INTEGRATED RISK AND ASSURANCE REPORT AS AT 30 NOV 2017

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

Executive Summary

Context

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

Questions

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

Conclusion

1. The highest rated principal risks on the BAF relate to variation between capacity and demand, workforce capacity and capability and delivery of the financial plan.
2. There are two annual priorities (both with regard to components of the Quality Commitment) which have been assessed as off-track at month end, with three priorities forecast to be at risk of non-delivery in 2017/18. All other priorities are rated as on-track for month end and year end. Copies of the current tracker scores, along with more detailed narrative about the annual priorities, are included in the BAF report at appendix one of the paper.
3. There are 45 organisational risks open on the UHL risk register scoring 15. No new risks have been entered on the organisational risk register during the reporting period of November 2017. Details of risks scoring 15 and above are included in the risk register dashboard at appendix two of the paper.
4. Thematic analysis of the organisational risk register shows the common risk causation themes as workforce shortages and imbalance between demand and capacity (which correlates to the principal risks on the BAF). Analysis in relation to the typical impact, should the risks identified occur, displays the potential for harm.

Input Sought

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

For Reference

Edit as appropriate:

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

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

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

a. Organisational Risk Register [Yes]

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

b. Board Assurance Framework [Yes]

BAF entry	BAF Title	Current Rating
	See appendix one	

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

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

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

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **UHL TRUST BOARD**

DATE: **4TH JANUARY 2018**

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

SUBJECT: **INTEGRATED RISK AND ASSURANCE REPORT (INCORPORATING UHL BOARD ASSURANCE FRAMEWORK & ORGANISATIONAL RISK REGISTER AS AT 30TH NOVEMBER 2017)**

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1 INTRODUCTION

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

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

2. BOARD ASSURANCE FRAMEWORK SUMMARY

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

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

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

2.3 Following the change to the annual priority tracker rating methodology in September, two annual priorities (both with reference to components of the Quality Commitment) have been assessed as off-track at month end, with

three forecasted to be at risk of non-delivery in 2017/18. Copies of the current tracker scores, along with more detailed narrative about the annual priorities, are included in the BAF report at appendix one.

3. UHL RISK REGISTER SUMMARY

3.1 For the reporting period ending 30th November 2017, there are 45 organisational risks open on the risk register scoring 15 and above. These risks are described in a dashboard at appendix two with full details at appendix three.

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

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

- Workforce shortages;
- Imbalance between demand and capacity.

4 RECOMMENDATIONS

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

Appendix 1

UHL Board Assurance Dashboard: 2017/18							NOV 2017								
Objective	Principal Risk No.	Principal Risk Description	Current risk rating CxL	Target risk rating CxL	Monthly Risk Change	Annual Priority No.	Annual Priority	Current Tracker Rating	Monthly Tracker	Year-end Forecast Tracker	Exec Owner	SRO	Executive Board Committee for Endorsement	Trust Board / Sub-Committee for Assurance
Primary Objective														
QUALITY COMMITMENT: Safe, high quality, patient centered, efficient healthcare	1	If the Trust is unable to achieve and maintain the required levels of clinical effectiveness, patient safety & patient experience, caused by inadequate clinical practice and ineffective information and technology systems, then it may result in widespread instances of avoidable patient harm, leading to regulatory intervention and adverse publicity that damage the Trust's reputation and could affect CQC registration.	4 x 3 = 12	4 x 2 = 8	↔	1.1	**Clinical Effectiveness - To reduce avoidable deaths:**							
						1.1.1	We will focus interventions in conditions with a higher than expected mortality rate in order to reduce our SHMI	2	↔	2	MD	J Jameson (R Broughton)	EQB	QOC
						1.2	**Patient Safety - To reduce harm caused by unwarranted clinical variation:**							
						1.2.1	We will further roll-out track and trigger tools (e.g. sepsis care), in order to improve our vigilance and management of deteriorating patients	1	↔	2	CN/MD	J Jameson (H Harrison)	EQB	QOC
						1.2.2 a	We will introduce safer use of high risk drugs **(e.g. insulin)** in order to protect our patients from harm	2	↑	1	MD/CN	E Meldrum	EQB	QOC
						1.2.2 b	We will introduce safer use of high risk drugs **(e.g. warfarin)** in order to protect our patients from harm	2	↔	2	MD/CN	C Marshall	EQB	QOC
						1.2.3	We will implement processes to improve diagnostics results management in order to ensure that results are promptly acted upon	2	↑	2	MD	C Marshall	EQB	QOC
						1.3	**Patient Experience - To use patient feedback to drive improvements to services and care:**							
						1.3.1	We will provide individualised end of life care plans for patients in their last days of life (5 priorities of the Dying Person) in that our care reflects our patients' wishes	2	↔	2	CN	S Hotson (C Ribbins) (H Harrison)	EQB	QOC
						1.3.2	We will improve the patient experience in our current outpatients service and begin work to transform our outpatient models of care in order to make them more effective and sustainable in the longer term	2	↔	1	DCIE / COO	J Edyvean / D Mitchell	EQB	FIC
	2	If the Trust is unable to manage the level of emergency and elective demand, caused by an inability to provide safe staffing and fundamental process issues, then it may result in sustained failure to achieve constitutional standards in relation to ED; significantly reduced patient flow throughout the hospital; disruption to multiple services across CMGs; reduced quality of care for large numbers of patients; unmanageable staff workloads; and increased costs.	5 x 4 = 20	5 x 3 = 15	↔	1.4	**Organisation of Care - We will manage our demand and capacity:**							
						1.4.1	We will utilise our new Emergency Department efficiently and effectively We will use our bed capacity efficiently and effectively (including Red2Green, SAFER, expanding bed capacity) We will implement new step down capacity and a new front door frailty pathway We will use our theatres efficiently and effectively	1	↔	1	COO	S Leak	EPB	FIC
OUR PEOPLE: Right people with the right skills in the right numbers	3	If the Trust is unable to achieve and maintain staffing levels that meet service requirements, caused by an inability to recruit, retain and utilise a workforce with the necessary skills and experience, then it may result in extended unplanned service closures and disruption to services across CMGs.	4 x 5 = 20	4 x 3 = 12	↔	2.1	We will develop a sustainable workforce plan, reflective of our local community which is consistent with the STP in order to support new, integrated models of care	2	↔	2	DWOD	J Tyler-Fantom	EWB	FIC
						2.2	We will reduce our agency spend towards the required cap in order to achieve the best use of our pay budget	2	↔	2	DWOD	J Tyler-Fantom	EPB	FIC
						2.3	We will transform and deliver high quality and affordable HR, OH and OD services in order to make them 'Fit for the Future'	2	↔	2	DWOD	B Kotecha	EWB	FIC
EDUCATION & RESEARCH: High quality, relevant, education and research	4	If the Trust does not have the right resources in place and an appropriate infrastructure to run clinical education and research, then we may not maximise our education and research potential which may adversely affect our ability to drive clinical quality, attract and retain medical students and deliver of our research strategy.	4 x 4 = 16	4 x 2 = 8	↑	3.1	We will improve the experience of medical students at UHL through a targeted action plan in order to increase the numbers wanting stay with the Trust following their training and education	2	↔	2	MD	S Carr	EWB	TB
						3.2	We will address specialty-specific shortcomings in postgraduate medical education and trainee experience in order to make our services a more attractive proposition for postgraduates	2	↔	2	MD	S Carr	EWB	TB
						3.3	We will develop a new 5-Year Research Strategy with the University of Leicester in order to maximise the effectiveness of our research partnership	2	↔	2	MD	N Brunskill	ESB	TB
PARTNERSHIPS & INTEGRATION: More integrated care in partnership with others	5	If the Trust does not work collaboratively with partners, then we may not be in a position to deliver safe, high quality care on a sustainable basis, patients might not be able to access the services that they require and we may not be in a position to meet our contractual obligations.	5 x 3 = 15	5 x 2 = 10	↔	4.1	We will integrate the new model of care for frail older people with partners in other parts of health and social care in order to create an end to end pathway for frailty	2	↔	2	DSC	J Currington / A Taylor	ESB	TB
						4.2	We will increase the support, education and specialist advice we offer to partners to help manage more patients in the community (integrated teams) in order to prevent unwarranted demand on our hospitals	2	↔	2	DSC	J Currington / A Taylor	ESB	TB
						4.3	We will form new relationships with primary care in order to enhance our joint working and improve its sustainability							
Supporting Objectives														
KEY STRATEGIC ENABLERS: Progress our key strategic enablers	6	If the Trust is unable to secure external capital funding to progress its reconfiguration programme then our reconfiguration strategy may not be delivered.	5 x 3 = 15	5 x 2 = 10	↔	5.1	We will progress our hospital reconfiguration and investment plans in order to deliver our overall strategy to concentrate emergency and specialist care and protect elective work	2	↔	2	CFO	N Topham (A Fawcett)	ESB	TB
	7	If the Trust does not have the right resources in place and an appropriate infrastructure to progress towards a fully digital hospital (EPR), then we will not maximise our full digital strategy.	3 x 3 = 9	3 x 2 = 6	↔	5.2	We will make progress towards a fully digital hospital (EPR) with user-friendly systems in order to support safe, efficient and high quality patient care	2	↔	2	CIO	J Clarke	EIM&T	FIC
	8	If the Trust is unable to maximise its potential to empower its workforce and sustain change through an effective engagement strategy, then we may experience delays with delivering Year 2 of the UHL Way.	3 x 3 = 9	3 x 2 = 6	↔	5.3	We will deliver the year 2 implementation plan for the 'UHL Way' and engage in the development of the 'LLR Way' in order to support our staff on the journey to transform services	2	↔	2	DWOD	B Kotecha	EWB	FIC
	9	If operational delivery is negatively impacted by additional financial cost pressures, then the delivery of the requirements of the Carter report will be adversely impacted resulting in an inefficient back-office support function.	3 x 3 = 9	3 x 2 = 6	↔	5.4	We will review our Corporate Services in order to ensure we have an effective and efficient support function focused on the key priorities	2	↔	2	DWOD/CFO	L Tibbert (J Lewin)	EWB	FIC
	10	If the Trust cannot allocate suitable resources to support delivery of its Commercial Strategy then we will not be able to fully exploit all available commercial opportunities.	4 x 3 = 12	4 x 2 = 8	↔	5.5	We will implement our Commercial Strategy, one agreed by the Board, in order to exploit commercial opportunities available to the Trust	2	↔	2	CFO	P Traynor	EPB	FIC
	11	If the Trust is unable to achieve and maintain its financial plan, caused by ineffective solution to the demand and capacity issue and ineffective strategies to meet CIP requirements, then it may result in widespread loss of public and stakeholder confidence with potential for regulatory action such as financial special measures or parliamentary intervention.	5 x 4 = 20	5 x 2 = 10	↔	5.6	We will deliver our Cost Improvement and Financial plans in order to make the Trust clinically and financially sustainable in the long term	2	↔	2	CFO/COO	P Traynor (B Shaw)	EPB	FIC

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

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

How to assess BAF principal risk rating:

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

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

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

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

How to assess the BAF annual priority tracker rating:

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

Current Position:

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

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

Year-end Forecast (from Sept onwards):

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

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

Controls assurance (planning)	Performance assurance (measuring)
Governance: Mortality Review Committee, chaired by Medical Director.	Published Summary Hospital-level Mortality Indictor (SHMI) - </= 99 - Latest published SHMI - 100 (period July 16 to June 17) within expected range. *If the national measure for calculating data of hospital mortality, for 'in-house deaths' and 'deaths occurring within 30 days of discharge from hospital', is reduced due to improvements made by other English Acute Trusts, then in-hospital improvement work may not reflect the national adjusted SHMI target (3057).*
Medical Examiner Mortality Screening of In-hospital Deaths.	% of deaths screened - target is 95% of all adult inpatient deaths. 97% of Adult Deaths were screened by the Medical Examiners in Qs 1&2 (includes Community and ED deaths).
Case Note Reviews using National Structured Judgement Review Tool (SJR) and thematic analysis.	% 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. 249 adult cases referred for SJR in Qs1&2 . All of April's deaths should have been classified by end of October To date, details of SJR findings and death classifications have been identified for 30 of the 44 (68%). (GAP) Capacity constraints of both MEs and Admin Team leading to delays with screening of Q2 deaths and following up of Q1 and Q2 SJR outcomes. Bereavement Support Service are seeing an increase in activity.
UHL's Risk Adjusted Mortality Rates (SHMI) monitored using Dr Foster Intelligence and HED Clinical Benchmarking Tools.	UHL's latest rolling 'unpublished' 12 month SHMI July 16 to June 17 is 98.
Five top mortality governance priorities identified through the AQuA comparator report are now standing agenda items at the Mortality Review Committee.	Actions related to CUSUM alerts on track / completed (performance target is all actions on track / completed): April 2017 = Dr Foster CUSUM alert received (Coronary arterosclerosis disease) and actions on track response submitted to CQC on 26th July. July 17 - Dr Foster CUSUM alert received for Coronary Artery Bypass Graft 'Other' received. Response and action plan submitted to CQC on 29th September.
ME / M&M administration support and ME assistant now in place.	
UHL "Learning from the Deaths" Work Programme.	

Actions planned to address gaps identified in sections above	Due Date	Owner
Recruit additional Medical Examiners and ME / M&M administration support (risk entry 3079 - current rating = high). 5. Actions in place are recruitment to ME Assistant vacancy – new post-holder due to started 20th November and additional Medical Examiners – Induction Programme took place 15th November, 1 ME due to start end of December 2017.	Dec-17	RB

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

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

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

Controls assurance (planning)	Performance assurance (measuring)
Governance: Deteriorating Adult Patient Board - last meeting held 21st Nov 2017.	Audit EWS & Sepsis in all adult & paediatric wards in scope; day case, labour ward, CCU and ITU out of scope daily.
Electronic handover supported by NerveCentre.	
Sepsis and AKI awareness and training mandatory for clinical staff.	Review audit results of EWS & Sepsis fortnightly.
Team based training packages for recognition of a deteriorating patient.	Review of Datix reported incidents related to the recognition of the deteriorating patient quarterly - last report to DAPB July 2017.
7 days a week critical care outreach service - launched May 2017.	
Harm review of patients with red flag sepsis who did not receive Antibiotics within 3 hours - reviewed fortnightly by the EWS & Sepsis Review Group.	**Outcome KPIs:** ED KPI 90% of patients with red flag sepsis receive IV antibiotics within 1 hour. TRUST KPIs 95% of patients with an EWS of 3+ appropriately escalated & of those patients with an EWS 3+, 95% screened for sepsis & of those screened for sepsis and identified to have red flag sepsis, 90% receive IV antibiotics within 1 hour.
Roll out of e-obs to the modified National Early Warning Scoring System - with the exception of maternity & ward 27.	
Sepsis e-learning module on HELM - launched July 2017	
(GAP) Deteriorating patient e-learning module - due end of Dec 2017.	**Quality Commitment KPIs:** Q1 position: N/A Q2 position: • Clinical Rules for sepsis (NerveCentre) fully implemented - Complete. • Alerts for sepsis (NerveCentre) fully implemented - outstanding: revised implementation date dependant upon outcome of sepsis assessment forms testing. • Trust wide implementation of e-Obs (MEOWS) - outstanding: revised implementation date end of Jan 2018. • Fully automated EWS reporting (NerveCentre) - Complete. Q3 position: • Assessments for sepsis (NerveCentre) fully implemented. • Fully automated Sepsis reporting (NerveCentre). Q4 position: N/A.
Sepsis screening tool and care pathway - updated & relaunched July 2017	
Review of admissions to ITU with red flag sepsis at all 3 sites monthly - LRI, LGH, GGH.	
Monitoring of SUIs related to the deteriorating patient.	
Latest version of NerveCentre mobile app deployed trust wide (w/c 20/11/2017) to enable alerts for sepsis to go live.	
Sepsis assessment form gone into test environment (w/c 20/11/2017) prior to trust wide deployment.	
e-Obs (MEOWS) undergone further testing (w/c 20/11/2017) prior to trust wide deployment.	
GPAU gone live with NerveCentre EDWISE - 12/11/2017. Will enable deployment of e-Obs in GPAU in Dec 2017.	

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

Trust Sepsis assessment form to go into live environment (date tbc) prior to trust wide deployment	tbc	JB
Trust wide deployment of Obs (MEOWS)	31/01/2018	JB

Corporate Oversight (TB / Sub Committees)			
Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	Audit Committee		
TB sub Committee	QOC	Oct-17	This priority is tied into the overall IT strategy that is planning to further develop NerveCentre and this detail has yet to be agreed.

Independent (Internal / External Auditors)			
Source:-	Title:	Date:	Feedback:
Internal Audit	Internal Audit Report 2017/2018 CQC Follow up review	Oct-17	2 low risk findings identified - none relating specifically to the deteriorating patient actions.

BAF 17/18: As of…	Nov-17											
Objective:	Safe, high quality, patient centered, efficient healthcare											
BAF Risk:	If the Trust is unable to achieve and maintain the required levels of clinical effectiveness, patient safety & patient experience, caused by inadequate clinical practice and ineffective information and technology systems, then it may result in widespread instances of avoidable patient harm, leading to regulatory intervention and adverse publicity that damage the Trust's reputation and could affect CQC registration.											
Annual Priority 1.2.2 (a) Insulin	We will introduce safer use of high risk drugs (e.g. **insulin**) in order to protect our patients from harm. **Trust QC Aim: Reduce incidents that result in severe / moderate harm by further 9%.**											
Objective Owner:	MD/CN	**SRO Insulin:**		E Meldrum		**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				
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				

Controls assurance (planning)	Performance assurance (measuring)
Insulin	
Governance: Diabetes Inpatient Safety Committee.	**Outcome KPIs:**
E-learning for Insulin Safety mandatory for staff who have responsibility for prescribing, preparing and administering insulin.	Reduce number of severe inpatient hypoglycaemia episodes by 20%.
	To have no in hospital Diabetic Ketoacidosis (DKA) "events" in quarter 4.
(GAP) Nursing staff manually enter BM into NerveCentre.	
(GAP) Implement a networked blood glucose meter system to record and monitor episodes of severe hypoglycaemia.	
RCA analysis of all in hospital DKAs - first review of case in Oct 2017.	
Insulin safety Pulse Check in Q2 & Q4.	
UHL guidelines for the management of hypoglycaemia approved by PAG Cttee.	
(GAP) spot check audits of recording of BM on NerveCentre.	
An all staff newsletter has been circulated via Comms in relation to DKA.	
A structured review process for any in-hospital DKA event (similar to pressure ulcers and falls) has been developed and is up and is up and running.	

Actions planned to address gaps identified in sections above	Due Date	Owner
This project has an agreed action plan, to implement fit for purpose electronic systems, monitored through Quality Commitment oversight group and the Diabetes Inpatient Safety Committee.	Mar-18	EM
The data report for all CBG recorded on Nerve Centre (NC) <3.0 is now set up and daily reports are being run by informatics. NerveCentre have committed to building a diabetes admission assessment due for completion by the end of December 2017.	Mar-18	EM

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

TB sub Committee	QOC	Nov-17	Despite the KPIs being at significant risk of not being achieved by year end, a significant amount of work has been undertaken by the diabetes team to provide assurance that pace with the above initiatives has increased and work is progressing to ensure staff have the knowledge and skills to effectively manage patients with diabetes. **Training Assurance:** Numbers of staff who have completed mandatory training are increasing each month. There remain on-going issues with accessing the e-learning and ability to indicate training completed on HELM. We noted very few doctors had completed the e-learning and so to address this have put on essential to role training sessions at end of working day for doctors and if attended then signed off as recieved training. Evaluation of these sessions has been good

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

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

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

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

Corporate Oversight (TB / Sub Committees)			
Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	Audit Committee		
TB sub Committee	QOC	Nov-17	WARFARIN: The project continues to make good progress against its objectives with KPIs on track to deliver by year end. The only two elements of the project that are yet to deliver are developing an e-learning module, and doing more work to improve the time to antidote for bleeding patients who present to the ED.

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

Controls assurance (planning)	Performance assurance (measuring)
Governance: Acting on Results programme board and task and finish groups to report to EQB quarterly.	Development of metrics for monitoring performance against target. % of results acknowledged - target is 85% of results acknowledged by Q4 2017/18.
UHL diagnostic testing policy	
Acting on results detailed action plan monitored via EQB. This covers: developing a fit for purpose electronic system to acknowledge results; in depth work with each specialty to develop standard operating procedures; review of radiology and MDT processes; human factors review of our results reporting service; reviw of how urgent resutls are escalated with a view to putting them on NerveCentre; increasing patient involvement; and improved training in how to use ICE for results acknowledgment.	
(GAP) Conserus (alert email to clinician for unexpected imaging results) pilot in CDU (highest risk area) prior to Trust roll-out.	

Actions planned to address gaps identified in sections above	Due Date	Owner
Prioritise IT resource to the project.	Review monthly	CM

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

TB sub Committee	QOC	Nov-17	In November, the project has got back on Track with IT now able to prioritise resource to the project. A new server has been built which will enable a live pilot of Mobile ICE in respiratory medicine and in acute medicine in December. The project has also had its first view of baseline metrics. Conserus is being piloting with a small group of clinicians and problems that are preventing a wider roll out are being resolved. Provided that the pilot of Mobile ICE is successful the project should be able to deliver its objectives by year end, although it is anticipated that for full embedding of processes more work will need to be done next year.

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…	Nov-17											
Objective:	Safe, high quality, patient centered, efficient healthcare											
BAF Risk:	If the Trust is unable to achieve and maintain the required levels of clinical effectiveness, patient safety & patient experience, caused by inadequate clinical practice and ineffective information and technology systems, then it may result in widespread instances of avoidable patient harm, leading to regulatory intervention and adverse publicity that damage the Trust's reputation and could affect CQC registration.											
Annual Priority 1.3.1	We will provide individualised end of life care plans for patients in their last days of life (5 priorities of the Dying Person) in that our care reflects our patients' wishes. **Trust QC Aim: >75% of patients in the last days of life have individualised End of Life Care plans.**											
Objective Owner:	CN		**SRO:**	C Ribbins / S Hotson		**Executive Board:**		EQB		**TB Sub Committee**		QOC
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4	4	4	4	2	2	2				

Controls assurance (planning)	Performance assurance (measuring)
Governance: Palliative & End of Life Care Committee meets bi-monthly.	**Quality Commitment KPIs**: (GAP) Patients in the last days of life will have an individual care plan in place as per the "One Chance to Get it Right" Guidance (2014): Care plan implemented in 75% of wards in new CMG and care plan sustained in 75% of CMG wards already implemented on.
Detailed project plan presented at the Palliative & End of Life Care Committee.	
End of life care plans which include specialist palliative care end of life care service.	
End of Life Care Facilitators rolling out implementation of taining and support in the use of End of Life care plans (reflected in the detailed project plan).	EoLC audits quarterly - Q1 results reported at the November 2017 P&EoLCC. Audit methodology to be refined to enhance and validate the audit sample confidence level.
"Guidance for care of patients in the last days of life" & "Individualised End of Life Care Plan" reviewed by the Palliateive & End of Life Care Committee - awaiting P&GC approval.	EOLC facilitators attending board rounds (on implementaiton rollout wards) to ensure clinical teams are recognise dying patients.

Actions planned to address gaps identified in sections above	Due Date	Owner
Audit methodology to be refined to enhance and validate the audit sample confidence level.	TBA	

Corporate Oversight (TB / Sub Committees)

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

Independent (Internal / External Auditors)

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

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

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

Corporate Oversight (TB / Sub Committees)			
Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	QAC	Nov-17	Year end position is rated as a high risk due to resources and capacity to deliver the scale of ambition and the cultural change across the organisation to sustain transformation. Report to Quality and outcomes meeting due in February 2018.

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

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

BAF 17/18: Version	Nov-17											
Objective:	Safe, high quality, patient centered, efficient healthcare											
BAF Risk:	If the Trust is unable to manage the level of emergency and elective demand, caused by an inability to provide safe staffing and fundamental process issues, then it may result in sustained failure to achieve constitutional standards in relation to ED; significantly reduced patient flow throughout the hospital; disruption to multiple services across CMGs; reduced quality of care for large numbers of patients; unmanageable staff workloads; and increased costs.											
Annual Priorities 1.4.1	Organisation of Care - We will manage our demand and capacity to improve our Emergency flow (4 hour wait target): We will utilise our new Emergency Department efficiently and effectively. We will use our bed capacity efficiently and effectively (including Red2Green, SAFER, expanding bed capacity). We will implement new step down capacity and a new front door frailty pathway. We will use our theatres efficiently and effectively.											
Objective owner:	COO		**SRO:**	S Leak		**Executive Board:**		EPB		**TB Sub Committee**		FIC / QOC
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4	4	3	2	1	1	1				

Controls assurance (planning)	Performance assurance (measuring)
Submission of demand and capacity plan to NHSI – The major shortfalls are in medicine at the LRI and Glenfield. Deficit of 32 against a plan of 39 This progress has not delivered the material drop in occupancy required due to medicine seeing 1116 admissions above the (downside) plan (9%) - additional demand is using what would have been vacant capacity.	ED 4 hour wait performance trajectory submitted to NHSI - Performance currently below national benchmark.
	Ambulance handover (delays over 60 mins) submitted to NHSI.
	RTT Incomplete waiting times trajectory submitted to NHSI.
	2WW for urgent GP referral as per the NHSI submitted trajectories.
New ED building open to public from 26th April 2017.	31 day wait for 1st treatment as per submitted NHSI trajectories.
Demand and Capacity plans being progressed for 2018 / 19.	62 day wait for 1st treatment as per submitted NHSI trajectories.
Programme Director appointed.	105 bed gap mitigated.
Theatre trading model in place along with ACPL targets. Fours eyes consultancy supporting deliverability.	Reduced cancelled operations due to no available bed.
	Occupancy of 92% (as of June 2017).
Ward 7 moves to Ward 21 and becomes a medical ward in the recurrent baseline (+28 beds)	ACPL target achieved.
	The demand and capacity plan is not currently balanced for the year.
(GAP) Staffing of additional 8 beds on the medicine emergency pathway at LRI on Ward 7 to meet continued demand in medicine.	
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.	
(GAP) Out of hospital step-down solution at LRI for Winter 17/18.	
Population of additional evening and overnight senior medical shifts in ED.	
Daily Improvement meeting chaired by the Chief Executive with ED colleagues working with clinical teams in the component parts of the UEC system.	
Daily SCRUM in place ensuring rapid action and change programme.	

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

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

Corporate Oversight (TB / Sub Committees)

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

Independent (Internal / External Auditors)

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

BAF 17/18: As of…	Nov-17											
Objective:	Right people with the right skills in the right numbers											
BAF Risk:	If the Trust is unable to achieve and maintain staffing levels that meet service requirements, caused by an inability to recruit, retain and utilise a workforce with the necessary skills and experience, then it may result in extended unplanned service closures and disruption to services across CMGs.											
Annual Priority 2.1	We will develop a sustainable workforce plan, reflective of our local community which is consistent with the STP in order to support new, integrated models of care											
Objective Owner:	DWOD		**SRO:**	J Tyler-Fantom		**Executive Board:**		EWB		**TB Sub Committee**		FIC/ PPPC
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4	4	4	4	2	2	2				
Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3	3	3	3	3	2	2	2				

Controls assurance (planning)	Performance assurance (measuring)
Workforce plan relating to reduction in dependency on non contracted workforce, safe staffing, review of urgent and emergency care, impact of seven day services, shift of activity into community settings and increased specialised services where appropriate.	Apprenticeship levy - 430 predicted in 17/18 against 334 target. Currently falling short of TNA for range of reasons including lack of sign off of trailblazer programmes.
	BME Leadership - target 28%
People strategy and programme of work to address the leadership priorities, wellbeing of our workforce and ensure we focus on addressing actions to improve the diversity of our workforce - UHL Leadership programme.	Workforce sickness - target 3% - reporting for Estates and Facilities not adequate and when introduced will affect sickness levels.
	Safe Staffing targets: in accordance with Nursing requirements
Governance structure in place comprising internal and external groups, including Workforce OD Board and the Local Workforce Action Board and subgroups thereof who oversee delivery of the workforce and organisational development components of the Sustainable Transformation Plan.	Seven day services stats:
	Shift of activity in to community:
Apprenticeship workforce strategy.	(GAP 6) Reduction in dependency of our non-contracted workforce - forecast to achieve NHSI target of £20.6 m but run rate suggests a gap of £0.6m at end of year 17/18. £770K medical agency expenditure reduction.
NHS WRES Technical Guidance refreshed - includes changes made to NHS Standard Contract (2017/18 to 2018/19) and definitions of terminology used in WRES indicators, and how affects organisations subject to WRES.	(GAP 7) Vacancy rates -target below 10% (equivalent to turnover to be proposed and agreed). Scrutinised as part of CMG performance review meetings.
(GAP 1) STP refresh in progress – to provide a more accurate workforce prediction based on current capacity requirements - (revised deadline to be confirmed but likely to relate to revised consultation deadlines) - UHL revised their component following demand and capacity review - planning underway across Health Community.	
(GAP 2) insufficent resource to support system wide workforce planning and modelling approach - business case submitted to CSU. In place in some parts (Cardio Respiratory model of care) - complete - all other workstreams to develop a workforce plan.	

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

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

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	Audit Committee		
TB sub Committee	FIC	Mar-18	The gaps in supply of future workforce cannot be readily met therefore a revised Workforce Plan is being developed which will have a greater emphasis on new teams around the patient.

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

Controls assurance (planning)	Performance assurance (measuring)
NHSI overall agency cap is £20.6m for 2017/18, specific target for medical agency reduction is £717,930 in 17/18 - incorporated into CMG financial planning.	£20.6 ceiling target and agency spend - monthly monitoring through financial trajectories in place to measure variance to plan. Forecast to achieve NHSI target of £20.6m but run rate suggests a gap of £0.6m at the end of year 17/18.
Monitoring of agency cap breaches to NHSI weekly.	Medical Agency Dashboard to Medical Oversight board.
Medical Oversight Broad established.	(GAP) Regional deliverables, including regional rate card, to be defined through regional working group in line with TOR - in development.
(GAP) Regional MOU and establishment of a regional working group for medical agency.	(GAP) No. of retrospective bank and agency bookings reported through to Premium Spend Group - target to be determined.
Monitoring of agency spend and tracker (including data analysis which shows reasons for request and rates of use by ward level) through Premium Spend Group with EWB, EPB, IFPIC oversight - There is a detailed agency action tracker in place, with monitored actions against agreed activities to reduce agency expenditure.	
Agreed escalation processes / break glass escalation control.	
Review of top 10 agency highest earners and long term through ERCB linking to vacancy positions and CMG recruitment plans.	
Process for signing off bank and agency staff at CMG level through Temporary staffing office following appropriate senior approval.	
Nursing rostering prepared 8 weeks in advance.	
Monthly premium spend meeting to monitor progress via agency tracker.	
No agency invoice is paid without booking number.	

Actions planned to address gaps identified in sections above	Due Date	Owner
Work on-going through regional MOU workstream - Trust /supplier engagement event on 20th Oct - actions confirmed.	Dec-17	LT/JTF

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

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

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

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

Controls assurance (planning)	Performance assurance (measuring)
Vision and programme plan in place (transforming HR Function) - HR Fit for the future programme roadmap.	Staff engagement staff survey score.
Maximising use of Technology (enabling processes).	Workforce Report Outcomes and Measures agreed and reviewed at monthly CMG Performance Assurance Meetings.
Listening Events held in July 2017 to work with stakeholders and customers to deliver service differently and to gain ownership.	
(GAP) Redefine and Up skill staff within the Service in order to be fit for the future: UHL Way Annual Priorities Map agreed: HR / OD Team have undergone development in UHL Way during June and will be supporting transformation aspects of UHL priority delivery.	
(GAP) Delivery structures not fit for purpose until target operating model has been developed - target operating model informed by feedback from listening events in July.	
(GAP) Full implementation of new Health Education Learning Management System - Additional implementation funds agreed by CMIC in September 2017.	
HELM progress updates provided to Executive Team weekly.	

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

Corporate Oversight (TB / Sub Committees)			
Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	Audit Committee		
TB sub Committee	PPP Committee	Nov-17	Update concerning HELM Recovery Action and contingency plans.

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

Internal Audit	Induction of temporary staff	Q2 17/18	Will review the adequacy of the policy for induction of temporary staff and consider whether this is being effectively implemented.
Internal Audit	Review of Payroll Contract	Q3 17/18	Will review the robustness of the contract management arrangements for new payroll provide who will be in place from 01/08/17.
External Audit	work plan TBA		

BAF 17/18: As of…	Nov-17											
Objective:	High quality, relevant, education and research											
BAF Risk	If the Trust does not have the right resources in place and an appropriate infrastructure to run clinical education and research, then we may not maximise our education and research potential which may adversely affect our ability to drive clinical quality, attract and retain medical students and deliver of our research strategy.											
Annual Priority 3.1	We will improve the experience of medical students at UHL through a targeted action plan in order to increase the numbers wanting stay with the Trust following their training and education											
Objective Owner:	MD		**SRO:**	S Carr		**Executive Board:**		EWB		**TB Sub Committee**		
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3	3	3	3	3	2	2	2				
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				

Controls assurance (planning)	Performance assurance (measuring)
Medical Education Strategy to improve learning culture.	GMC/ HEE regional meeting scheduled for 21/09/17 to review progress against action plans for all Trusts visited. UHL's action plan submitted to HEE & the GMC.
Medical Education Quality Improvement Plan.	
(GAP) Transparent and accountable SIFT funding / expenditure in CMGs.	Leicester Medical School feedback (satisfaction / experience) - areas for improvement in 17/18 plan.
(GAP) UHL Multi-professional education facilities strategy to progress EXCEL@UHL.	
	UHL UG education quality dashboard (satisfaction / experience) - launched in Sept 17 - Draft to be submitted to EWB in Oct - outcomes available in Dec 17.
(GAP) CMG ownership of undergraduate education outcomes.	
(GAP) Overarching strategy with University of Leicester to integrate undergraduate and postgraduate training to improve outcomes and retention.	GMC National student survey (satisfaction / experience) - 2017 survey headlines show a decline in Overall Satisfaction for UoL.
MJPCC - either SC or DL to attend future meetings with details of individual's educational roles. This will be used to confirm and inform the job plan.	Currently <20% medical students complete the end of block feedback. The Medical School have agreed to address and improve this. We anticipate improvement by Dec 17.
UG representatives on the UHL Doctors in Training Committee.	
Undergraduate Education has now been included in the monthly CMG APRM.	(GAP) HEE Quality Management Process (satisfaction / experience)- new process still to be confirmed for 2017/18.
	Student Exit Survey - areas for improvement included in 17/18 QI plan.
	UKFPO shows that whilst 2017 figures for the % of LMS students who 'preferenced' LNR Foundation School has increased slightly to 25% (19 % in 2016), Leicester is still ranked 23rd out of 31 for 'Local Applications by Medical School'.

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

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

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

Independent (Internal / External Auditors)			
Source:-	Title:	Date:	Feedback:
Internal Audit	Consultant Job Planning	Q1 17/18	Will review the arrangements in place for consultant job planning and carry out testing of a sample of job plans to assess whether these meet good practice set out in 'A guide to Consultant Job Planning'.
External Audit	work plan TBA		

BAF 17/18: As of…	Nov-17											
Objective:	High quality, relevant, education and research											
BAF Risk	If the Trust does not have the right resources in place and an appropriate infrastructure to run clinical education and research, then we may not maximise our education and research potential which may adversely affect our ability to drive clinical quality, attract and retain medical students and deliver of our research strategy.											
Annual Priority 3.2	We will address specialty-specific shortcomings in postgraduate medical education and trainee experience in order to make our services a more attractive proposition for postgraduates											
Objective Owner:	MD		**SRO:**	S Carr		**Executive Board:**		EWB		**TB Sub Committee**		
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4	4	4	4	2	2	2				

Controls assurance (planning)	Performance assurance (measuring)
Medical Education Strategy to address specialty-specific shortcomings.	GMC/ HEE regional meeting scheduled for 21/09/17 to review progress against action plans for all Trusts visited.
Medical Education Quality Improvement Plan for 2017/18.	
HEEM quality management visits for following specialties - Cardiology, Maxillo-Facial School of Surgery / Dentistry, Trauma & Orthopaedics School of Surgery and Respiratory Medicine.	(GAP) HEE Quality Management Process (satisfaction / experience) - new process still to be confirmed for 2017/18. It's likely that self assessment will increase and HEE will only visit areas with training challenges- 'triggered visits'.
(GAP) CMGs Quality Improvement Action Plans in response to GMC visit and survey results to address concerns in postgraduate education.	UHL Medical Education Survey - 415 junior doctors responded to the survey. 88% recommend UHL as a place to work, an improvement since March (83%).
Monthly Medical Education reports included as part of the CMG Performance Review Meeting data packs.	UHL PG education quality dashboard (satisfaction / experience) - to be completedin Sept 17 outcomes available in Nov 17.
(GAP) Overarching strategy with University of Leicester to integrate undergraduate and postgraduate training to improve outcomes and retention.	UHL Trainer Survey completed in conjunction with the Clinical Senate - work is underway to re-launch the Grand Round within UHL.
GMC 'Approval and Recognition' of Clinical and Educational Supervisors - central database monitored and maintained.	(GAP) Data to show the number of postgraduate medical and trainees retained in the specialties with shortcomings. Data for Foundation trainees is available via the UKFPO. Specialty data is held by HEE.
GMC visit report - UHL action plan developed.	
A pilot audit of job plans for Cardiology shows a deficit in education time of 7 eSPAs. (GAP) Audit for other services to be commenced.	The Chief Resident is looking at junior doctor morale within UHL, to compare this against the recent HEE document and recommendations.
On-going support work for Trust Grade doctors to minimise rota gaps and improved trainee experience at UHL.	
Cardio-Respiratory Improvement Steering group in place to respond to HEE triggered visit in Jul 17. Action plan in place and resources identified.	
An LiA will commence early in 2018 to act on the Junior Dr Morale survey results. John Adler and Andrew Furlong are the Executive Sponsors.	
Attitudes and Behaviours to Improve Care' group has been established (chaired by Suzanne Khalid) - will support the GMC action on undermining in UHL.	

Actions planned to address gaps identified in sections above	Due Date	Owner
The UHL/UoL Strategic Group is developing the overarching strategy.	Mar-18	Strategic Group
MJPCC- either SC or DL to attend future meetings with details of individual's educational roles. This will be used to confirm and inform the job plan.		SC/DL

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

Corporate Oversight (TB / Sub Committees)

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

Independent (Internal / External Auditors)

Source:-	Title:	Date:	Feedback:
Internal Audit	Consultant Job Planning	Q1 17/18	Will review the arrangements in place for consultant job planning and carry out testing of a sample of job plans to assess whether these meet good practice set out in 'A guide to Consultant Job Planning'.
External Audit	work plan TBA		

BAF 17/18: As of…	Nov-17											
Objective:	High quality, relevant, education and research											
BAF Risk	If the Trust does not have the right resources in place and an appropriate infrastructure to run clinical education and research, then we may not maximise our education and research potential which may adversely affect our ability to drive clinical quality, attract and retain medical students and deliver of our research strategy (3065).											
Annual Priority 3.3	We will develop a new 5-Year Research Strategy with the University of Leicester in order to maximise the effectiveness of our research partnership											
Objective Owner:	MD		**SRO:**	N Brunskill		**Executive Board:**		ESB		**TB Sub Committee**		
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Sept**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Controls assurance (planning)	Performance assurance (measuring)
(GAP) UHL Research and Innovation Strategy in UHL - due Q2 2017/18.	Internal monitoring via metrics reported at joint strategic meetings including finance, communications, patient and public involvement.
(GAP) Dialogue with UoL to articulate (year 1 of the 5 year) research strategy which will consolidate our position in areas of existing strength such as BRU, Cancer, Respiratory and Cardiovascular and identify new areas for possible development such as Obstetrics and Childrens - due Q2 2017/18.	External monitoring via annual reports from NIHR re performance for funded research projects - report Q2 2017/18.
	(GAP) Sign-off (year 1 stage) of the 5 year research strategy.
Functioning organisational relationship in place with UoL which includes joint strategic meetings to discuss research performance and opportunities.	

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

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

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

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

Actions planned to address gaps identified in sections above	Due Date	Owner
The Frailty Oversight Task and Finish Group is responsible for monitoring and mitigating the impact of the identified gaps.	Mar-18	DCIO

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

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

BAF 17/18: As of…	Nov-17											
Objective:	More integrated care in partnership with others											
BAF Risk	If the Trust does not work collaboratively with partners, then we may not be in a position to deliver safe, high quality care on a sustainable basis, patients might not be able to access the services that they require and we may not be in a position to meet our contractual obligations.											
Annual Priority 4.2	We will increase the support, education and specialist advice we offer to partners to help manage more patients in the community (integrated teams) in order to prevent unwarranted demand on our hospitals											
Annual Priority 4.3	We will form new relationships with primary care in order to enhance our joint working and improve its sustainability											
Objective Owner:	DSC		**SRO:**	J Currington		**Executive Board:**		ESB		**TB Sub Committee**		
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3	3	3	3	3	2	2	2				

Controls assurance (planning)	Performance assurance (measuring)
Clinical Lead identified (Associate Medical Director – Primary Care Interface).	Performance assurance and reporting identified through UHL Project Charter to include number of new relationships with primary care.
UHL designated clinical lead and management lead report to UHL Exec boards.	
Clinical Lead member of STP Primary Care Resilience Group.	(GAP) Description of UHL offer or "Brochure" will be produced. Bid Support Manager started 31 July.
Project Plan / Project Charter in place. Better Change Project Charter, Benefits Realisation. Milestone Tracker and Stakeholder Analysis - Expert group implemented.	(GAP) A Baseline Mapping of existing integration initiatives which can be used as a measure the outputs of the project.
Primary Care Oversight Board (PCOB) in place.	Review to be carried out re. Consultant Connect impact on clinicians and PA's.
Tender opportunity search process reported through ESB monthly.	(GAP) Research - what training and support do GPs want.
(GAP) A suite of Tender Response Documents ready for responding to any competitive tenders and to include a description of UHL's response team. Recruitment to Strategy and Bid Office Manager post completed - Work in progress.	GP Hotline quarterly report to PCOB.
	CQUIN 6 A&G reports to come to PCOB.
	Consultants and clinicians "top gripes" survey scheduled for December.
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.	

Actions planned to address gaps identified in sections above	Due Date	Owner
Tender response documents being collated, timeline to be presented to Jan PCOB and DRAFT suite of documents to the February board.	Feb-18	JS
UHL offer or "Brochure" will be produced.	Q4 17/18	JS
Stakeholder Communciation/ Engagement plan in progress - to be agreed at Nov PCOB meeting. DRAFT presented - will be signed off at December PCOB.	Dec-17	AT
Availabilty of funding is being tracked and managed by PCOB.	ongoing	MW
Individual meetings with GPs - questionairre to agree training needs.	Jan-18	AT

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

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

BAF 17/18: Version	Nov-17											
Objective:	Progress our key strategic enablers											
BAF Risk	If the Trust is unable to secure external capital funding to progress its reconfiguration programme then our reconfiguration strategy may not be delivered.											
Annual Priority 5.1	We will progress our hospital reconfiguration and investment plans in order to deliver our overall strategy to concentrate emergency and specialist care and protect elective work											
Objective owner:	CFO		**SRO:**	N Topham		**Executive Board:**		ESB		**TB Sub Committee**		FIC
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**June**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Planning (controls)	Performance Management (assurance sources)
(GAP) Develop EMCHC full business case - 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.
(GAP) Deliver year 1 (of 3 year) Interim ICU project - external capital funding has been confirmed but receipt is subject to external approval of business cases. Confirmation now received that one OBC and one FBC to be completed within 2017/18 for the whole project of £30.8m.	Performance against updated Interim ICU project plan is on track - OBC approved by the UHL TB in November, and the CCG Boards on 14th November; FBC to be completed by end Jan 2018. NHSI have advised that the OBC is scheduled to be presented to the January 10th National Resource meeting; any delay in their process will delay the submission of the FBC to March 2018. We will be advised on whether we have a likely delay before Christmas.
Deliver Emergency Floor Phase 2 (to complete in 2017/18).	Performance against Emergency Floor Phase 2 project plan - on track.
(GAP) Deliver Vascular Outpatients move to GH subject to outcome of scoping exercise and decision at ESB (to complete in 2017/18).	Performance against Vascular Outpatients project plan - is dependent on project scoping – outcome delayed owing to complexity of solution. 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).	Performance against Reconfiguration Programme project plan - on track. Impact of using PF2 on overall affordablity has been assessed, and discussion has taken place with the DH Private Funding Unit to discuss impact of using PF2 as an alternative funding source if DH funding not forthcoming. Awaiting the outcome of the prioritisation process following the Autumn Budget on 22nd November.

Actions planned to address gaps identified in sections above	Due Date	Owner
EMCHC move to LRI - scope for project is being finalised, detailed delivery plan being developed	Dec-17	MW
Interim ICU project - FBC is being drafted as first part of external approval process.	Feb-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		
TB sub Committee	FIC	Oct-17	Interim ICU case apporved.

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

Controls assurance (planning)	Performance assurance (measuring)
EPR Plan - Best of breed (new systems & building on our Nervecentre solution).	(GAP) EPR Plan - key milestones to be developed.
(GAP) Implement NC forms and rules to support clinical practice.	IM&T Project Dashboard - Milestones reported are on track
Implemented NC bed management (Roll-out to LRI Oct 17, GH & LGH in Dec 17).	
(GAP) Create outpatient NC/ICE functionality	
IM&T Project Dashboard reported to EIM&T Board.	
IM&T Governance structure and specialty sub-groups in place. Paperless Hospital 2020 Programme Board and SRO approved. Initial mtg in Jan 18.	
(GAP) IM&T Project Management Support.	

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

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	Audit Committee		IM&T report provided on request.
TB sub Committee	FIC		Quarterly paper provided: EPR plan – Best of Breed is progressing and alternative solutions are being reviewed. Work continues to implement NC Forms and Rules and Bed Management, the IM&T elements of these functions have been enabled and does now require support from the stakeholders to implement.
TB sub Committee	QOC		IM&T report provided on request.

Independent (Internal / External Auditors)

Source:-	Title:	Date:	Feedback:

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

BAF 17/18: Version	Nov-17											
Objective:	Progress our key strategic enablers											
BAF Risk	If the Trust is unable to maximise its potential to empower its workforce and sustain change through an effective engagement strategy, then we may experience delays with delivering Year 2 of the UHL Way (3068).											
Annual Priority 5.3	We will deliver the year 2 implementation plan for the 'UHL Way' and engage in the development of the 'LLR Way' in order to support our staff on the journey to transform services											
Objective owner:	DWOD		**SRO:**	B Kotecha		**Executive Board:**		EWB		**TB Sub Committee**		PPP
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
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Annual Priority Tracker Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**August**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4	4	4	4	2	2	2				

Controls assurance (planning)	Performance assurance (measuring)
UHL Way	
UHL Way governance structure (with programme leads for the 4 components of Better - engagement, teams, change and Academy).	UHL Pulse check dashboard (Quarterly) - Q2 2017/18 results show an improvement against overall engement score however we note that several of the indicators have decreased - energy continues to be the lowest scoring indicator. (GAP) Must achieve a 30% response rate in the quarterly pulse check to ensure reliable and valid data.
Year 2 - Close liaison with all SROs for annual priorities in 17/18 to process map their journey to identify gaps against the 4 components of the UHL Way.	
UHL Way Year 2 implementation plan and tracker.	
LIA processes embedded.	(GAP) Metrics to measure number of UHL Way interventions utilised in supporting annual priorities - as a minimum Project Charter to be produced for all priorities.
	National staff survey (annually) - April 2017 = UHL joint 47th position.
	Metrics to measure number of staff through UHL Way Master Class - 70 staff completed as at the end of Dec.
	Better Teams Aggregated Pulse Check Scores.
LLR Way	
LLR OD and Change Group (workforce enabling group).	(GAP) Metrics to measure no. of people through introduction.
LLR Governance structure with clinical and senior leadership from LLR services (including UHL, LPT, City & County Councils, EMAS) - Better care together improvement framework.	(GAP) Metrics to measure no. of interventions utilised.
	Funding secured to progress LLR Way Elements.
LLR standardised improvement framework to approach change implemented.	
(GAP) Framework to raise awareness of STP and LLR Way.	

Actions planned to address gaps identified in sections above	Due Date	Owner
Final Review of LLR Way Introduction Programme including identifying metrics (undertaken by LLR CLG).	Dec-17	BK

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	Audit Committee		
TB sub Committee	PPP Committee	Nov-17	Workforce Update Report - deep dive on Health and Well Being and Sickness Absence provided.

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

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

Actions planned to address gaps identified in sections above	Due Date	Owner
Conclude Diagnostic Phase with Milestones and KPIs agreed.	Jan-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).	Jan-18	DWOD

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	Audit Committee		
TB sub Committee	PPP	Nov-17	The PID for the Corporate Services review was ratified by IFPIC in August 2017. A Diagnostic Phase across all Corporate Services commenced in June 2017. This is progressing to an options appraisal assigning delivery targets across service lines which will be completed in January 2018.

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

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

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

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

Corporate Oversight (TB / Sub Committees)

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

Independent (Internal / External Auditors)

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

BAF 17/18: As of…	Nov-17											
Objective:	Progress our key strategic enablers											
BAF Risk	If the Trust is unable to achieve and maintain its financial plan, caused by ineffective solution to the demand and capacity issue and ineffective strategies to meet CIP requirements, then it may result in widespread loss of public and stakeholder confidence with potential for regulatory action such as financial special measures or parliamentary intervention (3070).											
Annual Priority 5.6	We will deliver our Cost Improvement and Financial plans in order to make the Trust clinically and financially sustainable in the long term											
Objective Owner:	CFO		**SRO:**	CFO		**Executive Board:**		EPB		**TB Sub Committee**		FIC
Annual Priority Tracker - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4	4	4	4	4	2	2	2				
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				

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 M8, there remains an unidentified gap that is being worked through with CMGs in an escalation process where appropriate. Revised control totals have been set for all CMG and Corporate Directorates.
Quarterly quality assurance reporting.	
Monthly CMG/Corporate meetings to include detailed review of CIP delivery and forecast - escalating to weekly where CMGs/Corporate departments are materially varying from plan.	
(GAP) Deliver more activity through a more productive capacity through beds, theatres & outpatients – improve efficiency indicators; Reduce the price we pay for goods/services; Remove waste and eliminate unnecessary variation.	
Financial Plans	
CIP (including supplementary) to achieve 100% delivery in 2017/18.	CIP measurement and reporting monthly.
CMGs to achieve their control totals or better.	Monthly I&E submissions to NHSI, Trust Board, FIC and EPB.
Cost pressures and service developments to be minimised and managed through RIC and CEO chaired 'Star Chamber'.	Expenditure run rates for pay, non-pay, capital charges and agency spend.
A minimum of £18m of additional technical and other solutions to be transacted.	Contract income levels consistently being achieved and commissioner challenges resolved quarter by quarter.
Agree an appropriate level of investment supporting the resolution of the demand/capacity issue.	Year on year reduction in agency spend in line with our 2 year trajectory.
	I&E monitoring of progress against £18m technical challenge.
Manage CCG and NHSE contracts to ensure accurate and full receipt of income noting changes to tariff (HRG4+) and new Emergency Floor currencies/flows.	Overall level of overdue debtors to reduce, BPPC performance to improve - monitored within cash paper to FIC.
Implementation of first stages of UHL's Commercial Strategy and use of TGH Ltd.	Improvement in cash position as per the agreed plan.
Reduction in agency spend moving towards the NHSI agency ceiling level.	Revised control totals have been set for all CMG and Corporate Directorates.

New income streams realised and effective, financially beneficial use of TGH Ltd.	Additional corporate controls are being identified to assist in the delivery of the year end position and revised control totals.
Monitoring of CQUIN Targets.	
(GAP) Better retrieval of overdue debtors.	

Actions planned to address gaps identified in controls / assurances	Due Date	Owner
Escalation process in place for retrieval of CCG overdue debtors	Ongoing	CFO
Revised Control Totals to be signed-off by CMG Boards	Dec-17	DoOF

Corporate Oversight (TB / Sub Committees)

Source:-	Title:	Date:	Assurance Feedback:
TB sub Committee	Audit Committee	Monthly	Finance / CIP reports for assurance
TB sub Committee	FIC	Monthly	I&E information to FIC to include monitoring of progress against £18m technical challenge.

Independent (Internal / External Auditors)

Source:-	Title:	Date:	Feedback:
Internal Audit	Cash Management	Q3 17/18	Will review the adequacy of Trust's arrangements for cash flow forecasting and processes for managing working capital.
Internal Audit	Financial Systems	Q3 17/18	Will meet the requirements of external audit and will also include data analysis.
Internal Audit	CIP function and process	Q1 17/18	Will review the adequacy of arrangements for delivery of CIP and the robustness of planning for future years. This will include a review of arrangements against the NHS Efficiency Map.
External Audit	work plan TBA		

Appendix 2 **UHL Full Risk Register Dashboard as at 30 November 2017**

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Risk Manager	Thematic Analysis of Risk Causation
2264	CHUGGS	If an effective solution for the nurse staffing shortages in CHUGGS at LGH and LRI is not found, then the safety and quality of care provided will be adversely impacted.	20	6	Georgina Kenney	Workforce
2621	CHUGGS	If recruitment and retention to vacancies on Ward 22 at the LRI does not occur, then patients may be exposed to harm due to poor skill mix on the Ward.	20	6	Georgina Kenney	Workforce
2566	CHUGGS	If the range of Toshiba Aquilion CT scanners are not upgraded, then patients will experience delays with their treatment planning process.	20	1	Ms Lorraine Williams	Resource
2354	RRCV	If the capacity of the Clinical Decisions Unit is not expanded to meet the increase in demand, then will continue to experience overcrowding resulting in potential harm to patients.	20	9	Sue Mason	Demand & Capacity
2149	ESM	If we do not recruit and retain into the current Nursing vacancies within SM, then patient safety and quality of care may be compromised resulting in potential delayed care.	20	6	Susan Burton	Workforce
2804	ESM	If the ongoing pressures in medical admissions continue, then ESM CMG medicine bed base will be insufficient thus resulting in jeopardised delivery of RTT targets.	20	12	Susan Burton	Demand & Capacity
2763	ITAPS	Risk of patient deterioration due to the cancellation of elective surgery as a result of lack of ICU capacity at LRI	20	10	Chris Allsager	**CLOSED**
2193	ITAPS	If an effective maintenance schedule for Theatres and Recovery plants is not put in place, then we are prone to unplanned loss of capacity at the LRI.	20	4	Gaby Harris	**CLOSED**
2940	W&C	Risk that paed cardiac surgery will cease to be commissioned in Leicester with consequences for intensive care & other services	20	8	Mrs Nicola Savage	Demand & Capacity
3054	Human Resources	If the Trust's Statutory and Mandatory Training data can no longer be verified on the new Learning Management System, HELM, then it is not possible to confirm staff training compliance which could result in potential harm to patients, reputation impact, increased financial impact and non-compliance with agreed targets.	20	3	Edward Thurlow	IM&T
2403	Corporate Nursing	There is a risk changes in the organisational structure will adversely affect water management arrangements in UHL	20	4	Elizabeth Collins	Estates
2404	Corporate Nursing	There is a risk that inadequate management of Vascular Access Devices could result in increased morbidity and mortality	20	16	Elizabeth Collins	Resource
3040	RRCV	If there are insufficient medical trainees in Cardiology, then there may be an imbalance between service and education demands resulting in the inability to cover rotas and deliver safe, high quality patient care.	16	9	Darren Turner	Workforce
2820	RRCV	If a timely VTE risk assessments is not undertaken on admission to CDU, then we will be breach of NICE CCG92 guidelines resulting patients being placed at risk of harm.	16	3	Karen Jones	Processes and Procedures
3031	RRCV	If the MDT activities for vasc surg are not resolved there is a risk of signif loss of income & activity from referring centres	16	1	Martin Watts	**CLOSED**
3088	ESM	If non-compliant with national and local standards in Dermatology with relation to Safer Surgery checking processes, then patients may be exposed to an increased risk of potential harm.	16	6	Jodie Bale	Processes and Procedures
3025	ESM	If there continues to be high levels of nursing vacancies and issue with nursing skill mix across Emergency Medicine, then quality and safety of patient care could be compromised.	16	4	Kerry Johnston	Workforce
3080	RRCV	If an alternative provider and procedure is not identified for wasp/bee venom desensitisation then patients will have an increased risk of anaphylaxis due to treatment & waiting list delays	16	6	Karen Jones	**CLOSED**
3044	ESM	If under achievement against key Infectious Disease CQUIN Triggers (Hepatitis C Virus), then income will be affected.	16	8	Elaine Graves	Demand & Capacity
2333	ITAPS	If we do not recruit into the Paediatric Cardiac Anaesthetic vacancies, then we will not be able to maintain a WTD compliant rota resulting in service disruption.	16	8	Chris Allsager	Workforce
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	Ms Nicola Grant	Workforce
2955	CSI	If system faults attributed to EMRAD are not expediently resolved, then we will continue to expose patient to the risk of harm	16	4	Cathy Lea	IM&T
2673	CSI	If the bid for the National Genetics reconfiguration is not successful then there will be a financial risk to the Trust resulting in the loss of the Cytogenetics service	16	8	Lara Cresswell	Demand & Capacity
2378	CSI	If we do not recruit, up skill and retain staff into the Pharmacy workforce, then the service will not meet increasing demands resulting in reduced staff presence on wards or clinics.	16	8	Claire Ellwood	Workforce

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Risk Manager	Thematic Analysis of Risk Causation
2916	CSI	If blood samples are mislabeled, caused by problems with ICE printers and human error with not appropriately checking the correct label is attached to the correct sample, then we may expose patients to unnecessary harm.	16	6	Debbie Waters	IM&T
3082	W&C	If funding from NHS England Specialised Commissioning for the CenTre Neonatal Transport call handling service is withdrawn, then calls regarding critically-ill & unstable patients will be delayed or mislaid resulting in the potential for serious harm to patients referred for critical care transfer.	16	5	Andrew Leslie	Demand & Capacity
3008	W&C	If the paediatric retrieval and repatriation teams are delayed mobilising to critically ill children due to inadequately commissioned & funded provision of a dedicated ambulance service, then this will result in failure to meet NHS England standards, delayed care, potential harm and inability to free-up PICU capacity.	16	5	Andrew Leslie	Demand & Capacity
2153	W&C	Shortfall in the number of all qualified nurses working in the Children's Hospital.	16	8	Ms Hilliary Killer	Workforce
2237	Corporate Medical	If a standardised process for requesting and reporting inpatient and outpatient diagnostic tests is not implemented, then the timely review of diagnostic tests will not occur.	16	8	Colette Marshall	Workforce
2608	Estates & Facilities	If there are insufficient Management controls in place to meet Regulation 4 of the Control of Asbestos Regulations (CAR) then there is a increased risk of enforcement action by the HSE resulting in prosecution, and/or significant financial impact and reputational damage.	16 ↑	4	Glyn Lambley	Estates
2247	Corporate Nursing	If we do not recruit and retain Registered Nurses, then we may not be able to deliver safe, high quality, patient centred and effective care.	16	12	Maria McAuley	Workforce
1693	Operations (Corporate)	If clinical coding is not accurate then income will be affected.	16	8	Shirley Priestnall	Workforce
3027	CHUGGS	If the UHL adult haemoglobinopathy service is not adequately resourced, then it will not function at its commissioned level	15	4	Ann Hunter	Workforce
3047	RRCV	If the service provisions for vascular access at GH are not adequately resourced to meet demands, then patients will experience significant delays for a PICC resulting in potential harm.	15	6	Sue Mason	Demand & Capacity
3041	RRCV	If there are insufficient cardiac physiologists then it could result in increased waiting times for electrophysiology procedures and elective cardiology procedures	15	8	Darren Turner	Workforce
3043	RRCV	If there is insufficient cardiac physiologists then it could result in reduced echo capacity resulting in diagnostics not being performed in a timely manner	15	6	Darren Turner	Workforce
2872	RRCV	If a suitable fire evacuation route for bariatric patients on Ward 15 at GGH is not found, then we will be in breach of Section 14.2b of The Regulatory Reform (Fire Order) 2005.	15	6	Vicky Osborne	**CLOSED**
3077	ESM	If there are delays in the availability of in-patient beds, then the performance of the Emergency Department at Leicester Royal Infirmary could be adversely affected, resulting in overcrowding in the Emergency Department and an inability to accept new patients from ambulances.	15	10	Dr Ian Lawrence	Demand & Capacity
2837	ESM	If the migration to an automated results monitoring system is not introduced, then follow-up actions for patients with multiple sclerosis maybe delayed resulting in potential harm.	15	2	Dr Ian Lawrence	IM&T
2466	ESM	Current lack of robust processes and systems in place for patients on DMARD and biologic therapies in Rheumatology resulting >	15	1	Dr Alison Kinder	Processes and Procedures
2973	CSI	If the service delivery model for Adult Gastroenterology Medicine patients is not appropriately resourced, then the quality of care provided by nutrition and dietetic service will be suboptimal resulting in potential harm to patients.	15	6	Cathy Steele	Workforce
2787	CSI	If we do not implement the EDRM project across UHL which has caused wide scale recruitment and retention issues then medical records services will continue to provide a suboptimal service which will impact on the patients treatment pathway.	15	4	Debbie Waters	IM&T
2965	CSI	If we do not address Windsor pharmacy storage demands, then we may compromise clinical care and breach statutory duties	15	6	Claire Ellwood	Estates
2601	W&C	There is a risk of delay in gynaecology patient correspondence due to a backlog in typing	15	6	Donna Marshall	Workforce
3023	W&C	There is a risk that the split site Maternity configuration leads to impaired quality of Maternity services at the LGH site	15	6	Ms Cornelia Wiesender	Workforce
3083	W&C	If gaps on the Junior Doctor rota are not filled then there may not ne enough junior doctors to staff the Neonatal Units at LRI	15	3	Jonathan Cusack	Workforce
2946	CSI	If the service delivery model for Head and Neck Cancer patients is not appropriately resourced, then the Trust will be non-compliant with Cancer peer review standards resulting in poor pre and post-surgery malnutrition.	15	2	Cathy Steele	**CLOSED**
2985	Corp Nurse	If delays with supplying, delivering and administrating parental nutrition at ward level are not resolved, then we will deliver a suboptimal and unsafe provision of adult inpatient parental nutrition resulting in the Trust HISNET Status.	15	4	Cathy Steele	**CLOSED**

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Risk Manager	Thematic Analysis of Risk Causation
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	Jonathan Cusack	Workforce
2394	Communications	If a service agreement to support the image storage software used for Clinical Photography is not in place, then we will not be able access clinical images in the event of a system failure.	15	3	Simon Andrews	IM&T
3079	Corporate Medical	If the insufficient capacity with Medical Examiners is not addressed then this may lead to a delay with screening all deaths and undertaking Structured Judgement Reviews resulting in failure to learn from deaths in a timely manner and non-compliance with the internal QC and external NHS England duties	15	6	Rebecca Broughton	Workforce
760	Estates & Facilities	If the integrity of compartmentation is compromised then during a real event the rate of fire and/or smoke spread will accelerate resulting in a greater impact to the building occupiers. The ability to utilise horizontal and/or vertical evacuation will be limited and the potential exists for a greater loss of areas / beds until the fire and resultant damage is contained.	15 ↑	2	Mr Michael Blair	Estates
1149	CHUGGS	There is a risk to patient diagnosis and treatment due to a failure to deliver the cancer waiting time targets	12	6	Michael Nattrass	Demand & Capacity
2771	CHUGGS	There is a risk to quality of patient care due to insufficient clinical oncologist PAs for radiotherapy treatments &Haem MDTs	12	8	Christopher Kent	Workforce
2976	CHUGGS	If capacity is not increased to accommodate the growing new patient oncology referrals and change in complex treatment offered, then delivery of cancer access targets will be compromised resulting in a breach of 7 days CQUIN target.	12	4	Maxine Tipler	Demand & Capacity
2977	CHUGGS	If capacity is not increased to accommodate new patient referrals and changes in complex radiotherapy planning - SABR, then patients will experience delays to their treatment due to an increased waiting time for radiotherapy planning.	12	4	Maxine Tipler	Demand & Capacity
2978	CHUGGS	If DoH accreditation is lost, then radiotherapy SABR delivery model will be reduced.	12	4	Maxine Tipler	Processes and Procedures
3109	RRCV	If additional capacity, resource and support is not provided for the Respiratory Consultant Pharmacist then there is a risk of patient harm as they will be unable to deliver current commitments, service requirements or meet the future demands of the CMG due to the significant gaps in resource versus demand in this highly specialised role.	12	8	Kristina link	Demand & Capacity
2917	RRCV	If the Ambulatory ECG Analysis equipment nearing obsolete are not replaced and appropriately supported with a suitable data management system, then patients may experience delays with analysing & processing of results.	12	2	Judy Gilmore	Resource
2900	RRCV	If patients cannot be isolated as per UHL Isolation Policy due to the lack of side room provision in CDU, then likelihood of cross infection would be increased.	12	8	Sue Mason	Processes and Procedures
2886	RRCV	If we do not invest in the replacement of the Water Treatment Plant at LGH, then we may experience downtime from equipment failure impacting on clinical treatment offered.	12	8	Geraldine Ward	Estates
2997	RRCV	If the technical malfunctions with the NxStage machines are not resolved, then our patients will be exposed to potential harm	12	4	Mrs Lorraine Bertram-Dickens	Resource
3051	RRCV	If we do not effectively recruit to the Medical Staffing gaps for Respiratory Services, then there is a risk to deliver safe, high quality patient care, operational services and impacts on the wellbeing of all staff including medical staffing.	12	6	Karen Jones	Workforce
2870	RRCV	Audit of DNACPR form have shown that the discussion with the patient or family is not consistently recorded	12	2	Elved Roberts	Processes and Procedures
2905	RRCV	If the gaps in workforce are not addressed, then the delivery of the 62 day cancer target will be affected resulting in delays to patient diagnosis and treatment.	12	6	Sue Mason	Workforce
2936	ESM	Failure to handover urgent medical jobs/information on transfer from AMU to a base ward	12	6	Dr Lee Walker	Processes and Procedures
2937	ESM	Failure to arrange follow up, or act on results, following discharge from the Acute Medical Unit	12	6	Dr Lee Walker	Processes and Procedures
2388	ESM	There is risk of delivering a poor and potentially unsafe service to patients awaiting MH admission &/or fruther MH assessment.	12	6	Mark Williams	Demand & Capacity
2234	ESM	There is a medical staffing shortfall resulting in a risk of an understaffed Emergency Department impacting on patient care	12	6	Dr Vivek Pillai	Workforce
2838	ESM	NRU temporary ward environment does not fully meet the needs of the younger patients with disabilities	12	2	Richard Phillips	Estates
2415	ITAPS	Uncertainty in relation to the continued status of the LGH ITU could impact on Consultant recruitiment & retention	12	2	Chris Allsager	**CLOSED**
2557	ITAPS	If the Consultant and Junior Doctors vacancies impacting of staffing levels at Glenfield ITU are not recruited to, then patient care could be impacted.	12	5	RVA	**CLOSED**

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Risk Manager	Thematic Analysis of Risk Causation
2532	ITAPS	Poor Physical Environment at the LRI and LGH ITUs	12	8	RVA	**CLOSED**
3018	MSK & SS	There is a risk to the quality, standards and safety of ALL patients requiring Ambulance transportation	12	4	Paula Eddy	Demand & Capacity
3019	MSK & SS	There is a risk to the quality and safety of patients due to an increase in nursing vacancies on the ASU unit LRI.	12	4	Charlotte Pawley	Workforce
3017	MSK & SS	Medinet - Use of an external provider to reduce RTT Backlog	12	4	Sarah Turner	Demand & Capacity
2991	MSK & SS	There is a risk of delayed outpatient corrospondance to referer/patient following clinic attendance.	12	6	Sarah Turner	Demand & Capacity
2759	MSK & SS	There is a risk that performance targets are not met due to a capacity gap within the ENT department	12	2	Sarah Turner	Demand & Capacity
3020	MSK & SS	Patients could suffer permanent damage to their eye sight due to lack of capacity within the Corneal Service	12	4	Clare Rose	Demand & Capacity
2191	MSK & SS	Lack of capacity within the ophthalmology service is causing delays that could result in serious patient harm.	12	8	Clare Rose	Demand & Capacity
2380	CSI	There is a risk of breach of Same Sex Accommodation Legislation in Imaging	12	3	Miss Rona Gidlow	Demand & Capacity
2575	CSI	Risk to patients due to a delay in Image reporting as there is a lack of reporting capacity in neuroradiology and head and neck.	12	4	Mosheir Elabassy	Workforce
2576	CSI	There is a risk due to lack of qualified & experienced radiographers to the quality of the service provided to patients	12	4	Cathy Lea	Workforce
2815	CSI	There is a risk of unescorted Inpatients, in the Imaging Department, becoming ill and of this not being noticed.	12	4	Miss Rona Gidlow	Workforce
2890	CSI	Reduced delivery in the National Breast Screening Service due to a shortage of qualified mammographers	12	8	Amanda Gibby	Workforce
2983	CSI	There is a risk that high and low ambient temperatures in the Microbiology Laboratory will impact on service delivery and future	12	4	Bud Dziombak	Estates
2947	CSI	Risk to provide a robust Virology service with :Single-handed Consultant Virologist	12	2	Bud Dziombak	Workforce
2615	CSI	Integrity and capacity of containment level 3 laboratory facility in Clinical Microbiology	12	2	Bud Dziombak	Estates
1206	CSI	If the backlog of unreported Chest and Abdomen images on PAC'S are not cleared, then we will breach IRMER and Royal College of Radiologist guidelines.	12	6	ARI	IM&T
182	CSI	POCT- Inappropriate patient Management due to inaccurate diagnostic results from Point Of Care Testing (POCT) equipment	12	4	Anne Freestone	Resource
2994	CSI	Lack of planned IT hardware replacement resulting in high levels of non functioning / non repariable EPMA CoWs	12	2	Claire Ellwood	IM&T
2391	W&C	Inadequate numbers of Junior Doctors to support the clinical services within Gynaecology & Obstetrics	12	8	Ms Cornelia Wiesender	Workforce
2364	W&C	Electronic Access to EMPath	12	3	Louise Payne	IM&T
593	W&C	There is a risk of inadequate neonatal nursing staff /skill mix levels to meet clinical requirements	12	6	Anna Duke	Workforce
1367	W&C	Lack of Capacity in the Neonatal Service	12	8	Jonathan Cusack	Demand & Capacity
2993	W&C	Paediatric Emergency Single Front Door	12	4	Carol Stevenson	Demand & Capacity
2938	W&C	Inability to provide home INR testing for Leicester based adult congenital heart patients transferred from paediatric services.	12	1	Karen Duncan	Demand & Capacity

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Risk Manager	Thematic Analysis of Risk Causation
3006	W&C	There is a risk to patient safety due to shortage of space in the Ward 27 day case and outpatient clinics.	12	2	Ms Hilliary Killer	Demand & Capacity
2853	W&C	Quality improvement, governance and safety initiatives not being implemented/supported within Children's services	12	6	Dr Simon Robinson	Processes and Procedures
2854	W&C	Poor environment on Ward 28 impacting on safety of patients, staff and visitors	12	6	Valerie Baker	Estates
2338	Corporate Medical	If the Homecare market remains unstable, caused by a major company leaving the market, then existing providers of homecare services will experience difficulties achieving satisfactory levels of deliveries resulting in patients not receiving medication and patients receiving the incorrect medication.	12	9	Claire Ellwood	Processes and Procedures
2330	Corporate Medical	If clinical staff do not consistently recognise and act on early indicators of sepsis, then patients will be placed at risk of increased mortality due to ineffective implementation of best practice identification and treatment of sepsis.	12	6	John Parker	Processes and Procedures
3015	Corporate Medical	If ISO compliant non-luer devices are not implemented when available from the manufactures then patients may be placed at harm during the administration of medicines.	12	4	Colette Marshall	Resource
3107	Estates & Facilities	Increased risk that equipment failure may occur	12	8	Darryn Kerr	Resource
1597	Estates & Facilities	If a replacement program for the ageing electrical infrastructure at the GH is not adequately resourced and implemented, then the Trust is at an increased likelihood of experiencing a sudden loss of electrical supply.	12	3	Nigel Bond	Resource
1612	Estates & Facilities	Foul Drain Blockages	12	2	Nigel Bond	Processes and Procedures
1179	Estates & Facilities	If a replacement program for the ageing electrical infrastructure at the LRI is not adequately resourced and implemented, then the Trust is at an increased likelihood of experiencing a sudden loss of electrical supply.	12	3	Mike Webster	Estates
1180	Estates & Facilities	If a replacement program for the ageing electrical infrastructure at the LGH is not adequately resourced and implemented, then the Trust is at an increased likelihood of experiencing a sudden loss of electrical supply.	12	3	Mike Webster	Estates
3012	Estates & Facilities	If a planned down time program for maintaining and cleaning the Theatres facilities across all UHL sites cannot be agreed, then staff and patients will be exposed to increased likelihood of airborne microbiological contamination.	12	1	Mike Webster	Estates
2941	Estates & Facilities	If the integrity of external footpaths, road surfaces, car park surfaces across all UHL sites are not restored, then the Trust may be susceptible to personal injury and property damage claims.	12	3	Nigel Bond	Estates
2942	Estates & Facilities	If the technical fault with main fire alarm system at GH is not resolved, then the timely and safe evacuation of the premises may be jeopardised resulting in harm.	12	4	Mr Michael Blair	Estates
2672	Estates & Facilities	If restrictors on windows above ground level are not installed, then staff, patients, visitors and contractors may utilise unrestricted windows to expose themselves to harm.	12	4	Glyn Lambley	Processes and Procedures
2776	Estates & Facilities	If the current Fire alarm system (panels and devices) fail or need to be replaced then due to the age and lack of available replacement parts a new system would need to be installed at considerable cost to ensure fire detection and alarm provision is consistent and reliable throughout the hospital.	12	1	Mr Michael Blair	Estates
2861	Estates & Facilities	If the aging medical gases pendent hoses are not replaced to the manufactures recommendations, then patients and staff may be placed at risk of harm.	12	3	Glyn Lambley	Resource
2267	Corporate Nursing	Risk of reduced compliance with DoH requirements in relation to adherence to antimicrobial prescribing policy	12	3	Corrine Ashton	Processes and Procedures
2970	Corporate Nursing	If ENFit ISO Standard for enteral feeding is not implemented, then the Trust will be non-compliant resulting increased potential of never events and harm.	12	4	Cathy Steele	Resource
2850	Operations (Corporate)	If patients follow up or cancelled appointments are not rebooked within the appropriate clinical timescale, then patients may experience harm as a result of the delays between appointments.	12	6	Warren Berman	Processes and Procedures
2774	Operations (Corporate)	If there are delays with dispatching post consultation outpatient correspondences, then this may result in significant risk to patient safety.	12	6	William Monaghan	Processes and Procedures
2878	Operations (Corporate)	If the technical faults attributed to the video conferencing facilities for cancer MDTs in the Osborne seminar room and Glenfield Radiology rooms are not resolved, then discussion of cancer patients will continue to be interrupted resulting in increased likelihood of clinical errors.	12	4	Lewis Cade	IM&T
2987	CHUGGS	If the lack of availability of safe and appropriate ambulatory infusion devices for subcutaneous infusions is not resolved, then patients may be exposed to harm.	10	6	Michael Nattrass	Resource
2999	RRCV	Lack of perfusion availability if theatre and ECMO case in progress at the same time out of hours	10	5	Judy Gilmore	Workforce

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Risk Manager	Thematic Analysis of Risk Causation
2235	ESM	There is a risk of harm to patients during inter hospital transfers & transfers across to other UHL sites	10	8	Lisa Lane	Demand & Capacity
3039	MSK & SS	If temperatures in OTTA cannot be adequately regulated, then income may be reduced due to cancellations of theatre cases and overcrowding of ward 18.	10	8	Ms Yvonne Kenmuir-Hogg	Estates
2409	W&C	There is an insufficient number or middle-grade doctors, both SpR's and SHO's to provide adequate service cover in Childrens	10	10	Charlotte King	Workforce
3081	W&C	If essential neonatal equipment (including patient administration and monitoring systems, ventilator and syringe pumps) is not replaced in a timely manner then there might be loss of service capacity, resulting in potential hazards for patients and staff.	10	5	Andrew Leslie	Resource
2604	W&C	Lack of continuity in patient care due to Gynaecology Consultant cross site working	10	6	Mr Rod Teo	Workforce
3013	W&C	There is a risk to the safety of patients, staff and visitors at St Mary's Birth Centre due to the condtion of the building/deco	10	3	Louise Payne	Resource
2565	CHUGGS	If capacity is not increased to meet demand, then delivery of national targets in General Surgery, Gastro and Urology will be compromised resulting in delays in patient treatment pathways.	9	6	Suzanne Nancarrow	Demand & Capacity
2894	CHUGGS	If the insufficient staffing levels in Radiotherapy Physics is not resolved, then the likelihood of breaching waiting time targets and possibility of serious radiotherapy treatment error will be increased.	9	3	Andrea Wynn-Jones	Workforce
2821	CHUGGS	There is a risk of breaching the single sex accommodation policy on Osbsorne Day Care Unit	9	4	Georgina Kenney	Processes and Procedures
2823	CHUGGS	If recruitment to admin workforce gaps does not occur, then potential for errors with patient medical review and chemotherapy appointments will increased resulting in potential harm.	9	6	Jenny Carlin	Workforce
2926	RRCV	If there is a shortage of capacity to meet the current demand for patients awaiting intervention Cardiac Angio Procedures then this may result in patients treatment being delayed	9	4	Judy Gilmore	Demand & Capacity
2670	RRCV	If recruitment to the Clinical Immunology & Allergy Service Consultant vacancy does not occur, then patient backlog will continue to increase, resulting in delayed patient sequential procedures and patient management.	9	6	Karen Jones	Workforce
3005	RRCV	If recruitment and retention to the current Thoracic Surgery Ward RN vacancies does not occur, then Ward functionality will be compromise, resulting in an increased likelihood of incidences leading to patient harm.	9	6	Sue Mason	Workforce
2656	ESM	If Dermatology services is not adequately resourced, then the level and quality of the service provided will be impacted.	9	6	Jodie Bale	Workforce
2023	ITAPS	There is a risk that continued rise in critcal care occupancy results in insufficient non med Staffed Level 3 Critical Care Beds	9	6	Heather Allen	**CLOSED**
2687	MSK & SS	Lack of appropriate medical cover will clinically compromise care or ability to respond in Trauma Orthopaedics	9	9	Carolyn Stokes	Workforce
2504	MSK & SS	There is a risk that patients will wait for an unacceptable length of time for trauma surgery resulting in poor patient outcomes	9	6	Carolyn Stokes	Demand & Capacity
1196	CSI	If we do not increase the number of Consultant Radiologists, then we will not be able provide a comprehensive out of hours on call rota and PM cover for consultant Paediatric radiologists resulting in delays for patients requiring paediatric radiology investigations and suboptimal treatment pathway.	9 ↓	2	Miss Rona Gidlow	Workforce
2496	CSI	Risks associated with implementation of an Electronic Blood Tracking (Phase 2)	9	4	Hafiz Arif	IM&T
2845	CSI	There is a risk to the delivery of a quality microbiology service due to lack of appropriate staffing.	9	1	Bud Dziombak	Workforce
1157	CSI	Lack of planned maintenance for medical equipment maintained by Medical Physics	9	6	Mark Norton	Workforce
2578	W&C	Scans undertaken in GAU & Gynaecology clinic cannot be archived (Screening)	9	2	Lesley Shepherd	IM&T
1042	W&C	Unavailability of USS and not meeting National Standards for USS in Maternity (Screening)	9	6	Louise Harvey	Processes and Procedures
3094	W&C	If the existing call system (Aidcall) is not replaced (current system is now obsolete and compatible spares cannot be obtained) then not all areas of the Birth Centre will have a working system (there are only 5 of the 22 original units working) ad response times may be delayed resulting in deterioration of the situation and a worse outcome for the patient such as delay in resuscitation.	9	2	Louise Payne	Resource

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Risk Manager	Thematic Analysis of Risk Causation
2327	Communications	If an effective collaborative relationship with stakeholders cannot be established and sustained, then the Trust may lose support from stakeholder.	9	4	Karl Mayes	Processes and Procedures
2777	Communications	If fundraising targets for the new Childrens's Hospital are greater than the amount held, then the charity will not be able to underwrite the required expenditures.	9	4	Simon Andrews	Demand & Capacity
2775	Finance & Procurement	If we do not have robust systems to manage supply of goods then it may impact on clinical service provision	9	9	Mr David Streets	Processes and Procedures
3010	Human Resources	There is a risk that the office space for Recruitment Services and Training are not fit for purpose	9	2	Joanne Tyler-Fantom	Demand & Capacity
3033	RRCV	If Vascular inpatients and theatre is moved to Glenfield Hospital, leaving Outpatients at the LRI, then this may result in a fragmented and less efficient vascular surgery department	8	1	Martin Watts	Demand & Capacity
2840	ESM	If the faulty windows affecting all ESM Wards in Windsor are not replaced, then patient will continue to be exposed to challenging temperature levels.	8	4	Susan Burton	Estates
3016	MSK & SS	There is a risk of cross-infection between patients with dental instruments	8	4	Charlotte Pawley	Processes and Procedures
2876	MSK & SS	There is a risk that male and female patients will be cared for in the same area when wearing hospital gowns.	8	2	Michelle Atterbury	Demand & Capacity
510	CSI	There is a risk of staff shortages impacting on the Blood Transfusion Service at UHL	8	4	Hafiz Arif	Workforce
2969	CSI	There is a risk of failure to deliver the TAT Standards of NHS Cervical and NHS Bowel Cancer Screening programmes	8	4	Anne Freestone	Workforce
2863	CSI	There is a risk of a reduced service and possible non-compliance with legislation due to a failure to recruit in RPS	8	4	Mark Norton	Workforce
2136	CSI	If the aging asset base of infusion pumps is not addressed then this could result in infusion pump obsolescence which may result in patients being exposed to harm.	8	4	Mark Norton	Resource
2307	CSI	The Forensic Toxicology service will fail resulting in a substantial loss of income and prestige for the Department/empath	8	4	Hafiz Arif	Workforce
2832	W&C	Use of non safe sharp devices for peripheral cannulation with risk of contamination to staff	8	4	Elizabeth Aryeetey	Resource
2154	Communications	If Directorates and CMGs do not adequately engage with PPI processes, then we could breach our legal obligations.	8	6	Karl Mayes	Processes and Procedures
1336	Estates & Facilities	Access (DDA) Compliance with standards	8	2	Nigel Bond	Estates
2980	RRCV	If there is no mechanism set up to permit sharing and safe storage to the UHL shared renal drive of photographs of patients fistula, then this could lead to delay in review by nephrologists or surgeons	6	1	Jo Bayes	IM&T
3014	RRCV	If there is no fit for purpose Renal Proton Clinical System to collect all information required for reimbursement of dialysis, then this may result in poor patient experience, submission of data to the UK Renal Registry and tariffs	6	4	Lisa Jeffs	IM&T
3078	ESM	If the patient group directions used within the Emergency Department are not reviewed and updated there is a risk of harm to patients/Trust resulting from supply / administration of medicines to patients by non-medical professionals operating under patient group directions (PGDs) that have expired.	6 ↓	1	Kerry Johnston	Processes and Procedures
2858	MSK & SS	Risk to the quality and safety of patients due to an increase in nursing vacancies across the elective orthopaedic wards at LGH	6	4	Ms Yvonne Kenmuir-Hogg	Workforce
2988	MSK & SS	There is a risk of delays for appointments for the ARMD service that could result in loss of sight	6	3	Clare Rose	Demand & Capacity
3011	CSI	Risk to patient safety, business continuity and Department reputation when in hours generator tests are performed at GH.	6	1	Cathy Lea	Estates
2166	Communications	If fundraising plans are not aligned with CMG and Directorate plans, then fundraising will be affected.	6	4	Timothy Diggle	Demand & Capacity
2711	Estates & Facilities	If the main Vacuum Insulated Evaporates (VIE) and back up VIE are not located at separate areas, then we will be in breach of HTM 02-01 standard.	5	4	Mike Webster	Processes and Procedures
2705	CHUGGS	If blood factor products and medicinal products are issued to patients without "dispensing" in conjunction with a prescription, then there will be a breach of Leicestershire medicines code for prescribing and supply of medications.	4	2	Sarah O'Connell	Processes and Procedures

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Risk Manager	Thematic Analysis of Risk Causation
2867	CSI	If the Mortuary flooring is not repaired, then we will continue to breach Department of Health Building note 20 and the HSAC (Health Services Advisory Committee) advice by exposing staff to harm.	4	3	Anne Freestone	Estates

Appendix 3 **UHL Risk Register Report as at 30 Nov 17**

Risk ID	CMG	Specialty	Risk Description	Opened	Review Date	Risk Subtype	Controls in place	Impact	Likelihood	Current Risk	Action summary	Target Risk Score	Risk Manager	Risk Type
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.	03/Dec/13	31/12/2017	Harm (Patient/Non-patient)	Staffing levels checked on daily basis and staff movement from other areas decided by Matron on site/bleep holder. Head of Nursing and Deputy Head of Nursing available at weekends to advise about staffing moves. All shifts required out to bank and agency contract due to lack of fill from Staff bank for some areas, other wards adhoc. Over time offered to all staff in advance. Reassurance and support from Matron where possible to pick up non clinical duties and sickness management, bank requests etc.	Major	Almost certain	20	CHUGGS Participation in all international recruitment during 2016; Deputy Head of Nursing to meet with HR Shared Services on a monthly basis; Active recruitment to Assistant Practitioner posts - due 31/01/17; Closed 26/Jan/2017. Participate in recruitment from Philippines and India; Pilot increased bank rates of pay on all GI, Medicine and Surgery and Urology wards at LRI and LGH Corporate HCA recruitment to be a priority for CHUGGS - 31/10/17 Shifts for ward 22 at LRI/LGH, 27 LGH and SAU's on both sites going to break glass two weeks in advance- 31/12/17 First and second tier agencies to be offered long lines of work for two months in advance, including educational opportunities - 31/12/2017 Explore opportunities for recruiting to non-nursing roles that will support the nursing workforce, such as Ward Clerks and Pharmacy Technicians. 31/12/2017. Explore other opportunities for support from other CMG's. 31/12/17 Matrons to work one clinical shift per week. Head of Nursing and Deputy Head of Nursing to work clinical shift every two weeks. - 30/12/17 Head of Nursing meeting with ITAPS and MSS CMG to explore joint working opportunities. - 31/10/17. Head of Nursing had meeting with ITAPS. GSSU set up and opened 31/07/17 to remain open for 6 months. Review date 31/01/2018.	6	Georgina Kenney	CMG Risk
2621	CHUGGS	General Surgery	If recruitment and retention to vacancies on Ward 22 at the LRI does not occur, then patients may be exposed to harm due to poor skill mix on the Ward.	20/10/2015	31/01/2018	Harm (Patient/Non-patient)	Shifts escalated to bank and agency at an early stage; Increased the numbers of band 6's to provide leadership support. Agency contract in place for one nurse on day shift and night shift to increase nursing numbers. Staffing is reviewed on a day by day basis and staff are moved across the CMG to support the ward as required. Matron to work clinically on the ward for 2 days a week to provide support and increase nursing numbers. Matron to ensure daily matron ward rounds for leadership/ increased monitoring of care standards/accessibility to patients/relatives to discuss any concerns.	Major	Almost certain	20	Ongoing recruitment of trained and untrained nurses as per CHUGGS nursing action plan 31/12/17; Training needs analysis of all registered nurses and action plan developed - 30/11/17. Restructuring of team to provide more senior support on a day by day basis - 31/12/17 Action plan being developed to be discussed with the Chief Nurse - 31/12/17 GSSU opened and being staffed by ITAPS for 6 months - 31/01/2018 Educational support and supervision requested for all new starters to the ward - 31/12/17	6	Georgina Kenney	CMG Risk
2566	CHUGGS	Oncology	If the range of Toshiba Aquilion CT scanners are not upgraded, then patients will experience delays with their treatment planning process.	26/06/2015	31/01/2018	Harm (Patient/Non-patient)	Limited arrangements for planning palliative patients only (unable to treat radical patients) Comprehensive Service Contract with Toshiba for scanner up until May 2016.	Extreme	Likely	20	Update 18.10.17 Alternative contingency plans explored but not progressed due to technical difficulties. Business case approved and CT scanner to be purchased by MES provisional installation date of March 2018 Installation of new CT scanner - 31 Mar 18	1	Ms Lorraine Williams	CMG Risk

Risk ID	CMG	Specialty	Risk Description	Opened	Review Date	Risk Subtype	Controls in place	Impact	Likelihood	Current Risk	Action summary	Target Risk Score	Risk Manager	Risk Type
2354	RRCV	Respiratory Medicine	If the capacity of the Clinical Decisions Unit is not expanded to meet the increase in demand, then will continue to experience overcrowding resulting in potential harm to patients.	28/05/2014	31/12/2017	Harm (Patient/Non-patient)	Respiratory Consultant on CDU 5 days/week 0800-20 00 hrs Respiratory Consultant on CDU at weekends and bank holidays 0800-1200 hrs and on call thereafter Cardiology Consultant assigned on CDU 5 days a week (shared rota) Cardio Respiratory Streaming flow, including referral criteria and acceptance Short stay ward adjacent to CDU Discharge Lounge utilised GH duty Manager present 24/7 Bed co-ordinator and Flow co-ordinator, providing 7 day cover CDU dash board – performance indicators UHL bed state and triage times includes CDU data Daily nurse staffing review with plan to ensure safe staffing levels on CDU EDIS operational on CDU Daily patient discharge conference calls for all wards Matron of the day - rota covers 7 day working Daily board rounds across all wards Primary Care Co-ordinators and increased community support Escalation plans Implementation of triage audit CDU Operations Meeting Monitoring of patient triage times and other quality performance indicators at monthly CDU ops meeting with appropriate representation from all staff groups	Major	Almost certain	20	Additional Imaging at weekends - 31.12.17 Restructure pharmacy provision at weekends - 31.12.17 To revise Matron of the Day and Manager of the Day responsibilities - 31.1.18 To open additional 14 beds for winter capacity - 31.12.17 Additional Respiratory Consultant resource for weekend discharges - 31.1.18 Develop business case for Respiratory & Cardiology medical cover and gain RIC approval - 31.1.18 Winter plan to cancel OPD clinics between Christmas & New Year - 31.12.17	9	Sue Mason	CMG Risk
2149	ESM		If we do not recruit and retain into the current Nursing vacancies within SM, then patient safety and quality of care may be compromised resulting in potential delayed care.	21/02/2013	31/01/2018	Harm (Patient/Non-patient)	*Staffing Escalation policy *Staffing Bleep Holder / Matron support ,Site Manager and Duty Manager *Incident reporting *Complaints monitoring *Daily Staffing Meetings *Monitor staffing levels *Monitoring recruitment and retention *Monitoring sickness levels *Provision of nursing support from other base wards *Support from the Outreach Team *Support from Education & Development Team *Support from Deputy/ Head of Nursing. *Moving staff between clinical areas as a means to balance risk. *Agency and bank as a means to increase nursing numbers. *Clinical matron/senior nurse available daily to ensure clinical risk is mitigated and managed. * Silver Nursing structure in place to review safe staffing 3 times a day linked in with safe care *Bed management meeting at 9.00, 11.00 16.00, 18.00 and 20.00 to review bed demands and staffing issues across the Trust. *Matron visibility on wards Monday to Friday 8 - 8pm and 8 - 4pm at weekends to ensure Trust Safe Staffing Monitor sheet. *Agreed staffing levels and establishment reviews completed bi-annually. *Workforce meeting for CMG. *Dashboards in place for clinical issues to monitor quality. *Engaging in Trust recruitment strategy. *Monthly staffing engagement forum. *Block book contracts with agency to improve fill rate	Major	Almost certain	20	New staff from Philippines and India are awaiting IELT's and Visa's. Discussion with Eleanor Meldrum and Maria McAuley on how to attract agency staff to Long Lines. Ongoing work with the "Team around the patient and Tomorrow's Ward"	6	Susan Burton	CMG Risk

Risk ID	CMG	Specialty	Risk Description	Opened	Review Date	Risk Subtype	Controls in place	Impact	Likelihood	Current Risk	Action summary	Target Risk Score	Risk Manager	Risk Type
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.	06/May/16	31/01/2018	Harm (Patient/Non-patient)	Review of capacity requirements throughout the day 4 X daily. Issues escalated at Gold command meetings and outlying plans executed as necessary taking into account impact on elective activity. Opportunities to use community capacity (beds and community services) promoted at site meetings. Daily board rounds and conference calls to confirm and challenge requirements for patients who have met criteria for discharge and where there are delays ICS/ICRS in reach in place. PCC roles fully embedded. Discharges before 11am and 1pm monitored weekly supported by review of weekly ward based metrics. Ward based discharge group working to implement new ways of delivering safe and early discharge. Explicit criteria for outlying in place supported. Review of complaints and incidents data. Safety rota developed to ensure there is an identified consultant to review outliers on non-medical wards. Access to community resources to enable patients to be discharged in a timely manner. CMG to access and act on additional corporate support to focus on discharge processes. Matron for discharge appointed to provide consistent care for patients needing to be outlied.	Major	Almost certain	20	E-Beds being rolled out live on 20 November and to review 31/12/2017	12	Susan Burton	CMG Risk
2940	W&C	Paediatrics	Risk that paed cardiac surgery will cease to be commissioned in Leicester with consequences for intensive care & other services	30/09/2016	04/Jan/18	Financial loss (Annual)	Weekly staff communications briefings. Regular staff 'open' meetings to provide opportunity for concerns to be raised. Dedicated EMCHC project manager recruited. Dedicated project campaign resourced. Data manager employed to monitor EMCHC KPIs and performance. Legal advice instructed (Sharing the same legal team with Brompton Hospital). Opening additional ward capacity to meet the commissioning cardiac standards. UHL performance recognised by the Care Quality Commission who, in their initial feedback letter following their inspection in June 2016, reported: "We noted the excellent clinical outcomes for children following cardiac surgery at Glenfield Hospital. EMCHC website developed High priority activity strategy to meet the standard of 375 cases per year Trust Board led challenge to reject the NHSE decision by way of a signed letter by the CEO (05/07/16). NHS England visit to Leicester QC to brief the legal options to the TB in Oct 2016 Expansion of Ward 30 to open an extra 7 beds Liaising with East Midlands MP's	Extreme	Likely	20	Ensure project to relocate EMCHC to Children's Hospital stays within capital budget allocation due 30/04/2019	8	Mrs Nicola Savage	CMG Risk

Risk ID	Specialty CMG	Risk Description	Opened	Review Date	Risk Subtype	Controls in place	Impact	Likelihood	Current Risk	Action summary	Target Risk Score	Risk Manager	Risk Type
3054	HR Training 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.	31/07/2017	13/Jan/18	Service disruption	Preventive: eUHL has been turned back on for those staff whose accounts could not be created or data integrity is in question Social media communication has been sent to all bank staff with clear guidelines and actions in relation to using HELM or eUHL Core Training Team working with bank team and supporting where required Core Training Team monitoring daily Detective: Currently over 9000 staff have access to the new HELM system, the core Training Team with OCB Media and JOLT monitor this on a daily basis. There should be an increase in staff having access to HELM and all data is correct. The plan agreed for governance and assurance is that all staff will have an account and data correct by 31 July 17. Corrective: Weekly telephone conference arranged with the Chief Information Officer for assurance plus weekly telephone meetings with the developers (OCB Media and JOLT) to hold to account on deadlines. Removal of requirement to provide evidence of statutory and mandatory completion at time of appraisal.	Extreme	Likely	20	HELM development priority - data accuracy - completion of adjustments required Implementation of HELMX2 - Jan 2018 Maintain and correct issues raised through HELM support desk (interrvals as per attached Actiion Plan) - 30 Jan 18 Correct misaligned accounts on HELM (at intervals as per attached Action Plan) - 30 Jan 18 Correct misaligned accounts on HELM (at intervals as per attached Action Plan) - 30 Jan 18 Creation of compliance reporting - 30 Jan 18 HELM development priority - centralised reporting - 30 Jan 18 HELM development priority - data accuracy / integrity - 30 Jan 18 Implementation of eGreen Book - 31 Mar 18 Implementation of HELMX2 - 31 Mar 18 Testing of compliance reports - 31 Jan 18	3	Edward Thurlow	Corporate Risk
2403	Infection prevention Corporate Nursing	There is a risk changes in the organisational structure will adversely affect water management arrangements in UHL	19/08/2014	31/Jan/18	Harm (Patient/Non-patient)	Instruction re: the flushing of infrequently used outlets is incorporated into the Mandatory Infection Prevention training package for all clinical staff. Infection Prevention inbox receives all positive water microbiological test results and an IPN daily reviews this inbox and informs affected areas. This is to communicate/enable affected wards/depts to ensure Interserve is taking necessary corrective actions. Flushing of infrequently used outlets is part of the Interserve contract with UHL and this should be immediately reviewed to ensure this is being delivered by Interserve All Heads of Nursing have been advised through the Nursing Executive Team and via the widely communicated National Trust Development Action Plan (following their IP inspection visit in Dec 2013) that they must ensure that their wards and depts are keeping records of all flushing undertaken and this must be widely communicated Monitoring of flushing records has been incorporated into the CMG Infection Prevention Toolkit (reviewed monthly) and the Ward Review Tool (reviewed quarterly). Senior Infection Prevention Nurse working with Facilities.	Major	Almost certain	20	To review and agree Water Safety Plan-Revised Water Management Policy and Water Safety Plan approved by the Trust Infection Prevention Committee. Implementation programme to be confirmed by Facilities colleagues - 30/12/17	4	Elizabeth Collins	Corporate Risk
2404	Infection prevention Corporate Nursing	There is a risk that inadequate management of Vascular Access Devices could result in increased morbidity and mortality	19/08/2014	31/Jan/18	Harm (Patient/Non-patient)	UHL Policies are in place to minimise the risk to patients that staff are required to adhere too. A revised data report is being produced for the January 2017 Trust Infection Prevention Assurance Committee that will provide greater transparency with regard to audit results and allow Clinical Management Group boards and Senior staff the insight into areas that require actions to address poor performance	Major	Almost certain	20	Targeted surveillance in areas where low compliance identified via trust CVC audit - Yet to be established due to lack of staff required. For further review by the Vascular Access Committee - 31 Jan 18. Develop the recommendations of the Vascular Access Committee action plans to increase the Vascular Access Team within the Trust in line with other organisations. Business Case to be submitted within the organisation by the CSI CMG with support from the Assistant Medical Director appointed by the Medical Director to oversee this objective - 31 Jan 18. Support the recommendations of the Vascular Access Group action plans to reduce the risk of harm to patients and improve compliance with legislation and UHL policies - 31 Jan 18.	16	Elizabeth Collins	Corporate Risk

Risk ID	CMG	Specialty	Risk Description	Opened	Review Date	Risk Subtype	Controls in place	Impact	Likelihood	Current Risk	Action summary	Target Risk Score	Risk Manager	Risk Type
3040	RRCV	Cardiology	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.	27/06/2017	31/12/2017	Harm (Patient/Non-patient)	Preventive: •Medical workforce Manager and JDA team monitor the current rotas to identify significant gaps and complete the necessary actions and planning to ensure cover or reduce the number of medical gaps •Planning of rotations during the 2017/18 with the support of Medical HR to identify gaps and complete the necessary actions to ensure cover or reduce the number of medical gaps •Efficient recruitment processes – rolling adverts •Maximising current resources to cover the gaps where possible •Effective communication with medical group and escalation procedures •Increased educational sessions in Trust Grade job plan to develop skills and career progression •Provide a more supportive network to Trust Grades within cardiology Detective: •RRCV CMG performance meetings where medical cover is discussed •Respiratory and Cardiology Board meetings with attendance from Education representatives to escalate concerns •Junior Dr and other Dr forums and 'gripe' system to identify themes of issues •LRI support •Review of different working models and RRCV investment to explore alternative options	Major	Likely	16	Medical Workforce Manager and JDA team to continue to monitor rotation gaps and take the necessary steps to make base wards and CDU safe ensuring escalation is completed when required - 30.12.17 Effective and timely recruitment completed with the support of the medical HR team to fill medical staffing gaps and reduce risk as much as possible - 30.12.17 Frequent scheduled meetings to ensure the monitoring of the HEE-EM action plan and reassurance of actions being completed. - 30.12.17 RRCV CMG winter and operational plans and escalation of issues to appropriate Executive Trust Board(s) - 30.12.17	9	Darren Turner	CMG Risk
2820	RRCV	Clinical Decisions Unit (CDU)	If a timely VTE risk assessments is not undertaken on admission to CDU, then we will be breach of NICE CCG92 guidelines resulting patients being placed at risk of harm.	01/Jun/16	31/12/2017	Harm (Patient/Non-patient)	Interim solution to highlight the VTE risk assessment form on the CDU Medical Clerking proforma with a bold red/white sticker. Raise awareness at Junior Doctor Local Induction training. Close monitoring of the monthly VTE target with support from VTE nurse specialist. Complete 'spot check' audit at least once a month - complete	Major	Likely	16	Review current CDU Medical Clerking proforma and agree changes through correct Trust procedures to ensure the VTE risk assessment form is prominent (12 months of old stock) - 1.10.16. - emailed Caroline Baxter for a response - 18.11.16 - An SpR has been identified to review the CDU medical clerking proforma - alternative solution identified and VTE assessments to be potentially recorded on NERVE centre - 30.12.17 Review of Nerve Centre System to identify opportunity to use system to record VTE assessment Implementation of Nerve Centre in CDU which will support the recording of VTE status	3	Karen Jones	CMG Risk

Risk ID	CMG	Specialty	Risk Description	Opened	Review Date	Risk Subtype	Controls in place	Impact	Likelihood	Current Risk	Action summary	Target Risk Score	Risk Manager	Risk Type
3088	ESM	Dermatology	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.	21/09/2017	31/01/2018	Harm (Patient/Non-patient)	"Safer surgery checklist Capacity and demand review undertaken to identify size of the problem and resources required this has been completed and no knowledge of gaps identified but Admin staff did feel overwhelmed with current demands. LOCSIPS/NATSIPS pertaining to dermatology procedures robust team briefings will take place before all outpatient procedure lists start in dermatology to include medics and outpatient staff immediately. spot audits of checking & consent processes and procedures for dermatology procedure lists for the next 2 weeks Immediately. All staff have received and read new SOP, Service Manager has met with all admin staff to ensure training needs are met. No training needs identified. GM from ophthalmology to provide external review of Dermatology admin processes taken place. Admin & clerical vacancies with HR service agreed a plan to recruit and retain admin & clerical staff. Current gap x2 wte, put out to bank and pulling from other areas where possible, posts now filled with permanent and bank until March 2018	Major	Likely	16	Demand and capacity work undertaken review of vacancy gap completed by Jodie Bale, this has highlighted a gap in current capacity in clinics and Jodie is looking at options to close gap due for review and update by 31.12.2017 Agreement to be reached regarding plan to resource service (as required) in the longer term after capacity and demand review. Current gap os 2 x WTE, where possible we are pulling from other teams across ESM to help we have also put out bank shifts. 1 post recruited to and 1 out to advert 31/12/2017 Process mapping of admin processes to be undertaken regarding key patient pathways to identify inefficiencies in service delivery due 31.12.2017 Jodie Bale & Katrina Toland to review tasks undertaken by nurse specialists to ensure maximum efficiency in the short term overdue 31.12.2017. Review tasks undertaken by medical staff to ensure maximum efficiency in the short term, job planning meeting taken place and agreed to extend PA to 4 hour sessions. Jodie Bale to review demand and capacity to see if there is any additional capacity ongoing and due 31.12.2017 Jodie Bale and Katrina Toland to communicate Safer Surgery checklist process to all medical and nursing staff in dermatology for clarity due 31.12.2017 Dr Lawrence to Review Risk ID 2590 in conjunction with this risk to ensure that all key actions are taking place/planned due 31.12.2017	6	Jodie Bale	CMG Risk
3025	ESM	Emergency Department	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.	30/05/2017	31/12/2017	Harm (Patient/Non-patient)	1.Shifts escalated to bank and agency at an early stage. 2.Increased the numbers of Band 6's to provide leadership support on the floor. 3.Agency shifts escalated to break glass agencies one week in advance. 4.Amvale paramedic in assessment bay to support timely ambulance handover. 5. Incentive scheme payments for HCA's and RN's working additional shifts in ED on the bank. 6.VAC Nurse in place to observe the waiting areas for patients at all times to ensure patient safety whilst awaiting assessment. 7. Lead role for recruitment within the Matron team and dedicated time spent on recruitment. 8.Rolling advert for recruitment to band 5 and band 2 roles. Continue actively recruiting to all grades of nursing staff. 9.International recruitment undertaken - awaiting start dates of staff 10.Review of staffing levels across all areas on a daily basis and staff moved around to support areas most in need. 11.Active Management of staff absence to maximise staff availability to work. 12.Agency staff working regular shifts for continuity of care.	Major	Likely	16	Advertise to recruit to GPAU and CSSU as individual areas to work 31/01/2018 Recruit to nursing associate roles31/01/2018 Further recruitment to vacant ECP / ACP Roles 31/01/2018 Offer rotational posts across dept/wards 31/01/2018 Offer rotational posts into Childrens ED 31/01/2018	4	Kerry Johnston	CMG Risk

Risk ID	CMG	Specialty	Risk Description	Opened	Review Date	Risk Subtype	Controls in place	Impact	Likelihood	Current Risk	Action summary	Target Risk Score	Risk Manager	Risk Type
3044	ESM	Infectious Diseases	If under achievement against key Infectious Disease CQUIN Triggers (Hepatitis C Virus), then income will be affected.	13/07/2017	31/12/2017	Financial loss (Annual)	Monthly business meetings to monitor progress. Monitoring run rate on a monthly basis. Regular updates with Northampton and Kettering around low cost acquisition drugs. ODN meeting to take place in June 21st at Northampton.	Major	Likely	16	Letter to ODN network leads from UHL senior finance manager Jon Currington currently on hold. Secure honorary contract for Prof Wiselka to work at Northampton ongoing. Set up formal ODN network business meeting. Set up monthly clinics in Northampton. Monthly updates to ESM Board by Richard Philips. 29 Dec 17 Set up monthly clinics in Northampton - 29 Dec 17 Set up formal ODN network business meetings - 29 Dec 17 Secure honorary contract for Prof Wiselka to work at Northampton - 29 Dec 17 Monthly updates to ESM Board - 29 Dec 17	8	Elaine Graves	CMG Risk
2333	ITAPS	Anaesthesia	If we do not recruit into the Paediatric Cardiac Anaesthetic vacancies, then we will not be able to maintain a WTD compliant rota resulting in service disruption.	17/04/2014	01/Apr/18	Harm (Patient/Non-patient)	1:4 rota covered by 3 colleagues Fellow appointed in July 2016 who has now undergone appointments process and started as consultant on 1st of May 2017.	Major	Likely	16	The service still has a consultant vacancy which is proving difficult to recruit to due to the uncertainty of future commissioning/?service closure 9. Updated 03/07/17 - 1 consultant appointed. The second vacant post to be converted to a fellowship post as currently unable to recruit. The revised JD is being reviewed. Due to this change the review date has been moved to 30/12/17.	8	Chris Allsager	CMG Risk
2989	MSK & SS	Trauma Orthopaedics	If we do not recruit into the Trauma Wards nursing vacancies, then patient safety and quality of care will be placed at risk	02/Mar/17	30/12/2017	Harm (Patient/Non-patient)	The wards are on electronic staff rostering and off duties is produced 6 weeks in advance; requests for temporary staffing are made 6 weeks in advance when possible. All shifts required are escalated to bank and agency and over time is offered to all staff in advance. Staffing levels are checked on a daily basis by the bed co-ordinator and matron. Staff are moved between the areas to try & maintain safety & service. Staff are moved from other areas if / when possible when escalated to Matron / head (or assistant head) of nursing / duty manager. New staff to the area attend the relevant study days in order to gain the relevant skills to look after the patients. Exploring the possibility of staff moving from other areas within the CMG (on a daily basis) where possible & potentially needing to close more beds.	Major	Likely	16	Review Ward 18's decrease in bed base to 24 beds if unable to safely staff. - 30.12.17	4	Ms Nicola Grant	CMG Risk
2955	CSI		If system faults attributed to EMRAD are not expediently resolved, then we will continue to expose patient to the risk of harm	17/01/2017	31/Jan/18	Harm (Patient/Non-patient)	Use of out sourcing in order to make up for reduced service efficiency Conference calls with GE to ensure system faults are expediently brought to their attention for a swift resolution in order to minimise service impact. Continued meetings with GE and IMT to obtain solutions and deadline dates to restore service efficiency. Log of system faults recorded and monitored to ensure developers are finding resolutions in a timely manner.	Major	Likely	16	2. GE to provide breakdown of reported issues with the EMRAD system and feedback on their resolution (with timescales - although GE have stated some items they will not be able to provide timescale) - 31st Jan 2018. 3. GE to upgrade eRC to version 6.05 to rectify performance issues and crashes (to resolve issues with reporting examinations) - Currently due March (GE currently updating timescales as this was originally scheduled for December) - 31st Jan 2018. 5. Review and resolution of system reference data processes and management of central reference data that impacts on patient care - Due to discuss with IT 18th Mar 17, no resolution date agreed. -- 31st Jan 2018.	4	Cathy Lea	CMG Risk

Risk ID	CMG	Specialty	Risk Description	Opened	Review Date	Risk Subtype	Controls in place	Impact	Likelihood	Current Risk	Action summary	Target Risk Score	Risk Manager	Risk Type
2673	CSI	Pathology - Cytogenetics	If the bid for the National Genetics reconfiguration is not successful then there will be a financial risk to the Trust resulting in the loss of the Cytogenetics service	14/10/2015	15/Jan/18	Financial loss (Annual)	Empath procurement specification utilising exiting services within UHL and NUH pathology services. This includes Molecular genetics at NUH and Empath molecular diagnostics to ensure that all elements of the procurement be addressed. Public consultation period clarifying the scope and service specification requirements in autumn 2014. Plans to form a single genetic laboratory service for the east midlands under Empath which would be able to cover the expected requirement s of the service specification There is a verbal agreement to submit a joint response to the tender between UHL and NUH incorporating Empath services and genetics at NUH.(Update Dec 2016:Time line now Spring 2017 with advice to bidders Autumn 2017)	Major	Likely	16	Empath response to procurement (with NUH). To submit a successful bid to provide the Genetics lab service for E.Midlands- 28 Feb 18 L.C updated 15/11/2017:UHL, NUH and CUH have shared activity data as part of a NDA. The working group from the 3 trusts met on 3/11/17 to discuss the test groupings and what consolidation might be possible across the region; the location for this testing hasn't been decided but there were several tests that would be required to stay provided locally. NHSE have asked for data on staffing to assess the financial implications with regards to TUPE/redundancy this has a deadline of Nov 20th.A second draft of the specification and an updated annex 4 have been released (10/11/17) and can be commented on following the next bilateral meeting with the NHSE team on 22/11/17. This updated draft includes more details on subcontractors and the requirement for laboratories to work collaboratively. This appears to give more assurance to any subcontractors in the bidding process. It is likely that UHL will be a subcontractor to the GLH although this has yet to be confirmed. Next teleconference is 17/11/17. Still awaiting the draft test directory from NHSE.	8	Lara Cresswell	CMG Risk
2378	CSI	Pharmacy	If we do not recruit, up skill and retain staff into the Pharmacy workforce, then the service will not meet increasing demands resulting in reduced staff presence on wards or clinics.	19/06/2014	31/Mar/18	Harm (Patient/Non-patient)	extra hours being worked by part time staff, payment for weekend commitment / toil and reduction in extra commitments where possible team leaders involved in increased 'hands' on delivery staff time focused on patient care delivery (project time, meeting attendance reduced) Prioritisation of specific delivery issues e.g. high risk areas and discharge prescriptions, chemo suite . Reduced presence at non direct patient focused activities e.g. CMG board/ Q&S and delay projects / training where possible. Revised rotas in place to provide staff/ service based on risk Recruit 8A pharmacists to replace those promoted to 8B Release band 3 staff to support onc/haem satellite	Major	Likely	16	review technician deployment and impact of band 5 technician losses at GH - 31/03/2018	8	Claire Elwood	CMG Risk
2916	CSI	Phlebotomy	If blood samples are mislabeled, caused by problems with ICE printers and human error with not appropriately checking the correct label is attached to the correct sample, then we may expose patients to unnecessary harm.	11/Aug/16	31/12/2017	Harm (Patient/Non-patient)	1 - Training guide in place - Staff must check the label before putting it on sample bottle and make sure the correct information is put on, if any problems with the ICE printer they must Log it X8000 and report it to Management . 2 - Daily audit by each member of staff for each ward on all 3 sites listing numbers of issues with reprinting and printing of incorrect patient details. 3 - Reported to IM&T daily and CSI management as an additional monitoring process 4 - Policy reviewed and all phlebotomy staff have received refresher training and advice on monitoring and reporting 5 - Weekly spot check audits by Phlebotomy management to ensure staff are following processes	Major	Likely	16	IT now updating weekly however still no resolution to the issue - DW to chase weekly - ongoing chasing and feedback received but no resolution to the issue as yet - DW to continue escalating and chasing IM&T IM&T confirmed that they now have this risk on their risk register as well A working group was set up to review the implementation of the Blood trac system as being a possible solution to the risk of patient samples being mixed up. Review 31/12/17	6	Debbie Waters	CMG Risk
3082	W&C	CSI	Centre Neonatal Transport Service	If funding from NHS England Specialised Commissioning for the CenTre Neonatal Transport call handling service is withdrawn, then calls regarding critically-ill & unstable patients will be delayed or mislaid resulting in the potential for serious harm to patients referred for critical care transfer.	04/Sep/17	20/12/2017	Harm (Patient/Non-patient)	Preventive: Work with NHSE to secure intermediate and longer-term solutions. Detective: We will hold monthly contract monitoring meetings during the 6 month notice period to monitor service levels. Corrective: Paediatric, neonatal and ECMO transport services will produce operational contingency plans by 8 weeks into the notice period.	Major	Likely	16	Arrange for NHSE & LPT to meet with clinical service leads if no solution by mid-Oct - Due 20/12/17 Review & upgrade risk rating if no solution by from the commissioners due 20/12/2017	9	Andrew Leslie	CMG Risk

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3008	Centre Neonatal Transport Service 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.	20/12/2017	18/05/2017	Harm (Patient/Non-patient)	From March 2017 the transport team will continue to dial for an ambulance when required. An escalation procedure through Trust & EMAS management has been developed for when vehicles are not available as needed. Datix forms will be submitted for delayed response. The EMPTS core team will continue to discuss with EMAS and NHSE to develop a solution. Enquiries will be made to other ambulance providers, regarding specification of vehicles, accessibility and cost. All material will be shared with the Trusts' Implementation group who meet on a monthly basis to update and discuss.	Major	Likely	16	EMPTS working with EMAS and NHSE to develop a solution due 20/12/2017	5	Andrew Leslie	CMG Risk
2153	Paediatrics W&C	Shortfall in the number of all qualified nurses working in the Children's Hospital.	05/Mar/13	31/12/2017	Harm (Patient/Non-patient)	Where possible the bed base is flexed on a daily bases to ensure we are maintaining our nurse to bed ratios There is an active campaign to recruit nurses locally, national and internationally Additional health care assistance have been employed to support the shortfall of qualified nurses. Specialise Nurses are helping to cover ward clinical shifts. Cardiac Liaison Team cover Outpatient clinics Overtime, bank & agency staff requested Head of Nursing, Lead Nurse, Matron and ECMO Co-ordinator cover clinical shifts Adult ICU staff cover shifts where possible Recruitment and retention premium in place to reduce turn-off of staff Part time staff being paid overtime Program in place for international nurses in the HDU and Intensive Care Environment Second Registration for Adult nurses in place	Major	Likely	16	Continue to recruit to remaining vacancies in PICU & Ward 30 GH - due 31/12/17	8	Ms Hilliary Killer	CMG Risk
2237	Patient Safety 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.	07/Oct/13	31/12/2017	Harm (Patient/Non-patient)	Abnormal pathology results escalation process Suspicious imaging findings escalated to MDTs Trust plan to replace iCM (to include mandatory fields requiring clinicians to acknowledge results). Diagnostic testing policy approved.	Major	Likely	16	Update Oct 24th 2017: Conserus is currently being piloted before more widespread roll-out. IT have just allocated project resource to project which will allow aspirations to develop ICE to be taken forward - this be contingent on upgrade of hardware and software which is unlikely to take place before Jan 2018. In the interim, small scale piloting of the Mobile ICE app will be able to take place with a group of 20 clinicians	8	Colette Marshall	Corporate Risk
2608	Estates & Facilities Corporate Medical	If there are insufficient Management controls in place to meet Regulation 4 of the Control of Asbestos Regulations (CAR) then there is a increased risk of enforcement action by the HSE resulting in prosecution, and/or significant financial impact and reputational damage.	30/11/2017	31/12/2017	Reputation	Interim Asbestos register created in Excel by Head of QSHE. All pre-existing remedial actions from latest re-inspection surveys sent to Capital to generate 3 Capital Schemes across the 3 locations. Removal project tendered for - awaiting contract award. Asbestos Working Group established Re-Survey Scope to be generated and sent for Tender. Update Floorplans on MICAD to allow ACM details to be uploaded and managed.	Major	Likely	16	Current Status: - Interim Asbestos Register created, UHL is currently operating on a part manual and par automatic register. Perform Asbestos survey - 31 Dec 18	4	Glyn Lambley	Corporate Risk
2247	Corporate Nursing Corporate Nursing	If we do not recruit and retain Registered Nurses, then we may not be able to deliver safe, high quality, patient centred and effective care.	30/10/2013	31/Jan/18	Harm (Patient/Non-patient)	HRSS structure review. A temporary Band 5 HRSS Team Leader appointed. A Nursing lead identified. Recruitment plan developed with fortnightly meetings to review progress. Vacancy monitoring. Bank/agency utilisation. Shift moves of staff. Ward Manager/Matron return to wards full time.	Major	Likely	16	Recruitment continues with monthly rolling adverts, under the umbrella of the national shortage of Registered Nurses. International recruitment continues with 38 non EU commenced in 2017. Second cohort of trainee Nursing Associates will hopefully be recruited in January 2018 (50 places for LLR, minimum of 20 places for UHL). Review 5/3/18	12	Maria McAuley	Corporate Risk

Risk ID	Specialty	CMG	Risk Description	Opened	Review Date	Risk Subtype	Controls in place	Impact	Likelihood	Current Risk	Action summary	Target Risk Score	Risk Manager	Risk Type
1693	Clinical Coding	Operations (Corporate)	If clinical coding is not accurate then income will be affected.	02/Aug/11	31/03/2018	Financial loss (Annual)	As at November 2017, We are commencing an LiA scheme to improve quality of documentation and casenote flow to the coding offices. In July a further 4 Trainee Coders commenced and have completed their 21 Day Standards course in-house with our 2 Trainers. They are already contributing to the Coding workload under close supervision. The training room at LGH (refurbished old Porters Lodge) is now in full use. Additional accommodation at GH is urgently needed. We have ceased all use of agency staff because there are now sufficient substantive staff to manage the workload. We still need to appoint to remaining vacancies to ensure the team is working to recommended coding volume (7500 episodes/year). The workload remains too high to ensure good quality Coding. An audit cycle and plan and a training plan are established. Coding backlog is being maintained at approximately <7 days (<7000 cases uncoded). Reduced backlog minimises inefficiencies of multiple casenote transfers. Medicode (the Encoder interfaced to PAS) has been upgraded to the current version. An apprentice Coding runner has been employed to help with transfer of casenotes to the Coders for specific wards. An enhanced sessional weekend rate for our own trained Coders encourages additional weekend working. 3 year refresher training for all Coders is in place and funded recurrently Coding manager/trainers present overview for Junior doctor induction.	Major	Likely	16	Additional accommodation required at GH site - 31/03/18 Discontinue use of Agency Coders - 31/03/18 LiA to be established to work with CMGs / ward clerks to maximise transfer of casenotes to Clinical Coding - 31 Aug 18	8	Shirley Priestnall	Corporate Risk
3027	Haematology	CHUGGS	If the UHL adult haemoglobinopathy service is not adequately resourced, then it will not function at its commissioned level	13/07/2017	30/11/2017	Harm (Patient/Non-patient)	Preventive Control: Dr Hunter is taking on the Lead for the service. NUH lead to cover annual reviews at NGH for ta period of 12 months. Interim consultant cover from Haematology Malignancy Team to provide annual reviews for UHL patients. Policy for emergency management of ED patients in place, education sessions planned.	Moderate	Almost certain	15	Case of Need for an additional consultant in Haemoglobinopathy for comprehensive care link. AH - Due date 30/06/2017(completed and submitted to CMG management for further action) All patients within the service need to be checked to ensure they have had a yearly review - 30/11/2017	4	Ann Hunter	CMG Risk
3047	Cardiology	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.	13/07/2017	31/12/2017	Harm (Patient/Non-patient)	Preventive: Optimise PiCC line insertion on days it is available Cannula insertions kept to minimum Robust I.P plans constantly being reviewed – cannulae care pathway completion Detective: Ward reporting delays on Datix Matron utilising Red to Green to identify patients who are awaiting for service and take actions to iradicate the causation of the delay in accordance with Red to Green protocols. IP performance indicators	Moderate	Almost certain	15	Recruitment to vascular access service - 1.10.17 - this is ongoing as the service expands 31.12.17	6	Sue Mason	CMG Risk

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3041	RRCV	Cardiology	If there are insufficient cardiac physiologists then it could result in increased waiting times for electrophysiology procedures and elective cardiology procedures	27/06/2017	31/Jan/18	Harm (Patient/Non-patient)	Preventive: Additional sessions being undertaken by UHL staff Patients referred back to GP for Non Attendance. Communication to referrers to ensure all referrals are essential/appropriate to manage demand WLI initiative for Saturday EP procedures Overtime offered to current band 7 to complete EP training on Saturdays/Days off Detective: On-going to source locum support On-going to actively advertise Corrective: On going recruitment of staff into vacant posts	Possible	Extreme	15	Recruit 3.0 WTE staff - Recruited for two and out to 1 more and that we have resourced two agency locums within the department - 3 Jan 18 Explore Support from equipment manufacturers- continue to use to support for complex cases, but not as stand alone option - 1 Feb 18 Demand management - EP specialty meeting to be held 18.8.17 - discussed RTT and demand management plan, market share analysis to be completed review of current capacity - 3 Jan 18	8	Darren Turner	CMG Risk
3043	RRCV	Cardiology	If there is insufficient cardiac physiologists then it could result in reduced echo capacity resulting in diagnostics not being performed in a timely manner	27/06/2017	31/12/2017	Harm (Patient/Non-patient)	Controls: List what is currently in place and having a positive effect to control the risk Preventive: •Additional sessions being undertaken by UHL staff •Communication to referrers to ensure all referrals are essential/appropriate to manage demand •Strict adherence to auditing of referrals with clinical input/support when required Detective: •Continue to source locum support •Establish if external providers are able to provide support/capacity Corrective: •Recruitment of staff into vacant posts	Almost certain	Moderate	15	Recruit 2.0 WTE staff , recruited 1 wte internal - review 31.10.17 - ongoing 31.1.18	6	Darren Turner	CMG Risk
3077	ESM	Emergency Department	If there are delays in the availability of in-patient beds, then the performance of the Emergency Department at Leicester Royal Infirmary could be adversely affected, resulting in overcrowding in the Emergency Department and an inability to accept new patients from ambulances.	04/Aug/17	31/12/2017	Harm (Patient/Non-patient)	All ambulance staff perform a clinical assessment prior to arrival at the Emergency Department. Patients who are identified as requiring immediate assessment in the Emergency Room are pre-alerted by means of a dedicated phone line to give staff advance notification of the patient's arrival. Patients have a "Dynamic Priority Score" (DPS) calculated which is reported at the time of registration. This score is used to triage and prioritise the sickest patients for entry into the Emergency Department for assessment and treatment. A senior Emergency Department clinician (ST3 or above, Consultant, or Advanced Nurse Practitioner) re-assesses each patient who is waiting in an ambulance for entry into the Emergency Department, to confirm their DPS and to identify any patient who needs prioritisation for entry into the Emergency Department. There is an expectation that this assessment will occur within 15 minutes of the patient's arrival, and that patients will be re-assessed hourly while they are still waiting on the ambulance for entry into the Emergency Department. This ensures that those who are most ill are allocated space in the Emergency Department as a priority. Patients who have spent more than 2 hours in an ambulance waiting to enter the Emergency Department are considered for an increase in their DPS to expedite their entry into the Emergency Department. Such reviews of DPS are undertaken by senior clinicians working in the Assessment Zone, in liaison with the Nurse in Charge, Doctor in Charge, and site management team as necessary. Key roles and responsibilities within the Emergency Department - in particular the Nurse in Charge and	Possible	Extreme	15	An effective in-reach escalation plan is required for when in-patient speciality assessment beds are not available - 31 Oct 17 Initiatives to discharge suitable patients from medical wards earlier in the day, for example by increased use of Discharge Lounge - 31 Oct 17 A review of the feasibility of direct admission of medical patients to Short Stay Unit rather than to the Acute Medical Unit (AMU) - 30 Nov 17	10	Dr Ian Lawrence	CMG Risk

Risk ID	CMG	Specialty	Risk Description	Opened	Review Date	Risk Subtype	Controls in place	Likelihood	Impact	Current Risk	Action summary	Target Risk Score	Risk Manager	Risk Type
2837	ESM	Neurology	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.	09/May/16	31/01/2018	Harm (Patient/Non-patient)	Paper results for blood, urine tests and MRI scans are sent to consultant. Face-to-face outpatient clinic reviews by doctors or MS nurses.	Possible	Extreme	15	Dawn on hold until additional; MSSN Business Case has been approved by RIC. Plan to review DAWN progress due 31 Jan 18. Business Case in development to review 31 Jan 2018	2	Dr Ian Lawrence	CMG Risk
2466	ESM	Rheumatology	Current lack of robust processes and systems in place for patients on DMARD and biologic therapies in Rheumatology resulting >	03/Dec/14	31/12/2017	Harm (Patient/Non-patient)	The Rheumatology Department follows the 'BSR/BHPR guideline for disease-modifying anti-rheumatic drug (DMARD) therapy in consultation with the British Association of Rheumatologists (2). This stipulates the type and frequency of blood test monitoring, as well as recommendations for actions if results are found to be abnormal. *Action plan in place to identify and act on further risks, process review; supported by LiA programme. *General Manager appointed for 6 months to support service review and implementation. *Matron appointed to establish current specialist nursing establishment job plans and skill mix.*Pharmacy support lead identified for service (due to start August 2017). *Database administration team fully established. Long standing spread sheet system remains in place - Nurse Prescribers currently validating to move towards full DAWN implementation. *Process mapping is on-going of prescriptions which will involve senior engagement completed and agreed 13 October 2017. *Prescribing pharmacist to work in the service with CMG back filling on the wards for initial 6 months. Pharmacy Staff member identified to support service from August 2017. *MBP Project Manager allocated to DAWN project and meeting arranged to review MER forms and to clarify scope and timeframes for on-going IT support, Dawn upgrade is now complete. *IM&T and 4S to ensure updates and adequate licenses are in place.	Almost certain	Moderate	15	Full Service review including workforce in progress completion due 31 December 2017	1	Dr Alison Kinder	CMG Risk
2973	CSI	Dietetics	If the service delivery model for Adult Gastroenterology Medicine patients is not appropriately resourced, then the quality of care provided by nutrition and dietetic service will be suboptimal resulting in potential harm to patients.	20/01/2017	31/01/2018	Harm (Patient/Non-patient)	There is an Enteral Feeding Guideline in place which means that any patient on enteral feeding can start on a protocol, with risk of refeeding identified. This then has a 3 day build up, after which a Dietitian will need to give a full assessment. Agreement from the Divisional Head of Nursing that all qualified nurses in CHUGGS CMG are to complete Malnutrition Universal Screening Tool (MUST) e-learning module. Dietetic education of medical and nursing staff on a case by case basis by dieticians for catering queries and first line nutritional care plan. Helen Ord (Dietetic Practice Learning Lead) to train all four new housekeepers on nutritional care. Dietetics and CHUGGS CMG to plan for increased dietetic investment.	Almost certain	Moderate	15	Withdraw FODMAP dietary management for IBS until resourced with adequate dietetic time - 30 Dec 17 Develop virtual telephone outpatient clinics to safely manage outpatient caseload - 30 Dec 17 Implement the Nutrition Liver Care Pathway at ward level for inpatients - 30 Dec 17 Develop a first line ward procedure for consideration of prescribable oral nutritional supplements for acutely admitted IBD inpatients - 30 Dec 17	6	Cathy Steele	CMG Risk

Risk ID	CMG	Specialty	Risk Description	Opened	Review Date	Risk Subtype	Controls in place	Impact	Likelihood	Current Risk	Action summary	Target Risk Score	Risk Manager	Risk Type
2787	CSI	Medical Records	If we do not implement the EDRM project across UHL which has caused wide scale recruitment and retention issues then medical records services will continue to provide a suboptimal service which will impact on the patients treatment pathway.	17/02/2016	31/12/2017	Harm (Patient/Non-patient)	Use of A&C bank staff where possible, though very limited in supply. Use of overtime from remaining substantive staff (though dwindling due to duration of the EDRM project and subsequent delays); staff are tired and under pressure. Cancellation of non-clinical requests for case notes daily (e.g. audit) to minimise disruption to front line clinical need (though with clear consequent impact on other areas of service delivery). On going urgent recruitment to existing vacancies. A waiting list of suitable applicants is created to minimise the risk of the current staffing levels reoccurring in the future. Medical records management supporting HRSS by chasing references and other checks. Daily review of staffing levels and management of requests with concentration of staffing in areas of greatest demand and clinical priority.	Moderate	Almost certain	15	EDRm paediatric pause as of 18/7/16 - relaunch agreed April 2017 - awaiting time line for go live - 31 Dec 17 Review of staffing and activity levels and subsequent business case for increased staffing to RIC - 31 Dec 17	4	Debbie Waters	CMG Risk
2965	CSI	Pharmacy	If we do not address Windsor pharmacy storage demands, then we may compromise clinical care and breach statutory duties	23/12/2016	30/Apr/18	Harm (Patient/Non-patient)	Reduction/removal of non-pharmaceutical products to other areas. Transfer of non-pharmaceutical consumables to external storage containers. Additional fridges purchased to maximum capacity. Direct delivery of IV fluids to ward areas where possible. Regular pest control visits with reports monitored.	Moderate	Almost certain	15	Extension to pharmacy stores, capital project - 30 Jun 18	6	Claire Elwood	CMG Risk
2601	W&C	Gynaecology	There is a risk of delay in gynaecology patient correspondence due to a backlog in typing	24/08/2015	06/Dec/17	Harm (Patient/Non-patient)	2 week wait clinics or any letters highlighted on Windscribe in red are typed as urgent. Weekly admin management meeting standing agenda item: typing backlog by site also by Colposcopy and general gynaecology. Using Bank & Agency Staff. Protected typing for a limited number of staff.	Moderate	Almost certain	15	Clearance of backlog of letters - due 06/12/2017	6	Donna Marshall	CMG Risk
3023	W&C	Maternity	There is a risk that the split site Maternity configuration leads to impaired quality of Maternity services at the LGH site	18/05/2017	31/Dec/17	Harm (Patient/Non-patient)	Consultant Obstetrician presence until 20.00 Delay of elective LSCS if emergency LSCS are required Use of second theatre if emergency LSCS required while El LSCS in progress Post natal pathway of care for elective LSCS cases for staff to follow Delivery Suite Consultant & SpR can be contacted for any emergencies Consultants undertaking additional sessions to cover rota gaps (unpaid) and visit wards prior to clinics etc Locum Consultants are employed to provide cover if no other alternative Senior Specialist Trainee's only allocated to cover out of hours Formation of working party to implement recommended changes in working practices	Moderate	Almost certain	15	Formulation of Business case for extra Obstetric Consultant Due 31/12/2017 Implementation of Trust reconfiguration strategy: LGH to LRI site Due 31/12/2017 Review into expanding elective capacity at LRI Due 31/12/2017 Review of provision of maternity services (efficiency and different ways of working) Due 31/12/2017 Formulation of Business case for extra Gynaecology Consultant due 31/12/2017	6	Ms Cornelia Wiesender	CMG Risk
3083	W&C	Neonatology	If gaps on the Junior Doctor rota are not filled then there may not ne enough junior doctors to staff the Neonatal Units at LRI	04/Sep/17	31/12/2017	Harm (Patient/Non-patient)	Range of options to recruit middle grade staff from UK and overseas being urgently pursued Flexible use of ANNP workforce Additional clinical fellow posts approved and currently in recruitment process Explore options of acquiring high cost agency locums from their agency Implementation of the escalation Standard Operating Procedure for addressing neonatal rota gaps (appended).	Moderate	Almost certain	15	To continue to try and recruit to unfilled gaps - Due 31/12/2017 To provide the service on a single site would dramatically reduce the number of Drs required to maintain the service - Due 31/12/2022	3	Jonathan Cusack	CMG Risk

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3084	W&C Neonatology	If there continues to be insufficient Neonatal Consultant cover to run 2 clinical sites, then it could impact on service provision resulting in potential for suboptimal care to the babies on the units at LRI & LGH.	30/Dec/17 06/Sep/17	Harm (Patient/Non-patient)	"A business case to incrementally recruit to a 6 person resident consultant rota has been produced. There is current resident consultant cover 1/3 of the time at LRI. "There is 24 hour registrar cover at LGH with 2.5 gaps in tier 2 rota from August 2017. "Obstetrician and midwives on delivery suite trained in neonatal resuscitation "Criteria developed for in-utero transfer of babies considered at high risk of neonatal complications for delivery at LRI "Activation of escalation SOP for Neonatal Staffing (appended) when necessary, ultimately leading to transfer of new obstetric admissions to the LRI site until adequate staffing restored. "Community midwives to advise women with pre term labour (less than 32 weeks gestation) to attend the LRI	Possible Extreme	15	To have a single site service - Due 31/12/2022 Explore options for clinical fellows and non training grade doctors - Due 28/02/2018 Continue to electively move all high risk obstetric work to LRI site to decrease the risk of simultaneous emergencies - Due 31/12/2017	5	Jonathan Cusack	CMG Risk
2394	Communications 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.	31/Dec/17 04/Jul/14	Harm (Patient/Non-patient)	IM&T hardware support; IM&T Integration & Development team best endeavours to support the application software; separate backup of images on Apple server in Medical Illustration. Project brief published Nov 2014 for new database. IM&T Functional Spec complete Dec 2015. Tender prepared Feb 2016. Supplier demos held Nov 2016. Supplier chosen Dec 2016. Funding agreed by RIC August 2017.	Almost certain Moderate	15	Waiting for project engagement from GE Healthcare Nov 2017. IM&T to commit resource to deliver project - Review 31 Dec 17	3	Simon Andrews	Corporate Risk
3079	Corporate Medical	If the insufficient capacity with Medical Examiners is not addressed then this may lead to a delay with screening all deaths and undertaking Structured Judgement Reviews resulting in failure to learn from deaths in a timely manner and non-compliance with the internal QC and external NHS England duties	31/12/2017 16/08/2017	Reputation	Preventive: Currently we have the equivalent of 13 PAs a week of ME time. Whilst there are delays in the screening process, they have been managing to screen the majority of cases (93% for Quarter 1) but this is during the quietest time of year from a mortality point of view. We have 1 WTE ME Assistant and 0.8 WTE M&M Assistant supported by 1 WTE M&M Clerk to support both the ME process and SJR Process (corporately). We have a Lead Bereavement Support Nurse in post (continued from CQUIN scheme) and supported by a Bank Nurse (with Chaplaincy experience). Bank staff (Medical Students) currently supporting M&M Admin team with maintaining the ME Process but further backlog with collating outcomes of SJRs and details of Death Classifications. Detective: The UHL Mortality database includes details of all in-hospital, ED and community deaths (brought to UHL's mortuary) and where deaths are screened by the ME, this information is inputted into the database by either the ME Assistant or M&M Admin Team. The Database is also used to input information about SJR completion and outcome. Reports on both of the above are submitted to the UHL Mortality Review Committee on a monthly basis.	Almost certain Moderate	15	Recruit additional MEs - Advert for additional MEs sent out in September. Expressions of Interest received from 6 Consultants and Induction Session being held 15th November. Expectation is that 2 new MEs to start in post from end of December - Review Dec 2017. Recruit ME/M&M Admin Support - Replacement ME Assistant recruited and due to commence in post 20/11/17 - Review Dec 2017. Bereavement Services Database modification to include ME and Bereavement Support Nurse data - Discussions held with IM&T Senior Architect and scoping work being undertaken to inform Minor Enhancement Request submission - Review Dec 2017.	6	Rebecca Broughton	Corporate Risk

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760	Facilities	Estates & Facilities	If the integrity of compartmentation is compromised then during a real event the rate of fire and/or smoke spread will accelerate resulting in a greater impact to the building occupiers. The ability to utilise horizontal and/or vertical evacuation will be limited and the potential exists for a greater loss of areas / beds until the fire and resultant damage is contained.	30/11/2017	31/03/2018	Harm (Patient/Non-patient)	Fire Plans to be generated / amended as required to reflect the above position and to act as a baseline. Fire Risk assessment programme continues to identify potential compartmentation breaches across the 3 sites Fire Door Maintenance across the 3 sites. Fire Door replacement schemes as part of Capital Backlog Fire Stopping protocol / specification to be developed. Fire risk assessment monitored on a regular basis. Early warning fire detection and alarm systems. Staff statutory fire safety training. Fire Advisors and Capital Teams aware of issues.	Extreme	Possible	15	Current Status: - Repair/Replacement work partially completed, remainder due to for completion by Dec 17 Fire door seals repaired/replaced in ward areas as identified in the Fire Risk Assessments - 30 Mar 18	2	Mr Michael Blair	Corporate Risk