INTEGRATED RISK AND ASSURANCE REPORT: NOVEMBER 2018 FINAL

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

Executive Summary

Context

The purpose of this paper is to enable the UHL Trust Board to review the current position with progress of the risk control and assurance environment, including the Board Assurance Framework (BAF) and the organisational risk register.

Note - The BAF should also be reviewed in the context of the assurances being provided in other reports also being considered at this Board meeting.

Questions

1. What are the highest rated principal risks on the 2018/19 BAF?
2. What are the significant changes on the organisational risk register since the previous version?
3. What are the key risk management themes evidenced on the organisational risk register?

Conclusion

1. The principal risks on the BAF have been identified by the Board and are linked to Trust objectives. They relate to: PR1 – Quality standards; PR2 – Staffing levels; PR3 – Financial control total; PR4 – Emergency care pathway; PR5 – IM&T service; PR6 – Estates and Facilities service; PR7 – Partnership working. The highest rated principal risks (currently rated at 20) concern staffing levels, emergency care pathway and delivery of the financial control total.
2. There are 232 risks recorded on the organisational risk register (including 79 with a current rating of 15 and above - high). The Trust's risk profile continues to demonstrate active review across all CMGs and corporate services. There have been three new risks scoring 15 and above entered on the risk register during this reporting period.
3. Thematic Analysis of the CMGs risks shows the two key causation themes as gaps in staffing levels and demand pressures. Financial challenges, including funding and internal control arrangements, are recognised as key enablers to support the delivery of the Trust's objectives as well.

Input Sought

The Board is invited to review and approve the content of this report, note the updated position to items on the 2018/19 BAF and to advise as to any further action required in relation to principal risks recorded 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 to TB meeting]

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **UHL TRUST BOARD**

DATE: **10TH JANUARY 2019**

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

SUBJECT: **INTEGRATED RISK AND ASSURANCE REPORT (INCORPORATING UHL BOARD ASSURANCE FRAMEWORK & ORGANISATIONAL RISK REGISTER – NOV 2018)**

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1 INTRODUCTION

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

a. A copy of the 2018/19 Board Assurance Framework (BAF);
b. A summary of the organisational risk register.

2. 2018/19 BOARD ASSURANCE FRAMEWORK SUMMARY

2.1 The Board has overall responsibility for ensuring controls are in place, sufficient to mitigate principal risks which may threaten the success of the Trust's strategic objectives. The format of the BAF is designed to provide the Board with a simple but comprehensive method to monitor the management of principal risks to the achievement of its strategic objectives. The purpose of the BAF is therefore to enable the Board to ensure that it receives assurance that all principal risks are being effectively managed and to commission additional assurance where it identifies a gap in control and/or assurance.

2.2 The BAF remains a dynamic document and all principal risks have been reviewed by their leads or delegated officers (to report performance for November), and have been scrutinised and endorsed by their relevant Executive Boards during December 2018. This reporting period has seen a change to the rating for principal risk 7, reduced from (4x4) 16 to (4x3) 12, following the positive outcomes from the collaborative work with partners. An updated version of the BAF is attached at appendix one.

2.3 The three highest rated principal risks on the BAF relate to delivery of the financial control total, the emergency care pathway and workforce capacity and are described below:

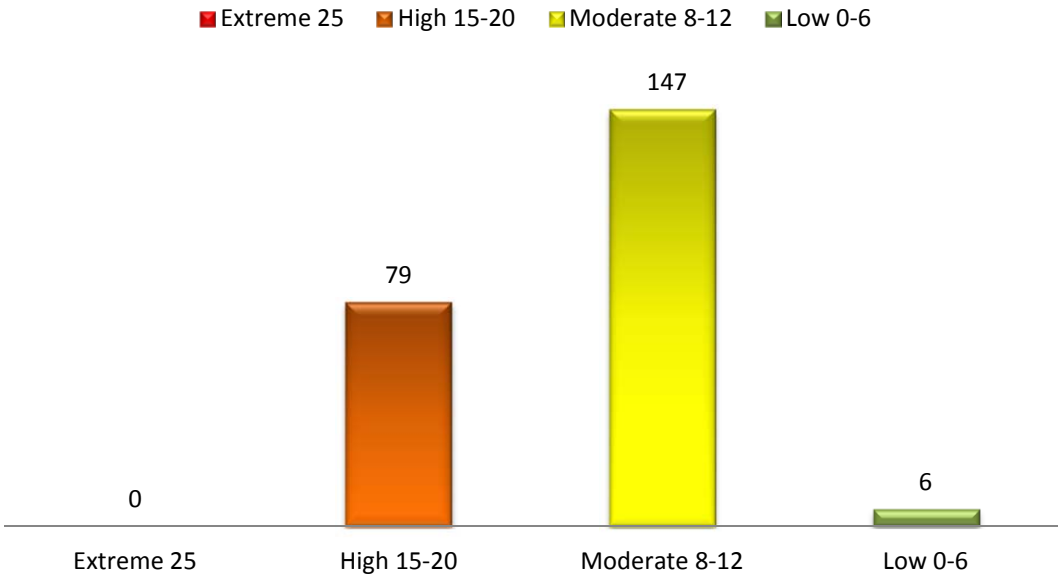
Principal Risk Description 2018/19	Risk Rating	Objective & Lead Director
PR2: If the Trust is unable to achieve and maintain the required ***workforce capacity and capability*** standards, then it may result in widespread instances of poor clinical outcomes for patients and increased staff workloads, impacting business (quality / finance) and reputation (regulatory duty / adverse publicity).	20	Our People DPOP
PR3: If the Trust is unable to achieve and maintain ***financial sustainability***, then it will result in a failure to deliver the financial plan, impacting business (finance & quality) and reputation (regulatory duty / adverse publicity).	20	Financial Stability CFO
PR4: If the Trust is unable to effectively manage the ***emergency care pathway***, then it may result in widespread	20	Organisation of Care

instances of poor clinical outcomes for patients and sustained failure to achieve constitutional standards, impacting business (quality & finance) and reputation (regulatory duty / adverse publicity).		COO

3. ORGANISATIONAL RISK REGISTER SUMMARY

3.1 The Trust's risk register has been kept under review by the Executive Performance Board and CMG Boards during December and displays 232 organisational risks. The Trust's risk profile, by current risk rating, is illustrated in Figure 1, below and a dashboard of the high risks is attached at appendix two.

Figure 1: UHL Risk Register profile - residual risk rating



3.2 There have been three new risks rated 15 and above entered on the risk register during the reporting period.

CMG /ID	Risk Description	Current Rating	Target Rating
CSI / 3329	If Pharmacy Technician and Pharmacist staffing levels are below establishment, caused by retention and recruitment challenges during periods of increased workloads, then it may result in prolonged disruption to the continuity of core services across the Trust leading to service disruption	16	8
CSI / 3330	If the ventilation physiotherapy department staffing is below establishment, then it may result in detrimental impact on quality of delivered care and patient safety in the physiotherapy service, leading to potential for harm	15	6
W&C / 3332	If the paediatric asthma service remains below clinic capacity, then it may result in significant delay with reducing the waiting list and patient review or treatment, leading to potential patient harm	15	4

3.3 No risks have reduced from high to moderate during the reporting period.

3.4 No risks rated 15 and above have been closed during the reporting period.

3.5 Thematic analysis of the organisational risk register shows the key risk causation themes as:

- Staffing shortages;
- Imbalance between demand and capacity.

3.6 A number of operational risks make reference also to financial pressures, as a result of limited funding and challenging internal control arrangements, which are recognised as enablers to support the delivery of the Trust's operational and strategic objectives. These thematic findings on the risk register are reflective of the highest rated principal risks on the BAF.

4 RECOMMENDATIONS

4.1 The Board is invited to review and approve the content of this report, noting the position to principal risks on the 2018/19 BAF and organisational risk register, and to advise as to any further action required in relation to management of the BAF and the organisational risk register.

UHL Board Assurance Framework 2018/19:

The Board Assurance Framework (BAF) is designed to provide the Trust Board with a simple but comprehensive method for the effective and focussed management of principal risks to the achievement of its strategic objectives. The Trust Board defines the principal risks within the BAF and ensures that each is assigned to a Lead Director, as well as to a lead Executive Board for scrutiny, and to a lead Committee of the Board for regular review and assurance.

The principal risk descriptions include, in italics, the key *threats* likely to increase the risk and which may influence the achievement of the Trust's strategic objectives.

The focus within the BAF is on the effectiveness of the primary controls, which we are replying on, whose impact could have a direct bearing on the achievement of the Trust's strategic objectives, should the controls be ineffective.

The BAF is linked to performance metrics with detective risk indicators as a further source of evidence to inform the regular review and re-assessment. The assurance sections focus on where internal and external scrutiny of the operation of primary controls takes place, along with a summary of what the evidence received tells us in relation to the effectiveness of the controls which are being relied on.

Through scrutiny of principal risks at the relevant Executive Board meetings attention should be taken to recognise gaps in the primary controls (i.e. what should be in place to manage the risk but is not) and/or assurances (i.e. what evidence should be in place to tell us in relation to the effectiveness of the controls / systems which are being relied on but is not), to endorse risk ratings, and to agree and monitor appropriate actions to treat the gaps through to progression.

The principal risk rating is based on evidence in relation to the effectiveness of the primary controls which are being relied on and will be reviewed at the relevant Executive Boards, as part of a robust governance process to scrutinise the principal risk, in order to endorse a final position for reporting to the Trust Board.

BAF Rating System: rating on the effectiveness of controls / systems which we are relying on (I x L):

Likelihood due to Effectiveness of Controls	Impact UHL Reputation (if the risk was to materialise)				
	Very Low	Minor	Moderate	Major	Extreme
Very good controls	1	2	3	4	5
Good controls	2	4	6	8	10
Limited effective controls	3	6	9	12	15
Weak controls	4	8	12	16	20
Ineffective controls	5	10	15	20	25

PR Score	PR Rating
1-6	Low
8-12	Moderate
15-20	High
25	Extreme

Appendix 1 - November FINAL

2018/19 BAF Dashboard

Principal Risk Description	Strategic Objective	Exec Direc	Exec Team	Trust Board Cmttee	Current Rating I x L
1) A) If the Trust is unable to achieve and maintain the required quality and clinical effectiveness standards, ***caused by inadequate clinical practice and/or ineffective clinical governance,*** then it may result in widespread instances of avoidable harm to a large number of patients, affecting reputation (breach in regulatory duty / adverse publicity).	Quality Commitment: to deliver safe, high quality, patient centred, healthcare	MD / CN	EQB	AC / QOC	4 x 3 = 12
B) If the Trust is unable to achieve and maintain the required quality and patient safety standards, ***caused by inadequate clinical practice and/or ineffective clinical governance,*** then it may result in widespread instances of avoidable harm to a large number of patients, affecting reputation (breach in regulatory duty / adverse publicity).	Quality Commitment: to deliver safe, high quality, patient centred, healthcare	MD / CN	EQB	AC / QOC	4 x 4 = 16
C) If the Trust is unable to achieve and maintain the required quality and patient experience standards, ***caused by inadequate clinical practice and/or ineffective clinical governance,*** then it may result in widespread instances of avoidable harm to a large number of patients, affecting reputation (breach in regulatory duty / adverse publicity).	Quality Commitment: to deliver safe, high quality, patient centred, healthcare	MD / CN	EQB	AC / QOC	4 x 3 = 12
2) If the Trust is unable to achieve and maintain the required workforce capacity and capability standards, ***caused by employment market factors (such as availability and competition to recruit, retain and utilise a workforce with the necessary skills and experience), lack of extensive education, training and leadership, and demographic changes***, then it may result in widespread instances of poor clinical outcomes for patients and increased staff workloads, affecting business (finance) and reputation (breach in regulatory duty / adverse publicity).	We will have the right people with the right skills in the right numbers in order to deliver the most effective care	DPOD	EWB / EPB	AC/ PPPC	5 x 4 = 20
3) If the Trust is unable to achieve and maintain financial sustainability, ***caused through delivery of income, the control of costs or the delivery of cost improvement plans***, then it will result in a failure to deliver the financial plan, affecting business (finance) and reputation (breach in regulatory duty / adverse publicity).	We will continue on our journey towards financial stability - deliver target 18/19	CFO	EPB	AC / FIC	5 x 4 = 20
4) If the Trust is unable to effectively manage the emergency care pathway, ***caused by persistent unprecedented level of demand for services, primary care unable to provide the service required, ineffective resources to address patient flow, and fundamental process issues***, then it may result in widespread instances of poor clinical outcomes for patients and sustained failure to achieve constitutional standards, affecting business (finance) and reputation (breach in regulatory duty / adverse publicity).	We will improve our Emergency Care Performance	COO	EPB	AC / PPPC	5 x 4 = 20
5) If the Trust is unable to deliver a fit for the future IM&T service, ***caused by inability to secure appropriate resources (including external capital and workforce), a critical infrastructure failure, ineffective system resilience and preparedness of an external IT supplier or an external shut-down attack***, then it may result in a significant disruption to the continuity of core critical services, affecting reputation (breach in regulatory duty / adverse publicity).	To progress our strategic enabler – IM&T	CIO	EIMT / EPB	AC / PPPC	4 x 4 = 16
6) If the Trust does not adequately develop and maintain its estate to meet statutory compliance obligations and minimise the potential for critical infrastructure failure, ***caused by a lack of resources to address the backlog maintenance programme, insufficient clinical decant capacity and the sheer volume of technical work to address ageing buildings***, then it may result in an increased risk of failure of critical plant, equipment and core critical services leading to compliance issues, risk of regulatory intervention, impact upon business and patient critical infrastructure and adverse publicity.	To progress our strategic enabler - Estates	DEF	ESB	AC / QOC	5 x 3 = 15
7) If the Trust is unable to work collaboratively with partners to secure the support of community and STP stakeholders, ***caused by breakdown of relationships amongst partners and ineffective clinical service strategies of the local population***, then it may result in disruption to transforming sustainable clinical services, affecting business (finance) and reputation (breach in regulatory duty / adverse publicity).	To develop more integrated care in partnership with others	DSC	ESB	AC / PPPC	4 x 3 = 12

2018/19 BAF Bubble Chart

			← Impact →				
			1	2	3	4	5
			Rare	Minor	Moderate	Major	Extreme
Likelihood ↑ ↓	1	Rare					
	2	Unlikely					
	3	Possible				PR1A PR1C PR7	PR6
	4	Likely				PR1B PR5	PR2 PR3 PR4
	5	Almost certain					

DATE: @ Nov 2018	Director:	MD / CN (SH / JJ / RB)	Executive Board:	EQB	TB Sub Committee:	AC / QOC
Linked Objective	Our Quality Commitment… to deliver safe, high quality, patient centred, healthcare: To improve patient outcomes by greater use of key clinical systems and care pathways					
BAF Principal Risk: 1A– Quality & clinical effectiveness	If the Trust is unable to achieve and maintain the required quality and clinical effectiveness standards, ***caused by inadequate clinical practice and/or ineffective clinical governance,*** then it may result in widespread instances of avoidable harm to a large number of patients, affecting reputation (breach in regulatory duty / adverse publicity).				**Current Risk & Assurance Rating (I x L):**	**4 x 3 = 12**

BAF Ratings	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**
Exec Team:	New risk entered in June		**4 x 3 = 12**	**4 x 3 = 12**	**4 x 3 = 12**	**4 x 3 = 12**	**4 x 3 = 12**	**4 x 3 = 12**				

Primary Controls

Quality and Clinical Effectiveness Reporting

- 2018/19 UHL Quality Commitment measured through PIDs reported to EQB in relation to:
  - Improve patient outcomes by greater use of key clinical systems and care pathways.
- Quality Framework (Strategy) outlining how quality is managed within the Trust reported in AOP.
- Schedule of external visits maintained and reviewed at CMG service and Exec Team levels
- Deteriorating Adult Patient Board monitors outcomes related to ICU, sepsis, EWS, AKI and diabetes.
- Clinical service structures, resources and governance arrangements in place at Trust Exec and CMG / Specialty levels ensuring appropriate escalation of quality matters.
- Monthly reporting of Mortality Rates and Learning from Deaths (LFD) to the UHL MRC.
- CMG monthly Performance Review Meetings chaired by CN, MD, COO, CFO and DPOD.
- Reporting to Commissioner led Clinical Quality Review Group (CQRG) on compliance with quality schedule and CQUINS – including Commissioner Quality visits schedule for 2018/19.
- CQC improvement plan monitored at CMG Boards, Exec Team and Trust Board.
- NHSI Board to Board performance review meetings.

Quality and Clinical Effectiveness Work Programmes

- Clinical Policies, guidelines, SOPs including NatSSIPs/ LocSSIPs on INsite.
- Trust wide risk management and governance structure in place including: risk register, CAS, incident reporting, Complaints, Claims & Inquest management. Datix risk management software.
- Clinical audit programme, including participation in national audits.
- Consultant outcomes, participation in national clinical registries
- GIRFT and External Peer Reviews.
- Management and assessment against NICE guidance.
- Professional standards and Code of Practice / Clinical supervision.
- Appraisal and Revalidation process.
- Learning from Deaths work stream to include Medical Examiner and Specialty M&M Processes and the Bereavement Support Service.
- Clinical Harm review process - Case note reviews, morbidity reviews and thematic findings.
- Analysis and benchmarking of UHL's mortality rates using Dr Foster's Intelligence and HED data.
- Stroke and Fractured Neck of Femur improvement programmes.
- Quality Commitment 'Improving patient outcomes' work programmes to include: Implementing the Clinical Frailty Score; Embedding use of Nerve Centre for all medical handover board rounds and escalation of care; Fully implement plans to standardise Red2Green.

Detective Risk Indicators

	Ref	Indicators	18/19 Target	Nov - 18	18/19 YTD
EFFECTIVE	E1	Readmissions <30 days – Discharge work stream – one month in arrears	Red >8.6%		9.1%
	E2	Mortality (SHMI) – JJ	<=99	Apr 17 to Mar 18 = 95	95
	E5	Crude Mortality Emergency Spells – JJ	<=2.4%	1.9%	2%
	E6	#NOF <36 hours – CMG / Max Chauhan	Red <72%	83.5%	72.5%
	E7	Stroke – 90% stay on stroke unit – one month in arrears – CMGs/ S SNAP – RACHEL MARSH	Red <80%		84.9%
	E8	Stroke – TIA – RACHEL MARSH	Red <60%	87.3%	56.7%

Internal Assurances	External Assurances	Gaps Identified & Pending Actions
• UHL Quality Commitment components monitored at Exec Team and QOC, quarterly. • Both Operational management and Executive/Board reporting is in place for Clinical effectiveness. Reports provide assurance and highlight threats to delivery of the programme along with any mitigating actions. Latest reports received include: ➢ NEWS2 NPSA alert (NHS/PSA/RE/2018/003) compliance monitored via ADPB and confirmed to EQB. ➢ Stroke - Actions currently taken have meant the TIA clinic has met the target for high risk referrals of 60% within 24 hours for Aug & Sept. 90% stay on a Stroke Unit has been achieved for 80% of patients for the past 12 months. • Mortality report to QOC and Trust Board - Information Analyst and Bereavement Support Nurse in Post. • LLR Frailty Task Force (led by UHL) is in place with a focus on identifying and responding to the needs of frail multi morbid patients. This group is responsible for the overall embedding of the CFS in ED and the wider hospital, and responding to these patients holistically in the community to ensure better outcomes and prevent readmission into acute care. • A readmission working group has been set up within UHL to understand the data and identify a mechanism to refer these patients to STP provided community neighbourhood teams. Community partners are now involved with this group to ensure a system wide response. Readmissions CQUIN agreed, Q2 successfully delivered. Targeted specialities all involved. Readmission coordinator post - funded by city CCG to provide community follow up for patients at high risk of readmission. (PARR>40) • #NOF Task and Finish group involving senior consultants from Trauma, Anaesthetics, Orthogeriatrics, ED as well as Nursing, Theatres and Management met to discuss problems and develop a new action plan. Fractured Neck of Femur – pilot update and action plan, jointly owned by ITAPS and MSS, presented to QOC in Dec. Risk assessment undertaken and approved by CMG Board (= 16). • Stroke and TIA Clinic performance monitored by CMG. Exception report being submitted to EQB to advise on actions being taken to address the deterioration in TIA Clinic Performance.	• CQC comprehensive review in 2017/18 - inspectors have rated our Trust overall as Requires Improvement; rating us Good for being effective and caring, and Requires Improvement for being safe, responsive and well-led. • CQC unannounced inspection 29.5.18 with written feedback provided. • Human Fertilisation & Embryology Authority Inspection – UHL's IVF and ICSI success rates in line with national average. • GIRFT review of Orthopaedic Services found UHL has very low revision rates but potential area for reduction in Length of Stay. • **Internal Audit Programme 2018/19:** ➢ Learning from Deaths Programme – Audit report due Dec 18. • **Internal Audit 2016/17:** ➢ Clinical Audit - medium risk (associated with CMG engagement). • **Consultant Outcomes Programme:** ➢ **National Congenital Heart Disease Audit results** published for 2014-17 in November – UHL's survival rates for paediatric CHD are higher than predicted.	**Mortality** • Information Analyst in Post. Further interviews to be held for M&M Assistant **Review Jan 19 (DMD)** **#NOF** • A 'Rapid Cycle Fortnight' from 1st to 12th October has been completed. The main intervention was to provide a team and theatre access over the weekend for NOF patients. The outcome of this trial will be reported to EQB in December 2018. **Review Dec 18 (MSS CMG CD)** • Agreement that Fractured Hip Operating lists are to be protected for NOF patients with immediate effect. There has been a drift over time which needs to be stopped. These lists can only be used for other trauma cases if there are no patients with fractured NOF waiting or if the alternative trauma case is life/limb threatening and there is no other trauma theatre available. Introduction of the senior 'Hot' consultant of the week for Trauma commenced beginning of August. This new process should help support the NOF service. **Review Dec 18 (MSS CMG CD)** **Readmissions** • Although the process for reviewing patients has been agreed in principle, a formal proposal has yet to be designed and tested pre-winter 2018. This includes allowing a field on discharge letters specifying what the readmission risk for patients is and requesting the GP to refer patient for MDT review. **Review Dec 18 – (HoSD)** • Respiratory – plans to reduce the PARR score to >30 for patient follow up – Resources to be discussed / what can be delivered safely in the community? **Review Jan 19 – (HoSD)** • EoL emergency readmissions increase of 16%/20%, from average baseline, noted in July and August, requires further investigation. **Review Jan 19 – (HoSD)** **Frailty** • The CFS score has been built into NerveCentre and tested through August. It is ready to be formally launched across the Trust. A training and education plan has been devised specifically for ED and will be rolled out through Sept-Oct 2018. **Review Nov 18 – (HoSD)** **Stroke - 90% Stay on Stroke Unit** • CRO had an effect in August as well as the increased emergency activity and pressure on beds. Preliminary data suggests target met for September **Review Dec 18 – (ESM CMG CD)** **TIA Clinic – High Risk Patients** Work plan in place to increase capacity for high-risk patients and discussions being held with commissioners to look at deflecting obvious non TIA referrals. - **Review Feb 19 – (ESM CMG CD)**

DATE: @ Nov 2018	Director:	MD / CN (MD / CM)	Executive Board:	EQB	TB Sub Committee:	AC / QOC
Linked Objective	Our Quality Commitment… to deliver safe, high quality, patient centred, healthcare: To reduce harm by embedding a 'Safety Culture'					
BAF Principal Risk: 1B – Quality & patient safety	If the Trust is unable to achieve and maintain the required quality and patient safety standards, ***caused by inadequate clinical practice and/or ineffective clinical governance,*** then it may result in widespread instances of avoidable harm to a large number of patients, affecting reputation (breach in regulatory duty / adverse publicity).				**Current Risk & Assurance Rating (I x L):**	**4 x 4 = 16**

BAF Ratings	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**
Exec Team:	**4 x 4 = 16**	**4 x 4 = 16**	**4 x 4 = 16**	**4 x 4 = 16**	**4 x 4 = 16**	**4 x 4 = 16**	**4 x 4 = 16**	**4 x 4 = 16**				

Primary Controls

- 2018/19 UHL Quality Commitment measured through PIDs reported to EQB in relation to:
  - To reduce harm by embedding a 'safety culture'.
- Clinical service structures, resources and governance arrangements in place at Trust Exec and CMG / Specialty levels ensuring appropriate escalation of quality matters.
- Clinical Policies, guidelines, SOPs including NatSSIPs/ LocSSIPs.
- Professional standards and Code of Practice / Clinical supervision.
- Trust wide risk management and governance structure in place including: risk register, CAS, incident reporting, Complaints, Claims & Inquest management, patient safety portal.
- Clinical audit programme & monitoring arrangements including assessment against NICE guidance.
- Never Events action plan and walkabout sessions.
- Infection Prevention and Control programme including policies / procedures; staff training; environmental cleaning audits and inspections.
- Freedom to Speak up Guardian and escalation processes.
- Senior leadership safety walkabout programme.
- Quality Framework (Strategy) outlining how quality is managed within the Trust reported in AOP.
- Schedule of external visits maintained and reviewed at CMG service and Exec Team levels.
- CQC improvement plan monitored at CMG Boards, Exec Team and Trust Board.
- NHSI Board to Board performance review meetings.
- Maintenance of defined safe staffing levels on wards & departments – nursing and medical.
- Clinical staff recruitment campaigns, induction processes, registration and re-validation practices.
- Regular liaison meetings with Leic Coroner re hospital deaths and inquests.
- UHL Q&P Report including 'safe' indicators reported to EPB monthly.
- CMG monthly Performance Review Meetings chaired by CN, MD, COO, CFO and DPOD.
- Reporting to Commissioner led Clinical Quality Review Group on compliance with quality schedule and CQUINS – including Commissioner Quality visits schedule for 2018/19.
- Learning from claims and inquests – key themes identified and reported to EQB / QOC.
- Medical Examiner and Learning from Deaths reviews and triangulated with patient safety incidents.
- GIRFT reports and NHSR scorecard.
- Recent analysis on harm with targeted action for improvement.
- Increased incident reporting.
- UHL Patient Safety Alert Panel.

Detective Risk Indicators

	Ref	Indicators	18/19 Target	Nov - 18	18/19 YTD
SAFE	S1	Reduction for moderate harm and above PSIs - reported 1 month in arrears	9% REDUCTION FROM FY 16/17 (<12 per month)		143
	S2	Serious Incidents - actual number escalated each month	<=37 by end of FY 18/19	2	24
	S8	Overdue CAS alerts	0	1	1
	S10	Never Events	0	1	6
	S11	Clostridium Difficile	61	4	44
	S12	MRSA Bacteraemias - Unavoidable	0	0	0
	S13	MRSA Bacteraemias (Avoidable)	0	0	1
	S14	MRSA Total	0	0	1
	S23	Falls per 1,000 bed days for patients > 65 years (1 month in arrears)	<6.6		6.5
	S24	Avoidable Pressure Ulcers Grade 4	0	0	0
	S25	Avoidable Pressure Ulcers Grade 3	<27	0	3
	S26	Avoidable Pressure Ulcers Grade 2	<84	5	41

Internal Assurances	External Assurances	Gaps Identified & Pending Actions
• Annual Governance statement providing assurance on the strength of internal control regarding risk management processes endorsed by Audit Committee (May 2018). • Patient Safety Report (Dec 2018) to EQB/QOC: Two Serious Incidents escalated in November. There are currently 10 finally approved incidents showing evidence gaps for full Duty of Candour compliance. Pleasing increase in numbers of PSIs reported. One CAS Estates & Facilities Alert (EFA-2018-004) breached deadline in November. • 1 Never event reported in November. The NE action plan has been further revised to provide further interventions at corporate and ward level to improve management of Never Events in the Trust. The 15 poster produced and distributed to all clinical areas. 50% of Never Event specific Director lead safety walkabouts completed. • Q2 Harms Review - We have seen a slight decrease in the actual number of harm incidents in Q2 2018/19 compared to Q1 but there has been a sustained increased level of moderate plus harm this year to date compared with 17/18. • Triangulation of incident and learning from death themes reviewed and reported to EQB in Nov. • F2SU clinics and surgeries at all three sites during F2SU month (October 2018).	• CQC comprehensive review in 2017/18 - inspectors rated Trust overall as Requires Improvement; rating us Good for being effective and caring, and Requires Improvement for being safe, responsive and well-led. The Trust must embed learning from never events in order to prioritise safety and reduce risk; ➢ The Trust did not always control infection risk well - Staff did not always adhere to trust policy in relation to cleaning of equipment, completing infection control risk assessments and hand hygiene. ➢ CQC Warning notice issued following unannounced inspection in Nov 2017 – re the care given to diabetic patients in relation to the management of their insulin requires significant improvement. Evidence supports actions have delivered improvements. However, the CCGs visited some of the same wards during April, which the CQC had visited, and found some areas still had some improvements to make. • CQC unannounced inspection 29.5.18 with written feedback provided. • **Internal Audit Programme 2018/19:** ➢ Quality Commitment review – scheduled Q3; ➢ Patient Safety Alert review – scheduled Q3 – due Dec 2018. • **Internal Audit 2016/17:** ➢ Risk management – medium risk (associated with CMG processes). ➢ Clinical Audit - medium risk (associated with CMG engagement). • **External Audit 2016/17:** ➢ Incident reporting and evidence of validation of grading of harm – outcome assured (safety nets in place and being monitored). • National Freedom to Speak up Guardian visit in Q3 2017 – positive verbal feedback received about systems and processes in place in UHL. • Parliamentary ombudsman enquires – only 1 partially upheld case in 17/18, reduced from 7 the previous year. • Healthwatch – independent complaints review panel – Feedback received from the Panel that met in June 2018 and actions agreed. • Human Fertilisation & Embryology Authority (HFEA) Inspection June 2018 – Two major areas of non-compliance, 1) Safety and suitability of premises (including inadequate storage facilities including for storage of liquid nitrogen dewars) and 2) Medicines management (carry over stock not recorded in the controlled drugs register and only a single patient identifier used in the controlled drugs register). • CQC (IR)MER inspection to Cath. Lab. On the 23rd November 2018. • Latest NHSI Never Events data published 30th October 2018.	• Communication of key safety messages to front line staff: develop strategy to embed learning from never events in order to prioritise safety and reduce never events / patient safety culture programme to be developed / increase awareness via website and intranet broadcasting – during Q2 2018/19 (CN / MD). • IP team to undertake sample audit of completion of paper RA with feedback to the Nurse in Charge in real time and a report to the Matron / Review all Infection Prevention policies with a one page 'at a glance' care bundle produced for each organism / Convert current paper patient Risk Assessment (RA) booklet to electronic format – during Q2/3 2018/19 (CN). • Internal Audit of Patient Safety Alerts (reference NHS Improvement letter 1st June 2018) – due Q3 2018/19. • Overdue RCA actions require urgent attention from relevant CMGs (CMG CDs). Items also monitored at CMG PRMs. • Improve culture and empower staff to 'Stop the Line' in all clinical areas – QC priority 2018/19 – Stop the line audit currently in progress – results expected in Q3 2018 (AMD). • More work required to embed systems to ensure abnormal results are recognised and acted upon – QC priority 2018/19 – Reviewed at EQB quarterly (AMD). • Improve the management of diabetic patients treated with Insulin – QC priority 2018/19 – Reviewed at EQB quarterly (AMD). • Some critical nurse staffing gaps reported in CMGs. • Action plan to address the two major non-compliances in HFEA Inspection report - Consultant Embryologist, Leicester Fertility Centre & Medical Director – to be reviewed at future EQB meeting. • Full review of CRO outbreak to be undertaken in Q3 2018/19. • Cluster of VTE harms identified in November 2018 – VTE Task Force established December 2018 to report monthly to EQB. • Non-integrated / weak IT systems remain a patient safety risk – UHL IM&T e-hospital programme established (see PR 5).

DATE: @ Nov 2018	Director:	MD / CN (HL)	Executive Board:	EQB	TB Sub Committee:	AC / QOC
Linked Objective	Our Quality Commitment… to deliver safe, high quality, patient centred, healthcare: To use patient feedback to drive improvements to services and care					
BAF Principal Risk: 1C – Quality & patient experience	If the Trust is unable to achieve and maintain the required quality and patient experience standards, ***caused by inadequate clinical practice and/or ineffective clinical governance,*** then it may result in widespread instances of avoidable harm to a large number of patients, affecting reputation (breach in regulatory duty / adverse publicity).				**Current Risk & Assurance Rating (I x L):**	**4 x 3 = 12**

BAF Ratings	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**
Exec Team:	New risk entered in June		**4 x 3 = 12**	**4 x 3 = 12**	**4 x 3 = 12**	**4 x 3 = 12**	**4 x 3 = 12**	**4 x 3 = 12**				

Primary Controls

- 2018/19 UHL Quality Commitment measured through PIDs reported to EQB in relation to:
  - Use patient feedback to drive improvements to services and care.
- Clinical service structures, resources and governance arrangements in place at Trust Exec and CMG / Specialty levels ensuring appropriate escalation of quality matters.
- Clinical Policies, guidelines, SOPs including NatSSIPs/ LocSSIPs on INsite.
- Professional standards and Code of Practice / Clinical supervision.
- Trust wide risk management and governance structure in place including: risk register, CAS, incident reporting, Complaints, Claims & Inquest management. Datix risk management software.
- Clinical audit programme & monitoring arrangements including assessment against NICE guidance.
- CMG monthly Performance Review Meetings chaired by CN, MD, COO, CFO and DPOD.
- Complaints process including Trust Policy.
- Staff surveys and FFTs monitored at local and Exec Team levels.
- Patient and public involvement forums and patient experience focus groups.
- Engagement / Patient Experience issues monitored through the Patient Involvement, Patient Experience and Equality Assurance Committee (PIPEEAC).
- UHL Q&P Report includes 'caring' indicators reported to EPB and Trust Board Monthly.
- Reporting to Commissioners led Clinical Quality review Group on successful collection of feedback from patients across clinical areas.

Detective Risk Indicators

	Ref	Indicators	18/19 Target	Nov - 18	18/19 YTD
CARING	C1	Formal complaints rate per 1000 IP,OP and ED attendances	No Target	1.7	1.6
	C2	% of upheld PHSO cases	No Target	0	0
	C3	Published Inpatients and Daycase Friends and Family Test - % positive	97%	97%	97%
	C6	A&E Friends and Family Test - % positive	97%	95%	95%
	C7	Outpatients Friends and family Test - % positive	97%	95%	95%
	C10	Single sex accommodation breaches (patients affected)	0	0	41

Internal Assurances	External Assurances	Gaps Identified & Pending Actions
• UHL Quality Commitment components monitored at Exec Team and QOC quarterly. • Outpatient Programme Board leading and monitoring the improvements in outpatients identified in response to patient feedback. Monthly reports shared at clinic level with CMGs. • End of Life Care and Palliative Care Committee monitors improvements to increase positive patients experience in relation to feeling involvement in care. • The Trust seeks to ensure services develop in response to patient's feedback and therefore all "suggestions for improvement/complaints/areas that were lacking from the patients perception", referred to as SfI's, are triangulated allowing overall themes at Trust and CMG level to be derived. The CMGs are then able to demonstrate their response to this feedback. • The Clinical Audit Team have streamlined this process facilitating the production of high level themes with minimum workload as it is acknowledged that understanding the themes from feedback from patients and monitoring CMG response to these themes is necessary to ensure patient led services and care. • The areas for improvement identified by patients in the triangulation of feedback are the areas of focus identified in the Trust's Quality Commitment and overseen at PIPEEAC. • Complaints Data report (Nov 2018): Increase in performance for 10 day and 25 day complaints, 45 day complaints have had a decrease in performance. The Emergency Department is the speciality with the most complaints and concerns this month. Decrease in the number of formal complaints this month. Decrease in the number of re-opened complaints this month. No new PHSO cases this month. Two PHSO cases were closed this month; one upheld and the other not upheld. The in-depth review of the 39 complaints that missed their deadline in the November EQB report is not quite complete but review of the cases completed to date has identified that there is learning for both CMGs and the Corporate Team. A full summary will be reported to the January EQB which will include any CMG or speciality themes. • Independent Complaints Review Panel met in Oct and actions following this include a review of the Terms of Reference for the Independent Complaints Review Panel and the new ToR have been added to the revised Complaints Policy (approved in Oct 2018) in the appendices.	• CQC comprehensive review in 2017/18 - inspectors have rated our Trust overall as Requires Improvement; rating us Good for being effective and caring, and Requires Improvement for being safe, responsive and well-led. • CQC unannounced inspection 29.5.18 with written feedback provided. • **Internal Audit Programme 2018/19:** ➢ Quality Commitment review – scheduled Q3. • **Internal Audit 2016/17:** ➢ Risk management – medium risk (associated with CMG processes). ➢ Clinical Audit - medium risk (associated with CMG engagement).	• Improving experience of care for patients in the outpatient facilities. As part of the Trust's Quality Commitment there is a Trust wide improvement plan and an Outpatient Group with representatives from all CMGs to drive this forward – QC priority 2018/19 – Reviewed at EQB quarterly. • Improving patient involvement in care in ED. This is being taken forward through the End of Life Care Hospital Improvement Programme (ELCHIP) programme and monitored via the End of Life and Palliative Care Committee – QC priority 2018/19 – Reviewed at EQB quarterly.

DATE: @ Nov 2018	Director:	DPOD	Executive Board:	EWB	TB Sub Committee:	AC / PPPC
Linked Objective	We will have the right people with the right skills in the right numbers in order to deliver the most effective care					
BAF Principal Risk: 2 - workforce	If the Trust is unable to achieve and maintain the required workforce capacity and capability standards, ***caused by employment market factors (such as availability and competition to recruit, retain and utilise a workforce with the necessary skills and experience), lack of extensive education, training and leadership, and demographic changes***, then it may result in widespread instances of poor clinical outcomes for patients and increased staff workloads, affecting business (finance) and reputation (breach in regulatory duty / adverse publicity).				**Current Risk & Assurance Rating (I x L):**	**5 x 4 = 20**

BAF Ratings	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Exec Team:	5 x 4 = 20	5 x 4 = 20	5 x 4 = 20	5 x 4 = 20	5 x 4 = 20	5 x 4 = 20	5 x 4 = 20	5 x 4 = 20				

Primary Controls

- Executive Workforce Board (meet Quarterly) – reports to Trust Board.
- People, Process and Performance Committee – Sub-committee of the Trust Board (meet monthly) – report to Trust Board.
- Local workforce Action Group – report to – Local Workforce Action Board – report to – LLR Senior Leadership Team.
- Leadership and people management policies, processes and professional support tools (including training & UHL Way tools).
- Temporary staffing approval and recruitment process with appropriate authorisation levels.
- Vacancy management and recruitment/ retention system and processes – i.e. TRAC system. Revised ERCB Board and CON in place from July 2018.
- Staff communication & engagement forums – *LiA events, Ask the Boss events, Freedom to Speak up forum, Insite staffroom forum.*
- Staff appraisal systems and people capability framework.
- Core Skills Learning & Development including statutory & mandatory training system – i.e. HELM.
- Employee Health & Wellbeing Plan.
- Equality & Diversity Board, delivery plan, dedicated lead in place, and Equality Impact assessments undertaken for policy and procedure function.
- Defined safe medical and nurse staffing levels for all wards and departments.
- Medical Education Workforce Group & Medical Education and Training Committee – report to EWB (Quarterly).
- Embedded Medical Education Strategy to address specialty specific shortcomings.
- GMC 'Approval and Recognition' of Clinical and Educational Supervisors.
- Working with deanery and medical schools re medical staffing (gaps).
- CMG Performance Review/Assurance Meetings (Monthly).
- Establishment of financial recovery board (FRB) and executive oversight of workforce actions.
- Cultural Ambassador Programme, delivered by the RCN, following concerns regarding the disproportionate impact of formal disciplinary and grievance processes on BAME staff.
- Strategic Workforce Plan in place.

Detective Risk Indicators

	Ref	Indicators	Red RAG/ Exception Report Threshold (ER)	Nov - 18	18/19 YTD
Well Led	W7	Friends & Family staff survey: % of staff who would recommend the trust as place to work (from Pulse Check)	TBC		61.1%
	W8	Nursing Vacancies overall	Separate report submitted to QOC		15%
	W10	Turnover Rate	Red = 11% or above ER = Red for 3 Consecutive Mths	8.3%	8.3%
	W11	Sickness absence (reported 1 month in arrears)	Red if >4% ER if 3 consecutive mths >4.0%		3.9%
	W12	Temporary costs and overtime as a % of total paybill	TBC	10.6%	11.1%
	W13	% of Staff with Annual Appraisal (excluding facilities Services)	Red if <90% ER if 3 consecutive mths <90%	92.2%	92.2%
	W14	Statutory and Mandatory Training	95%	82%	82%
	W15	% Corporate Induction attendance	Red if <90% ER if 3 consecutive mths <90%	96%	96%
	W16	BME % - Leadership (8A – Including Medical Consultants)	4% improvement on Qtr 1 baseline		29%
	W20	DAY Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	TBC	79.1%	82.1%
	W22	NIGHT Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	TBC	90%	90.1%
Education		Improve the number of good/satisfactory 'overall satisfaction' score in the GMC NTS from 76% to >80%			
Education		Maintain the number of trainee and trust grade doctors reporting satisfaction with their post at 80%			

Internal Assurances	External Assurances	Gaps Identified & Pending Actions
• Workforce risks in CMGs recorded on organisational risk register – *majority relate to nursing and medical.* • Workforce and Organisational Development Plan, with a delivery plan to reduce our nursing and medical vacancy rates and reduce time to hire reports agreed at EWB in July 2018. • Staffing levels on wards (for nursing and medical groups) continue to be challenging and are monitored through daily operational command meetings, with action plans identified to mitigate operational pressures, and reported to Exec Boards. • UHL Medical Education Survey - *415 junior doctors responded to the survey in 2018. 88% recommend UHL as a place to work, which is an improvement since March 2017 (83%).* • Monitoring agency spends and tracker through Financial Recovery Operation Group with EWB, EPB, PPPC oversight. • Friends & Family staff survey 2017: – 4808 returned *a completed survey, giving a response rate of 34%, a decrease of 2.2% from 2016. Compared to the 2016 survey, in 2017 scored:* o *Significantly BETTER on 3 questions* o *Significantly WORSE on 4 questions* o *The scores show no significant difference on 81 questions* • *57% of staff would recommend the trust as place to work (from Pulse Check – March 2018).* • Our latest national staff survey results for 2017 were not as good as the improving trend we saw in previous years. • Equality and Diversity Board discussions on workforce race equality targets show current overall workforce reflects local BAME communities (32%) and that leadership representation is continually improving (15.2 % up from 13.6% 17/18 year-end). • We now have 9 Cultural Ambassadors. • CMG Performance Review / Assurance Meetings – *all CMGs reviewed during July and appropriate action plans developed and being monitored.*	• **Internal Audit 2018/19:** ➢ Workforce planning – scheduled Q3 – to review the Trust's progress in developing the 18/19 workforce plan and the 2018-2023 strategic workforce plan. • GMC visit report of 2016 – report received and *actions implemented.* • GMC Survey - 82% of programmes within UHL had satisfactory or good scores in the 2018 GMC survey (includes all programmes with >3 trainees). • HEEM quality management visits **-** *HEE re-visited Cardio-respiratory on May 4th 2018 to review progress against their action plan – HEE now formally confirmed happy with progress; risk will be removed from HEE risk register and have been removed from GMC enhanced monitoring.* • Leicester Medical School feedback **–** *retention rate report demonstrates an increase to 33% of students staying in Leicester.* • Performance monitored by NIHR Central Commissioning Facility **–** *UHL are currently ranked 11th in league one and delivering 76% of trial to time and target (March 2018).* • East Midlands Clinical Research Network – *UHL remains the highest recruiting Trust within the East Midlands (March 2018).*	• Refresh of People strategy (including Nursing and Midwifery and Medical Workforce Strategies) to TBTD in Dec and then PPPC in January 2019 to ensure alignment with Quality Improvement strategy. • Improve levels of employment from distinct populations/ communities to all levels of the Trust e.g. MOD veterans, disabled people, women, BAME, LGBT so they are representative of LLR population. Targets for each agreed at Diversity Board meeting and PPPC in July 2018. Overarching action plan in place with defined objectives and timescales. • Based on the feedback in the national staff survey, key themes to make improvements during 2018/19 are: o Making appraisals more meaningful o Treating our staff equally o Looking after UHL – health and well-being o Tackling behaviours New full staff survey to be undertaken for 18/19 - closing date 7th Dec 2018. Results expected in February 2019. • Creation of CT3/FY3 innovative posts in order to aide retention of Junior Doctors by providing greater training experience and reduced agency costs and improve out of hours cover. Development plan incorporated into CMG workforce plans with oversight obtained by EWB quarterly. • Review of Undergraduate and Postgraduate medical education roles (including Educational Supervisors) to ensure identified time included in job plans. • Understanding of the impact of Brexit and national shortages of nurses and consultants – monitor in line with our strategy and maintain communication & engagement with EU staff & their managers. • Developing Workforce Safeguard national guidance received in October 2018 and to be reviewed to ensure fully incorporated into planning processes. • Agreement being sought for implementation of the National change to medical training – Shape of Training – report to EWB in October 2018 agreed approach to be followed. • NHSI Culture and Leadership programme Diagnostic expected to complete May 2019. • Developing Workforce Safeguards to be part of National Operational Planning Frameworks from April 2019.

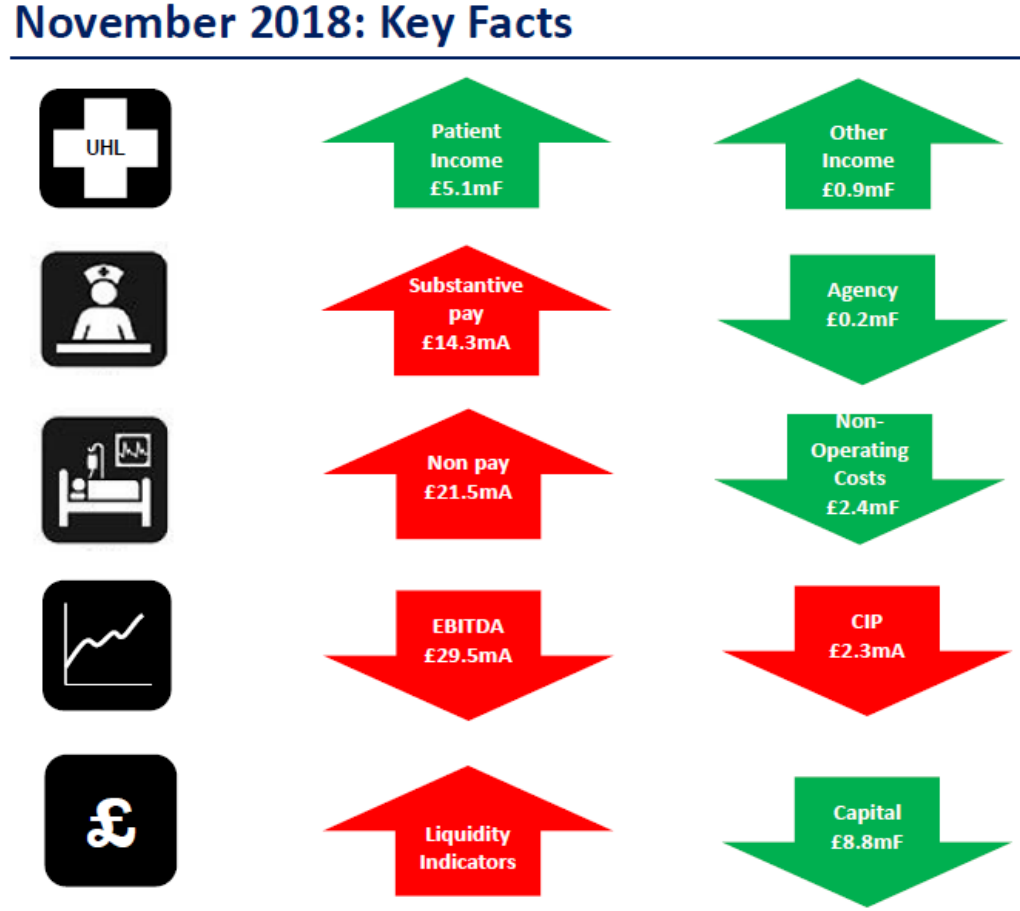
DATE: @ Nov 2018	Director:	CFO	Executive Board:	EPB	TB Sub Committee:	AC / FIC
Linked Objective	We will continue on our journey towards financial stability - deliver our target of £29.9m in 18/19					
BAF Principal Risk: 3 - Finance	If the Trust is unable to achieve and maintain financial sustainability, ***caused through delivery of income, the control of costs or the delivery of cost improvement plans***, then it will result in a failure to deliver the financial plan, affecting business (finance) and reputation (breach in regulatory duty / adverse publicity).				**Current Risk & Assurance Rating (I x L):**	**5 x 4 = 20**

BAF Ratings	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Exec Team:	5 x 4 = 20	5 x 4 = 20	5 x 4 = 20	4 x 5 = 20	4 x 5 = 20	4 x 5 = 20	4 x 5 = 20	4 x 5 = 20				

Primary Controls

- Annual and long-term financial model describing a statement of income and expenditure, a statement of long and short term assets and liabilities (including capital expenditure) and a statement of cash flow.
- Working capital, capital loan, and internal capital funding arrangements.
- CIP Plans for CMGs and Corporate Departments with cross-cutting schemes being supported by corporate based resource in addition to local CMG transformation leads.
- Finance Improvement and Technical planning processes and project management led coordination of delivery.
- Control Totals for CMGs and Corporate Departments that are being monitored and managed within the Financial Accountability Framework.
- Appropriate level of investment supporting the resolution of the demand/capacity challenges.
- Financial governance and performance monitoring arrangements at Trust Board (FIC), Audit Committee, Executive (EPB), directorate and CMG service line levels.
- Cost pressures and service developments minimised and managed through RIC and CEO chaired 'Star Chamber'.
- NHS I performance review meetings including I&E submissions and additional monthly review meetings with NHSI Finance team to review financial position including CIP and assessment of financial risks.
- Commercial Strategy - to help exploit commercial opportunities available to the Trust and working with NHSI to ensure a consistent and jointly agreed position statement is made with regards the Trust's subsidiary company.
- Corporate Services review (in line with the requirements of the Carter report).
- Quality safeguards - to reduce expenditure are subject to Quality Impact Assessment – overseen by the COO, Medical Director, Chief Nurse & CFO.
- Financial Recovery Board chaired by CEO. Meets fortnightly to monitor progress of the Financial Recovery Action Plan.
- Financial Recovery Operational Group is in place to support the work of the Financial Recovery Board and the delivery of the benefits.

Detective Risk Indicators



Internal Assurances	External Assurances	Gaps Identified & Pending Actions
• CFO's Financial Reports to EPB (monthly) key issues considered at the meeting for month 8 relate to delivering the revised planned deficit of £51.8m (exc PSF). The financial impact caused by the recent NHSI decision to not allow the LLP alongside a re-forecast of the year end position has been recognised within the monthly reporting. This was submitted as part of the Q2 reporting process and has been communicated to NHSI including compliance with the relevant governance processes. • The income position has over-preformed and a corresponding overspend within non-pay has been seen. The pay bill (substantive) is overspent by £14.0m to plan (including £7.2m relating to A4C national pay award). Cost improvement plans show an under-performance to plan at month 8. Capital expenditure has under-spent within the year to date position and will not lead to an over spend within the programme. Cash flow and deficit funding has been received in line with the submitted plan. • FIC Summary to Trust board (Monthly). Key issues are as described above and as reported to EPB. The Committee also reviewed the additional report detailing a more granular analysis of the Trust's cash position. • Capital Monitoring and Investment Committee (monthly). A detailed review of month 6 capital expenditure was reviewed with key variances explored in the context of the overall capital programme. • Revenue Investment Committee (monthly). The committee had a limited number of business cases for review. All actions are being progressed. • Update on the Commercial Strategy. The Trust Board, at its last thinking day, has an agreed approach to ensure successful delivery of year 2 of the commercial strategy. • Alliance Contract. This quarterly review was discussed and reviewed at an Executive Quality Board in November.	• **External Audit of Financial Systems 2018/19:** ➢ Work programme for 2018/19 to be reviewed and approved at the relevant meeting of the Audit Committee. • **Internal Audit 2018/19:** ➢ Financial systems Q3 - financial systems controls work to meet the requirements of External Audit and to address specific risks identified by management. Work will include data analysis on specific areas of risk in order to identify trends/ anomalies and to direct our controls-based work. ➢ Review of cost improvement programme Q2 - will review the adequacy of arrangements for delivery of the CIP and the robustness of planning for future years. • NHSI Carter Corporate Service review: - *Carter Target for back office cost to be no more than 6% of turnover by March 2020.* The Trust's Director of Efficiency and CIP is leading this initiative, as part of the overall review of Model Hospital, and engaging across the Corporate Teams to ensure robust plans are in place to achieve the 2020 target. • Four Eyes support is being deployed within the cross cutting theatre/elective pathway work-stream and the cross cutting outpatient work-scheme. • NHSI increased scrutiny through monthly performance review meetings and specific Finance focused monthly meetings.	**Gap:** Effectiveness of budget management and control at CMG and Corporate directorate levels**.** **Actions:** 2018/19 planning requires the delivery of a deficit of £29.9m inclusive of a £51m CIP programme. Each CMG and Corporate Directorate has an allocated budget totalling £29.9m however due to the current work in progress with respect of demand and capacity modelling CMGs are yet to sign-off a fully phased month by month budgetary control position in line with the accountability framework. This process has concluded with MSS being finalised as part of month 5 reporting. Within June the Trust received a revised Control Total offer from NHSI. This revised Control Total was subject to review and subsequent approval at a special Trust Board meeting held on 18 June 2018. As a response to this challenge a Financial Recovery Board has been created and is chaired by the CEO. The financial recovery board action plan currently had an identified gap of £11m and included the risk within the Cost Improvement Programme of £3.2m when compared to the target of £51m. The Financial Recovery Board meets fortnightly with each work-stream being sponsored by an Executive Director. As part of Q2 reporting the Trust has reported a revised forecast outturn for 2018/19. This includes the impact of not progressing with the FM LLP and recognition of a further deterioration of £8.7m. A revised deficit of £51.8m was submitted with a recovery action in place to address the remaining £3.2m financial challenge. This position remains for M8 reporting. The Trust has engaged with PWC to complete a review of the financial reforecast, the robustness of the current CIP programme and highlight any potential opportunities that may present themselves within 2018/19 to improve the current financial reforecast position. This report will be presented to the Trust Board in January 2019. Star chamber process (led by CEO) reviewing the new investment requirements. There is a significant shortfall in available funding compared to the complete list of investment requirements with the Star Chamber prioritising and approving spend. The allocation of funds to investment requirements has been agreed but further scrutiny is required and forms part of the Financial Recovery Board. The capital programme has been approved by CMIC and then further ratification by the Star Chamber. The relevant scheme holders are providing further analysis on a risk based assessment detailing the potential risks due to the limited availability of capital funds. Cash flow and enhanced cash reporting continues to be reviewed and discussed at FIC. Cash for deficit funding has been received in line with planned levels. This planned level of cash excludes any additional working capital requirements that will be required as a result of the revised deficit position. An application for this additional cash has been made in October with cash received in November and planned for the remaining months of the year.

DATE: @ Nov 2018	Director:	COO	Executive Board:	EPB	TB Sub Committee:	AC / QOC / PPPC
Linked Objective	We will improve our Emergency Care performance					
BAF Principal Risk: 4 – Emergency care	If the Trust is unable to effectively manage the emergency care pathway, ***caused by persistent unprecedented level of demand for services, primary care unable to provide the service required, ineffective resources to address patient flow, and fundamental process issues***, then it may result in widespread instances of poor clinical outcomes for patients and sustained failure to achieve constitutional standards, affecting business (finance) and reputation (breach in regulatory duty / adverse publicity).				**Current Risk & Assurance Rating (I x L):**	**5 x 4 = 20**

BAF Ratings	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**
Exec Team:	**5 x 4 = 20**	**5 x 4 = 20**	**5 x 4 = 20**	**5 x 4 = 20**	**5 x 4 = 20**	**5 x 4 = 20**	**5 x 4 = 20**	**5 x 4 = 20**				

Primary Controls

- **Emergency management:**
  - Emergency care pathway;
  - 4 times daily operational command meeting;
  - Capacity Flow and escalation policy;
  - Robust escalation protocols including OPEL triggers, CMG triggers, Full Hospital Process, Breach process for 8, 10 & 12 hour occurrences;
  - LLR system calls daily to review the position and ensure whole system responsiveness;
  - NHSI reporting;
  - System support provided by the National Emergency Care Improvement Programme (ECIP).
  - Red to Green embedded in medicine and RRCV and Trauma.
  - In Hospital (SAFER Care Bundle, Ambulatory Care and workforce) and Out of Hospital (DTOC) as well as admission prevention & avoidance projects.

- **Forums to identify and implement changes:**
  - A&E Delivery Board and sub groups - system wide actions, chaired by CCG MD.
  - New Emergency Care Board chaired by the COO.
  - Flow and Outflow board.
  - Monthly winter planning forum.
  - Demand and capacity work streams including plans for the vital few.
  - Performance Review and Assurance arrangement between CMGs, Specialties and Executive Directors / Executive Team.
  - System wide Frailty Board chaired by UHL CEO.

- **Emergency performance monitoring:**
  - 4 hour wait;
  - ED attendances;
  - Time to assessment;
  - Time to discharge;
  - Total breaches;
  - Emergency admissions;
  - Beds status.

Detective Risk Indicators

	Q&P Ref	Indicators	18/19 Target	18/19 Red RAG/ Exception Report Threshold (ER)	Nov - 18	18/19 YTD
Responsive	R1	**ED 4 Hour Waits UHL**	**95% or above**	Red if <85% Green 90%+	**72.6%**	**78.6%**
	R2	**ED 4 Hour Waits UHL + LLR UCC (Type 3)**	**95% or above**	Red if <85% Green 90%+	**79.1%**	**84.4%**
	R3	**12 hour trolley waits in A&E**	**0**	Red if >0 ER via ED TB report	**0**	**0**
	R12	**% Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE**	**0.8% or below**	Red if >0.8% ER if >0.8%	**1.1%**	**1.1%**
	R14	**Delayed transfers of care**	**3.5% or below**	Red if >3.5% ER if Red for 3 consecutive mths	**1.3%**	**1.4%**
	R15	**Ambulance Handover >60 Mins (CAD+ from June 15)**	**0**	Red if >0 ER if Red for 3 consecutive mths	**3%**	**2%**
	R16	**Ambulance Handover >30 Mins and <60 mins (CAD+ from June 15)**	**0**	Red if >0 ER if Red for 3 consecutive mths	**9%**	**7%**

Internal Assurances	External Assurances	Gaps Identified & Pending Actions, responsible officer & measure
• There remain significant nursing and medical staffing vacancies in ED and Specialist Medicine. This is a CMG board agenda item and there is a CMG recruitment plan to manage vacancies supported by corporate nursing. Additional medical staff commence in post in October. Alternative skill mix models are being considered and have been implemented e.g. medical step down ward. Additional investment in Phase II emergency floor posts currently being recruited. 51 international nurses to commence during November and December. • ED process: ➢ Time from arrival to decision to admit was 52% (average) in November. ➢ Patients allocated a bed within 60 minutes for all locations averaged 40% and for majors 36% • DTOC: ➢ Remain within tolerance • Acuity: ➢ Reducing number 80+ age in ESM beds ➢ Super stranded numbers. At the end of November there were 170 adults in hospital 21+ days. DCOO meeting with senior teams to confirm and challenge current plans for those off target. • Internal Action plans: ➢ Urgent action plan ➢ Winter plan • CMGs have a range of operational demand and capacity risks reported on the UHL Trust risk register which (for items scoring 15+) is reported to Exec Team and Trust Board monthly.	• NHSE national ranking official figures: 111–125 (out of 134). • NHSE November UHL 4 hour performance = 72.6%. LLR performance = 79.1%. • AEDB fortnightly to manage system wide actions. • NHSI Escalation meetings to provide system wide assurance. • Winter Assurance Visit – NHSI/NHSE 22/11/18. • Weekly assurance calls with NHSI. • System wide conference calls. • **Internal Audit 2018/19:** ➢ Review of ED front door service contract - scheduled Q1. ➢ Discharge processes – Red to Green – scheduled Q2 - to review how effectively the Red to Green process is operating and how well embedded this is across the Trust. • Stranded: ➢ Rated by NHSI in the best performing group as an organisation - Decreased +21 day LOS.	• IT Booking systems for DHU and OOH (MN – There is a delay with Nervecentre change so a work around is being developed for implementation in December 18; • Nervecentre embedding with teams to increase usability (CMG Heads of Ops 1.10.18 – admission discharge and transfer data to • measure outcome; • Red to Green in medicine and RRCV, Trauma and Children's– gap in delivery in the rest of the organisation (GS - 1.1.19 – gradual roll out across UHL); • Significant bed gap – activity and demand planning and bridge actions for the gap have been developed and as part of the winter plan; • Variation in process in ED and on the wards (Heads of ops – minimise pre winter 1.10.18 – NAB performance to measure outcome); • TASL resource flexibility – managed via CCG (JD 1.10.18 – decrease re- beds – TASL data to measure outcome); • ESM nursing and medical staffing vacancies – managed by CMG Board (Heads of Ops – on-going recruitment strategy – vacancy numbers to measure outcome); • DHU staffing gaps – managed through weekly meetings with ESM CMG and DHU and through Executive presence (MN -1.8.18 – measured by staffing numbers increasing). Trial of new assessment/deflection process at front door started on 18/09/18 – 2 different rapid cycle tests were explored. Current RCT has shown good improvement and is currently under evaluation. Urgent care action log has further details about the actions, owners and completion dates.

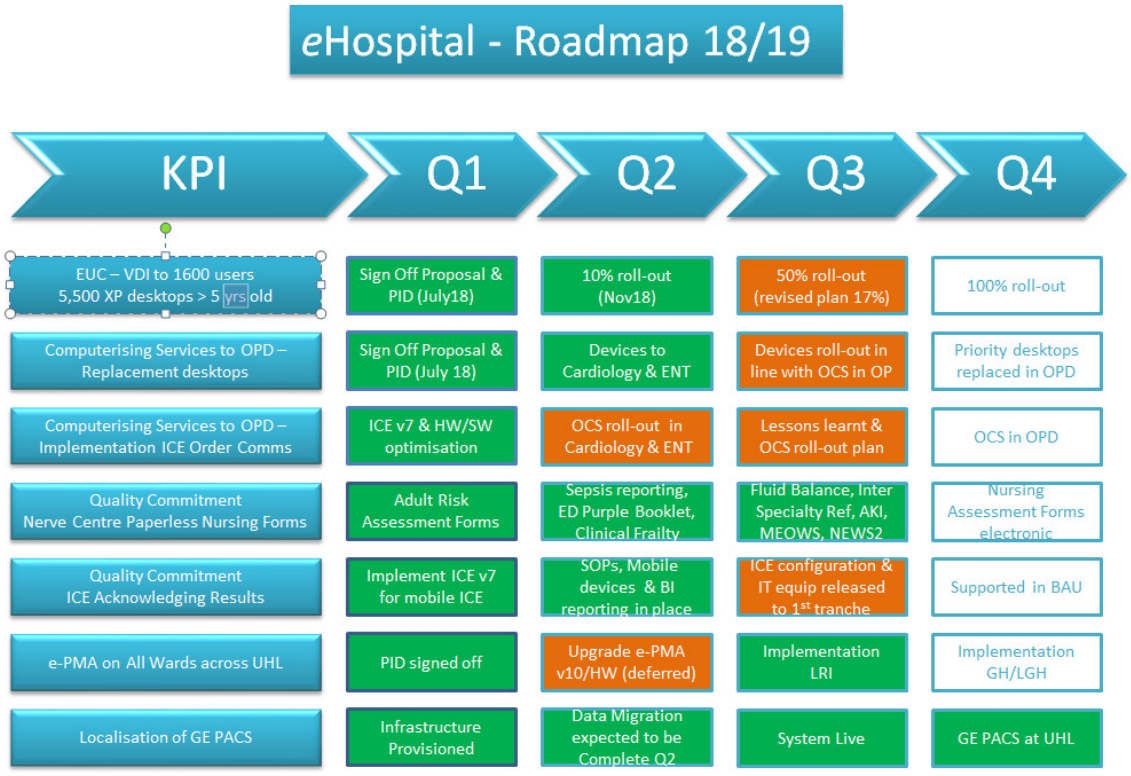
DATE: @ Nov 2018	Director:	CIO	Executive Board:	EIM&T (quarterly)/EPB	TB Sub Committee:	AC / PPPC
Linked Objective	To progress our strategic enabler – IM&T					
BAF Principal Risk: 5 – Information Technology	If the Trust is unable to deliver a fit for the future IM&T service, ***caused by inability to secure appropriate resources (including external capital and workforce), a critical infrastructure failure, ineffective system resilience and preparedness of an external IT supplier or an external shut-down attack***, then it may result in a significant disruption to the continuity of core critical services, affecting reputation (breach in regulatory duty / adverse publicity).				**Current Risk & Assurance Rating (I x L):**	**4 x 4 = 16**

BAF Ratings	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Exec Team:	**4 x 4 = 16**	**4 x 4 = 16**	**4 x 4 = 16**	**4 x 4 = 16**	**4 x 4 = 16**	**4 x 4 = 16**	**4 x 4 = 16**	**4 x 4 = 16**				

Primary Controls

- IM&T eHospital (previously known as Paperless hospital 2020) strategy including Board structure and clinical leads in place.
- Overarching 18/19 IM&T strategic plan.
- Cyber security measures in place including regular assessments and close working relationship with managed business partner.
- Information Governance arrangements including IG toolkit, IG Steering Group and GDPR plan.
- Working arrangements aligned with clinical strategies through clinical and medical workforce information officers.
- Disaster Recover plans in place for IM&T systems.
- IM&T governance and performance monitoring through IM&T Service Board reporting to Trust Board (via FIC/PPPC), Audit Committee and Executive (EMI&T).
- IT Network providers early warning notifications monitored.
- Resources against service demand – IM&T prioritise CMGs work requests/demands against their service constraints through the IT request form and prioritisation matrix.
- Organisational change capacity – CMGs liaise with IM&T to agree IM&T support required to implement new IT programmes / systems for each (sub) project. Process defined in the PID and LORA (local organisational readiness assessment).
- CMGs Business Continuity Plans (following BIAs) included in the EPRR work plan and progress monitored through UHL EPRR Board.

Detective Risk Indicators



Internal Assurances	External Assurances	Gaps Identified & Pending Actions
• Information Governance IG Toolkit reported to AC – All components of the IGT in relation to data quality were self-assessed as the highest level 3 for 2017-18 – UHL is a trusted organisation as defined in the IG Toolkit. With the move from IGT to the Data Security and Protection Toolkit from April 2018, specific requirements for management of Data Quality are still being finalised. We have contacts with NHS Digital as well as good connections across a network of peer Data Quality leads at other regional Trusts. • GDPR progress reported to Exec Team (EIM&T) and AC – GDPR Project Lead appointed in July 2018. • Paperless hospital 2020 strategy reported to Exec Team and to Trust Board sub-committees on a regular basis - The pace of achievement of the Paperless Hospital 2020 is dependent on available resources to effect the changes and prioritisation of other demands on IT services. • The Trust's avoidance of any significant impact from the WannaCry ransomware has highlighted the good standard of our processes related to cyber security, although with no room for complacency given the speed with which this threat evolves. • IM&T Capital Plan Briefing to PPPC.	• **Internal Audit 2018/19:** ➢ Information Governance – to perform validation work on the Information governance toolkit in line with the annual audit requirement – Audit review completed March 2018 – Medium Risk. ➢ IG / GDPR follow-up - to review the adequacy of the Trust's information governance processes through 1) validation work on the new Data Security and Protection (DSP) Toolkit, which replaces the Information Governance toolkit from April 2018 and 2) Specific follow up work on the actions raised in the 2017/18 GDPR review – Audit scheduled Q4 2018/19. ➢ Paperless 2020 programme review - following an initial review of EPR 'Plan B' a follow up to assess how the programme is progressing using a diagnostic 'Twelve elements of programme management excellence' – Audit review completed May 2018 – High risk - progress with actions tracked via the e-Hospital Board, delays against plan but expected to complete by Mar 19. Actions completed except infrastructure which is due to complete Mar 19. New audit by PWC in progress, report expected Dec 18. ➢ Emergency Preparedness, Resilience and Response (EPRR) – to review a selection of the IM&T Disaster Recovery plans – Audit scheduled Q4 2018/19. • ISO 27001:2013 – The MBP maintains an accreditation (in 2017) – due for review in 2018/19. • NHS digital Health Check – cyber security audit – Jan 2018 – remediation plan agreed. • NHS IT Maturity Index – Completed Q1 2018/19 - scores for UHL higher on all domains than national average.	• **Project resource** to finance the acceleration of the Trust's IT service including desktop replacement project – *Secure adequate resources to fund 18/19 IT strategy* – Financial plan confirmed by CIO July 18 for eMeds. Project priorities resource plan to the end of Mar19. • **eHospital engagement** - *Deliver support to the quality commitment by identifying priority work that can be undertaken on existing systems, i.e. nervecentre or ICE as per the agreed UHL annual priorities. For 2018/19 will involve the following 5 areas (Responsible Officers MD & CIO):* ➢ *Replacing old computing/mobile hardware- roll-out started Aug 18* ➢ *Nervecentre- in progress, assessment forms being deployed Q3* ➢ *PACS – completed* ➢ *ICE– in progress- Implement in Cardiology and ENT Dec 18* ➢ *E-Prescribing – in progress roll-out to start LRI liveNov18, GH Q4, LGH deferred.* • **Information Governance plan** for implementation of **GDPR** – gap analysis by Internal Auditors identified there are a number of gaps with regard to the new regulation commenced in May 2018. Mitigating actions include undertaking a Corporate Records Audit by Mar 2019 (CIO). • **Cyber security** – raising awareness to reduce risk of human factors and on-going medical equipment challenges – IM&T awareness campaigns including IM&T newsletter and new GDPR training - Commenced Oct 18 (CIO). • **Cyber security** - Reducing risks are dependent on the roll-out of the eQuip hardware refresh programme and in particular replacement of PCs running old operating systems – 12 month project commenced July 2018 and due July 2019. Additional 3 month resources purchased to accelerate the roll-out for eMeds from Nov 18 • CMGs **Business Continuity Plans** have been identified as a gap in control following the IM&T power failure downtime in Oct 18. Developing effective plans is included as part of the EPRR work programme in 2019/20 and actions assigned to CMGs to develop their plans for all IT systems. • **External IT supplier preparedness -** UHL to seek assurance from external providers about their system resilience arrangements. CIO linking with CMGs HoOs to request they liaise with their external providers (requested 06/08/18) – Q2 2018/19 (CIO).

DATE: @ Nov 2018		Director:	DEF	Executive Board:	ESB	TB Sub Committee:	AC / QOC				
Linked Objective	To progress our strategic enabler… to deliver safe, high quality, patient centred, healthcare										
BAF Principal Risk: 6 – Estates	If the Trust does not adequately develop and maintain its estate to meet statutory compliance obligations and minimise the potential for critical infrastructure failure, ***caused by a lack of resources to address the backlog maintenance programme, insufficient clinical decant capacity and the sheer volume of technical work to address ageing buildings***, then it may result in an increased risk of failure of critical plant, equipment and core critical services leading to compliance issues, risk of regulatory intervention, impact upon business and patient critical infrastructure and adverse publicity.									**Current Risk & Assurance Rating (I x L):** 5 x 3 = 15	
BAF Ratings	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**
Exec Team:	5 x 3 = 15	5 x 3 = 15	5 x 3 = 15	5 x 3 = 15	5 x 3 = 15	5 x 3 = 15	5 x 3 = 15	5 x 3 = 15				

Primary Controls	**Detective Risk Indicators**
• Estates & Facilities directorate governance structure to deliver effective estates and facilities services. • Estates Strategy - directs investment and resources how the Trust will maintain a fit for purpose estate that enables delivery of high quality, safe and effective care (in line with CQC core standards: Safety and suitability of premises; Safety, availability and suitability of equipment; Cleanliness and infection control), including Clinical Strategy priorities and the organisation's wider five year plan. • Prioritised Annual and Five-Year capital programme developed in consultation with CMGs and Trust Exec Team. • Statutory Compliance monitoring programme provides assurance that statutory obligations are met. The Compliance Assessment Audit System (CAAS) is used to monitor compliance rate and assist UHL in evidencing its Premises Assurance Model (PAM) position. The PAM dashboard is reported to Exec Team. Independent Authorising Engineer annual reports to measure conformance against HTM / HBN guidance. • Estates & Facilities Risk Management Process – monthly multi-disciplinary Estates & Facilities Capital Risk Management Group review new and existing E&F risks prior to reporting for scrutiny to the E&F SMT. Significant risks are escalated to the UHL Risk Register, thus providing a consistent governance approach to monitoring and review in-line with the Trust risk plan. • Backlog Maintenance & maintainability surveys and business continuity and condition surveys. • Reactive maintenance capability and 24/7 emergency call out arrangements across all sites. • Infection Prevention and Control programme embedded in Estates including policies / procedures; staff training; environmental cleaning audits and inspections. • Estates & Facilities Help Desk provides single focal point for all works requests. • Patient-led Assessments of the Care Environment (PLACE). • All key projects are taken through a rigorous business case process to ensure they deliver benefits based on the situation at the time of their development.	• Key Estates & Facilities Performance Indicators: ➢ Model Hospital benchmark. ➢ Carter Indices. ➢ Naylor recommendations for E&F. ➢ Internal KPIs and performance thresholds (hard and soft FM) ➢ Premises Assurance Model Reports ➢ CAAS Reports ➢ Specialist Reports and verifications ➢ DoH acceptance of Trust ERIC submission

Internal Assurances	External Assurances	Gaps Identified & Pending Actions
• Risk Assessments identify significant risks are reviewed by E&F Senior Management Team on a quarterly basis, prior to being put onto the Trust Risk Register. • Risk action plans/action notes are generated and monitored and reviewed in accordance with Trust risk management policy. • Data from Backlog maintenance & maintainability (age & replacement parts), business continuity and condition surveys ensures highest identified risks are prioritised and considered for funding. • Planned Preventative Maintenance tasks and Reactive maintenance calls are monitored on a monthly basis and reported to the Estates & Facilities Senior Management team. The planned schedule is affected by the volume of reactive calls and the shortage of engineers to carry out tasks and administration personnel to close tasks down on the system.	• Backlog maintenance – reported in the ERIC return to the Department of Health and benchmarked against other NHS Trusts annually. • Premises Assurance Model – current rating: 'Steady State'. • External audit for Piped Medical Gases carried out by an Independent Authorising Engineer, annually. • Electrical Low Voltage, High Voltage and Lifts audited by an Independent Authorising Engineer, annually. • Water audit carried out by an Independent Authorising Engineer, six monthly. • External audit for Specialist Ventilation carried out by an Independent Authorising Engineer, annually. • Patient-led Assessments of the Care Environment (PLACE) report benchmarking, • **Internal Audit 2017/18:** ➢ Backlog maintenance – Audit action plan monitored and reviewed at UHL Audit Committee. • **Internal Audit 2019/20:** ➢ Capital Programme (TBC) - a review of the prioritisation process for developing the capital programme, how resources are allocated across the key areas and the monitoring / reporting around the programme.	• Insufficient funding allocated to fully implement the Sustainable Development Management Plan. A review of the plan is underway with a proposed re-launch of the action plan 2019/20. • Reconfigure the estate in-line with clinical and estates strategy. A five-year backlog maintenance reduction programme with Trust Board backing is required. • Detailed build-up of capital costs to provide an overall 5 year capital programme to ensure appropriate finances are allocated to implement the changes required. • A full asset list of all plant and equipment is being collated - to be completed in 2019. • LLR STP funding position to be updated for a 2019/20 bid and put forward to NHS Improvement and NHS England. This includes backlog and infrastructure investment. • Confirmation of planning assumptions and service model which will lead to refinements in the proposed DCP design solutions – Further revision of the DCPs based the current level of information and forecasts. • Incorporate priorities from the Galliford Try infrastructure review 2018 into the 2019/20 Capital programme. • Identify appropriate level of upgrade works; to be informed by the latest condition survey and linked to the Galliford Try review. The review has identified proposed areas of spend, these are being refined into a five year plan. • Recruitment and retention of key operational and maintenance E&F staff challenges, resulting in gaps in service delivery and standards – DEF to review following a change in E&F trajectory as a result of not moving to the planned E&F Subsidiary model – Review of E&F structure progressing and will be completed by 31/03/2019. • Recruitment and Retention of Estates Specialist Services Authorised Person (AP) specialists identified as a potential threat to Capital Development schemes as AP support is key to quality & safety in the delivery of capital schemes. AP training matrix developed and progressing with a 31/03/2019 target for new appointments. • A monthly performance report for internal use by E&F is being compiled. This will lead into an annual, or six monthly, report for presentation to the Executive.

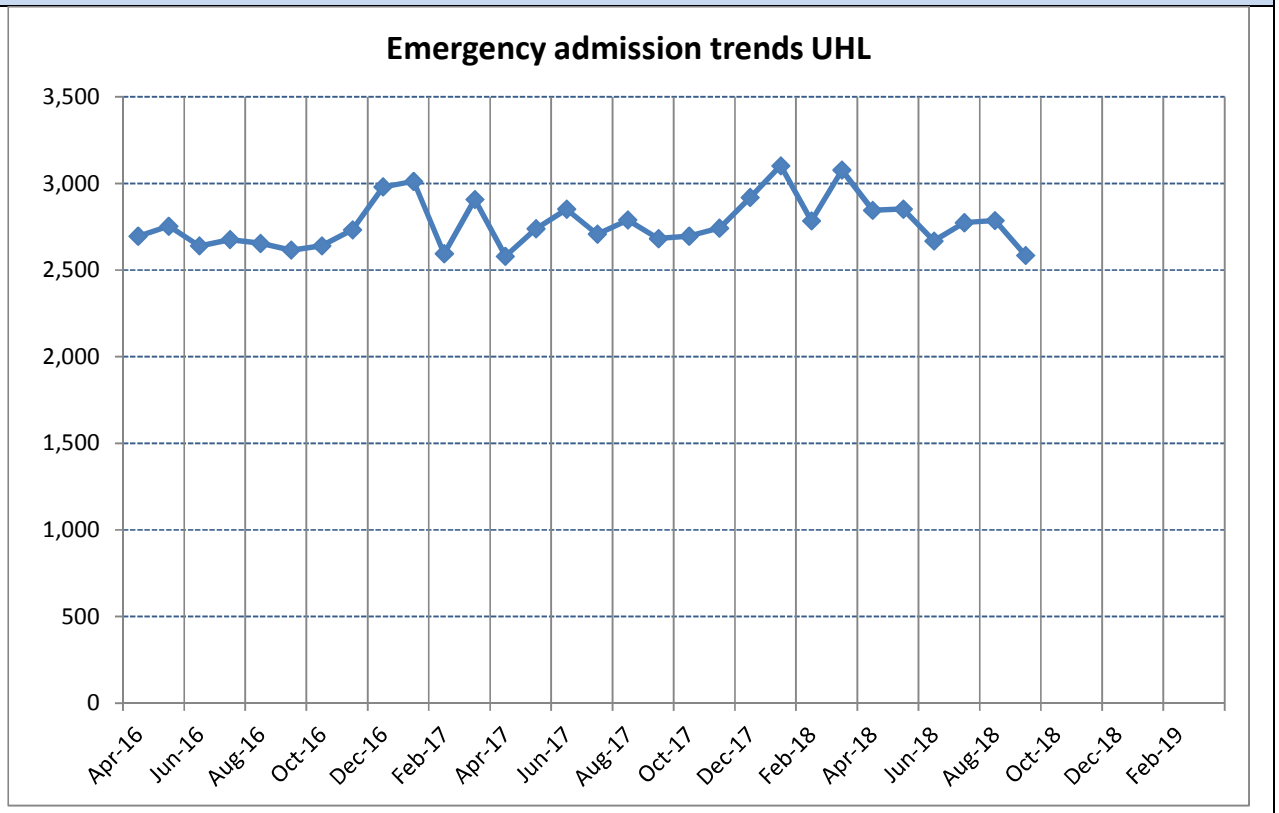
DATE: @ Nov 2018	Director:	DSC	Executive Board:	ESB	TB Sub Committee:	AC / PPPC
Linked Objective	To develop more integrated care in partnership with others					
BAF Principal Risk: 7 – Partnerships	If the Trust is unable to work collaboratively with partners to secure the support of community and STP stakeholders, ***caused by breakdown of relationships amongst partners and ineffective clinical service strategies of the local population***, then it may result in disruption to transforming sustainable clinical services, affecting business (finance) and reputation (breach in regulatory duty / adverse publicity).				**Current Risk & Assurance Rating (I x L):**	**4 x 3 = 12**

BAF Ratings	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**
Exec Team:	**4 x 4 = 16**	**4 x 4 = 16**	**4 x 4 = 16**	**4 x 4 = 16**	**4 x 4 = 16**	**4 x 4 = 16**	**4 x 4 = 16**	**4 x 3 = 12**				

Primary Controls

- Attendance and active participation in:
  - All STP work streams at senior strategic level and at operational level where relevant.
  - Health and wellbeing Boards across City and County.
  - Active engagement with primary care across city and county.
- Revised Trust objectives and annual priorities agreed for 2018/19.
- LLR Integrated Community Board, Frailty programme, AE Delivery Board and internal flow metrics.
- LLR Frailty Checklist agreed by health and social care. This is a single page reminding professionals to check that vaccinations, falls assessments, medication reviews etc. have been completed.
- Clinical Frailty Scale score has been built into Nerve Centre with a tailored training package for all EF staff.
- Active Clinical input and leadership across key STP work streams such as planned care, urgent care, Integrated Locality teams, and Home First.
- System wide PMO including: Project and programme management; Specialist Support e.g. business intelligence, strategic planning; Change Management and Transformation Function.
- Readmissions working group set up to analyse data at specialty level (inc. benchmarking) and assess the actions needed.

Detective Risk Indicators



Internal Assurances	External Assurances	Gaps Identified & Pending Actions
• Internal self-assessment reviews about the efficacy of the controls for this risk have been reported to ESB; Stakeholder meetings; Trust Board sub-committees and have identified gaps in active participation in several related STP work streams – this has been rectified from June 2018, with operations and strategy attendance at key STP meetings. • Multiple CMGs and services now involved in improving this system of care for frail and multi-morbid patients internally and with external partners. Positive engagement noted to date.	• Review of the LLR STP has shown that this risk is not fully mitigated as assurance of efficacy of the partnership working is limited at this point. This tells us that the current governance processes are not yet fit for purpose and will not fully mitigate the risk as presented. • The work will be referenced in LLR escalation meetings with NHS England and NHS Improvement, with the LLR frailty programme held up as an exemplar across the regional system. New Integrated Community Services Board formed, covering the duplicative work of the Integrated Locality Teams and the Home First STP work streams. UHL fully engaged at strategic and operational level. Outcomes being aligned to those of the Frailty programme.	• First new Integrated Community Services Board met in October 2018 but with limited progress made on action plan. UHL COO escalated that the work programme for the Board was not specific nor tailored enough in November 2018. As an action, HoSD engaged to rewrite action plan with system colleagues, bringing together the requirements needed from community partners using population health methodology. This will be presented to the December 2018 Board. • Gaps/Delays in the community services redesign process to be highlighted to Frailty Task Force and SLT in November. As a result, CSR team invited in to present the modelling used to a UHL MDT consisting of BI, Operations and Strategy in early December 2018.

Appendix 2 UHL Risk Register Dashboard (15+) as at 30 November 2018

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score
2333	ITAPS	If we do not recruit into the Paediatric Cardiac Anaesthetic vacancies to maintain a WTD compliant rota, then it may result in suboptimal patient treatment leading to potential for patient harm.	20	8
2264	CHUGGS	If an effective solution for the nurse staffing shortages in CHUGGS at LGH and LRI is not found, then it may result in detrimental impact on quality of delivered care and patient safety leading to potential for patient harm.	20	6
1149	CHUGGS	If there is an increase to cancer patients waiting times, caused by competing priorities between cancer targets, patient compliance, capacity and administration processes, then it may result in widespread delays with patient diagnosis or treatment leading to potential for patient harm and waiting time target breach	20	9
2565	CHUGGS	If capacity is not increased to meet demand in General Surgery, Gastro and Urology, then it may result in widespread delays with patient diagnosis or treatment leading to potential for patient harm and breach against delivery of national targets	20	9
3183	RRCV	If Cardiac Surgery is unable to operate on elective patients due to winter pressures and/or availability of ward and ITU beds, then it may result in widespread delays with patients treatment and patients' conditions could deteriorate resulting in a need for urgent admission or more complex surgery with greater risk of complications.	20	15
3186	RRCV	If RRCV CMG fails to achieve the allocated financial control total then this could result in an deterioration in the Trust overall financial deficit.	20	9
2354	RRCV	If the capacity of the Clinical Decisions Unit is not expanded to meet the increase in demand and reduce overcrowding, then it may result in detrimental impact on quality of delivered care and patient safety leading to potential harm to patients.	20	9
2149	ESM	If we do not recruit and retain into the current Nursing vacancies within Specialist Medicine, then it may result in detrimental impact on quality of delivered care with widespread delays with patient diagnosis or treatment leading to potential for patient harm.	20	6
2804	ESM	If the ongoing pressures in medical admissions continue and Specialist Medicine bed base is insufficient with the need to outlie into other specialty/ CMG beds, then it may result in detrimental impact on quality of delivered care and patient safety leading to potential for patient harm	20	12
3222	ESM	If a member of the public is violent or aggressive outside or inside ED receptions/waiting rooms, then it may result in a detrimental impact on health, safety & security of staff, patients and visitors leading to harm	20	10
3077	ESM	If there are delays in the availability of in-patient beds leading to overcrowding in the Emergency Department and an inability to accept new patients from ambulances, then it may result in detrimental impact on quality of delivered care and patient safety within the ED leading to potential harm.	20	15
3114	ITAPS	If we are unsuccessful in recruiting ITU medical and nursing staff to agreed establishment, then it may result in widespread delays with patient diagnosis or treatment leading to potential for patient harm.	20	6
3115	ITAPS	If there is an IT infrastructure failure or delay in accessing systems due to out of date and obsolete hardware and software in theatres and other clinical areas, then clinical teams will not be able to access essential patient information or imaging in a timely manner leading to potential for patient harm.	20	4
3120	ITAPS	If there is a continued mismatch between capacity and demand for access to emergency theatres, then it may result in cat 2 and 3 patients not receiving surgery within the NCEPOD timeframes, leading to potential for patient harm	20	12
3113	ITAPS	If the infrastructure in our ITU's is not updated and expanded to meet current standards and demand for all patients requiring level 2 or 3 care, then it may result in deterioration in clinical outcomes benchmarked against other centres (ICNARC), leading to potential for patient harm.	20	8
3200	ITAPS	If the practices, workforce, estate and facilities in LRI ITU are not compliant to current standards and expectations, caused by staffing shortages, inadepquate capacity for demand and an aging estate with suboptimal environment for critical care patients, then clinical teams will not be able to provide safe care to all patients requiring level 2/3 care due to an increased risk of cross contamination	20	10
3119	ITAPS	If there is a deterioration in our theatre staff vacancies and we are unsuccessful in recruiting ODP's to agreed establishment, then it may result in widespread delays with patient treatment leading to potential for patient harm and service disruption	20	6
2777	Comms	If fundraising targets for the Charity fundraising campaign do not reach target charitable income	20	8
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, leading to potential harm to patients, reputation impact, increased financial impact and non-compliance with agreed targets.	20	3
3148	Corporate Nursing	If the Trust does not recruit the appropriate nursing staff with the right skills in the right numbers then we may not be able to deliver safe, high quality, patient centred, efficient care and reduce our current nursing vacancy levels resulting in potential increased clinical risk to our patients and poor patient experience	20	12
2404	Corporate Nursing	If the process for identifying patients with a centrally placed vascular access (CVAD) device within the trust are not robust, and there is no oversight of all Vascular Access activity across UHL then this could result in increased morbidity and mortality.	20	16
3298	Corporate Nursing	If the outbreak of Carbapenem-resistant Organisms continues, we are at risk of under achievement of key clinical standards and a decrease in bed capacity for emergency admissions so reducing our ability to continue to provide an acceptable level of health service leading to potential harm to patients, adverse reputation and service delivery impact.	20	5
3109	RRCV	If additional capacity, resource and support is not provided for the Respiratory Consultant Pharmacist then there is a risk of patient harm as they will be unable to deliver current commitments, service requirements or meet the future demands of the CMG due to the significant gaps in resource versus demand in this highly specialised role.	16	8
3181	RRCV	If the Prescribing Administration and Monitoring of Oxygen in Adults Policy is to be adhered to, then the e-obs system settings must be adjustable for Cardio-Respiratory patients, resulting in in improved patient care or chronic hypoxic conditions and for patients who do not have Type 2 respiratory failure.	16	6
3040	RRCV	If there are insufficient medical trainees in Cardiology, then there may be an imbalance between service and education demands resulting in the inability to cover rotas and deliver safe, high quality patient care.	16	9
3297	RRCV	If there is no improvement in the number of cardiac surgery admin staff, and staff with the right admin skills, caused by long term and continued episodic sickness absence, then cardiac patients may experience delay in diagnosis or treatment resulting in potential harm to patients, service disruption, adverse reputation and financial loss.	16	9
2820	RRCV	If a timely VTE risk assessments is not undertaken on admission to CDU, then we will be breach of NICE CCG92 guidelines resulting patients being placed at risk of harm.	16	3
3325	RRCV	If we do not replace the entire lung function equipment, then it may result in a prolonged disruption to the continuity of services and widespread delays to provide lung function tests for UHL patients, leading to potential service disruption and patient harm.	16	4
3233	RRCV	If VSU diagnostic ultrasound images and reports are not made available on the UHL PACS & CRIS systems, then it may result in widespread delays with patient diagnosis or treatment due to the difficulties associated with not being able to access the relevant patient VSU diagnostic ultrasound images and reports, leading to harm.	16	1
3198	ESM	If there is a failure to administer insulin safely and monitor blood glucose levels accurately, in accordance with any prescriber's instructions and at suitable times, then this may lead to patients not having their diabetes appropriately monitored/managed, leading to severe harm	16	4
3203	ESM	If Dermatology is not adequately resourced, then we will be unable to provide high quality and timely care to our patients and recruitment of staff will be affected, resulting in threat of not meeting RTT and skin cancer targets.	16	4
3025	ESM	If there continues to be high levels of qualified nursing vacancies and issue with nursing skill mix across Emergency Medicine, then quality and safety of patient care could be compromised.	16	4
3121	ITAPS	If operating theatres' ventilation systems fail due to lack of maintenance, then the affected theatres cannot be used to provide patient care resulting in reduced theatre capacity and pressure on other theatres to meet demand and may lead to patient cancellations	16	9
2191	MSK	If workforce constraints within the ophthalmology service are not addressed, then backlogs and delays could result in serious patient harm.	16	8
2989	MSK	If we do not recruit into the T&O Wards nursing vacancies, then patient safety and quality of care will be placed at risk	16	4
2955	CSI	If system faults attributed to EMRAD are not expediently resolved, then we will continue to expose patients to the risk of harm	16	4
3205	CSI	If the breast screening round length is not reduced, caused by a multitude of factors including workforce gaps, implementation of new PACS EMRAD, lack of unit space and unplanned equipment downtime, then the PHE performance indicator may not be met leading to delays with patients three yearly breast screening appointments impacting early cancer diagnosis.	16	8

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score
3320	CSI	If CSI CMG is unsuccessful in controlling expenditure, finding additional efficiency savings over and above the Trust set target and maximising income then the CMG is at risk of failing to achieve the financial target of breakeven, leading to unmet financial performance targets, increased pressure on resource allocation for 2018-2019, adverse implications on service delivery through constrained future funding.	16	4
3329	CSI	NEW: If Pharmacy Technician and Pharmacist staffing levels are below establishment, caused by retention and recruitment challenges during periods of increased workloads then it may result in prolonged disruption to the continuity of core services across the Trust leading to service disruption	16	8
3129	CSI	If a 100% traceability (end fate) of blood components is not determined Then BSQR 2005 legal requirement of 100% traceability will not be met Resulting in legal implications and delay in providing blood and blood components	16	4
3206	CSI	If staff are not appropriately trained on the usage of POC medical device equipment then this may lead to improper use that may result in inaccurate diagnostic test results affecting patient care and leading to potential harm to the patient.	16	6
3286	CSI	If continual failure in meeting key performance indicators for urgent blood cancer diagnostic testing, caused by limited Consultant Immunologist availability then this will result in delayed diagnosis and treatment of acute leukaemia patients and withdrawal of weekend standby service	16	6
3008	W&C	If the paediatric retrieval and repatriation teams are delayed mobilising to critically ill children due to inadequately commissioned & funded provision of a dedicated ambulance service, then this will result in failure to meet NHS England standards, delayed care, potential harm and inability to free-up PICU capacity.	16	5
2153	W&C	If the high number of vacancies of qualified nurses working in the Children's Hospital is not addressed, then there will be a shortfall in the nurse to patient ratio which could impact on the quality of patient care.	16	8
3201	Comms	If the Mac desktop computers fail/break down or the shared server fails, then there is a loss of service to the Trust because photographers and/or graphics are unable to do their job and potential loss of work products that are saved/stored on there. There is no IM&T support for these machines and no IM&T support or management of this server.	16	2
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
3138	Estates & Facilities	If there are insufficient management controls in place to meet Regulation 4 of the Control of Asbestos Regulations, then there is an increased risk of enforcement action by the HSE, resulting in prosecution, and/or significant financial impact and reputational damage.	16	4
3140	Estates & Facilities	If sufficient 'downtime' for Planned Preventative Maintenance and corrective maintenance is not scheduled into the theatre annual programmes, then functional defects will emerge and evolve in specialist ventilation systems, resulting in potential risk of microbiological contamination in the theatre environment.	16	8
3141	Estates & Facilities	If the integrity of fire compartmentation is compromised, then during a real fire event the rate of fire and/or smoke spread will accelerate through the building limiting the ability to utilise horizontal and/or vertical evacuation methods, resulting in potential life safety concerns and loss of areas / beds / services.	16	8
3143	Estates & Facilities	If sufficient capital funding is not committed to reduce backlog maintenance across the estate there will be an increasing risk of key/critical failures in buildings, building services and infrastructure impacting on service provision and patient care.	16	6
3144	Estates & Facilities	If Estates & Facilities are unable to recruit and retain staff, or fund posts to deliver services to meet the Trust's expectations, then there is a risk of a service delays and interruption/failure to achieve required standards, resulting in adverse impacts to patient & non-clinical services, environment, equipment and infrastructure.	16	9
3145	Estates & Facilities	If there is not a significant investment to upgrade electrical infrastructure across the UHL, then there will be an increased risk of a loss of 'normal' electrical supply and potential failures in generator stand-by electrical supply leading to interruption to patient care, key electrical equipment breakdown, and provision of normal patient care and support services	16	6
3137	Estates & Facilities	If calls made to the Switchboard via '2222' are not recorded, then there is a risk that vital/critical information passed verbally between caller and call handler cannot be verify if the emergency response is not appropriate for the reported situation.	16	4
3180	IM&T	If fragility in the underlying UHL IM&T infrastructure is not addressed, then there may be limited or no access to Trust IM&T critical systems, resulting in service disruption and impacting provision of care	16	6
3155	IM&T	If the PABX system fails then the telephone system will not work for a range of telephone numbers resulting in significant service disruption and potential patient harm.	16	4
3191	IM&T	If the Trust is unable to demonstrate 95% compliance with IG training, then the Trust may lose level 2 IG accreditation, resulting in potential loss of research status and difficulties with forging future collaborative working arrangements with prospective business partners which could adversely impact on the delivering strategic aims.	16	9
2621	CHUGGS	If recruitment and retention to vacancies on Ward 22 at the LRI does not occur, then patients may be exposed to harm due to poor skill mix on the Ward.	15	6
3312	RRCV	If recurrent funding is not provided to retain the 2 nursing posts (B6 and B3) for the LTBI programme current services will have to be be withdrawn. This includes the TB nurse-led outpatient list and in addition there will be no safe community follow-up for LTBI cases that are treated as part of the Migrant Screening Programme.	15	1
3211	RRCV	If Additional appropriately trained sedationists are not provided in Angiocatheter suite. Then Patients undergoing cardiology procedures may receive an inadequate level of monitoring during conscious sedation.	15	8
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
2837	ESM	If migration to an automated results monitoring system is not introduced in the Neurology department, then it may result in delays with treatment for follow-up patients with multiple sclerosis, leading to potential harm.	15	2
3317	CSI	If breast care services are unable to consistently deliver the 2WW demand, due to high volumes of vacancies, lack of equipment and adequate space to house the service, then patients may experience delayed appointment time and treatment, resulting in harm	15	9
2615	CSI	Integrity and capacity of containment level 3 laboratory facility in Clinical Microbiology	15	2
2973	CSI	If the service delivery model for Adult Gastroenterology Medicine patients is not appropriately resourced, then the quality of care provided by nutrition and dietetic service will be suboptimal resulting in potential harm to patients.	15	6
3262	CSI	If the pressure on the Cellular Pathology Urology service caused by the continuing increase in cases from external sources is not effectively matched with appropriate resources then the service will become unsustainable potentially leading to reporting errors and impacting on patient safety.	15	3
3288	CSI	If no additional storage space can be identified in UHL pharmacy to stock essential filtration fluids, caused by robot rebuild starting summer 2018, then patients that clinically require Continuous Renal Replacement Therapy may experience delayed treatment or diagnosis, resulting in potential for suboptimal therapy, significant irreversible harm and increased LOS to AICU patient population	15	5
2965	CSI	If we do not address Windsor pharmacy storage demands, then we may compromise clinical care and breach statutory duties	15	6
3330	CSI	NEW: If the ventilation physiotherapy department is below establishment, then it may result in detrimental impact on quality of delivered care and patient safety in the physiotherapy service leading to potential for harm	15	6
3023	W&C	There is a risk that the split site Maternity configuration leads to impaired quality of Maternity services at the LGH site	15	6
3093	W&C	If there is insufficient Midwifery establishment to achieve the recommended Midwife to Birth ratio, in view of increased clinical acuity, then patient care may be delayed resulting in potential increase in maternal and fetal morbidity and mortality rates	15	6
3083	W&C	If gaps on the Junior Doctor rota in the Neonatal Units at both the LRI and LGH reach a critical level, then it may result in widespread delays with patient diagnosis or treatment, leading to potential for harm.	15	3
3084	W&C	Due to the current split site Consultant cover of the Neonatal Units at the LRI and LGH; there is a risk to patient care, quality of service and reputation to the unit and Trust. This may also result in the withdrawal of the neonatal service from the LGH site impacting significantly the Maternity Service.	15	5
3332	W&C	NEW: If the paediatric asthma service remains below clinic capacity, then it may result in significant delay with reducing the waiting list and patient review or treatment leading to potential patient harm	15	4
2394	Comms	If a service agreement to support the image storage software used for Clinical Photography is not in place, then we will not be able access clinical images in the event of a system failure.	15	3

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score
3079	Corporate Medical	If there is insufficient capacity with the administrative support for the Learning from Deaths Framework and the Specialty M&M Structured Judgment Review process which is not addressed and substantive funding is not identified for an additional Bereavement Support Nurses, then this will lead to a delay with screening all deaths, undertaking Structured Judgment Reviews, and speaking to bereaved relatives, resulting in failure to learn from deaths in a timely manner and non-compliance with the internal QC and external NHS England and Statutory Quality Account requirement	15	6
2434	IM&T	If computers operating on Windows XP are not upgraded, then we may experience significant service disruptions in the event of a cyber attack.	15	6
1615	IM&T	If flooding occurs at the LRI, then the Servers and Network equipments in our Data Centre may become damaged resulting in Trust-wide service disruption and potential harm to patients.	15	6
3172	IM&T	If systems and services provided by IM&T are not continuously maintained to ISO accredited standard, then our systems may be vulnerable to potential cyber attack resulting in in significant service disruption, harm to patients and financial loss	15	15
3289	Operations	If the Trust fails to improve its emergency preparedness, resilience and response (EPRR) arrangements, caused by a lack of appropriate time and resources to develop them, then there is a risk that the Trust is not adequately prepared to respond to a business continuity, critical or major incident.	15	6