INTEGRATED RISK AND ASSURANCE REPORT AS AT 30TH April 2018

Author: Risk and Assurance Manager Sponsor: Medical Director

Trust Board paper G

Executive Summary

Context

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

Note - The BAF should also be reviewed in the context of the assurances being provided in the self-certification declarations and other reports, also being considered at this meeting.

Questions

1. What are the principal risks on the on the new revised 2018/19 BAF?
2. What new risks, scoring 15 and above, have been entered on the organisational risk register since the previous version?
3. What is the reporting structure for the 2018/19 BAF?
4. What are the key risk management themes evidenced on the organisational risk register?

Conclusion

1. The principal risks have been identified and linked to objectives. The principal risks relate to: PR1 – Quality standards; PR2 – Staffing levels; PR3 – Financial sustainability; PR4 – Emergency care pathway; PR5 – IM&T service; PR6 – Estates and Facilities service; PR7 – Partnership working. The highest rated principal risks (currently rated at 20) relate to staffing levels, emergency care pathway and financial sustainability.
2. There are 191 risks recorded on the organisational risk register (including 75 with a current rating of 15 and above). Two new risks scoring 15 and above have been entered on the risk register during the reporting period.
3. The lead Director will be responsible for updating their principal risk and for presenting to the relevant Executive Board each month for executive endorsement. It is proposed that the Audit Committee (AC) will have the role of overseeing the BAF at each meeting. The BAF will be reported to the Trust Board at each meeting for approval. Due to deferral of the BAF at AC in May 2018, this proposal will be worked up with the AC Chair and the Executive Team during quarter one 2018/19.
4. There are 191 risks recorded on the organisational risk register. Analysis of the CMG risks on the organisational risk register has identified the two key risk causation themes as gaps in staffing levels and demand against capacity. Financial pressures, including external funding and internal arrangements are recognised as key enablers to support the delivery of the Trust's objectives.

Input Sought

The Trust Board are invited to review and approve the content of this report, note the updated position to items on the new revised 2018/19 BAF and to advise as to any further action required in relation to principal risks recorded on the BAF and items on the organisational risk register.

For Reference

Edit as appropriate:

1. The following **objectives** were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes]
Effective, integrated emergency care	[Yes]
Consistently meeting national access standards	[Yes]
Integrated care in partnership with others	[Yes]
Enhanced delivery in research, innovation & ed'	[Yes]
A caring, professional, engaged workforce	[Yes]
Clinically sustainable services with excellent facilities	[Yes]
Financially sustainable NHS organisation	[Yes]
Enabled by excellent IM&T	[Yes]

2. This matter relates to the following **governance** initiatives:

a. Organisational Risk Register [Yes]

Datix Risk ID	Operational Risk Title(s) – add new line for each operational risk	Current Rating	Target Rating	CMG
	See appendix two			

b. Board Assurance Framework [Yes]

BAF entry	BAF Title	Current Rating
	See appendix one	

3. Related **Patient and Public Involvement** actions taken, or to be taken: [N/A]

4. Results of any **Equality Impact Assessment**, relating to this matter: [N/A]

5. Scheduled date for the **next paper** on this topic: [5.7.18 Trust Board]

6. Executive Summaries should not exceed **2 pages**. [My paper does comply]

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **UHL TRUST BOARD**

DATE: **7TH JUNE 2018**

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

SUBJECT: **INTEGRATED RISK AND ASSURANCE REPORT (INCORPORATING UHL BOARD ASSURANCE FRAMEWORK & ORGANISATIONAL RISK REGISTER AS AT 30TH APRIL 2018)**

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1 INTRODUCTION

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

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

2. 2018/19 BOARD ASSURANCE FRAMEWORK SUMMARY

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

2.2 The BAF remains a dynamic document and, following approval of the new process and principal risk descriptions by the Trust Board last month, has been worked-up by the lead Directors (to report April data) and reviewed at the relevant Executive Boards during May 2018, who have endorsed the final version, which is attached at appendix one.

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

2.4 The new principal risks relate to:

PR1 – Quality standards;
PR2 – Staffing levels;
PR3 – Financial sustainability;
PR4 – Emergency care pathway;
PR5 – IM&T service;
PR6 – Estates and Facilities service;
PR7 – Partnership working.

2.5 The seven principal risk themes form the Trust's risk and assurance framework and corresponding organisational (corporate and operational) risks will be linked at a Trust-wide and service level.

2.6 For the reporting period ending 30th April 2018, the three highest rated principal risks on the BAF, all with residual ratings of 20, relate to financial

sustainability, emergency care pathway and staffing levels, and are described below:

Principal Risk Description	Risk Rating	Objective & Lead Director
PR2: If the Trust is unable to achieve and maintain staffing levels that meets service requirements, *caused by employment market factors (such as availability and competition to recruit, retain and utilise a workforce with the necessary skills and experience), lack of extensive education, training and leadership, and demographic changes,* then it may result in poor clinical outcomes and experience, failure to achieve constitutional standards and increased staff workloads.	20	Our People DPOD
PR3: If the Trust is unable to achieve and maintain financial sustainability, *caused through delivery of income, the control of costs or the delivery of cost improvement plans,* then it will result in a failure to deliver the financial plan, leading to a loss of public and stakeholder confidence with the potential for regulatory action that may include financial special measures.	20	Financial Stability CFO
PR4: If the Trust is unable to effectively manage the emergency care pathway, *caused by persistent unprecedented level of demand for services, primary care unable to provide the service required, ineffective resources to address patient flow, and fundamental process issues*, then it may result in widespread instances of reduced quality of care and experience for large number of patients and sustained failure to achieve constitutional standards, leading to increased financial penalties and possible breach of license.	20	Organisation of Care COO

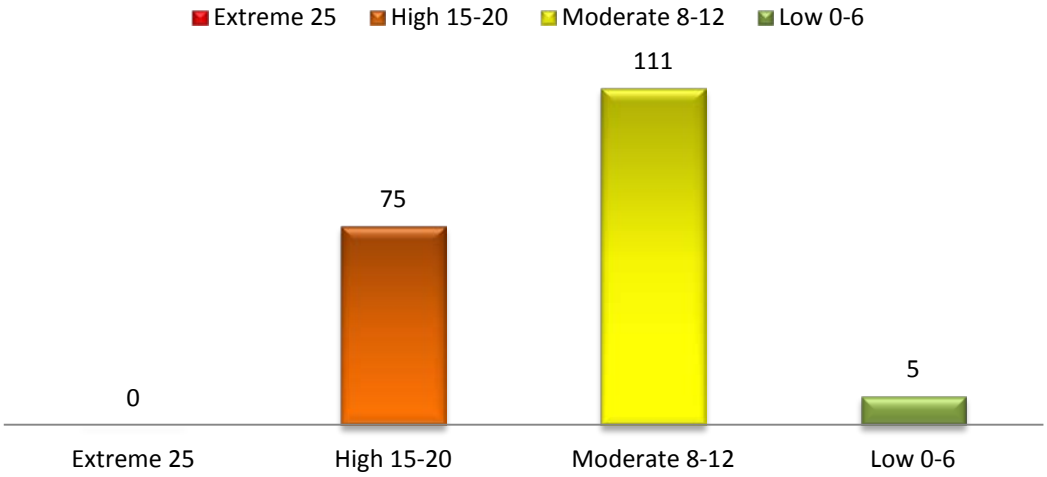
2.7 An area for further development in the Trust's risk and assurance framework is to define our risk appetite by way of a statement for each principal risk on the BAF. A risk appetite statement will help our staff and stakeholders understand the level of risk that we are prepared to accept in any given area and reduce the likelihood of inopportune risk taking, which could expose the organisation to a threat that it cannot tolerate, or prevent it from exploiting an opportunity it should take. It is proposed that a risk appetite and tolerance session will be included on the schedule for a TBTD during Q2 of 2018/19, following which tolerable risk ratings will be reported for each principal risk on the BAF.

2.8 It is proposed that the Audit Committee (AC) will have the role of overseeing the BAF at each meeting. The Chairs of the other Trust Board Sub-Committees will be in attendance at AC to interact in relation to the BAF. The AC may ask for a 'deep dive' into a principal risk if they have not received sufficient assurance from a lead Director / Committee or when a Committee has asked for AC to complete a 'deep dive'. As management of the BAF evolves, the AC, having considered the assurances received on the effectiveness of the primary controls, may agree an assurance rating (i.e. positive / negative / inconclusive) to each principal risk. The BAF will continue to be reported to the Trust Board at each meeting for approval. Due to deferral of the BAF at AC in May 2018, this proposal will be worked up with the AC Chair and the Executive Team during quarter one 2018/19.

3. ORGANISATIONAL RISK REGISTER SUMMARY

3.1 For the reporting period ending 30th April 2018, there are 191 risks recorded on the organisational risk register. A dashboard of all risks rated 15 and above is attached at appendix two and figure 1, below, illustrates the Trust's risk profile by current residual risk rating.

Figure 1: UHL Risk Register profile - residual risk rating



3.2 Two new risks, scoring 15 and above, have been entered on the risk register during the reporting period and their descriptions are included below:

CMG	Risk Description	Current Rating	Target Rating
ITAPS	If the practices, workforce, estate and facilities in LRI ITU are not compliant to current standards and expectations, caused by staffing shortages, inadequate capacity for demand and an aging estate with suboptimal environment for critical care patients, then clinical teams will not be able to provide safe care to all patients requiring level 2/3 care due to an increased risk of cross contamination	20	10
ESM	If there is a failure to administer insulin safely and to monitor blood glucose levels accurately, in accordance with any prescribers instructions and at suitable times, then this may lead to patients not having their diabetes appropriately monitored/managed resulting in a prolonged length of stay and potential of severe harm	16	4

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

- Staffing shortages;
- Imbalance between demand and capacity.

3.4 Managing financial pressures, as a result of limited external funding and internal control arrangements, is also well recognised on the risk register as an enabler to support the delivery of the Trust's operational and strategic objectives.

4 RECOMMENDATIONS

4.1 The TB are invited to review and approve the content of this report, note the position to principal risks on the 18/19 BAF and advise as to any further action required in relation to management of the BAF and items on the organisational risk register.

UHL Board Assurance Framework 2018/19:

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

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

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

A new section has been included in the 2018/19 BAF to link principal risks with detective risk indicators as a further source of evidence to inform the regular review and re-assessment. The assurance sections focus on where internal and external scrutiny of the operation of primary controls takes place, along with a summary of what the evidence received tells us in relation to the effectiveness of the controls which are being relied on.

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

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

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

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

Appendix 1 - April FINAL

2018/19 BAF Dashboard

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

DATE: April 2018	Director:	MD / CN	Executive Board:	EQB	TB Sub Committee:	AC / QOC
Linked Objective	Our Quality Commitment… to deliver safe, high quality, patient centred, healthcare					
BAF Principal Risk: 1 – Quality	If the Trust is unable to achieve and maintain the required levels of Quality standards (clinical effectiveness, patient safety & patient experience), ***caused by a general loss of focus on patient safety culture, IM&T systems failure, demand exceeds capacity for a prolonged period, critical shortage of workforce, and increasing service receivers and family expectations***, then it may result in widespread instances of avoidable patient harm and poor clinical outcomes to a large number of patients, leading to regulatory intervention and adverse publicity.				**Current Risk & Assurance Rating (I x L):**	**4 x 4 = 16**

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

Primary Controls

- 2018/19 UHL Quality Commitment measured through PIDs reported to EQB monthly in relation to:
  - Reduce avoidable deaths / Reduce harm caused by unwarranted clinical variation / Use patient feedback to drive improvements to services and care.
- Clinical service structures, resources and governance arrangements in place at Trust Exec and CMG / Specialty levels ensuring appropriate escalation of quality matters.
- Clinical Policies, guidelines, SOPs including NatSSIPs/ LocSSIPs on INsite.
- Professional standards and Code of Practice / Clinical supervision.
- Trust wide risk management and governance structure in place including: risk register, CAS, incident reporting, Complaints, Claims & Inquest management. Datix risk management software.
- Clinical audit programme & monitoring arrangements including assessment against NICE guidance.
- Patient safety improvement programme including sign up to safety and patient safety portal.
- Never Events action plan.
- Infection Prevention and Control programme including policies / procedures; staff training; environmental cleaning audits and inspections.
- Freedom to Speak up Guardian and escalation processes.
- Senior leadership safety walkabout programme.
- Quality Framework (Strategy) outlining how quality is managed within the Trust reported in AOP.
- Schedule of external visits maintained and reviewed at CMG service and Exec Team levels.
- CQC improvement plan monitored at CMG Boards, Exec Team and Trust Board.
- NHSI Board to Board performance review meetings.
- Maintenance of defined safe staffing levels on wards & departments – nursing and medical.
- Clinical staff recruitment campaigns, induction processes, registration and re-validation practices.
- Clinical Harm review process.
- Learning from Deaths work stream to scrutinise hospital deaths.
- Regular liaison meetings with Leic Coroner re hospital deaths and inquests.
- UHL Q&P Report including 'safe' and 'caring' indicators reported to EPB monthly.
- CMG monthly Performance Review Meetings chaired by CN, MD, COO, CFO and DPOD.
- Reporting to Commissioner led Clinical Quality Review Group on compliance with quality schedule and CQUINS – including Commissioner Quality visits schedule for 2018/19.
- Staff surveys and FFTs monitored at local and Exec Team levels.
- Patient and public involvement forums and patient experience focus groups.

Detective Risk Indicators

	Ref	Indicators	18/19 Target	Apr-18	18/19 YTD
SAFE & CARING	S1	Reduction for moderate harm and above PSIs - reported 1 month in arrears	9% REDUCTION FROM FY 16/17 (<12 per month)	Awaiting update	
	S2	Serious Incidents - actual number escalated each month	<=37 by end of FY 18/19	4	4
	S8	Overdue CAS alerts	0	0	0
	S10	Never Events	0	1	1
	S11	Clostridium Difficile	61	12	12
	S12	MRSA Bacteraemias - Unavoidable or Assigned to third Party	0	0	0
	S13	MRSA Bacteraemias (Avoidable)	0	0	0
	S14	MRSA Total	0	0	0
	C1	>75% of patients in the last days of life have individualised End of Life Care plans	75%	Awaiting update	
	C2	Formal complaints rate per 1000 IP,OP and ED attendances	No Target	1.6	1.6
	C4	Published Inpatients and Daycase Friends and Family Test - % positive	97%	97%	97%
	C7	A&E Friends and Family Test - % positive	97%	95%	95%

Internal Assurances	External Assurances	Gaps Identified & Pending Actions
• UHL Quality Commitment monitored at Exec Team monthly. • Monthly integrated quality and safety metrics (Q&P): *See detective risk indicators.* • Annual Governance statement providing assurance on the strength of internal control regarding risk management processes, review and effectiveness reported to Audit Committee (scheduled for May 2018). • Staffing levels on wards (for nursing and medical work groups) continue to be challenging and are monitored through daily operational command meetings with action plans identified to mitigate operational pressures. • Insulin Safety – Update in Chief Exec Briefing in April - Following the CQC inspection and warning notice concerning managing patients with diabetes - we continue to seeing increasing numbers of staff engaging with training and Datix incident reporting is going up without a rise in reported harm events which indicates raised awareness of insulin safety issues and a positive reporting culture.	• CQC comprehensive review in 2017/18 - inspectors have rated our Trust overall as Requires Improvement; rating us Good for being effective and caring, and Requires Improvement for being safe, responsive and well-led. Actions to be taken: ➢ The trust must embed learning from never events in order to prioritise safety and reduce never events; ➢ The trust did not always control infection risk well - Staff did not always adhere to trust policy in relation to cleaning of equipment, completing infection control risk assessments and hand hygiene. • CQC Warning notice issued following unannounced inspection in Nov 2017 – re the care given to diabetic patients in relation to the management of their insulin requires significant improvement. Early evidence supports actions have delivered improvements in knowledge and care of patients with diabetes. However, the CCGs visited some of the same wards during April, which the CQC had visited, and found some areas still had some improvements to make. • **Internal Audit Programme 2018/19:** ➢ Corporate Governance and Risk Management – scheduled Q1; ➢ Data Quality review – scheduled Q3; ➢ Learning from deaths – scheduled Q3; ➢ Quality Commitment review – scheduled Q1 & Q3; • **Internal Audit 2016/17:** ➢ Risk management – medium risk (associated with CMG processes). ➢ Clinical Audit - medium risk (associated with CMG engagement). • **External Audit 2016/17:** ➢ Incident reporting and evidence of validation of grading of harm – outcome assured (safety nets in place and being monitored). • National Freedom to Speak up Guardian visit in Q3 2017 – positive verbal feedback received about systems and processes in place in UHL. • Parliamentary ombudsman enquires – only 1 partially upheld case in 17/18, reduced from 7 the previous year. • Healthwatch – independent complaints review panel – positive verbal feedback received during 2017 about complaints management and handling processes.	• IM&T systems and infrastructure – close links into the overall IT strategy to optimise IT systems including NerveCentre and ICE – review during 2018 (CIO). • Workforce gaps in nursing and medical professions - develop a sustainable 5 year outline workforce plan by the end of Q1 18/19 (DPOD). • Imbalance between demand and capacity – on-going work to improve emergency care and reduce ad hoc cancellations of elective care at times of pressure. To support this we are planning for emergency activity overall to be about 1% more than in 2017/18 (this is more than originally planned due to the "March 2018 effect"). Our priority is to have enough beds for predicted emergency demand, with the balance available for elective care. Even with this approach, we still need more bed capacity – review during 2018 (COO/CEO). • Communication of key safety messages to front line staff: develop strategy to embed learning from never events in order to prioritise safety and reduce never events / patient safety culture programme to be developed / increase awareness via website and intranet broadcasting – during 2018/19 (CN / MD). • IP team to undertake sample audit of completion of paper RA with feedback to the Nurse in Charge in real time and a report to the Matron / Review all Infection Prevention policies with a one page 'at a glance' care bundle produced for each organism / Convert current paper patient Risk Assessment (RA) booklet to electronic format – during 2018/19 (CN).

DATE: April 2018	Director:	DPOD	Executive Board:	EWB	TB Sub Committee:	AC / PPPC
Linked Objective	We will have the right people with the right skills in the right numbers in order to deliver the most effective care					
BAF Principal Risk: 2 - workforce	If the Trust is unable to achieve and maintain staffing levels that meets service requirements, ***caused by employment market factors (such as availability and competition to recruit, retain and utilise a workforce with the necessary skills and experience), lack of extensive education, training and leadership, and demographic changes***, then it may result in poor clinical outcomes and experience, failure to achieve constitutional standards and increased staff workloads.				**Current Risk & Assurance Rating (I x L):**	**5 x 4 = 20**

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

Primary Controls

- Executive Workforce Board (meet Quarterly) – reports to Trust Board.
- People, Process and Performance Committee – Sub-committee of the Trust Board (meet monthly) – report to Trust Board.
- Local workforce Action Group – report to – Local Workforce Action Board – report to – LLR Senior Leadership Team.
- Leadership and people management policies, processes and professional support tools (including training & UHL Way tools).
- Temporary staffing approval and recruitment process with appropriate authorisation levels.
- Vacancy management and recruitment/ retention system and processes – i.e. TRAC system.
- Staff communication & engagement forums – *LiA events, Ask the Boss events, Freedom to Speak up forum, Insite staffroom forum.*
- Staff appraisal systems and people capability framework.
- Statutory & mandatory training system – i.e. HELM.
- Equality & Diversity Board, delivery plan, dedicated lead in place, and Equality Impact assessments undertaken for policy and procedure function.
- Defined safe medical and nurse staffing levels for all wards and departments.
- Medical Education Workforce Group & Medical Education and Training Committee – report to EWB (Quarterly).
- Embedded Medical Education Strategy to address specialty specific shortcomings.
- GMC 'Approval and Recognition' of Clinical and Educational Supervisors.
- Working with deanery and medical schools re medical staffing (gaps).
- CMG Performance Review/Assurance Meetings (Monthly).

Detective Risk Indicators

	Ref	Indicators	Red RAG/ Exception Report Threshold (ER)	Apr-18	18/19 YTD
Well Led	**W7**	**Friends & Family staff survey: % of staff who would recommend the trust as place to work (from Pulse Check)**	**TBC**	Awaiting update	
	W8	**Nursing Vacancies**	**Separate report submitted to QAC**	Awaiting update	
	W10	**Turnover Rate**	**Red = 11% or above ER = Red for 3 Consecutive Mths**	**8.5%**	**8.5%**
	W11	**Sickness absence (reported 1 month in arrears)**	**Red if >4% ER if 3 consecutive mths >4.0%**	Awaiting update	
	W12	**Temporary costs and overtime as a % of total paybill**	**TBC**	**11.0%**	**11.0%**
	W13	**% of Staff with Annual Appraisal (excluding facilities Services)**	**Red if <90% ER if 3 consecutive mths <90%**	**89.3%**	**89.3%**
	W14	**Statutory and Mandatory Training**	**TBC**	**89%**	**89%**
	W15	**% Corporate Induction attendance**	**Red if <90% ER if 3 consecutive mths <90%**	**96%**	**96%**
	W16	**BME % - Leadership (8A – Including Medical Consultants)**	**4% improvement on Qtr 1 baseline**	Awaiting update	
	W20	**DAY Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)**	**TBC**	**87.2%**	**87.2%**
	W22	**NIGHT Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)**	**TBC**	**93.5%**	**93.5%**

Internal Assurances	External Assurances	Gaps Identified & Pending Actions
• Workforce risks in CMGs recorded on organisational risk register – *35% of workforce risks relate to Medical, 53% relate to nursing.* • UHL Medical Education Survey - *415 junior doctors responded to the survey in 2018. 88% recommend UHL as a place to work, which is an improvement since March 2017 (83%).* • Monitoring agency spends and tracker through Premium Spend Group with EWB, EPB, PPPC oversight - *YTD month 12 – delivered against plan.* • Friends & Family staff survey 2017: *– 4808 returned a completed survey, giving a response rate of 34%, a decrease of 2.2% from 2016. Compared to the 2016 survey, in 2017 scored:* ➢ *Significantly BETTER on 3 questions* ➢ *Significantly WORSE on 4 questions* ➢ *The scores show no significant difference on 81 questions* • *57% of staff would recommend the trust as place to work (from Pulse Check – March 2018).* • Our latest national staff survey results for 2017 were not as good as the improving trend we saw in previous years. • CMG Performance Review / Assurance Meetings – *all CMGs reviewed during April and appropriate action plans developed and being monitored.*	• **Internal Audit 2018/19:** ➢ Diversity & gender pay gap – scheduled Q4 **–** to review adequacy of the actions being taken. ➢ Recruitment – scheduled Q4 **–** to audit safe staffing checks (are these happening properly and timely), fixed term contracts (and where there are contract extensions and end dates, is the monthly check working), timescales for time to hire KPIs. ➢ Induction of temporary staff (deferred from 2017/18) – scheduled TBA **–** review deferred from 2016/17 and 2017/18 due to delays with HELM and making the Green Book electronic. The review was originally included due to issues identified by CQC. Review to consider the adequacy of the checks being carried out by the Staff Bank team. • GMC visit report **–** *GMC survey results due in June 2018.* • HEEM quality management visits **-** *HEE re-visited Cardio-respiratory on May 4th 2018 to review progress against their action plan – formal report is awaited.* • Leicester Medical School feedback **–** *retention rate report awaited.* • Performance monitored by NIHR Central Commissioning Facility **–** *UHL are currently ranked 11th in league one and delivering 76% of trial to time and target (March 2018).* • East Midlands Clinical Research Network – *UHL remains the highest recruiting Trust within the East Midlands (March 2018).*	• We will develop a sustainable 5 year outline workforce plan by the end of Q1 18/19, with a delivery plan to reduce our nursing and medical vacancy rates and reduce time to hire. • We will launch our People Strategy in Q2 2018/19 to attract, recruit & retain a workforce that reflects our local communities across all levels of the Trust, with a specific focus on meeting the Workforce Race Equality Standards. • Improve levels of employment from distinct populations/ communities to all levels of the Trust e.g. MOD veterans, disabled people, women, BAME, LGBT so they are representative of LLR population. Targets for each to be agreed at first meeting of the new Diversity Board in June 2018. • Based on the feedback in the national staff survey, key themes to make improvements during 2018/19 are: o Making appraisals more meaningful o Treating our staff equally o Looking after UHL – health and well-being o Tackling behaviours • Creation of CT3/FY3 innovative posts in order to aide retention of Junior Doctors by providing greater training experience and reduced agency costs and improve out of hours cover. • Review of Undergraduate and Postgraduate medical education roles (including Educational Supervisors) to ensure identified time included in job plans.

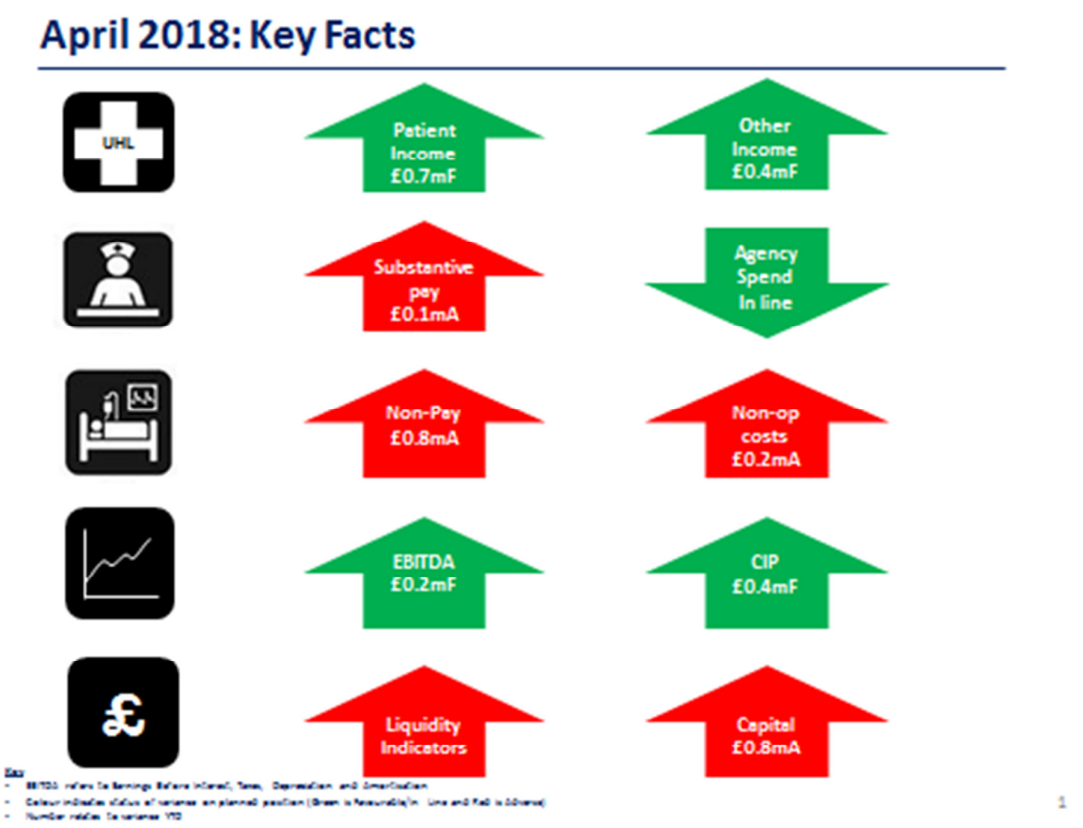
DATE: @ April 2018	Director:	CFO	Executive Board:	EPB	TB Sub Committee:	AC / FIC
Linked Objective	We will continue on our journey towards financial stability - deliver our target of £29.9m in 18/19					
BAF Principal Risk: 3 - Finance	If the Trust is unable to achieve and maintain financial sustainability, ***caused through delivery of income, the control of costs or the delivery of cost improvement plans***, then it will result in a failure to deliver the financial plan, leading to a loss of public and stakeholder confidence with the potential for regulatory action that may include financial special measures.				**Current Risk & Assurance Rating (I x L):**	**5 x 4 = 20**

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

Primary Controls

- Annual and long-term financial model describing a statement of income and expenditure, a statement of long and short term assets and liabilities (including capital expenditure) and a statement of cash flow.
- Working capital, capital loan, and internal capital funding arrangements.
- CIP Plans for CMGs and Corporate Depts.
- Finance Improvement and Technical planning processes and project management led coordination of delivery.
- Control Totals for CMGs and Corporate Depts.
- Appropriate level of investment supporting the resolution of the demand/capacity challenges.
- Financial governance and performance monitoring arrangements at Trust Board (FIC), Audit Committee, Executive (EPB), directorate and CMG service line levels.
- Cost pressures and service developments minimised and managed through RIC and CEO chaired 'Star Chamber'.
- NHS I performance review meetings including I&E submissions.
- Corporate Services review (in line with the requirements of the Carter report).
- Quality safeguards - to reduce expenditure are subject to Quality Impact Assessment – overseen by the COO, Medical Director, Chief Nurse & CFO.
- Commercial Strategy - to help exploit commercial opportunities available to the Trust.

Detective Risk Indicators



Internal Assurances	External Assurances	Gaps Identified & Pending Actions
• CFO's Financial Reports to EPB (monthly). Key issues considered at the meeting for month 1 relate to delivery of the planned deficit of £9.8m. The income position has over-preformed and a corresponding overspend within non-pay has been seen. The pay bill (both substantive and agency pay) is in-line with plan. Cost improvement plans have over-delivered against the month 1 plan although an element of the total annual requirement remains unidentified for future months. Capital expenditure has over-spent within the month but this relates to the acceleration of spend from month 2 and will not lead to an over-spend within the programme. Cash flow and deficit funding has been received in line with the submitted plan. • FIC Summary to Trust board (Monthly). Key issues are as described above and as reported to EPB. The Committee also reviewed the additional report detailing a more granular analysis of the Trust's cash position. • Capital Monitoring and Investment Committee (monthly). A detailed review of month 1 capital expenditure was reviewed with key variances explored in the context of the overall capital programme. • Revenue Investment Committee (monthly). The committee had a limited number of business cases for review. All actions are being progressed. • Update on the Commercial Strategy. The Trust Board, at a thinking day, agreed an approach to ensure successful delivery of year 2 of the commercial strategy. • Alliance Contract. This quarterly review was discussed and reviewed at the Executive Quality Board in May.	• **External Audit of Financial Systems 2018/19:** ➢ Work programme for 2018/19 to be reviewed and approved at the relevant meeting of the Audit Committee. • **Internal Audit 2018/19:** ➢ **Financial systems Q3** - financial systems controls work to meet the requirements of External Audit and to address specific risks identified by management. Work will include data analysis on specific areas of risk in order to identify trends/ anomalies and to direct our controls-based work. ➢ **Review of cost improvement programme Q2** - will review the adequacy of arrangements for delivery of the CIP and the robustness of planning for future years. • NHSI Carter Corporate Service review: **-** *Carter Target for back office cost to be no more than 6% of turnover by March 2020.* The Trust's Director of Efficiency and CIP is leading this initiative, as part of the overall review of Model Hospital, and engaging across the Corporate Teams to ensure robust plans are in place to achieve the 2020 target.	**Gap: Effectiveness of budget management and control at CMG and Corporate directorate levels.** **Actions:** 2018/19 planning requires the delivery of a deficit of £29.9m inclusive of a £51m CIP programme. Each CMG and Corporate Directorate has an allocated budget totalling £29.9m however due to the current work in progress with respect of demand and capacity modelling CMGs are yet to sign-off a fully phased month-by-month budgetary control position in line with the accountability framework. This process is forecast to be completed by the end of May 2018. There is currently a shortfall within the Cost Improvement Programme of £6m when compared to the target of £51m. Escalation meetings are in place to reduce this unidentified amount with fortnightly updates being presented to Executive Boards. There is a star chamber process (led by CEO) reviewing the new investment requirements. There is a significant shortfall in available funding compared to the complete list of investment requirements with the Star Chamber prioritising and approving spend. This process is forecast to be completed by the end of May 2018. The capital programme has been approved by Capital Monitoring and Investment Committee and further ratification by the Star Chamber in May. The relevant scheme holders are providing further analysis on a risk-based assessment detailing the potential risks due to the limited availability of capital funds. Cash flow and enhanced cash reporting continues to be reviewed and discussed at FIC. Cash for deficit funding has been received in line with planned levels. This planned level of cash excludes any additional working capital requirements that may be required.

DATE: @ April 2018	Director:	COO	Executive Board:	EPB	TB Sub Committee:	AC / QOC / PPPC
Linked Objective	We will improve our Emergency Care performance					
BAF Principal Risk: 4 – Emergency care	If the Trust is unable to effectively manage the emergency care pathway, ***caused by persistent unprecedented level of demand for services, primary care unable to provide the service required, ineffective resources to address patient flow, and fundamental process issues***, then it may result in widespread instances of reduced quality of care and experience for large number of patients and sustained failure to achieve constitutional standards, leading to increased financial penalties and possible breach of license.				**Current Risk & Assurance Rating (I x L):**	**5 x 4 = 20**

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

Primary Controls

- **Emergency management:**
  - Emergency care pathway;
  - 4 times daily operational command meeting;
  - Capacity Flow and escalation policy;
  - Robust escalation protocols including OPEL triggers, CMG triggers, Full Hospital Process, Breach process for 8, 10 & 12 hour occurrences;
  - LLR system calls daily to review the position and ensure whole system responsiveness;
  - NHSI reporting;
  - System support provided by the National Emergency Care Improvement Programme (ECIP).
  - Red to Green embedded in medicine and RRCV.
- **Forums to identify and implement changes:**
  - A&E Delivery Board and sub groups - system wide actions, chaired by UHL CEO.
  - Daily SCRUM meetings to ensure pace on actions in ED, medicine and RRCV.
  - Flow and Outflow board.
  - Winter planning forum.
  - Demand and capacity work streams including plans for the vital few.
  - Performance Review and Assurance arrangement between CMGs, Specialties and Executive Directors / Executive Team.
- **Emergency performance monitoring:**
  - 4 hour wait;
  - ED attendances;
  - Time to assessment;
  - Time to discharge;
  - Total breaches;
  - Emergency admissions;
  - Beds status.

Detective Risk Indicators

	Q&P Ref	Indicators	18/19 Target	18/19 Red RAG/ Exception Report Threshold (ER)	Apr-18	18/19 YTD
Responsive	R1	**ED 4 Hour Waits UHL**	**95% or above**	Red if <92% ER via ED TB report	**76.1%**	**76.1%**
	R2	**ED 4 Hour Waits UHL + LLR UCC (Type 3)**	**95% or above**	Red if <92% ER via ED TB report	**82.8%**	**82.8%**
	R3	**12 hour trolley waits in A&E**	**0**	Red if >0 ER via ED TB report	**0**	**0**
	R12	**% Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE**	**0.8% or below**	Red if >0.8% ER if >0.8%	**1.1%**	**1.1%**
	R14	**Delayed transfers of care**	**3.5% or below**	Red if >3.5% ER if Red for 3 consecutive mths	**1.6%**	**1.6%**
	R15	**Ambulance Handover >60 Mins (CAD+ from June 15)**	**0**	Red if >0 ER if Red for 3 consecutive mths	**4%**	**4%**
	R16	**Ambulance Handover >30 Mins and <60 mins (CAD+ from June 15)**	**0**	Red if >0 ER if Red for 3 consecutive mths	**8%**	**8%**

Internal Assurances	External Assurances	Gaps Identified & Pending Actions
• There remain significant nursing and medical staffing vacancies in ED and Specialist Medicine. This is a CMG board agenda item and there is a CMG recruitment plan to manage vacancies. Alternative skill mix models are being considered and have been implemented e.g. medical step down ward. • ED process: ➢ Time from arrival to decision to admit improved to 74% in April ➢ Bed request to allocation in 60 mins improved to 82.7% in April • DTOC: ➢ Remain below national average ➢ A system wide meeting took place in April to review themes and actions to enable further improvement • Acuity: ➢ Decrease in 80+ admission age ➢ Decrease in stranded and super stranded • Internal Action plans: ➢ Recovery action plan ➢ SCRUM action plan ➢ Winter plan • CMGs have a range of operational demand and capacity risks reported on the UHL Trust risk register which (for items scoring 15+) is reported to Exec Team and Trust Board monthly.	• NHSE national ranking official figures 124 – 96/137. • NHSE April data - 4 hour performance = 82.1 % (inc LLR). • AEDB fortnightly to manage system wide actions. • NHSI Escalation meetings to provide system wide assurance. • **Internal Audit 2018/19:** ➢ Discharge processes – Red to Green – scheduled Q2 - to review how effectively the Red to Green process is operating and how well embedded this is across the Trust.	• IT Booking systems for DHU and OOH. • Nerve centre embedding with teams to increase usability. • Red to Green in medicine and RRCV – gap in delivery in the rest of the organisation. • Significant bed gap – activity and demand planning and bridge for the gap is under development. • Variation in process in ED and on the wards – managed via the SCRUM's. • TASL resource flexibility – managed via CCG. • ESM nursing and medical staffing vacancies – managed by CMG Board. • DHU staffing gaps – managed through weekly meetings with CMG and DHU and through Executive presence in SCRUMS.

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

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

Primary Controls

- IM&T Paperless hospital 2020 strategy including Board structure and clinical leads in place.
- Overarching 18/19 IM&T strategic plan.
- Cyber security measures in place including regular assessments and close working relationship with managed business partner.
- Information Governance arrangements including IG toolkit, IG Steering Group and GDPR plan.
- Working arrangements aligned with clinical strategies through clinical and medical workforce information officers.
- Disaster Recover plans in place for IM&T systems.
- IM&T governance and performance monitoring through IM&T Service Board reporting to Trust Board (via FIC/PPPC), Audit Committee and Executive (EMI&T).
- IT Network providers early warning notifications monitored.

Detective Risk Indicators

Internal Assurances	External Assurances	Gaps Identified & Pending Actions
• Information Governance IG Toolkit reported to AC – All components of the IGT in relation to data quality were self-assessed as the highest level 3 for 2017-18 – UHL is a trusted organisation as defined in the IG Toolkit. With the move from IGT to the Data Security and Protection Toolkit from April 2018, specific requirements for management of Data Quality are still being finalised. We have contacts with NHS Digital as well as good connections across a network of peer Data Quality leads at other regional Trusts. • GDPR progress reported to Exec Team (EIM&T) and AC - Recruitment is underway for GDPR resources. • Paperless hospital 2020 strategy reported to Exec Team and to Trust Board sub-committees on a regular basis - The pace of achievement of the Paperless Hospital 2020 is dependent on available resources to effect the changes and prioritisation of other demands on IT services. • IM&T Capital Plan Briefing to PPPC.	• **Internal Audit 2018/19:** ➢ Information Governance – to perform validation work on the Information governance toolkit in line with the annual audit requirement – March 2018 – Medium Risk. ➢ Paperless 2020 programme review - following an initial review of EPR 'Plan B' a follow up to assess how the programme is progressing using a diagnostic 'Twelve elements of programme management excellence' – Audit review planned for17th May 2018. • ISO 27001:2013 – The MBP maintains an accreditation (in 2017) – due for review in Q1 2018/19. • NHS digital Health Check – cyber security audit – Jan 2018 – remediation plan agreed. • NHS IT Maturity Index – Results to be published during Q1 2018/19.	• **Investment resource** to finance the acceleration of the Trust's IT service including desktop replacement project – *Secure adequate resources to fund 18/19 IT strategy* – CIO to present update to EIM&T Board in May 2018. • **Paperless Hospital engagement** - *Deliver support to the quality commitment by identifying priority work that can be undertaken on existing systems, i.e. nervecentre or ICE. For 2018/19 will involve the following 5 areas:* ➢ *Replacing old computing/mobile hardware* ➢ *Nervecentre* ➢ *PACS* ➢ *ICE* ➢ *E-Prescribing* • **Information Governance plan** for implementation of **GDPR** – gap analysis by Internal Auditors identified there are a number of gaps with regard to the new regulation to commence in May 2018. Mitigating actions include the appointment of an interim GDPR project lead – CIO to lead – due Q1 2018/19. • **Cyber security** – raising awareness to reduce risk of **human factors** and on-going **medical equipment** challenges – IM&T awareness campaigns scheduled during Q2 2018/19. • **Disaster recovery plans** – effectiveness of **CMGs Business Continuity Plans** (following BIAs) to be monitored through UHL EPRR Board – due review and to agree timeframe for completion at EPRR Board in May 2018. • **Resources against service demand** – CMGs to prioritise IM&T work requests against their service constraints. • **Organisational change capacity** – CMGs to liaise with IM&T to agree IM&T support required to implement new IT programmes / systems. • **External IT supplier preparedness-** UHL to seek assurance from external providers about their system resilience arrangements. CIO to email CMGs HoOs to request they liaise with their external providers – Q1 2018/19.

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

Primary Controls	Detective Risk Indicators
• Estates & Facilities directorate governance structure to deliver effective estates and facilities services. • Estates Strategy - directs investment and resources how the Trust will maintain a fit for purpose estate that enables delivery of high quality, safe and effective care (in line with CQC core standards: Safety and suitability of premises; Safety, availability and suitability of equipment; Cleanliness and infection control), including Clinical Strategy priorities and the organisation's wider five year plan. • Prioritised Annual and Five-Year capital programme developed in consultation with CMGs and Trust Exec Team. • Statutory Compliance monitoring programme provides assurance that statutory obligations are met. The Compliance Assessment Audit System (CAAS) is used to monitor compliance rate. Implementation of Premises Assurance Model (PAM) dashboard reported to Exec Team. Independent Authorising Engineer reports to measure conformance against HTM / HBN guidance. • Estates & Facilities Risk Management Process – monthly multi-disciplinary Estates & Facilities Capital Risk Management Group review new and existing E&F risks prior to reporting for scrutiny to the E&F SMT. Significant risks are escalated to the UHL Risk Register, thus providing a consistent governance approach to monitoring and review in-line with the Trust risk plan. • Backlog Maintenance programme based on 6 Facet Condition Survey ensures highest identified risks are prioritised and considered for funding. • 24/7 reactive maintenance capability across all sites. • Infection Prevention and Control programme including policies / procedures; staff training; environmental cleaning audits and inspections. • Estates & Facilities Help Desk provides single focal point for all works requests.	• Key Estates & Facilities Performance Indicators: ➢ Model Hospital benchmark. ➢ Carter Indices. ➢ Naylor recommendations for E&F. ➢ Internal Cleaning audits performance.

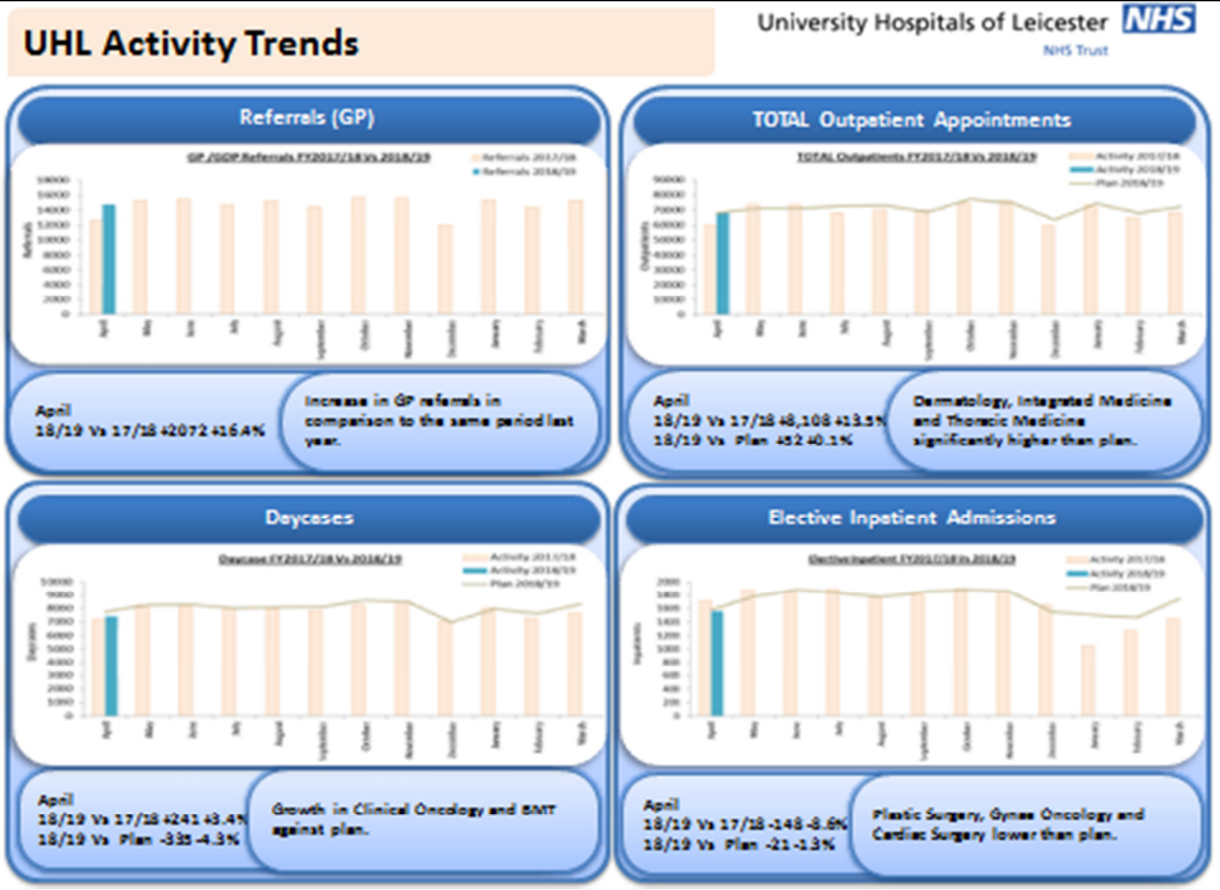
Internal Assurances	External Assurances	Gaps Identified & Pending Actions
• Risk Assessments identify significant risks reviewed by E&F Senior Management Team monthly, prior to being put onto the Trust Risk Register. Risks rated 15 or above are presented to Exec Team for review and scrutiny. • Risk action plans/action notes are generated and monitored and reviewed in accordance with Trust risk management policy.	• Backlog maintenance – reported in the ERIC return to the Department of Health and benchmarked against other NHS Trusts annually. Indicative capital programme tabled but not formally been signed off yet. Still being debated as part of the Star Chamber discussions. • Premises Assurance Model – current rating: 'Steady State'. • External audit for Piped Medical Gases carried out by an Independent Authorising Engineer, annually. • Electrical Low Voltage, High Voltage and Lifts audited by an Independent Authorising Engineer, annually. • Water audit carried out by an Independent Authorising Engineer, six monthly. • External audit for Specialist Ventilation carried out by an Independent Authorising Engineer, annually. • Patient-led Assessments of the Care Environment (PLACE) – Audit results will not be available until Q2 2018/19. • **Internal Audit 2017/18:** ➢ Backlog maintenance – Audit action plan and assurance monitored and reviewed at UHL Audit Committee. • **Internal Audit 2018/19:** ➢ Estates and Facilities – HR and payroll review scheduled Q1 - a detailed review of the key payroll and HR controls within Estates and Facilities. Specific risks have been flagged in this area following the transition from Interserve and due to the use of different systems / processes compared to the rest of the Trust. ➢ Capital Programme (TBC) - a review of the prioritisation process for developing the capital programme, how resources are allocated across the key areas and the monitoring / reporting around the programme.	• Insufficient funding allocated to fully implement the Sustainable Development Management Plan and reconfigure the estate in-line with clinical and estates strategy – to be reviewed by DEF (due Q1 18/19). • Develop a five-year backlog maintenance reduction programme and gain Trust Board backing and commitment – DEF (due 18/19). Trust has now appointed our supply chain partner, Galliford Try (GT). Discussion on going with GT M&E sub-contractors to undertake a review. • Detailed build-up of capital costs to provide an overall 5 year capital programme to ensure appropriate finances are allocated to implement the changes required. Incumbent upon GT work – to be reviewed by DEF (18/19). • LLR STP funding position to be confirmed by NHS Improvement and NHS England, which includes backlog and infrastructure investment – due 18/19. • Confirmation of planning assumptions and service model which will lead to refinements in the proposed design solutions – Further revision of the DCPs is underway for submission to appropriate NHS organisation. Draft capital bid due 22.06.2018; final bid due 16.07.2018. • Identify appropriate level of upgrade works; to be informed by the latest condition survey and linked to GT review - to be reviewed by DEF (18/19). • Ensure all key projects are taken through a rigorous business case process to ensure they deliver benefits based on the situation at the time of their development – reviewed by DEF and monitored monthly. • Recruitment and retention of key E&F staff challenges, resulting in gaps in service delivery and standards – reviewed by DEF and monitored monthly.

DATE: April 2018		Director:	DSC	Executive Board:	ESB	TB Sub Committee:	AC					
Linked Objective	To develop more integrated care in partnership with others											
BAF Principal Risk: 7 – Partnerships	If the Trust is unable to work collaboratively with partners to secure the support of our community and STP stakeholders, ***caused by breakdown of relationships amongst partners and ineffective clinical service strategies of the local population***, then it may result in disruption to transforming sustainable clinical services, leading to barriers to access local healthcare services, poor patient pathways and potential breach of contractual obligations.										**Current Risk & Assurance Rating (I x L):** **4 x 4 = 16**	
BAF Ratings	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**
Exec Team:	**4 x 4 = 16**											

Primary Controls

- Attendance and active participation in:
  - All STP work streams at senior strategic level and at operational level where relevant.
  - Health and wellbeing Boards across City and County.
  - Active engagement with primary care across city and county.
- Revised Trust objectives and annual priorities agreed for 2018/19.
- Frailty programme, AE Delivery Board and internal flow metrics.
- Active Clinical input and leadership across key STP work streams such as planned care, urgent care, Integrated Locality teams, and Home First.

Detective Risk Indicators



Internal Assurances	External Assurances	Gaps Identified & Pending Actions
• Internal self-assessment reviews about the efficacy of the controls for this risk have been reported to ESB; Stakeholder meetings; Trust Board sub-committees and have identified gaps in active participation in several related STP work streams - this will be rectified from May 2018.	• Review of the LLR STP has shown that this risk is not fully mitigated as assurance of efficacy of the partnership working is limited at this point. This tells us that the current governance processes are not yet fit for purpose and will not fully mitigate the risk as presented. • The work will be referenced in LLR escalation meetings with NHS England and NHS Improvement.	• A governance review is under way at LLR STP level – the Trust will feed in to this review robustly to ensure that relationships remain stable and the STP framework delivers the plans outlined – outcome of this review is planned for completion by the end of Q2 2018/19 through the STP programme. • Frailty/Home first/Integrated Locality Teams: ➢ The UHL internal frailty programme has begun to meet to deliver the internal requirements as per Trust priorities - to ensure delivery of a new model of care for frail patients by winter 18. ➢ External meeting structures and deliverables for frailty were agreed on May 17th 2018 at the Senior Leadership Team. The aim of the programme will be to have designed the system by July 2018, with key interventions implemented by Dec 2018. UHL CEO will chair this programme, with Head of Strategic Development as managerial lead. • Planned care: ➢ System wide LiA events for key specialties continue to take place. 5 have been completed so far, with working groups in place to inform transformed models of care for each specialty.

Appendix 2 - Risk Register Dashboard 15+

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Thematic Analysis of Risk Causation
2264	CHUGGS	If an effective solution for the nurse staffing shortages in CHUGGS at LGH and LRI is not found, then the safety and quality of care provided will be adversely impacted.	20	6	Workforce
3139	CHUGGS	If ageing decontamination equipment and poor general environment in Endoscopy where some equipment is cited is not improved, then the service may fail to meet national guidelines, resulting in a poor level of service for patients with the increased risk of harm to both patients and staff	20	3	Resource
3183	RRCV	If Cardiac Surgery is unable to operate on elective patients due to winter pressures and availability of ward and ITU beds, there is a risk that patients' conditions could deteriorate, resulting in a need for urgent admission or more complex surgery with greater risk of complications.	20	15	Demand & Capacity
3186	RRCV	If the CMG fails to achieve the allocated financial control total then this could result in an deterioration in the Trust overall financial deficit.	20	9	Finance
2354	RRCV	If the capacity of the Clinical Decisions Unit is not expanded to meet the increase in demand, then will continue to experience overcrowding resulting in potential harm to patients.	20	9	Demand & Capacity
2149	ESM	If we do not recruit and retain into the current Nursing vacancies within SM, then patient safety and quality of care may be compromised resulting in potential delayed care.	20	6	Workforce
2804	ESM	If the ongoing pressures in medical admissions continue, then Specialist Medicine CMG bed base will be insufficient thus resulting in outlying patients to other CMG's.	20	12	Demand & Capacity
3077	ESM	If there are delays in the availability of in-patient beds, then both Emergency Care performance and safety of patients within the Emergency Department at Leicester Royal Infirmary could be adversely affected, resulting in overcrowding in the Emergency Department and an inability to accept new patients from ambulances.	20	15	Demand & Capacity
3114	ITAPS	If we are unsuccessful in recruiting ITU medical and nursing staff to agreed establishment, then we are at risk of not being able to deliver a safe and effective service, resulting in delay in treatment to patients and deterioration in performance.	20	6	Workforce
3115	ITAPS	If there is an IT infrastructure failure or delay in accessing systems due to out of date and obsolete hardware and software in theatres and other clinical areas, then clinical teams will not be able to access essential patient information or imaging in a timely manner resulting in potential for patient harm.	20	4	IT
3120	ITAPS	If there is a continued mismatch between capacity and demand for access to emergency theatres we are at risk of cat 2 and 3 patients not receiving surgery within the NCEPOD timeframes and increased requirement for out of hours working with cases that should have been completed during day-time hours, and a knock on effect for the consultants on call and their next day working	20	12	Demand & Capacity
3122	ITAPS	If we are unsuccessful in controlling expenditure, finding efficiency savings and maximising income within ITAPS then the CMG is at risk of not achieving its set control total of £2,548k deficit and will under deliver further against the CIP	20	6	Finance
3200	ITAPS	NEW: If the practices, workforce, estate and facilities in LRI ITU are not compliant to current standards and expectations Caused by staffing shortages, inadequate capacity for demand and an aging estate with suboptimal environment for critical care patients Then clinical teams will not be able to provide safe care to all patients requiring level 2/3 care due to an increased risk of cross contamination	NEW 20	10	Process & Procedures
3113	ITAPS	If the infrastructure in our ITU's is not updated and expanded to meet current standards and demand, then clinical teams will not be able to provide safe care to all patients requiring level 2 or 3 care resulting in deterioration in clinical outcomes benchmarked against other centres (ICNARC).	20	8	Estates
3119	ITAPS	If there is a deterioration in our theatre staff vacancies and we are unsuccessful in recruiting ODP's to agreed establishment; then we are at risk of not being able to deliver a safe and effective service.	20	6	Workforce
2777	Comms	If fundraising targets for the Charity fundraising campaign does not reach target charitable income	20	8	Demand & Capacity
3054	HR	If the Trust's Statutory and Mandatory Training data can no longer be verified on the new Learning Management System, HELM, then it is not possible to confirm staff training compliance which could result in potential harm to patients, reputation impact, increased financial impact and non-compliance with agreed targets.	20	3	IT

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3172	IM & T	If systems and services provided by IM&T are not continuously maintained to ISO accredited standard, then our systems may be vulnerable to potential cyber attack resulting in in significant service disruption, harm to patients and financial loss	20	15	IT
3148	Corporate Nursing	If the Trust does not recruit the appropriate staff with the right skills in the right numbers then we may not be able to deliver safe, high quality, patient centred, efficient care and reduce our current nursing vacancy levels resulting in potential increased clinical risk to our patients and poor patient experience	20	12	Workforce
2404	Corporate Nursing	If the process for identifying patients with a centrally placed vascular access (CVAD) device within the trust are not robust, then this could result in increased morbidity and mortality.	20	16	Resource
2566	CHUGGS	If the range of Toshiba Aquilion CT scanners are not upgraded, Then patients will experience delays with their treatment planning process.	16	1	Resource
3176	RRCV	If the current shortfall in nursing staff vacancies in RRCV is not addressed, then this will affect the ability to achieve appropriate Nurse to Patient ratio, resulting in increased clinical risk to our patients and poor patient experience	16	12	Workforce
3181	RRCV	If the Prescribing Administration and Monitoring of Oxygen in Adults (B27/2010) Policy is to be adhered to, Then the e-obs system settings must be adjustable for Cardio-Respiratory patients, Resulting in in improved patient care or chronic hypoxic conditions and for patients who do not have Type 2 respiratory failure.	16	6	Process & Procedures
3040	RRCV	If there are insufficient medical trainees in Cardiology, then there may be an imbalance between service and education demands resulting in the inability to cover rotas and deliver safe, high quality patient care.	16	9	Workforce
2820	RRCV	If a timely VTE risk assessments is not undertaken on admission to CDU, then we will be breach of NICE CCG92 guidelines resulting patients being placed at risk of harm.	16	3	Process & Procedures
3198	ESM	NEW: If there is a Failure to administer insulin safely and monitor blood glucose levels accurately, in accordance with any prescriber's instructions and at suitable times then this may lead to patients not having their diabetes appropriately monitored/managed resulting in a risk of prolonged length of stay, severe harm	NEW 16	4	Process & Procedures
3088	ESM	If non-compliant with national and local standards in Dermatology with relation to Safer Surgery checking processes, then patients may be exposed to an increased risk of potential harm.	16	6	Process & Procedures
3025	ESM	If there continues to be high levels of nursing vacancies and issue with nursing skill mix across Emergency Medicine, then quality and safety of patient care could be compromised.	16	4	Workforce
2388	ESM	There is risk of delivering a poor and potentially unsafe service to patients awaiting MH admission &/or further MH assessment.	16	6	Demand & Capacity
3044	ESM	If under achievement against key Infectious Disease CQUIN Triggers (Hepatitis C Virus), then income will be affected.	16	8	Demand & Capacity
3121	ITAPS	If operating theatres' ventilation systems fail due to lack of maintenance, then the affected theatres cannot be used to provide patient care resulting in reduced theatre capacity and pressure on other theatres to meet demand and may lead to patient cancellations	16	9	Estates
2333	ITAPS	If we do not recruit into the Paediatric Cardiac Anaesthetic vacancies, then we will not be able to maintain a WTD compliant rota resulting in service disruption.	16	8	Workforce
2191	MSK & SS	If workforce constraints within the ophthalmology service are not addressed, then backlogs and delays could result in serious patient harm.	16	8	Demand & Capacity
3133	MSK & SS	If non compliant with MHRA guidance on the follow up of metal-on-metal (MoM) hip replacements, Then patients may be placed at risk of harm due to a lack of timely detection and intervention.	16	8	Process & Procedures
2989	MSK & SS	If we do not recruit into the Trauma Wards nursing vacancies, then patient safety and quality of care will be placed at risk	16	4	Workforce
2955	CSI	If system faults attributed to EMRAD are not expediently resolved, then we will continue to expose patients to the risk of harm	16	4	IT

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3128	CSI	If undated blood components previously issued (2015 to 2017) are not evidenced then BSQR 2005 legal requirement of 100% traceability will not be met resulting in regulatory implications and delay in providing blood and blood components.	16	4	Process & Procedures
3129	CSI	If a 100% traceability (end fate) of blood components is not determined Then BSQR 2005 legal requirement of 100% traceability will not be met Resulting in legal implications and delay in providing blood and blood components	16	4	Process & Procedures
2673	CSI	If the bid for the National Genetics reconfiguration is not successful then there will be a financial risk to the Trust resulting in the loss of the Cytogenetics service	16	8	Demand & Capacity
2378	CSI	If we do not recruit, up skill and retain staff into the Pharmacy workforce, then the service will not meet increasing demands resulting in reduced staff presence on wards or clinics.	16	8	Workforce
3118	CSI	If there is a lack of planned IT hardware replacement then this will result in high levels of non-functioning/ non-repairable ePMA COWs Resulting in Nursing staff being non-compliant with requirements of both NMC and Leicestershire Medicines Code because the Computers on Wheels (COWS) will be unable to be taken to the bedside of the patient for drug administration.	16	1	IT
2916	CSI	If blood samples are mislabelled, caused by problems with ICE printers and human error with not appropriately checking the correct label is attached to the correct sample, then we may expose patients to unnecessary harm.	16	6	IT
3008	W&C	If the paediatric retrieval and repatriation teams are delayed mobilising to critically ill children due to inadequately commissioned & funded provision of a dedicated ambulance service, then this will result in failure to meet NHS England standards, delayed care, potential harm and inability to free-up PICU capacity.	16	5	Demand & Capacity
2153	W&C	If the high number of vacancies of qualified nurses working in the Children's Hospital is not addressed, then there will be a shortfall in the nurse to patient ratio which could impact on the quality of patient care.	16	8	Workforce
2237	Corporate Medical	If a standardised process for requesting and reporting inpatient and outpatient diagnostic tests is not implemented, then the timely review of diagnostic tests will not occur.	16	8	Process & Procedures
3138	Estates & Facilities	If there are insufficient Management controls in place to meet Regulation 4 of the Control of Asbestos Regulations (CAR) then there is an increased risk of enforcement action by the HSE resulting in prosecution, and/or significant financial impact and reputational damage.	16 ↑	4	Process & Procedures
3140	Estates & Facilities	If sufficient 'downtime' for Planned Preventative Maintenance (PPM) and corrective maintenance is not scheduled into the theatre annual programmes, functional defects will emerge and evolve in specialist ventilation systems, potentially increasing the risk of microbiological contamination in the theatre environment.	16 ↑	8	Demand & Capacity
3141	Estates & Facilities	If the integrity of compartmentation is compromised then during a real fire event the rate of fire and/or smoke spread will accelerate resulting in a greater impact to the building occupiers. The ability to utilise horizontal and/or vertical evacuation will be limited and the potential exists for a greeted loss of areas / beds until the fire and resultant damage is contained.	16 ↑	8	Resource
3143	Estates & Facilities	If sufficient capital funding is not committed to reduce backlog maintenance across the estate there will be an increasing risk of key/critical failures in buildings, building services and infrastructure impacting on service provision and patient care.	16	6	Finance
3144	Estates & Facilities	If Estates & Facilities are unable to recruit and retain staff, or fund posts to deliver services to meet the Trust's expectations. Then there is a risk of a service delays and interruption/failure to achieve required standards Resulting in adverse impacts to patient non-clinical services, environment, equipment and infrastructure.	16	9	Workforce
3145	Estates & Facilities	If there is not a significant investment to upgrade electrical infrastructure across the UHL there will be an increased risk of a loss of 'normal' electrical supply and potential failures in generator stand-by electrical supply. Then interruption to patient care, key electrical equipment, and provision of normal patient care and support services resulting in adverse impacts to patient care and non-clinical services.	16 ↑	6	Finance

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3137	Estates & Facilities	If calls made to the Switchboard via '2222' are not recorded, then there is a risk that vital/critical information passed verbally between caller and call handler cannot be verify if the emergency response is not appropriate for the reported situation.	16	4	Process & Procedures
3174	HR	If UHL does not enrol and support the needs of our new apprentices from new recruitment or existing post holders by March 2018, then it will not meet the statutory obligation in line with the Enterprise Act 2016, resulting in a financial loss to the Trust.	16	1	Workforce
3180	IM & T	If fragility in the underlying UHL IM&T infrastructure is not addressed, then there may be limited or no access to Trust IM&T critical systems, resulting in service disruption and impacting provision of care	16	6	IT
3191	IM & T	If the Trust is unable to demonstrate 95% compliance with IG training, then the Trust may lose level 2 IG accreditation, resulting in potential loss of research status and difficulties with forging future collaborative working arrangements with prospective business partners which could adversely impact on the delivering strategic aims.	16	12	IT
3192	IM & T	If GDPR is not effectively implemented, then the Trust will be unable to demonstrate compliance resulting in potential enforcement action from the ICO and reputational damage	16	12	IT
3155	IM & T	If the PABX system fails then the telephone system will not work for a range of telephone numbers resulting in significant service disruption and potential patient harm.	16	4	IT
2621	CHUGGS	If recruitment and retention to vacancies on Ward 22 at the LRI does not occur, then patients may be exposed to harm due to poor skill mix on the Ward.	15	6	Workforce
3027	CHUGGS	If the UHL adult haemoglobinopathy service is not adequately resourced, then it will not function at its commissioned level	15	4	Workforce
3047	RRCV	If the service provisions for vascular access at GH are not adequately resourced to meet demands, then patients will experience significant delays for a PICC resulting in potential harm.	15	6	Demand & Capacity
3041	RRCV	If there are insufficient cardiac physiologists then it could result in increased waiting times for electrophysiology procedures and elective cardiology procedures	15	8	Workforce
3043	RRCV	If there is insufficient cardiac physiologists then it could result in reduced echo capacity resulting in diagnostics not being performed in a timely manner	15	6	Workforce
2837	ESM	If migration to an automated results monitoring system is not introduced, Then follow-up actions for patients with multiple sclerosis maybe delayed resulting in potential harm.	15	2	IT
2973	CSI	If the service delivery model for Adult Gastroenterology Medicine patients is not appropriately resourced, then the quality of care provided by nutrition and dietetic service will be suboptimal resulting in potential harm to patients.	15	6	Workforce
2787	CSI	If we do not implement the EDRM project across UHL which has caused wide scale recruitment and retention issues then medical records services will continue to provide a suboptimal service which will impact on the patients treatment pathway.	15	4	IT
2965	CSI	If we do not address Windsor pharmacy storage demands, then we may compromise clinical care and breach statutory duties	15	6	Estates
2601	W&C	If the vacancies in the gynaecology services are not addressed, then there will be backlogs with typing patient correspondence, resulting in delays with patients receiving appointment letters and results	15	6	Workforce
3023	W&C	There is a risk that the split site Maternity configuration leads to impaired quality of Maternity services at the LGH site	15	6	Workforce
3093	W&C	If there is insufficient Midwifery establishment to achieve the recommended Midwife to Birth ratio, in view of increased clinical acuity, then patient care may be delayed resulting in potential increase in maternal and fetal morbidity and mortality rates	15	6	Workforce
3083	W&C	If gaps on the Junior Doctor rota are not filled then there may not ne enough junior doctors to staff the Neonatal Units at LRI	15	3	Workforce

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3084	W&C	If there continues to be insufficient Neonatal Consultant cover to run 2 clinical sites, then it could impact on service provision resulting in potential for suboptimal care to the babies on the units at LRI & LGH.	15	5	Workforce
2394	Comms	If a service agreement to support the image storage software used for Clinical Photography is not in place, then we will not be able access clinical images in the event of a system failure.	15	3	IT
3079	Corporate Medical	If there is insufficient capacity with the administrative support for the Learning from Deaths Framework and the Specialty M&M Structured Judgment Review process is not addressed and substantive funding identified for an additional Bereavement Support Nurses, then this will lead to a delay with screening all deaths and undertaking Structured Judgment Reviews, resulting in failure to learn from deaths in a timely manner and non-compliance with the internal QC and external NHS England and Statutory Quality Account requirements	15	6	Workforce
2434	IM & T	If computers operating on Windows XP are not upgraded, then we may experience significant service disruptions in the event of a cyber attack.	15	6	IT
1615	IM & T	If flooding occurs at the LRI, then the Servers and Network equipment's in our Data Centre may become damaged resulting in Trust-wide service disruption and potential harm to patients.	15	6	IT