INTEGRATED RISK AND ASSURANCE REPORT: MARCH 2019

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.

Questions

1. What are the significant changes to the 2018/19 BAF since the previous version?
2. What are the highest rated principal risks on the 2018/19 BAF?
3. How is work progressing to refresh the 2019/20 BAF?
4. What are the significant changes to the organisational risk register since the previous version?
5. What are the key risk management themes evidenced on the organisational risk register?

Conclusion

1. There have been no new principal risks entered and no changes to risk ratings for current principal risks on the 2018/19 BAF during this final reporting period.
2. The principal risks on the 2018/19 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, delivery of the financial control total and estate infrastructure.
3. A number of principal risks from the 2018/19 BAF have been included (in slightly re-worded forms) in the new principal risks on the 2019/20 BAF, which has been reviewed and approved by the Executive Team at its EPB meeting in March and by the Trust Board at its meeting in April. The refresh of the BAF has involved two sessions with the Trust Board at its Thinking Day in March, to identify the new principal risks, and in April, to inform the principal risk ratings (including inherent, current and target). A first draft of the 2019/20 BAF will be presented to the Trust Board at its meeting in June 2019.
4. There are 253 risks recorded on the organisational risk register (including 88 rated high). There have been two new risks scoring 15 and above entered on the risk register during this reporting period.
5. Thematic Analysis of the CMGs risk registers shows the key causation theme as gaps in staffing across all CMGs.

Input Sought

The Board is invited to review and approve the content of this report 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: [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: **2ND MAY 2019**

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

SUBJECT: **INTEGRATED RISK AND ASSURANCE REPORT (INCORPORATING UHL BOARD ASSURANCE FRAMEWORK & ORGANISATIONAL RISK REGISTER – MARCH 2019 FINAL)**

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1 INTRODUCTION

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

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

2. 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 evidence that all principal risks are being effectively managed and to commission additional review 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 the final month of 2018/19), and have been scrutinised and endorsed by their relevant Executive Boards during April 2019. An updated version of the 2018/19 BAF, along with a copy of the approved 2019/20 principal risks, is attached at appendix one.

2.3 There have been no new principal risks entered and no changes to existing risks ratings on the BAF during this reporting period.

2.4 The highest rated principal risks on the 2018/19 BAF relate to delivery of the financial control total, the emergency care pathway, workforce capacity and capability, and estate infrastructure:

Principal Risk Description 2018/19	Risk Score (IxL)	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	5 x 4 = 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	4 x 5 = 20	Financial Stability CFO
PR4: If the Trust is unable to effectively manage the ***emergency care pathway***, then it may result in widespread instances of poor	5 x 4 = 20	Organisation of Care

clinical outcomes for patients and sustained failure to achieve constitutional standards		COO
PR6: If the Trust does not adequately develop and maintain its ***estate***, then it may result in an increased risk of failure of critical plant, equipment and core critical services	5 x 4 = 20	Key Strategic Enabler DEF

2.5 A number of principal risks from the 2018/19 BAF have been included (in slightly re-worded forms) in the new principal risks on the 2019/20 BAF, which has been reviewed and approved by the Executive Team at its EPB meeting in March and by the Trust Board at its meeting in April. The refresh of the BAF has included two sessions with the Board at their Thinking Day in March, to identify the new principal risks, and in April, to inform the principal risks ratings (including inherent, current and target).

2.6 At the Thinking Day in April there was suggestion that the new principal risk concerning reconfiguration should be split into two (one around clinical services and the second about estate infrastructure) and this proposal was agreed by the Executive Team at its EPB meeting in April. The Executive Directors will update their new principal risks (to report April position) which will be presented to the relevant Executive Board meetings during May, for approval, ahead of the first version of the 2019/20 BAF being presented to the Board for approval at its meeting in June.

2.7 At its Thinking Day in April, the Board agreed a new BAF reporting structure, as described below:

- Executive Directors to update their principal risks, monthly;
- As now, Executive Board's to receive monthly updates for principal risks relating to their area of focus, presented by the relevant Executive Director, to oversee effectiveness of controls and progress of actions to manage the risk to the target rating. Also, the Executive Board will identify any significant gaps in control / assurance for escalation to the relevant Trust Board Sub-Committee (and Trust Board meeting, outside of the usual reporting process, if necessary) for assurance purposes;
- Trust Board to receive a BAF report no less than quarterly to assure themselves that principal risks are being managed in line with their agreed appetite. *The Trust Board will continue to receive a monthly risk management update as part of the Chef Executives monthly report;*
- As now, Trust Board Sub-Committees to receive reports pertaining to their area of focus in accordance with matters identified and escalated by an Executive Board, where escalation is necessary to assure the Sub-Committee about progress (good or bad). The report must clearly reference which principal risk it relates to and the purpose of the report (i.e. for decision/ discussion/ information about effectiveness of control measure in place or, where there are gaps in control / assurance, the treatment plan, including action time frame, to mitigate the level of risk);
- Audit Committee (as a committee of the Board) to undertake a 'deep dive' of all principal risks during 2019/20 to provide an independent and objective view of internal control.

3. ORGANISATIONAL RISK REGISTER SUMMARY

3.1 The Trust's organisational risk register, consisting of operational and corporately owned risks, has been kept under review by the Executive Performance Board and CMG Boards during the reporting period and displays 253 risk entries. The risk profile, by current risk rating, is illustrated in Figure 1,

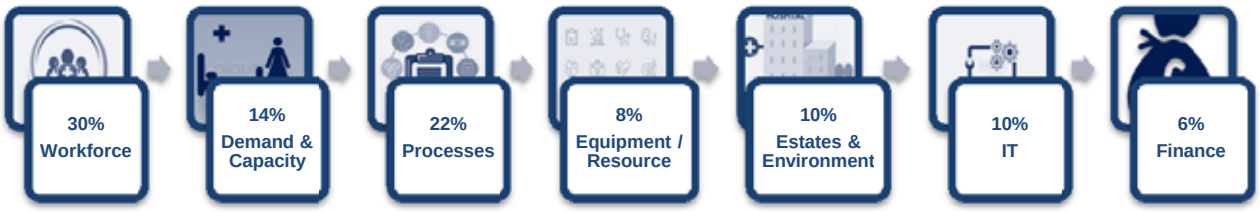
below, and a dashboard of the risks rated 15 and above is attached at appendix two.

Fig 1: UHL Organisational Risk Register Profile

3.2 There have been two new risks rated 15 and above entered on the organisational risk register during the reporting:

ID	CMG	Risk Description – New Risks	Current Rating	Target Rating
3413	RRCV	If nurse staffing levels are below establishment and availability of appropriate monitoring equipment is not increased to care for patients requiring acute NIV, then it may result in delays with patient diagnosis or treatment and failure to achieve compliance national recommended guidance, leading to potential harm and increased length of stay for patients requiring NIV	16	12
3412	CSI	If two dedicated Critical Care Occupational Therapy posts are not recruited, then it may result in significant disturbance to the continuity of patient care on the ICU units or within the follow-up clinics over the 3 UHL sites, leading to service disruption.	15	6

3.3 Thematic analysis of the organisational risk register shows the key risk causation theme as workforce challenges (including nursing and medical shortages) across all CMGs. Thematic findings from the risk register are reflective of the highest rated principal risks on the 2018/19 and 2019/20 BAF. The risk causation themes for items open on the organisational risk register are illustrated in the graphic below:



4 RECOMMENDATIONS

4.1 The Board is invited to review and approve the content of this report, noting the final position to principal risks on the 2018/19 BAF, the work underway to refresh the 2019/20 BAF and the position to entries on the organisational risk register, and to advise as to any further action required in relation to the UHL risk management agenda.

Report prepared by Risk & Assurance Manager, 25/04/2019.

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 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 of risk event – controls assurance	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

2018/19 BAF Dashboard

Principal Risk Description	Strategic Objective	Exec Director	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 may 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	4 x 5 = 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 3 = 12
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 4 = 20
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 4 = 16

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 PR5	
	4	Likely				PR1B PR7	PR2 PR4 PR6
	5	Almost certain				PR3	

DATE: @ March 2019	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**	**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.
- 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	March - 19	18/19 YTD
EFFECTIVE	E1	Readmissions <30 days – Discharge work stream – Head of Strategic Development	Red >8.6%		9.0%
	E2	Mortality (Published SHMI) – Deputy Medical Director	<=99	Oct 17 to Sept 18 = 99	99
	E5	Crude Mortality Emergency Spells – Deputy Medical Director	<=2.4%	2.1%	2.1%
	E6	#NOF <36 hours – MSS CMG CD	Red <72%	75.3%	74.6%
	E7	Stroke – 90% stay on stroke unit – one month in arrears – ESM CMG CD	Red <80%		84.7%
	E8	Stroke – TIA – ESM CMG CD	Red <60%	29.9%	55.6%

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. • 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 Jan 2019 Identified 2 areas of medium risk relating to manual data entry processes and different approaches to Medical Examiner Screening and Specialty M&M Reviews. • **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. ➢ **British Association of Urological Surgeons –** reported UHL's Cystectomy Mortality Rates (2015-17) as being above the national average but within expected. Urology HoS requested to attend the April MRC.	**Mortality** • Action Plan in place in response to the Internal Audit - **Review June 19 DMD.** • Backlog of January cases for Medical Examiner screening following the increased number of deaths over the winter months and delays in requesting and collating further reviews by Specialty M&Ms. Additional ME sessions arranged and temporary admin staff being used in March and April to meet end of year targets - **Review June 19 (DMD.** • Further analysis and benchmarking with 'best in class' being undertaken of those diagnosis groups with highest number of deaths in order to see if further improvement can be made to our overall SHMI/HSMR - **Review June 19 (DMD).** **#NOF** • Since the Rapid cycle fortnight in October whilst we have not been able to sustain the same level of resource, we have had much better performance. The NOF theatre is much better protected for NOF patients and we are steadily increasing the availability for all day surgeons in theatre for NOF's. The pressure points are much clearer and are the weekends when we don't have all day lists. • Collaborative work between ITAPS and MSS continues. We have weekly NOF meetings to review and monitor the processes and results. • Further improve in-reach to and collaboration with ED to reduce transfer time of patients to ward. • A new associate physician has been appointed and will help to support the NOF processes • Review of job plans to sustain all day seamless operating list continues. New consultant appointed who will further support the NOF process when he comes into post later this year. • Business case for dedicated radiographer/Imaging machine for NOF theatre. This will also cover increased resource from ITAPS (improve anaesthetic cover) and extending weekend theatre capacity. • We continue with our vision of 'holding' 1 NOF 'hot beds' for fast tracking of admissions but bed pressures have continued to impact on this. Have managed to place most patients on Ward 32 over the winter - **Review Jun 19 (MSS CMG CD).** **Readmissions** • Additional practices joining the West CCG pilot. Parr score changed so all patients with CFS and Parr score >20 now referred for MDT. Report due April with results so far. KPI number of readmissions <30 days. **Review end April 19 (HoSD)** • Respiratory - 3 day IDT referrals. Pilot now being embedded. (Of 25 pts seen 4 readmitted) Next step is in reach for discharge. • Crisis response mini pilot, 2 GP practices in Hinckley, low prevalence COPD, high admission rate. • Proposed IAPT pathway, to reduce COPD readmissions • COPD Prism pathway • EoL taskforce driver diagram with focus on patient flow and the number of readmissions in last 90 days.

		• CHKS shows Trust readmissions rate declining whilst nationally there is an upward trend. (NB this is 28 day readmission data)
		  o April 2018 UHL readmissions rate was 9.361% whilst our peers sat at 8.226%
		  o December 2018 Trust readmissions rate has reduced to 8.97% whilst Peers have increased month on month to 8.68% (at out lowest in November we sat at 8.64%)
		Review May 19 (HoSD)
		Frailty
		• The final programme report for the Frailty taskforce has been produced highlighting the results and lessons learned.
		  • CFS embedded in ED and nerve centre (therefore available to wider hospital). Training for ED staff on-going, needs to roll out to wider hospital
		  • Discharge letters now stipulate CFS and PARR scores and request GP's to consider referral to community MDT
		  • Additional actions delivered included long standing wicked issues such as access to care plans within UHL, knowledge of this access across UHL and LPT colleagues and training programmes across staff groups in terms of identifying and managing frailty. Podcasts for these are being filmed
		Review May 19 (HoSD)
		TIA Clinic – High Risk Patients
		• NICE guidance is for all suspected TIA patients to be seen within 24 hours if their symptoms were within the last 7 days. From April 1st the new Plexias system will be in place in order to move to that way of working from 1st April. This will initially be focused on in house referrals.
		• Working on a new PRISM referral form for primary care..
		• We are currently transitioning into the new system for TIA clinic with all patients considered high risk if had event within the last 7 days. We have changed our slot to 90% high risk and currently adding on extra slots to reduce the low risk back log. This will continue to settle down over the next couple of months **Review (Jun 19 ESM CMG CD)**
		Stroke 90% Stay
		• December performance reflects bed pressures . We have met the 80% threshold for January and February and will continue to focus on having a 'stroke hot bed' **Review Jun 19 (ESM CMG CD**)

DATE: @ March 2019	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	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	March - 19	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)		228
	S2	Serious Incidents - actual number escalated each month	<=37 by end of FY 18/19	1	29
	S8	Overdue CAS alerts	0	0	1
	S10	Never Events	0	2	8
	S11	Clostridium Difficile	61	5	57
	S12	MRSA Bacteraemias - Unavoidable	0	1	3
	S13	MRSA Bacteraemias (Avoidable)	0	0	0
	S14	MRSA Total	0	1	3
	S23	Falls per 1,000 bed days for patients > 65 years (1 month in arrears)	<6.6		6.4
	S24	Avoidable Pressure Ulcers Grade 4	0	0	0
	S25	Avoidable Pressure Ulcers Grade 3	<27	0	7
	S26	Avoidable Pressure Ulcers Grade 2	<84	5	62
	S27	Maternal Deaths	0	0	2
	S28	Emergency C Sections	Not within highest decile	18.3%	18.3%

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 (March 2019) to EQB/QOC: One Serious Incident was escalated in March which was a wrong site surgery Never Event. We have six incidents with evidence gaps in Duty of Candour (on finally approved incidents).This month we have seen a significant reduction in incidents related to lack of nursing staff. • Q3 Harms Review - We have seen a slight decrease in the actual number of harm incidents in Q3 2018/19 compared to Q1/2 but there has been a sustained increased level of moderate plus harm this year to date compared with 17/18. The number of Serious Incidents being escalated in 2018/19 compared to previous years is lower. • Triangulation of incident and learning from death themes reviewed. • F2SU clinics and surgeries at all three sites. • Cluster of VTE harms identified in November 2018 – VTE Task Force established December 2018. Latest action summary on this committee reported to February QOC. • Throughout 2018, the Diabetes team have been auditing insulin prescribing and management every 3 months. Insulin Safety training has been delivered over the same period to doctors, nurses and pharmacists. Results of the audits demonstrate: Insulin errors in UHL have halved since Dec 2017; Improvements across the board in the prescription of insulin, the administration of insulin and in the management of insulin when patients' capillary blood sugars (CBGs) were out of range; In Dec 2018 >200 patients with diabetes were audited, 123 patients were treated with insulin. This was the first time EVER that we found no abbreviations ("u" or "iu")* in the insulin prescriptions.	• 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:** ➢ Patient Safety Alert review – low risk, largely reassuring report (Jan 2019). • **External Audit 2018/19:** ➢ Awaiting Grant Thornton audit for 2018/19 data for validation of major harms and death in line with QA dataset. • 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. • Visit of Dr Aidan Fowler, National Director of Patient Safety (NHSI) on 20/12/18 provided external assurance of approach and performance around QI and Patient Safety. • HSIB reports on Never Events/Serious Incidents.	• 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 2018/19 (CN / MD). • 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 Q4 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 and monitored via risk register and daily command and control meetings. • Action plan to address the two major non-compliances in HFEA Inspection report - Consultant Embryologist, Leicester Fertility Centre & Medical Director – progress reviewed at EQB meetings. • Non-integrated / weak IT systems remain a patient safety risk – UHL IM&T e-hospital programme established (see PR 5). • Increased ED incidents reported with concerns escalated regarding overcrowding. • Gaps relating to improvement work – to be picked up in the Quality Strategy / Quality Commitment in 19/20 (relating to safe and timely discharge and consistent processes for invasive procedures. • GP concern themes need to be built into existing or proposed work improvement work programmes. • Inconsistent implementation of LocSSIPs and checking processes for invasive procedures.

DATE: @ March 2019	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	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	March - 19	18/19 YTD
CARING	C1	Formal complaints rate per 1000 IP,OP and ED attendances	No Target	1.8	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%	92%	95%
	C7	Outpatients Friends and family Test - % positive	97%	95%	95%
	C10	Single sex accommodation breaches (patients affected)	0	2	58

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. • 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. • National Patient Survey results from Maternity Services, Emergency Department, Paediatrics and general Inpatients are reviewed via the Patient Involvement, Patient Experience Assurance Committee. • CQC unannounced inspection 29.5.18 with written feedback provided. • **Internal Audit Programme 2018/19:** ➢ Quality Commitment review – scheduled Q3/Q4. • **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 – This Improvement Plan has clear success indicators that are monitored and reviewed through 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 – This ELCHIP has clear outcomes that are monitored and reviewed through EQB quarterly. • Specific feedback from patients contained in the national patient surveys to be tracked using local surveys providing front line staff with 'real time' feedback against national survey priorities.

DATE: @ March 2019	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	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)	March - 19	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	57%	59.8%
	W8	Nursing Vacancies overall	Separate report submitted to QOC	13.0%	13.0%
	W10	Turnover Rate	Red = 11% or above ER = Red for 3 Consecutive Mths	8.4%	8.4%
	W11	Sickness absence (reported 1 month in arrears)	Red if >4% ER if 3 consecutive mths >4.0%		3.8%
	W12	Temporary costs and overtime as a % of total paybill	TBC		10.8%
	W13	% of Staff with Annual Appraisal (excluding facilities Services)	Red if <90% ER if 3 consecutive mths <90%	92.6%	92.6%
	W14	Statutory and Mandatory Training	95%	90%	89%
	W15	% Corporate Induction attendance	Red if <90% ER if 3 consecutive mths <90%	98%	97%
	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	77.0%	80.8%
	W22	NIGHT Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	TBC	88.2%	89.8%
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

• Final version of the People Strategy and supporting appendices aligned to the Quality Strategy agreed at TB March 2019.
• Workforce risks in CMGs recorded on organisational risk register – *majority relate to nursing and medical.*
• People Strategy presented to Trust Board in December 2018 with defined deliverables to formulate overarching work plan.
• 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.
• National Survey (incorporating Friends and Family)) for 2018 5448 responses, giving a response rate of 37%, an increase of 3% from the previous year. Compared to the previous year the survey scored
  ○ Significantly Better on 8 questions
  ○ Significantly Worse on 9 questions
  ○ The scores show no significant difference o n73 questions
• National survey results for 2018 – High level analysis broadly on par with previous year – flat lined.
• 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.*
• Understanding of the impact of Brexit and national shortages of nurses and consultants – Communication plan in place and details on Insite
	• **Internal Audit 2018/19:**
	  ➢ Workforce planning – scheduled Q3/4 – to review the Trust's progress in developing the 18/19 workforce plan and the 2018-2023 strategic workforce plan – In progress.
	• 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).*
	• Apprenticeship provision monitored against the common inspection framework and areas of strength and for improvement identified December 2018. Self-assessment report underway March 2019.
	• Board Development Review Diagnostic phase 1 completed against Well Led framework and feedback provided by EMLA in January 2019.
		• Final version of the People Strategy and supporting appendices aligned to the Quality Strategy agreed at TB March 2019 – deliverables will define 19/20 priorities work programme in development with alignment of resources (and identification of any gaps).
		• 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. Overarching action plan in place with targets, defined objectives and timescales.
		• National staff survey 2018 results obtained – further analysis expected to define next steps and plans to PPPC in March 19. Actions to be aligned to Becoming the Best.
		• 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 – monitored in line with our strategy including 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. Assurance statement provided.
		• Agreement obtained for implementation of the National change to medical training – Shape of Training –progress to be monitored and reported to next EWB in April 2019.
		• Becoming the Best Diagnostic expected to complete June-2019. Work will subsequently involve developing Leadership and culture strategy due to complete 1st Phase by July 2019. Programme is integral to setting out the Quality Improvement approach.
		• Developing Workforce Safeguards to be part of National Operational Planning Frameworks from April 2019.

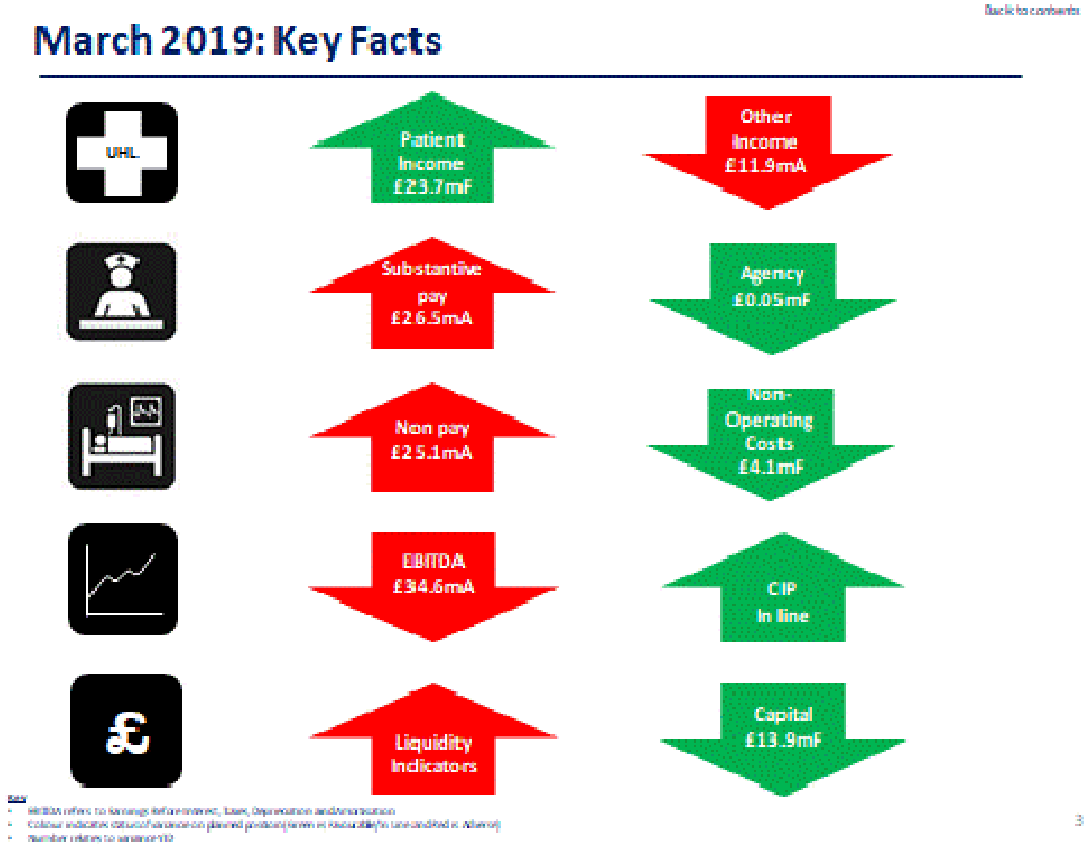
DATE: @ March 2019	Director:	CFO	Executive Board:	EPB	TB Sub Committee:	AC / FIC
Linked Objective	We will continue on our journey towards financial stability - deliver our target of £29.9m in 18/19					
BAF Principal Risk: 3 - Finance	If the Trust is unable to achieve and maintain financial sustainability, ***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):**	**4 x 5 = 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	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 weekly 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.
- Enhanced pay and non-pay controls as approved through the Financial Recovery Board.

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 12 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 £26.5m to plan (including £11m relating to A4C national pay award). Cost improvement plans show –performance in line with plan at month 12. Although capital expenditure has shown a significant under-spend within the year to date position the capital programme is in line with CRL. 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 meeting.	• **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 - has reviewed 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 has been 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 financial challenge. The Trust 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 has been finalised, presented to the Trust Board and shared with NHSI. The report concludes that the re-forecast deficit of £51.8m is not risk-free and the scope to improve upon this position is limited. 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: @ March 2019	**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**	**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 weekly to review the position and ensure whole system responsiveness, these occur daily if we trigger Opel level 3 or 4;
  - 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.
  - Integrated Community Board.
- **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)	March - 19	18/19 YTD
Responsive						
	R1	**ED 4 Hour Waits UHL**	**95% or above**	Red if <85% Green 90%+	**75.1%**	**77.0%**
	R2	**ED 4 Hour Waits UHL + LLR UCC (Type 3)**	**95% or above**	Red if <85% Green 90%+	**82.0%**	**83.2%**
	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%	**1.2%**	**1.1%**
	R14	**Delayed transfers of care**	**3.5% or below**	Red if >3.5% ER if Red for 3 consecutive mths	**1.7%**	**1.5%**
	R15	**Ambulance Handover >60 Mins (CAD+ from June 15)**	**0**	Red if >0 ER if Red for 3 consecutive mths	**5%**	**4%**
	R16	**Ambulance Handover >30 Mins and <60 mins (CAD+ from June 15)**	**0**	Red if >0 ER if Red for 3 consecutive mths	**13%**	**8%**

Internal Assurances	External Assurances	Gaps Identified & Pending Actions, responsible officer & measure
• There remains significant nursing 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. Alternative skill mix models are being considered and have been implemented e.g. medical step down ward. Additional investments in Phase II emergency floor posts have been recruited. 51 international nurses have commenced. • ED process: ➢ Time from arrival to decision to admit was 50.6% (average) in Mar. ➢ Patients allocated a bed within 60 minutes for all locations averaged 44.0%. • DTOC: ➢ Remain within tolerance • Acuity: ➢ Reducing number 80+ age in ESM beds ➢ Super stranded numbers. At the end of March there were 177 adults in hospital 21+ days. DCOO meeting with senior teams to confirm and challenge current plans for those off target. Target was reached before Christmas. • 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: 91-104 (out of 134). • NHSE Mar UHL 4 hour performance = 75.1%. LLR performance = 82.0%. • AEDB fortnightly to manage system wide actions. • NHSI Escalation meetings to provide system wide assurance. • Weekly assurance calls with NHSI. • System wide conference calls. • **Internal Audit 2018/19:** ➢ Review of ED front door service contract ➢ Discharge processes – Red to Green • Stranded: ➢ Rated by NHSI in the best performing group as an organisation - Decreased +21 day LOS.	• IT Booking systems for DHU and OOH. • 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 – improving position. New assessment is now embedded to help in reduction of non-admitted breaches. This is now performing above 90% • New action plan being developed to improve performance. Urgent care action log has further details about the actions, owners and completion dates.

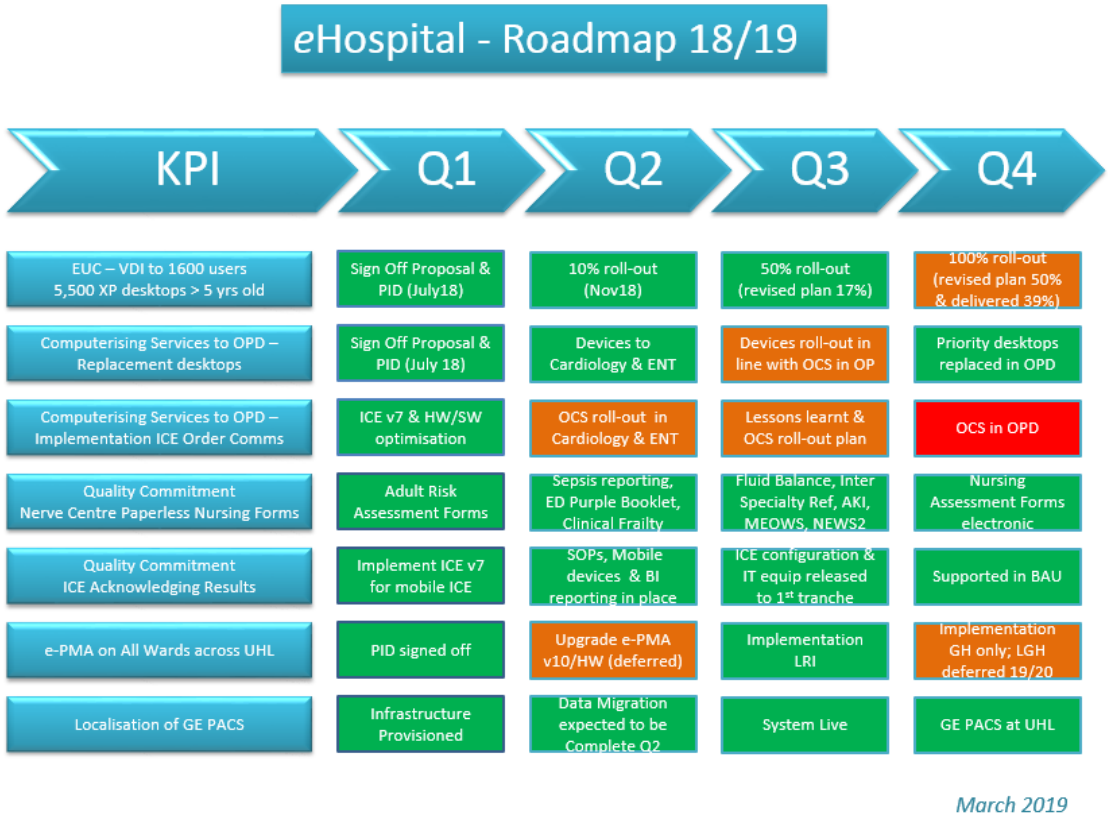
DATE: @ March 2019	Director:	Acting CIO	Executive Board:	EIM&T (quarterly)/EPB	TB Sub Committee:	AC / PPPC
Linked Objective	To progress our strategic enabler – IM&T					
BAF Principal Risk: 5 – Information Technology	If the Trust is unable to deliver a fit for the future IM&T service, ***caused by inability 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 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 4 = 16	4 x 3 = 12	4 x 3 = 12	4 x 3 = 12	4 x 3 = 12

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 commenced in Feb 19 main issues are training and contracts. ➢ 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, final report received Feb 19 – Medium risk on resources for change management and programme dependencies. ➢ Emergency Preparedness, Resilience and Response (EPRR) – to review a selection of the IM&T Disaster Recovery plans – PWC Audit took place on the 27 Mar 19, awaiting final outcome. The DR plans were reviewed and passed under the MBP ISO27001 audit. The first year of the 3 year plan is complete and signed off at the EPRR Board 13/03/19. • ISO 27001:2013 – The MBP passed their ISO 27001 accreditation in March 2019. • NHS digital Health Check – cyber security audit – Jan 2018 – remediation plan agreed. Cyber essentials plus audit took place on 12th Mar 19 and formal report has been received. A remediation plan is in development. • 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. Additional funding is due to be received from NHS England (HSLI) to fund the eHospital schemes relating to shared health records for the next 3 years. This will support the resource issues as well as development of solutions. Funding from HSLI has been deferred to 19/20. Lack of HSLI funding will impact on the 19/20 plans as NHSE have not confirmed dates for the release of funds. A workshop has been arranged for June 19. • **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 on plan to deliver in 12 months replacing all XP machines* ➢ *Nervecentre- in progress, 90% of nursing assessment forms deployed by Q4.* ➢ *PACS – completed* ➢ *ICE– in progress- Implement in Cardiology and ENT - delayed* ➢ *E-Prescribing – in progress roll-out to start LRI liveNov18, GH completed Q4, Women's and Children's and LGH planned for Q1 19/20.* • **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. The date has been deferred to Dec 2019 (approved at the Exec IM&T Board Nov18) Review commenced Dec 18 for 12 month period. Approach set up and records being added to UHL info Asset Register (IAR) (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: @ March 2019	**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 4 = 20**	

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**	**5 x 3 = 15**	**5 x 4 = 20**	**5 x 4 = 20**	**5 x 4 = 20**

Primary Controls

- 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 annual dashboard is reported to Exec Team. Independent Authorising Engineer annual reports to measure conformance against HTM / HBN guidance.
- Estates & Facilities Risk Management Process – A monthly Estates & Facilities Management Group is starting from March 2019 to review risks prior to reporting for to the E&F Senior Management Team. 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 reported to IPAC.
- Estates & Facilities Help Desk provides single focal point for all works requests.
- Annual Patient-led Assessments of the Care Environment (PLACE) with scorecard reported nationally and benchmarked.
- 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. E&F Capital Development reports to trust Executive meetings.

Detective Risk Indicators

- 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
  - Datix Incident reports
  - Reactive maintenance reported through the E&F Customer Service Centre
  - Business continuity interruptions and condition monitoring of sub-optimal plant, equipment, buildings and building services maintained beyond its expected lifecycles.

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. • ESB (Feb): The risk score for Principal Risk 6 increased from 15 to 20 in the light of the assessed increase likelihood of critical infrastructure failure, and taking into account the significant pressures placed on the Trust's capital programme which have a limiting effect on being able to address backlog maintenance.	• 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, four 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. • A 2019 review of Engineering Infrastructure is programmed for the first half of 2019, to include: ➢ Condition; ➢ Compliance; ➢ Resilience; ➢ Single point Failures.	• 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. 2019/20 draft Capital programme completed and being submitted for Trust approval. • 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 with a draft completion extended to May 2019 to incorporate an independent review of Engineering and Building infrastructure data, including findings from the Galliford Try report 2018. A report and high level presentation is being developed to further inform the Trust Executive/Trust Board of the current infrastructure liability and projected risk. This will include risk treatment options. • 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. High level review completed and plans are in place to implement operational changes in 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 for new appointments - Minor delay – on-going. • 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. • Risk of sudden & unexpected failure of critical infrastructure elevated to 20 on the Trust Risk Register (Risk 3143) due to infrastructure attrition through lack of financial backlog and end of lifecycle investment over many years manifesting as increasing incidence/risk of infrastructure failure interruptions. DEF to highlight key risks and required actions as part of state of the nation report to be presented to Executive Committees in April and TB in May 2019. Increased risk to be incorporated into allocation requests for 2019/20 capital to address key Infrastructure and Backlog Maintenance liabilities.

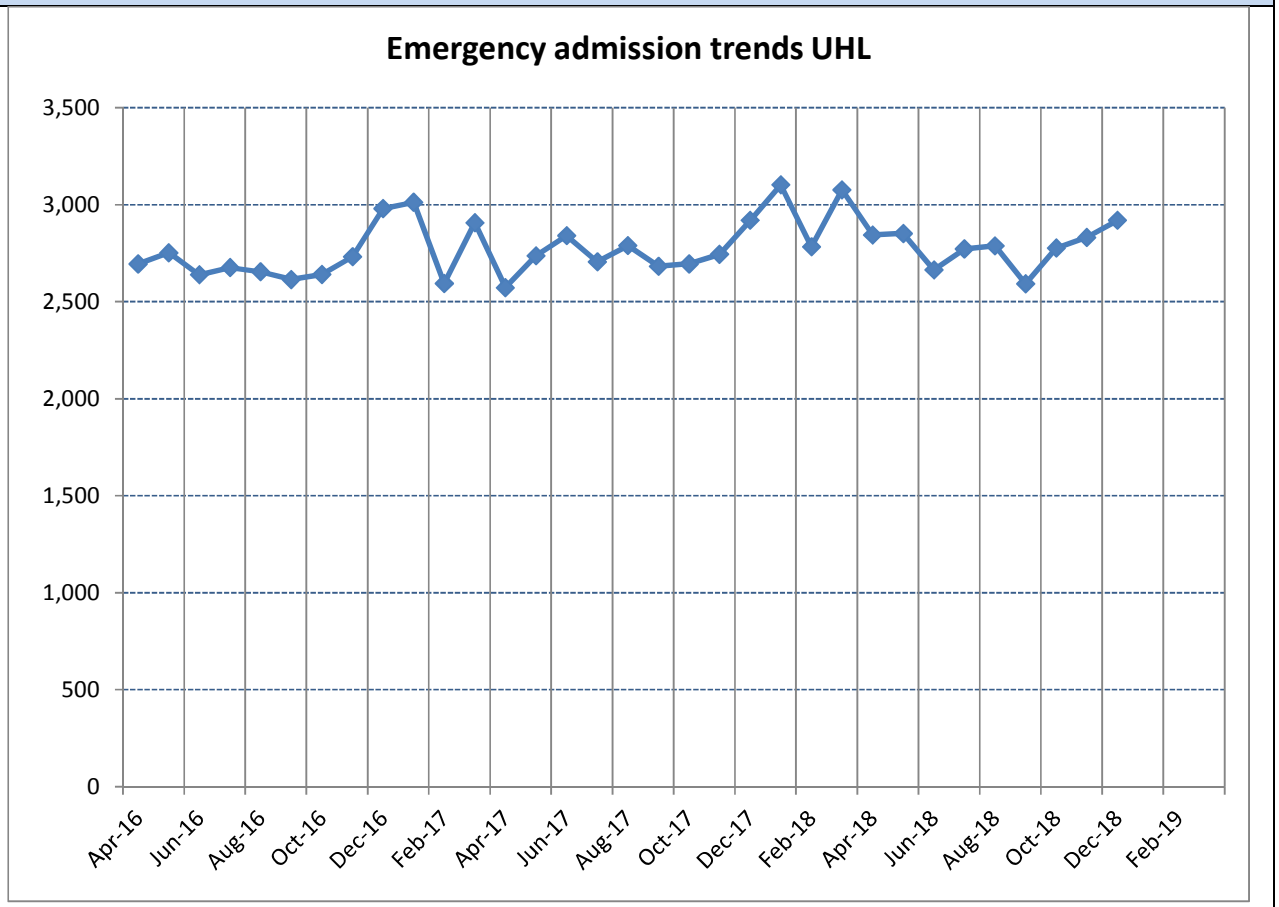
DATE: @ March 2019	Director:	DSC	Executive Board:	ESB	TB Sub Committee:	AC / PPPC
Linked Objective	To develop more integrated care in partnership with others					
BAF Principal Risk: 7 – Partnerships	If the Trust is unable to work collaboratively with partners to secure the support of community and STP 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 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 3 = 12	4 x 4 = 16	4 x 4 = 16	4 x 4 = 16	4 x 4 = 16

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. • Community services redesign model presented to UHL team in December – full response with UHL concerns sent back to Commissioners. New CSR Implementation Group established with UHL representation secured. • The system has responded appropriately to the actions detailed in the Frailty action plan; however wider system actions, such as the CSR & planned care pathways, are not progressing at the pace required to enable quality or financial improvement in the acute or planned pathways, hence maintaining the increased score.	• 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. The Trust has driven the work programme for the ICB and the newly formed Primary care Board; the risk of non-delivery within these structures could be significant given the pressure on financial position of the system as well as stretched clinical and managerial support across the wider system.	• Work programmes for ICB and PCB delivered; HOSD engaged to ensure that the interventions and outcomes within and across these programmes of work have the appropriate representation from the Trust - review end of March 2019 • Communication, engagement and feedback between each of the STP work streams and the Trust (at CMG level and exec level) needs to be reviewed, particularly in light of the launch of the UHL Quality Strategy. Action with STP lead and UHL HOSD to work through. A proposal will be taken to UHL exec board asap – review end of March 2019. UPDATE: As part of the planning for19/20, CMG's have been engaged regarding QIPP/ transformation required to deliver integrated systems of care in 19/20. New process is under development to strengthen CMG-CCG dialogue about elective and non-elective QIPP/ transformation delivery.

UHL Board Assurance Framework 2019/20 – draft Principal Risks:

Principal Risk No.	**Strategic Threats** (the high level factors that might cause the risk event to happen) If we don't put in place effective systems and processes to deal with…	**Principal Risk Event** (the event that may happen if the strategic threats were to materialise) …then it may result in…
1	• Employment market factors - local and national shortages in Nursing, Medical, AHP job specialties; competition to recruit and retain a workforce with the necessary skills and experience; doctors and nurses leaving their jobs early; fragmentation of responsibility for workforce issues at a national level • Demographic changes – EU Exit with no deal (Brexit) • Cultural pressures - supporting people to gain the skills to enable improvement; developing the right kind of leadership	**a critical shortage of workforce capacity with the required skills to manage demand** *(Supporting priority 19/20 = 8)*
2	• Operational Pressures - persistent unprecedented level of demand for services, primary care unable to provide the service required, fundamental process issues to address patient flow • National Standards compliance - achieving key performance standards • Regulatory Inspections - criticism from regulators such as NHSI and the CQC	**a breach of regulatory requirements and compliance** *(Quality priorities 19/20 =4 & 5)*
3	• An empowered culture of high quality care; widespread loss of organisational focus on patient safety and quality of care; compliance with clinical protocols / Inadequate clinical practice / Lack of training and development / absence of effective team working	**a failure to deliver high quality patient care** *(Quality / Supporting priorities 19/20 =1, 2, 3, 7, 11)*
4	• Capital programme pressures – delivering the agreed capital programme (including non-delivery of critical investments and/or inefficient use of resources) • Financial performance pressures - generating the income or controlling expenditure to deliver the agreed budget • Productivity pressures - responding to Carter Report, GIRFT and Model Hospital programmes leading to poor productivity and use of resources • Financial sustainability pressures - developing a financial plan which is consistent with commissioner assumptions and regulatory expectations	**a failure to deliver the financial control total** *(Supporting priority 19/20 =12)*
5	• Partnerships – working effectively with wider system partners • Ineffective clinical service pathways / strategies of the local population • Insufficient focus (lack of clear plans and pace) in delivering the level of transformation required	**disruption to transforming sustainable clinical services** *(Quality priority 19/20 =6)*
6	• External reconfiguration funding process – failure to acquire capital investment • Physical infrastructure - sustained under-investment in Estate infrastructure	**unsustainable clinical reconfiguration of estate infrastructure** *(Supporting priority 19/20 =9)*
7	• External reconfiguration funding process – failure to acquire capital investment • Clinical resources - sustaining duplicated and triplicated services; many planned, elective and outpatient services currently run alongside emergency services and as a result when emergency pressures increase, elective patients are cancelled (often at the last minute cancellations)	***un*sustainable clinical reconfiguration of hospital services** *(Supporting priority 19/20 =9)*

8	• Estate services – failure of infrastructure / critical services (water, power, gases, ventilation, waste) / plant • IM&T services – failure of software / hardware • Information security - cyber security breach • Big bang event - fire, flood, terrorist attack	**service interruption during a major disruptive incident** *(Supporting priority 19/20 =10)*

Integrated risk report Appendix 2 - risk register 15+ (March Final)

Risk ID	CMG	Specialty	Opened	Review Date	Risk Description	Impact	Likelihood	Current Risk Score	Target Risk Score
1149	CHUGGS		16/04/2009	30/Jun/19	If demand for cancer patients' service exceeds capacity, then it may result in widespread delays with patient diagnosis or treatment, leading to potential for patient harm and waiting time target breach	Major	Almost certain	20	9
2264	CHUGGS		03/Dec/13	30/Jun/19	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 safety & effectiveness of patient care delivered, leading to potential for patient harm.	Major	Almost certain	20	6
2565	CHUGGS		03/Jun/15	30/Jun/19	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	Major	Almost certain	20	9
3183	RRCV		23/02/2018	30/06/2019	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 leading to a need for urgent admission or more complex surgery with potential of complications and harm.	Extreme	Likely	20	15
3186	RRCV		07/Mar/18	01/Apr/19	If RRCV CMG fails to achieve the allocated financial control total then this could result in an deterioration in the Trust overall financial deficit.	Major	Almost certain	20	9
3354	RRCV		06/Dec/18	28/04/2019	If medical staffing gaps in Allergy Service are not addressed, then it may result in waiting list increases and widespread delays with patient diagnosis or treatment leading to potential for harm and non-compliance of RTT national targets	Major	Almost certain	20	8
2354	RRCV	Respiratory Medicine	28/05/2014	01/Aug/19	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 safety & effectiveness of patient care delivered leading to potential harm to patients.	Major	Almost certain	20	9
3359	ESM		27/12/2018	30/06/2019	If ESM CMG do not recruit and retain into the current nursing vacancies within Specialist Medicine, including the extra capacity wards opened, then it may result in widespread delays with patient diagnosis or treatment, leading to potential harm.	Extreme	Likely	20	9
3222	ESM	ED	21/06/2018	30/04/2019	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	Extreme	Likely	20	10
3077	ESM	ED	04/Aug/17	30/Apr/19	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.	Extreme	Likely	20	15
3114	ITAPS		24/10/2017	18/09/2019	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.	Major	Almost certain	20	6
3115	ITAPS		11/Dec/17	30/Apr/19	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 it may result in a detrimental impact on safety & effectiveness of patient care delivered (with delays to access essential patient information or imaging in a timely manner) leading to potential for patient harm.	Major	Almost certain	20	8
3132	ITAPS		19/02/2019	30/Jun/19	If ITAPS CMG is unsuccessful in controlling expenditure, finding efficiency savings and maximising income, then it may result in non-delivery of the set budget, leading to financial impact, impact on quality and performance outcomes for patients, wellbeing of staff and risk the future sustainability of services provided within the CMG.	Major	Almost certain	20	6

Risk ID	CMG	Specialty	Opened	Review Date	Risk Description	Impact	Likelihood	Current Risk Score	Target Risk Score
3113	ITAPS	Critical Care	08/Dec/17	30/Sep/19	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 detrimental impact on safety & effectiveness of patient care delivered benchmarked against other centres (ICNARC), leading to potential for patient harm.	Major	Almost certain	20	8
3200	ITAPS	Critical Care	18/04/2018	30/Sep/19	If the practices, workforce, estate and facilities in LRI ITU are not compliant to current standards and expectations, then it may result in a detrimental impact on safety & effectiveness of patient care delivered by clinical teams to all patients requiring level 2/3 care, leading to potential harm	Extreme	Likely	20	10
3119	ITAPS	Theatres	04/Oct/17	30/04/2019	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	Major	Almost certain	20	12
3414	CSI	Pathology - Immunology	28/02/2019	30/Jun/19	If additional Immunology senior (Consultant) medical / clinical scientist staff cannot be recruited, then it may result Loss of UKAS accreditation of the service leading to service disruption with the Immunology clinical and laboratory services becoming non-viable within 6-8 months	Extreme	Likely	20	9
2777	Communications	Charity	27/01/2016	30/Apr/19	If the Charity fundraising campaign do not reach target charitable income, then it may result in significant reduction in planned income, leading to financial impact	Major	Almost certain	20	8
3143	Estates & Facilities		11/Jan/18	28/04/2019	If sufficient capital funding is not committed to reduce backlog maintenance across the estate and infrastructure, then it may result in a prolonged disturbance to the continuity of core services across the Trust leading to potential service disruption and patient harm	Major	Almost certain	20	6
3226	Finance	Finance	29/06/2018	30/Apr/19	If we overspend on non-pay, then it may result in us exceeding our annual budget plan, leading to financial and reputational impact	Extreme	Likely	20	10
3054	Human Resources	HR Training	31/07/2017	30/04/2019	If the Trust's Statutory and Mandatory Training data can no longer be verified on the new Learning Management System, HELM, then it may result in non-compliance with training standards, leading to potential harm to patients, reputation impact, increased financial impact and non-compliance with agreed targets.	Extreme	Likely	20	3
3148	Corporate Nursing		12/Jan/18	30/Apr/19	If the Trust does not recruit the appropriate nursing staff with the right skills in the right numbers, then it may result in detrimental impact on safety & effectiveness of patient care delivered leading to potential harm and poor patient experience	Major	Almost certain	20	12
2404	Corporate Nursing	Infection prevention	19/08/2014	30/03/2019	If the processes for identifying patients with a centrally placed vascular access (CVAD) device within the trust are not robust, then it may result widespread delays with patient diagnosis or treatment leading to potential harm and increased morbidity and mortality.	Major	Almost certain	20	16
3298	Corporate Nursing	Infection prevention	28/08/2018	31/03/2019	If there are ward and bay closures during the outbreak of Carbapenem-resistant Organisms (CRO), then it may result in widespread delays with patient transfer of care/ flow for emergency admissions leading to potential harm, adverse reputation and service delivery impact.	Extreme	Likely	20	5
3260	CHUGGS	General Surgery	22/08/2018	30/Jun/19	If medical patients are routinely outlied into the Surgical Assessment Unit at LRI along with surgical admissions and triage, then it may result in widespread delays with surgical patients not being seen in a timely manner therefore not getting pain relief or appropriate treatment in the right place, leading to potential for patient harm and impact on surgical flow.	Major	Likely	16	6
3300	CHUGGS	Haematology	11/Sep/18	31/May/19	If staffing levels in the Haemophilia Centre are below establishment, then it may result in widespread delays with patient diagnosis (breeching the 17 week wait for new appointments) or treatment or patients with life-long bleeding disorders, leading to potential for patient harm	Major	Likely	16	12

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3352	CHUGGS	Haematology	30/11/2018	31/May/19	If staffing levels in Haematology service are below establishment then it then it may result in widespread delays for patients requiring operations who have bleeding or thrombotic problems leading to patient harm.	Major	Likely	16	12
3355	RRCV		06/Dec/18	28/04/2019	If staffing levels are below establishment (for nursing, technician and admin) within the Home oxygen service, then it may result in patient delays leading to potential harm, reduced quality of life for patients, increased costs of oxygen provision and potential for withdrawal of CCG funding.	Major	Likely	16	8
3413	RRCV		07/Mar/19	31/05/2019	If nurse staffing levels are below establishment and availability of appropriate monitoring equipment is not increased to care for patients requiring acute NIV, then it may result in delays with patient diagnosis or treatment and failure to achieve compliance national recommended guidance, leading to potential harm and increased length of stay for patients requiring NIV	Major	Likely	16	12
3109	RRCV		28/11/2017	30/04/2019	If additional capacity, resource and support are not provided for the Respiratory Consultant Pharmacist, then it may result in widespread delays with patient diagnosis or treatment, leading to potential for patient harm and service disruption	Major	Likely	16	8
3297	RRCV	Cardiac Surgery	04/Sep/18	30/04/2019	If cardiac surgery admin staffing levels are below establishment, then it may result in delays with diagnosis or treatment leading to potential harm to patients, service disruption, adverse reputation and financial loss.	Major	Likely	16	9
2820	RRCV	CDU	01/Jun/16	30/Apr/19	If a timely VTE risk assessments are not undertaken on admission to CDU, then it may result in detrimental impact on safety & effectiveness of patient care delivered, leading to potential harm and breach of NICE CCG92 guidelines.	Major	Likely	16	3
3210	RRCV	Renal Transplant	23/05/2018	31/May/19	If staffing levels in the Transplant Laboratory were below establishment and the Quality Management System was not appropriately maintained, then it may result in a prolonged disruption to the continuity of the service, leading to service disruption	Major	Likely	16	4
3233	RRCV	Vascular Services	06/Jul/18	31/03/2019	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.	Major	Likely	16	4
3198	ESM		12/Apr/18	31/07/2019	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 it may result in detrimental impact on safety & effectiveness of patient care delivered, leading to potential harm with patients not having their diabetes appropriately monitored/managed	Major	Likely	16	4
2388	ESM	ED	29/10/2014	30/06/2019	If Mental Health patients are waiting in the ED & EDU for prolonged periods of time, for further specialist MH assessment and admission to MH beds, then it may result in detrimental impact on safety & effectiveness of patient care delivered leading to potential harm.	Major	Likely	16	6
3025	ESM	ED	30/05/2017	31/05/2019	If staffing levels are below establishment and issues with nursing skill mix across Emergency Medicine, then it may result in widespread delays in assessment and in initial treatment/care leading to potential harm.	Major	Likely	16	4
2333	ITAPS	Anaesthesia	17/04/2014	30/04/2019	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.	Major	Likely	16	8
3121	ITAPS	Theatres	18/10/2017	30/Jun/19	If operating theatres' ventilation systems fail due to lack of maintenance, then it may result in widespread delays with patient treatment and pressure on other theatres to meet demand, leading to patient harm and cancellations	Major	Likely	16	9

Risk ID	CMG	Specialty	Opened	Review Date	Risk Description	Impact	Likelihood	Current Risk Score	Target Risk Score
3321	MSK & SS		26/09/2018	31/03/2019	If MSS CMG has unplanned expenditure, then it may result in non-delivery of its allocated financial control total, leading to financial impact	Major	Likely	16	4
3341	MSK & SS		22/11/2018	30/04/2019	If there is a lack of theatre time and lack of acknowledgement of urgency for getting NoF patients operated on, then it may result in widespread delays with patient treatment, leading to harm (mortality and morbidity) with patient outcome compromised the longer they await theatre.	Major	Likely	16	8
2989	MSK & SS	Trauma Orthopaedics	02/Oct/17	31/05/2019	If Trauma and Orthopaedics nurse staffing levels are below establishment, then it may result in a detrimental impact on safety & effectiveness of patient care delivered leading to potential harm	Major	Likely	16	4
3320	CSI		26/09/2018	31/03/2019	If CSI CMG is unsuccessful in controlling expenditure, finding additional efficiency savings over and above the Trust set target and maximising income, then it may result in non-delivery of its allocated financial control total, leading to unmet financial performance targets, financial escalation, increased pressure on resource allocation, and adverse implications on service delivery through constrained future funding.	Major	Likely	16	8
3129	CSI	Pathology - Blood Transfusion	19/12/2017	15/04/2019	If a 100% traceability (end fate) of blood components is not determined, then it may result in widespread delays with providing blood and blood components for patient treatment, leading to potential patient harm, and breach of legal requirements (BSQR 2005 requirement of 100% traceability will not be met).	Major	Likely	16	4
3205	CSI	Imaging - Breast	20/06/2018	30/04/2019	If the breast screening round length is not reduced, then it may result in widespread delays with patients three yearly breast screening appointments, leading to patient harm (impacting early cancer diagnosis), and breach of PHE performance indicators.	Major	Likely	16	8
3206	CSI	Pathology - General Pathology	11/May/18	15/05/2019	If staff are not appropriately trained on the usage of POC medical device equipment, then it may result in detrimental impact on safety & effectiveness of patient care delivered with inaccurate diagnostic test results, leading to potential harm to the patient.	Major	Likely	16	6
3286	CSI	Pathology - Immunology	31/08/2018	15/05/2019	If Consultant Immunologist staffing levels are below establishment, then it may result in widespread delays with acute leukaemia patient's diagnosis or treatment, leading to potential for patient harm and failure in meeting key performance indicators for urgent blood cancer diagnostic testing	Major	Likely	16	6
3329	CSI	Pharmacy	24/10/2018	30/06/2019	If Pharmacy Technician and Pharmacist staffing levels are below establishment, then it may result in prolonged disruption to the continuity of core services across the Trust leading to service disruption	Major	Likely	16	8
3335	CSI	Pharmacy	30/11/2018	30/04/2019	If Pharmaceutical products stored in Windsor Pharmacy are contaminated due to the current pest control issues, then it may result in widespread delays with patient treatment due to unavailability of pharmaceutical products, leading to potential for patient harm; or contaminated product may be supplied to patients	Major	Likely	16	4
3008	W&C	Neonatal Transport	18/05/2017	05/Apr/19	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 it may result in significant delay in reaching the patient and treatment from the specialist team commencing, leading to potential harm, failure to meet NHS England standards, and inability to free-up PICU capacity.	Major	Likely	16	5
2153	W&C	Paediatrics	05/Mar/13	31/May/19	If the high number of vacancies of qualified nurses working in the Children's Hospital is below establishment, then it may result in widespread delays with patient diagnosis or treatment leading to potential harm.	Major	Likely	16	8
3201	Communications		20/06/2018	30/Apr/19	If the Mac desktop computers fail/break down or the shared server fails, then it may result in a prolonged disruption to the continuity of photography and/or graphics services across the Trust leading to service disruption.	Major	Likely	16	2

Risk ID	CMG	Specialty	Opened	Review Date	Risk Description	Impact	Likelihood	Current Risk Score	Target Risk Score
2237	Corporate Medical	Patient Safety	07/Oct/13	31/03/2019	If a standardised process for requesting and reporting inpatient and outpatient diagnostic tests is not implemented, then it may result in widespread delays with patient diagnosis and treatment leading to potential harm	Major	Likely	16	8
3144	Estates & Facilities		10/Jan/18	28/04/2019	If Estates & Facilities are unable to recruit and retain staff, or fund posts to deliver services to meet the Trust's expectations, then it may result in a prolonged disturbance to the continuity of core services across the Trust leading to potential service disruption, patient harm, failure to achieve required standards	Major	Likely	16	12
3145	Estates & Facilities		10/Jan/18	28/04/2019	If there is not a significant investment to upgrade electrical infrastructure across the UHL, then it may result in prolonged disturbance to the continuity of core services across the Trust leading to potential service disruption and patient harm	Major	Likely	16	6
3138	Estates & Facilities		09/Jan/18	28/04/2019	If there are insufficient management controls in place to meet Regulation 4 of the Control of Asbestos Regulations (CAR), then it may result in failure to achieve compliance with regulations & standards leading to potential reputational impact, enforcement action by the HSE, and significant financial penalties.	Major	Likely	16	4
3140	Estates & Facilities		09/Jan/18	30/06/2019	If sufficient 'downtime' for Planned Preventative Maintenance and corrective maintenance is not scheduled into the theatre annual programmes to maintain specialist ventilation systems, then it may result in detrimental impact on safety & effectiveness of patient care delivered leading to potential harm from microbiological contamination in the theatre environment.	Major	Likely	16	8
3141	Estates & Facilities		10/Jan/18	28/04/2019	If the integrity of fire compartmentation is compromised, then it may result in a detrimental impact on the health and safety of staff, patients and visitors due to fire and/or smoke spread through the building limiting the ability to utilise horizontal and/or vertical evacuation methods leading to potential life safety concerns and loss of areas / beds / services.	Major	Likely	16	8
3364	Estates & Facilities		14/02/2019	30/Apr/19	If there is no suitable physical security barrier at the Windsor main entrance reception desk, then it may result in a detrimental impact on health, safety & security of receptionist staff, leading to harm.	Major	Likely	16	8
3137	Estates & Facilities	Estates	08/Jan/18	28/04/2019	If calls made to the Switchboard via '2222' are not recorded, then it may result in a detrimental impact on health, safety & security of staff, patients and visitors as there is limited evidence of vital/critical information passed verbally between caller and call handler for reported situations leading to potential for harm and reputational impact	Major	Likely	16	4
3180	IM&T		19/02/2018	30/06/2019	If fragility in the underlying UHL IM&T infrastructure is not addressed, then it may result in limited or no access to Trust IM&T critical systems, leading to potential service disruption and provision of patient care	Major	Likely	16	8
3155	IM&T	IM&T	30/01/2018	31/03/2019	If the PABX system fails, then it may result in limited or no access to Trust telephony system for a range of numbers, leading to potential service disruption and provision of patient care	Major	Likely	16	8
3340	Corporate Nursing	Staff Bank	21/12/2018	26/06/2019	If our IM&T systems under the current contract provider for locum bookers are unable to support fundamental processing, payment, and reporting, then it may result in non-delivery to contractual specification requirements, leading to potential service disruption, financial and reputational impact	Major	Likely	16	8
2774	Operations		25/01/2016	30/Jun/19	If there are delays with dispatching post-consultation outpatient correspondences, then it may result in delays with patient discharge and treatment leading to potential patient harm.	Major	Likely	16	8
2621	CHUGGS	General Surgery	20/10/2015	31/May/19	If staffing levels on Ward 22 at LRI are below establishment, then it may result in detrimental impact on safety & effectiveness of patient care delivered, leading to potential for patient harm	Moderate	Almost certain	15	6

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3391	CHUGGS	General Surgery	14/02/2019	30/Jun/19	If CHUGGS CMG is unable to operate within the financial envelope this financial year (18/19), then it may result in non-delivery of the set budget, leading to financial impact, impact on quality and performance outcomes for patients, wellbeing of staff and risk the future sustainability of services provided within the CMG.	Moderate	Almost certain	15	6
3401	RRCV		20/02/2019	30/04/2019	If the cardiac monitors are not correctly and securely fixed to the wall in Ward 28, GH, then it may result in a detrimental impact on health and safety of staff, patients and visitors if a monitor was to fall, leading to potential for serious harm	Extreme	Possible	15	5
3312	RRCV		20/09/2018	30/Jun/19	If recurrent funding is not provided to retain the 2 nursing posts (B6 and B3) for the LTBI programme services, then it may result in a prolonged disruption to the continuity of services across the Trust, leading to service disruption.	Moderate	Almost certain	15	3
3211	RRCV	Cardiology	29/05/2018	30/06/2019	If additional appropriately trained sedationists are not provided in Angiocatheter suite, then it may result in detrimental impact on safety & effectiveness of patient care delivered with patients undergoing cardiology procedures receiving an inadequate level of monitoring during conscious sedation, leading to potential harm.	Extreme	Possible	15	8
3047	RRCV	Cardiology	13/07/2017	28/05/2019	If the service provisions for vascular access at GH are not adequately resourced to meet demands, then it may result in patients experiencing significant delays for a PICC, leading to potential harm.	Moderate	Almost certain	15	6
2804	ESM		06/May/16	30/Apr/19	If the ongoing pressures in medical admissions continue and Specialist Medicine CMG 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	Moderate	Almost certain	15	12
3379	ESM		27/02/2019	30/Apr/19	If nursing, medical, AHP and support staffing resources and appropriate equipment resources are not available on the winter extra capacity ward (W7, LRI), then it may result in a detrimental impact on safety & effectiveness of patient care delivered, leading to potential patient harm.	Extreme	Possible	15	10
2837	ESM	Neurology	09/May/16	31/03/2019	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.	Extreme	Possible	15	2
3412	CSI		01/Mar/19	30/04/2019	If two dedicated Critical Care Occupational Therapy posts are not recruited, then it may result in significant disturbance to the continuity of patient care on the ICU units or within the follow-up clinics over the 3 UHL sites, leading to service disruption.	Moderate	Almost certain	15	6
3317	CSI	Imaging - Breast	19/09/2018	30/04/2019	If breast care services staffing levels are below establishment, then it may result in widespread delays with patient diagnosis or treatment, leading to potential for patient harm and failure to consistently deliver the 2WW demand targets	Moderate	Almost certain	15	9
2615	CSI	Pathology - Clinical Microbiology	11/Sep/15	15/05/2019	If a critical infrastructure failure was to occur in containment level 3 laboratory facility in Clinical Microbiology, then it may result in a prolonged disruption to the continuity of core services across the Trust, leading to service disruption	Extreme	Possible	15	2
3288	CSI	Pharmacy	31/08/2018	30/04/2019	If no additional storage space can be identified in UHL pharmacy to stock essential filtration fluids, then it may result in delayed treatment or diagnosis to patients that clinically require Continuous Renal Replacement Therapy, leading to potential for suboptimal therapy, significant irreversible harm and increased LOS to AICU patient population	Extreme	Possible	15	5
3331	CSI	Physiotherapy	25/10/2018	31/05/2019	If the cardiorespiratory physiotherapy service staffing is below funded establishment at the Glenfield Hospital then it may result in detrimental impact on quality of delivered care and patient safety leading to potential for harm	Moderate	Almost certain	15	9

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3093	W&C	Maternity	05/Dec/17	30/04/2019	If there is insufficient Midwifery establishment to achieve the recommended Midwife to Birth ratio, in view of increased clinical acuity, then it may result in patient care being delayed leading to potential harm with an increase in maternal and fetal morbidity and mortality rates	Moderate	Almost certain	15	6
3023	W&C	Maternity	18/05/2017	30/04/2019	If the split site Maternity configuration strategy is not enacted, then it may result in a detrimental impact on safety & effectiveness of Maternity services at the LGH site leading to potential harm	Moderate	Almost certain	15	6
3083	W&C	Neonatology	04/Sep/17	30/Jun/19	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.	Moderate	Almost certain	15	3
3332	W&C	Paediatrics	30/10/2018	30/Jun/19	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	Extreme	Possible	15	4
2394	Communications	Communications	04/Jul/14	30/06/2019	If there is no service agreement to support the image storage software used for Clinical Photography, then it may result in widespread delays with patient diagnosis or treatment because Clinicians would not be able to view the photographs of their patients leading to potential harm	Moderate	Almost certain	15	3
3079	Corporate Medical		16/08/2017	31/03/2019	If there is insufficient capacity with the administrative support for the Learning from Deaths Framework and the Specialty M&M Structured Judgment Review process, then it may result in a delay with screening all deaths, undertaking Structured Judgment Reviews, and speaking to bereaved relatives leading to reputational impact and non-compliance with the internal QC and external NHS England and Statutory Quality Account requirements	Moderate	Almost certain	15	6
2434	IM&T		28/10/2014	31/Aug/19	If computers operating on Windows XP are not upgraded, then it may result in limited or no access to Trust systems in the event of a cyber attack, leading to potential service disruption and provision of patient care	Moderate	Almost certain	15	6
1615	IM&T	IM&T	23/05/2011	31/03/2019	If flooding occurs in our Data Centre at the LRI site, then it may result in limited or no access to Trust systems, leading to potential service disruption and provision of patient care	Extreme	Possible	15	10
3172	IM&T	Privacy	07/Feb/18	31/Dec/19	If systems and services provided by IM&T are not continuously maintained to ISO accredited standard and vulnerable to potential cyber attack, then it may result in breach of confidentiality & integrity of information leading to potential reputational impact, significant service disruption, harm to patients and financial loss	Extreme	Possible	15	10
3289	Operations		13/09/2018	31/Oct/19	If the Trust fails to improve its emergency preparedness, resilience and response (EPRR) arrangements, then it may result in significant disruption to delivery of its critical and essential services in a business continuity, critical or major incident leading to service disruption and potential harm.	Moderate	Almost certain	15	6