of EWS & Sepsis fortnightly.
- Review of Datix reported incidents related to the recognition of the deteriorating patient quarterly - last report to DAPB July 2017.

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.

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: To accommodate recent changes in MEOWS, changes to the Obstetric EWS (MEOWS) scope are under development, this has delayed implementation which is now planned for April 2018.
• Fully automated EWS reporting (NerveCentre) - Complete.
Q3 position:
• Assessments for sepsis (NerveCentre) fully implemented - Complete: Deployed to Haematology & Oncology for further testing prior to trust wide rollout.
• Fully automated Sepsis reporting (NerveCentre) - outstanding: revised implementation date (phased implementation during) Q1 2018/19.
Q4 position: N/A.

e-Obs & NerveCentre ED WISE deployed to GPAU.	

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	Q1 18/19	JJ
Trust wide deployment of Obs (MEOWS)	Q1 18/19	JB

Corporate Oversight (TB / Sub Committees)			
Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	QOC	Mar-18	This priority is tied into the overall IT strategy that is planning to further develop NerveCentre. Further testing of sepsis assessment form required in Haematology & Oncology prior to trust wide rollout. Changes to Obstetric EWS (MEOWS) have delayed implementation - now planned for April 2018.

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…	Mar-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**
	3	3	2	2	2	2	1	2	1	1	1	1
Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4	3	2	3	2	1	1	1	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 and meets monthly chaired by the Clinical Lead for Inpatient Diabetes Care. A weekly task & finish group has been established.	(GAP) To have no in hospital Diabetic Ketoacidosis (DKA) "events" in quarter 4.
Diabetes decision support tool (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 Clinical Rules to be developed by the end of Mar 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 running.	
Portfolio of data to evidence improvements in insulin safety since the CQC unannounced inspection.	

Actions planned to address gaps identified in sections above	Due Date	Owner
To be included in annual priorities for 2018/19	2018/19	EM

Corporate Oversight (TB / Sub Committees)			
Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	QOC	Mar-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. The Insulin Safety Action Plan includes actions to address the CQC warning notice and incorporates specific actions to support the annual priority for 17/18 Safer Use of High Risk Drugs. EQB will receive a separate monthly report confirming progress with Insulin Safety

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...	Mar-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**
	3	3	3	3	3	2	2	2	2	1	2	1
Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4	3	3	3	2	2	2	2	2	2	1

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.	
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
The anticoagulation group will continue to meet and will undertake quality improvement projects to aim to improve the current metrics. Now that anticoagulation is no longer in the quality commitment this group will report into MeDOC who will monitor performance going forwards.		CM

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

TB sub Committee	QOC	Mar-18	This project has delivered the processes that it set out to at the beginning of the year: • New anticoagulant policy and bridging policy • Creation of an anticoagulation group to oversee quality improvement work that is permanent • Creation of communications to the organisation in the form of a regular newsletter • Availability of antidotes for bleeding in ED • Reduction in the number of patients with INR > 6 • Business case written to support continuation of anticoagulation in-reach role – to be presented to "star chamber" for consideration of prioritisation for forthcoming financial year • Improved processes for communication to GPs with a dedicated anticoagulation discharge summary put in place • Reduced numbers of complaints from GPs regarding anticoagulation issues • E-learning package – already access to package through NHS e-learning resources. Despite these processes being put in place, the three key performance metrics have not consistently delivered the expected benefits: INR >6, missed dosages of warfarin on the safety thermometer, and missed dosages on the electronic prescribing wards showed a reduction mid-year but from Nov 2017 have worsened. This is likely to be due to the operational pressures due to winter. Metrics for March are not yet available but given that winter pressures continue it is unlikely that these metrics will improve into the green zone. As such the year end delivery is graded as "risk of non-delivery" despite the numerous process improvements.

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…	Mar-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**
	3	3	3	2	2	2	1	1	1	1	1	1
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	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 will not be met. Communication WC 26th March has been sent to clinicians requesting filing of results to be completed on current version of ICE and will be monitored.
UHL diagnostic testing policy	
Acting on results detailed action plan monitored via EQB. This covers: developing a fit for purpose electronic system to acknowledge results; in depth work with each specilaty to develop standard operating procedures; review of radiology and MDT processes; human factors review of our results reporting service; reviw of how urgent resutls are escalated with a view to putting them on NerveCentre; increasing patient involvement; and improved training in how to use ICE for results acknowledgment.	Current metrics show that compliance with % of results acknowledged is <1%. (Gap) Communications campaign planned to boost compliance, but will not meet year end target until upgrade of ICE and Mobile ICE in place. Development of ICE is awaiting an upgrade which will commence in April 2018. Work has begun on establishing funtionality requirements for discssion with SunQuest (Supplier of ICE).
Conserus (alert email to clinician for unexpected imaging results) pilot in CDU (highest risk area) prior to Trust roll-out.	The go-live date for all specialities has been set as Monday 14th of May.

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	Mar-18	The requirement of input from IT to Upgrade ICE before further development can take place has delayed the project considerably. As such it is rolling over into the 2018-19 Quality Commitment. Next Steps are now identified as • Upgrade of ICE to latest version April 2018 • Work to optimise ICE to make it easier to use for Clinicians June 2018 • Paperless in Out patients for requesting work will be on-going throughout 2018 • Development of Mobile ICE to enable requesting and reviewing diagnostic tests during 2018 In March clinicians will be requested to File (Acknowledge) all results on the current system and this will be monitored. A new project plan will be agreed with support from IT once all the testing and the Upgrade of ICE has been completed. Work with IT has begun to identify functionality preferences/ options with ICE and will continue with the engagement of Clinicians. The development of ICE in ALL areas (not just Acting on Results) will become part of one larger Programme to ensure consistency of approach and oversight of developing the IT system cohesively. The go-live date for Conserus will be Monday 14th of May 2018 –communication activities and intranet pages informing staff of the go-live will occur through April 2018

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

BAF 17/18: As of…	Mar-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

	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Annual Priority Tracker - Current position @	1	1	1	1	1	2	2	2	2	2	2	3
Annual Priority Tracker Year end Forecast @	4	4	4	4	4	2	2	2	2	2	2	3

Controls assurance (planning)	Performance assurance (measuring)
Governance: Palliative & End of Life Care Committee meets bi-monthly. 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.	**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.
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). "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.	

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	QOC	Mar-18	Audit methodology refined and further audits being undertaken during 2018/19

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
External Audit	work plan TBA		

BAF 17/18: Version	Mar-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	1	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	1	1	1	1	1

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) - off plan due to operational pressures and requirement to support emergency care. Estimated end of month position 833 12months+.
(GAP) Generate additional capacity and book patients in time order.	Outpatients Friends and Family Test - Red if <93%. (Dec 17 = 95.6%)
Long term follow up report which allows us to track performance.	Clinical audit of additional schemes related to changes in the new to follow up ratio - Completed as planned.
Agreed action plan in place and monitored through the Outpatient Quality report and this is monitored at CPM and in contracting meetings.	Q2 KPI's (baselines 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 impact on availbility of resources to deliver)Key deliverables for 2018/19 to be reviewed April 2018.
Milestone plan agreed at Trust Board and Executive Performance Board - monitored via OP Programme Board.	(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 limiting progress.
Monthly reports included in performance repost for EQB and PPPC (KPI Dashboard completed).	Cross cutting initiatives progressing with some escalated delays.

Actions planned to address gaps identified in sections above	Due Date	Owner
Service specific plans for ENT and cardiology hindered by emergency pressures. Operational and change management support to be re-evaluated with speciality leads. IT Developments dependent on capital funding and Trust wide priorities.	Q1 18/19	JE
Application of Apprenticeship levy being explored to develop bepoke Customer Care training programme	Q1 18/19	DW/BK
Milestone plan and deliverables for 2018/19 under review with plans for delivery confirmed April 2018. Includes LLR System priority areas of work.	01/04/18	JE

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:

TB sub Committee	QOC	Mar-18	Year end position is rated red due to resources and capacity to deliver the scale of ambition and the cultural change across the organisation to sustain transformation. Emergency pressures impacting on progress.

Independent (Internal / External Auditors)			
Source:-	Title:	Date:	Feedback:
Internal Audit	Follow up from CQC inspection (June 2016)	Q2 17/18	Action plan and evidence submitted against March 2018 published CQC report.
External Audit	work plan TBA		

BAF 17/18: Version	Mar-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**
	3	3	3	3	2	1	1	1	1	1	1	1

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	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 capacity and demand modelling for 18/19 and actions to bridge the deficit - Improvement action log being progressed	Apr-18	ED
Daily SCRUM meetings with CEO to ensure pace on actions in ED, medicine and RRCV	On-going	SL
AEDB system wide actions	on going	ED

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	PPPC	Mar-18	The percentage of patients discharged or admitted via Emergency Department within 4 hours in March was 69.7% compared to 71.5% in February, this is below trajectory level of 92.2%. With the inclusion of LLR performance reached 77.3%.

Independent (Internal / External Auditors)

Source:-	Title:	Date:	Feedback:
Internal Audit	ED - Dynamic Priority Score	Q2 17/18	Will review the process for assessing patients on arrival at ED through the DPS process.

BAF 17/18: As of...	Mar-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**
	4	4	4	4	4	2	2	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	2	1

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	2018/19	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	2018/19	LG
GAP 4 - Urgent and Emergency Care Workstream utilising Whole Systems Partnership to predict activity and impact on capacity	2018/19	U 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	2018/19	EM
GAP 6 - Focus on specific plans for reduction on high earner and long term agency bookings ensuring recruitment/ replacement plans are in place	2018/19	CB/MM

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	FIC	Mar-18	Recognising the continuing gap between supply and demand of workforce, particularly in nursing, we have not delivered a sustainable workforce plan in 17/18, which is consistent with the challenging national position on workforce and unprecedented demand relating to emergency care activity. This was in part mitigated by a number of initiatives to introduce new roles, overseas recruitment and more innovative work practices. Further work is still required to address a widening gap which will form part of the 5 year workforce plan to be formulated by the end of quarter 1 18/19.

BAF 17/18: As of...	Mar-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

	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Annual Priority Tracker - Current position @	4	4	4	4	4	2	2	2	2	2	2	3
Annual Priority Tracker Year end Forecast @	3	3	3	3	3	2	2	2	2	2	2	3

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.	The agency cap for 2017/18 was £20.6m and we achieved £20.39m through a robust approach to our management of agency expenditure including reducing rates and volumes. We have achieved particular success in reducing medical agency expenditure from £10.1m to £8.85m which overachieved our national target of a reduction of £718K. This has been achieved through a more robust approach to gap management and authorisation.
Nursing rostering prepared 8 weeks in advance.	
Monitoring of agency cap breaches to NHSI weekly.	
Medical Oversight Broad established.	
Monthly premium spend meeting to monitor progress via agency tracker.	Regional deliverables, including regional rate card, to be defined through regional working group in line with TOR - in development.
Regional MOU and establishment of a regional working group for medical agency.	No. of retrospective bank and agency bookings reported through to Premium Spend Group.
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.	Medical Agency Dashboard to Medical Oversight board.
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.	

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	FIC	Mar-18	Delivered against the £20.6m target for year end.

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…	Mar-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	2	3
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	2	3

Controls assurance (planning)	Performance assurance (measuring)
Vision and programme plan in place (transforming HR Function) - HR Fit for the future programme roadmap.	Staff engagement staff survey score - overall deteriation in scores and actions to be agreed.
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.	
People Strategy finalised.	

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	PPP Committee	Mar-18	Staff Survey Results presented to PPPC

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...	Mar-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	1	3
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	2	3

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 & 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 - outcomes to be presented as part of the APRM report in March 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.
(GAP) New curriculum and an increase in medical student numbers, requires greater Clinical Teacher input/bedside teaching. More Clinical Teachers and examiners to be recruited.	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'.
Foundation Apprenticeships have commenced and information included in CEO briefing.	A 'Medical Educator' LiA for UG Medical Education is confirmed and 3 dates have been promoted for listening events (April).
(GAP) Lead for Apprenticeship to be appointed.	
	Job planning data for UG roles was presented at the January APRMs for each CMG. CMGs will respond to the findings as part of the APRM process.
	Low return rates for July-December UG block feedback.

Actions planned for next stage of development in 2018/19	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.	Apr-18	Strategic Group
A 'Medical Educator' LiA for UG Medical Education will be launched in ~~January 18~~ April 18.	Apr-18	SC/SW
lead for Apprenticeship recruitment to be commenced.	May-18	UoL/SW
Clinical Teacher recruitment in progress.	Apr-18	SW

Corporate Oversight (TB / Sub Committees)			
Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee		Mar-18	External factors, including the impact of clinical pressures on training and the Dr Hadiza Bawa-Gaba case, are impacting on Medical students on clinical placement. However, recent statistics (UKFPO) show a small improvement in the % of Leicester Medical Students who ‘preferenced’ the LNR Foundation School.

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…	Mar-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	1	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	1	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.	The revised HEE Quality Management Process has been implemented. A process of risk assessment will identify 'high risks' whereby HEE will implement formal process. Low risk issues will be managed by the Trust and, in some cases, Specialty Schools. Regular collaborative meetings between the Trust and HEE Quality Management team have been stopped (by HEE) - HEE will only visit the Trust if concerns are classified as 'high risk' and there is a potential to lose trainees.
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.	
(GAP) CMGs Quality Improvement Action Plans in response to GMC visit and survey results to address concerns in postgraduate education.	UHL Medical Education Survey - March 2018. 502 responses with 79% recommending UHL as a place to work, a deterioration since Oct 2017 (88%).
Monthly Medical Education reports included as part of the CMG Performance Review Meeting data packs.	Uncertain impact on recruitment due to recent investigations and media coverage.
(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 - the Grand Round will be relaunched on May 4th and include 'UHL Educator Awards' for senior and junior medical staff
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.	
The CEO and Medical Director have hosted a number of open meetings for medical staff to discuss recent investigations and associated media coverage.	The Junior Doctor LiA Sponsor Group met on March 7th 2018. An action plan is in place and the next meeting is on April 18th 2018.
On-going support work for Trust Grade doctors to minimise rota gaps and improved trainee experience at UHL.	
Cardio-Respiratory Improvement Steering group in place to respond to HEE triggered visit in Jul 17. Action plan in place and resources identified.	The UHL Medical Education Survey was launched in February 2018. This will include questions about exception reporting. Outcomes of the survey will be available in April 2018.

As part of the 'Attitudes and Behaviours to Improve Care' group work, Suzanne Khalid is writing a business case to support new initiatives.	Job planning data and the postgraduate education quality dashboard were presented at the January APRM to each CMG. CMGs will respond to the findings as part of the APRM process.
The Director of Medical Education has written to the Postgraduate Dean about cross cover on medical wards due to clinical pressures.	HEE will re-visit Cardio-respiratory on May 4th 2018 to review progress against their action plan.
A meeting with Paediatric trainees took place in February 2018. The DME has formally responded to trainee concerns.	Junior doctors are being encouraged to raise exception reports where clinical pressures are impacting on training (due to cross cover or cancelled activity).

Actions planned for next stage of development in 2018/19	Due Date	Owner
The UHL/UoL Strategic Group is developing the overarching strategy.	Apr-18	Strategic Group
HEE will re-visit Cardio-respiratory on May 4th 2018 to review progress against their action plan	May-18	SC
MJPCC- either SC or DL to attend future meetings with details of individual's educational roles. This will be used to confirm and inform the job plan.		SC/DL

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
		Mar-18	External factors will potentially impact on recruitment over the next 6-12 months. Whilst there are on-going actions, within UHL, to address shortcomings and improve trainee experience, the media coverage and winter pressures are likely to have had an adverse effect on UHL's reputation.
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...	Mar-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	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	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…	Mar-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	1	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	1	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		Mar-18	Although there has been some 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 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...	Mar-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	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	2	1

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 - to be presented to April PCOB.	

(GAP) GP Hotline info to be shared with Mortality and Morbidity meetings.	
(GAP) Vacancy for Bid Support Manager.	
GP Engagment Coordinator in post.	

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. Documents updated and "Responding to Tenders" paper to be presented to ESB in March 2018.	March 18	JB
UHL offer or "Brochure" will be produced. Structure of "Brochure" planned for end of March 2018. Series of scoping meetings planned with GPs and commisisoners to inform.	Q4 17/18	JB
Stakeholder Communciation/ Engagement plan in progress - to be agreed at Nov PCOB meeting. DRAFT presented - will be signed off in April PCOB as needs to include new annual priorities. Slight delay.	~~March 18~~ April 18	AT
Individual meetings with GPs - questionaire to agree training needs.	ongoing	AT
GP Hotline SOP to be presented to April PCOB	Apr-18	CH
Recruitment for Bid Support Manager underway - interviews 25th April	Jul-18	JC
Monthly report to be produced for M&M meetings	Apr-18	CH

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee		Mar-18	Please note that due to delays with GP strategy and the Offer brochure the delivery of this (combined) priotiry has slipped - both are being progressed accordingly now we have the annual priorities to include in the documents / literature.

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	Mar-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	2	3
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	2	3

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 programme. Critical milestone will be in June.
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 May 2018 owing to the NHSI requirement for us to have gone out to tender prior to submission. NHSI have just advised that the OBC is scheduled to be presented to the April National Resource meeting. The delay in OBC approval will not impact on the submission of the FBC to the June Trust Board.
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 affordability 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. We have met with the Regional Transactor for the newly devised procurement method called Regional Health Investment Company (RHIC) which is the next iteration of LIFT which covers projects of a value up to £100m. Further discussion is anticipated on alternative sources of funding with the regional DoF. It is now clear that we will not receive funding this year for reconfiguration. We are undertaking an assessment of the impact of this on the STP, clinicla sustainability and the strutural deficit.

Actions planned for next stage of development in 2018/19	Due Date	Owner
EMCHC move to LRI - scope for project is being finalised, detailed delivery plan to progress the Kensington option.	Jun-18	MW
Interim ICU project - FBC is being drafted as first part of external approval process.	May-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	Mar-18	Performance against whole of Reconfiguration Programme project plan – delayed owing to lack of funding this year. Impact assessment being carried out; along with alternative sources of funding. NB: whilst we have received the outcome of the Autumn Budget that we have not been allocated capital funding this year for the whole programme; delivery of the ICU, EMCHC and EF schemes are to plan.

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

BAF 17/18: Version	Mar-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**	**2**	3
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**	**2**	3

Controls assurance (planning)	Performance assurance (measuring)
EPR Plan - Paperless Hospital 2020 (PH2020) scoped in Prog Def Doc.	EPR Plan - key milestones to be developed for 18/19.
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 - programme governance mtgs in place
Outpatient - Specification for NC agreed. ICE OCS pilot completed	
Upgrade legacy systems - part of prioritisation plan included into 18/19 plans.	
Desktop replacement programme - awaiting sign-off.	
IM&T Project Dashboard reported to EIM&T Board.	
IM&T Project Management Support in place.	

Actions planned for next stage of development in 2018/19	Due Date	Owner
EPR Plan - Prog plan & deliverables developed for 18/19 and agree the EPR KPIs.	2018/19	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

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	Mar-18	PC/Desktop refresh proposal is waiting for financial sign off. Plan for 2018/19 approved by Truist Board and will feature in new BAF for 18/19.

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. Report completed Feb 18.
External Audit	work plan TBA		

BAF 17/18: Version	Mar-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	2	3
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	2	3

Controls assurance (planning)	Performance assurance (measuring)
UHL Way	
UHL Way governance structure (with programme leads for the 4 components of Better - engagement, teams, change and Academy).	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.
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 2017-18.
	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 for next stage of development in 2018/19	Due Date	Owner
Awaiting UHL Annual survey results by key finding areas in order to conduct detailed analysis - in progress - Action plan to be agreed at UHL Way Steering Group Meeting on 16/4	Apr-18	BK

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	PPP Committee	Mar-18	Staff Survey Results presented to PPPC committee

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...	Mar-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	2	3
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	2	3

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. PID ratified at IFPIC on 31/08/17.	Carter target for back office cost to be no more than 7% of turnover by March 2018 has been achieved.
Project governance defined in PID. Project Board meeting monthly.	(GAP) Carter Target for back office cost to be no more than 6% of turnover by March 2020.
(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).	
(GAP) There is a newly identified gap concerning project management resource; this is being explored by the CFO, DWOD and Director of CIP.	

Actions planned for next stage of development in 2018/19	Due Date	Owner
Conclude Diagnostic Phase with Milestones and KPIs agreed.	Apr-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).	Apr-18	DWOD

Corporate Oversight (TB / Sub Committees)

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

TB sub Committee	PPP	Mar-18	The "Carter" target for back office cost to be no more than 7% of turnover by March 2018 has been achieved and work continues to identify long term sustainable efficiencies across all Corporate Services. A project has commenced with the support of the NHSI Corporate Productivity team to map processes and learning within specific teams. All service line leads are producing strategy roadmaps outlining the direction of travel across the next three years alongside a thorough review of existing contracts (for goods and services both provided and bought in).Detailed KPIs and milestone will be defined following the conclusion of the Diagnostic Phase currently scheduled to conclude in April 2018, this may be revised or extended following a planned Programme refresh in early 2018/19.

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…	Mar-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	2	3
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	2	3

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.	

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...	Mar-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	1	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	2	1

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 M12, there remained an unidentified gapof £4.9m which was reflected in updated Control Totals and with the financial impacted mitigated in year through additional technical actions.
Quarterly quality assurance reporting.	
Monthly CMG/Corporate meetings to include detailed review of CIP delivery and forecast - escalating to weekly where CMGs/Corporate departments are materially varying from plan.	
(GAP) Deliver more activity through a more productive capacity through beds, theatres & outpatients – improve efficiency indicators; Reduce the price we pay for goods/services; Remove waste and eliminate unnecessary variation.	
Financial Plans	
CIP (including supplementary) to achieve 100% delivery in 2017/18.	CIP measurement and reporting monthly.
CMGs to achieve their control totals or better.	Monthly I&E submissions to NHSI, Trust Board, FIC and EPB.
Cost pressures and service developments to be minimised and managed through RIC and CEO chaired 'Star Chamber'.	Expenditure run rates for pay, non-pay, capital charges and agency spend.
A minimum of £18m of additional technical and other solutions to be transacted.	Contract income levels consistently being achieved and commissioner challenges resolved quarter by quarter.
Agree an appropriate level of investment supporting the resolution of the demand/capacity issue.	Year on year reduction in agency spend in line with our 2 year trajectory.
	I&E monitoring of progress against £18m technical challenge.
Manage CCG and NHSE contracts to ensure accurate and full receipt of income noting changes to tariff (HRG4+) and new Emergency Floor currencies/flows.	Overall level of overdue debtors to reduce, BPPC performance to improve - monitored within cash paper to FIC.
Implementation of first stages of UHL's Commercial Strategy and use of TGH Ltd.	Improvement in cash position as per the agreed plan.
Reduction in agency spend moving towards the NHSI agency ceiling level.	Revised control totals have been set for all CMG and Corporate Directorates.
New income streams realised and effective, financially beneficial use of TGH Ltd.	Additional corporate controls are being identified to assist in the delivery of the year

Monitoring of CQUIN Targets.	end position and revised control totals.
(GAP) Better retrieval of overdue debtors.	Quarter 4 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 has delivered the forecast deficit of £34.4m which represents £9.9m under-performance driven by operational winter pressures.
	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.
	The financial impact of winter operational pressures and the nationally directed requirement to stop elective activity has negatively impacted the Trust's financial position by £10m. This results in the Trusts forecast financial delivery to be an income and expenditure deficit of £34.5m against a plan of £24.5m.

Actions planned to address gaps identified in controls / assurances	Due Date	Owner
We had an end of year deficit target of £26.7m which was reduced to £24.7m with the winter funding. Given the £10m impact of cancelled electives/ loss of income, we will be reporting an end of year deficit of £34.7m. This is a direct result of extreme winter pressures		CFO

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.

Appendix 2 - 18/19 BAF Dashboard: DRAFT

BAF Strategic Risk Description	Strategic Objective	Exec Direc	Exec Team	Trust Board Cmmttee	Current Rating C x L	Change
If the Trust is unable to achieve and maintain the required levels of Quality standards (clinical effectiveness, patient safety & patient experience), caused by a general loss of focus on patient safety, unsuccessful IM&T systems, critical shortage of workforce, and increasing service receivers and family expectations, then it may result in widespread instances of avoidable patient harm and poor clinical outcomes to a large number of patients, leading to regulatory intervention and adverse publicity.	Quality Commitment: to deliver safe, high quality, patient centred, healthcare	MD / CN	EQB	AC		
If the Trust is unable to achieve and maintain staffing levels that meets service requirements, caused by employment market factors (such as availability and competition to recruit, retain and utilise a workforce with the necessary skills and experience) and demographic changes, then it may result in poor clinical outcomes and experience, failure to achieve constitutional standards and increased staff workloads.	We will have the right people with the right skills in the right numbers in order to deliver the most effective care	DPOD	EWB / EPB	AC		
If the Trust is unable to achieve and maintain financial sustainability, caused by a lack of government funding, inability to deliver the annual control total (including CIP requirements) and unplanned cost pressures due to growth in extent of backlog maintenance, then it may result in failure to deliver financial plan leading to widespread loss of public and stakeholder confidence and potential for regulatory action such as financial special measures.	We will continue on our journey towards financial stability - deliver our target of £Xm in 18/19	CFO	EPB	AC		
If the Trust is unable to effectively manage the emergency care pathway, caused by persistent unprecedented level of demand for services, ineffective resources to address patient flow, and fundamental process issues, then it may result in widespread instances of reduced quality of care and experience for large number of patients and sustained failure to achieve constitutional standards, leading to increased financial penalties and possible breach of license.	We will improve our Emergency Care Performance	COO	EPB	AC		
If the Trust is unable to deliver a fit for the future IM&T infrastructure, caused by inability to secure appropriate resources (including external capital), then it may affect delivery of the digital paperless hospital leading to significant delays with work streams in the Trust's Quality Commitment.	To progress our strategic enabler – IM&T	CIO	EIM&T / EPB	AC		
If the Trust is unable to modernise its real estate and infrastructure, caused by a lack of resources to invest in the backlog maintenance programme, lack of access clinical workspace due to high levels of service demand and sheer volume of work to address ageing buildings, then it may result in infrastructure that is not safe or fit for purpose, leading to non-compliance with statutory compliance obligations, delays with progressing reconfiguration plans and regulatory intervention.	To progress our strategic enabler - Estates	DEF	EQB	AC		
If the Trust is unable to work collaboratively with partners to secure the support of our community and STP stakeholders, caused by breakdown of relationships amongst partners and ineffective clinical service strategies of the local population, then it may result in disruption to transforming sustainable clinical services, leading to barriers to access local healthcare services, poor clinical outcomes and experience to a large number of patients and a breach of contractual obligations.	To develop more integrated care in partnership with others	DSC	ESB	AC		

Appendix 3 UHL Risk Register (15+) as at 31 March 2018

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score
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
3139	CHUGGS	If ageing decontamination equipment and poor general environment in Endoscopy where some equipment is cited 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	20 ↑	3
3183	RRCV	If Cardiac Surgery is unable to operate on elective patients due to winter pressures and availability of ward and ITU beds, there is a risk that patients' conditions could deteriorate, resulting in a need for urgent admission or more complex surgery with greater risk of complications.	20	15
3186	RRCV	NEW - If the CMG fails to achieve the allocated financial control total then this could result in an deterioration in the Trust overall financial deficit.	20	9
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
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
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
3077	ESM	If there are delays in the availability of in-patient beds, then both Emergency Care performance and safety of patients within 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.	20 ↑	15
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
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
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 with cases that should have been completed during day-time hours, and a knock on effect for the consultants on call and their next day working	20	12
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
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
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
3153	W&C	If the HFEA licence to treat patients in ACU is revoked there will be a loss of income and inability to meet the CIP and could lead to a breach of confidentiality.	20	10
2777	Communications	If fundraising targets for the Charity fundraising campaign does not reach target charitable income	20	8

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score
3054	Human Resources	If the Trust's Statutory and Mandatory Training data can no longer be verified on the new Learning Management System, HELM, then it is not possible to confirm staff training compliance which could result in potential harm to patients, reputation impact, increased financial impact and non-compliance with agreed targets.	20	3
3172	IM&T	If systems and services provided by IM&T are not continuously maintained to ISO accredited standard, then our systems may be vulnerable to potential cyber attack resulting in in significant service disruption, harm to patients and financial loss	20	15
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
2404	Corporate Nursing	If the process for identifying patients with a centrally placed vascular access (CVAD) device within the trust are not robust, then this could result in increased morbidity and mortality.	20	16
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
3176	RRCV	If the current shortfall in nursing staff vacancies in RRCV is not addressed, then this will affect the ability to achieve appropriate Nurse to Patient ratio, resulting in increased clinical risk to our patients and poor patient experience	16	12
3181	RRCV	If the Prescribing Administration and Monitoring of Oxygen in Adults (B27/2010) Policy is to be adhered to, Then the e-obs system settings must be adjustable for Cardio-Respiratory patients, Resulting in in improved patient care or chronic hypoxic conditions and for patients who do not have Type 2 respiratory failure.	16	6
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
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
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
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
2388	ESM	There is risk of delivering a poor and potentially unsafe service to patients awaiting MH admission &/or fruther MH assessment.	16	6
3044	ESM	If under achievement against key Infectious Disease CQUIN Triggers (Hepatitis C Virus), Then income will be affected.	16	8
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
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
2191	MSK & SS	If workforce constraints within the ophthalmology service are not addressed, then backlogs and delays could result in serious patient harm.	16	8
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
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
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

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score
3128	CSI	If unfated blood components previously issued (2015 to 2017) are not evidenced then BSQR 2005 legal requirement of 100% traceability will not be met resulting in regulatory implications and delay in providing blood and blood components.	16	4
3129	CSI	If a 100% traceability (end fate) of blood components is not determined Then BSQR 2005 legal requirement of 100% traceability will not be met Resulting in legal implications and delay in providing blood and blood components	16	4
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
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
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
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
2916	CSI	If blood samples are mislabelled, caused by problems with ICE printers and human error with not appropriately checking the correct label is attached to the correct sample, then we may expose patients to unnecessary harm.	16	6
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
2153	W&C	If the high number of vacancies of qualified nurses working in the Children's Hospital is not addressed, then there will be a shortfall in the nurse to patient ratio which could impact on the quality of patient care.	16	8
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
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
3144	Estates & Facilities	If Estates & Facilities are unable to recruit and retain staff, or fund posts to deliver services to meet the Trust's expectations. Then there is a risk of a service delays and interruption/failure to achieve required standards Resulting in adverse impacts to patient non-clinical services, environment, equipment and infrastructure	16	9
3174	Human Resources	If UHL does not enrol and support the needs of 334 new apprentices from new recruitment or existing post holders by March 2018 Then UHL will not meet the statutory obligation in line with the Enterprise Act 2016 Resulting in a financial lose to the Trust.	16	1
3180	IM&T	If fragility in the underlying UHL IM&T infrastructure is not addressed, then there may be limited or no access to Trust IM&T critical systems, resulting in service disruption and impacting provision of care	16	6
3191	IM&T	NEW - If the Trust is unable to demonstrate 95% compliance with IG training, then the Trust may lose level 2 IG accreditation, resulting in potential loss of research status and difficulties with forging future collaborative working arrangements with prospective business partners which could adversely impact on the delivering strategic aims.	16	12
3192	IM&T	NEW - If GDPR is not effectively implemented, then the Trust will be unable to demonstrate compliance resulting in potential enforcement action from the ICO and reputational damage	16	12
3155	IM&T	If the PABX system fails then the telephone system will not work for a range of telephone numbers resulting in significant service disruption and potential patient harm.	16	4
1693	Operations (Corporate)	If clinical coding is not accurate then income will be affected.	16	8

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score
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.	15 ↓	6
3027	CHUGGS	If the UHL adult haemoglobinopathy service is not adequately resourced, then it will not function at its commissioned level	15	4
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
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
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
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
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
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
2965	CSI	If we do not address Windsor pharmacy storage demands, then we may compromise clinical care and breach statutory duties	15	6
2601	W&C	If the vacancies in the gynaecology services are not addressed, then there will be backlogs with typing patient correspondence, resulting in delays with patients receiving appointment letters and results	15	6
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
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
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
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
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
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
2434	IM&T	If computers operating on Windows XP are not upgraded, then we may experience significant service disruptions in the event of a cyber attack.	15	6
1615	IM&T	If flooding occurs at the LRI, then the Servers and Network equipments in our Data Centre may become damaged resulting in Trust-wide service disruption and potential harm to patients.	15	6