The Integrated Risk and Assurance Report

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Trust Board paper H

Purpose of report:

This paper is for:	Description	Select (X)
Decision	To formally receive a report and approve its recommendations OR a particular course of action	
Discussion	To discuss, in depth, a report noting its implications without formally approving a recommendation or action	X
Assurance	To assure the Board that systems and processes are in place	X
Noting	For noting without the need for discussion	

Previous consideration:

Meeting	Date	Please clarify the purpose of the paper to that meeting using the categories above
CMG Board (specify which CMG)	Monthly	Review and update operational risks on Datix risk register
Executive Board	EFPB Oct 2020	To discuss BAF and risk register ahead of TB meeting
Trust Board	Today	To review and approve the BAF

Executive Summary

Context

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

Questions

1. What are the highest rated principal risks on the 2020/21 BAF?
2. What changes have been proposed to the BAF during review at Executive Board meetings in October?
3. What are the typical risk causation themes on the organisational risk register?

Conclusion

1. At the end of quarter 2 2020/21, the highest rated principal risks on the BAF, all rated 20, include:

PR No.	Principal Risk Event	Executive Lead Owner	Current Rating: (L x I)
2	Failure to meet constitutional performance targets	COO	5 x 4 = 20
3	Failure to provide adequate staffing capacity, skill mix and diversity	CPO	5 x 4 = 20
4	Failure to create and maintain a financially sustainable model	ACFO	4 x 5 = 20
6	Failure of the Trust's critical infrastructure	DEF	4 x 5 = 20

2. At the ESB meeting in October, Executive Leads for PR 8 (COVID 19 – recovery, restoration and renewal) proposed a reduction in rating from 16 (high) to 12 (moderate) following the submission of phase 3 plans and the progress with the CMGs recovery plans. However, it should be noted, it is anticipated that the current score may rise over the coming months with a second peak.
3. There are 313 risks recorded on the organisational risk register as at 30th September 2020.

There have been two new risks scoring 15 and above entered on the risk register during this reporting period. Thematic Analysis of the organisational risk register shows the key causation theme is around gaps in workforce capacity and capability across all CMGs. Other causation themes include gaps in infrastructure and environment, equipment and resources, information and protocols and demand exceeding capacity.

Input Sought

The Board is invited to receive assurance on the process of risk management through the content of this report, noting the work on the Principal Risks on the Board Assurance Framework 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.

For Reference:

This report relates to the following UHL quality and supporting priorities:

1. Quality priorities

Safe, surgery and procedures	[Yes]
Improved Cancer pathways	[Yes]
Streamlined emergency care	[Yes]
Better care pathways	[Yes]
Ward accreditation	[Yes]

2. Supporting priorities:

People strategy implementation	[Yes]
Investment in sustainable Estate and reconfiguration	[Yes]
e-Hospital	[Yes]
Embedded research, training and education	[Yes]
Embed innovation in recovery and renewal	[Yes]
Sustainable finances	[Yes]

3. Equality Impact Assessment and Patient and Public Involvement considerations:

- N/A

4. Risk and Assurance

Risk Reference:

Does this paper reference a risk event?	Select (X)	Risk Description:
Strategic: Does this link to a ***Principal Risk*** on the BAF?	X	See appendix 1
Organisational: Does this link to an ***Operational/Corporate Risk*** on Datix Register	X	See appendix 2
New Risk identified in paper: What ***type*** and ***description***?		
None		

5. Scheduled date for the **next paper** on this topic: Quarterly
6. Executive Summaries should not exceed **5 sides** My paper does comply

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **UHL TRUST BOARD**

DATE: **5TH NOVEMBER 2020**

REPORT BY: **STEPHEN WARD – DIRECTOR OF CORPORATE & LEGAL AFFAIRS**

SUBJECT: **INTEGRATED RISK AND ASSURANCE REPORT (INCORPORATING UHL BOARD ASSURANCE FRAMEWORK & ORGANISATIONAL RISK REGISTER AS AT 30TH SEPT 2020)**

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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 assurance on the risks contained within the:-

a. Board Assurance Framework (BAF) and ;
b. Organisational risk register (including corporate and operational risks).

2. BOARD ASSURANCE FRAMEWORK SUMMARY

2.1 The BAF is an essential governance tool providing board assurance over the key controls in place to mitigate the Principal Risks to the achievement of the Trust's strategic objectives. The BAF is informed by the organisational risk register, in addition to consideration about external threats to the delivery of the Trust's objectives and priorities.

2.2 A detailed version of the 2020/21 BAF for quarter two is attached at appendix one. Executive leads have updated their Principal Risks during October and they have been discussed and endorsed at the relevant Executive Board meetings as part of the Trust's established BAF governance arrangement.

2.3 The table below provides an overview of the Principal Risks on the 2020/21 BAF:

PR Ref.	Principal Risk Titles	Executive Lead Owner	Current Rating: (L x I)	Target Rating - beyond 2020/21 (L x I)
1	Clinical quality and patient safety	MD/CN	3 x 5 = 15	2 x 5 = 10
2	Operational performance	ACOO	5 x 4 = 20	3 x 4 = 12
3	Workforce sustainability	CPO	5 x 4 = 20	3 x 4 = 12
4	Financial sustainability	ICFO	4 x 5 = 20	3 x 5 = 15
5	IT (eHospital programme, and maintaining/ improving existing critical infrastructure)	CIO	4 x 4 = 16	3 x 4 = 12
6	Estates - Maintaining/ improving existing critical infrastructure	DEF	4 x 5 = 20	2 x 5 = 10
7	Estates - reconfiguration - new estate	DEF	4 x 4 = 16	3 x 4 = 12
8	COVID 19 – recover and restoration / renewal	DSC & ACOO	3 x 4 = 12 ↓	3 x 4 = 12

2.4 The Executive Strategy Board has suggested the current risk rating for Principal Risk 8 (COVID 19 – recover, restoration and renewal) should be reduced from 16 (high) to 12 (moderate) this reporting period (ending 30th September 2020) following the submission of phase 3 plans and the progress with the CMGs recovery plans. However, the Board should note that the PR lead anticipates the current score may rise over the coming months with a second peak.

2.5 In the early stages of the COVID-19 pandemic the Trust developed a dedicated COVID-19 assurance framework as a means of overseeing the strategic risks presented by the pandemic and as a means of assuring the Board whilst the new BAF was in the development stage. However, the risks in the original COVID-19 framework have now been embedded within the established Principal Risks on the BAF and consequently, since October 2020, the UHL Strategic Recovery Group have been carrying out a review of the BAF at their weekly meetings to ensure significant matters concerning the COVID-19 pandemic are reported.

2.6 Following the initial discussions about risk appetite at the Trust Board Thinking Day in March 2020, the Corporate Risk Team will carry out some work with our Internal Auditors to identify Key Risk Indicators (KRI) linked to Principal Risks on the BAF as part of the risk appetite refresh programme. The KRIs are measures of how 'risky' an activity is and are metrics used to provide an early signal of increasing risk exposure. The plan is to work on developing KRIs for all principal risks, starting with PRs 2 (operational performance), 3 (workforce sustainability), and 4 (financial sustainability) and progress will be reported so the Board can schedule a session to review their appetite for taking risk and it can be subsequently communicated to leaders so that boundaries for risk taking behaviour can be understood and applied by leaders across the Trust.

3. ORGANISATIONAL RISK REGISTER SUMMARY

3.1 The Trust's organisational risk register, consisting of local CMG and corporate risks, has been kept under review by the Executive Finance and Performance Board and by CMG Boards during October. The organisational risk profile, by current risk rating, is illustrated in Figure 1, below, and a dashboard of the risks rated 15 and above (high) is attached at appendix two.

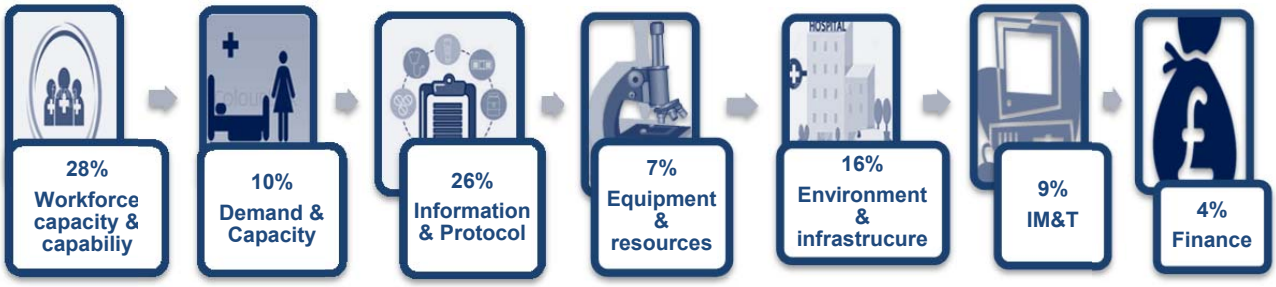
Fig 1: UHL Organisational Risk Register profile by current rating (30/09/20)

3.2 New risks identified by CMGs and Corporate Directorates, rated 15 and above, are presented to the Executive Board meeting on a weekly basis for review and endorsement ahead of being reported on the organisational risk register. Details of the two new risks approved during September are provided for information below:

ID	CMG	Risk Description – New Risks	Current Rating	Target Rating
3682	CMG 1 - CHUGGS	If the current ventilation system in the Endoscopy Units is not improved, then it may result in delayed diagnosis and treatment for diagnostic tests for both routine and cancer pathways, leading to potential patient harm, non-compliance with RTT and Cancer waiting time targets, adverse reputation and financial loss.	20	10
3679	CMG 5 -	If additional capacity and space is not identified to meet the ever	16	12

	MSK & SS	increasing demand on ophthalmology services, then it may result in delayed patient diagnosis and treatment, leading to potential patient harm		

3.3 Analysis of the risks open on the organisational risk register shows the typical risk causation themes illustrated in the graphic below:



4 RISK MANAGEMENT WORK PROGRAMME

4.1 The Corporate Risk Team has now launched the new Datix-web CAS Safety Alerts module and is working with CMGs to monitor compliance responses. The next significant programme of work for the Corporate Risk Team will be to progress the new Datix-web risk register, linking closely with clinical and non-clinical colleagues in CMGs to develop and test the module. It is anticipated the new module will be functional across the organisation early in the New Year.

5 RECOMMENDATIONS

5.1 The Board is invited to receive assurance on the process of risk management through the content of this report, noting the work to the Principal Risks on the Board Assurance Framework 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 Head of Risk & Assurance, 29/10/2020.

Appendix 1 - 2020/21 Board Assurance Framework – (Trust Board 05.11.20)

2020/21 - Board Assurance Framework

Strategic Objective: Quality & Supporting Priorities - Becoming the Best - Delivering caring at its best to every patient, every time	PR No.	Risk Title	Risk Event	Executive Lead Owner	Decision Boards /Monitoring Forums		BAF Current Rating: (L x I)	*Target* Rating - beyond 2020/21 (L x I)	AC Deep Dive Assurance
	1	Clinical quality and patient safety	Failure to deliver agreed quality and clinical outcomes and high standards of patient care	MD/CN	EQB	QOC	3 x 5 = 15	2 x 5 = 10	TBC
	2	Operational Performance	Failure to meet constitutional performance targets	ACOO	EFPB	QOC / PPPC	5 x 4 = 20	3 x 4 = 12	Next AC
	3	Workforce sustainability	Failure to provide adequate staffing capacity, skill mix and diversity	CPO	EPCB	PPPC	5 x 4 = 20	3 x 4 = 12	24/01/20 (2019/20)
	4	Financial sustainability	Failure to create and maintain a financially sustainable model	ACFO	EFPB / FRB	FIC	4 x 5 = 20	3 x 5 = 15	06/09/19 (2019/20)
	5	IT (e-Hospital programme, and maintaining/ improving existing critical infrastructure)	Failure to provide optimised and reliable digital services, realise projected savings and transformational change	CIO	EIM&T	QOC / PPPC	4 x 4 = 16	3 x 4 = 12	06/03/20 (2019/20)
	6	Estates - critical infrastructure	Failure of the Trust's critical infrastructure	DEF	ESB	QOC	4 x 5 = 20	2 x 5 = 10	08/11/19 (2019/20)
	7	Estates: reconfiguration - new estate	Failure to create and sustain an estate fit for the future	DEF	ESB / ERB	TB	4 x 4 = 16	3 x 4 = 12	TBC
	8	COVID 19 – recover and restoration / renewal	Rapid operational instability	DSC	ESB	TB	3 x 4 = 12	3 x 4 = 12	TBC

Appendix 1 - 2020/21 Board Assurance Framework – (Trust Board 05.11.20)

PR Ref:	PR 1	**PR Title:**	Clinical quality and patient safety								**Last Updated:**	06/10/20
Executive lead(s):	Medical Director & Chief Nurse	**Lead Executive Board:**	EQB		**Lead TB sub-committee:**	QOC		**Strategic Objective**	Quality Priorities			
AC Deep Dive: Overall Assurance	**AC Deep Dive Date:**	**Have all significant high-level drivers to the risk been identified?**		**Are there appropriate effective controls in place to mitigate the risk?**		**Is there adequate outcome evidence the risk is being successfully mitigated?**		**Are there clear plans in place to treat / manage the risk in the long term?**				
	TBC											
BAF tracker - month	**APR**	**MAY**	**JUN (Q1)**	**JUL**	**AUG**	**SEP (Q2)**	**OCT**	**NOV**	**DEC (Q3)**	**JAN**	**FEB**	**MAR (Q4)**
Current rating (L x I)	3 x 5 = 15	3 x 5 = 15	3 x 5 = 15	3 x 5 = 15	3 x 5 = 15	3 x 5 = 15						
Target rating (L x I)			3 x 5 = 15			3 x 5 = 15			3 x 5 = 15			2 x 5 = 10
Rationale for score:	COVID has already led to considerable reduction of clinical services and there is a potential for patient harm in those not treated or those that have had delays in treatment											
PR Description	Inability to address the drivers to deliver effective clinical quality and patient safety, may result in fail to deliver high standards of patient care											

Cause(s): *Drivers*	**PR event:** *If we are unable to address the PR drivers, then it may result in…*	**Impact:** *leading to…*
• A widespread loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction. • An outbreak of infectious disease (such as pandemic) that forces closure to one or more areas of the hospital and/or causes avoidable serious harm or death to service users.	failure to deliver agreed quality and clinical outcomes and high standards of patient care	negative impact on patient safety, outcomes and experience, widespread reduction in the quality and effectiveness of clinical care, repeated failure to achieve constitutional standards, service disruption and loss of public confidence in the trust

Current Likelihood of PR event occurring caused by the drivers described (after controls in place)	**Current Impact after controls**
3	5
Target Likelihood rating of PR event occurring caused by the drivers described	**Target Impact (beyond 2020/21)**
2	5

Drivers	**Primary controls:** What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Sources of assurance** Evidence that the controls/ systems which we are placing reliance on are effective. Internal & External sources of evidence.	**Gaps** What (a) further action is still needed or (b) controls are not working effectively? (provide details and progress of actions)	**key current focus (and dates)** Are there further controls possible in order to reduce risk exposure within tolerable range?
A widespread loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than	• Annual quality priorities, along with key enabler priorities – included in the Quality Strategy (BtB), agreed by TB and monitored via the Executive Team. • Clinical service structures, accountability & quality governance arrangements at corporate, CMG & specialty levels. • Trust wide risk monitoring and governance structure in place including for: risk register, CAS broadcasts, Incident reporting, Complaints, Claims & Inquests, GP concerns,	**Internal** • Ward assessment & accreditation audits. • Monthly Care Review & Learn CMG meetings focussing on the Harm Free Care priorities of Falls and HAPU. • Monthly nursing and midwifery sensitive indicators – audit and dashboard review. • Quarterly harms review to monitor compliance with incident theme	• Lack of audit of improvement from actions taken to address incidents, risks, alerts, complaints. • Some clinical policies and procedures have elapsed review dates. • Assessment & accreditation not fully rolled out. • Gaps in resource to support the Quality Strategy priorities.	• External (PWC and CCG) audit review of five steps to safer surgery compliance. • Policy and Guideline process efficiency review. • Continue roll-out for A&A (including specialties other than inpatient general wards). Themed analysis report to be produced. Standard Operating Procedure to be approved. • Quality Improvement posts recruitment complete. Resource being deployed and aligned to support Quality Strategy, Transformation and Efficiency work under new Director post.

expected mortality, and significant reduction in patient satisfaction.	clinical audit and other patient feedback. • Staff training programmes (induction, statutory & mandatory and non-mandatory) – recorded on HELM and monitored via Executive Team. • Maintenance of defined safe staffing levels on wards & departments – nursing and medical monitored on a daily basis. • Policies and procedures and guidelines including NatSSIPs/ LocSSIPs – process for policy approval and docs stored on Policy and Guideline Library. • Senior leadership walkabout programme. • QI safety initiatives embedded in clinical settings – stop the line. • Patient Safety Portal – available on insite and accessible to all staff. • Dedicated Quality & Safety and 'time2train' sessions quarterly. • Appointment of a QI nurse to embed the LocSSIP Quality Assurance framework for invasive procedures. • Bi monthly Quality and Performance nursing and midwifery meeting – Reporting to Nursing and Midwifery Board bi monthly. • Monthly 1:1 Head of Nursing meeting with Deputy Chief Nurse to include all elements of harm free care, patient satisfaction and 15 step/walkabout methodologies. • Monthly meeting with Chief Nurse, Medical Director, Director of Quality Governance, Head of Risk, Head of Patient Safety and Head of Quality Assurance to review and triangulate patient safety/risk themes. • Quality Impact Assessment process for investments.	boards (i.e. falls, safer surgery, VTE, diabetes, deteriorating patient) to detect and monitor harms. • CMG PRMs monitor Quality performance and provide 2-way communication forum. • Revised Q&P report facilitates identification of incident / harm themes / trends. • Review and refresh of monthly nursing and midwifery sensitive indicators in line with national guidance and evidence based best practice via the Matrons forum. • Bi-monthly Pressure Ulcer Steering Group with improvement plan, audit schedule and forward plan. • Bi-monthly nursing and midwifery Harm Free Care reports by CMG to the NMQEB. • National Patient experience award winner. **External** • CQC inspection reports. • PwC safety audits. • CCG quality visits. • GIRFT reviews. • HSIB reviews for Maternity Services.	• Unknown impact of endemic risk of COVID-19. • Backlogs in outpatients and clinics due to restricted attendance to comply with COVID-19 social distancing requirements. • Review and refresh of monthly nursing and midwifery sensitive indicators in line with national guidance and evidence based best practice. • Quality Impact Assessment process not established for CIP. • Quality Governance and Assured Services process isn't fully established. • Outcomes and findings from external assurance reviews which have been on hold during Covid-19.	• Review and implement GIRFT actions. • Ongoing Command and Control arrangements to manage COVID-19. • COVID Restoration and Recovery Cells at Trust and CMG level. • Cancer harms review process for emerging Covid-related delays / harms. • Safer Surgery assessment and accreditation process being developed as part of the Safe Surgery and Procedures Quality priority work stream. • Commencement of Pressure Ulcer QI collaborative. • Linking nursing and midwifery assessments completed on NerveCentre directly through to the indicators dashboard. • Harms review process for emerging Covid-related delays / harms. • Development of a QIA process for CIP. • Development of a Quality Governance Assured Services process.
An outbreak of infectious disease (such as pandemic) that forces closure / significant disruption to one or more service(s)	• Chief Nurse identified as DIPaC. • IP service provided Trust wide by the IPC Team incl Lead IP Nurse and IP Doctor. • Infection Prevention policy. • Infection Prevention procedures, including: o Management of infected linen. o Provision of food to quarantined patients	**Internal**: • Infection Prevention Team providing expert and professional advice to the DIPaC (CN) and Executive Team. • Extraordinary TIPAC meeting (Covid-19: 6th May with outline guidance/SOP circulated to CMGs). • In receipt of national guidance re	• Ability and infrastructure to be able to provide acute care to patients in the right place at the right time. • Ability to social distance in some outpatient/ waiting areas / triage areas.	• National Board Assurance Framework completed and reviewed by EQB and QOC, as well as submitted to CQC as part of Emergency Framework Review. • Three phase governance review of IP arrangements being undertaken to ensure best practice.

in the hospital.	• Staff training including mandatory e-learning and fit testing. • Environmental cleaning Procedures / Standards in all areas • Decontamination standards • Designated side rooms & cohorting areas identified for suspected patients. • Restricted access to wards, units and departments by staff and visitors. • Measures to support social distancing in public areas. • PPE guidance & regular communication in place in line with PHE recommendations. • PPE safety champions implemented. • Covid-19 Outbreak RCA process. • IP Masterclass delivered for all Heads of Nursing and IPN's.	Covid-19 swabbing of patients, which the Microbiology team and ICD advise CMGs and the Demand and Capacity Group. • FFP3 mask risk assessment fit/check process undertaken by Infection Control Doctor and agreed by COVID-19 Strategy Group. • Receipt of correspondence from the centre confirming stabilisation of FFP3 supply, meaning we will be in receipt of 80:20 split of brands of masks. Requests for stocks, of the Trust's preferred FSM18 mask, will continue to be escalated to the National Team/Supply Chain. **External** • CQC Infection control Board Assurance Framework. • LLR SLT providing a co-ordinated response to threats.		

Appendix 1 - 2020/21 Board Assurance Framework – (Trust Board 05.11.20)

PR Ref:	PR 2	**PR Title:**	Operational Performance									**Last Updated:**	09/10/20
Executive lead(s):	Acting Chief Operating Officer	**Lead Executive Board:**	EFPB		**Lead TB sub-committee:**	PPPC / QOC		**Strategic Objective**	Quality Priorities				
AC Deep Dive: Overall Assurance	**AC Deep Dive Date:**	**Have all significant high-level drivers to the risk been identified?**		**Are there appropriate effective controls in place to mitigate the risk?**		**Is there adequate outcome evidence the risk is being successfully mitigated?**		**Are there clear plans in place to treat / manage the risk in the long term?**					
	TBC												
BAF tracker - month	**APR**	**MAY**	**JUN (Q1)**	**JUL**	**AUG**	**SEP (Q2)**	**OCT**	**NOV**	**DEC (Q3)**	**JAN**	**FEB**	**MAR (Q4)**	
Current rating (L x I)	5 x 4 = 20	5 x 4 = 20	5 x 4 = 20	5 x 4 = 20	5 x 4 = 20	5 x 4 = 20							
Target rating (L x I)			5 x 4 = 20			5 x 4 = 20			5 x 4 =20			5 x 4 =20	
Rationale for score:	It is still rated as more likely to happen than not, especially following the COVID-19 pandemic. We ensure there is clinical involvement risk assessing patients to try to ensure the impact does not increase further. Urgent and Cancer are prioritised over long waiters using the national framework.												
PR Description	Inability to address the drivers to deliver the key operational performance standards, may result in failure to deliver trajectories for emergency, planned and cancer care												

Cause(s): *Drivers*	**PR event:** *If we are unable to address the PR drivers, then it may result in…*	**Impact:** *leading to…*
• Emergency care: Growth in demand for care caused by an ageing population; reduced social care funding; increased acuity leading to more admissions & longer length of stay; operational system failure (including GP ability to cope with demand). Also the requirement to cohort patients by COVID creates a risk on emergency care flow. • Planned Care: Emergency pressures for inpatient beds resulting in fewer elective operations than planned. Through the new process required within the theatre setting this has impacted heavily on the throughput of patients. There are a significant number of patients already breached 52 weeks and this will increase the risk of further patients breaching the 52 weeks each month. • Cancer Care: Diagnostic and Theatre capacity pressures through the reduction in throughput of patients through clinics and theatres. Also the available access to high dependency beds.	failure to meet constitutional performance targets (for emergency standard - 4 hour access and planned care standards - avoiding patients waiting in excess of 52 weeks for their planned treatment and maintaining performance against access standards for patients with cancer, with delivery of the 62 day standard)	negative impact on patient safety, outcomes and experience, widespread reduction in the quality and effectiveness of clinical care, repeated failure to achieve constitutional standards and loss of public confidence in the trust

Current Likelihood of PR event occurring caused by the drivers described (after controls in place)	**Current Impact after controls**
5	4
Target Likelihood rating of PR event occurring caused by the drivers described (beyond 2020/21)	**Target Impact (beyond 2020/21)**
3	4

Drivers	**Primary controls:** What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Sources of assurance** Evidence that the controls/ systems which we are placing reliance on are effective. Internal & External sources of evidence.	**Gaps** What (a) further action is still needed or (b) controls are not working effectively? (provide details and progress of actions)	**key current focus (and dates)** Are there further controls possible in order to reduce risk exposure within tolerable range?

Appendix 1 - 2020/21 Board Assurance Framework – (Trust Board 05.11.20)

• Emergency Care: Growth in demand for care caused by an ageing population; reduced social care funding; increased acuity leading to more admissions & longer length of stay; operational system failure (including GP ability to cope with demand) Also the requirement to cohort patients by COVID create a risk on emergency care flow.	• Implementation of a Discharge Hub. With a philosophy of discharge within 24 hours of medically fit for discharge. • Maximise the use of SDEC. • Timely booking of transport to avoid delay to patient discharge. • Identification of next day discharges to support early flow. • Operational command meeting with OPEL triggers appropriate to each level. • Admission prevention & avoidance projects owned by LLR • Alert to system partners to ensure action is triggered prior to the 10.30am call • Increase utilisation of discharge lounge • Early initiation of TTO's from ward areas • Emergency Department separated into two, with covid/non-covid space • Frailty consultants on the phone for calls from EMAS and GPs for patients in care/residential homes to avoid admission where possible • Maximise Use of GPAU. • Simplified pathway changes in ED/emergency floor to access community beds since 3 September 2020	Internal: • ED patients waiting time report. • Bed occupancy report. • UHL Capacity Reports. • Daily medically fit for discharge numbers. • Daily medically fit for discharge complex patient list. • Stranded and super-stranded patient data. • Daily performance metrics for all ED areas	• Capacity gap for patients to be discharged within 24 hours of becoming medically fit especially for county patients. • Ability to discharge patients to community beds and care homes due to waiting for COVID-19 swabs. • Bed capacity modelling identifies a shortfall in medicine beds – medicine using other wards due to COVID-19 patients streams. • Rapid flow cannot occur due to COVID-19 nor can waiting rooms become crowded. • Patients cannot wait on the back of ambulances. • Medical workforce to cover 2 emergency departments and assessment areas.	• Utilisation of available community beds – support earlier identification and handover of patients on the day prior to discharge to support better discharge planning. Maximise the use of the discharge hub. • Review of discharge hub and pathways is currently being undertaken. • The onset of COVID-19 pandemic has resulted a change of business continuity plans in order to ensure emergency bed capacity is available for the forecasted increase in cases. The trust is now reinstating elective surgery and outpatients but ensuring this will not impact on emergency flow and maintains COVID-19 streams. • Implementation of Think 111 across LLR (September 2020). • Development of SDEC hub at LRI (December 2020).
• Planned care: Emergency pressures for inpatient beds resulting in fewer elective operations than planned. Through the new process required within the theatre setting this has impacted heavily on the	• Trust Access Policy. • NHS Constitution. • Demand and capacity modelling. • Bi-weekly calls with NHSE/I. • Weekly RTT submission.	Internal: • Weekly Access Meeting. • Monthly system Activity Triangulation meeting. • Performance Review Meeting. • Long Waiters Report. • Bi-weekly 40+ week report. • Weekly PTL Review meeting	• LLR FOT significantly over financial plan. System partners looking to further reduce spend including further flexing outwards of waiting times and waiting list size. • Emergency pressures for inpatient beds resulting in fewer elective operations than planned, Creating increase in number of patients that are at risk of breaching 52 weeks each month.	• Demand management plans including RSS supporting to bridge capacity gap. Waiting list is currently 72989. This is now being managed through the weekly access meeting with each speciality. • AIC agreed for planned for remainder of 2020/21. COVID-19 has impacted with cancellation of non-essential face to face activity and conversation to virtual/telephone appointments. • 3942 x 52 week breaches at the end of September due to pause in routine elective work during COVID-19 pandemic. The Trust has started to utilise the independent sector. Also looking how PCL can be utilised to help with

throughput of patients. There are a significant number of patients already breached 52 weeks and this will increase the risk of further patients breaching the 52 weeks each month.			• COVID-19 National mandate to stop all non-urgent and cancer routine elective work. Has caused a significant amount of 52+ week breaches. • Throughput in theatre sessions reduced, leads to a reduced amount of patients that can be treated within the current capacity. • Ability to social distance in some Outpatients clinics and waiting areas / triage areas.	long waiters and address the problem system wide. Next phase started for using the PCL, agreement from CCG to utilise contract. • Trust is currently following national guidance to convert outpatients to non-face to face where possible as a result of COVID-19. National guidance has stopped the transactional management of 52 week breaches. • Restore and Recovery plan now submitted to NHSI/E. We have started to implement this across UHL. Through the below point: • WLI funding agreed through financial recovery board on 11/08/2020 to help increase theatre capacity for long waiters. • Utilising 75% of Independent Sector capacity. • Theatres to return to 100% of sessions delivered last October. • Utilisation program being developed with support of Kingsgate to improve flow through theatres.
• Cancer Care: Increased cancer backlogs as a result of COVID and decreased activity during the peak of the pandemic and decreased activity post the pandemic peak due to PPE and social distancing and patients choosing not to attend.	• Trust Access Policy. • NHS Constitution. • Daily calls with NHSE/I and UHL to manage the backlog. • COVID demand and capacity and tactical meetings.	Internal: • Cancer Action Board. • CMG Performance Review Meetings (internal). • Escalation Meetings (internal). • UHL Cancer Board Meeting (internal). • System Cancer Pathway and Performance Board (internal). • Daily Cancer PTL report (internal). • Weekly backlog update report (internal). • Daily Tumour site TCI report (internal). • PWC internal audit Data Quality review – 62 day cancer target (external). • SOP for the assessment of potential harm to cancer patients where the treatment pathway/plan has deviated from nationally agreed clinical guidelines as a result of COVID-19 ratified by the MDTs.	• Increased 2ww referrals with capacity not back to pre COVID levels. • Decreased surgical capacity. • Decreased diagnostic capacity.	• Restart of cancer diagnostics e.g. endoscopy. • Increased theatre utilisation for cancer. • Continued use of IS re utilisation of their capacity to support cancer delivery Increased patient support during challenged period. • Daily 104 day chase from DOI to ensure patients are being seen as quickly as possible. • Trajectories agreed by tumour site for recovery over the next 6 weeks and then to full recovery • CMG's being engaged in agreeing trajectories and actions to deliver.

Appendix 1 - 2020/21 Board Assurance Framework – (Trust Board 05.11.20)

PR Ref:	PR 3	PR Title:	Workforce sustainability									Last Updated:	14/10/20
Executive lead(s):	Chief People Officer		Lead Executive Board:	EPCB		Lead TB sub-committee:	PPPC		Strategic Objective	People Strategy			
AC Deep Dive: Overall Assurance	AC Deep Dive Date:	Have all significant high-level drivers to the risk been identified?		Are there appropriate effective controls in place to mitigate the risk?		Is there adequate outcome evidence the risk is being successfully mitigated?			Are there clear plans in place to treat / manage the risk in the long term?				
	TBC												
BAF tracker - month	APR	MAY	JUN (Q1)	JUL	AUG	SEP (Q2)	OCT	NOV	DEC (Q3)	JAN	FEB	MAR (Q4)	
Current rating (L x I)	5 x 4 = 20	5 x 4 = 20	5 x 4 = 20	5 x 4 = 20	5 x 4 = 20	5 x 4 = 20							
Target rating (L x I)			5 x 4 = 20			5 x 4 = 20			5 x 4 = 20			4 x 4 = 16	
Rationale for score:	Given the current staffing capacity issues during Covid-19												
PR Description	Inability to address the drivers to deliver the People Strategy may result in failure to provide adequate staffing capacity, skill mix and diversity												

Cause(s): *Drivers*	PR event: *If we are unable to address the PR drivers, then it may result in…*	Impact: *leading to…*
• Failure to recruit • Failure to develop. • Failure to retain.	failure to provide adequate staffing capacity, skill mix and diversity	prolonged, widespread reduction in the quality and effectiveness of clinical care, repeated failure to achieve constitutional standards and loss of public confidence in the trust

Current Likelihood of PR event occurring caused by the drivers described (after controls in place)	Current Impact after controls
5	4

Target Likelihood rating of PR event occurring caused by the drivers described (beyond 2020/21)	Target Impact (beyond 2020/21)
3	4

Drivers	Primary controls: What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Sources of assurance Evidence that the controls/ systems which we are placing reliance on are effective. Internal & External sources of evidence.	Gaps What (a) further action is still needed or (b) controls are not working effectively? (provide details and progress of actions)	key current focus (and dates) Are there further controls possible in order to reduce risk exposure within tolerable range?
Failure to recruit	• People strategy in place covering talent identification, staff engagement and workforce planning - available on Insite, ratified by TB – Reporting to EPCB and PPPC. • Nursing and Midwifery WF plan (appendix of People Strategy) aligned to NHS interim People Plan – defined 12 month deliverables. • Medical WF plan (appendix of People Strategy) aligned to NHS interim People Plan – defined 12 month deliverables. • People management policies, processes and professional support tools – available on Insite	Internal: • Validation of CMG WF risks monitored monthly via PRMs. • Monthly Workforce Data Set. External: • PWC audit scheduled in Q4 19/20 – outcomes expected.	• Significant vacancy areas remain - e.g. Lack of skilled nursing workforce. • Developed WF plans for other staff groups e.g. AHP's, A&C staff. Lack of nationally defined and agreed benchmarks. • System & UHL capacity for WF planning. • Management of Workforce pressures	• Scoping Trust attraction and retention approach to align activities for maximum effect, incorporating EDI across the system and more increasing diverse supply routes (e.g. STEM and Health Ambassadors). • Refresh of 5 year WF plan - in progress to incorporate reconfiguration and system planning. • Rebranding recruitment campaigns following successful £450m monies – initial review complete – forms part of people promise deliverables. • WF Reporting - joined up approaches being reviewed as part of system and corporate priorities. • Confirming system & organisational capacity for delivery of

	(including Recruitment and Selection Policy and Procedure) – process to review and update policies as appropriate. • Vacancy management and recruitment / retention process (TRAC system) – Time to Hire KPI in place, Apprenticeships, Graduate scheme monitoring reported monthly as part of monthly WF data set. • Recruitment & overseas recruitment campaigns as part of corporate and CMG Workforce plans. • LLR System People Plan established and aligned to NHS People Plan and LLR System Expectations.		across the system i.e. PCN's. • Within UHL - Fully joined up and integrated reporting/ IT systems across Finance, Workforce (ESR) and E rostering in regard to WF numbers.	the core offer/ people promise. Appointments made in Sept – refreshed system governance being scoped – Engagement session to be developed to define and clarify WF system governance arrangements. • Scoping impact of restoration and recovery plans which may lead to further gap in workforce supply. Surge plans in development with CMG's throughout Oct 20. • Progress in developing UHL People Plan aligned to LLR System People Plan –Update EPCB in October 2020.
Failure to develop	• 5 year People strategy in place covering talent identification, staff engagement - available on Insite, ratified by TB – Reporting to EPCB & PPPC. • Becoming the Best – Revised quality improvement approach currently being linked with efficiency and being redesigned for implementation with effect from July to provide a much more integrated and joined up programme. • Nursing and Midwifery WF plan (appendix of People Strategy) aligned to NHS interim People Plan – defined 12 month deliverables. • Medical WF plan (appendix of People Strategy) aligned to NHS interim People Plan – defined 12 month deliverables. • People management & wellbeing strategies, policies, processes and professional support tools to support talent management and people capability development.	• Core skills development including Statutory and Mandatory training – regular reporting as part of CMG PRMs and EPCB.	• Capacity gap for delivery of People Strategy and capacity gap at system level identified.	• Refresh the mid leadership development programme to reflect the agreed 10 system expectations by End of Nov 20. • Review of people policies and practice to support People plan delivery - incorporated into review of work programme 20/21. • Assessment of workforce implications as part of surge planning. • LLR system approach to Restoration and recovery agreed – first iterative submission made. • Plan for full roll of all staff COVID Risk assessment process in place and being Implemented to ensure 100% of staff complete risk assessment. Targeted actions in place to address gaps – next reporting 20th October to Regional team. • Agreement of LLR EDI System Programme of work for next 12 months with key priorities around quality risk assessment, talent management and compassionate leadership development.
Failure to retain	• People Strategy – Becoming the Best – defined measures reporting to EPCB and PPPC. • Nursing and Midwifery WF plan (appendix of People Strategy) aligned to NHS interim People Plan – defined 12 month deliverables. • Medical WF plan (appendix of People Strategy) aligned to NHS interim People Plan – defined 12 month deliverables. • Health and Well Being Winter Plan. • Agile work stream established.	• Equality and Diversity Board and integrated action plan. • Employee Health & Wellbeing Steering Group and Action Plan. • Flexible working task and finish group established. • Flexible working and support for agile working being developed as part of recovering and restoration.	• Developed WF plans for other staff groups e.g. AHP's, A&C, E&F staff. • Difficulties releasing clinical staff from duties to attend training / development. • To add new indicators e.g. Learning Disability Employment programme and Sexual Orientation monitoring standard.	• Agreement of Workforce, HR and OD Priorities and alignment to NHS People Plan with key focus on: o Looking after our people o Belonging in the NHS o New ways of working and delivering care o Growing for the future Delivery programme being aligned to system plans – update to EPCB in Oct. • Development of staff group specific WF plans. Refreshed required subject to national people plan publication. • HWB Strategy and work programme agreed for 20/21 – comms in place strategy to support. On-going - Refresh in progress for COVID recovery. • Scoping of system wide mental HWB HUB to provide

				additional support. • Exploring approaches to strengthen UHL networks and the Trust Board – in progress. • EDI strategic plan and WRES/WDES delivery plans incorporating gender pay gap plan to Oct EPCB. • Undertaking a gap analysis of representation across UHL governance structures.- to form part of governance review • Strengthening approaches to flexible working and enabling an agile workforce. Agile work stream established – meeting as part of enabling services project board/ Reconfiguration. • Plan for asymptomatic staff testing being implemented alongside symptomatic testing in place / staff testing for symptomatic staff scaling up due to increasing demand – in place. • Review scope to retain staff brought back during pandemic – part surge planning going forward.

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PR Ref:	PR 4	PR Title:	Financial sustainability									Last Updated:	19/10/20
Executive lead(s):	Acting Chief Financial Officer		Lead Executive Board:	EFPB / FRB		Lead TB sub-committee:	FIC		Strategic Objective	Well governed finances			
AC Deep Dive: Overall Assurance	AC Deep Dive Date:	Have all significant high-level drivers to the risk been identified?		Are there appropriate effective controls in place to mitigate the risk?		Is there adequate outcome evidence the risk is being successfully mitigated?		Are there clear plans in place to treat / manage the risk in the long term?					
	TBC												

BAF tracker - month	APR	MAY	JUN (Q1)	JUL	AUG	SEP (Q2)	OCT	NOV	DEC (Q3)	JAN	FEB	MAR (Q4)
Current rating (L x I)	4 x 5 = 20	4 x 5 = 20	4 x 5 = 20	4 x 5 = 20	4 x 5 = 20	4 x 5 = 20						
Target rating (L x I)			4 x 5 = 20			4 x 5 = 20			4 x 5 = 20			3 x 5 = 15

Rationale for score:	Due to Covid-19 the Trust's monthly income and deficit was fully funded via national Top Up funding from April 2020 to September 2020. The Trust has a planned deficit from October 2020 to March 2021 of £30.1m, whilst delivering restoration and recovery of elective activity and the Trust's winter plan. The enhanced PMO structure and external support to deliver efficiencies will drive the delivery of an £8m cost improvement programme from October 2020 to March 2021, and the investment controls (capital and revenue) and oversight by the Financial Recovery Board (FRB) will ensure that cost pressures are controlled. Performance against the financial plan will be monitored and reported to FIG, FRB, EPB, FIC and TB, and any risk assessed remedial measures will be implemented. A reduction in the risk score will reflect the delivery of improved financial controls and governance, and delivery of operational and financial plan trajectories.
PR Description	Inability to address the drivers risking delivery of the agreed 2020/21 required operational and financial plan trajectories may result in a failure to achieve and maintain financial sustainability.

Cause(s): *Drivers*	**PR event:** *If we are unable to address the PR drivers, then it may result in…*	**Impact:** *leading to…*
• Failure to deliver the agreed Trust Control Totals. At the highest level this will be through a failure to maintain revenue and capital expenditure within the agreed Control Totals and/or receive the planned income from commissioners and other external sources. There could be a number of reasons for this: o Failure of CMGs and Directorates to deliver their approved budgets via inability to deliver Covid-19 restoration and recovery plans within available resource, and non-delivery of workforce and operational efficiency and savings plans, resulting in unplanned use of premium costs to deliver patient activity. o Failure to make necessary improvements required to Trust financial controls and governance, via training and development of the Board on NHS financial management, and lack of adherence to Trust policies and strengthened financial controls. o Failure to deliver the Trust's capital programme within the approved expenditure limits (CDEL). o System imbalance and commissioner affordability.	failure to create and maintain a financially sustainable model	Prolonged, widespread reduction in the quality and effectiveness of clinical care, repeated failure to achieve constitutional standards, deteriorating condition of clinical estate and growth in the burden of backlog maintenance and medical equipment replacement, and loss of public confidence in the Trust.

Current Likelihood of PR event occurring caused by the drivers described (after controls in place)	Current Impact after controls
4	5
Target Likelihood rating of PR event occurring caused by the drivers described (beyond 2020/21)	**Target Impact (beyond 2020/21)**
3	5

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Drivers	**Primary controls:** What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Sources of assurance** Evidence that the controls/ systems which we are placing reliance on are effective. Internal & External sources of evidence.	**Gaps** What (a) further action is still needed or (b) controls are not working effectively? (provide details and progress of actions)	**key current focus (and dates)** Are there further controls possible in order to reduce risk exposure within tolerable range?
Failure of CMGs and Directorates to deliver their approved budgets - Non-delivery of, CMG, Corporate Directorate Control Totals and overall Trust financial plan.	• 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. • Signed-off interim April to September 2020 Control Totals for CMGs and Corporate Directorates that are monitored and managed within the Financial Performance Management Framework. • Finalisation and approval of the Trust's workforce and operational plans and final 2020/21 CMG and Corporate Control Totals signed off by 31st October 2021. • Approval of 2020/21 savings plan by 20th October 2020. • CIP tracker which logs and reports CIP schemes at a departmental and work stream level. Transformation Leads within the CMGs to lead delivery of local schemes and an enhanced PMO to oversee and report on progress. • Quality Impact Assessment (QIA) gateway process for investments and cost savings/CIPs – i.e. assessing the potential impact of investments and efficiencies on patient safety/ demand/capacity challenges. This process is overseen by the COO, Medical Director, Chief Nurse & ICFO. • Strengthened financial controls and governance as approved through the FRB, in line with national and Trust guidance. • Kingsgate appointed as external support to drive delivery of the 2020/21 CIP.	• FRB chaired by Acting CEO - providing increased scrutiny and corporate oversight including strengthening "Grip and Control" measures. • Financial governance • Monthly reporting of savings to FRB, EPB and FIC, incorporating progress on key actions and savings delivered. • Cost pressures and service developments minimised and managed through the FRB. • NHSE&I performance review meetings including I&E submissions and additional monthly review meetings with NHSE&I Finance Team to review financial position including CIP and assessment of financial risks. • Delivery of the Internal Audit Plan reported to Audit Committee.	• Development and support of the Finance and Procurement function to ensure effective financial control and oversight of the improvements outlined. Initial work has commenced via a development and training programme (see further controls). Further actions to address resource gaps within the central Finance function are also in progress. • Reporting of service Line financial performance and patient level costs to FRB, EPB and FIC (initially on a quarterly basis, and then monthly) from October 2020.	• Development and support of the Finance and Procurement function: It is proposed that the initial development programme already outlined is followed up with a comprehensive and ongoing programme of support and improvement for the Finance and Procurement function. The aim should be to progressively improve the effectiveness of the function and this will be demonstrated accreditation against the NHS Future Focused Finance Programme by July 2021. Securing accreditation will provide additional assurance that the improvements being made are sustainable and ultimately considered best practice nationally within the NHS. • Strengthening of the Finance and Procurement function by 31st March 2021. • Strengthening financial performance management from June 2020, via the CMG Performance Review meetings, with focus on financial performance consistent to that of operational and quality performance. • Updated Finance Section of the PRM pack, to enhance financial reporting, and ensure robust understanding of financial impact of winter, restoration and recovery, Covid-19 and CIP. Go live from month 7. • Training and development programme on financial management for budget holders and other staff, commencing March 2021.

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Failure to make improvements required to Financial controls and governance.	• Action plan to strengthen financial governance overseen by FID via FIG, reported to FRB and FIC, (incorporating recommendations from the NHSE&I investigation), approved by FRB. • Redesign and strengthening of Financial Management Meeting to Financial Recovery Board (FRB) • Trust Standing Financial Instructions (SFI's), Standing Orders (SO's) and Scheme of Delegation (SoD). • Board training and development programme on NHS financial management. • Finance Improvement Director appointed.	• Delivery of the Internal Audit Plan reported to Audit Committee. • NHSE&I Use of Resources Assessment. • Ongoing reporting of financial controls and governance action plan to FIG, FRB, EPB, FIC and TB.	• NHSE&I oversight via Financial Oversight meetings.	• Development of an action plan to strengthen financial controls and governance, for approval by FRB on 8th September 2020 and reported to FIC on 24th September 2020. • Linked to the above the review and amendment to the Trusts SFI's, SO's and SoD by 31st March 2021.
Failure to deliver the Trust's capital programme within the approved expenditure limits (CDEL).	• Approval of annual capital plan by Capital Investment & Monitoring Committee (CMIC), FRB, EPB and FIC.	• Monthly reporting of c • Review of capital expenditure by FRB.	• Development of a long term Trust and LLR system capital plan, incorporating the Trust's reconfiguration plan and Estates Strategy.	• FRB now has approval and oversight of the Trust's Capital Plan.
System imbalance and Commissioner affordability.	• Governance structure and escalation process in place with regular reports around Contract Management Performance with CCGs and Specialised Commissioning. • Engagement with stakeholders across local health system to establish foresight and adaptive capacity in the event of practice collapse.	• FRB chaired by CEO (internal). • LLR system-wide Financial Recovery Board in place in conjunction with System Sustainability Group (SSG) (external).	• Development of a Trust and LLR system long term plan (operational, workforce and financial plan).	• Development of a Trust and LLR system long term plan (operational, workforce and financial plan) – review by 31st March 2021.

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PR Ref:	PR 5	**PR Title:**	IT (e-Hospital programme, and maintaining/ improving existing critical infrastructure)									**Last Updated:**	16/10/20
Executive lead(s):	Chief Information Officer		**Lead Executive Board:**	EIM&TB		**Lead TB sub-committee:**	PPPC		**Strategic Objective**	e-Hospital			
AC Deep Dive: Overall Assurance	**AC Deep Dive Date:**	**Have all significant high-level drivers to the risk been identified?**		**Are there appropriate effective controls in place to mitigate the risk?**		**Is there adequate outcome evidence the risk is being successfully mitigated?**		**Are there clear plans in place to treat / manage the risk in the long term?**					
	TBC												
BAF tracker - month	**APR**	**MAY**	**JUN (Q1)**	**JUL**	**AUG**	**SEP (Q2)**	**OCT**	**NOV**	**DEC (Q3)**	**JAN**	**FEB**	**MAR (Q4)**	
Current rating (L x I)	4 x 4 = 16	4 x 4 = 16	4 x 4 = 16	4 x 4 = 16	4 x 4 = 16	4 x 4 = 16							
Target rating (L x I)			4 x 4 = 16			4 x 4 = 16			4 x 4 = 16			3 x 4 = 12	
Rationale for score:	IM&T capital infrastructure and e-Hospital (EPR) programmes for 20/21 are progressing. The completion of work so far in 20/21 has not yet significantly impacted on the risk score. In line with the target rating therefore it is not proposed to alter the score below 16 for September. Delays to release of agreed external funds is proving a particular problem with an impact on available resource and delays to scheduling of project work.												
PR Description	Inability to address the drivers to deliver the e-Hospital programme and improve existing IT infrastructure, may result in a failure to provide optimised digital services												

Cause(s): *Drivers*	**PR event:** *If we are unable to address the PR drivers, then it may result in…*	**Impact:** *leading to…*
• Lack of capital funding / investment in IT infrastructure may lead to critical failure - failure of software / hardware, cyber-attack, information security breach – loss of patient data, Big Bang or Rising Tide event - fire, flood, terrorist attack • Lack of ability to change process and/or culture at sufficient pace to realise the projected benefits of the e-Hospital programme by 2022.	failure to provide optimised and reliable digital services, realise projected savings and transformational change	widespread disruption to the continuity of core critical services, poorly coordinated care and experience for patients, reduction in the quality and effectiveness of clinical care, repeated failure to achieve constitutional standards and loss of public confidence in the trust

Current Likelihood of PR event occurring caused by the drivers described (after controls in place)	**Current Impact after controls**
4 - likely	4 – major
Target Likelihood rating of PR event occurring caused by the drivers described (beyond 2020/21)	**Target Impact (beyond 2020/21)**
3 – possible	4 – major

Drivers	**Primary controls:** What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Sources of assurance** Evidence that the controls/ systems which we are placing reliance on are effective. Internal & External sources of evidence.	**Gaps** What (a) further action is still needed or (b) controls are not working effectively? (provide details and progress of actions)	**key current focus (and dates)** Are there further controls possible in order to reduce risk exposure within tolerable range?
Critical failure caused by lack of capital funding / historic investment in IT infrastructure (failure of software / hardware, cyber-attack,	• Emergency Preparedness, Resilience and Response (EPRR) Board - chaired by AEO, meets quarterly to review (3 year) work plan, which includes include IM&T resilience work, with representative from all CMGs and corporate services. • EPRR Policy & Incident response plans on Insite, in date. • Cyber security measures in place including	• PWC Audit of EPRR & IM&T Disaster Recovery – report (external): o EPRR: the plan contains the activities to improve compliance. o Good practice around disaster recovery identified	• Trust wide Business Continuity Plans incomplete / variable quality and not fully tested. • Critical applications not fully redundant by design – EPR is work in progress • Information Asset Register (IAR) incomplete and not up to date	• EPRR Team to support development and testing of CMG Business Continuity plans - delayed due to COVID, review February 2021. • With IM&T vendors, develop redundant architecture for critical applications in particular the electronic patient record (EPR) system (February 2021); • Undertake Corporate Records Audit and completion of the Info Asset Register (IAR) (March 2021). • Progress data centre strategy including improved

information security breach – loss of patient data, Big Bang or Rising Tide event - fire, flood, terrorist attack)	monitoring of threats via NHS Digital CareCert, vulnerability scanning & anti-virus/anti malware tools, Monthly Cyber Security Board, IG toolkit, IG Steering Group and GDPR plan, regular penetration testing and close working relationship with IM&T managed business partner, recognised corporate risk around behaviours with actions to raise awareness via comms campaigns. • Critical IM&T applications redundant by design utilising hybrid cloud hosting capabilities to reduce dependency on physical data centres. • IM&T Business Continuity and Disaster Recovery Plans in place and tested regularly. • Organisation wide Business Continuity Plans in development (recognised there is a gap at present because some are incomplete). • Regular IT – estates forum in place to agree responsibility for and prioritise critical remedial works	in PwC Audit - Compliance within IT data centres (May 2019). • NHSE EPRR Core Standards self-assessment – partially compliant (2018/19) (external). • EPRR and IM&T infrastructure risks uploaded onto the Datix risk register (internal). • Regular independent testing and cyber security audits (internal & external). • PWC Review - Data Security and Protection (DSP) Toolkit as required by NHS Digital. • Internal audit of cyber security posture scoped for inclusion in trust IA plan for 2020/21. • NHS Digital funded support via Templar Executives for cyber security and awareness activities during 2020/21.	• Risks around server infrastructure dependent on execution of IM&T data centre strategy and move away from dependency on LRI Kensington data centre. There is a dependency on the reconfiguration programme and ability to fund IT infrastructure changes to the level necessary. • Small number (<100) of remaining legacy desktop items (Windows XP/7) tied to medical equipment and legacy applications • Cyber Essentials Plus equivalence not yet attained	redundancy via cloud hosting options. A) Priority investment in gas fire suppression systems required to protect telephony and network hub rooms. Capital funding identified via estates emergency capital plan – work scheduled for Q3 20/21 (Dec 2020). D) Ensure reconfiguration programme input and mitigation of data centre risks is included in design of IT infrastructure to support new build projects (Jan 2021) • Implement protected network infrastructure for residual legacy devices in progress, some delay to implementation due to COVID and availability of supplier (Dec 2020). • Update and validate Information Asset Register (IAR) (March 2021) • Achieve Cyber Essentials Plus equivalence (March 2021) • Internal Audit Cyber Security review scheduled Q4 20/21 (March 2021). • Cyber Essentials Plus remediation plan agreed and support activities scheduled with NHSD funded support from Templar (March 2021).
Lack of ability to change process and/or culture at sufficient pace to realise the projected benefits of the e-Hospital programme by 2022.	• e-Hospital board meets monthly, reports to quarterly executive IM&T board and governs the EPR programme including prioritisation of deliverables and tracking of plans. • Clear vision, delivery and communication plans in place to ensure staff are aware of the programme objectives and how this will impact on their roles in future	• Communication plan agreed and monitored via the programme board which identifies the appropriate audiences, establishes the programme communication schedule and manages the flow of information to staff and patients • Benefits realisation plan in place monitored via the programme board, including for delivery of change to working practice	• Further work is required to improve awareness and communications with staff and patients • Identification of local IT champions required to assist with the cascade of information and inform changes to process • Pace of change a particular challenge when implementing simultaneously alongside other programmes (e.g. efficiency, reconfiguration)	• e-Hospital 'Live Event' to brief / update staff (June 2020) – Complete and further events being planned. • Additional intranet and social media presence including 'what does this mean to me' content. Delayed pending recruitment to IM&T vacancies (Dec 2020). • Patient and public involvement initiative underway to ensure PPI engagement for relevant work streams, initial meetings held, some delay due to COVID and progress of patient facing project elements (March 2021). • Digital aspirant funding stream to be utilised to enable fixed term clinical backfill to support a broader involvement from staff and more in depth engagement from teams as part of project development and go live. Funding plan submitted, expected Dec 2020. • Programme Management Office function within IM&T to work closely with reconfiguration and efficiency PMO to ensure a balanced approach to clinical engagement (Oct 2020)

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PR Ref:	PR 6	**PR Title:**	Estates - Maintaining/ improving existing critical infrastructure									**Last Updated:**	26/10/20
Executive lead(s):	Director of Estates & Facilities		**Lead Executive Board:**	ESB		**Lead TB sub-committee:**	TB		**Strategic Objective**	Sustainable estate			

AC Deep Dive: Overall Assurance	**AC Deep Dive Date:**	**Have all significant high-level drivers to the risk been identified?**	**Are there appropriate effective controls in place to mitigate the risk?**	**Is there adequate outcome evidence the risk is being successfully mitigated?**	**Are there clear plans in place to treat / manage the risk in the long term?**
	TBC				

BAF tracker - month	**APR**	**MAY**	**JUN (Q1)**	**JUL**	**AUG**	**SEP (Q2)**	**OCT**	**NOV**	**DEC (Q3)**	**JAN**	**FEB**	**MAR (Q4)**
Current rating (L x I)	4 x 5 = 20	4 x 5 = 20	4 x 5 = 20	4 x 5 = 20	4 x 5 = 20	4 x 5 = 20						
Target rating (L x I)			4 x 5 = 20			4 x 5 = 20			4 x 5 = 20			4 x 5 = 20

Rationale for score:	Maintaining a steady state through Covid-19 impacts. Reconfiguration and on-going capital investment will provide traction on the journey towards achieving sustainable risk reduction.
PR Description	Inability to address the drivers to deliver the Estates Strategy including to reconfigure new and maintain existing critical infrastructure, may result in a failure to achieve a fit for the future and safe estate

Cause(s): *Drivers*	**PR event:** *If we are unable to address the PR drivers, then it may result in…*	**Impact:** *leading to…*
• Lack of capital funding / investment in estate and resources (skilled specialists) may lead to critical infrastructure failure - interruption to the supply of one or more utilities (electricity, gas, water), an uncontrolled fire or security incident or failure of the built environment that renders a significant proportion of the estate inaccessible or unserviceable, disrupting services for a prolonged period - Critical infrastructure maintained in operational condition beyond design lifecycle and increasingly becoming liable to 'sudden and unexpected' failure	failure of the Trust's critical infrastructure	widespread disruption to the continuity of core critical services, poorly coordinated care and experience for patients, reduction in the quality and effectiveness of clinical care, repeated failure to achieve constitutional standards and loss of public confidence in the trust

Current Likelihood of PR event occurring caused by the drivers described (after controls in place)	**Current Impact after controls**
4	5
Target Likelihood rating of PR event occurring caused by the drivers described (beyond 2020/21)	**Target Impact (beyond 2020/21)**
2	5

Drivers	**Primary controls:** What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Sources of assurance** Evidence that the controls/ systems which we are placing reliance on are effective. Internal & External sources of evidence.	**Gaps** What (a) further action is still needed or (b) controls are not working effectively? (provide details and progress of actions)	**key current focus (and dates)** Are there further controls possible in order to reduce risk exposure within tolerable range?
Lack of capital funding / investment in estate / resources may lead to critical infrastructure failure	• Risk based prioritised plan developed by E&F Risk & Governance Group to support the 2020/21 Capital Programme across the following fields : o Condition; o Compliance; o Resilience; o Single point Failures. • E&F Escalation and Emergency corrective response arrangements in place to respond to	• Backlog maintenance reported in the ERIC return to the Department of Health and benchmarked against other NHS Trusts annually (internal). Backlog Maintenance liability reported to DoH in the 4th September 2020 ERIC submission. • Annual assurance reports from independent specialists for services including: Electrical, Piped Medical	• Insufficient capital investment to adequately address the backlog maintenance liability (risk register 3143). • Recruitment and retention of key operational and maintenance E&F staff. Potential shortfall in operational budget for	• Following the successful emergency backlog maintenance bid, the £10.3 work has been scheduled in the 2020/21 programme. • E&F management restructure completed and plans are in place to implement operational changes including recruitment into key roles. Management of change process (shift pattern changes) is progressing across Estates workforce. Recruitment into key operational roles by 31/12/2020.

	breakdowns and failures. • 24/7 response from Estates & Facilities and specialist contractors, including 'out of hours' arrangements. • Some critical plant and equipment have back-up systems (contingency plans) in the event of 'loss of' power/engineering services. • Successful with a £10.3m emergency backlog maintenance funding bid in September 2019 targeted to help mitigate some of the priority backlog maintenance risks.	Gas, Water and Specialist Ventilation (internal). • Annual Premises Assurance Model (PAM) assessment (internal). The 2020 PAM assessment and a Trust Board report have been completed and work has started on gathering information for the 2021 PAM return. • Annual Patient-led Assessments of the Care Environment (PLACE) with scorecard reported nationally and benchmarked (internal). Monthly PPM reports measured against KPIs (internal). • Actions from internal and external audit and inspection reports are put into action plans and progress is reviewed through E&F & UHL specialist groups with significant issues escalated using the Trust's Risk Management policy methodology and through the Trust's governance arrangements for escalation.	recruitment of sufficient cleaning and Estates maintenance staff to deliver services and maintain estate with resilience and drive quality improvement (risk register 3144). • Access to key clinical areas such as Theatres, NNU, Maternity, Osborne building Hope Unit, PICU and BMTU to carry out invasive works to reduce risk and improve compliance to current standards for critical ventilation and water quality (Pseudomonas).	• Water quality is tested for Pseudomonas across all augmented care wards and there is a programme of Legionella testing in place across patient care areas. Adverse results are subject to a risk assessment from Infection Prevention and Local clinical/nursing staff to protect patient welfare. Water outlets are taken out of use, or the risks controlled by the use of point of use water filters on taps and showers as an initial control. However, a significant interruption/decant is often required to enable a more permanent solution to be progressed. It is a similar position with upgrading critical ventilation and endoscopy suite compliance. A comprehensive critical ventilation review in 2020 has identified a number of areas that require upgrading to meet current standards. Funding and access arrangements will need to be agreed on a priority basis and incorporated in the Capital Development plans going forward. Priority ventilation and water works have been evaluated for cost and access requirements by the Capital Development Team and will go into a 2020/21 action plan. The E&F Capital Development team have been successful in a bid for endoscopy compliance funding and have put a programme in place to upgrade UHL endoscopy suites that will enable full compliance to current endoscopy unit standards by the end of March 2021.

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PR Ref:	PR 7	PR Title:	Estates: reconfiguration - new estate									Last Updated:	29/10/20
Executive lead(s):	Director of Estates & Facilities	Lead Executive Board:	ESB	Lead TB sub-committee:	TB	Strategic Objective	Sustainable reconfiguration						

AC Deep Dive: Overall Assurance	AC Deep Dive Date:	Have all significant high-level drivers to the risk been identified?	Are there appropriate effective controls in place to mitigate the risk?	Is there adequate outcome evidence the risk is being successfully mitigated?	Are there clear plans in place to treat / manage the risk in the long term?
	TBC				

BAF tracker - month	APR	MAY	JUN (Q1)	JUL	AUG	SEP (Q2)	OCT	NOV	DEC (Q3)	JAN	FEB	MAR (Q4)
Current rating (L x I)	4 x 4 = 16	4 x 4 = 16	4 x 4 = 16	4 x 4 = 16	4 x 4 = 16	4 x 4 = 16						
Target rating (L x I)			4 x 4 = 16			4 x 4 = 16			4 x 4 = 16			3 x 4 = 12

Rationale for score:	Delay not mitigated until all business case processes concluded; and construction complete
PR Description	Inability to address the drivers to deliver the Estates Strategy including to reconfigure new and maintain existing critical infrastructure, may result in a failure to achieve a fit for the future and safe estate

Cause(s): *Drivers*	PR event: *If we are unable to address the PR drivers, then it may result in…*	Impact: *leading to…*
• Failure to deliver the Trust's site investment and reconfiguration programme within resources - Delays to business case approval or construction could result in inflation increases on prices, reducing available budget to complete the programme.	failure to create and sustain an estate fit for the future	widespread disruption to the continuity of core critical services, poorly coordinated care and experience for patients, reduction in the quality and effectiveness of clinical care, repeated failure to achieve constitutional standards and loss of public confidence in the trust

Current Likelihood of PR event occurring caused by the drivers described (after controls in place)	Current Impact after controls
4	4
Target Likelihood rating of PR event occurring caused by the drivers described (beyond 2020/21)	**Target Impact (beyond 2020/21)**
3	4

Drivers	Primary controls: What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Sources of assurance Evidence that the controls/ systems which we are placing reliance on are effective. Internal & External sources of evidence.	Gaps What (a) further action is still needed or (b) controls are not working effectively? (provide details and progress of actions)	key current focus (and dates) Are there further controls possible in order to reduce risk exposure within tolerable range?
Failure to deliver the Trust's site investment and reconfiguration programme within resources.	• Pre Consultation Business Case (PCBC) concluded the national assurance process and was formally approved on the 1st September. Public Consultation commenced on the 28th September. • PCBC has been reviewed by lawyers to ensure likelihood of judicial review (JR) or referral to secretary of state is minimised (as potentially this could delay programme by 6 – 9 months). • Commitment from NHSE & NHSI to streamline business case approval process.	• Robust programme management through Reconfiguration Programme Committee with monthly progress reporting to, executive committee and the Trust Board (internal). • Appointment of Trust Side professional advisors to provide assurance: PwC on finance and governance; Ryder Levett Bucknell (RLB) on project and cost management; Capsticks on legal	• Strategic governance arrangements to be agreed by Trust Board • Agreement of capital drawdown through business case development. • We need to agree the detailed scope of the scheme to take account of the assessment of the impact of COVID (future	• Governance of programme agreed at executive level, arrangements for Trust to be finalised at the Trust Board meeting on 3rd December. • Continue to progress discussions on early drawdown of capital in order to continue resourcing the programme after October. • Escalation of the impact of delay on inflation and costs of possible policy changes resulting from the need to comply to the digital and sustainability requirements; Awaiting outcome of submitted costs to NHSE/I.

	• Development of robust programme with adequate time allowed for external approval process. • One Outline Business Case for the whole scheme, with 3 separate Full Business Cases aligned to the overall 6 year delivery programme. • Budget aligned to delivery programme with allowance in budget for inflation, optimism bias and contingency. • Cash flow developed to request early draw down of resource for business case development before FBC is approved. • Monthly meetings with DHSC and National NHSI/E colleagues to discuss consultation process and business case approvals to expedite the process; weekly meetings with Regional NHSE/I colleagues • Projects not dependant on consultation will be fast-tracked to commence delivery in 2021.	issues. • Capsticks have confirmed legitimacy of consultation during COVID pandemic using virtual media.	pandemic proofing).	

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PR Ref:	PR 8	PR Title:	COVID 19 – recover and restoration / renewal									Last Updated:	29/10/2020
Executive lead(s):	Director of Strategy and Communications / Acting Chief Operating Officer		Lead Executive Board:	ESB		Lead TB sub-committee:	TB		Strategic Objective	Quality priorities and innovation in recovery and restoration			
AC Deep Dive: Overall Assurance	AC Deep Dive Date:	Have all significant high-level drivers to the risk been identified?		Are there appropriate effective controls in place to mitigate the risk?		Is there adequate outcome evidence the risk is being successfully mitigated?			Are there clear plans in place to treat / manage the risk in the long term?				
	TBC												
BAF tracker - month	APR	MAY	JUN (Q1)	JUL	AUG	SEP (Q2)	OCT	NOV	DEC (Q3)	JAN	FEB	MAR (Q4)	
Current rating (L x I)	4 x 4 = 16	4 x 4 = 16	4 x 4 = 16	4 x 4 = 16	4 x 4 = 16	3 x 4 = 12							
Target rating (L x I)			4 x 4 = 16			3 x 4 = 12			3 x 4 = 12			3 x 4 = 12	
Rationale for score:	At the outset of the COVID-19 pandemic and increase of the national NHS incident level to 4, UHL deployed an adaptable command and control arrangements to ensure Strategic, Tactical & Operational oversight of risks. This process enabled rapid and targeted steps to be taken which increased capacity (through reductions in elective activity, increased levels of discharge and procurement of additional ventilators) & ensure at no time within the first peak of COVID-19 (March-May 2020) did demand for acute UHL services at any time outstrip supply. The balance of risk within the population has now shifted from ensuring the rate of transmission is reduced and ensuring acute COVID-19 sickness treated, to addressing the community harm & disease burden that has arisen following a significant reduction in emergency presentations and 60% reduction in elective referrals. Current rates of national COVID-19 transmission sit at 1 per 1,900 people within the UK (ONS August 2020), down significantly since April 2020. This reduction in community transmission & commensurate risk reduction in nosocomial transmission, has allowed risk realignment to the process of addressing the potential increased disease burden within the community. This reduced presentation and potential increased level of disease burden is perhaps best represented by the reduction in attendance to A&E departments of those suffering from a TIA (Transient ischaemic attack/Mini Stroke). TIA's/Mini Strokes are an important early warning sign for a major stroke and an opportunity to prevent future ill health. Between March-May, TIA presentation levels to UHL emergency department were 60% down on 2019 levels. This reduction highlights a future potential risk to our population of further ill health and increased stroke activity within UHL. The same rigour applied to the command and control structure at the onset of COVID-19 is now being applied to the restoration/recovery process and addressing the backlogs in elective services & mitigating the drivers in the population deciding not to present to A&E with major conditions (such as TIA's). This process of renewed focus is supported by the release by NHSE/I of detailed planning guidance (Phase 3 Restoration/Recovery) for the months of August-November 2020. This renewed focus and detailed planning guidance will reduce this risk score level from 16-12 before potentially rising again (when NHSE/I COVID-19 transmission levels & demand for acute services are anticipated to rise again). In relation to the December Q3 position, based on current knowledge, the risk remains at a 12. However, the risk will escalate depending on trajectory of COVID-19/ Flu in winter and therefore it could possibly rise to 16. The release of new Infection Control guidance (from Public Health England) and reinstatement of elective theatre lists to October 2019 levels, have supported the development of Best & Likely case activity forecasts, that begins to address the increase in elective and diagnostics waiting lists (created during the COVID-19 pandemic).											
PR Description	Inability to efficiently return to operating as an acute specialist teaching Trust whilst maintaining our ability to respond to COVID, including preparedness and planning for late presentation of multiple epidemiological events, may result in rapid operational instability												

Cause(s): *Drivers*	**PR event:** *If we are unable to address the PR drivers, then it may result in…*	**Impact:** *leading to…*
• Pandemic disease outbreak peaks that results in a temporary or prolonged disruption to the continuity of core services across the Trust, which also impacts significantly on the local health service community. • The ability to stop and reverse the trend in backlog & waiting list increases is impacted by the requirement to maintain COVID-19 safety measures and the commensurate reduction in throughput/productivity of existing capacity.	Rapid operational instability	Negative impact to the health and safety of patients, staff and visitors (with increased waiting list & backlog numbers and the associated patient harm) as well as impact on the organisation's ability to provide an acceptable level of health service and adverse reputation.
Current Likelihood of PR event occurring caused by the drivers described (after controls in place)		**Current Impact after controls**
4		4

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Target Likelihood rating of PR event occurring caused by the drivers described (beyond 2020/21)	Target Impact (beyond 2020/21)
3	4

Drivers	Primary controls: What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Sources of assurance Evidence that the controls/ systems which we are placing reliance on are effective. Internal & External sources of evidence.	Gaps What (a) further action is still needed or (b) controls are not working effectively? (provide details and progress of actions)	Key current focus (and dates) Are there further controls possible in order to reduce risk exposure within tolerable range?
Inability of organisation to meet the ambitions within the Phase 3 Restoration/Recovery process due to decreased throughput associated with maintaining COVID-19 IP safety measures.	• UHL & LLR System wide Recovery and Restoration plan (supported by a detailed specialty/POD demand and capacity plan). • Close partnership working with multi-agency partners through the LLR health Tactical Coordination Group (HTCG) and LLR Health Strategic Coordination Group (HSCG). Implementing the direction and guidance received from the UHL COVID-19 Strategic Group, LLR CCGs, NHS England and NHS Improvement. • A new performance dashboard has been introduced to monitor the gap between recovery/restoration targets and existing performance. • Increased use of the independent sector & maximisation of LLR Alliance capacity. • Innovation log maintained by UHL strategy team & LLR CCG design groups. • All CMGs have designed and presented Recovery and Restoration plans approved by Demand and Capacity Cell, extraordinary Tactical Group and Strategic Group meetings. • Leicestershire / Northants' data cell established to share business intelligence approach to recovery, demand and capacity planning. • Local SAGE approach agreed for system alerts. This will ensure system remains focussed on restoration/recovery until cases & demand begins to increase. • Daily monitoring of data including attendances.	Internal: • Realigning command and control arrangements to focus on restoration/recovery. • LLR Strategic oversight and escalation. • Daily performance monitoring and exception reporting internally and with external partners involved. (Internal/ External).	• Gap analysis to identify demand post COVID-19. • As yet the work to understand what achievable trajectories for recovery of services have yet to be set at Trust and system level. • Solutions to bridge the gap in meeting trajectories to ensure delivery during the next three months.	• At present confirm and challenge processes with CMGs are taking place to ensure that current restoration/recovery plans are ambitious with focussed actions that maximise the potential of the next three months. • System level conversations, through the new LLR design groups are focussed on resolving the gap between current levels of performance and the ambitions within the phase 3 recovery process. • The restoration/recovery process will be driven by the understanding of the differential impact of COVID-19 and the potential wider disease burden. The LLR system & UHL are currently investigating the level of health inequalities within our health economy and designing plans to resolve this.

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Potential second wave of COVID-19 (Earlier than the anticipated December/January dates) that results in a temporary or prolonged disruption to the continuity of core services across the Trust, which also impacts significantly on the local health service community.	• UHL COVID-19 Escalation Framework provides a clear response framework for managing demand in response to COVID-19 • UHL COVID-19 Response Plan. • UHL COVID-19 Strategic Recovery Group chaired by member of the Executive Team. • UHL COVID-19 Tactical Group chaired by Deputy COO to monitor operational matters and escalate to UHL Strategic Group as appropriate. • The Trust has an Emergency Planning Team. • The Trust has identified Priority Work Streams (including IP; Demand, Capacity & Escalation; Procurement & Supplies, Estates & Facilities; HR & Occupational Health; Communications; Data; Finance; IM&T) and CMGs, each with a Nominated Lead & Deputy. • The Trust is an active member of the LLR Strategic and Tactical Coordinating Groups (HSCG). • The Trust is an active member of various LLR 'work stream' cells. • Accountable Emergency Officer (COO) in place. • NED in place with oversight of EPRR. • Daily SITREP reporting internally and externally to NHSEI. • The Trust has financial approval and monitoring arrangements with specific Covid-19 cost code to record and monitor expenditure - Must be of a standard to meet public and parliamentary scrutiny and external audit. • Participation in national & regional executive specific COVID-19 webinars. • Tactical Group maintain a log of deviations from national directives, local policies / best practice / guidance during COVID-19 for learning purposes.	• UHL COVID-19 Daily SitRep. • Collaborative decision making through UHL COVID-19 Tactical and Strategic Groups and Board meetings (Internal). • Compliance with Midland region command and control arrangements (External). • Transparency and oversight of rapid decision making provided through regular weekly updates to Governors and non-executive directors (Internal). • BAF Principal Risk 8 reviewed at UHL COVID-19 Strategic Group and escalated to Chairman and NEDs (via TB papers) (Internal). • Ensuring lessons are learnt from the first wave of covid-19 (such as ensuring we retain additional capacity within the Independent Sector for elective backlog clearance).	• Ensuring the benefits identified through the first wave of COVID-19 (such as greater discharges & reduced levels of stranded patients) are 'locked in'. Early evidence suggests traditional system challenges are re-emerging. This is being addressed at the system level.	• The recovery from the initial wave of COVID-19 presents a unique window of opportunity for the Trust to truly and rapidly transform. • CMGs to review surge / winter plans in preparation for 2nd wave – to be monitored via UHL Tactical / ICC. • Winter plans are currently in development (based on three scenarios, Best, Worst & Likely case), with a primary focus on managing COVID-19 & normal winter pressures, whilst delivering as much elective activity as possible.

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BAF Scoring process:

- **Likelihood of Risk Event - score & example descriptors**

1	2	3	4	5
Extremely unlikely	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Extremely unlikely to happen except in very rare circumstances. Less than 1 chance in 1,000 (< 0.1% probability). No gaps in control. Well managed.	Unlikely to happen except in specific circumstances. Between 1 chance in 1,000 & 1 in 100 (0.1 - 1% probability). Some gaps in control; no substantial threats identified.	Likely to happen in a relatively small number of circumstances. Between 1 chance in 100 & 1 in 10 (1-10% probability). Evidence of potential threats with some gaps in control	Likely to happen in many but not the majority of circumstances. Between 1 chance in 10 & 1 in 2 (10 - 50% probability). Evidence of substantial threats with some gaps in control.	More likely to happen than not. Greater than 1 chance in 2 (>50% probability). Evidence of substantial threats with significant gaps in control.

How to assess the likelihood score: The likelihood is a reflection of how likely it is the risk event will occur (with the '**current** controls' / '**target** actions' in place).

- **Impact / Consequence score & example descriptors**

Risk Sub-type	1	2	3	4	5
	Rare	**Minor**	**Moderate**	**Major**	**Extreme**
REPUTATION - **loss of public confidence / breach of statutory duty / enforcement action** - **Harm (patient / non-patient - physical/ psychological)** - **Service disruption**	No harm. Minimal reduction in public, commissioner and regulator confidence Minor non-compliance Negligible disruption – service continues without impact	Minor harm – first aid treatment. Minor, short term reduction in public, commissioner and regulator confidence. Single breech of regulatory duty Temporary service restriction (delays) of <1 day	Moderate harm – semi permanent /medical treatment required. Significant, medium term reduction in public, commissioner and regulator confidence. Single breach of regulatory duty with Improvement Notice Temporary disruption to one or more Services (delays) of >1 day	Severe permanent/long-term harm. Widespread reduction in public, commissioner and regulator confidence. Multiple breeches in regulatory duty with subsequent Improvement notices and enforcement action Prolonged disruption to one or more critical services (delays) of >1 week	Fatalities/ permanent harm or irreversible health effects caused by an event. Widespread loss of public, commissioner and regulator confidence. Multiple breeches in regulatory duty with subsequent Special Administration or Suspension of CQC Registration / prosecution Closure of services / hospital

How to assess the consequence score: The impact / consequence is the effect of the risk event if it was to occur.

BAF Scoring Matrix: (L x I)

Likelihood is a reflection of how likely it is the risk event will occur 'x' impact / consequence is the effect of the risk event if it was to occur)

Likelihood \ Impact	Rare	Minor	Moderate	Major	Extreme
Extremely unlikely	1	2	3	4	5
Unlikely	2	4	6	8	10
Possible	3	6	9	12	15
Likely	4	8	12	16	20
Almost certain	5	10	15	20	25

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

Audit Committee – Deep Dive outcomes:

G	Satisfactory	A	Partial - generally satisfactory with some improvements required	R	Unsatisfactory

Appendix 2 - Organisational risk register - rated 15> (as at 30th September)

Risk ID	CMG	Risk Description	Cause	Effect	Current Impact	Current Likelihood	Current Risk Score	Target Risk Score
2565	CMG 1 - CHUGGS	If capacity is not increased to meet demand in General Surgery, Gastro and Urology, then it may result in widespread delays with patient diagnosis or treatment leading to potential for patient harm and breach against delivery of national targets	Demand & Capacity	Harm (Patient/Non-patient)	4. Major	5. Almost certain	20	9
3139	CMG 1 - CHUGGS	If the ageing and failing decontamination equipment in Endoscopy is not improved / replaced, then it may result in delays and inaccuracies with patient diagnosis or treatment, leading to potential for patient harm, failure to meet national guidelines with diagnostic targets and decontamination and Infection Control requirements, increasing waiting list size and failure to secure JAG approval	Equipment	Harm (Patient/Non-patient)	4. Major	5. Almost certain	20	4
3682	CMG 1 - CHUGGS	If the current ventilation system in the Endoscopy Units is not improved, then it may result in delayed diagnosis and tratement for diagnostic tests for both routine and cancer pathways, leading to potential patient harm, non-compliance with RTT and Cancer waiting time targets, adverse reputation and financial loss	Environment	Harm (Patient/Non-patient)	5. Extreme	4. Likely	20	10
2264	CMG 1 - CHUGGS	If an effective solution for the nurse staffing shortages in CHUGGS at LGH and LRI is not found, then it may result in detrimental impact on safety & effectiveness of patient care delivered, leading to potential for patient harm.	Workforce	Harm (Patient/Non-patient)	4. Major	5. Almost certain	20	6
1149	CMG 1 - CHUGGS	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	Demand & Capacity	Harm (Patient/Non-patient)	4. Major	5. Almost certain	20	9
3333	CMG 1 - CHUGGS	If staffing levels in Oncology service remains below clinic capacity, then it may result in significant delay with patients receiving their first appointments, leading to potential adverse impact on their outcomes and longevity.	Workforce	Harm (Patient/Non-patient)	4. Major	5. Almost certain	20	4
3534	CMG 2 - RRCV	If RRCV CMG are unable to recruit and retain to Trust Grade level medical staff, then it may result in widespread delays with patient diagnosis or treatment, leading to potential harm and disruption to the base wards and critical areas (CDU & CCU)	Workforce	Service disruption	5. Extreme	4. Likely	20	9
3645	CMG 2 - RRCV	If the Haemodialysis Unit at LGH does not undergo significant refurbishment or replacement, then it may result in detrimental impact on safety & effectiveness of patient care delivered, including spread of infection between patients, leading to potential for patient harm and adverse reputation	Environment	Harm (Patient/Non-patient)	5. Extreme	4. Likely	20	2
3533	CMG 2 - RRCV	If there is insufficient Medical staff at consultant and registrar level within cardiology services to meet inpatient and outpatient demand, then it may result in widespread delays with patient diagnosis, prognosis and treatment, leading to potential patient harm.	Workforce	Harm (Patient/Non-patient)	4. Major	5. Almost certain	20	8
3597	CMG 2 - RRCV	If there is failure to digitally transmit ECG images from the scene / ambulance to CCU, then it may result in delays with patient treatment, leading to potential harm	IM&T	Harm (Patient/Non-patient)	5. Extreme	4. Likely	20	10
3014)	CMG 2 - RRCV	If there is no fit for purpose Renal Proton Clinical System to collect all information required for reimbursement of dialysis, then it may result in poor impact on the patient experience poor leading to reputational impact	IM&T	Reputation	4. Major	5. Almost certain	20	9
3359	CMG 3 - ESM	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.	Workforce	Harm (Patient/Non-patient)	5. Extreme	4. Likely	20	9
3077	CMG 3 - ESM	If there are delays in the availability of in-patient beds leading to overcrowding in the Emergency Department and an inability to accept new patients from ambulances, then it may result in detrimental impact on quality of delivered care and patient safety within the ED leading to potential harm.	Demand & Capacity	Harm (Patient/Non-patient)	5. Extreme	4. Likely	20	15
3202	CMG 3 - ESM	If there are shortfalls or gaps in medical staffing of the Emergency Department, including EDU, then it may result in widespread delays in patients being seen and treated leading to potential harm.	Workforce	Harm (Patient/Non-patient)	4. Major	5. Almost certain	20	8
3132	CMG 4 - ITAPS	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	Process & Procedures	Financial loss (Annual)	4. Major	5. Almost certain	20	6

Risk ID	CMG	Risk Description	Cause	Effect	Current Impact	Current Likelihood	Current Risk Score	Target Risk Score
2333	CMG 4 - ITAPS	If we do not recruit into the Paediatric Cardiac Anaesthetic vacancies to maintain a WTD compliant rota, then it may result in suboptimal patient treatment leading to potential for patient harm.	Workforce	Harm (Patient/Non-patient)	4. Major	5. Almost certain	20	2
3475	CMG 4 - ITAPS	If there is no effective maintenance programme in place to improve the operating theatres at the LGH, LRI & GGH sites, including ventilation, and fire safety, then it may result in failure to achieve compliance with required regulations & standards, leading to reputational impact and service disruption	Environment	Service disruption	5. Extreme	4. Likely	20	12
2615	CMG 6 - CSI	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	Environment	Service disruption	5. Extreme	4. Likely	20	2
3667	CMG 7 - W&C	If the EMCHC service is unable to recruit to paediatric posts to meet the NHSE Congenital Heart Disease standards and to allow the paediatric service to split from the adult congenital service, then it may result in widespread service and reconfiguration disruption, leading to potential for harm, loss of service, activity and associated income	Workforce	Service disruption	5. Extreme	4. Likely	20	5
3023	CMG 7 - W&C	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	Demand & Capacity	Harm (Patient/Non-patient)	5. Extreme	4. Likely	20	6
3483	CMG 7 - W&C	If the Viewpoint Maternity Scan system is not upgraded to the supported 6.0 version and the archiving solution is not addressed, then it may result in a detrimental impact on quality of delivered care and patient safety with missed fetal anomalies, leading to harm	IM&T	Harm (Patient/Non-patient)	5. Extreme	4. Likely	20	5
3083	CMG 7 - W&C	If gaps on the Junior Doctor rota in the Neonatal Units at both the LRI and LGH reach a critical level, then it may result in widespread delays with patient diagnosis or treatment, leading to potential for harm.	Workforce	Harm (Patient/Non-patient)	5. Extreme	4. Likely	20	3
3084	CMG 7 - W&C	If split site Consultant cover of the Neonatal Units at the LRI and LGH is not addressed, then it may result in widespread delays with patient treatment leading to potential harm and withdrawal of the neonatal service from the LGH site impacting significantly the Maternity Service	Workforce	Harm (Patient/Non-patient)	5. Extreme	4. Likely	20	5
3332	CMG 7 - W&C	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	Demand & Capacity	Harm (Patient/Non-patient)	5. Extreme	4. Likely	20	4
3090	CMG 8 - The Alliance	If the poor condition of the estate at the Hinkley and District Hospital is not rectified, this will hinder the delivery of activity and stop developments and transformation of care in line with the STP	Environment	Service disruption	5. Extreme	4. Likely	20	5
3143	Estates & Facilities	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	Finance	Service disruption	4. Major	5. Almost certain	20	6
3437	Estates & Facilities	If there is a lack of investment to procure new, and maintain existing, medical equipment, then it may result in a prolonged downtime to the continuity of core clinical services across the Trust due to equipment failure, leading to service disruption, potential for harm and adverse reputation	Equipment	Harm (Patient/Non-patient)	4. Major	5. Almost certain	20	12
3655	Finance & Procurement	If the Trust is unable to maintain an adequate supply of critical clinical supplies and equipment, caused by critical supply chain failure affecting supply of medicines, medical devices such as ventilators, NIV, CPAP and pumps, clinical consumables, nonmedical goods and PPE, then it may result in sub-optimal patient care, leading to potential for harm and poor experience and clinical outcomes.	Process & Procedures	Service disruption	5. Extreme	4. Likely	20	20
3148	Corporate Nursing	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	Workforce	Harm (Patient/Non-patient)	4. Major	5. Almost certain	20	12
3298	Corporate Nursing	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.	Demand & Capacity	Harm (Patient/Non-patient)	5. Extreme	4. Likely	20	5
2404	Corporate Nursing	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.	Process & Procedures	Harm (Patient/Non-patient)	4. Major	5. Almost certain	20	4

Risk ID	CMG	Risk Description	Cause	Effect	Current Impact	Current Likelihood	Current Risk Score	Target Risk Score
3623	Operations	If UHL does not sufficiently plan for, respond to and recover from a major outbreak of COVID-19, then it may result in rapid operational instability, leading to negative impact to the health and safety of patients, staff and visitors as well as impact on the organisation's ability to provide an acceptable level of health service	Process & Procedures	Service disruption	5. Extreme	4. Likely	20	20
3654	Operations	If UHL experiences an unprecedented demand for Respiratory, Medical, Critical Care & Palliative Care services for patients requiring oxygen and ventilator support and is unable to establish appropriate pathways for patients with suspected or confirmed COVID-19, then is may result in a delay in patient treatment and a potential deterioration in the patient's condition	Process & Procedures	Service disruption	5. Extreme	4. Likely	20	20
3550	CMG 1 - CHUGGS	If the full surgical take is moved to the LGH site (Wards 28 and 29) without any additional resources (i.e. medical and triage nursing staff) then it may result in delays with timely diagnosis and treatment of deteriorating patients, leading to potential harm	Workforce	Harm (Patient/Non-patient)	4. Major	4. Likely	16	8
3485	CMG 1 - CHUGGS	If the specialist Palliative Care Team staffing levels are below establishment, caused due to staff vacancies and service resources, then it may result in a detrimental impact for palliative and end of life care patients, leading to poor experience and harm	Workforce	Harm (Patient/Non-patient)	4. Major	4. Likely	16	12
3615	CMG 1 - CHUGGS	If there is insufficient investment to procure replacement Endoscopic Ultrasound Scopes, then it may result in poor quality of patient care delivered which may result in patient harm and service disruption	Equipment	Harm (Patient/Non-patient)	4. Major	4. Likely	16	8
3260	CMG 1 - CHUGGS	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	Demand & Capacity	Harm (Patient/Non-patient)	4. Major	4. Likely	16	6
3350	CMG 1 - CHUGGS	If staffing levels are not increased within the radiographic workforce of the radiotherapy department during times of peak activity, then it may result in widespread delays with patient diagnosis or treatment, leading to potential patient harm	Workforce	Harm (Patient/Non-patient)	4. Major	4. Likely	16	4
3519	CMG 1 - CHUGGS	If availability of essential replacement uroscopes in Urology is not adequaltely resourced, then it may result in delays with patient treatment due to insufficient effective/working scopes available to undertake booked lists, leading to potential for harm (increased patient waits both cancer and RTT), disruption to the service and adverse effect on reputation	Equipment	Harm (Patient/Non-patient)	4. Major	4. Likely	16	8
3555	CMG 2 - RRCV	If the Trust is unable to demonstrate compliance against key clinical standards outlined in the NHSE Home Ventilation Service specification (A 14/S/01), then it may result in the loss of registration as a provider for the Respiratory Home Ventilation Service (Adults) leading to service disruption and potential harm to patients	Workforce	Service disruption	4. Major	4. Likely	16	4
3175	CMG 2 - RRCV	If the clinical pathway proposed that allows Lincolnshire patients to be treated closer to home and repatriated from UHL to the United Hospitals of Lincolnshire in a timely manner does not take place, then it may result in detrimental impact on safety & effectiveness of patient care delivered, leading to potential harm and the reduced bed base required for the interim reconfiguration will not be realised	Demand & Capacity	Harm (Patient/Non-patient)	4. Major	4. Likely	16	6
3210	CMG 2 - RRCV	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	Workforce	Service disruption	4. Major	4. Likely	16	2
3413	CMG 2 - 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	Workforce	Harm (Patient/Non-patient)	4. Major	4. Likely	16	12
3025	CMG 3 - ESM	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.	Workforce	Harm (Patient/Non-patient)	4. Major	4. Likely	16	4
3198	CMG 3 - ESM	If there is a failure to administer insulin safely and monitor blood glucose levels accurately, in accordance with any prescriber's instructions and at suitable times, then 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	Process & Procedures	Harm (Patient/Non-patient)	4. Major	4. Likely	16	4

Risk ID	CMG	Risk Description	Cause	Effect	Current Impact	Current Likelihood	Current Risk Score	Target Risk Score
3140	CMG 4 - ITAPS	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.	Process & Procedures	Harm (Patient/Non-patient)	4. Major	4. Likely	16	8
3679	CMG 5 - MSK & SS	If additional capacity and space is not identified to meet the ever increasing demand on ophthalmology services then this may result in delayed patient diagnosis and treatment and could lead to potential patient harm (due to patient's having to wait longer for the care they require)	Demand & Capacity	Harm (Patient/Non-patient)	4. Major	4. Likely	16	12
3341	CMG 5 - MSK & SS	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.	Demand & Capacity	Harm (Patient/Non-patient)	4. Major	4. Likely	16	8
3205	CMG 6 - CSI	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.	Workforce	Harm (Patient/Non-patient)	4. Major	4. Likely	16	8
3482	CMG 6 - CSI	If there is a lack of investment to procure replacement, and maintain existing, medical equipment, then it may result in a prolonged downtime to the continuity of core clinical services across the Trust due to equipment failure, leading to service disruption, potential for harm and adverse reputation	Equipment	Service disruption	4. Major	4. Likely	16	12
3460	CMG 6 - CSI	If we are unable to address non-compliances with ISO 15189:2012 (medical laboratories quality management systems and competence), then it may result in failure to achieve compliance with relevant regulations & standards, leading to reputational and financial impacts.	Workforce	Financial loss (Annual)	4. Major	4. Likely	16	4
3206	CMG 6 - CSI	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.	Equipment	Harm (Patient/Non-patient)	4. Major	4. Likely	16	6
3514	CMG 6 - CSI	If there are insufficient staffing resources in the Cellular Pathology Service to meet diagnostic TRT targets, then it may result in widespread delays to patient receiving results and treatment, leading to potential patient harm and affecting the reputation of the service	Workforce	Harm (Patient/Non-patient)	4. Major	4. Likely	16	4
3329	CMG 6 - CSI	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	Workforce	Service disruption	4. Major	4. Likely	16	6
3558	CMG 7 - W&C	If paediatric neurology is unable to secure cover for current consultant vacancy and cover long term sickness of specialist nurse, then it may result in widespread delays with patient diagnosis and treatment, resulting in patient harm and substantial service disruption.	Workforce	Reputation	4. Major	4. Likely	16	8
3560	CMG 7 - W&C	If Children's services are unable to comply with the recommendations in NICE Guideline Recommendations in NG61 (End of life care for infants, children & young people), then it may result in Children having inappropriate treatments and interventions, leading to potential for harm.	Process & Procedures	Harm (Patient/Non-patient)	4. Major	4. Likely	16	6
3561	CMG 7 - W&C	If Children's services are unable to comply with the recommendations in NICE Guideline Recommendations in NG61 (End of life care for infants, children and young people with life-limiting conditions), then it may result in Children having inappropriate treatments and interventions, leading to potential for harm	Process & Procedures	Harm (Patient/Non-patient)	4. Major	4. Likely	16	6
3628	CMG 7 - W&C	If we fail to address the shortfall in consultant cover for paediatric and TYA haematology and oncology, then it may result in delays with diagnosis and treatment to non-malignant and malignant haematology and oncology patients in the region, leading to Patient harm and reputational damage.	Workforce	Reputation	4. Major	4. Likely	16	8
3585	CMG 7 - W&C	If HDU provision within Leicester Children's Hospital continues to be inadequate for children requiring higher levels of care, then it may result in poor quality of care, flow, and patient harm.	Environment	Harm (Patient/Non-patient)	4. Major	4. Likely	16	8
3586	CMG 7 - W&C	If there is a shortage of workforce to care for paediatric high dependency and intensive care patients, then it may result in poor quality of care and patient harm	Workforce	Harm (Patient/Non-patient)	4. Major	4. Likely	16	8
2153	CMG 7 - W&C	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.	Workforce	Harm (Patient/Non-patient)	4. Major	4. Likely	16	8

Risk ID	CMG	Risk Description	Cause	Effect	Current Impact	Current Likelihood	Current Risk Score	Target Risk Score
3663	CMG 7 - W&C	If we fail to address the staffing shortfall in Medical and Nursing cover for the Paediatric Nephrology Service, then it may result in delayed diagnosis and treatment to Nephrology patients in the region, leading to potential patient harm, reputational damage, service disruption and financial loss	Workforce	Harm (Patient/Non-patient)	4. Major	4. Likely	16	8
3217	CMG 8 - The Alliance	If a solution is not found for flexible endoscope decontamination across all UHL and Alliance units then the organisation will not be compatible with HTM 01-06 or JAG regulations and will not be able to provide a high quality, reliable process for the decontamination of flexible endoscopes, to support the endoscopy service, which could result in lost activity and income, reduced patient satisfaction with the service and patient harm from delayed or cancelled procedures	Equipment	Financial loss (Annual)	4. Major	4. Likely	16	8
3471	CMG 8 - The Alliance	If the poor communication with the Alliance and lack of responsiveness to issues on the part of NHSPS does not improve, then it may result in a detrimental impact on quality of delivered care and patient / staff safety leading to harm and reputational impact including non-compliant with national legislation	Environment	Harm (Patient/Non-patient)	4. Major	4. Likely	16	6
2593	CMG 8 - The Alliance	If the endoscopy decontamination units on all Alliance sites cannot be made compliant with JAG and HTM regualtions, then they will not meet JAG requirements and will lose JAG accreditation.	Environment	Harm (Patient/Non-patient)	4. Major	4. Likely	16	4
3201	Communications	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	IM&T	Service disruption	4. Major	4. Likely	16	4
3662	Corporate Medical	If staff find it difficult to communicate (person-to-person and phone-to-phone) caused by wearing AGP PPE during the Covid-19 pandemic, then it may result in errors and delays with patient diagnosis and treatment (including response to time critical transfers), leading to potential for harm	Process & Procedures	Harm (Patient/Non-patient)	4. Major	4. Likely	16	8
3141	Estates & Facilities	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	Process & Procedures	Harm (Patient/Non-patient)	4. Major	4. Likely	16	8
3138	Estates & Facilities	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	Process & Procedures	Reputation	4. Major	4. Likely	16	4
3144	Estates & Facilities	If Estates & Facilities are unable to recruit and retain staff, or fund posts to deliver services to meet the Trust's expectations, then 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	Workforce	Service disruption	4. Major	4. Likely	16	12
3145	Estates & Facilities	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	Finance	Service disruption	4. Major	4. Likely	16	6
3489	Estates & Facilities	If water stagnation occurs in the hospital water system and Pseudomonas aeruginosa bacteria form, then it may result in a detrimental impact on patient safety, leading to potential harm, reputational impact and service disruption	Environment	Harm (Patient/Non-patient)	4. Major	4. Likely	16	4
3364	Estates & Facilities	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.	Environment	Harm (Patient/Non-patient)	4. Major	4. Likely	16	8
3137	Estates & Facilities	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	IM&T	Harm (Patient/Non-patient)	4. Major	4. Likely	16	4
3340	Corporate Nursing	If the locum bookers systems under the current contract provider 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	IM&T	Service disruption	4. Major	4. Likely	16	8

Risk ID	CMG	Risk Description	Cause	Effect	Current Impact	Current Likelihood	Current Risk Score	Target Risk Score
3344	Corporate Nursing	If staff are not mask fit tested for an FFP3 mask or provided with full respirator hoods (if they cannot be fitted) during an outbreak of respiratory viruses (including pandemics) or mycobacterium tuberculosis, then it may result in a detrimental impact on health & safety of staff, patients and visitors, leading to harm	Process & Procedures	Harm (Patient/Non-patient)	4. Major	4. Likely	16	12
2774	Operations	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.	Process & Procedures	Harm (Patient/Non-patient)	4. Major	4. Likely	16	8
1693	Operations	If clinical coding is not accurate, then it may result in a loss of income resulting in financial impact and loss of Trust reputation	Process & Procedures	Financial loss (Annual)	4. Major	4. Likely	16	8
3391	CMG 1 - CHUGGS	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	Process & Procedures	Financial loss (Annual)	3. Moderate	5. Almost certain	15	6
3617	CMG 1 - CHUGGS	If LLR system-wide governance (including policy, paperwork, process, audit and education) is not agreed for use of subcutaneous medications to manage symptoms in adult patients at the end of life, then it may result in delays for symptom control or medications could be administered without an appropriate assessment of reversible causes of deterioration, leading to potential harm to patients	Process & Procedures	Harm (Patient/Non-patient)	5. Extreme	3. Possible	15	5
3576	CMG 2 - RRCV	If we do not have adequate staffing resource to support current in-patient service demand for the Home oxygen team, then it may result in patient harm with delays, incomplete or inconsistent assessments, reduced quality of life for patients, increased costs of oxygen provision and potential for withdrawal of CCG funding	Workforce	Harm (Patient/Non-patient)	3. Moderate	5. Almost certain	15	6
3520	CMG 2 - RRCV	If a confused patient mobilises off a RRCV ward on the Glenfield site (no ward areas have restricted access doors) and through one of the multiple exit points out of the hospital unchecked, then it may result in a detrimental impact on patient safety, leading to potential for harm	Process & Procedures	Harm (Patient/Non-patient)	5. Extreme	3. Possible	15	5
3043	CMG 2 - RRCV	If cardiac physiologists staffing levels are below establishment, then it may result in diagnostics not being performed in a timely manner, leading to patient harm	Workforce	Harm (Patient/Non-patient)	3. Moderate	5. Almost certain	15	6
3047	CMG 2 - RRCV	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.	Workforce	Harm (Patient/Non-patient)	3. Moderate	5. Almost certain	15	6
2804	CMG 3 - ESM	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	Demand & Capacity	Harm (Patient/Non-patient)	3. Moderate	5. Almost certain	15	12
3222	CMG 3 - ESM	If a member of the public is violent or aggressive outside or inside ED receptions/waiting rooms, then it may result in a detrimental impact on health, safety & security of staff, patients and visitors leading to harm	Process & Procedures	Harm (Patient/Non-patient)	5. Extreme	3. Possible	15	10
3496	CMG 3 - ESM	If patients with previously identifed alert organisms attending ED and CED are not booked in via Patient Centre, then it may result in delays with appropriate infection prevention precaustions and treatment, leading to potential harm with increased risk of exposure of the organism to others in the environment	IM&T	Harm (Patient/Non-patient)	3. Moderate	5. Almost certain	15	6
3510	CMG 5 - MSK & SS	If the lack of facilities to support single sex accommodation in the Professor Harper trauma clinic. (PHTC) are not addressed, then it may result in Patient Dignity being compromised (single sex breach is a never event), leading to poor experience, and reputational impacts	Environment	Reputation	3. Moderate	5. Almost certain	15	9
3492	CMG 7 - W&C	If demand for the maternity ultrasound scan provision exceeds capacity, causing a delay, then it may result in a preventable stillbirth or an increase in the risk of the fetus developing cerebral palsy due to widespread delay in providing a growth scan for women identified to have an increased risk of a problem with fetal growth or reduced fetal movements, leading to potential harm	Demand & Capacity	Harm (Patient/Non-patient)	5. Extreme	3. Possible	15	10
3093	CMG 7 - W&C	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	Workforce	Harm (Patient/Non-patient)	3. Moderate	5. Almost certain	15	6

Risk ID	CMG	Risk Description	Cause	Effect	Current Impact	Current Likelihood	Current Risk Score	Target Risk Score
3657	CMG 7 - W&C	If Newborn bloodspot samples do not arrive in the screening laboratory within 3 working days, caused due to samples being delayed or lost in the post, then it may result in delay in the diagnosis and treatment of life threatening conditions in newborn babies, leading to potential harm to a baby's health and wellbeing, adverse reputation with non-compliance against the Newborn screening standard, and financial implications with repeat samples	Process & Procedures	Harm (Patient/Non-patient)	5. Extreme	3. Possible	15	5
2394	Communications	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	IM&T	Harm (Patient/Non-patient)	3. Moderate	5. Almost certain	15	3
3619	Estates & Facilities	If Estates & Facilities operational services are unable to obtain sufficient resources such as spare parts, cleaning materials, tools, food and replenishable goods and equipment, including Personal Protective Equipment (PPE) in sufficient quantities and in a timely manner, then it may result in significant disruption to a 'normal' level of service	Process & Procedures	Service disruption	5. Extreme	3. Possible	15	8
1615	IM&T	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	Environment	Service disruption	5. Extreme	3. Possible	15	10