The Integrated Risk and Assurance Report

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Trust Board paper F

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 Jan 2021	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 3 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
8	COVID 19 – recover and restoration / renewal	DSC & ACOO	4 x 5 = 20

2. The Executive Strategy Board in January approved the increased risk rating for Principal Risk 8 (COVID 19 – recover, restoration and renewal) to 20 (high) to reflect the peak of the second wave and how this peak is notably larger than the first. The Restoration/Recovery process will recommence when demand and pressure reduces. This process will be managed via the established COVID-19 tactical and strategic command and control process.
3. There are 302 risks recorded on the organisational risk register as at 31st December 2020.

Thematic Analysis of the organisational risk register shows a key causation theme is around gaps in workforce capacity and capability across all CMGs. Other causation themes include information and protocol compliance, infrastructure and environment, equipment and resources, 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: **4TH FEBRUARY 2021**

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

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

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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 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 themes from 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 three is attached at appendix one. Executive leads have kept their risks under regular review and they have been discussed and endorsed at their relevant Executive Board meetings as part of the Trust's established BAF governance procedure.

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	BAF 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	4 x 5 = 20
7	Estates - reconfiguration - new estate	DEF	4 x 4 = 16	3 x 4 = 12
8	COVID 19 – recover and restoration / renewal	DSC & ACOO	4 x 5 = 20 (increased)	3 x 4 = 12

2.4 The Executive Strategy Board has approved the current risk rating for Principal Risk 8 (COVID 19 – recover, restoration and renewal) be increased from 16 to 20 (high) during the reporting period ending 31st January 2021, to reflect the peak of

the second wave and how this peak is notably larger than the first. All non-urgent (other than P1 & P2) elective activity is being stood down (including Outpatient activity) where this supports a reallocation of staff to manage the COVID-19 related demand. The Restoration/Recovery process will recommence when demand and pressure reduces. This process will be managed via the established COVID-19 tactical and strategic command and control process.

2.5 Following the initial discussions about risk appetite at the Trust Board Thinking Day in March 2020, our Internal Auditors, in conjunction with the Corporate Risk Team, have commenced the work programme to meet with Principal Risk Leads to identify Key Risk Indicators (KRI). Preliminary discussions have taken place with the CPO concerning Principal Risk 3 (workforce sustainability), and the CIO about Principal Risk 5 (IM&T). Further work is being undertaken to focus on the strategic causal factors to support identification of KRIs for these risks. Progress will continue to be reported through the Executive Team and to the Board. Following the exercise to review the current BAF, the Corporate Risk Team will facilitate a wider programme to communicate findings 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 operational CMG and corporate risks, has been kept under review by the Executive Finance and Performance Board and by CMG Boards during quarter three. 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.

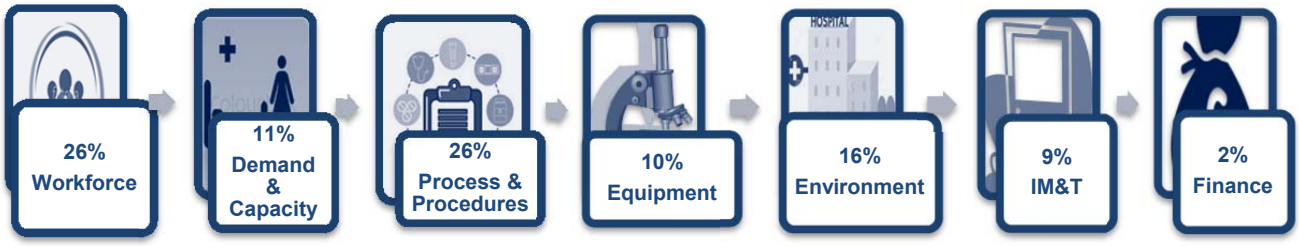
Fig 1: UHL Organisational Risk Register profile by current rating (31/12/20)

3.2 New risks continue to be identified by CMGs and presented to the Executive Board meetings on a weekly basis for review and endorsement ahead of being reported on the organisational risk register. Details of the new risks scoring 15 and above which have been approved during December 2020 are provided for information below:

ID	CMG	Risk Description – New Risks	Current Rating	Target Rating
3711	RRCV	If the Clinical Decisions Unit is unable to comply with social distancing measures during periods of prevalent infectious respiratory pathogens such as Covid 19, due to overcrowding and the limited ability to segregate patients, then it may result in an increase in exposure to patients, staff and visitors leading to potential harm and significant service disruption	20	10
3714	MSK & SS	If the Max Fax's H&N Consultant Posts cannot be recruited into to meet service demand, then it may result in delayed Cancer Patient Pathways and Treatment, leading to potential harm, adverse performance (failing to achieve Head & Neck 2WW 14 Day appointments for patients and 62 Day Cancer Breaches), adverse reputation, service disruption and financial loss.	16	8
3708	CSI	If the MultiDiagnost Eleva fluoroscopy equipment in Room 12 at the	16	1

		LRI is not replaced (due to its age and service support ceasing), then it may result in delays with patient diagnosis and treatment, leading to potential harm and significant service disruption		
3658	W&C	If there is a lack of safety equipment (Microbiological Safety Cabinet) to analyse semen samples in the ACU, then it may result in delays with patient analysis and treatment, leading to potential mental and physical harm to Gynaecology, women 40 years+ patients, service delivery impact, reputational and financial loss	16	4

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 Following successful launch of the Datix-web CAS Safety Alerts module, 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. This work programme has been delayed due to the increasing operational pressures on CMGs and corporate services and staff as a result of the ongoing pandemic / winter challenges and it is anticipated the new module will be functional across the organisation early in 2021/22.

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.

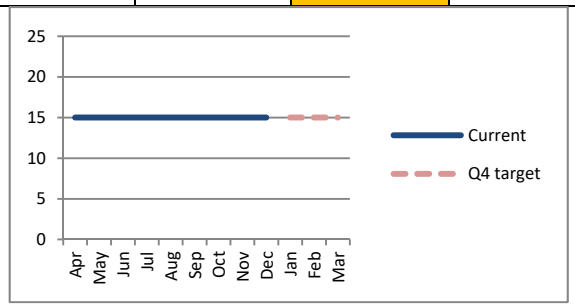
Report prepared by Head of Risk & Assurance, 29/01/2021.

Appendix 1 - 2020/21 Board Assurance Framework – (Trust Board version 4th February 2021)

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 achieve and maintain financial sustainability.	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	4 x 5 = 20	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	4 x 5 = 20 (increased)	3 x 4 = 12	TBC

Appendix 1 - 2020/21 Board Assurance Framework – (Trust Board version 4th February 2021)

PR Ref:	PR 1	PR Title:	Clinical quality and patient safety								Last Updated:	06/01/21
Executive lead(s):	Medical Director & Chief Nurse	Lead Executive Board:	EQB			Lead TB sub-committee:	QOC		Strategic Objective	Quality Priorities		
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	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			3 x 5 = 15
Rationale for score:	As we now concentrate on recovering the services that were suspended at the height of the pandemic, the Trust continue to work hard to minimise the risk of COVID-19 spreading in our services, and also focus on our approach to embedding the fundamentals of care, which are important to providing patients with the quality care they deserve.					Risk rating tracker:					Target rating Beyond 2020/21 (L x I)	2 x 5 = 10
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											

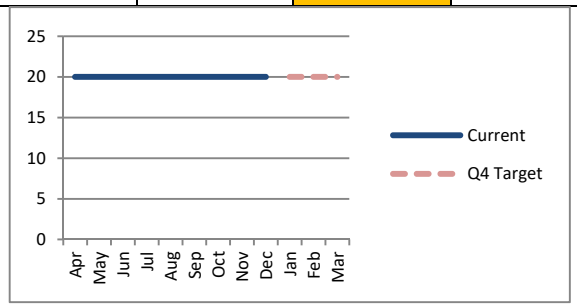
Cause(s): *Drivers*	PR event: *If we are unable to address the PR drivers, then it may result in…*	Impact: *leading to…*
• A widespread loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected 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; potential for regulatory action being taken against the Trust; service disruption; and loss of public confidence in the trust

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 expected	• 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 ongoing. • 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. • Safer Surgery assessment and accreditation process being developed as part of the Safe Surgery and Procedures Quality priority work

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 – e.g. 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. • Quarterly 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 and CIPs.	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 - 2020. • Response to Ockenden Report. **External** • CQC inspection reports. • PwC safety audits. • CCG quality visits. • GIRFT reviews. • HSIB reviews for Maternity Services.	• 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 Governance and Assured Services process isn't fully established. • Outcomes and findings from external assurance reviews which have been on hold during Covid-19. • Established risk appetite framework under review. • Internal review of Maternity Governance processes.	stream. • Review and implement GIRFT actions. • Ongoing Command and Control arrangements to manage COVID-19. • Cancer harms review process for emerging Covid-related delays / harms. • 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. • Corporate risk team working with PWC (2020/21 programme) to develop Key Risk Indicators for Principal Risks on the BAF as part of the risk appetite work programme. • Maternity Governance review commissioned by Chief Nurse will review corporate, CMG and Team governance processes.
An outbreak of infectious disease (such as pandemic) that forces closure / significant disruption to one	• 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	**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).	• 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 undertaken to ensure best practice and recommendations being worked

or more service(s) in the hospital.	patients • 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 vaccination hub established at LGH to vaccinate staff and patients.	• In receipt of national guidance re Covid-19 swabbing of patients, which the Microbiology team and ICD advise CMGs and the Demand and Capacity Group. **External** • CQC Infection control Board Assurance Framework. • LLR SLT providing a co-ordinated response to threats.	• Inconsistent supply of preferred FFP3 masks to UHL (and to other Healthcare organisations in UK). • Vaccination hubs on Glenfield and LRI sites.	on. • A fit-mask test Task and Finish group has been convened to oversee the systems and processes required to manage existing stock of preferred choice, to assess alternative FFP3 mask(s) and to commence fit-mask testing to relevant staff in UHL. • Vaccination hubs to be established at Glenfield and LRI sites during January 2021.

Appendix 1 - 2020/21 Board Assurance Framework – (Trust Board version 4th February 2021)

PR Ref:	PR 2	PR Title:	Operational Performance								Last Updated:	20/01/2021
Executive lead(s):	Acting Chief Operating Officer	Lead Executive Board:	EFPB			Lead TB sub-committee:	PPPC / QOC		Strategic Objective	Quality Priorities		
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	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.					**Risk rating tracker:**				**Target rating Beyond 2020/21 (L x I)**	3 x 4 = 12	
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											

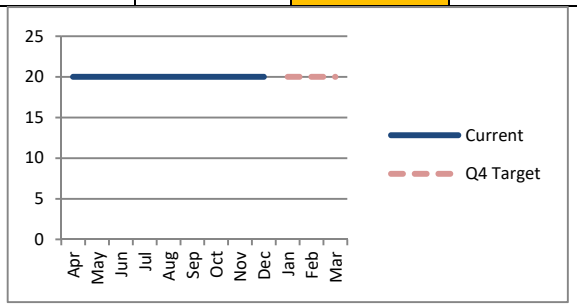
Cause(s): *Drivers*	**PR event:** *If we are unable to address the PR drivers, then it may result in…*	**Impact:** *leading to…*
• Emergency care: Growth in demand for care caused by an ageing population; reduced social care funding; increased acuity leading to more admissions & longer length of stay; 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; loss of public confidence in the trust; financial penalties; and regulatory action

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?
• Emergency Care: Growth in demand for care caused by an ageing population; reduced social	• 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	Internal: • ED patients waiting time report. • Bed occupancy report. • UHL Capacity Reports. • Daily medically fit for discharge numbers. • Daily medically fit for discharge	• Capacity gap for patients to be discharged within 24 hours of becoming medically fit especially for county patients. • Ability to discharge patients to community	• 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

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.	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	complex patient list. • Stranded and super-stranded patient data. • Daily performance metrics for all ED areas	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.	of business continuity plans in order to ensure emergency bed capacity is available for the forecasted increase in cases. • Implementation of Think 111 across LLR (September 2020). • New front door model approved and recruitment on track. • Direct referrals to GPAU from Clinical Navigation Hub as part of NHS 111 First initiative, from 7 December.
• 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	• 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. • 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	• Demand management plans including RSS supporting to bridge capacity gap. Waiting list is currently 78005. 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. • 6355 x 52 week breaches at the end of December above trajectory due to the impact of COVID-19 Wave 2. 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. • Agreeing activity Levels for Q4 with IS providers following changes in the national framework agreement. • Reduction in theatre sessions due to Wave 2. • Utilisation program being developed with support of Kingsgate to improve flow through theatres. • Planning commenced for 2021/22 to include resources required for elective recovery.

breaching the 52 weeks each month.			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.	
• 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 • CMGs being engaged in agreeing trajectories and actions to deliver. • All surgical pts to be priority scored. • Use of the IS for as much activity as possible.

Appendix 1 - 2020/21 Board Assurance Framework – (Trust Board version 4th February 2021)

PR Ref:	PR 3	PR Title:	Workforce sustainability								Last Updated:	28/01/2021
Executive lead(s):	Chief People Officer		Lead Executive Board:	EPCB		Lead TB sub-committee:	PPPC		Strategic Objective	People Strategy		
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	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:	Given the current staffing capacity issues during Covid-19					Risk rating tracker:					Target rating Beyond 2020/21 (L x I)	3 x 4 = 12
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 to meet the needs of the current and future patient base	prolonged, widespread reduction in the quality and effectiveness of clinical care; repeated failure to achieve constitutional standards; loss of public confidence in the trust; and financial unsustainability of some services

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 (including Recruitment and Selection Policy and Procedure) – process to review and update policies as	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 across the system i.e. PCN's.	• 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 the core offer/ people promise. Budget signoff to enable MOC/ aligned capacity – received sign off 14th Dec

	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.		• Within UHL - Fully joined up and integrated reporting/ IT systems across Finance, Workforce (ESR) and E rostering in regard to WF numbers.	• Scoping impact of restoration and recovery plans which may lead to further gap in workforce supply. Surge plans in development /challenge which continues. • Strong focus on healthcare worker support as part of priority planning/ next steps. • Re-initiated regional talent management activity with key focus on inclusivity and widening participation. • WF supply / redeployment cell in place and co-ordination through professional leads for planning and deployment activity.
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. • All staff COVID Risk assessment process – 96% of all staff with risk assessments completed (Oct 2020). •	• 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 and compassionate leadership. Further work underway in strengthening 'looking after our finances' elements. Update to be provided to EPCB at Feb meeting. • Review of people policies and practice to support People plan delivery - incorporated into review of work programme 20/21. – Prioritisation in progress Start/Stop/continue to manage deliverables in light of COVID 2nd wave. • LLR system approach to Restoration and recovery agreed – first iterative submission made / planning in progress for next submission for phase 4 in Feb 2021. • Agreement of LLR EDI System Programme of work for next 12 months - new priority to set up system wide BAME Voice Gripe Tool. Project Team established to take this forward working in partnership with EDI Team within the LLR Commissioning Support Unit.
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. • EDI strategic plan and WRES/WDES delivery plans incorporating gender pay gap plan.	• 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.	• 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. New Health and Wellbeing winter plan agreed and being implemented. • Scoping of system wide mental HWB HUB to provide additional support complete – LLR Hub Board established and agreement on implementation projects and resource requirement. • Exploring approaches to strengthen UHL networks and the Trust Board – in progress. Work underway to develop new LGBTQ+ Network – first meeting in Jan 2021. LGBTQ+ Rainbow badge campaign early adoption in Peads and ED with 170 staff pledges made. • Undertaking a gap analysis of representation across UHL

				governance structures - to form part of governance review. Now taken forward as part of Inclusive Decision Making Framework programme of work. Reconfiguration Programme Case study drafted and communicated across senior teams. • Strengthening approaches to flexible working and enabling an agile workforce. Agile work stream established – meeting as part of enabling services project board/ Reconfiguration. • Staff testing for symptomatic staff scaling up due to increasing demands – in place. Staff asymptomatic testing – lateral flow testing roll-out for front facing staff - 12 week programme in progress pilots in place. • Review scope to retain staff brought back during pandemic – part surge planning going forward. • Set up of COVID 2nd wave supply cell to provide oversight to processes supporting supply/demand. • Roll out of COVID vaccine – through Hospital HUB model commenced 12th Dec 20 – increasing capacity across all 3 HUB sites – approx. 61% have received first dose. System wide scoping of Equality Impact Analysis underway.

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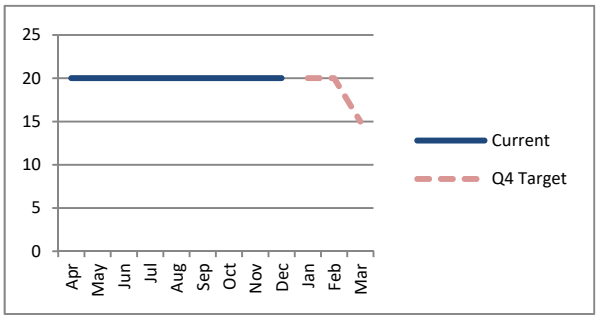
PR Ref:	PR 4	PR Title:	Financial sustainability								Last Updated:	28/01/21
Executive lead(s):	Chief Financial Officer		Lead Executive Board:	EFPB / FRB		Lead TB sub-committee:	FIC		Strategic Objective	Well governed finances		
BAF tracker - month	APR	MAY	JUN (Q1)	JUL	AUG	SEP (Q2)	OCT	NOV	DEC (Q3)	JAN	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	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:	Risk rating tracker:	Target rating Beyond 2020/21 (L x I)
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 submitted a planned deficit to NHSE&I from October 2020 to March 2021 of £30.1m, whilst delivering restoration and recovery of elective activity and the Trust's winter plan, and is now forecasting a £0.1m surplus, with the significant improvement in financial position reflecting the impact of Covid-19 on elective activity. The enhanced PMO structure and external support to deliver efficiencies is driving 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) is ensuring that cost pressures are controlled. Performance against the financial plan is being monitored and reported to FIG, FRB, EFPB, 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.		3 x 5 = 15

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 achieve and maintain financial sustainability.	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

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Target Likelihood rating of PR event occurring caused by the drivers described				Target Impact after actions
3				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?
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. • External support procured and appointed re CIP, with contract extension approved to support identification and delivery of 2021/22 CIPs.	• FRB chaired by Acting CEO - providing increased scrutiny and corporate oversight including strengthening "Grip and Control" measures. • Financial governance and performance monitoring arrangements at Trust Board (TB), Finance & Investment Committee (FIC), Audit Committee, Executive Meetings (EPB), CMG PRMs, Directorate and CMG service line reviews. • 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. April 2021	• 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 December 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. Permanent appointments have been made, Deputy Director (Financial Services) commenced in January 2021, and Deputy Director (Financial Management) appointed and commences in April 2021. Additional interim resources secured, as agreed with NHSE&I within the Financial Improvement Plan, and reported to FRB and FIC. • 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. • Enhanced Financial Performance Report to FRB,

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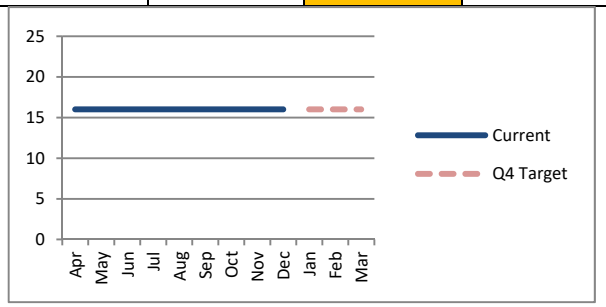
				FIC and TB from month 9. • Training and development programme on financial management for budget holders and other staff, commencing March 2021. • Trust 2020/21 forecast, reported to Trust Board on 7th January 2021, and revised forecast approved by FRB on 20th January 2021 and by the Chairman for submission to NHSE&I on 26th January 2021. • Development of 2021/22 income and expenditure plan and CMG and Directorate budgets, for approval at Trust Board on 1st April 2021.
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.	• 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 30th June 2021. • Enhanced journal approval policy implemented from December 2020.
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 capital expenditure to CMIC, EPB, FIC and TB. • 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. • 2020/21 capital scheme expenditure forecasts reviewed and signed off by CMIC, and reported to FRB, FIC and Trust Board. • Review of capital governance and processes being undertaken by Senior Capital Accountant, to be reported and approved by CMIC by 31st March 2021. • Development and approval of 2021/22 capital plan and five year capital plan by the Trust Board on 1st April 2021.
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/strategy) to deliver financial recovery – review by 31st March 2021.

Appendix 1 - 2020/21 Board Assurance Framework – (Trust Board version 4th February 2021)

PR Ref:	PR 5	PR Title:	IT (e-Hospital programme, and maintaining/ improving existing critical infrastructure)								Last Updated:	12/01/2021
Executive lead(s):	Chief Information Officer	Lead Executive Board:	EIM&TB	Lead TB sub-committee:	PPPC	Strategic Objective	e-Hospital					

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	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			4 x 4 = 16

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 November. Delays to release of agreed external funds and urgent COVID pandemic related works have delayed scheduling of planned project work and had an impact on available resource this year. As a consequence, our target risk score is unlikely to reduce below 16 by the end of March.	**Risk rating tracker:**		**Target rating Beyond 2020/21 (L x I)** 3 x 4 = 12

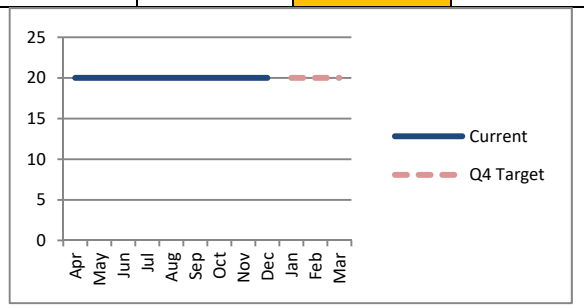
PR Description	Inability to address the drivers to deliver the e-Hospital programme and improve existing IT infrastructure, may result in a failure to provide optimised digital services

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 adverse publicity and reputational damage

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, information security breach – loss of patient	• 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 monitoring of threats via NHS Digital CareCert, vulnerability scanning & anti-virus/anti malware tools, Monthly Cyber Security Board, IG	• 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 in PwC Audit - Compliance within IT data centres (May 2019).	• 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 • Risks around server infrastructure dependent on execution of IM&T data centre strategy and move away from dependency on LRI Kensington	• 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 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

data, Big Bang or Rising Tide event - fire, flood, terrorist attack)	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	• 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. • PwC internal audit of cyber security controls in place to mitigate risks arising from the Covid-19 outbreak regarding people security, incident response and remote working for staff completed Oct 2020. • NHS Digital funded support via Templar Executives for cyber security and awareness activities during 2020/21.	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 • IT outsource contract arrangements for cyber security services are outdated and require re-scoping, including the provision of expertise by UHL IM&T function. • Full Security Incident Event Management (SIEM) solution required to provide end to end 'real time' analysis of security alerts generated by applications and network hardware.	plan – work scheduled for Q4 20/21 (Mar 2021). 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 - Work in progress with some delay due Mar 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). • Cyber security service to be re-specified as a priority following strategic IT partner contract novation in December 2020 (April 2021) • IM&T team security expertise to be reviewed and strengthened (April 2021) • Business case for SIEM solution to be developed and submitted (Aug 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. • Programme Management function facilitated by reconfiguration IT lead.	• 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 (March 2021). • 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 draw down during Jan 2021, re-planning for 20/21 spending in progress including staffing and backfill.

Appendix 1 - 2020/21 Board Assurance Framework – (Trust Board version 4th February 2021)

PR Ref:	PR 6	PR Title:	Estates - Maintaining/ improving existing critical infrastructure								Last Updated:	18/12/2020
Executive lead(s):	Director of Estates & Facilities	Lead Executive Board:	ESB		Lead TB sub-committee:	TB		Strategic Objective	Sustainable estate			
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	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.					Risk rating tracker:					Target rating Beyond 2020/21 (L x I)	4 x 5 = 20

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 adverse publicity and reputational damage

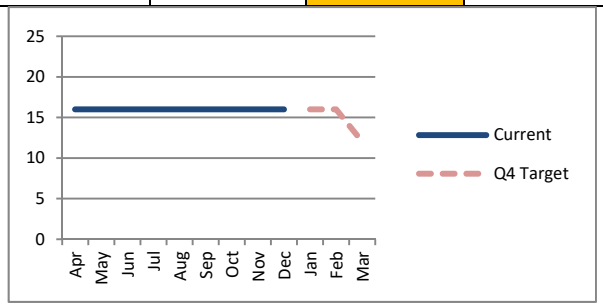
Drivers	Primary controls: What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Sources of assurance Evidence that the controls/ systems which we are placing reliance on are effective. Internal & External 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 breakdowns and failures.	• 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	• 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 recruitment of sufficient cleaning and Estates	• 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 30/06/2021, this target has been extended as we have been successful in recruiting a Deputy Director of E&F (Operational Services) starting 04/01/2021 to

	• 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.	from independent specialists for services including: Electrical, Piped Medical 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.	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). • There is a potential risk to the programme because of covid infections. We are seeing incidents of contractors closing their sites and project managers having to self-isolate. This was discussed at the November CMIC.	drive the transformation of E&F Operational Services. • 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.

Appendix 1 - 2020/21 Board Assurance Framework – (Trust Board version 4th February 2021)

PR Ref:	PR 7	PR Title:	Estates: reconfiguration - new estate								Last Updated:	21/12/2020
Executive lead(s):	Director of Estates & Facilities	Lead Executive Board:	ESB	Lead TB sub-committee:	TB	Strategic Objective	Sustainable reconfiguration					

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	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	Risk rating tracker:		Target rating Beyond 2020/21 (L x I)	3 x 4 = 12

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

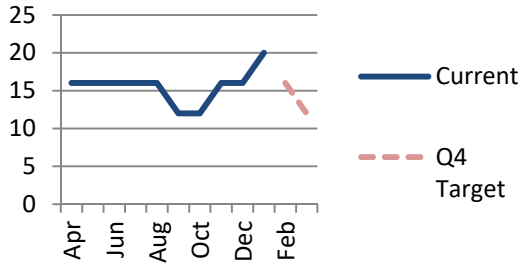
Cause(s): *Drivers*	PR event: *If we are unable to address the PR drivers, then it may result in…*	Impact: *leading to…*
• Failure to deliver the Trust's site investment and reconfiguration programme within resources - Delays to business case approval or construction could result in inflation increases 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

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. • Development of robust programme with adequate time allowed for external approval	• 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;	• 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 pandemic proofing). • Creation and adoption of a Social Values strategy to take account of the opportunities generated by	• Continue to progress discussions on early drawdown of capital in order to continue resourcing the programme. • 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. • RLB have been commissioned to produce a Social Values strategy for UHL. In January they will engage with a range of stakeholders both within UHL and external partners as information gathering to inform the strategy. Draft strategy to be presented in Feb to the Reconfiguration Programme Committee.

	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.	Capsticks on legal issues. • Capsticks have confirmed legitimacy of consultation during COVID pandemic using virtual media.	the Reconfiguration capital investment.	

Appendix 1 - 2020/21 Board Assurance Framework – (Trust Board version 4th February 2021)

PR Ref:	PR 8	PR Title:	COVID 19 – recover and restoration / renewal									Last Updated:	18/01/2021
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			
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	3 x 4 = 12	4 x 4 = 16	4 x 4 = 16	4 X 5 = 20			
Target rating (L x I)			4 x 4 = 16			3 x 4 = 12			4 x 4 = 16			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 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 same rigour applied to the command and control structure at the onset of COVID-19 is was 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 reduced this risk score from 16-12 until potentially rising again (when NHSE/I COVID-19 transmission levels & demand for acute services are anticipated to rise again). With the onset of the 'second peak' of COVID-19 in November 2020, elective activity reduced. In line with the first peak, cases prioritised on the basis agreed by the UHL Executive COVID-19 forum. Cancer and urgent elective work prioritised. This position monitored on a weekly basis with elective capacity for long waiting patients restored as soon as possible. Capacity within the Independent Sector and the Alliance has been protected for urgent elective work and diagnostics. As of January 2021, UHL is currently in the peak of the second wave and this peak is notably larger than the first. All non-urgent (other than P1 & P2) elective activity is being stood down (including Outpatient activity) where this supports a reallocation of staff to manage the COVID-19 related demand. The Restoration/Recovery process will recommence when demand and pressure reduces. This process will be managed via the COVID-19 tactical and strategic command process.	**Risk rating tracker:**		**Target rating Beyond 2020/21 (L x I)** 3 x 4 = 12
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.

Appendix 1 - 2020/21 Board Assurance Framework – (Trust Board version 4th February 2021)

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 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 LLR design groups are focussed on resolving the gap between current levels of performance and the ambitions within the 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.
Potential future wave of COVID-19 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	• 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	• 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	• Ensuring the benefits identified through each 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. • Gaps in clinical workforce	• The recovery from each wave of COVID-19 presents a unique window of opportunity for the Trust to truly and rapidly transform. • CMGs to review surge plans in preparation for future wave – to be monitored via UHL Tactical and Strategic / ICC. • Workforce plans are continuously under review. All non-urgent (other than P1 & P2) elective activity is being stood down (including Outpatient activity) where this supports a reallocation of staff to manage the COVID-19 related demand.

community.	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.	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).	to manage the COVID-19 related demand.	

Appendix 1 - 2020/21 Board Assurance Framework – (Trust Board version 4th February 2021)

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

Appendix 2 - Risk Register Report 15> as at 31st Dec 2020 (Trust Board 4 Feb 2021)

Risk ID	CMG	Specialty	Risk Description	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	20	9
3139	CMG 1 - CHUGGS	Endoscopy	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.	20	4
3682	CMG 1 - CHUGGS	Endoscopy	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.	20	10
2264	CMG 1 - CHUGGS	General Surgery	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.	20	6
1149	CMG 1 - CHUGGS	Oncology	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	20	9
3333	CMG 1 - CHUGGS	Oncology	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.	20	4
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	20	2
3711	CMG 2 - RRCV	Clinical Decisions Unit (CDU)	If the Clinical Decisions Unit (CDU) is unable to comply with social distancing measures during periods of prevalent infectious respiratory pathogens such as Covid 19 due to overcrowding and the limited ability to segregate patients this may result in an increase in exposure to patients, staff and visitors leading to potential harm and significant service disruption	20	10
3014	CMG 2 - RRCV	Renal Transplant	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	20	9
3325	CMG 2 - RRCV	Respiratory Medicine	If we do not replace the entire lung function equipment, then it may result in widespread delays to provide lung function tests for UHL patients, leading to potential patient harm and service disruption.	20	4
3359	CMG 3 - ESM	Acute Medicine	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.	20	9
3202	CMG 3 - ESM	Emergency Department	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.	20	8
3077	CMG 3 - ESM	Emergency Department	If there are delays in the availability of in-patient beds leading to overcrowding in the Emergency Department and an inability to accept new patients from ambulances, then it may result in detrimental impact on quality of delivered care and patient safety within the ED leading to potential harm.	20	15
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.	20	6
2333	CMG 4 - ITAPS	Anaesthesia	If we do not recruit into the Paediatric Cardiac Anaesthetic vacancies to maintain a WTD compliant rota, then it may result in suboptimal patient treatment leading to potential for patient harm.	20	2
3475	CMG 4 - ITAPS	Theatres	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.	20	12
2404	CMG 6 - CSI		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.	20	4
2615	CMG 6 - CSI	Pathology - Clinical Microbiology	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	20	2
3667	CMG 7 - W&C	East Midlands Congenital Heart Centre (EMCHC)	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	20	5
3483	CMG 7 - W&C	Maternity	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	20	5
3023	CMG 7 - W&C	Maternity	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	20	6
3083	CMG 7 - W&C	Neonatology	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.	20	3
3084	CMG 7 - W&C	Neonatology	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.	20	5
3332	CMG 7 - W&C	Paediatrics	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	20	4
3090	CMG 8 - The Alliance	Alliance - Hinckley	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	20	5
3143	Estates & Facilities	Corporate	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	20	6
3437	Estates & Facilities	Radiation Safety Service	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	20	12
3655	Finance	Corporate	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.	20	20
3148	Corporate Nursing	Corporate	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	20	12
3654	Corporate Operations	Corporate	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.	20	20
3623	Corporate Operations	Corporate	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.	20	20
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	16	12
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.	16	8
3615	CMG 1 - CHUGGS	Endoscopy	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	16	8
3260	CMG 1 - CHUGGS	General Surgery	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.	16	6
3350	CMG 1 - CHUGGS	Radiotherapy	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	16	4
3519	CMG 1 - CHUGGS	Urology	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.	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	16	4
3533	CMG 2 - RRCV	Cardiology	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.	16	8
3309	CMG 2 - RRCV	Haemodialysis Units (Including Satellite Units)	If the Haemodialysis units do not meet the national requirements for number of isolation facilities, then it may result in detrimental impact on safety & effectiveness of patient care delivered, leading to potential for harm	16	4
3175	CMG 2 - RRCV	Haemodialysis Units (Including Satellite Units)	If the clinical pathway proposal to allow 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.	16	6
3413	CMG 2 - RRCV	Respiratory Medicine	If nurse staffing levels are below establishment and availability of appropriate monitoring equipment is not increased to care for patients requiring acute NIV, then it may result in delays with patient diagnosis or treatment and failure to achieve compliance national recommended guidance, leading to potential harm and increased length of stay for patients requiring NIV	16	12
3378	CMG 3 - ESM	Emergency Department	If the process of referring patients from Emergency Medicine to fracture clinic fails, or patients are bounced back to Emergency Medicine, then it may result in delays with identifying and managing their injuries leading to potential clinical harm	16	8
3025	CMG 3 - ESM	Emergency Department	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.	16	4
3706	CMG 3 - ESM	Stroke Services	If the Stroke Unit does not increase and recruit into current nursing vacancies, then it may result in increased risk of patient morbidity and mortality, and accompanying delays in the process of care, leading to potential harm and adverse reputation	16	8
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.	16	8
3641	CMG 5 - MSK & SS		If we cannot achieve a 2 metre distance between the clinic chairs for all essential face to face reviews in the Ophthalmology waiting room then this may result in delayed patient diagnosis or treatment leading to possible patient harm and service disruption.	16	6
3714	CMG 5 - MSK & SS	Maxillofacial	If the Max Fax's H&N Consultant Posts cannot be recruited into to meet service demand, then it may result in delayed Cancer Patient Pathways and Treatment, leading to potential harm (failing to achieve Head & Neck 2WW 14 Day appointments for patients and 62 Day Cancer Breaches), adverse reputation, service disruption and financial loss.	16	8
3683	CMG 5 - MSK & SS	Ophthalmology	If Glaucoma service consultant workforce are below establsihement 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)	16	12
3679	CMG 5 - MSK & SS	Ophthalmology	If additional capacity and space is not identified to meet the ever increasing demand on ophthalmology services then itmay result in delayed patient diagnosis and treatment, leading to potential patient harm (due to patient's having to wait longer for the care they require)	16	12

Risk ID	CMG	Specialty	Risk Description	Current Risk Score	Target Risk Score
3618	CMG 5 - MSK & SS	Ophthalmology	If there is no process in HISS (PAS) system to identify patients who become overdue on the Long Term Follow Up waiting list in Ophthalmology, then it may result in delays in diagnosis and treatment, leading to potential for harm	16	9
3341	CMG 5 - MSK & SS	Trauma Orthopaedics	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.	16	8
3205	CMG 6 - CSI	Imaging - Breast	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.	16	8
3482	CMG 6 - CSI	Clinical Engineering	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	16	12
3206	CMG 6 - CSI	Pathology - General Pathology	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.	16	6
3329	CMG 6 - CSI	Pharmacy	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	16	6
3708	CMG 6 - CSI	Imaging	If the MultiDiagnost Eleva fluoroscopy equipment in Room 12 at the LRI is not replaced (due to its age and service support ceasing) then it may result in delays with patient diagnosis and treatment, leading to potential harm and significant service disruption	16	1
3658	CMG 7 - W&C	Gynaecology	If there is a lack of safety equipment (Microbiological Safety Cabinet) to analyse semen samples in the ACU, then it may result in delays with patient analysis and treatment, leading to potential mental and physical harm to Gynaecology, women 40 years+ patients, service delivery impact, reputational and financial loss	16	4
3663	CMG 7 - W&C	Paediatrics	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	16	8
3647	CMG 7 - W&C	Paediatrics	If we are unable to resolve the medical staffing issues within the Paediatric Rheumatology Service then this may result in delayed patient diagnosis and treatment (due to increased waiting times) leading to potential patient harm and service disruption	16	1
3628	CMG 7 - W&C	Paediatrics	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.	16	8
3585	CMG 7 - W&C	Paediatrics	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.	16	8
3586	CMG 7 - W&C	Paediatrics	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	16	8
3558	CMG 7 - W&C	Paediatrics	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.	16	8
3560	CMG 7 - W&C	Paediatrics	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.	16	6
3561	CMG 7 - W&C	Paediatrics	If Children's services are unable to comply with the recommendations in NICE Guideline Recommendations in QS 160, then it may result in Children having inappropriate treatments and interventions, leading to potential for harm.	16	6
2153	CMG 7 - W&C	Paediatrics	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.	16	8
3217	CMG 8 - The Alliance		If a solution is not found for flexible endoscope decontamination across all UHL and Alliance units then it may result in lost activity and income, reduced patient satisfaction with the service and patient harm from delayed or cancelled procedures.	16	8
3201	Communications	Corporate	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.	16	4
3662	Corporate Medical	Corporate	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	16	8
3344	Corporate Medical	Corporate	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.	16	12
3364	Estates & Facilities	Corporate	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.	16	8
3489	Estates & Facilities	Corporate	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	16	4
3141	Estates & Facilities	Corporate	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.	16	8
3144	Estates & Facilities	Corporate	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	16	12
3145	Estates & Facilities	Corporate	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	16	6
3138	Estates & Facilities	Corporate	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.	16	4
3137	Estates & Facilities	Estates	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	16	4
3688	Estates & Facilities	Estates	If the Trust's clinical waste capacity is exceeded, caused by insufficient collections, then it may result in disruption to the continuity of core services across the Trust leading to potential for major service disruption for clinical services	16	6
3340	Corporate Nursing	Staff Bank	If our IM&T systems under the current contract provider for locum bookers are unable to support fundamental processing, payment, and reporting, then it may result in non-delivery to contractual specification requirements, leading to potential service disruption, financial and reputational impact	16	8
2774	Corporate Operations	Corporate	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.	16	8
3391	CMG 1 - CHUGGS	General Surgery	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.	15	6
3617	CMG 1 - CHUGGS	Palliative Care	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.	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.	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	15	5
3597	CMG 2 - RRCV	Cardiology	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	15	10
3043	CMG 2 - RRCV	Cardiology	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	15	6
3047	CMG 2 - RRCV	Cardiology	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.	15	6
2804	CMG 3 - ESM	Acute Medicine	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	15	12
3222	CMG 3 - ESM	Emergency Department	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	15	10
3496	CMG 3 - ESM	Emergency Department	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	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	15	9
3705	CMG 6 - CSI		If the oncology, haematology and pharmacy clinical services fail to follow documented protocol (guidelines, policies, procedures and mandated standards) relating to both pharmacy and oncology/haematology, then it may result in increased medication errors, leading to potential harm, adverse reputation, service disruption and financial loss	15	5
3492	CMG 7 - W&C	Maternity	If demand for the maternity ultrasound scan provision exceeds capacity, 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	15	10
3657	CMG 7 - W&C	Maternity	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.	15	5
3093	CMG 7 - W&C	Maternity	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	15	6
2394	Communications	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	15	3
3619	Estates & Facilities	Corporate	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	15	8
3695	Estates & Facilities	Estates	If areas requiring specialist ventilation for infection prevention are not updated to the current healthcare standards, caused due to age and condition of the plant and lack of access, then it may result in a reduction in infection control, leading to potential patient harm, adverse reputation, service disruption and financial loss	15	5
1615	IM&T	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	15	10

Risk ID	CMG	Specialty	Risk Description	Current Risk Score	Target Risk Score
3677	Corporate Operations	Cancer Centre	If we are unable to secure funding to deliver Personalised Stratified Follow Up (PSFU) in Breast, Colorectal and Prostate, then it may result in delays in identifying patients concerns and timely addressing of patient physical, psychological, emotional and practical needs, leading to potential patient harm, poor experience and adverse reputation.	15	15