# INTEGRATED RISK AND ASSURANCE REPORT AS AT 30TH SEPT 2017

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

# Executive Summary

## Context

The purpose of this paper 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 significant updates from the mid-year review of the BAF?
2. What are the top rated (highest scoring) principal risks on the BAF?
3. What new items 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. Following the mid-year review of how the BAF is administered, the dashboard now includes the principal risks to delivering the strategic objectives and the use of a risk rating methodology to grade the risks. Other changes include an updated 'tracker' rating to show whether the related annual priority is on-track or off-track/at risk of non-delivery (for month-end and year-end).
2. The highest rated BAF risks relate to workforce capacity and capability, management of finances, and variation between capacity and demand.
3. Five 'high' risks have been entered by CMGs on the organisational risk register including three risks scoring 16 and two rated as 15. Further details are included in the risk register dashboard at appendix two of the paper.
4. Thematic analysis of the CMGs risk registers shows the common risk causation themes as workforce shortages and imbalance between demand and capacity. Analysis in relation to the typical impacts, should the risks occur, displays the main consequence as potential for harm to patients, staff or others.

## 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 items 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 TB meeting]

6. Executive Summaries should not exceed **1 page**. [My paper does comply]

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

**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST**

**REPORT TO:** **UHL TRUST BOARD**

**DATE:** **2ND NOVEMBER 2017**

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

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

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## 1 INTRODUCTION

1.1 This integrated risk and assurance report will assist the Trust Board (TB) to discharge its 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 September 2017. Executive owners have updated the BAF to take account of progress with delivering against the annual priorities for 2017/18, with the Executive Boards having corporate oversight to scrutinise and endorse the final version, which is included at appendix one.

2.2 A mid-year review about how the BAF is administered has been performed, which included advice from Audit Committee, TB and our internal auditors. This review identified areas of the framework that could be strengthened, including a description of the principal risks that could prevent delivering the strategic objectives and the use of a risk rating methodology to grade the risks. Details of the principal risks are included in the BAF dashboard at appendix one and the highest rated risks relate to workforce capacity and capability, management of finances, and variation between capacity and demand.

2.3 Other changes to the framework, agreed at the TB Thinking day in Sept, include the use of 'tracker' rating to show whether the related annual priority is on-track or off-track/at risk of non-delivery. Following the change to the tracker rating methodology in September, all annual priorities have been assessed by their SROs, and approved by the Executive Team, as being on track for delivery in 2017/18, with the exception of annual priority 1.4.1 - we will manage our demand and capacity – and the TB should note the deteriorating position for this BAF entry. Copies of the current tracker scores are included in the BAF dashboard at appendix one.

## 3. UHL RISK REGISTER SUMMARY

3.1 For the reporting period ending 30th September 2017, there were 56 organisational risks open on the risk register scoring 15 and above. These risks are described in appendix two.

3.2 During the reporting period, five 'high' risks have been entered on the risk register and are identified in the risk register dashboard at appendix two.

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

## 4 RECOMMENDATIONS

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

Appendix 1 UHL BAF as at 30th September 2017

| UHL Board Assurance Dashboard: 2017/18 | | | | | | SEPT 2017 - FINAL | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 | New Sept 2017 | 1.1 | **Clinical Effectiveness - To reduce avoidable deaths:** | | | | | | | |
| | | | | | | 1.1.1 | We will focus interventions in conditions with a higher than expected mortality rate in order to reduce our SHMI | 2 | ↔ | 2 | MD | J Jameson (R Broughton) | EQB | QOC |
| | | | | | | 1.2 | **Patient Safety - To reduce harm caused by unwarranted clinical variation:** | | | | | | | |
| | | | | | | 1.2.1 | We will further roll-out track and trigger tools (e.g. sepsis care), in order to improve our vigilance and management of deteriorating patients | 2 | ↔ | 2 | CN/MD | J Jameson (H Harrison) | EQB | QOC |
| | | | | | | 1.2.2 a | We will introduce safer use of high risk drugs **(e.g. insulin)** in order to protect our patients from harm | 2 | ↔ | 2 | MD/CN | E Meldrum / C Free | EQB | QOC |
| | | | | | | 1.2.2 b | We will introduce safer use of high risk drugs **(e.g. warfarin)** in order to protect our patients from harm | 2 | ↔ | 2 | MD/CN | C Marshall | EQB | QOC |
| | | | | | | 1.2.3 | We will implement processes to improve diagnostics results management in order to ensure that results are promptly acted upon | 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 | ↔ | 2 | DCIE / COO | J Edyvean / D Mitchell | EQB | FIC |
| | 2 | If the Trust is unable to manage the level of emergency and elective demand, caused by an inability to provide safe staffing and fundamental process issues, then it may result in sustained failure to achieve constitutional standards in relation to ED; significantly reduced patient flow throughout the hospital; disruption to multiple services across CMGs; reduced quality of care for large numbers of patients; unmanageable staff workloads; and increased costs. | 5 x 4 = 20 | 5 x 3 = 15 | New Sept 2017 | 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<br>We will use our bed capacity efficiently and effectively (including Red2Green, SAFER, expanding bed capacity)<br>We will implement new step down capacity and a new front door frailty pathway<br>We will use our theatres efficiently and effectively | 1 | ↓ | 1 | COO | S Barton | EPB | FIC |
| **OUR PEOPLE:** Right people with the right skills in the right numbers | 3 | If the Trust is unable to achieve and maintain staffing levels that meet service requirements, caused by an inability to recruit, retain and utilise a workforce with the necessary skills and experience, then it may result in extended unplanned service closures and disruption to services across CMGs. | 4 x 5 = 20 | 4 x 3 = 12 | New Sept 2017 | 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 3 = 12 | 4 x 2 = 8 | New Sept 2017 | 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 | New Sept 2017 | 4.1 | We will integrate the new model of care for frail older people with partners in other parts of health and social care in order to create an end to end pathway for frailty | 2 | ↔ | 2 | DCIE | J Currington | ESB | TB |
| | | | | | | 4.2 | We will increase the support, education and specialist advice we offer to partners to help manage more patients in the community (integrated teams) in order to prevent unwarranted demand on our hospitals | 2 | ↔ | 2 | DCIE | J Currington | ESB | TB |
| | | | | | | 4.3 | We will form new relationships with primary care in order to enhance our joint working and improve its sustainability | 2 | ↔ | 2 | DCIE | J Currington ( U Montgomery) | ESB | TB |
| 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 | New Sept 2017 | 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 | New Sept 2017 | 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 | New Sept 2017 | 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 | New Sept 2017 | 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 | New Sept 2017 | 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 | New Sept 2017 | 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…** | Sep-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.<br>**Trust QC Aim: SHMI < 99.** | | | | | | | | | | | |
| **Objective Owner:** | MD | | **SRO:** | J Jameson | | **Executive Board:** | | EQB | | **TB Sub Committee** | | QAC |
| **Annual Priority Tracker - Current position @** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 4 | 4 | 4 | 4 | 4 | 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 | | | | | | |

| Controls assurance (planning) | Performance assurance (measuring) |
|---|---|
| Governance: Mortality Review Committee, chaired by Medical Director. | Published Summary Hospital-level Mortality Indictor (SHMI) - </= 99 - Latest published SHMI - 101 (period Apr 16 to March 17) within expected range.<br>*If the national measure for calculating data of hospital mortality, for 'in-house deaths' and 'deaths occurring within 30 days of discharge from hospital', is reduced due to improvements made by other English Acute Trusts, then in-hospital improvement work may not reflect the national adjusted SHMI target (3057).* |
| Medical Examiner Mortality Screening of In-hospital Deaths. | % of deaths screened - target is 95% of all adult inpatient deaths. 96% of Adult Deaths were screened by the MEs in Q1 (includes Community and ED deaths)<br>88% of July's deaths and 80% of August's deaths have been screened to date. |
| Case Note Reviews using National Structured Judgement Review Tool (SJR) and thematic analysis. | % deaths referred for structured judgement reviews (SJR) have death classification within 3 months - target is 75% of SJR cases have death classification within 4/12 and all within 6/12 of death. Process commenced 01/04/17.<br>112 adult cases referred for SJR in Q1 (April = 44; May = 34; June = 36). April's deaths should have been classified by end of August To date, 28 of the 44 (68%) have been classified.<br>(GAP) Capacity constraints of both MEs and Admin Team leading to build up of July and August's cases to be screened and SJRs to be followed up. Bereavement Support Service 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 June 16 - May 17) is 99. |
| 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):<br>April 2017 = Dr Foster CUSUM alert received (Coronary arterosclerosis disease) and actions on track response submitted to CQC on 26th July.<br>July 17 - New Dr Foster CUSUM alert received for Coronary Artery Bypass Graft 'Other' received. Response and action plan submitted to CQC on 29th September. |
| (GAP) ME / M&M administration support. | |

| | |
|---|---|
| | |

| 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). | Dec-17 | RB |
| | | |

| **Corporate Oversight (TB / Sub Committees)** | | | |
|---|---|---|---|
| Source:- | Title: | Date: | Assurance Feedback: |
| TB sub Committee | Audit Committee | | |
| TB sub Committee | QAC | Sep-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…** | Sep-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.<br>**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** | | QAC |
| **Annual Priority Tracker - Current position @** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 3 | 3 | 3 | 3 | 3 | 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 | | | | | | |

| Controls assurance (planning) | Performance assurance (measuring) |
|---|---|
| Governance: Deteriorating Adult Patient Board - last meeting held 22nd August. | Audit EWS & Sepsis in all adult & paediatric wards in scope; day case, labour ward, CCU and ITU out of scope daily. |
| Electronic handover supported by NerveCentre. | |
| Sepsis and AKI awareness and training mandatory for clinical staff. | Review audit results of EWS & Sepsis fortnightly. |
| Team based training packages for recognition of a deteriorating patient. | Review of Datix reported incidents related to the recognition of the deteriorating patient quarterly - last report to DAPB July 2017. |
| 7 days a week critical care outreach service - launched May 2017. | |
| Harm review of patients with red flag sepsis who did not receive Antibiotics within 3 hours - reviewed fortnightly by the EWS & Sepsis Review Group. | **Outcome KPIs:**<br>ED KPI 90% of patients with red flag sepsis receive IV antibiotics within 1 hour.<br>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:**<br>Q1 position: N/A<br>Q2 position:<br>• Clinical Rules for sepsis (NerveCentre) fully implemented<br>• Alerts for sepsis (NerveCentre) fully implemented<br>• Trust wide implementation of e-Obs (NerveCentre)<br>• Fully automated EWS reporting (NerveCentre)<br>Q3position:<br>• Assessments for sepsis (NerveCentre) fully implemented<br>• Fully automated Sepsis reporting (NerveCentre)<br>Q4 position: N/A |
| EWS & Sepsis audit results reported to CQC monthly. | |
| Sepsis screening tool and care pathway - updated & relaunched July 2017 | |
| Review of admissions to ITU with red flag sepsis at all 3 sites monthly. | |
| Monitoring of SUIs related to the deteriorating patient. | |
| | |
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| | |
| | |
| | |
| | |

| Actions planned to address gaps identified in sections above | Due Date | Owner |
|---|---|---|
| Content for e-learning module under development. | 31/12/2017 | HH |
| Implementation of an electronic system. | | |

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

| | | | |
|---|---|---|---|
| TB sub Committee | Audit Committee | | |
| TB sub Committee | QAC | Jun-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 | Follow up from CQC inspection (June 2016) | Q2 17/18 | Will validate and assess how the Trust is addressing the findings, in relation to the quality commitment, from the inspection in 2016. |
| External Audit | work plan TBA | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: As of…** | Sep-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** and 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 Insulin:** | | E Meldrum / C Free | | **Executive Board:** | | EQB | | **TB Sub Committee** | | QAC |
| **Annual Priority Tracker - Current position @** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 3 | 3 | 2 | 2 | 2 | 2 | | | | | | |
| **Annual Priority Tracker Year end Forecast @** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 4 | 4 | 3 | 2 | 3 | 2 | | | | | | |

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

| Actions planned to address gaps identified in sections above | Due Date | Owner |
|---|---|---|
| This project has an agreed action plan, to implement fit for purpose electronic systems, monitored through Quality Commitment oversight group. | | EM |

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

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|---|---|---|---|
| TB sub Committee | QAC | Jul-17 | In light of current challenges around the delays in implementing the controls assurance for Insulin Safety, including the reporting issues linked e-learning on HELM, we will be implementing a Trust wide theoretical assessment for registered nurses and HCAs to assess knowledge around insulin safety and blood glucose monitoring. This will be led by the Advanced Practitioner for Diabetes and Nurse Education Leads w/c 8th August commencing in CHUGGs LRI and RRCV. this process will be similar to the one used to test knowledge of staff in the care of the deteriorating patient. The assessments will provide assurance around staff ability to manage patients with Type 2 Diabetes but additional education and training will be given post assessment to ensure that there is a consistent level of knowledge across all inpatient wards. |

| **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 | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: As of…** | Sep-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. insulin and **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** | | QAC |
| **Annual Priority Tracker - Current position @** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 3 | 3 | 3 | 3 | 3 | 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 | | | | | | |

| 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:<br>- Number of missed doses of warfarin.<br>- Number of INRs>6.<br>- 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. | Oct-17 | CM |
| Project management support for the project needs to be identified to help support the clinicians who are delivering the actions. | | CM |
| This project has an agreed action plan, to implement fit for purpose electronic systems, monitored through Quality Commitment oversight group. | | CM |

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

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|---|---|---|---|
| TB sub Committee | QOC | Oct-17 | WARFARIN: Delay due to contract negotiations with City Clinical Commissioning Group around start dates for the new anticoagulation service which has been delayed from an original start date of April 2017 to October 2017. This delay affects the ability to deliver the proposed in-reach service which is a key element in the implementation of quality improvements in anticoagulation. Project management support for the project needs to be identified to help support the clinicians who are delivering the actions.<br>August 17 : support from MD to develop 'non compulsory' e-learning package for anticoagulation. Agreement reached with ED & Haematology to ensure Octaplex is available in ED, currently with pharmacy colleagues to finalise paperwork needed. UHL Anticoagulation policy now finalised, all CCGs using the same policy. Anticoagulation discharge template in place, on ICE. |

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

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: As of…** | Sep-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** | | QAC |
| **Annual Priority Tracker - Current position @** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 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 | 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. | (GAP) (GAP) Development of metrics for monitoring performance against target. % of results acknowledged - target is 85% of results acknowledged by Q4 2017/18. |
| UHL diagnostic testing policy | |
| Acting on results detailed action plan monitored via EQB. This covers: developing a fit for purpose electronic system to acknowledge results; in depth work with each specialty to develop standard operating procedures; review of radiology and MDT processes; human factors review of our results reporting service; reviw of how urgent resutls are escalated with a view to putting them on NerveCentre; increasing patient involvement; and improved training in how to use ICE for results acknowledgment. | |
| (GAP) Conserus (alert email to clinician for unexpected imaging results) pilot in CDU (highest risk area) prior to Trust roll-out - slipped to mid-October 2017. | |
| | |

| Actions planned to address gaps identified in sections above | Due Date | Owner |
|---|---|---|
| It is expected that IT resource for this project will be made available in Oct. Piloting of Conserus has also been delayed due to technical difficulties. | Oct-17 | CM |
| The current gap in assurance is around knowing what percentage of results are viewed and acted upon. The project action plan has the agreed actions required to rectify the gaps in control and assurance. | | |

**Corporate Oversight (TB / Sub Committees)**

| Source:- | Title: | Date: | Assurance Feedback: |
|---|---|---|---|
| TB sub Committee | Audit Committee | | |
| TB sub Committee | QOC | Oct-17 | Roll out of Conserus radiology solution for reporting unexpected findings to clinicians has been delayed until mid-October due to technical issues. An electronic solution using Mobile ICE is due to be piloted pending allocation of IT resource to project. This will be rolled out trust-wide if successful. Development of reporting metrics is happening in tandem. |

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

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: As of…** | Sep-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.<br>**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** | | QAC |
| **Annual Priority Tracker - Current position @** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 3 | 3 | 3 | 3 | 3 | 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 | | | | | | |

| Controls assurance (planning) | Performance assurance (measuring) |
|---|---|
| Governance: Palliative & End of Life Care Committee meets bi-monthly. | **Quality Commitment KPIs**: (GAP) Patients in the last days of life will have an individual care plan in place as per the "One Chance to Get it Right" Guidance (2014): Care plan implemented in 75% of wards in new CMG and care plan sustained in 75% of CMG wards already implemented on. |
| Detailed project plan presented at the Palliative & End of Life Care Committee. | |
| End of life care plans which include specialist palliative care end of life care service. | |
| End of Life Care Facilitators rolling out implementation of taining and support in the use of End of Life care plans (reflected in the detailed project plan). | Review of Datix reported incidents related to the syringe drivers - last report to P&EoLCC July 2017. |
| "Guidance for care of patients in the last days of life" & "Individualised End of Life Care Plan" reviewed by the Palliateive & End of Life Care Committee - awaiting P&GC approval. | EoLC audits quarterly. |
| | |
| | |
| (GAP) Implementation of an electronic system. | |
| | |

| Actions planned to address gaps identified in sections above | Due Date | Owner |
|---|---|---|
| Audit of Individualised End of Life Care Plans to commence September 2017. | 30/11/17 | HH |
| Implementation of an electronic system (NerveCentre) (risk id 3058) . | | HH |

**Corporate Oversight (TB / Sub Committees)**

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

**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 | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: Version** | Sep-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.<br>Trust QC Aim: outpatients tba | | | | | | | | | | | |
| **Objective owner:** | DCIE | | **SRO:** | J Edyvean / D Mitchell | | **Executive Board:** | | EQB | | **TB Sub Committee** | | IFPIC |
| **Annual Priority Tracker - Current position @** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 3 | 3 | 3 | 3 | 3 | 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 | | | | | | |

| Controls assurance (planning) | Performance assurance (measuring) |
|---|---|
| Governance: Outpatient Performance Board & Executive Quality Board. | Patients waiting in excess of 12 months for a follow up (KPI trajectory: Q1-379 currently amber rating of 3;Q2-321; Q3-189; Q4 - 0 Year end position on track). |
| (GAP) Generate additional capacity and book patients in time order. | |
| Long term follow up report which allows us to track performance. | Outpatients Friends and Family Test - Red if <93%. |
| Agreed action plan in place and monitored through the Outpatient Quality report and this is monitored at CPM and in contracting meetings. | Clinical audit of additional schemes related to changes in the new to follow up ratio - Completed as planned. |
| (GAP) 50% of remaining outpatients opportunity to be added to the PMTT. | (GAP) Q2 Finalise and Agree KPI's and programme plan, Q3 Initiate delivery, Q4 speciality delivery (TBC). |
| (GAP) Out patient transformation project initiated (Objectives and KPI's TBC). | |
| | (GAP) Delivery of CMG plans for ENT and Cardiology dependent on resources being released at speciality level to deliver changes. |
| | |
| | |

| Actions planned to address gaps identified in sections above | Due Date | Owner |
|---|---|---|
| Present action plan and KPI's to EPB at the end of October and Trust Board early November 2017. | | JE |
| Implementation of fit for purpose electronic systems, developed and implemented to monitor and ensure outpatient diagnostic results are promptly acted upon. | | JE |

**Corporate Oversight (TB / Sub Committees)**

| Source:- | Title: | Date: | Assurance Feedback: |
|---|---|---|---|
| TB sub Committee | QAC | Aug-17 | Year end position deliverable with moderate risk associated. The scale of cultural change across the organisation and the associated behavioural changes to sustain transformation is a significant challenge for the organisation is achieving the required outcomes |

**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** | Sep-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):<br>We will utilise our new Emergency Department efficiently and effectively.<br>We will use our bed capacity efficiently and effectively (including Red2Green, SAFER, expanding bed capacity).<br>We will implement new step down capacity and a new front door frailty pathway.<br>We will use our theatres efficiently and effectively. | | | | | | | | | | | |
| **Objective owner:** | COO | | **SRO:** | S Barton | | **Executive Board:** | | EPB | | **TB Sub Committee** | | FIC / QOC |
| **Annual Priority Tracker - Current position @** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 3 | 3 | 3 | 3 | 2 | 1 | | | | | | |
| **Annual Priority Tracker Year end Forecast @** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 4 | 4 | 4 | 3 | 2 | 1 | | | | | | |

| Controls assurance (planning) | Performance assurance (measuring) |
|---|---|
| Submission of demand and capacity plan to NHSI – We are forecasting an overall peak bed shortfall of 105 beds. The major shortfalls are in medicine at the LRI and Glenfield. | ED 4 hour wait performance trajectory submitted to NHSI - Performance currently below national benchmark. |
| | Ambulance handover (delays over 60 mins) submitted to NHSI. |
| New ED building open to public from 26th April 2017. | RTT Incomplete waiting times trajectory submitted to NHSI. |
| Demand and Capacity Governance structure progressed. | 2WW for urgent GP referral as per the NHSI submitted trajectories. |
| Programme Director appointed. | 31 day wait for 1st treatment as per submitted NHSI trajectories. |
| Theatre trading model in place along with ACPL targets. | 62 day wait for 1st treatment as per submitted NHSI trajectories. |
| Ward 7 moves to Ward 21 and becomes a medical ward in the recurrent baseline (+28 beds) | 105 bed gap mitigated. |
| | Reduced cancelled operations due to no available bed. |
| (GAP) Staffing of additional 8 beds on the medicine emergency pathway at LRI on Ward 7 to meet continued demand in medicine. | Occupancy of 92% (as of June 2017). |
| | ACPL target achieved. |
| Plan for elective service changes at LGH involving MSS & CHUGGs. | The demand and capacity plan is not currently balanced for the year. |
| Re-launch of Red 2 Green & SAFER within Medicine at LRI. | |
| Launch of Red 2 Green & SAFER at Glenfield. | |
| A staffing plan from Paediatrics for Winter 17/18. | |
| Care model and a detailed plan for stepdown facility. | |
| Feasibility work commenced into physical capacity solutions for both LRI & GH. Decision on option for physical expansion at GH. | |
| | |
| (GAP) Out of hospital step-down solution at LRI for Winter 17/18. | |
| | |

| Actions planned to address gaps identified in sections above | Due Date | Owner |
|---|---|---|
| Daily Improvement meeting chaired by the Chief Executive with ED colleagues working with clinical teams in the component parts of the UEC system | | |
| Implementation of a new model of care for Acute medicine at LRI | | |
| Implementation of a new model of command and infrastruture across the Trust | | |
| Population of additional evening and overnight senior medical shifts in ED | | |
| Opening of 14 extra beds at GH from 5/12 | | |
| | | |

| Strategic Risk assurance (assessment) | Movement |
|---|---|
| If the additional physical bed capacity cannot be opened, caused by an inability to provide safe staffing, then it will lead to a continued demand and capacity imbalance at the LRI 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.<br>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 | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: As of…** | Sep-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** | | IFPIC |
| **Annual Priority Tracker - Current position @** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 4 | 4 | 4 | 4 | 4 | 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 | | | | | | |

| Controls assurance (planning) | Performance assurance (measuring) |
|---|---|
| Workforce plan relating to reduction in dependency on non contracted workforce, safe staffing, review of urgent and emergency care, impact of seven day services, shift of activity into community settings and increased specialised services where appropriate. | Apprenticeship levy - 430 predicted in 17/18 against 334 target. Currently falling short of TNA for range of reasons including lack of sign off of trailblazer programmes. |
| | BME Leadership - target 28% |
| People strategy and programme of work to address the leadership priorities, wellbeing of our workforce and ensure we focus on addressing actions to improve the diversity of our workforce - UHL Leadership programme. | Workforce sickness - target 3% - reporting for Estates and Facilities not adequate and when introduced will affect sickness levels. |
| | Safe Staffing targets: in accordance with Nursing requirements |
| Governance structure in place comprising internal and external groups, including Workforce OD Board and the Local Workforce Action Board and subgroups thereof who oversee delivery of the workforce and organisational development components of the Sustainable Transformation Plan. | Seven day services stats: |
| | Shift of activity in to community: |
| Apprenticeship workforce strategy. | (GAP 6) Reduction in dependency of our non-contracted workforce - forecast to achieve NHSI target of £20.6 m but run rate suggests a gap of 1.5m at end of year 17/18. £770K medical agency expenditure reduction. |
| NHS WRES Technical Guidance refreshed - includes changes made to NHS Standard Contract (2017/18 to 2018/19) and definitions of terminology used in WRES indicators, and how affects organisations subject to WRES. | (GAP 7) Vacancy rates -target below 10% (equivalent to turnover to be proposed and agreed). |
| (GAP 1) STP refresh in progress – to provide a more accurate workforce prediction based on current capacity requirements - (revised deadline to be confirmed but likely to relate to revised consultation deadlines) - UHL revised their component following demand and capacity review - planning underway across Health Community. | |
| (GAP 2) insufficent resource to support system wide workforce planning and modelling approach - business case submitted to CSU. In place in some parts (Cardio Respiratory model of care) - complete - all other workstreams to develop a workforce plan. | |

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

| Actions planned to address gaps identified in controls and assurances sections above | Due Date | Owner |
|---|---|---|
| GAPS 1 and 3- Whole systems approach to STP workforce plan underway with greater engagement from clinical workstreams to understand the impact | Mar-18 | LG |
| GAP 2 - Bid submitted to STP Programme Office for additional resource, in interim use of external partner to enable high level planning to be undertaken | Mar-18 | LG |
| GAP 4 - Urgent and Emergency Care Workstream utilising Whole Systems Partnership to predict activity and impact on capacity | Dec-17 | Urgent Care w-stream |
| 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 | IFPIC | Jun-17 | The gaps in supply of future workforce cannot be readily met therefore a revised Workforce Plan is being developed which will have a greater emphasis on new teams around the patient. |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: As of…** | Sep-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** | | IFPIC |
| **Annual Priority Tracker - Current position @** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 4 | 4 | 4 | 4 | 4 | 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 | | | | | | |

| 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 £1.3m 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 being confirmed. | 31.10.17 | LT/JTF |

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

| | | | |
|---|---|---|---|
| TB sub Committee | Audit Committee | | |
| TB sub Committee | IFPIC | Aug-17 | The agency ceiling target is £20.6m . At the current run rate agency spend will exceed the annual ceiling by £1.54m 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.<br>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 | | |

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

| Controls assurance (planning) | Performance assurance (measuring) |
|---|---|
| Vision and programme plan in place (transforming HR Function) - HR Fit for the future programme roadmap. | Staff engagement staff survey score. |
| Maximising use of Technology (enabling processes). | (GAP) HR KPIs aligned to HR Roadmap (to be developed):<br>Processes -<br>Structure -<br>People & Culture -<br>Technology - |
| Listening Events held in July 2017 to work with stakeholders and customers to deliver service differently and to gain ownership. | (GAP) Reporting completion of statutory and mandatory training and essential to job training. |
| (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 will be informed by feedback from listening events in July. | |
| (GAP) Full implementation of new Health Education Learning Management System - Additional implementation funds agreed by CMIC in September 2017. | |
| | |

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

**Corporate Oversight (TB / Sub Committees)**

| Source:- | Title: | Date: | Assurance Feedback: |
|---|---|---|---|
| TB sub Committee | Audit Committee | | |
| TB sub Committee | PPP Committee | Sep-17 | Recovery action underway - HELM Reporting Functionality will be live by the 30 October 2017. |

**Independent (Internal / External Auditors)**

| Source:- | Title: | Date: | Feedback: |
|---|---|---|---|

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|---|---|---|---|
| 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 | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: As of…** | Sep-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 | | | | | | |
| **Annual Priority Tracker Year end Forecast @** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 4 | 4 | 4 | 4 | 4 | 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. |
| 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. | |
| (GAP) CMG ownership of undergraduate education outcomes. | UHL UG education quality dashboard (satisfaction / experience) - to be launched in Sept 17 - Draft to be submitted to EWB in Oct - outcomes available in Oct 17. |
| (GAP) Overarching strategy with University of Leicester to integrate undergraduate and postgraduate training to improve outcomes and retention. | GMC National student survey (satisfaction / experience) - 2017 survey headlines show a decline in Overall Satisfaction for UoL. |
| MJPCC - either SC or DL to attend future meetings with details of individual's educational roles. This will be used to confirm and inform the job plan. | Currently <20% medical students complete the end of block feedback. The Medical School have agreed to address and improve this. We anticipate improvement by Dec 17. |
| UG representatives on the UHL Doctors in Training Committee. | |
| | (GAP) HEE Quality Management Process (satisfaction / experience)- new process still to be confirmed for 2017/18. |
| | |
| | Student Exit Survey - areas for improvement included in 17/18 QI plan. |
| | UKFPO shows that whilst 2017 figures for the % of LMS students who 'preferenced' LNR Foundation School has increased slightly to 25% (19 % in 2016), Leicester is still ranked 23rd out of 31 for 'Local Applications by Medical School'. |
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| 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 | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: As of…** | Sep-17 | | | | | | | | | | | |
| **Objective:** | High quality, relevant, education and research | | | | | | | | | | | |
| **BAF Risk** | If the Trust does not have the right resources in place and an appropriate infrastructure to run clinical education and research, then we may not maximise our education and research potential which may adversely affect our ability to drive clinical quality, attract and retain medical students and deliver of our research strategy. | | | | | | | | | | | |
| **Annual Priority 3.2** | We will address specialty-specific shortcomings in postgraduate medical education and trainee experience in order to make our services a more attractive proposition for postgraduates | | | | | | | | | | | |
| **Objective Owner:** | MD | | **SRO:** | S Carr | | **Executive Board:** | | EWB | | **TB Sub Committee** | | |
| **Annual Priority Tracker - Current position @** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 3 | 3 | 3 | 3 | 3 | 2 | | | | | | |
| **Annual Priority Tracker Year end Forecast @** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 4 | 4 | 4 | 4 | 4 | 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 (should see improvements if more attractive) - bi annual- next due in Sept 2017 - results available in Oct 17. |
| | 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. | 2017 GMC national training survey - outcomes show improvements for some specialties (Anaesthetics, Paediatric Surgery) but deterioration in others (ENT, Cardiology, Resp Medicine). Improvements shown in 'Reporting Systems and Study Leave' but deterioration for 'Clinical Supervision and Feedback'. Detailed finding have been circulated and CMG Education Leads to present QI action plans on 20/09 |
| GMC 'Approval and Recognition' of Clinical and Educational Supervisors - central database monitored and maintained. | |
| 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. | (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. |
| 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. | UHL Trainer Survey completed in conjunction with the Clinical Senate- issues with workload and time for training were highlighted. Outcomes to be discussed on Sept 15th at Clinical Senate meeting. |
| Attitudes and Behaviours to Improve Care' group has been established (chaired by Suzanne Khalid) - will support the GMC action on undermining in UHL. | |
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| Actions planned to address gaps identified in sections above | Due Date | Owner |
|---|---|---|

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|---|---|---|
| CMG Leads have been asked to submit their action plans in response to the GMC survey by the end of October 2017. | Nov-17 | CMG Leads |
| The UHL/UoL Strategic Group is developing the overarching strategy. | Mar-18 | Strategic Group |
| MJPCC- either SC or DL to attend future meetings with details of individual's educational roles. This will be used to confirm and inform the job plan. | | SC/DL |
| | | |

| 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 | 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 | 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…** | Sep-17 | | | | | | | | | | | |
| **Objective:** | High quality, relevant, education and research | | | | | | | | | | | |
| **BAF Risk** | If the Trust does not have the right resources in place and an appropriate infrastructure to run clinical education and research, then we may not maximise our education and research potential which may adversely affect our ability to drive clinical quality, attract and retain medical students and deliver of our research strategy (3065). | | | | | | | | | | | |
| **Annual Priority 3.3** | We will develop a new 5-Year Research Strategy with the University of Leicester in order to maximise the effectiveness of our research partnership | | | | | | | | | | | |
| **Objective Owner:** | MD | | **SRO:** | N Brunskill | | **Executive Board:** | | ESB | | **TB Sub Committee** | | |
| **Annual Priority Tracker - Current position @** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 4 | 4 | 4 | 4 | 4 | 2 | | | | | | |
| **Annual Priority Tracker Year end Forecast @** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 4 | 4 | 4 | 4 | 4 | 2 | | | | | | |

| 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. | |
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| | |

| 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. | Oct-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 | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: As of…** | Sep-17 | | | | | | | | | | | |
| **Objective:** | More integrated care in partnership with others | | | | | | | | | | | |
| **BAF Risk** | If the Trust does not work collaboratively with partners, then we may not be in a position to deliver safe, high quality care on a sustainable basis, patients might not be able to access the services that they require and we may not be in a position to meet our contractual obligations. | | | | | | | | | | | |
| **Annual Priority 4.1** | We will integrate the new model of care for frail older people with partners in other parts of health and social care in order to create an end to end pathway for frailty | | | | | | | | | | | |
| **Objective Owner:** | DCIE | **SRO:** | U Montgomery / J Currington | | | **Executive Board:** | | ESB | | **TB Sub Committee** | | |
| **Annual Priority Tracker - Current position @** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 3 | 3 | 3 | 3 | 3 | 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 | | | | | | |

| Controls assurance (planning) | Performance assurance (measuring) |
|---|---|
| UHL working group established and reporting to UHL Exec boards. | (GAP) Milestones and success criteria to monitor progress of bringing partners across LLR together to be defined in the Project Charter Documentation. |
| STP Governance arrangements (Work streams reporting to System Leadership Team and will report summary updates to individual organisational boards / governing bodies from Q2 2017/18 - subject to confirmation from the STP PMO). | (GAP) Performance data to be monitored at service level, once defined. |
| UHL clinical lead identified - Dr Ursula Montgomery. | Frailty Oversight Task and Finish Group meeting to bring together frailty streams across UHL. |
| CMG clinical lead identified - Dr Richard Wong. | |
| Strategic Development and Integration Manager appointed. | |
| UHL project plan - Better Change Project Charter, Benefits Realisation, Milestone Tracker and Stakeholder Analysis. | |
| System wide project plan / PID specific to frailty in place. | |
| System wide Tiger Team bringing clinicians together across LLR. Clinical Leadership Group and senior clinical leaders meet scheduled for 8th June 2017 to discuss draft report of the Tiger Team and agreeing next steps across the system. | |
| External senior representation on relevant STP Work stream Boards. | |
| STP Work stream Project Initiations Documents (which relate to frailty). | |
| (GAP) Identification and management of interdependencies between STP work streams given most touch on frailty - work in progress. | |
| (GAP) Commissioning and contracting model that supports deliver of frailty pathway. | |
| South Warwickshire visit to UHL planned to share their experience. | |
| Phase II and in-reach models are being added into the Delivery Plan along with capturing other frailty work underway - First draft plan due by 12th September. | |

| 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 | 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 | No involvement identified in 17/18 plan. | | |
| External Audit | No involvement identified in 17/18 plan. | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: As of…** | Sep-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 | | | | | | | | | | | |
| **Objective Owner:** | DCIE | **SRO:** | U Montgomery / J Currington | | | **Executive Board:** | | ESB | | **TB Sub Committee** | | |
| **Annual Priority Tracker - Current position @** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 3 | 3 | 3 | 3 | 3 | 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 | | | | | | |

| Controls assurance (planning) | Performance assurance (measuring) |
|---|---|
| UHL designated clinical lead and management lead report to UHL Exec boards. | Milestones and success criteria defined in the Project Initiations Document. |
| ESB approved high level scope in March 2017. | (GAP) Performance data will be monitored at service level, once defined - Awaiting Project Board. |
| STP Governance arrangements (Work streams reporting to System Leadership Team and will report summary updates to individual organisational boards / governing bodies from Q2 - subject to confirmation from the STP PMO). | |
| Primary Care Oversight Board. | |
| Project plan - Better Change Project Charter, Benefits Realisation, Milestone Tracker and Stakeholder Analysis. | |
| System wide Tiger Team bringing clinicians together across LLR. | |
| External Senior representation on relevant STP Work stream Boards, namely Integrated Teams Programme Board. | |
| Integrated Teams Programme Board approved a high level proposal / scoping document in April 2017. | |
| STP Work stream Project Initiations Documents although these are not specific to this project / objective but align in a number of ways. | |
| (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. | |
| Draft - high level - educational programme established within UHL, which will need to now extend to wider stakeholders. | |
| | |

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

| | | | | |
|---|---|---|---|---|
| Education strategy with an agreed programme of delivery to be completed - this will cover the systemised approach | | | Jan-18 | JC/UM/CH |
| Availability of funding is being tracked and managed by the PCOB | | | ongoing | MW |
| **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 | 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 | No involvement identified in 17/18 plan. | | | |
| External Audit | No involvement identified in 17/18 plan. | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: As of…** | Sep-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 4.3** | We will form new relationships with primary care in order to enhance our joint working and improve its sustainability | | | | | | | | | | | |
| **Objective Owner:** | DCIE | | **SRO:** | J Currington | | **Executive Board:** | | ESB | | **TB Sub Committee** | | |
| **Annual Priority Tracker - Current position @** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 3 | 3 | 3 | 3 | 3 | 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 | | | | | | |

| 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. |
| Managerial Lead identified (Head of Partnerships and Business Development). | |
| 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 completed - Expert group identified. | (GAP) A Baseline Mapping of existing integration initiatives which can be used as a measure the outputs of the project. |
| Primary Care Oversight Board (PCOB) in place. | GP Hotline core themes & volumes of activity report to be brought to November PCOB. |
| Tender opportunity search process are reported through ESB monthly. | |
| (GAP) A Stakeholder Communication/Engagement Plan. | Review to be carried out re. Consultant Connect impact on clinicians and PA's. |
| (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. | |
| Roll out of GP hotline to be signed off by the PCOB. | |
| PRISM - to be managed through the Planned Care Board, with updates to PCOB. | |
| (GAP) An SRO within UHL needs to be agreed for Consultant Connect. | |
| | |

| Actions planned to address gaps identified in sections above | Due Date | Owner |
|---|---|---|
| Tender response documents being collated, will be presented to November PCOB. | Nov-17 | JS |
| UHL offer or "Brochure" will be produced | Q4 | JS |
| Consultant Connect SRO - Paper being taken to EQB in Nov to agree which CMG should have ownership. | Nov-17 | MW / UM |
| Stakeholder Communciation/ Engagement plan in progress - to be agreed at Nov PCOB meeting. | Nov-17 | JC |
| Strategic Risk assurance (assessment) | | Movement |

| | |
|---|---|
| If appropriate project resources are not allocated (caused by uncertainty regarding resources) then we may not develop effective relationships with primary care providers (Risk ID 1888). | |
| | |

| 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 | 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 | No involvement identified in 17/18 plan. | | |
| External Audit | No involvement identified in 17/18 plan. | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: Version** | Sep-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** | | IFPIC |
| **Annual Priority Tracker - Current position @** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 3 | 3 | 3 | 3 | 3 | 2 | | | | | | |
| **Annual Priority Tracker Year end Forecast @** | **April** | **May** | **June** | **June** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 3 | 3 | 3 | 3 | 3 | 2 | | | | | | |

| Planning (controls) | Performance Management (assurance sources) |
|---|---|
| (GAP) Develop EMCHC full business case - subject to outcome of national review, final decision expected at the end of November 2017. If the outcome concludes that the EMCHC service is de-commissioned then this will impact our reconfiguration plans (risk ID 3072). | Performance against EMCHC project plan - is dependent on the outcome of the national consultation – scope for project is being finalised - on track. |
| (GAP) Deliver year 1 (of 3 year) Interim ICU project - external capital funding has been confirmed but receipt is subject to external approval of business cases. Confirmation now received that one OBC and one FBC to be completed within 2017/18 for the whole project of £30.8m. | Performance against updated Interim ICU project plan that delivers OBC by end Oct and FBC by end Jan 2018 - on track. |
| Deliver Emergency Floor Phase 2 (to complete in 2017/18). | Performance against Emergency Floor Phase 2 project plan - on track. |
| (GAP) Deliver Vascular Outpatients move to GH subject to outcome of scoping exercise and decision at ESB (to complete in 2017/18). | Performance against Vascular Outpatients project plan - is dependent on project scoping – outcome delayed owing to complexity of solution. |
| Full review of affordability of Reconfiguration Programme, including use of PF2 to reduce reliance on external funding from the Department of Health, and re-assess capital priorities in line with the Trust's Strategic Objectives and Annual Priorities. Submission of capital bid for external funding (to complete in 2017/18). | Performance against Reconfiguration Programme project plan - on track. |
| | |

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

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

| | | | |
|---|---|---|---|
| TB sub Committee | Audit Committee | | |
| TB sub Committee | IFPIC | | |

| **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** | Sep-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** | | IFPIC/QAC |
| **Annual Priority Tracker - Current position @** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 4 | 4 | 4 | 4 | **4** | **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** | | | | | | |

| 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 |
| (GAP) Implement NC bed management. | |
| (GAP) Create outpatient NC/ICE functionality | |
| IM&T Project Dashboard reported to EIM&T Board. | |
| IM&T Governance structure and specialty sub-groups in place. | |
| (GAP) IM&T Project Management Support. | |
| | |

| Actions planned to address gaps identified in sections above | Due Date | Owner |
|---|---|---|
| Implementation of NC Bed Management | Nov-17 | IM&T/UHL |
| Implemenation of NC forms and rules | TBC | IM&T/UHL |
| ICE in OP Pilot | Oct-17 | IM&T/UHL |
| Strengthen the Project Management Support for the above implementations | TBC | IM&T/UHL |
| EPR Plan - work is progressing in finalising the EPR KPIs. | TBC | IM&T/UHL |
| | | |

**Corporate Oversight (TB / Sub Committees)**

| Source:- | Title: | Date: | Assurance Feedback: |
|---|---|---|---|
| TB sub Committee | Audit Committee | | IM&T report provided on request. |
| TB sub Committee | IFPIC | | 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 | QAC | | 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 | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: Version** | Sep-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** | | IFPIC |
| **Annual Priority Tracker - Current position @** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 4 | 3 | 4 | 4 | 4 | 2 | | | | | | |
| **Annual Priority Tracker Year end Forecast @** | **April** | **May** | **June** | **July** | **August** | **August** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 4 | 4 | 4 | 4 | 4 | 2 | | | | | | |

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

| Actions planned to address gaps identified in sections above | Due Date | Owner |
|---|---|---|
| Pulse Check scores to be discussed at next UHL Way Steering Group and key actions agreed. | Oct-17 | BK / LT |
| LLR Way Action Plan agreed with LLR Clinical Leadership Group and progress will be reviewed in October 2017 | Oct-17 | BK |

| Corporate Oversight (TB / Sub Committees) | | | |
|---|---|---|---|
| Source:- | Title: | Date: | Assurance Feedback: |
| TB sub Committee | Audit Committee | | |
| TB sub Committee | PPP Committee | Sep-17 | Update to be provided to new People Process and Performance Committee - Forms part of new work programme. |
| TB sub Committee | IFPIC | Jul-17 | Improvements in key measures including the Quarterly Pulse Check and full engagement by Annual Priority Senior Responsible Officers in implementing priorities the UHL Way.<br>Progress with LLR Way to be shared at LLR Clinical Leadership Group Event (140 clinicians to attend this event from across the system) and agreement reached on 'LLR Way' implementation actions in the first year (2017/18). Key implementation activity to be agreed at LLR Board to Board Meeting in July 2017. |

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

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: As of…** | Sep-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** | | IFPIC |
| **Annual Priority Tracker - Current position @** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 3 | 3 | 3 | 3 | 3 | 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 | | | | | | |

| 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 October 2017. | |
| Project manager resource in place. | |
| (GAP) Service line strategy roadmaps outlining the direction of travel across the next 3 years alongside a thorough review of existing contracts (for goods and services both provided and bought in). | |
| | |

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

**Corporate Oversight (TB / Sub Committees)**

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

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

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

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF 17/18: As of…** | Sep-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 | | | | | | |
| **Annual Priority Tracker Year end Forecast @** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| | 3 | 3 | 3 | 3 | 3 | 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 M6, there remains an unidentified gap that is being worked through with CMGs in an escalation process where appropriate. |
| Quarterly quality assurance reporting. | |
| Monthly CMG/Corporate meetings to include detailed review of CIP delivery and forecast - escalating to weekly where CMGs/Corporate departments are materially varying from plan. | |
| | |
| | |
| (GAP) Deliver more activity through a more productive capacity through beds, theatres & outpatients – improve efficiency indicators; Reduce the price we pay for goods/services; Remove waste and eliminate unnecessary variation. | |
| | |
| | |
| | |
| **Financial Plans** | |
| CIP (including supplementary) to achieve 100% delivery in 2017/18. | CIP measurement and reporting monthly. |
| CMGs to achieve their control totals or better. | Monthly I&E submissions to NHSI, Trust Board, FIC and EPB. |
| Cost pressures and service developments to be minimised and managed through RIC and CEO chaired 'Star Chamber'. | Expenditure run rates for pay, non-pay, capital charges and agency spend. |
| | Contract income levels consistently being achieved and commissioner challenges resolved quarter by quarter. |
| A minimum of £18m of additional technical and other solutions to be transacted. | |
| Agree an appropriate level of investment supporting the resolution of the demand/capacity issue. | Year on year reduction in agency spend in line with our 2 year trajectory. |
| | I&E monitoring of progress against £18m technical challenge. |
| Manage CCG and NHSE contracts to ensure accurate and full receipt of income noting changes to tariff (HRG4+) and new Emergency Floor currencies/flows. | Overall level of overdue debtors to reduce, BPPC performance to improve - monitored within cash paper to FIC. |
| Implementation of first stages of UHL's Commercial Strategy and use of TGH Ltd. | Improvement in cash position as per the agreed plan. |
| Reduction in agency spend moving towards the NHSI agency ceiling level. | |

| | |
|---|---|
| New income streams realised and effective, financially beneficial use of TGH Ltd. | |
| 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 |
| Detailed review of M6 year end forecasts | Oct-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 September 17**

| Risk ID | CMG | Risk Description | Current Risk Score | Target Risk Score | Thematic Analysis of Risk Causation |
|---|---|---|---|---|---|
| 2264 | CHUGGS | If an effective solution for the nurse staffing shortages in GI Medicine Surgery and Urology at LGH and LRI is not found, then the safety and quality of care provided will be adversely impacted. | 20 | 6 | Workforce |
| 2621 | CHUGGS | If recruitment and retention to vacancies on Ward 22 at the LRI does not occur, then patients may be exposed to harm due to poor skill mix on the Ward. | 20 | 6 | Workforce |
| 2566 | CHUGGS | If the range of Toshiba Aquilion CT scanners are not upgraded, then patients will experience delays with their treatment planning process. | 20 | 1 | Resource |
| 2354 | RRCV | If the capacity of the Clinical Decisions Unit is not expanded to meet the increase in demand, then will continue to experience overcrowding resulting in potential harm to patients. | 20 | 9 | Demand & Capacity |
| 2670 | RRCV | If recruitment to the Clinical Immunology & Allergy Service Consultant vacancy does not occur, then patient backlog will continue to increase, resulting in delayed patient sequential procedures and patient management. | 20 | 6 | Workforce |
| 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. | 20 | 8 | Estates |
| 2804 | ESM | If the ongoing pressures in medical admissions continue, then ESM CMG medicine bed base will be insufficient thus resulting in jeopardised delivery of RTT targets. | 20 | 12 | Demand & Capacity |
| 2149 | ESM | If we do not recruit and retain into the current Nursing vacancies within ESM, then patient safety and quality of care will be compromised resulting in potential financial penalties. | 20 | 6 | Workforce |
| 2763 | ITAPS | Risk of patient deterioration due to the cancellation of elective surgery as a result of lack of ICU capacity at LRI | 20 | 10 | Demand & Capacity |
| 2193 | ITAPS | If an effective maintenance schedule for Theatres and Recovery plants is not put in place, then we are prone to unplanned loss of capacity at the LRI. | 20 | 4 | Estates |
| 2191 | MSK | Lack of capacity within the ophthalmology service is causing delays that could result in serious patient harm. | 20 | 8 | Demand & Capacity |
| 2940 | W&C | Risk that paed cardiac surgery will cease to be commissioned in Leicester with consequences for intensive care & other services | 20 | 8 | Demand & Capacity |
| 3054 | Human Resources | If the Trust's Statutory and Mandatory Training data can no longer be verified on the new Learning Management System, HELM, then it is not possible to confirm staff training compliance which could result in potential harm to patients, reputation impact, increased financial impact and non-compliance with agreed targets. | 20 ↑ | 3 | IM&T |
| 2403 | Corporate Nursing | There is a risk changes in the organisational structure will adversely affect water management arrangements in UHL | 20 | 4 | Estates |
| 2404 | Corporate Nursing | There is a risk that inadequate management of Vascular Access Devices could result in increased morbidity and mortality | 20 | 16 | Resource |
| 3080 | RRCV | **NEW:** If an alternative provider and procedure is not identified for wasp/bee venom desensitisation then patients will have an increased risk of anaphylaxis due to treatment & waiting list delays | 16 | 4 | Estates |
| 3040 | RRCV | If there are insufficient medical trainees in Cardiology, then there may be an imbalance between service and education demands resulting in the inability to cover rotas and deliver safe, high quality patient care. | 16 | 9 | Workforce |
| 2820 | RRCV | If a timely VTE risk assessments 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 | Processes and Procedures |
| 3051 | RRCV | If we do not effectively recruit to the Medical Staffing gaps for Respiratory Services, then there is a risk to deliver safe, high quality patient care, operational services and impacts on the wellbeing of all staff including medical staffing. | 16 | 6 | Workforce |
| 3031 | RRCV | If the MDT activities for vasc surg are not resolved there is a risk of signif loss of income & activity from referring centres | 16 | 1 | Resource |
| 3088 | ESM | **NEW:** If non-compliant with national and local standards in Dermatology with relation to Safer Surgery checking processes, then patients may be exposed to an increased risk of potential harm. | 16 | 6 | Processes and Procedures |

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| 3025 | ESM | If there continues to be high levels of nursing vacancies and issue with nursing skill mix across Emergency Medicine, then quality and safety of patient care could be compromised. | 16 | 4 | Workforce |
| 3044 | ESM | If under achievement against key Infectious Disease CQUIN Triggers (Hepatitis C Virus), then income will be affected. | 16 | 8 | Demand & Capacity |
| 2333 | ITAPS | If we do not recruit into the Paediatric Cardiac Anaesthetic vacancies, then we will not be able to maintain a WTD compliant rota resulting in service disruption. | 16 | 8 | Workforce |
| 2955 | CSI | If system faults attributed to EMRAD are not expediently resolved, then we will continue to expose patient to the risk of harm | 16 | 4 | IM&T |
| 2673 | CSI | If the bid for the National Genetics reconfiguration is not successful then there will be a financial risk to the Trust resulting in the loss of the Cytogenetics service | 16 | 8 | Demand & Capacity |
| 2378 | CSI | If we do not recruit, up skill and retain staff into the Pharmacy workforce, then the service will not meet increasing demands resulting in reduced staff presence on wards or clinics. | 16 | 8 | Workforce |
| 2916 | CSI | If blood samples are 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 | IM&T |
| 3008 | W&C | Paediatric retieval & repatriation teams are delayed mobilising due to inadequate provision of a dedicated ambulance. | 16 | 5 | Demand & Capacity |
| 3082 | W&C | **NEW:** If funding from NHS England Specialised Commissioning for the CenTre Neonatal Transport call handling service is withdrawn, then calls regarding critically-ill & unstable patients will be delayed or mislaid resulting in the potential for serious harm to patients referred for critical care transfer. | 16 | 5 | Demand & Capacity |
| 2153 | W&C | Shortfall in the number of all qualified nurses working in the Children's Hospital. | 16 | 8 | Workforce |
| 2237 | Corporate Medical | If a standardised process for requesting and reporting inpatient and outpatient diagnostic tests is not implemented, then the timely review of diagnostic tests will not occur. | 16 | 8 | IM&T |
| 2247 | Corporate Nursing | If we do not recruit and retain Registered Nurses, then we may not be able to deliver safe, high quality, patient centred and effective care. | 16 | 12 | Workforce |
| 1693 | Operations | If clinical coding is not accurate then income will be affected. | 16 | 8 | Workforce |
| 3027 | CHUGGS | If the UHL adult haemoglobinopathy service is not adequately resourced, then it will not function at its commissioned level | 15 | 4 | Workforce |
| 3047 | RRCV | If the service provisions for vascular access at GH are not adequately resourced to meet demands, then patients will experience significant delays for a PICC resulting in potential harm. | 15 | 6 | Demand & Capacity |
| 3041 | RRCV | If there are insufficient cardiac physiologists then it could result in increased waiting times for electrophysiology procedures and elective cardiology procedures | 15 | 8 | Workforce |
| 3043 | RRCV | If there is insufficient cardiac physiologists then it could result in reduced echo capacity resulting in diagnostics not being performed in a timely manner | 15 | 6 | Workforce |
| 2872 | RRCV | If a suitable fire evacuation route for bariatric patients on Ward 15 at GGH is not found, then we will be in breach of Section 14.2b of The Regulatory Reform (Fire Order) 2005. | 15 | 6 | Estates |
| 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. | 15 | 6 | Workforce |
| 3077 | ESM | If there are delays in the availability of in-patient beds, then the performance of the Emergency Department at Leicester Royal Infirmary could be adversely affected, resulting in overcrowding in the Emergency Department and an inability to accept new patients from ambulances. | 15 | 10 | Demand & Capacity |
| 2837 | ESM | If the migration to an automated results monitoring system is not introduced, then follow-up actions for patients with multiple sclerosis maybe delayed resulting in potential harm. | 15 | 2 | IM&T |

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| 2466 | ESM | Current lack of robust processes and systems in place for patients on DMARD and biologic therapies in Rheumatology resulting | 15 | 1 | Processes and Procedures |
| 2989 | MSK | If we do not recruit into the Trauma Wards nursing vacancies, then patient safety and quality of care will be placed at risk | 15 | 4 | Workforce |
| 1196 | CSI | If we do not increase the number of Consultant Radiologists, then we will not be able provide a comprehensive out of hours on call rota and PM cover for consultant Paediatric radiologists resulting in delays for patients requiring paediatric radiology investigations and suboptimal treatment pathway. | 15 | 2 | Workforce |
| 2973 | CSI | If the service delivery model for Adult Gastroenterology Medicine patients is not appropriately resourced, then the quality of care provided by nutrition and dietetic service will be suboptimal resulting in potential harm to patients. | 15 | 6 | Workforce |
| 2946 | CSI | If the service delivery model for Head and Neck Cancer patients is not appropriately resourced, then the Trust will be non-compliant with Cancer peer review standards resulting in poor pre and post-surgery malnutrition. | 15 | 2 | Workforce |
| 2787 | CSI | If we do not implement the EDRM project across UHL which has caused wide scale recruitment and retention issues then medical records services will continue to provide a suboptimal service which will impact on the patients treatment pathway. | 15 | 4 | IM&T |
| 2965 | CSI | If we do not address Windsor pharmacy storage demands, then we may compromise clinical care and breach statutory duties | 15 | 6 | Estates |
| 3023 | W&C | There is a risk that the split site Maternity configuration leads to impaired quality of Maternity services at the LGH site | 15 | 6 | Workforce |
| 2601 | W&C | There is a risk of delay in gynaecology patient correspondence due to a backlog in typing | 15 | 6 | Workforce |
| 3083 | W&C | **NEW:** If gaps on the Junior Doctor rota are not filled then there may not enough junior doctors to staff the Neonatal Units at LRI | 15 | 3 | Workforce |
| 3084 | W&C | **NEW:** If there continues to be insufficient Neonatal Consultant cover to run 2 clinical sites, then it could impact on service provision resulting in potential for suboptimal care to the babies on the units at LRI & LGH. | 15 | 5 | Workforce |
| 2394 | Communications | If a service agreement to support the image storage software used for Clinical Photography is not in place, then we will not be able access clinical images in the event of a system failure. | 15 | 1 | IM&T |
| 3079 | Corporate Medical | If the insufficient capacity with Medical Examiners is not addressed then this may lead to a delay with screening all deaths and undertaking Structured Judgement Reviews resulting in failure to learn from deaths in a timely manner and non-compliance with the internal QC and external NHS England duties | 15 | 6 | Workforce |
| 2985 | Corporate Nursing | If delays with supplying, delivering and administrating parental nutrition at ward level are not resolved, then we will deliver a suboptimal and unsafe provision of adult inpatient parental nutrition resulting in the Trust HISNET Status. | 15 | 4 | Workforce |